SUICIDE IN IRELAND 2003-2008

Kevin M. Malone MD, FRCPI, FRCPsych

Foreword

Suicide is the leading cause of death for young men in Ireland. Whilst we have made great strides in research into such conditions as diabetes, heart disease and cancer - research into suicide in Ireland is scarce. Without knowledge, it is impossible to make progress and suicide persists unabated in the Irish knowledge gap. 3Ts (Turn The Tide of Suicide) is a registered charity founded in 2003 to raise awareness of the problem of suicide in Ireland and to raise funds to help lower suicide rates through support for dedicated research, education, intervention and prevention.

Our goal is to move out of the knowledge vacuum that fuels the stigma of suicide, and to move beyond awareness to knowledge and sustained and integrated action. We want Ireland to become the best at beating suicide and to foster leadership by example, rather than remaining defeated in the shadows.

We are passionate about finding a way to help reduce the incidence of Suicide in Ireland. 3Ts was the first group to call upon the Irish Government for the formation of a dedicated Suicide Prevention Authority, akin to the Road Safety Authority. We believe that only a Suicide Prevention Authority can deliver an effective solution.

We do acknowledge that there is positive work being done but we need to build upon that work in a systematic way.

I am very pleased to introduce this timely independent research report into suicide in Ireland, which has been undertaken by Prof Kevin Malone and his team at UCD. This is the most comprehensive programme of research to date into suicide in Ireland, which includes a systematic tracing of suicide around Ireland, assisted by the testimony of suicide bereaved families. It has a particular focus on suicide in Youths and Young Adults, where the bulge in Irish suicide statistics is observed.

The research results are both enlightening and challenging for our understanding of suicide in Irish society at many levels, and we - Society and Government - must sit up and take notice. We must understand more about our "teens in trouble" and we must ensure that they are not 'let down' at any level. Our systems and processes cannot be allowed to make matters worse for them, and we must learn from this.

If this requires mandatory training for all statutory services who engage with them at any level, so be it. We must conduct the necessary analyses to assess the gaps in our mental health literacy education and our responses to young people in mental distress. Toxic humiliation and polyvictimization are new terms that we must learn about and understand, particularly in the context of bullying, assaults and muggings. We must also understand more about "milestones to manhood", eloquently exposed in the "Many Young Men of twenty" project included in this report.

The families in this project 'have spoken' about their experiences of the interface with statutory services during a suicidal crisis, and in the aftermath of a suicide death. Their voice must be balanced against the professional and courageous efforts of so many of our 1st responders. But the response must be of a high quality throughout the land to afford best suicide intervention and prevention efforts. Training and sustained support at all levels will be required to ensure that this goal is reached. Effective and sensitive communication is essential by all statutory agencies with bereaved families in both the immediate aftermath of a suicide death, and also in the longer term.

This includes all 1st responders, coroners and healthcare professionals. The proposal for a "confidential inquiry" approach could bring about a positive change to the prevailing defensive healthcare position which needs to change.

The *Lived Lives* project is a unique Irish endeavour with universal humanitarian potential, and has the capacity to instil healing and hope, as well as engaging society in a deeper and durational conversation around suicide in our modern society.

We have made dramatic inroads into what used be described as "the carnage on our roads", where we have seen young male driving deaths reduced by 50%, and it has not been attained by accident. Surely this model can be embraced in our fight against suicide and a dedicated Suicide Prevention Authority can finally begin to turn the tide of suicide.

Noel Smyth
Chairman, 3Ts

To find out more about 3Ts, please visit www.3ts.ie.

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Table of Contents

"Family everything, Love Ye, Don't be worrying about me, Im fine xxx xxx Love Always"

Executive Summary: Overview

The Suicide in Ireland Survey set out to contribute new knowledge and understanding to the problem of elevated Irish youth suicide rates over the past 2 decades. The project was designed to inform national and international suicide research, as well as policy makers and clinicians. The project was imbedded in communities, and its roots can be traced to the kitchen tables of Ireland, where most of the research engagements for the descriptive case study happened.

The research team overcame many of the obstacles inherent in such a project, and viewed obstacles as challenges to be embraced, and this model has proved invaluable in bringing the study to fruition.

The project was conceptualised in 2002, and took 3 years to secure the necessary funding, assemble the project team, develop the project design and bring it to the starting line in 2006. 104 families from around Ireland were interviewed between 2006 - 2009, about their knowledge and experience of the lives of their loved ones lost to suicide in 2003-2008. Data analysis commenced in 2010. Such a project can and will most likely produce many findings of interest over time, as the analysis will continue beyond this report. This report describes the study background, methodology, design, data management and analysis challenges. Varying methodologies were employed, ranging from a descriptive case study approach to epidemiological analyses of national and international data. The report focusses on bringing new findings into the public domain, that may have implications not just for Irish suicide prevention efforts, but which may also be transferable to other countries and communities. The Report has a particular focus on young people. The results are summarized below, together with conclusions and recommendations.

Results

I. *"Many Young Men of Twenty said Goodbye"*
Recruitment into the Suicide in Ireland Survey was organic and non-prescriptive, described as a "volunteer sample". Like any recruitment technique, such a method has its strengths, limitations and weaknesses, but it proved fruitful in hindsight, as it provided access to "intuitive lay knowledge" in several domains of interest, including age factor for suicide risk (Malone et al 2012). Using this "intuitive lay knowledge", we pursued this line of enquiry in relation to age of risk into the national datasets of Ireland and the UK for all 11,964 suicide and undetermined deaths under 35 years between 2000-2006. We identified that there was an accelerated and highly significant four-fold rate of increased risk in males between aged 16 to aged 20, compared to after the age of 20 (from aged 21) (113.1 vs. 28.2 cases per year). A similar non-significant almost two-fold trend was noted for females (12.7 vs. 7.4 cases per year). As such, this discovery, which we have incorporated under the banner of the John B Keane Play *"Many Young Men of Twenty said Goodbye"*, identifies a previously un-reported age-dependent epidemiological transition for suicide.

II. Suicide in the Children of Ireland:
(i) An epidemiological Study 1993-2008
Following on from our inclusion of many families who had lost a child under 18 years to suicide, we undertook an epidemiological analysis of Suicide in the Children of Ireland over 2 decades (1993 - 2008), where we identified an increase in both male (9.3 - 13.5/100,000) and female (2.4 - 5.1/100,000) suicide rates (Malone et al, 2012). In human terms currently, although based on small numbers which vary annually, this translates into the death of a child (under aged 18) by suicide in Ireland every 18 days.

(ii) Suicide in the Children of Ireland: A Mixed Methods Approach
Psychological Autopsy methods are quantitative in nature and do not lend themselves to a discovery of the "meaning" behind suicide deaths. The study design (particularly the recording of and open narrative account of the lived life lost to suicide as recounted by family/next of kin) permitted a qualitative analysis approach, which we have described in more detail elsewhere (O'Loughlin et al, 2012). Mental distress, humiliation and violation emerged from the data as psychological and relational vectors in the suicide process. Connectivity and displacement also featured as possible mediators and modifiers of this process. A novel "teens-in-trouble/troubled teens" conceptual paradigm emerged intuitively from the research process, which may contribute nuanced insights into the suicide process in children and adolescents. It could potentially inform more tailored approaches to suicide intervention policy and practice, and is worthy of further research. The aftermath of a child suicide also fosters suicidal currents both within the bereaved family as well as peers and community, where media influences can take hold.

III. Suicide in Young Adults and across the Life cycle
"Family everything, Love Ye, Don't be worrying about me, Im fine xxx xxx Love Always"
Whilst several dozen psychological autopsy studies of young adults have previously been conducted internationally, not all studies have utilized a mixed methods analytic approach we utilized. This method facilitated quantitative descriptive exploration of known risk factors identified in previous studies, as well as conducting searching new analyses on social networks. (A case-control study including suicide non-attempters and suicide attempters from the INSURE Dataset together with suicide completer data from the Suicide in Ireland Survey dataset will be reported on later.) Possible contributory factors included domains such as Demographics, Mental Illness, Alcohol and Substance misuse, presence and intensity of negative life events including abuse, bullying, assaults and muggings. Like in our children's study, humiliation was at the fulcrum of these events. The study method permitted the identification of the previously un-described phenomenon of "suicide couplets / dyads" as well as "clusters", particularly amongst younger people, which we describe.

Statutory Services before and after a suicide death are reflected in a frequently unfavourable light by the research participants in this study. Health services and mental health services in particular are reported as negative or very negative by 66% of those who experienced such services. Justice and Education also rate poorly in several instances, with Justice being scored as negative by almost 20% of respondents in the aftermath of a suicide death, especially around effective and senstitive communication.

IV. Lived Lives - An Integrated Science / Arts Conversation and Journey through Suicide in Ireland *"my son is not a statistic, he was a human being"*:

A unique Visual Arts Autopsy Study was incorporated into the Suicide in Ireland Survey, to create an integrated Science Arts research platform. This ground-breaking Project is described in detail in *Lived Lives: Materializing Stories of Young Suicide 2003-2008* (McGuinness S, 2010). The death and loss of a loved one by suicide is excruciatingly painful for family and friends. Irish society has traditionally viewed such a death as criminal or evil or both, casting the bereaved experience as one of stigma and shame. Quickly, the deceased becomes defined by the manner of the death, moving from subject to object, and the lived life is reduced to a statistic, eclipsing the humanity which is at the core of each existence. *Lived Lives: Materializing Stories of Young Suicide 2003-2008*, sought to re-instate or "re-humanize" the subject in a death by suicide by working with suicide-bereaved families to learn more about the lived life of their loved ones lost to suicide. This culminated in a conversation and journey with artist, scientist and bereaved families, which led to the creation of artworks from images of and belongings associated with the suicide-deceased, reflecting the lived life. Family and public engagement with the artworks opened up a space for dialogue, catharsis and reflection. This project has received international acclaim (London, Chicago, Portugal, Italy, China).

The images contained throughout this report have been donated to this publication by the *Lived Lives* Creative Arts Project, and reflect the enduring research journey from the anonymity of cold dry national suicide statistics and abstract art depictions of suicide in Ireland to a living Arts / Science collaboration with suicide-bereaved families portraying Lived Lives lost to suicide.

"My son is not a statistic, he was a human being"

Conclusions

The epidemiological transition finding in relation to youth suicide is new to the field locally and internationally, and it has implications in relation to the wisdom of only reporting suicide statistics in 5-year age bands, the practice of which eclipsed the age-finding we have identified. It could be argued that existing suicide intervention and prevention programmes in Ireland and the UK may be "missing the boat" by not focussing highly specific attention (x 4) on the period of accelerated and greatest increase in year on year age of risk as identified in our study, namely 16-20 year-olds. A wave of young people is currently moving through Irish society where suicide rates amongst their peers have increased substantially from those of their parents. Not only is suicide likely to remain the leading cause of death in these children in the next decade, suicide will also be the leading cause of peer bereavement, with implications for tailored age and sex-specific psycho-education and bereavement support, especially for boys. As this age of risk corresponds in great measure with school teen-years, it is time for a national analysis of psycho-education (especially mental health literacy) and intervention strategies for young people. Our data suggest that communication of suicidal feelings occurs more frequently than not at peer level. This finding adds to the literature suggesting that such disclosure is occurring in a mental health literacy gap that is inclined to normalise the receipt of such information. This gap in knowledge and understanding requires a national educational response, probably from mid-childhood, as it is likely that suicidality emerges in early adolescence, manifesting itself in overtly suicidal acts towards the mid to later teens. Other countries are advocating screening for depression in children and adolescents. This up-stream approach to intervention and prevention should be considered as a possible public health mechanism to reduce morbidity and mortality from depression in Irish children.

An in-depth path analysis, needs analysis and gap analysis of care provision of supports for the "troubled-teen" and the "teen-in-trouble" as we have identified, would represent an important step in informing the most comprehensive, advanced, standardised and quality just-for-you / just-in-time responses, bearing in mind that some children are outside the school system by early to mid-teens.

In this regard, and given the research findings in relation to statutory services, it is of paramount importance that any and all statutory agencies are trained to respond appropriately, supportively and positively to such teens in all instances and in any setting, and under no circumstances can they afford to make matters worse. The same principle applies in the post-vention light of a suicide death. Mental health services in particular should consider a national review of management of the suicidal patient, because our data suggest that the standard of this response is widely variable. The findings also strongly support the notion of establishing a confidential inquiry approach (as per UK) to overcome the defensive / adversarial-type position adopted by many mental health services in the aftermath of a suicide death. Any post-suicide contact between families and mental health services providers was the exception rather than the norm, and the event was more typically initiated by families. Effective and sensitive communication between all statutory services and families in both the immediate and later aftermath is of paramount importance.

The increased rates of suicide we identified in children, as well as our findings from the qualitative study have indicated that future suicide prevention programmes will need to be revised and tailored to address the needs of this age group more specifically. Children should be written into the National Suicide Prevention Strategy. Research projects will need to be conducted (a) to capture new knowledge and understanding of risks for 16-20 year-olds, perhaps incorporating studies of milestones to manhood, and (b) to focus on factors associated with reaching aged 21 being a relative protective factor, as suggested by our findings.

The psychological descriptive case study component of the psychobiographical autopsy method yielded similar results that are typically seen in other such studies internationally. Mental illness in general and depression in particular is a significant factor in youth and young adult suicide. Our data also suggest that un-treated, partially treated and inappropriately treated mental illness (eg children in adult mental health hospitals) is over-represented, and supports the call for national suicidal depression screening (Brunstein et al, 2007, Gould et al, 2005, 2009), and an acceleration in the development of Child and Adolescent Mental Health Services nationally. Alcohol is undoubtedly a factor, being evident in 50% of cases studied. Many of the suicide deaths did not however have any alcohol in their system at death, and in 50% of cases, alcohol or substance abuse was not a factor immediately preceding death. 40% of our cases had made a prior suicide attempt (consistent with international studies). Whilst intervention and prevention efforts focus on suicide attempters (most of whom will not die by suicide), future research should also focus on 1st attempt suicide completers about whom we know precious little.

As is typically seen in other such suicide studies, our cases experienced a significant number (and intensity) of life events in the 6 months prior to death, including such events as bereavement, relocation, relationship break-up, and in the cases of our younger cases, bullying (both inside and outside the school environment) and / or having been assaulted was also evident in excess. In this regard, the psychological toxicity of humiliation in adolescence and early adulthood is worthy of further research.

We have clearly identified that suicide clusters occur around Ireland, and younger people, particularly under aged 18 appear to be vulnerable to this phenomenon. We were not able to assess what factors ignite, sustain or extinguish clusters, and this should be addressed in future studies of suicide in young people. A tribal culture, and a male tribal sub-culture has been identified in other communities sensitive to cluster effects, and this conceptualization warrants further research. Additionally, further research attention should be afforded the social and community impact of repatriated Irish suicide deaths (particularly from USA), as they do not feature in "official" Irish statistics, but nevertheless impact on Irish society. Several studies in other countries have highlighted the role that media influences may contribute to clusters. This has not been adequately studied in Ireland to date but should be considered. More research should focus on understanding "suicide couplets / dyads", 15 of which were identified in our study. As such, this phenomenon has not been previously reported. Efforts to identify such a phenomenon could possibly yield a dividend in terms of modifying suicide rates, as intervention and prevention efforts could be more concentrated on close associates / confidantes of a suicide death in the weeks and months following such an event. Ireland needs a national real-time database for teen and young adult suicide deaths to facilitate the early detection of evolving clusters. Such a complete system is not currently in place, so the monitoring system default mode is either one of partial knowledge or one of catch-up - a model which confounds comprehensive planning and response.

The *Lived Lives* Project is unique to both the fields of science and humanities research. Although not the exclusive focus of this report, a synopsis is included, as the design and methods were embedded in the Suicide in Ireland Survey. The images of *Lived Lives* artworks contributed to this Report by the artist Dr. Seamus McGuinness in collaboration with some of the suicide-bereaved families who participated in the Suicide in Ireland Survey are both profoundly simple and simply profound. Some of the early *Lived Lives* outputs have been described elsewhere as "equally powerful as they are troubling". *Lived Lives* is an example of an integrated collaboration in socially engaged art practice exploring a particular recess in humanity including pain and loss, and it has attracted interest and acclaim internationally. It's potential value to Ireland requires evaluation.

Based on the Survey findings, priority consideration should be given to:

Troubled Teen and Teen-in-Trouble: A gap, path and needs analysis of mental health and psychological supports for teens and young adults in Ireland which includes the troubled teen and the teen-in-trouble, with a focus on developing a modern understanding and tailored response to mental distress, victimization exposure and humiliation in school and beyond school.

Mental Health Literacy: A national review of psycho-education and mental health literacy and a bringing-forward / upstream intensive and evaluated approach to suicide intervention and prevention in Ireland into and beyond schools and into community in early teens.

Depression Screening: An early detection Adolescent Depression Screening programme should be considered , with resourced standardised pathways to care.

Real-time monitoring of suicide: Establishing a real-time monitoring of teen and young adult suicide in Ireland, to bring our latest knowledge of patterns of suicide into the present, with a particular focus on a greater understanding of suicide clusters in young people, and how best to modify them.

Violence and Muggings: Greater awareness of the psychological impact of violence and muggings on teens, including toxic humiliation, and the development and evaluation of effective psychological interventions.

Statutory standards: Mandatory upskilling and monitoring of all workers in statutory authority who interface with young people to eliminate the possibility of bullying / victimization or humiliation of young people by such authorities, with transparent disciplinary action for any such involvement. This requires a non-partisan cross-Departmental, integrated initiative particularly from Health, Education and Justice especially refined to address intervention as well as effective and sensitive communication during the immediate and longer term post-vention period.

Confidential inquiry: A confidential-type health / statutory services inquiry in the aftermath of any statutory services associated suicide death to overcome the defensive / adversarial position currently observed, and to gather new knowledge and understanding.

Alcohol: A deeper understanding of the role and culture of alcohol and its consumption in teens and young adults , particularly around the notion of "regretted disclosure" of suicidal thoughts to peers.

Research: A commitment to support (and fund) sustained research into suicidal activity including suicide in Irish teens and young adults. This needs to keep pace with the pace of change in 21st Century Ireland and should include: a modified Suicide Survey (as described above) approach for annual investigation of the phenomenon of Suicide in Children, also using the UK National Confidential Inquiry into Suicide approach. This should include both quantitative and qualitative approaches as we have described.

Further research (outside the alcohol industry) is warranted on alcohol habits within Irish culture, to further explore the phenomenon of "regretted disclosure", which could provide a pathway for suicide intervention or prevention.

Further research is required to better understand the Ageing towards 21 finding we have identified - both from the perspective of being a risk factor, and the concept of being a relative protective factor upon reaching aged 21. This finding may or may not be culture, community or country-specific.

A research study into social and community impacts of repatriated young Irish suicide deaths.

A research study into suicide deaths in older people, and the rural urban divide.

A research study into suicide in severely disadvantaged and marginalised communities.A National Coroners study and suicide database.

Lived Lives. The response and feedback nationally and internationally to the integrated Science / Arts *Lived Lives* project suggests that it has potential to provide a sensitive platform for mourning and loss around suicide, and perhaps healing. Critical evaluation should be pursued (and funded), and if effective, it should be considered (and funded) as an additional resource for Community education and learning and recovery.

Training: Ireland needs to become an international leader in training efforts around suicide intervention, prevention and its aftermath. Therefore, there needs to be a concerted and co-ordinated effort by all educational and training institutions to raise the standard of training in this regard across the country, and through all levels of society. It should be noted that this is distinct from, and beyond, "awareness".

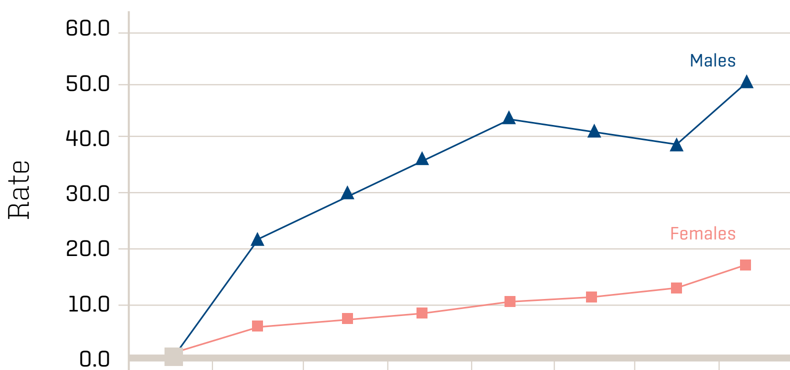
Ground Up: Our Survey identified very fragmented communities in the aftermath of a suicide event (or events). This suggests that support services are at a remove, and either dis-connected or un-connected to communities at ground level. This fosters a polarizing effect between voluntary and statutory agencies which engenders mis-trust, anger and hurt, and does not facilitate effective healing. Healing a family may require healing the community. A successful suicide prevention strategy requires an over-arching approach with active inclusion of ground level voluntary community agencies, many of whom are frequently best placed to lead local suicide response efforts.

This report demonstrates the added value of research which can contribute to a more in-depth knowledge and understanding of suicide in Modern Ireland. Tackling suicide is a challenge for Irish society which requires leadership and a renewed unity of purpose and effort. This challenge can be informed by research findings as identified in this report, which advocates an up-graded sustained, resourced, dedicated and over-arching collective statutory and voluntary effort to rapidly come to terms with and modify suicide rates in 21st century Ireland. Such effective, over-arching models to prevent young male adult deaths in Ireland from other causes, such as road traffic accidents, are worth considering. Surely, its people deserve no less.

Overview

The scale of the Problem: from Global to Local
Internationally, suicide rates in younger people have gradually increased over the past 50 years, with this phenomenon occurring more markedly in younger people (Figure 1.1 - 1.3) (Blum, 2009, Patton GC et al, 2009; Wasserman et al, 2005). WHO estimates that there are now in excess of 1 million suicide deaths worldwide annually, calculating that globally, someone dies from suicide every 40 seconds (WHO, 2012).

Figure 1.1. Global Distribution of Suicide Rates by Age and Gender (2000) (WHO)



	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75+
Males	1.5	22	30.1	37.5	43.6	42.1	41	50
Females	0.4	4.9	6.3	7.7	9.6	10.6	12.1	15.8

Figure 1.2. Global Distribution of Suicide Rates by Age and Gender (2000) (WHO)

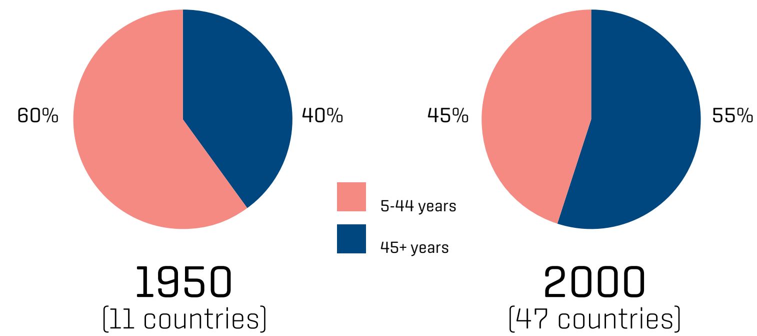
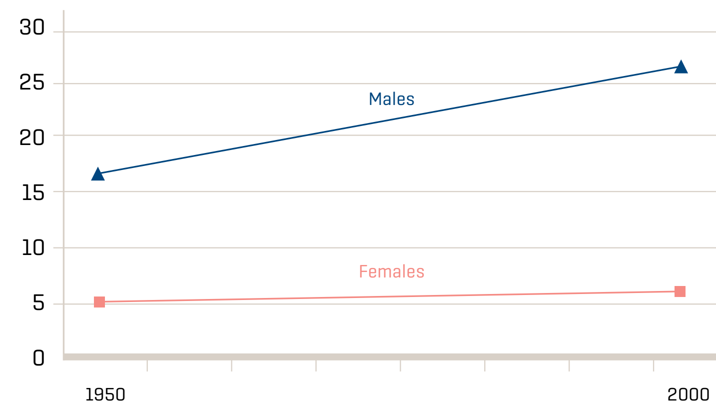


Figure 1.3. Evolution of Global of Suicide Rates by Age and Gender (2000) (WHO)



Suicide in Modern Ireland

Suicide rates in Ireland have traditionally been viewed as relatively low compared with the European average, although until the mid-1990s, it was estimated that there was an under-reporting rate of approximately 40% (Kelleher, 1998). Ireland up to the 1990s was a devoutly catholic country, where suicide was considered a mortal sin, and where suicide was deemed a criminal act by law until 1993, when it was de-criminalized. As a result of these factors, the topic of suicide has been deeply stigmatized, and clouded in secrecy and shame.

For all ages combined, the suicide rate in Ireland for the past 2 decades has been approximately 8.2/100,000, ranking Ireland as 18th out of 25 EU States (Figure 2.1). However, Youth Suicide rates (under 25 yrs) in Ireland have steadily increased since the late 1980s, such than the most recent complete WHO data (2009) indicates that Ireland has the 4th highest Youth Suicide rates in the expanded EU, with an annual rate of 14.4/100,000 (Figure 2.2), behind the Youth Suicide rates of Lithuania, Estonia and Finland. It is worth noting that the youth suicide rate in Finland, which has had a focussed, high priority national youth suicide prevention programme for the past 15 years, has reduced its youth suicide rate by over 10 points.

Figure 2.1. (WHO, 2012) Suicide Rates in EU 2009 (All Ages)

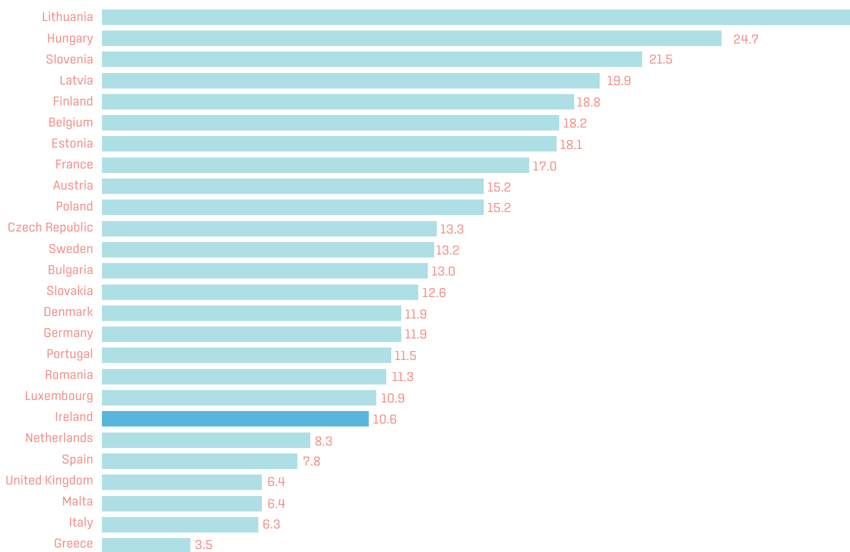
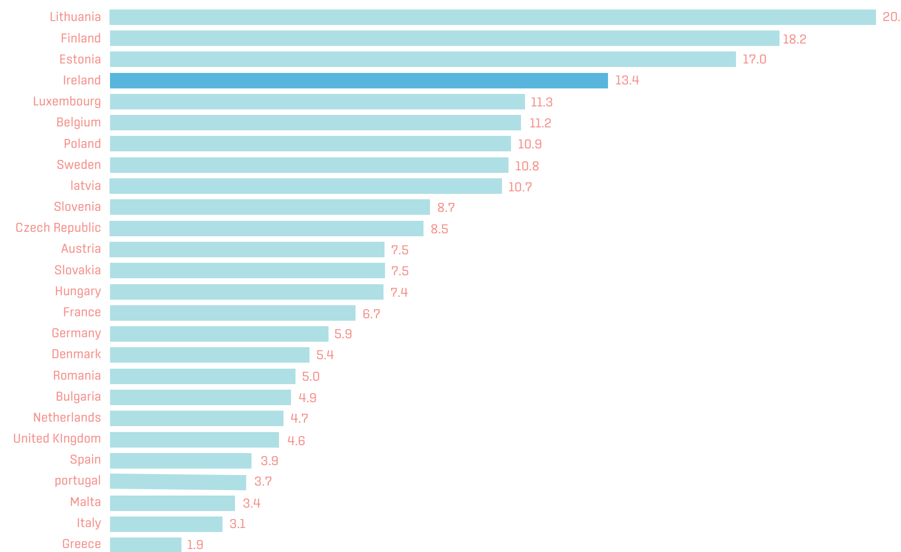


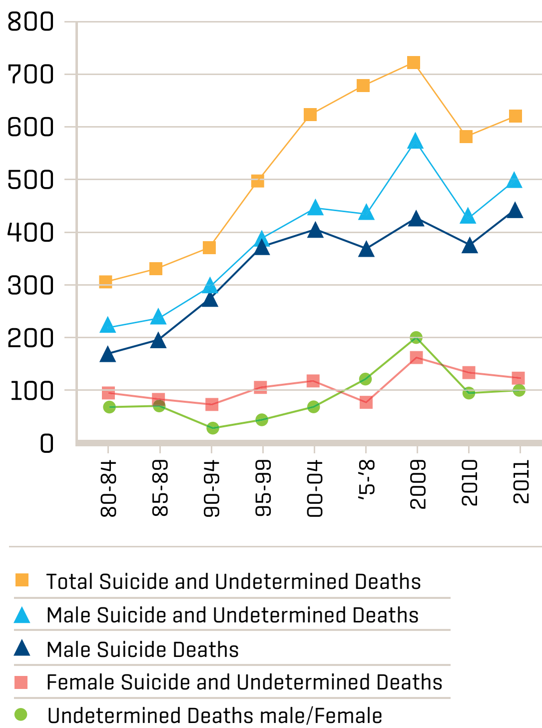
Figure 2.2 (WHO, 2012) Suicide Rates in EU 2009 (Ages 15-24)



Suicide Rates in Ireland 2009

In the past 30 years up to 2009, whilst "official" CSO statistics report that the were 510 suicide deaths in Ireland in 2009, if the open verdict deaths are included, the total number of definite and probable suicide deaths in Ireland for 2009 was 722 (Figure 3)

Figure 3. Numbers of Suicide Deaths in Ireland (1980-2011)



722 Suicide & Open Verdicts in 2009

Suicide Research and Prevention Funding: how do we measure up?
The response in Ireland to suicide included the establishment of a National Task Force, which made recommendations to the Department of Health and Children, and led to the establishment of the National Office for Suicide Prevention in 2002, and the publication of A 10-year National Action Plan for Suicide in 2005 (Dept of Health and Children, 2005). Around the same time, Scotland also established an Office for Suicide Prevention, with a suicide prevention plan "Choose Life" (Scottish Government, 2002), and a significantly larger budget per-capita, as did Northern Ireland "Protect Life: A Shared Vision" (Department of Health, Social Services and Public Safety, 2006). England "Preventing Suicide in England" (Department of Health, 2002) and Wales "Talk to me" (Welsh Assembly Government, 2008) also adopted active and superiorly funded Suicide Prevention strategies compared to Ireland, which are credited in part for reducing suicide in those jurisdictions by over 10%. In summary, despite the relative magnitude of the problem of Youth Suicide in Ireland, compared with the rest of Europe, the priority as measured in financial investment per capita in understanding and addressing the problem compares unfavourably with our closest neighbours. This national effort (or lack thereof) is in sharp contrast to the efforts and accomplishments of the Road Safety Authority during the same period, where road fatalities have been reduced by 50% in young men, the age-group at greatest risk. (see Figure 6.1. below)

Value of "Local" / Regional Research:
Since Emile's Durkheim's research observations on suicide over 100 years ago (Durkheim, 1897), most international researchers in suicidology recognise that suicide rates vary across countries, across and within communities and across cultures (Mann et al, 2005). As such, international suicide researchers recognise the need for local and regional suicide research to understand specific factors associated with local, regional and national suicide rates. In Ireland, the most stark and recent example of this variability is evident in findings from The Irish Traveller Study (Kelleher et al, 2010; McGorrian et al, 2013) where suicide rates in young traveller men are six times the national average. With the exception of the Traveller Study (which was set up to understand overall health issues, as opposed to a specific suicide study), there has been limited support for developing a robust and sustained suicide research platform across Ireland, open to all researchers.

Support for Suicide in Ireland Survey Research Proposal:
In the midst of this Irish knowledge vacuum in relation to youth suicide in particular, the

Suicide in Ireland Survey: The Context

suicide prevention charity 3Ts, established in 2003, supported a proposal from Prof Kevin Malone, to conduct a Research Study that would try to shed new light on Youth Suicide in Ireland. This study - The Suicide in Ireland Survey, proposed to conduct a modified National Psychological Autopsy Study with families from around Ireland who had been bereaved by suicide between 2003-2008. The proposal subsequently received co-funding from the National Office for Suicide Prevention and The National Lottery, and the study commenced in 2006.

This report provides:
a description of the study design and methods,

the first iteration of results, the key findings to date, and their implications,

future directions, including further proposed analyses from the study

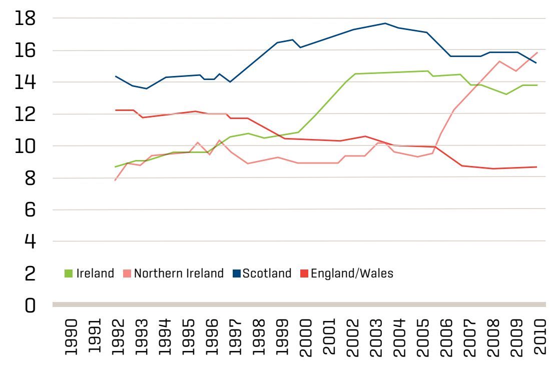


Fig 4.1 Suicide rates (per 100,000) in Ireland and the UK, Total Population, 3 - year moving averages.

Figures 4.1 and 4.2 show the suicide rates in Ireland and the UK from 1980-2010 for both the total population (Fig.4.1) and for young males (Fig.4.2) (Murphy et al, 2012). There has been a threefold increase in suicide among young males in Ireland over the last three decades from 8.9 per 100, 000 to 29.7 per 100,000. The suicide rates in young men are similar in Scotland and Northern Ireland but are up to three times higher than those of England and Wales. The rates in Scotland and Ireland have begun to stabilise somewhat and have even started to fall in the young male group (General Register Office for Scotland, 2012) (Fig. 4.2).

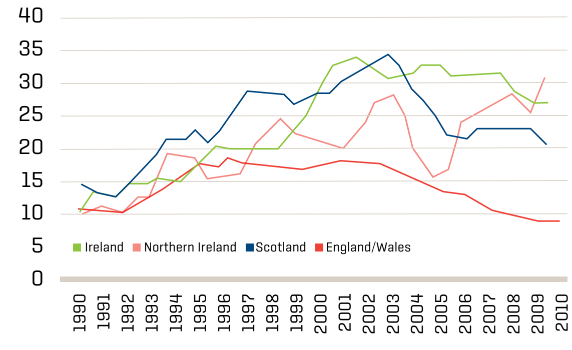


Fig 4.2 Suicide rates (per 100,000) in Ireland and the UK, 15-24 year old males, 3-year moving averages

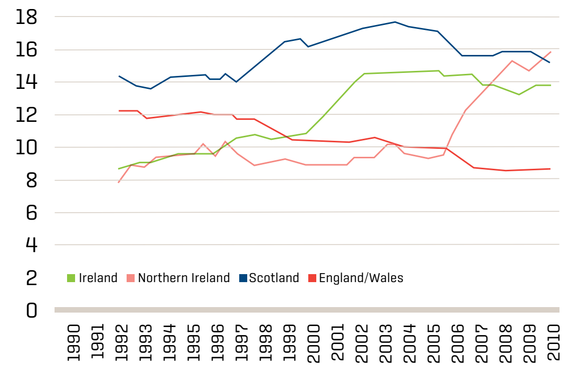


Fig 5. Percentage of suicides with Hanging, Strangulation or Suffocation as method of suicide in Ireland and the UK, 15-24 year old males, 3-year moving averages.

The proportion of reported suicides by HSS in 15-24 year old men has increased steadily over the period of study (Fig 5).

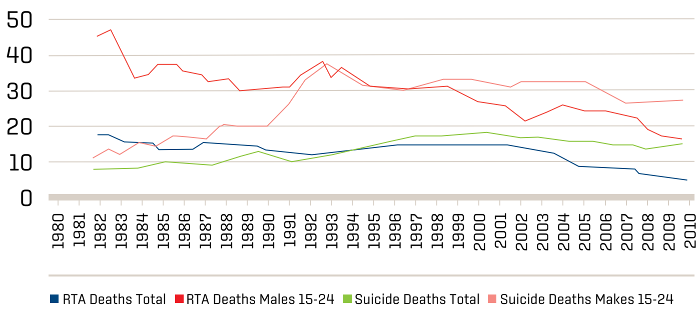
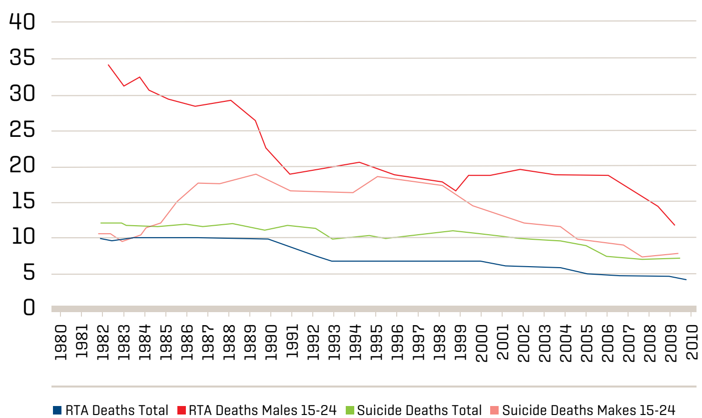


Fig 6.1. Rate of suicide deaths (per 100,000) Vs. Road Traffic Accident (RTA) Deaths (per 100,000) in Ireland, 3- year moving averages.

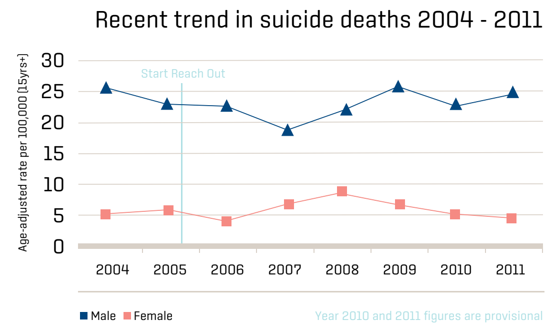
Fig 6.2. Rate of suicide deaths (per 100,000) Vs. RTA Deaths (per 100,000) in England/ Wales, 3 - year moving averages.



In both Ireland and in England & Wales a fall in RTA deaths in young males contributed to the overall decline in deaths from this cause in the period of study. While rates of suicide in this group rose between 1982 and 1998 in Ireland and in England & Wales, they declined after 2000 in England & Wales (Fig 6.1, 6.2).

Fig 7 (right). Age-Adjusted Suicide Rates per 100,000 in Ireland 2004-2011 (Arensman, 2012)

The rise in Suicide in Ireland over the past 3 decades, and youth suicide in particular (1980-2010) has occurred against the back-drop of a highly significant reduction in road traffic deaths for the same period (Figures 4-6) (Murphy et al, 2012). Death by hanging represents the most common method for suicide, and the particular lethality of this method may account in part for increased suicide rates in young people. Despite a rising rate of deaths by hanging in the UK, the overall UK suicide rates are in decline for at least the past 5 years, suggesting a real reduction. This reduction coincides to a degree with the implementation of the UK suicide prevention strategy (Mok et al, 2012). Suicide rates in Northern Ireland appear to be rising over the past decade. Whilst this is not the focus of this report, it is worthy of more specific research investigation.



Survey Designs & Methods

OVERVIEW

There are over 70 published Psychological Autopsy Studies in the International Literature to date (Hawton et al, 1998, Isometza, 2001, Cavanagh et al, 2003). These study methods have been broadly described as 1st generation studies (uncontrolled case interview studies with bereaved next-of-kin of suicide victims, conducted in the 1960s); 2nd generation studies interviews with bereaved next-of-kin using semi-structured interview schedules, conducted in the 70s and 80s) (Barraclough et al, 1974); and 3rd generation studies (quantitative descriptive or case - control studies using semi-structured standardised research instruments, conducted since the 90s) (eg Foster et al, 1997; Foster, 2011; Conner et al, 2012 a,b).

Design Rationale: For the purpose of this report, we will focus on the 3rd Generation methods employed in this study.

Qualitative Component: A further more recent study design has incorporated qualitative analysis techniques (Owens et al, 2008). It has been proposed that this type of methodology allows for the factoring of lay knowledge into understandings about suicide, and it has been further proposed that this type of knowledge may be more useful for informing community-oriented campaigns rather than the quantitative study methods, which are more likely to inform more tailored health service development.

3rd Generation Psychological Autopsy contribution
Informants for all cases were either a 1st degree relative or close friend of the suicide-deceased, who had contact with the deceased within 2 weeks of their death. Our quantitative semi-structured interview questionnaire included state-of-the-art standardised research instruments such as the MINI to record a DSM-IV Multi-axial diagnosis for all cases. (Sheehan et al, 1998)). We also included a standardised Suicide Life History Questionnaire (Posner et al, 2011). We also included a Life Events Scale, and a Global Assessment Scale (Endicott et al, 1976). Coroners files and medical files were accessed where possible. Because we were combining traditional psychological autopsy methods with an additional open narrative component, we called the combined approach a "psychobiographical autopsy" approach, not previously described.

Control Groups from INSURE
Age and sex-matched non-completer controls (attempters and non-attempters) will come from cases interviewed (under separate funding) as part of the Ireland North South Urban Rural Epidemiological (INSURE) Collaborative Study of Suicidal Behaviour in Major Psychiatric Disorders (Bannan et al, 2002, Murphy et al, 2013). This study (funded by the Health Research Board, and by Health Boards in the regions studied), which was undertaken between 1998 and 2005, interviewed 750 cases with and without suicidal features from six locations (Dublin, Belfast, Omagh, Letterkenny, Ballinasloe and Midlands), using the standardised semi-structured questionnaires included in the Suicide in Ireland Psychobiographical Autopsy Study. The Psychobiographical Autopsy Study was therefore designed as a stand-alone descriptive study, as well as being part of a larger case-control study of suicide non-attempters, attempters and completers. (Note: this Report will report only on the 3rd Generation Study Psychobiographical Autopsy component and will not include the case-control analysis, which will be reported elsewhere when these analyses are complete).

The development of The Psychobiographical Autopsy Design to incorporate Qualitative Analysis.
The quantitative Semi-structured interview is typically a "clip-board-type" model, which renders the interviewee (the suicide-bereaved in our case) objective, largely passive and external, without any facility to explore their perspectives (subjective and objective). In order to include the voice of the suicide-bereaved and their insights, we established an open, guided narrative component for the first section of the family engagement with the researchers. Of note, this method had subsequent coincidental parallels with the methods of Owens, (Owens et al, 2008), and more recently a variant method termed the "sociological autopsy" has been described, focussing on interviewing young men (Scourfield et al, 2012).

The interview began with an invitation to share whatever they wished to about the lived life of their loved one, rather than focussing in the 1st instance on their deaths. As such, this generated a biographical narrative rich in content, texture and themes, thus

Figure 8a. *21g* 2003 (McGuinness, 2005)

21g (2003) (Figure 8.) is an abstract representation of young male suicide in Ireland in 2003. *21g* (2003) is and continues to be, in its various iterations according to site and context, a social probe into official statistical data available concerning young Irish suicide.

providing valid and insightful material for subsequent qualitative thematic analysis. When the guided open narrative concluded, the participants were invited to take part in the quantitative semi-structured interview component (usually following a "tea"-break).

A unique Visual Arts Autopsy with an integrated science/arts design for Suicide in Ireland Survey

A unique Visual Arts Autopsy Study was incorporated into the Suicide in Ireland Survey, to create an integrated Science Arts research platform. This Project is described in detail in *Lived Lives: Materializing Stories of Young Suicide 2003-2008* (McGuinness S, 2010), and will be described briefly here.

McGuinness conducted independent Visual Arts research in 2004 which culminated in an art installation *21g* 2003. *21g* (2003) is an abstract representation of young male suicide in Ireland in 2003. According to official statistics available to Mc Guinness at the time of making this work, over 92 young men died by suicide in 2003, making suicide the leading cause of death in the young men of Ireland. The installation contains in excess of 92 male shirt fragments each weighing 21 grams (the mythical weight of the soul). The shirt fragments are collectively installed at different heights, as if in a silent crowd. This art work is and continues to be, in its various iterations according to site and context, a social probe into official statistical data available concerning young Irish suicide.

Building on this, McGuinness and Suicide in Ireland Survey Principal Investigator Kevin Malone began a research collaboration following on from *21g* 2003. This collaboration culminated in McGuinness being awarded a 4 year UCD Ad Astra Scholarship in Suicide Studies at UCD with Malone, funded by Denis Kelleher, Ireland Funds and which commenced in 2006. McGuinness's PhD proposal proposed to invite bereaved family research participants, in addition to donating their story of the Lived Life via the Psychobiographical Autopsy method, that they might also donate "anything associated with the Lived Life". From these donations, McGuinness proposed to make a series of artworks, and following a private individual and family viewing of such works, if the families consented, these works would be brought forward into the public domain. (McGuinness S, 2010).

Both Malone and McGuinness agreed that an integrated science arts approach would mutually benefit the research design, may bring new insights through humanities research, and that bereaved family members might relate to this integrated strategy.

Ethics

The study design was presented to the SVHG Ethics Committee in 2 phases. The 1st presentation sought approval for the Psychobiographical Study, which incorporated confidentiality and anonymity of the deceased and the research participants. This proposal satisfied the Ethics Committee requirements.

Figure 8b. *21g* 2003 (McGuinness, 2005)

The 2nd presentation sought approval a couple of months into the Psychobiographical Autopsy Study to include the integrated Visual Arts Autopsy Study. When we (Malone & McGuinness) commenced the Psychobiographical Autopsy family engagements, the first act the families initiated was to show pictures and images of the deceased (observed in other Psychological Autopsy studies, Conner et al, 2012a,b), stating that they wished these to be included when the Visual Arts Autopsy commenced. Clearly, this development revealed the identity of the deceased. Therefore, this was included in the Ethics Committee application.

Recruitment

The research design proposed a model of recruitment through the concept of "donation", which would yield "a volunteer sample". In brief, the invitation to be part of the Suicide in Ireland Survey was extended nationally through local media and press for families bereaved by suicide to donate the story of the lived life of their loved one lost to suicide, less than 35 years of age, and between 2003-2008 (of note, research interviews with several families of suicide-deceased over aged 35 were completed, as earlier versions of our recruitment advertising did not include an under 35 years age preference). This is an alternative recruitment strategy to "cold-calling" or mailing families via the Coroners office, which has had mixed success in other countries (evidence from NSRF that it may be more successful here now). As such, the bereaved families chose to be volunteers as opposed to the research study choosing them. This may have introduced a recruitment bias, which we have not yet articulated. However, because of the number of families interviewed (104), and the fact that they came from 23 counties, may have lessened recruitment bias (we failed to interview in Donegal, Carlow and Mayo). The interval between bereavement and interview was no shorter than 3 months, and was typically between 6 and 24 months. We advised against interviewing on anniversary events, but a small number of participants sought to be interviewed on such dates. All participants were informed that the study would not benefit them directly, but that it may help us glean new knowledge and understanding for the future of suicide in Ireland. This was stated by all research participants as their reason for taking part in the study.

Families wishing to take part were directed to complete a Suicide Survey expression of interest sheet and to forward this to the Research Co-ordinator's office (Suzanne O'Connor). She subsequently contacted them to screen in or out the participants (based on year of death of deceased loved one), and to schedule dates and times for interviewing. As calls came from all over Ireland, there were substantial logistics involved in facilitating families' schedules for interview. The research team always endeavoured to work around the family schedule.

Although not excluded, no family from the Travelling Community approached the study, nor did any non-national from Eastern Europe, despite both these groups carrying an increased risk for suicide. (Kelleher, 2010).

Informed Consent

All families who contacted us who fulfilled the criteria for the study were scheduled for engagement and interview, mostly in their own homes. Upon arrival at their homes, the researchers introduced themselves and the Study protocol, and proceeded through obtaining informed consent, which typically took 30-45 minutes. The Participant Information Leaflet (PIL) was read out in full (to negate any literacy problems), and questions were answered in advance of receiving signed informed consent. The interview was paused upon the arrival of any additional family members who arrived late to the interview, so that full informed consent could be obtained from them. Of the 104 families that signed informed consent for the Suicide in Ireland Survey, 62 families also signed the Visual Arts Autopsy Study informed consent.

The Research Engagement and Interview

All interviews were audio-recorded following on obtaining informed consent. These audiotapes were subsequently transcribed verbatim.

No more than one interview was scheduled per day, such that there would be no time constraints on the engagement process with families from the research team's end. The interviews lasted between 2.5 hours to 6 hours, with an average duration of 3.5 hours. The interview concluded when the semi-structured interview was complete and when the families decided that they had no more to relate to us. This was designed to facilitate the psychotherapeutic techniques of "presence", and "active listening" on behalf of the research team with the families, which allowed the engagement to flow, and for stories to emerge.

Data Management

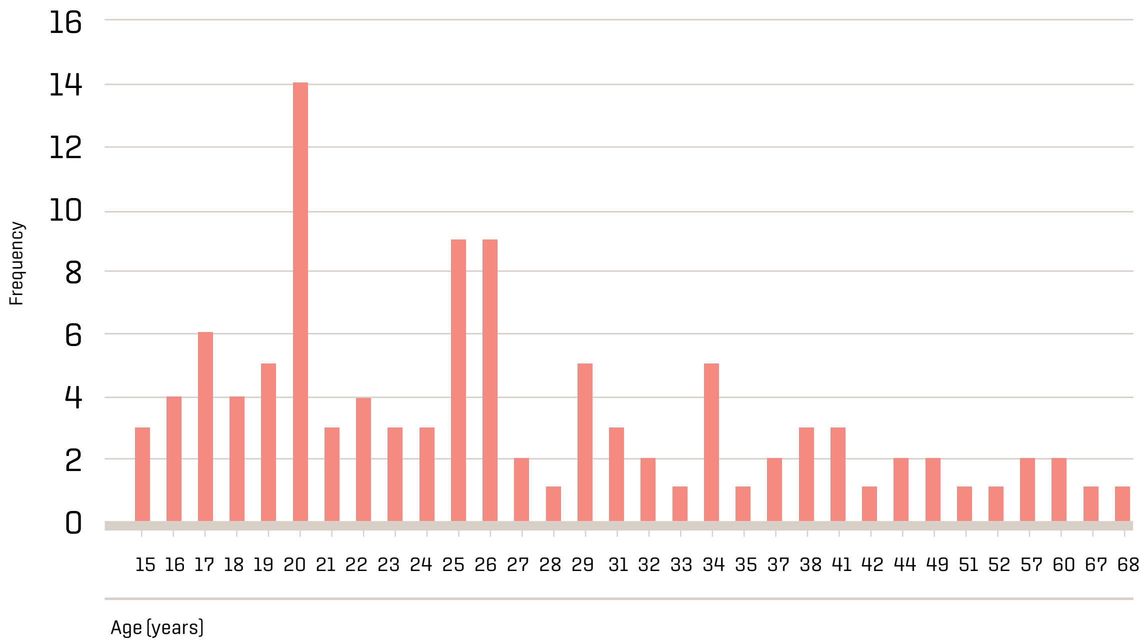
A unique purpose-fit, tailored, ACCESS relational database was constructed by an expert external IT consultant (at no cost to the Research study). This database was up-loaded onto a dedicated password-encrypted folder on the SVUH mainframe, containing the latest firewalls, and was backed up daily. Only members of the Suicide Research team had access to this folder through their password.

The hard copies of the data files (which were assigned research file numbers), were archived separately in a locked research office in the Dept of Psychiatry, Psychotherapy and Mental Health Research at SVUH.

Statistical Analyses

Statistical analyses were conducted by the suicide research team in collaboration with Prof Cecily Kelleher, UCD, and in consultation with members from the HRB-funded C-STAR statistical team at UCD. Ms Lucy Dillon provided consultation for qualitative analyses.

Results



PROJECT I

Suicide Survey Demographics and the early Emergence of Age as a Factor

The suicide-deceased originated from 23 counties, reflecting the recruitment spread. The age distribution of the deceased was the most immediately apparent and striking finding. 14 of the 83 cases were aged 20 years, with the next highest being 7 cases aged 25 and aged 26, and 6 cases being aged 17 (Figure 9). Whilst the intention of the study initially was to pursue an in-depth quantitative and qualitative analysis of factors related to young suicide death in all 83 cases, this spike in 20 year old cases prompted us to pursue this observation into national and international epidemiological datasets to either verify or refute this observation. Therefore, the next section of the report presents an examination of the international datasets of Ireland and UK for 2000-2006, and a qualitative thematic analysis of age-selected cases from the Suicide in Ireland data to try to further inform this possible new observation.

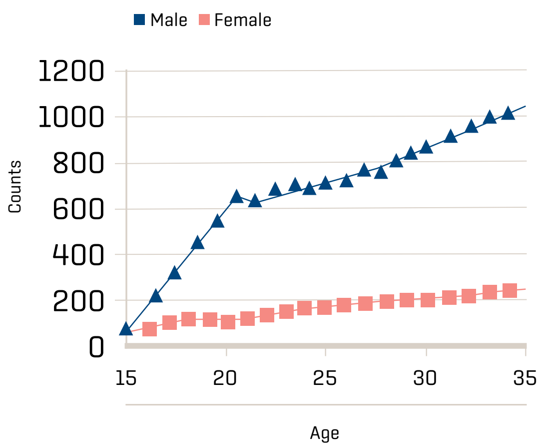
Fig 9 (Left). Age Distribution (in years) of Suicide Deaths in Suicide in Ireland Survey

Quantitative

Statistical Analysis of Year on Year Age of all Suicide Deaths in Ireland and UK, 2000-2006. *"Many Young Men of Twenty said Goodbye"* (Malone et al, EPS in press)

Using the "intuitive lay knowledge", from the Suicide Survey, we pursued this line of enquiry in relation to age of risk into the national datasets of Ireland and the UK for all 11,964 suicide and undetermined deaths under 35 years between 2000-2006, which we have reported elsewhere (Malone et al, EPS in Press). In summary, we identified that there was a highly significant four-fold rate of increased risk in males between aged 16 to aged 20, compared to after the age of 20 (113.1 vs. 28.2 cases per year). A similar non-significant almost two-fold trend was noted for females (12.7 vs. 7.4 cases per year (Figure 10). As such, this discovery, which we have incorporated under the banner of the John B Keane Play *"Many Young Men of Twenty said Goodbye"*, identifies an age-dependent epidemiological transition for suicide. This previously un-reported finding has come about through a combination of intuitive lay knowledge coming to light in the Suicide in Ireland Survey, and supported by rigorous statistical methods using national and international datasets.

Fig 10. Frequency of Suicide and Open Verdicts in UK and Ireland by age (in Years) UK and Ireland (2000-2006)



PROJECT II

Clinical and Psychosocial factors associated with Suicide in Young Adults (note some missing data so totals vary).

Demographic Factors (TABLE 1.1-1.10)
The deceased came from 23 counties in Ireland, although several of them did not die in their county of origin (eg had relocated from rural to urban living, occasionally overseas). A coroners report was obtained in 77 of 104 cases. 84 cases were male, and 20 cases were female. Age distribution is as described above. 90/104 cases were catholic, 96/104 cases were described as heterosexual, and 8 gay / lesbian. 73/104 were single, 17 were married, and 14 were separated / divorced. 50 of the cases lived in the primary family home 70/104 cases completed 2nd level education. 50/104 were in employment at the time of death. 14 / 104 cases had attained level 6 employment status. The highest level of father's occupation was 3[/7] (partial secondary school) or lower in 41 / 86 cases. 31/104 cases "definitely believed in God", 31 / 104 and "probably did". 15 definitely did not believe in God, and 25 "probably did not".

Mental Illness and Psychiatric Treatment Factors (TABLE 2.1-2.7)
62/104 had an Axis I psychiatric disorder lifetime diagnosis, 46/104 had definitely ever received psychotropic medication, 29/104 ever had a psychiatric hospitalization, and 32/104 ever had some form of outpatient psychotherapy. 7 cases had been kept back one year at school due to a learning delay.

Of the 62 cases with lifetime psychiatric disorder, 12/62 developed their psychiatric disorder before the age of 18, and 26 developed a psychiatric disorder before the age of 21.

48/104 had a diagnosis of Major Depression, and 11 had a diagnosis of Psychosis. In the month prior to death, 42/98 had a GAS score of 50 or below, 53 had a GAS of 60 or below, and 78/98 had a GAS of 70 or below.

50/97 cases had at least one 1st degree relative with a history of Major Depressive Disorder, 24/94 had a 1st degree relative with Alcohol Dependence, 8/95 cases had a 1st degree family history of suicide, 20/95 had a 1st degree history of a suicidal act, and 35/95 cases had 1st or 2nd degree family history of a suicidal act. 29 cases had a history of psychiatric hospitalization, and 6 of these were under aged 18. 32/104 cases had ever received out-patient psychotherapy, and 46 cases had ever been prescribed psychotropic medication.

Alcohol, Substance abuse and Co-Morbidity factors (TABLE 3.1-3.6)
51/104 had alcohol abuse within the past 12 months, and 26/104 had a history of non-alcohol substance abuse in previous 12 months. 8/104 (or 8/62 Axis I cases) had Major Depression, alcohol abuse and substance abuse within 12 months of death.

Suicidality Factors (TABLE 4.1-4.13)
"Family everything. Love Ye, Don't be worrying about me, I'm fine xxx xxx, Love Always" (suicide note case# 3069)
34/104 had previously attempted suicide. 58 died in the home, and a further 12 died on home ground. 79/98 cases died by hanging, 11 died by drug overdose, and the remainder by drowning, shooting or jumping (5 cases had accessed a firearm). 44/104 had left a suicide note (or text) and a further 3 had written but torn up note. 34 /104 cases were "in psychiatric treatment" at the time of death. 13/104 cases took "no precautions against discovery", while

34 cases took "active precautions". 54 cases took "passive precautions" and data were missing on 3 cases. Unequivocal communication of intent in previous month was apparent in 25/104 cases and a further 42 cases equivocal communication of intent was apparent. In 32/104 cases no communication of intent was apparent. In the 2 weeks prior to death, 32/98 cases scored 0 on the MINI Suicidality scale, 47/98 scored mild (8 or below), 14 scored medium (9-16), and 37/98 scored high (over 16)

Psychosocial and Life Event factors (TABLES 5.1-5.7)
38/104 cases "complained of feeling lonely", and 22/104 cases "complained of lacking friends". 54/104 cases reported "significant interpersonal conflict" in 2 weeks prior to death. 63/98 cases reported severe / extreme life event scores on the St. Paul Ramsey Scale. In 39/98 cases there was a change in living arrangements during the month prior to death, and in 20 of these there was a definite move in neighbourhood within the year prior to death. In those aged under 21, 14/36 recorded a history of relationship break-up. 6 cases were reportedly in significant financial debt.

Abuse Factors (TABLES 6.1-6.4)
A history of physical or sexual abuse was reported in 20/94 cases. 8 cases were physical, 7 cases were sexual, and 2 cases were both. In 16 cases, the abuse occurred before aged 15. Social services had been involved in 2 cases.

Bullying was recorded in 6 of 36 cases under aged 21, and an assault / mugging occurred in a further 8/36 cases (under 21) in the 6 months prior to death.

Separation and Loss Factors (TABLE 7.1-7.4)
24 cases had been bereaved by the death of a friend in the previous year.

25/99 cases experienced a separation from a parent, in 23 of these, the separation was on or before aged 16. There was at least one deceased parent in 23 cases. In 20/101 cases, the father was deceased, and in 13 of 101 cases the mother was deceased. Both parents were deceased in 10 of these cases. 70/98 cases had "exposure to a suicidal act" within 3 months of death.

Singletons, Couplets and Clusters (TABLE 8)
Debate exists in the literature as to whether or not a contagion factor exists that may impact suicide rates. Such literature suggests that suicide clusters may exist. It has not been examined on a national level in Ireland, however. NSRF has recently reported a 22 person cluster in North Cork (Arensman et al, 2012). The existence or extent of suicide clusters across Ireland however, has not been sufficiently explored.

Moreover, debate exists as to what exactly constitutes "a cluster". Most researchers have adopted the description by Gould et al and Beautrais et al that a cluster consists of "a group of suicides or acts of deliberate self harm (or both), that occur closer together in time and space than would normally be expected on the basis of statistical prediction and/or community expectation" (The suicide cluster literature also comments on point clusters, echo clusters and mass clusters) (Gould et al, 1990, Arensman 2012). In excess of 2 suicide deaths occurring in a small geographic area within a short space of time above the local frequency that is likely to be observed by chance is probably a cluster. In other words, 3 or more suicide deaths occurring in a small rural community population within weeks or months likely constitutes a cluster, as opposed to such events occurring in a larger urban population where such frequency may more likely occur by chance. However, this definition lacks precision, nor does it take into account the relevance of social / interpersonal connectivity that may exist between temporally and geographically adjacent suicide events (including rural and urban connectivity). Indeed such connectivity between suicide deaths may be the most important factor in the establishment of clusters, although to date, studies have not been adequately designed to evaluate this. We allowed for the possibility of identifying "remote" clusters if social connectivity between suicide deaths was evident and seemed of particular importance in the absence of geographic proximity.

Our study design enabled us to examine social / relational connectivity between suicide deaths in all our cases (N=104), through including a peer informant in most cases of suspected clusters. Rather that just documenting the existence of other suicide deaths occurring around the time and location of our suicide cases, we enquired about the social, interpersonal and relational connectivity in each case. In our data analysis, we adopted a conservative approach to defining whether or not any of our cases were part of a suicide cluster by insisting that such connectivity existed as well as there being a temporal and spatial proximity of such deaths. We therefore defined our

"it was totally out of the blue"; 'we didn't realise things were so serious (at the time)' 'We felt we may lose him' - "he would not be around much longer"

cases as either singletons (where no other apparent suicide occurred or was referenced), couplets / associated suicide deaths (where one other suicide death occurred adjacent to, and with apparent connectivity with our deceased case), or as part of a cluster (more than 2 deaths occurring within small geographic area in short space of time and with social / interpersonal / relational connectivity).

To account for possible internet clusters, we discarded the "geographic area" stipulation as essential, and included time and internet social connectivity as our primary definition in these cases.

Using these definitions from data on 104 cases in our dataset, we identified 79 singletons, 15 were part of couplets / associated suicide deaths, and 10 cases were part of suicide clusters. Within the cluster group we interviewed 2 cases from one of the clusters. 4 of the cases we recruited associated with clusters were female. Examples of the number of cases in a cluster included 3 deaths within 2 weeks in a rural 3km radius, 5 deaths in 11 months in 4k rural radius and 29 deaths over 3 years in 6k urban radius. There was one internet cluster and one "remote" cluster. (SEE TABLE 8)

Clusters were more likely to occur in younger suicide deaths. 9/12 cases associated with clusters were under aged 21, and 6 of those cases were under 18 (ie 50% of cases associated with clusters were under aged 18, and accounted for 6% of our database). One of the clusters surrounded a repatriated young suicide death.

Couplets were more associated with young adults (rather than under 18s), but were also observed across the lifecycle. 3/15 couplet cases were under aged 18, a further 8/15 cases were between 18-30, and 4/15 case were aged over 30. Suicide couplets as such have not been systematically described before. One possibility is that some or all of them might be attenuated clusters. If this is true, it might be of value to closely study couplets to investigate what factors, interventions, responses or changes may have occurred following the 2nd suicide death that may have attenuated the formation of a cluster. Certainly this phenomenon is worthy of extra research and scrutiny.

Age-Specific Life Stage Factors (TABLE 9)

References to Aged 20 vs any other age group.
Qualitative Thematic Analysis: Because of the significant excess of 20 years old cases identified (Figure 9), we conducted a separate qualitative analysis in 20 year old deaths vs those younger or older than aged 20. (TABLE 9)

Overall, the exclusively common feature cutting across all twenty narratives (aged 15-16 (n =5); aged 20 (n =9); and aged 23-24 (n=6)) was that each of their lives had ended in suicide. There were recurring themes within and between stories that offer insights into the lives of these young people and the challenges they faced (mental health literacy, mental health, Contagion/ clustering, humiliation, triggers and "tipping points"). For example, there was a wide variability in insights regarding mental health literacy, both peer to peer and cross-generational through the narratives. Whilst most of the deceased had disclosed suicidal ideas to someone close to them in the two weeks prior to their death, the range of awareness and knowledge varied, for example: *"it was totally out of the blue"; 'we didn't realise things were so serious (at the time)' 'We felt we may lose him' - "he would not be around much longer"*

Different themes were identified across ages. Where this was the case, they were between the fifteen/ sixteen year olds on the one hand, and the twenty and twenty four/five year olds on the other. The key differences between the groups apparent in families' narratives were related to their different life stages:

The majority of the interviews with families of twenty year olds made reference to their turning twenty-one. The 21st birthday tended to be presented by families as a landmark that their young person did not reach. This was evident where a young person wrote in his suicide note that *"at twenty years of age I shouldn't be asking you and mam for financial help"*. Two other twenty year olds were reported to have made reference to the fact that they 'wouldn't see their twenty-first'. Where plans had been made for a twenty-first birthday party, young people were reported to have been "looking forward" to the celebration. Families themselves used the twenty-first birthday as a landmark in their stories- it was referred to as a landmark that the young person had not reached, and one that could be particularly difficult to cope with.

Could Anything More Have Been Done? (TABLE 10)

Over 70% of respondents thought "more could have been done" surrounding the suicide death of their loved one.

Interface with Statutory Services

Verbatim quotes: The following are presented as verbatim quotes (raw data), following on an observation by one of the research participants "what's said is said, it can't be unsaid", and is intended as a transparent account of family experience of the interface with statutory services either during the suicidal process, or following the immediate and longer term aftermath of a suicide death.

Health (before)

32/56 (66%) with exposure to Health Services before suicide death (Primary Care / Mental Health) rated them as Neg / V. Neg

"Stitched up in A/E and given a months prescription"
"Sent home twice from A/E"
Sent home from A/E day before
"Impossible to get answers from anybody where his catchment area was - he was in the wrong hospital so they sent him to (another A/E) with a note "sorry, not our area"
"called psych hospital, no help, called opd, no help"
"Not in the catchment area"
"would you put a kid in an adult psych hosp"
"No opd counselling"
Letter stating "you failed to show for your appointment so obviously therapy is not indicated at this stage"
"Called the Consultant and the Consultant didn't call back"
"The services just aren't there"
"Saw a different doctor every time"
Patient requested ECT for depression - not given
Suicide death during hours out from Hosp
"Hospital may be a luxury for some, but it's a nightmare to me"
Alternative psychiatrist took him off his meds
"He told them in hospital he was suicidal"
"I'll kill myself before I go back into psych hospital (did)"
"The registrar couldn't speak any English"
Refused gambling rehab because on prescribed psychotropic meds
Lost his bed during leave with family (NHS)
Wrote letter of complaint to hosp about never seeing the same doctor twice
Very low dose antidepressant prescribed, sluggish referral time
GP assessment - no follow up
GP assessment - no follow up
No GP follow up
Consult lasted 5 minutes
No collateral history

Justice (before)

8/23 (45%) with exposure to Justice Services before suicide death (Gardai) rated them as Neg / V Neg

- Arrested to "teach him a lesson"
- Arrested to "teach him a lesson"
- Arrested on railway bridge - feeling suicidal
- Showed assault statement to perpetrator - assailant subsequently returned with violence
- Gardai called to house about psych incident - "it was to teach her a lesson"

Education (before)

6/103 (8%) of Ed experience before suicide death rated as Neg / v Neg

College didn't call when he failed to show for his Finals
"Beaten up" by one of teachers
Grounded by school and placed in junior class
Teacher retained student's private journal as threat
School knew there were problems
Singled out at a tutorial and humiliated in front of other 10 students

Post-Vention

19/103 (16%) rated statutory suicide post-Vention (Gardai, Coroner, Health) as Neg / v. Neg

"Garda 1st suicide..., didn't seem trained"
"Garda 1st suicide..., didn't seem trained"
"We ended up consoling the young Garda"
Gardai detained best friend (finder) for 6 hours when he reported finding his friend RIP
Garda "rude and derogatory" at suicide site "young people and drugs" (wasn't a drugs case - depression case)
"Oh no, it could be a lot worse, it could happen again" (Garda at the scene to Dad)
"Informed friend before family"
"Ambulance crew and Gardai very poorly trained"
Wife not informed of inquest
Mother not informed of inquest (aged 18)
"Had to sit through 2 other suicide deaths" (in Coroners Court)
"Had to sit in Coroners hallway for 2 hours"
"All 6 suicides together, it was Dickensian"
All 5 cases together in Coroners Court
All 8 suicide deaths before them in Coroners Court

Coroners Court - 5 suicide deaths
Coroner left details on answering machine
Coroner said to Mum "your problem is you know too much about drugs"
Inquest over 2 years later - coroner ill, no replacement
USA death repatriation took 9 days
"they took his brain out, ... gave it back to us 5 months later, in a box...I think maybe it was for research, I don't know"
"Calamity bad enough, compounded by silence (from psych services) that ensued"
"She would have been hospitalized if she had VHI"
Psychiatrist wrote back - "I didn't see it coming"
No communication (from psychiatry) in aftermath

Participant Feedback on Research Experience
(TABLE 11)
86 respondents rated the experience of participating in the research experience as either positive, quite positive or very positive (73/104). 3 respondents did not respond, and one respondent rated the experience as very negative, stating that everything to do with his son's suicide death was negative, and that there could be no positive (Table 11).

PROJECT III

Quantitative Epidemiological Analysis of Suicide in the Children of Ireland

Methods (Malone et al, 2012)
The Irish Central Statistics Office (CSO, 2012) were requested to provide the most disaggregated data permissible under the Data Protection Act for raw year on year age and sex mortality numbers of under 18 year olds who died by suicide and open verdict for 1993-1998, and 2003-2008. Population level age and sex data were retrieved from the National Census 1995 and 2005 to most accurately estimate rates per 100,000 in each age group and time period (National Archives of Ireland, 1995, 2005, Eurostat, 2012).

The CSO are limited by the Data Protection Act in relation to the granularity of "sensitive" data they can release to the public, and to those involved in research. Specifically, they are not permitted to provide data below a level where less than 5 cases are included in any data cell. For this reason, in order to include all year on year under 18 deaths recorded as suicide or open verdict, we sought grouped data for each age group for each 6 year time period being examined. We then divided this number by 6 to calculate both the average raw and per 100,000 population rate for each time period. As suicide rates can vary from year to year, international researchers often employ 3 year moving averages to control for this variability. In our examination, we averaged 6 years of data to calculate an average yearly count and rate for each time period.

The results of raw number of suicide deaths and suicide rates per 100,000 for 1993-1998 and 2003-2008 by age and sex in under 18s are presented in Table 12. Suicide in under 15 year-olds is extremely rare in both decades, with average overall rates of 1.6/100,000. Suicide occurs significantly more often in boys and more commonly between ages 15-17 in both sexes. Regression analysis (Poisson) identified significant age and sex effects for both number of suicide deaths (Table 13) and also for suicide rates per 100,000 (Table 14), but a decade effect was not significant.

“On average, every 18 days a child under 18 in Ireland dies by suicide”

PROJECT IV

Qualitative Analysis of Suicide in Children from the Suicide in Ireland Survey (McLoughlin, Kelleher & Malone, 2012)

Introduction: To date, research of childhood suicide in Ireland has been exclusively quantitative in nature. This Study endeavours to qualitatively uncover some meaning behind the statistics and is the first in-depth qualitative analysis of adolescent suicide in Ireland.

Methods: This Study thematically explored childhood suicide in Ireland using a Psycho-biographical Autopsy (modified Psychological Autopsy) approach. Adolescent suicides (n=14) between 2003-2008 are analysed. Sources of information included personal reflections of the deceased, and interviews with a volunteer sample of relatives and friends (n=28). Qualitative analysis used a grounded theory approach on the open narrative. Emerging themes were then used to frame and analyse the quantitative data.

Results: Mental distress, humiliation and violation emerged from the data as psychological and relational vectors in the suicide process. Connectivity and displacement also featured as possible mediators and modifiers of this process. A novel “teens-in-trouble/troubled teens” conceptual paradigm emerged intuitively from the research process, which may contribute nuanced insights into the suicide process in children and adolescents. Troubled teens included more enduring psychiatric, psychological and psychosocial problems. Teens-in-trouble included highly acute and traumatic personal events including assaults and muggings, acute inter-personal conflict including relationship break-up and family / parental conflict, as well as conflict with statutory agencies such as education, justice and health, and acute peer bereavements. While there was over-lap between these two groupings, they could also be usefully seen as separate entities requiring differing management approaches from 1st responders as well as other longer term statutory support agencies. Developing more tailored responses to these distinct groupings in policy and practice is worthy of further research. The aftermath of a child suicide also fosters suicidal currents both within the bereaved family as well as peers and community, where media influences can take hold. Further research is required to advance our knowledge and understanding of all factors associated with childhood suicide in Ireland.

Lived Lives

PROJECT V

Lived Lives: Materializing Stories of Young Irish Suicide (2003-2008) (Mc Guinness S, 2010)

Suicide is a complex subject matter, which is cloaked in secrecy and stigma. The increase in the number of younger people (under 35) taking their own lives in Ireland in recent years is a major cause of concern. Available statistical evidence indicates that suicide is the leading cause of death in young males, exceeding road traffic accidents and cancer. Hidden behind the statistics however, lies the personal, untold, stories of *Lived Lives* of loved ones lost to suicide. No research project to date internationally has combined an integrated cross-disciplinary art/science research model to address the gap in knowledge and understanding of suicide through a unique collaboration with families bereaved by suicide.

Lived Lives was conceived as a cross-disciplinary PhD located within The School of Medicine and Medical Science at UCD. Mc Guinness was awarded a PhD in 2010 for this research. The *Lived Lives* project captured stories of some of the *Lived Lives* of males and females lost to suicide in Ireland aged less than 35 years (2003-2008). The project started with conversations and research interviews in their homes with 62 of the suicide-bereaved families who participated in the Suicide in Ireland Survey project (n=104) from all over Ireland (2006-2010).

An integrated art/science cross-disciplinary platform was created placing emphasis on the lost but lived life. Part of the *Lived Lives* architecture was an adaptation of the Psychological Autopsy (as described above), recasting it as a tool for the pursuit of new forms of knowledge, and as a critical source of testimony going behind the "dry suicide statistics". To this end, the *Visual Arts Autopsy (VAA)* method was created to portray the lived life through stories about, and donations of belongings associated with suicide-deceased loved ones following informed consent.

Critically, many families chose to donate images and names revealing the identity of their deceased loved one. This use of identity challenged the prevailing academic research ethics codes, where confidentiality and anonymity are cornerstones of research and practice. Uniquely, *Lived Lives* received approval to use identity in a research process located in a School of Medicine and Medical Science. This use of image and identity is central to *Lived Lives*. It re-humanises the suicide-deceased, who are frequently defined by the manner of their death - this passage from identity to anonymity with the suicide-deceased is inclined to de-humanise the human subject. This may contribute to stigma around suicide loss. By moving away from anonymity towards identity and "re-humanising" the suicide-deceased as portrayed in the *Lived Lives* works, the silence of stigma may be challenged, through collaborative, truthful, sensitive and safe representation of the lived life lost to suicide.

With the material belongings and personal stories of the deceased as donated by their families, a series of artworks in progress were made, known as the *Lived Lives* Artworks, which were initially presented back to the families for private engagement, reflection and feedback (Ennistymon 2009; Galway 2009). Following the families informed approval, these artworks extended into the public domain. To date these public events include: Kaunas Biennial 2009, Lithuania; Vital Signs, Arts Council of Ireland, National College of Art and Design, October 2009, Dublin; Inaugural International Conference of the College of Psychiatry in Ireland, Croke Park, November 2009; Royal College of Physicians in Ireland, Public Lecture Series, Dublin, April/May 2010; Merriman Summer School, Lisdoonvarna, Summer 2011; Joint Oireachtas Committee, Health and Children, Sept 2011; Being Singular Plural, International Symposium Guimarães, Portugal 2012 and Hangzhou Triennial Fibre 2013, Hangzhou China..

The art / science research collaboration has also been the subject of workshops at the Dublin Contemporary (Oct 2011); School of Art, Institute of Chicago, USA, (June / Sept 2012); and the International Association for Suicide Prevention (Rome 2011). In addition this collaboration was also the subject matter of four International Roundtables as part of Mc Guinness's PhD. The first at SVUH, Dublin (2006), the second at Textile '07 Kaunas, Lithuania (2007), the third at Constance Howard Research Centre, Goldsmiths College, London (2008) and the fourth at GMIT Galway (2009).

Uniquely, the research participants (62 suicide bereaved Irish families), have been involved in decision-making from the conception of *Lived Lives*, and many continue to be actively involved in co-producing and disseminating their private experiences of loss into the public. Importantly, as the *Lived Lives* art process unfolded, guided by its ethical, moral and human values, the families became deeply embedded within the art process. Over a period of 6 years, the families' interaction with the art works in progress, made from their material donations, became a platform both for the integration of their experience of loss and for their re-connection with their deceased family members, by transposing their private experiences of loss into the public domain. By such actions, this making public of something that was once a private experience, providing insight to that experience to a wider group of people, may help to develop a way into the understanding of such loss within a wider community. It has become a collaborative creative action woven together.

The physical artworks that emerged from this collabrative process encompass sculpted shirts, donated clothing and objects pertaining to the suicide-deceased, jacquards portraits of young people lost to suicide, offical documents, video, sound and written analysis by both family members and members of the public who have engaged with the project during its development.

McGuinness is interested in how art works as oppossed to what art is. He believes art has always worked in society. Based on the concrete experience of *Lived Lives* he also believes that art can be transformative, which lies at the heart of any art process. These cloth-based artworks create a human platform that facilitates the creation of an empathic process where an aesthetic experience will unfold to reflect, bear witness to and mourn young lives lost to suicide. In that vein *Lived Lives* is socially engaged art practice, deeply rooted in interdisciplinary research methods, and society that can bear witness to, validate and responsibly engage society with sensitive human issues, where loss, identity and validation are overlooked, or eclipsed by the silence of stigma

Lived Lives has also identified effective and innovative research methods, informed by a collaborative and integrated process between an artist, a scientist, bereaved families, Doctoral panel, roundtable conversations, various cultural and medical institutions and public audiences. The outputs in various forms contain substantial evidence that this model can engage society in a different collaborative and empowering conversation about suicide, collectively challenging the silence that fuels the stigma about this subject. The *Lived Lives* model may also be applicable to other areas of research, where silence perpetuates stigma. It still is unfolding.

The following pages contain images of some of the artworks, including the engagement of donor families with these artworks and journey and subsequent manifestations within the public domain - a journey from anonymous and abstract to ownership and identity.

21g (2003)

21g (2010)

A further reiteration of *21g* was in the site of the main library of Royal College Physicians Ireland, Kildare St Dublin. This event, "A Conversation and Journey on Suicide in Ireland" was supported by RCPI as part of their 2010 Public Lecture series. *21g* (2010) consisted of 104 fargments of shirt collars, weighting 21g, 82 male and 18 female, reflecting the gender differences in the participants in the Suicide in Ireland survey. At this event members of the audience were invited to stand amidst the artwork, to physically experience the cloth metaphors of loss. This became a site of collective conversation, as members of the public spoke freely of their own experience of loss by suicide - as one of the research family members put it "we did not ask for this, but this is what we got" It became a transformative space for many.

"My Patrick is in there..." Patrick's father, *21g* (2003).

Lost Portrait Gallery

"The most profound part of this Visual Arts Autopsy for me was when I went into the circular white room... I stood in front of her and I put my hands either side of her face. There was nobody in the world but us... I kissed her and walked out of the circular room and stood outside looking in at her for what seemed like an age... Three days later, I still feel healing and warmth. I felt the best I have felt in 5 years since my beloved 1st born child Fiona (aged 20) handed her life back to God. My block of ice in my chest is thawing"


Rebecca, 14


Caroline, 16


Richard, 15


James, 16


Harry, 27


Mark, 16


Nessa, 17


Richard, 17


Kieran, 17


Cillian, 17


Anthony, 19


Ros, 20


Ross, 19


Clive, 20


Christopher, 20


Robert, 20


Fiona, 20

These words (left) were provided in written feedback by Fiona's mother Brigid as she recounted standing in front of her daughter Fiona's tapestry in the *Lost Portrait Gallery* during the private family viewing in Galway '09. The *Lost Portrait Gallery* is a circular structure containing 34 woven jacquard portraits. These tapestries were worked from a photographic image of the deceased, donated by their family. They were installed chronologically, each at the precise height of the deceased with their first name and age woven beneath their portrait image. Following a private viewing, families gave consent for this work to enter the public domain.

Dominic, 21

Mark, 22

Liam, 22

Stephen, 22

Patrick, 23

Robert, 23

Shane, 24

Martin, 24

John, 24

Robbie, 26

Alan, 26

Eric, 29

Lar, 32

Paul, 33

Damien, 41

Tony, 41

Hughie, 44

Lost Portrait Gallery

Lost Portrait Gallery (RCPI, May 2010)

The *Lost Portrait Gallery* was described in public feedback as "a site for conversation about suicide", "a safe space to mourn and acknowledge loss" and a "cathartic public experience". Touching the tapestries became an integral part of engagement and conversations flowed. As evidenced by feedback, written and documented in video, a cathartic impact was reported by many families, which was expressly not proposed by the research team. No adverse effects were reported.


Kieran
Anthony, 19

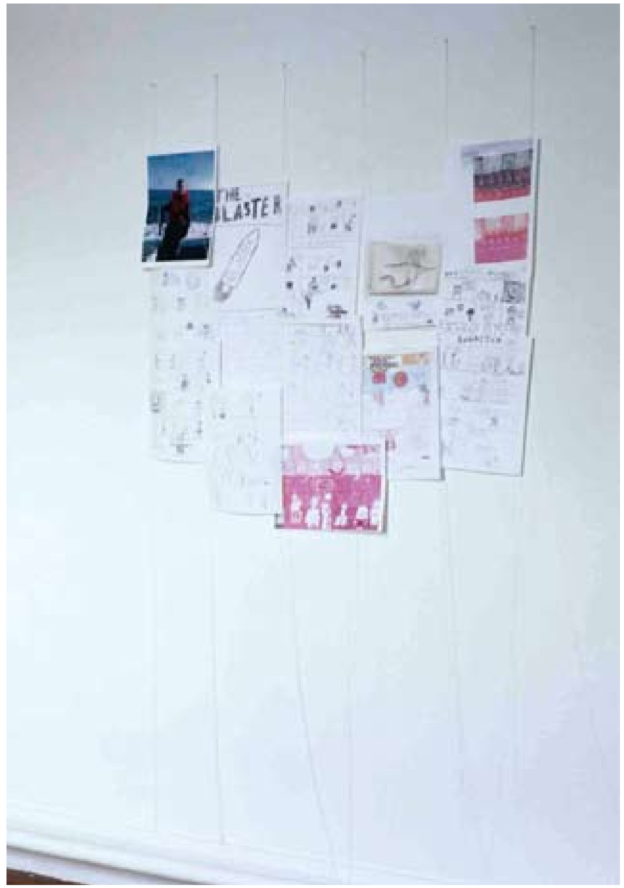

Patrick, 23

Archive Rooms

As part of the process 34 suicide-bereaved families donated personal belongings, images and stories of their deceased loved one to the *Lived Lives* archive, from which the *Archive Rooms* were created. The *Archive Rooms* consists of 34 discrete identically sized chambers containing the individual donated belongings of each suicide-deceased person. These belongings range from everyday objects of significance for the deceased (or their families), to such emotive objects as a gun or a debs dress. An audio extract from each family's narrative as recounted at the initial interview/ conversation played quietly in the background. Families engaged privately with this artwork whilst deciding whether or not the artwork from their donations should enter the "public domain". (*Archive Rooms*)

Alan, 26

Caroline, 16



Christopher, 20

Cillian, 17

"..each room is a family who has lost someone... each room is one of our sons or daughters.."

Richard's mother at Galway '09 Family Discussions.

Clive, 20

Damien, 41

Dominic, 21

Eric, 29

Archive Rooms

Fiona, 20

Harry, 27

Hughie, 44

James, 16

John, 24

Kieran, 17

Archive Rooms

Lar, 32

Rebecca, 14

Liam, 22

Mark, 16

Mark, 22

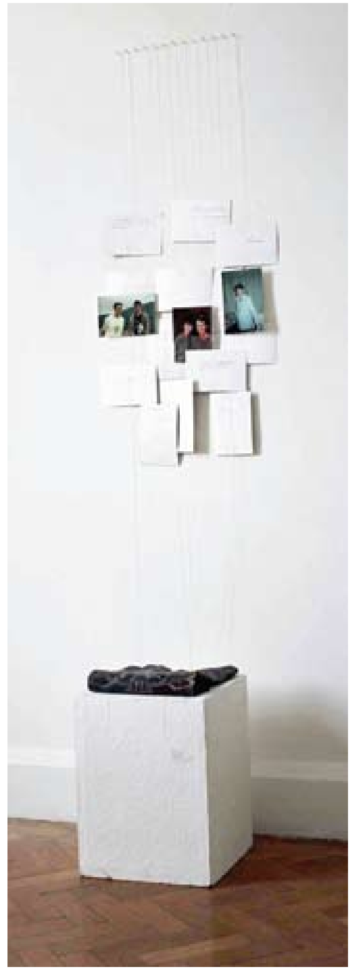
Martin, 24

Michael, 57

Neasa, 17

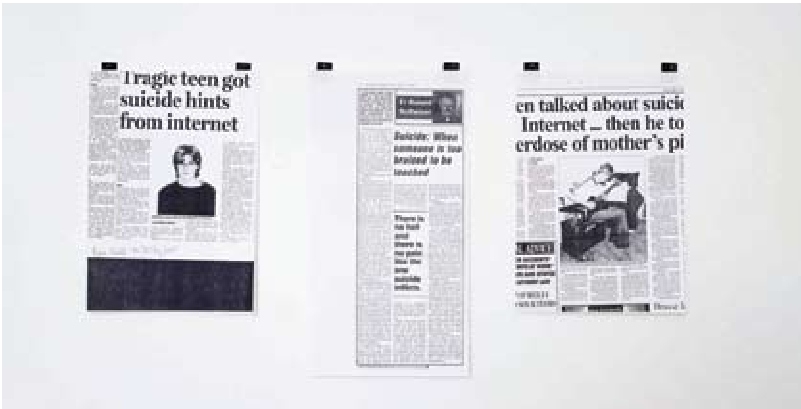
Archive Rooms

Patrick, 23



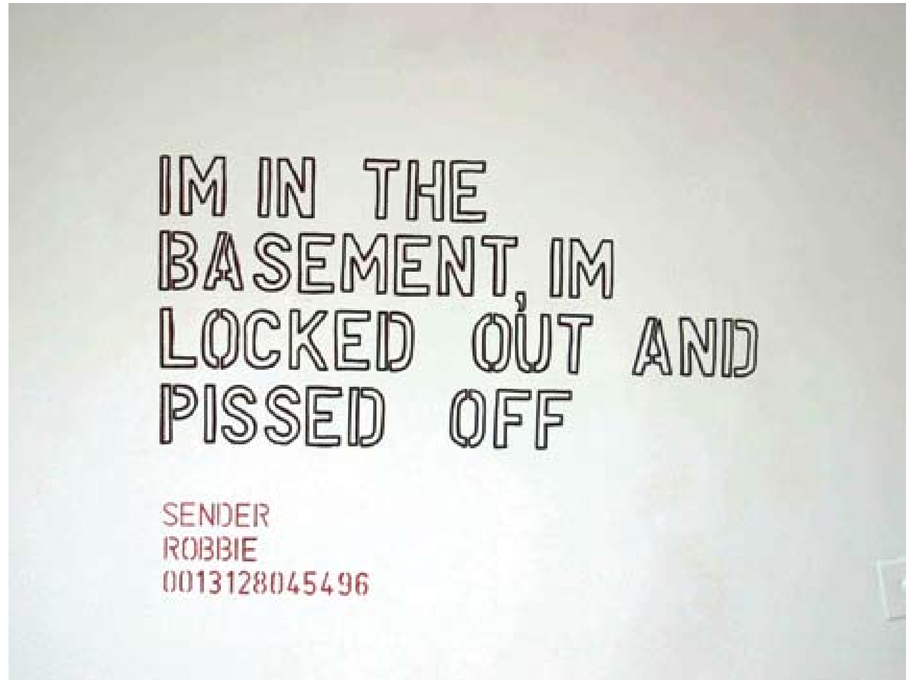
Ros, 20

Paul, 33



Richard, 15

Robert, 20



Robbie, 26

Archive Rooms

Robert, 23

Ross, 19

Shane 24


Tracy, 34


Stephen, 22


Tony, 41

"We didnt ask for this, but this is what we got"

Discussion

This is the first data-based systematic inquiry to quantitatively and qualitatively explore demographic, clinical, and psychosocial factors associated with suicide in 21st Century Ireland, derived from in-depth interviews with 104 families bereaved by suicide between 2003 and 2008, across the length and breath of Ireland. Many of the results are confirmatory in relation to suicide studies conducted previously internationally. However, due to a combination of study design factors and analytic factors, several new findings have emerged which may advance our knowledge especially in relation to young people, and may perhaps better inform our approach to suicide intervention and prevention.

Moving Towards Aged 21

Our decision to focus this particular suicide study on under 35 year old suicide deaths facilitated the discovery of the previously un-reported age-of-risk epidemiological transition effect - the "Many Young Men of Twenty" effect. An epidemiological transition effect has previously been observed with other factors in suicide risk such as economic development and suicide mortality (Moniruzzaman and Anderrson, 2004), elderly suicides (Shah, 2011), and social disadvantage (Wilkinson, 1994). The finding suggests that public health suicide prevention efforts should include an up-stream target towards much younger teens than has been the focus nationally heretofore, as this is where the age-acceleration effect is most observed. The gap in Mental health literacy identified elsewhere in this Report (and an allied study - Sweeney, 2011), suggests that this effort should be targeted at 12-15 year olds (or perhaps from aged 10), probably largely (but not exclusively) in schools. All teachers will require up-skilling in this effort, and it should have a particular and longitudinal positioning (from 10-18) within the primary and secondary school curriculum. Finally, further research should explore the possible protective effects of turning aged 21, and what it means within Irish communities.

Socio-demographics

Apart from the age effect described above, it is of note that 80% of deceased from our volunteer sample were male. Whilst suicide is a significantly male phenomenon in Ireland, concern should be noted with the rise in young female suicide rates as we have identified above, and elsewhere (O'Loughlin, 2009). Education of the father has previously been observed as a robust indicator of socioeconomic status (CSO 2012). In our study, the father had only partial secondary school education in 50% of cases. Further clarity and insights into the presence and extent of a social gradient for suicide in Ireland could be examined with national small area (electoral divisions) suicide data, as has been observed elsewhere (Taylor et al, 2005).

Mental Illness and Treatment, and Alcohol

The finding in relation to the frequency and impact of mental illness, particularly early onset depression is not surprising, as it tallies with similar suicide study findings internationally (Appleby et al, 2006; Barraclough et al, 1974; Foster et al, 1999; Mann et al, 1999). The many negative comments submitted by the research participants in relation to both the structure and in some instances the professional personnel providing statutory care, cannot be ignored. Providing acute psychiatric care for an adolescent in an inappropriate adult psychiatric facility is clinically compromising, and now illegal, yet it continues, albeit in fewer instances. Clearly it is frightening and undermining for the young person, and may be counter-therapeutic. Therapeutically, it makes little sense to use the barrier of aged 18 for admission to adult units, as adult units are not necessarily clinically appropriate for 18-22 year olds either. This will require further examination. Elsewhere, such as in Australia, the skills of a Young Adult Team and Unit would be made available (Commonwealth of Australia, 2009; Herrman et al, 2012, McGorry et al, 2013).

50 % of cases were identified as having alcohol abuse in the year prior to death. Of note, less than half of these cases had any alcohol in their system at death. Clearly alcohol is an important factor in the construction of the suicide process, but it is not the only one. We should also try to understand more about the social circumstances around alcohol intake. For example, an allied study (Sweeney 2011) identified what she termed "regretted disclosure" where a young person reveals his / her suicidal thinking to a peer while under the influence of alcohol, but denies this ideation the following day, and dismisses it as "drunk-talk", but tragically takes their life within two weeks. This disclosure creates a potential window of opportunity for intervention, if we can learn more about these circumstances. Whilst alcohol abuse and measures to try to curb bingeing deserve special attention, it also requires an understanding within a wider cultural and societal context for progress to be made.

Male Suicide and Communication of Suicidal Intent

The excess number of families of male suicide victims who volunteered to participate in our study reflects the male preponderance for suicide in Ireland. Suicide is 5 times more common in young males in Ireland compared with young females, for whatever reasons. 70% of young male suicide deaths in our study communicated some level of suicide intent equivocally or unequivocally to someone in the 4 weeks prior to death. This communication included overt statements about possible pending suicide (including a specific method) to more lateral and ambivalent references and hints to "not being around for much longer". Most of these disclosures were made to young peers (or siblings), occasionally under influence of alcohol (see above). Some of these disclosures were made to treating health professionals Clearly, such information-sharing must impact on young survivors (including guilt feelings), and in the absence of mental health literacy, (which tends to be lower in young men) such hints and references to suicide are frequently normalised, eclipsing the recognition of depression (Sweeney, 2011). Disclosure of suicidal ideas by young people to their peers has been described as potentially face-threatening situations requiring face-saving strategies, which often result in off-record, indirect, ambiguous, humorous and euphemistic communications (Owens et al, 2012). Listeners frequently find it difficult to judge the meaning and intention of utterances referring to suicide, such that the outcome is misunderstanding and closure of the communication. There is ample evidence that this mental health literacy gap needs to be addressed in Irish society and included as mandatory in the national teaching curriculum from early adolescence and perhaps earlier.

Life Events

As with several previous suicide studies internationally, both the presence and extent of extreme life events are associated with suicide deaths. Foster's Northern Ireland Study described the more life events the greater the suicide risk (Foster, 2011). Our data also identify significant negative life events being associated with suicide deaths.

Abuse

It may seem alarming that 20% of cases were known to have experienced either physical or sexual abuse, and 80% experienced this before aged 15. In a similar study in Ireland around the same period with live patients with psychiatric disorder (INSURE Study - n=176), 30% of those without a suicide attempt and 50% of those with a suicide attempt reported a history of abuse before aged 15 (Murphy et al, 2013). Clearly it is a factor that contributes to risk of suicidal acts and suicide (Brodsky et al, 2001), and it requires vigilance and sensitivity to allow victims to come forward.

Assaults, Muggings and Violence

Personal violation by assaults, muggings and violence has not previously received much notice in suicide literature. From our analyses, such events seemed to seriously undermine self-confidence, and trigger both fear and negative self emotion. It also preceded alcohol excess and prompted social withdrawal. In most instances, the acts of violence were perpetrated by persons known to the victim, thus constituting an extreme form of bullying and consequent humiliation. Recent studies elsewhere point to the role polyvictimization plays in the emergence of suicidal behaviour in adolescents (Fisher et al, 2012, Turner et al, 2012). Such acutely violating personal events contributed to the "teen-in-trouble" grouping in our childrens' study (above). Enforcement of legislation related to anti-social behaviour towards young people needs to occur on a national basis, in small towns as well as in larger cities, together with the development and evaluation of effective psychological interventions for victims.

Bullying

Whilst bullying has received much focus recently nationally, culminating in specific guidelines for schools, which should be welcomed (Department of Education and Skills, 2013), guidelines for the most part deal with bullying within schools, and by pupils on pupils. Our data suggest that bullying frequently occurs outside the school setting, or in cases who have left the school system. We have also identified instances where cases were possibly bullied or victimized by individuals in statutory authority such as teachers, gardai and health workers, under the guise of "teaching them a lesson". Any such instance is a mis-use of power and authority, and would constitutes one instance too many, and all statutory agencies engaging with young people require advanced training as well as monitoring and immediate remedial action to safeguard young peoples well-being.

Clusters

Discussions on suicide clusters have been largely anecdotal to date (eg Bridgend, North Cork) (Scourfield et al, 2010, Arensman, 2012). Assuming our dataset has elements of representativeness of youth suicide in Ireland, careful examination of our data, conservatively interpreted, has identified that 70% of younger suicide cases in Ireland may be exposed to a suicidal act in another within 3 months of their death by suicide. Across all ages, as many as 10% of suicide deaths in Ireland may be part of a cluster, and perhaps between 30-50% of suicide deaths under aged 21 may be part of a cluster. Clusters may be small (3-5 deaths), medium (6-9 deaths) or large (10 deaths), and they are likely to have a profound impact at a family and community level. When they repeat around the same location, they may also be referred to as point clusters. Whe they occur around an anniversary, the may be termed echo clusters. We have also demonstrated that inter-personal / social connectedness is more central than geography in relation to clusters, and this is now even moreso the case with the advent of internet social media sites. In practice, in our data there were usually social media connections with those already known to them in their geographical social circle of "friends". In theory, those to whom one is adjacent and most emotionally engaged with in a meaningful way in a virtual world could in theory be physically located anywhere on the planet. In one instance, this was observed in an apparent internet cluster, in advance of which, the young people in the cluster were accessing "suicide websites" encouraging them to end their lives.

Education, based on best practice in teaching and learning will be central to help young people effectively and safely navigate this largely un-supervised and policed internet space. Enforcement of current legislation or introduction of new legislation will also be required to ensure it is a safe space. The future role of the media is also relevant as media exposure of suicide is known to contribute to cluster effects (Biddle et al, 2012; Hawton et al, 2002). In this regard, current guidelines (and penalties for disregarding these) may need to be revised.

We have also described suicide couplets / dyads here for the 1st time. We propose that couplets are the gateway to cluster formations, and require further in-depth research to develop a deeper understanding of their genesis, and their contribution to clusters. Ireland may be considered a collection of relatively "closed communities" of approximately 50,000 people (county structure), and such a tribal structure may magnify the social (and media) reverberations that follow the community grief in the aftermath of a suicide death, particularly that of a young person, especially a male. Within this tribal structure, the sense of belonging lies within the tribe, on the margins of, parallel with, or outside society / community. Suicide may become encoded within "the tribe" as part of a retreat from threat, where it is not perceived as deviant or abnormal, but rather as uncomplicated - "just get on with it" - a surrendering signature of self-less unworthiness. It may become more inscribed in the "tribal code" if a suicide couplet arises. Efforts to identify such a phenomenon could possibly yield a dividend in terms of modifying suicide rates, as intervention and prevention efforts could be more concentrated on close associates / confidantes of a suicide death in the weeks and months following such an event. Further ethnographic / anthropological research into suicide in Ireland may give additional insights into elevated male suicide rates here (Saris, 2013). Ireland needs a national real-time database for teen and young adult suicide deaths to facilitate the early detection of evolving clusters. Such a complete system is not currently in place, so the monitoring system default mode is either one of partial knowledge or one of catch-up - a model which confounds comprehensive planning and response.

Suicide in Children

We have drawn on epidemiological research using data supplied by the CSO, which we conducted within the context of the Suicide in Ireland Survey. We have reported a rise in both male (50% increase) and female (100% increase) suicide in childhood over the last 2 decades (Malone et al, 2012). Preliminary qualitative analysis on the childhood subset of our dataset has identified mental distress, violation, humiliation and displacement as themes of particular relevance to suicide in childhood. The novel "teens-in-trouble/ troubled teens" conceptual paradigm may contribute nuanced insights into the suicide process in children and adolescents. A "teen-in-trouble" requires an integrated crisis, containment and de-escalation response at a statutory and community level, whereas a "troubled teen" requires a different and tailored co-ordinated multi-agency longitudinal model of intervention, ensuring quality and standardisation of care, nationally. This insight could potentially inform more tailored approaches to suicide intervention policy and practice, and is worthy of further research. The aftermath of a child suicide also fosters suicidal currents both within the bereaved family as well as peers and community, where media influences can take hold. These early findings will require additional in-depth exploration of analysis, and suggest that further research dedicated to suicide in childhood is warranted.

Statutory Services

Statutory Services before and after a suicide death are reflected in a frequently unfavourable light by the research participants in this study. Health services and mental health services in particular are reported as negative or very negative by 66% of those who experienced such services. Justice and Education also rate poorly in several instances, with Justice being scored as negative or very negative by almost 20% of respondents in the aftermath of a suicide death. The verbatim feedback quotes were provided to reflect the views of families "in their own words".

Many of the negative comments from research participants relate to lack of effective and sensitive communication between statutory services and either the distressed and possibly suicidal person, or the distressed bereaved family following a suicide death. Even the reference to the brain removal reported by one of the families, while it sounds most gruesome, is an unavoidable event that occasionally is requested by the pathologist examining the cause of death. It is assumed that any research activity would not have taken place without family consent, but nonetheless, in the family stress and confusion in the immediate aftermath of death, nothing is clear. A phonecall from the hospital is an insufficient and ineffective form of communication to relay exquisitely sensitive information about the coroners and pathologists duties, and will contribute to bereavement difficulties and complications, especially when any removed organs are returned for burial some months later. Guidelines exist to indicate best practice for all aspects of coroners relationship with families (HSE Guidelines - 2012). Clearly, these guidelines need to be enacted in every instance. Whilst over 3,000 people across the country have completed the 2 day ASIST Programme since the data for this report were gathered, this does not include the entire statutory service (as many of those who enrolled were from Voluntary Services), rendering the quality and sensitivity of response to suicidal individuals and bereaved families in the aftermath of a suicide death highly variable, with negative interactions still possible due to lack of necessary training.

There are many negative comments from families rrelating to structures within the mental health service, in addition to the communication deficiencies. These include the problem of psychiatric patients seeing a different doctor each visit. This is clearly a challenge in a specialty where the therapeutic alliance between doctor and patient is at very the cornerstone of treatment. All treating doctors treating these patients and dealing with families must have an advanced grasp of the English language. "Catchment area" is another recurring problem, where a postal boundary dispute arises between two neighbouring services as to who "owns" (or doesn't own) the patient, with the patient being caught in the middle of the dispute. This should cease immediately in the management and care of all psychiatric patients, but especially with patients who are distressed and suicidal.

In occasional cases, participants indicated that in their view, an individual in a statutory position of authority (such as a school teacher, or Garda) decided to use their position to "Teach a lesson" to a stressed, distressed or suicidal young person, and this action aggravated tension and stress for those young persons. Such assertions require serious consideration, and a mechanism for registering, processing and investigating such complaints should be simply accessible to the public. Once again, mandatory training for all statutory personnel is likely to eliminate the possibility of bullying or humiliation of young people by statutory services.

Several participants rated statutory responses negatively in both the immediate as well as longer term aftermath of a suicide death. There needs to be a consistency to the standard and quality of statutory response across all agencies to the patient and family in suicidal crisis, and similarly with all families in the aftermath of a suicide tragedy, where effective communication is essential. As this was a "volunteer sample", it is possible that the responses reflected in our study are less likely to contain positive comments about statutory services. Interviewing Coroners, Gardaí and Health Professionals was outside the scope of this project, but should be conducted to identify the challenges posed by the presence and extent of death by suicide to the agencies who deal with it most frequently. Nevertheless, in our study, any positive comments, particularly about health care were the exception. A national review of training and attitudes of 1st responders to patients in suicidal crisis as well as a quantification of the problem will immediately inform planners and policy makers about gaps in support and care. Similarly, the suicide post-vention period is exquisitely sensitive for bereaved families, and statutory responses mustn't add to their burden. Therefore, a similar review of training and attitudes will inform an upgrade of statutory post-vention response, with a particular emphasis on sensitive and effective communication. The UK Confidential inquiry model into suicide to include all statutory agencies has circumvented the defensive / adversarial position particularly in healthcare, evident in our research findings, and has yielded valuable knowledge and understanding, and a similar model should be considered in Ireland.

Science / Arts: Added value or New Dimension

The integration of Science / Arts into the research methodology to generate a Psychobiographical Autopsy and a Visual Arts Autopsy is entirely novel in the field of suicide research. It seemed to make sense for families to approach their tragedy using a science / humanities platform, and many families commented on this. In fact, it probably contributed to the overwhelmingly positive feedback scores the families provided following the research engagement. The subsequent bringing of the fruits of *Lived Lives* into the public domain suggests from feedback that such a model may bring a deeper level of understanding to both suicide and the effects of the aftermath to communities. This remains to be explored. International feedback has further encouraged the notion that this model deserves further exposure, examination feedback and evaluation in communities in Ireland , particularly young male communities, which are quite tribal (Sweeney, 2012). Often the social, emotional, cultural, spiritual and political determinants of suicide amongst tribal youth preclude the resolution of grief and lead to a permanent state of "sorry business" and "sense of hopelessness" within communities. This collective depression resulting from complicated grief results in dysfunctional communities and leads to ineffective decision making and cultural restitution. In other communities where suicide clustering has been observed, reference is made to "a healing circle", and propose that healing the family can only be attained by healing the community. In this regard, the *Lived Lives* approach may be analogous to such a healing circle (Hanssens 2010).

Strengths and Limitations

The dataset comes from a "volunteer sample", and so it is unknown whether this is a nationally representative sample. As the sample contains data on 36 cases aged under 21 years from over 20 counties, perhaps the findings may have somewhat more national validity in relation to youth suicide. Moreover, the demographics are broadly similar to a previously described national suicide sample (Dept of Public Health, 2001), who relied exclusively on coroners and clinicians data, compared with the psychobiographic autopsy model we employed, interviewing families in their homes, and using a modern research approach (Conner et al, 2012 a,b). Ethnic minorities did not contact our Survey, nor did any members from Ireland's indigenous ethnic minority, namely the Travelling community, who are known to carry a 6-fold increased risk for suicide amongst their males compared with Irish rates (Kelleher, 2010). The co-morbid psychopathology described in our dataset is comparable to that described in the Ireland North South INSURE dataset; N = 179; (Murphy et al 2012), as well as that described in other international suicide datasets (Barraclough 1974, Foster et al, 1999; Appleby et al, 2006). The ability in due course to compare suicide attempters and non-attempters from the INSURE Study (Bannan et al, 2012, Murphy et al, 2012) with the suicide completers from the Suicide in Ireland Survey will facilitate the statistical control of several potential confounding factors to identify predictors of suicidality in Ireland. The use of standardised research instruments and the construction of a tailored database are further strengths of the study.

As with all suicide studies using next-of-kin, the information is always indirect, second-hand, and may be consciously or un-consciously censored for a variety of reasons. Pursuing "new knowledge" in suicide studies is frought with challenges for researchers (Malone and Yap, 2009, Sweeney et al, 2009), in a field where bereavement support techniques in the aftermath of a suicide death frequently include efforts to "stop asking why". 2/3rds of Coroners sent Coroner's Report, indicating that there might be significant support from Corners if a national coroners study was undertaken, towards the establishment of a National Coroners Database. Pursuit of medical records was complicated, with some families not wishing this, whilst other families had already obtained records from treating hospitals. In others we received no response to our inquiries with health professionals. It is possible that lack of response in some cases was secondary to fear of legal liability. This dilemma could be resolved by adopting the UK approach of a National Confidential Inquiry which has been successful (Appleby et al, 2006).

Fortuitously, the window of study represented a period of relative economic stability (2003-2008), and so inordinate effects of economic recession represent one less confound in the interpretation of data. The identification of a small number of cases (6) where debt problems were in evidence may have been a harbinger of things to come. Whilst the stress of the burden of debt was articulated in some cases, the theme of external influences contributing to a humiliation factor was also in evidence. Obviously, this is worthy of further research and understanding.

Some find that research can be slow to materialise, and for a variety of reasons, this has been the case with this project. As with official CSO statistics (Central Statistics Office, 2013), it takes about 3 years for data to emerge that contains the full analysis of suicide data from around the country. Obviously it would have been preferable to produce the Survey and analysis more proximal to the actual suicide deaths under investigation. Nevertheless, the themes identified represent many of the stresses (modern and old-fashioned) for young people in modern Ireland. Despite any publication delay, we have still identified several new lines of inquiry that may support new ideas in suicide intervention and prevention in Ireland and beyond.

Implications & Recommendations

There are many implications deriving from this kind of research. Some may consider this "soft science", and perhaps it is. On the other hand, one has to consider the many difficulties in conducting any suicide research versus none. Ireland has a sufficiently significant youth suicide problem occurring in a research vacuum such that we remain in ignorance and fear, and at the mercy of anecdote, gossip and media influences to fill this vacuum. Moreover, we have the youngest demographic in the EU, such that a wave of young people are passing through this identified period of risk over the next two decades in the absence of any systematic knowledge that can inform early intervention and prevention efforts.

Based on the Survey findings, priority consideration should be given to: Troubled Teen and Teen-in-Trouble: A gap, path and needs analysis of mental health and psychological supports for teens and young adults in Ireland which includes the "troubled teen" and the "teen-in-trouble", with a focus on developing a modern understanding and tailored response to mental distress, victimization exposure and humiliation in school and beyond school.

Mental Health Literacy: A national review of psycho-education and mental health literacy and a bringing-forward / upstream intensive and evaluated approach to suicide intervention and prevention in Ireland into and beyond schools and into community in early teens.

Depression Screening: An early detection Adolescent Depression Screening programme should be considered, with resourced standardised pathways to care.

Real-time monitoring of suicide: Establishing a real-time monitoring of teen and young adult suicide in Ireland, to bring our latest knowledge of patterns of suicide into the present, with a particular focus on a greater understanding of suicide clusters in young people, and how best to modify them.

Violence and Muggings: Greater awareness of the psychological impact of violence and muggings on teens, including toxic humiliation, together with the development and evaluation of effective psychological interventions.

Statutory standards: Mandatory upskilling and monitoring of all workers in statutory authority who interface with young people to eliminate the possibility of bullying / victimization or humiliation of young people by such authorities, with transparent disciplinary action for any such involvement.
This requires a non-partisan cross-Departmental, integrated initiative particularly from Health, Education and Justice especially refined to address intervention as well as effective and sensitive communication during the immediate and longer term post-vention period.

Confidential inquiry: A confidential-type health / statutory services inquiry in the aftermath of any statutory services associated suicide death to overcome the defensive / adversarial position currently observed, and to gather new knowledge and understanding.

Alcohol: A deeper understanding of the role and culture of alcohol and its consumption in teens and young adults, particularly around the notion of "regretted disclosure" of suicidal thoughts to peers.

Research: A commitment to support (and fund) sustained research into suicidal activity including suicide in Irish teens and young adults. This needs to keep pace with the pace of change in 21st Century Ireland and should include:
A modified Suicide Survey (as described above) approach for annual investigation of the phenomenon of Suicide in Children, also using the UK National Confidential Inquiry into Suicide approach. This should include both quantitative and qualitative approaches as we have described.

Further research (outside the alcohol industry) is warranted on alcohol habits within Irish culture, to further explore the phenomenon of "regretted disclosure", which could provide a pathway for suicide intervention or prevention.

Further research is required to better understand the Ageing towards 21 finding we have identified - both from the perspective of being a risk factor, and the concept of being a relative protective factor upon reaching aged 21. This finding may or may not be culture, community or country-specific.

A research study into social and community impacts

of repatriated young Irish suicide deaths
A research study into suicide deaths in older people, and the rural urban divide
A research study into suicide in severely disadvantaged and marginalised communities
A National Coroners Study and establishment of a National Coroners Database for Suicide

Lived Lives: The response and feedback nationally and internationally to the integrated Science / Arts *Lived Lives* project suggests that it has potential to provide a sensitive platform for mourning and loss around suicide, and perhaps healing. Critical evaluation should be pursued (and funded), and if effective, it should be considered (and funded) as an additional resource for Community education and learning and recovery.

Training: Ireland needs to become an international leader in training efforts around suicide intervention, prevention and its aftermath. Therefore, there needs to be a concerted and co-ordinated effort by all educational and training institutions to raise the standard of training in this regard across the country, and through all levels of society. It should be noted that this is distinct from, and beyond, "awareness".

Ground Up: Our Survey identified very fragmented communities in the aftermath of a suicide event (or events). This suggests that support services are at a remove, and either dis-connected or un-connected to communities at ground level. This fosters a polarizing effect between voluntary and statutory agencies which engenders mis-trust, anger and hurt, and does not facilitate effective healing. Healing a family may require healing the community. A successful suicide prevention strategy requires an over-arching approach with active inclusion of ground level voluntary community agencies, who frequently are best placed to lead local suicide response efforts.

This report demonstrates the added value of research which can contribute to a more in-depth knowledge and understanding of suicide in Modern Ireland. Tackling suicide is a challenge for Irish society which requires leadership and a renewed unity of purpose and effort. This challenge can be informed by research findings as identified in this report, which advocates an up-graded sustained, resourced, dedicated and over-arching collective statutory and voluntary effort to rapidly come to terms with and modify suicide rates in 21st century Ireland. Such effective, over-arching models to prevent young male adult deaths in Ireland from other causes, such as road traffic accidents, are worth considering. Its people deserve no less.

Personal Reflections

In hindsight, it was remarkable that as many as 104 families from all over Ireland contacted the research team and invited the researchers who were unknown to them into their homes to share the re-telling of an event which was in most instances the greatest tragedy in their lives "we didn't ask for this, but this is what we got". They showed us kindness, generosity, hospitality and warmth. They also encouraged us to keep going, despite many adverse events and circumstances. Their motivation in taking part was to try to help one other family in Irish society avoid what they went through, and it provided us with a rare glimpse of humanity, a privilege which brought with it the responsibility of completing the project and publishing the results. In the midst of their grief, their wish was to help another.

There are deficits, shortcomings and omissions inevitably in such a complex project. I sincerely hope there are no major errors in this regard. My personal apologies for these, and for any upset this may cause. The findings in this Report should be challenged, and may also need replication to enhance validity. The conclusions and recommendations are solely the view of the author, and do not necessarily represent the views of any statutory or voluntary organisation.

We pledged that this would not end up as another report gathering dust on a shelf. To avoid this, we have already published some of the early findings in research journals in Ireland and internationally, to disseminate widely, with hopefully more to come. Furthermore, *Lived Lives*, the science arts collaborative, is slowly gathering momentum, more-so internationally than in Ireland to date. However, as word spreads, so too will the reputation of the *Lived Lives* enterprise, and it's potential to open communities to a more serious, informed, durational and empowered conversation, which may impact suicide and its aftermath in a novel way for Ireland. Surely, all those we have lost to suicide and also all our research participant families deserve no less than this.

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Carey O'Loughlin (2009). Suicide among Young Women in Ireland 1980-2005: A Socioeconomic Analysis. MSc Thesis. UCD

McGorrian C, Fitzpatrick P, Hamid N, Daly L, Malone KM, Kelleher CC (2013). Frequent Mental Distress (FMD) in Irish Travellers: Discrimination and Bereavement negatively influence Mental Health in the All- Ireland Traveller Health Study. Transcultural Psychiatry 2013 in press.

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Sweeney L, Quinlivan L, McGuinness S, Carey O'Loughlin E, Delaney L. Malone KM (2009). Is there a role for suicide research in modern Ireland? Ir J Psych Med; 26(3): 104-106

ASSOCIATED PRESENTATIONS TO DATE

Malone K & McGuinness S. Suicide in Ireland: Conversations and journeys through loss with Science and Arts:

- College of Psychiatry of Ireland, Annual Meeting, Croke Park, November 2009
- 13th International Symposium on Suicide and Suicidal Behaviour, Rome, Sept 1st, 2010
- Royal College of Physicians Public Lecture Series, Kildare St Dublin April 30th-May 1st 2010
- Joint Oireachtas Committee on Health and Children, Kildare St, Sept 6th 2010
- Annual Contact Conference, Stormont Hotel Belfast, November 22nd-23rd 2010
- Merriman Summer School, Summer 2010
- School of Art, Institute of Chicago, Summer 2012

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Suicide Research Team: Kevin Malone; Seamus McGuinness; Lorna Sweeney; Leah Quinlivan; Suzanne O'Connor; Lucy Madigan; Olivia Murphy; Aoibheann McLoughlin, Therese Murphy, Eimear Crowe and Emer Carey O'Loughlin.

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Suicide Survey: Tables

DEMOGRAPHIC FACTORS

1.1 Sex distribution of Survey	Total
Female	20
Male	4
Grand Total	**104**

1.2 Age distribution of Survey	
Age	**Total**
14	1
15	2
16	5
17	6
18	4
19	3
20	16
21	2
22	3
23	2
24	7
25	5
26	6
27	2
28	1
29	5
31	3
32	2
33	1
34	5
35	2
36	1
37	1
38	2
39	1
41	5
44	1
48	1
49	1
52	2
57	2
60	2
61	1
68	1
Grand Total	**104**

1.3 Age distribution of Survey	
Marital Status	**Total**
Divorced	14
Married	17
Single	73
Grand Total	**104**

1.4 Sexual Orientation	Total
1. Heterosexual	96
2. Homosexual	3
3. Other	5
Grand Total	**104**

1.5 Number of Years Full Time Education of deceased in Survey	Total
missing	1
0	2
6	1
7	2
8	5
9	21
10	4
11	5
12	31
13	8
14	9
15	4
16	8
17	2
19	1
Grand Total	**104**

1.6 Level of Household Income	Total
Missing	8
2	7
3	10
4	13
5	20
6	27
7	18
8	1
Grand Total	**104**

1.7 Highest Level of Education for Father	Total
Missing	11
01 partial primary school	5
02 completed primary school	12
03 partial secondary school	24
04 completed secondary school	26
05 attended College	7
06 completed College	9
07 completed post-grad training	3
Grand Total	**97**

1.8 Highest Employment Level for Deceased	Total
Missing	8
02	35
04	40
06	14
08	1
Grand Total	**98**

1.9 Occupation of Deceased at time of Death	Total
Unemployed / student	47
1	3
2	9
3 machine operator, semi-skilled worker	12
4	16
5	3
6 technician, semi-professional	6
7	5
8	1
9 higher executive, major professional	2
Grand Total	**104**

MENTAL ILLNESS & PSYCHIATRIC TREATMENT FACTORS

2.1 Major Depressive Episode Current	Total
	4
No	52
Yes	48
Grand Total	**104**

2.2 Psychotic Disorders Lifetime	Total
Missing	6
No	87
Yes	11
Grand Total	**104**

2.3 Psychotic Disorders Lifetime	Major Depressive Current Episode	Total
		4
	Yes	2
Total		6
No	No	48
	Yes	39
No Total		87
Yes	No	4
	Yes	7
Yes Total		11
Grand Total		**104**

2.4 Major Dep With Psy Features Current	Total
	102
No	1
Yes	1
Grand Total	**104**

2.5 Depression: number of 1st degree relatives with Depression	Total
-9	6
0	45
1	35
2	12
3	3
4	2
(blank)	1
Grand Total	**104**

2.6 Age Of Onset Of Psychiatric Illness	Total
0	62
8	1
14	3
15	1
16	5
17	2
18	3
19	5
20	6
21	2
23	1
24	1
25	1
29	1
30	1
32	1
33	1
35	1
38	1
45	1
49	1
52	1
57	2

2.7 Age Of First Psychiatric Hospitalisation	Total
Missing	1
0	75
15	1
16	2
17	3
18	1
19	2
20	1
21	2
22	1
23	1
25	3
30	1
32	2
35	1
39	1
41	1
48	1
49	1
50	1
52	1
61	1
Grand Total	**104**

SUBSTANCE ABUSE & COMORBIDIT FACTORS

3.1 Alcohol Abuse Past 12 Months	Total
Missing	7
No	46
Yes	51
Grand Total	**104**

3.2 Substance Abuse Non Alcoholic Past 12 Months	Total
Missing	8
No	70
Yes	26
Grand Total	**104**

3.3 Substance Abuse NonAlcoholic Past 12 Months	Alcohol Abuse Past 12 Months	Total
Missing		6
	No	1
	Yes	1
Total		8
No		1
	No	39
	Yes	30
No Total		70
Yes	No	6
	Yes	20
Yes Total		26
Grand Total		**104**

Suicide Survey: Tables

3.4 **Has Deceased Received Out Patient PsychoTherapy**	**Total**
Missing	3
1 Yes	32
2 No	65
-9 Unknown	4
Grand Total	**104**

3.5 **Did Deceased Ever Receive Psychotropic Medication**	**Total**
Missing	3
1 Yes	46
2 No	55
Grand Total	**104**

3.6 **Major Depressive Episode Current**	**Alcohol Dependence Past 12 Months**	**Total**
Missing		4
Total		4
No		1
	No	38
	Yes	13
No Total		52
Yes		1
	No	40
	Yes	7
Yes Total		48
Grand Total		**104**

SUICIDALITY FACTORS

4.1 **Address or Place Of Death**	**Total**
Missing	3
1. Home	58
10. Woods/Park/Playing Fields	1
2. At home but not in the house	12
4. Psychiatric Hospital	2
6. Garage or outhouse	1
7. Other	2
7. Statutory Accommodation	1
8. Other	1
8. Other	1
9. Other	6
9. Other	1
9.. Other	1
9.Other	1
Other	12
School	1
Grand Total	**104**

4.2 **Suicide Note**	**Total**
Don't know	2
1. Absence of Note	53
2. Note written but torn	
up or thought about	3
3.Presence of note	44
4. Missing	2
Grand Total	**104**

4.3 **Overt Communication Of Intent Before Attempt**	**Total**
Don't know	2
1. None	32
2. Equivocal Communication	42
3. Unequivocal Communication	25
4. Missing	3
Grand Total	**104**

4.4 **Precautions Against Discovery**	**Total**
Missing	2
1. No precautions	13
2. Passive Precautions	54
3. Active Precautions	34
4. Missing	1
Grand Total	**104**

4.5 **Did Subject Ever Attempt Suicide**	**Total**
FALSE	70
TRUE	34
Grand Total	**104**

4.6 **Exposure To Suicidal Behaviour**	1 case	2 cases	3 or more cases
FALSE	34	79	94
TRUE	70	25	10
Grand Total	**104**	**104**	**104**

4.7 **Friend Death**	**Total**
Missing	6
0 None	74
2 Definite or Positive	24
Grand Total	**104**

4.8 **In Treatment at Time of Attempt**	**Total**
Missing	10
No	59
Yes	34
Grand Total	**103**

4.9 **Firearms Owned Subject**	**Total**
Missing	3
0 None	94
2 Definite or Probably	6
NA	1
Grand Total	**104**

4.10 **Suicidality Current (MINI)**	**Total**
Missing	5
No	29
Yes	70
Grand Total	**104**

4.11 Suicidality Risk (MINI)	Total
Missing	5
1. Low	17
2. Medium	14
3. High	38
4. None	30
Grand Total	**104**

4.12 Suicide_1st degree Family History	Total
Missing	6
0	89
1	9
Grand Total	**104**

4.13 Suicide Attempt_1st Degree Family History	Total
Missing	6
0	81
1	12
2	3
3	1
(blank)	1
Grand Total	**104**

4.14 Method of Suicide	Total
Overdose	11
Jumping	2
Gun	5
Drown	5
Hanging	81
Grand Total	**104**

PSYCHOSOCIAL FACTORS & LIFE EVENTS FACTOR

5.1 Did Deceased Believe in God	Total
Missing	2
Definitely No	15
Definitely Yes	31
Probably No	25
Probably Yes	31
Grand Total	**104**

5.2 Did Dec Complain Of Lacking Friends	Total
Missing	3
1. Yes	22
2. No	78
3. Missing	1
Grand Total	**104**

5.3 Did Dec Ever Complain Of Feeling Lonely	Total
Missing	2
1. Yes	38
2. No	60
3. Missing	4
Grand Total	**104**

5.4 Change in Living Arrangements During Month Pre-Death	Total
Missing	6
No	59
Yes	39
Grand Total	**104**

5.5 Inter-Personal Conflict	Total
Missing	5
0	1
0 None	40
1 Probably	4
2 Definite or Positive	54
Grand Total	**104**

5.6 Face to Face Contact Primary Attachment Figure	Total
Missing	7
1. Lives with Parent	50
1. Lives with Spouse	7
1. Lives with spouse.	1
2. 1 time/week or more	13
3. 2-3 times per month	7
4. 6-11 times per year	2
5. 1-5 times per year	1
6. Summer and Vacations only	1
7. None	7
8. N/a or Parent deceased	6
8. N/a or Parent deceased/ Lives with spouse	1
-9	1
Grand Total	**104**

ABUSE FACTORS

6.1 History Of Physical Or Sexual Abuse Over Lifetime	Total
Missing	4
1 Yes	20
2 No	74
-9 Unknown	6
Grand Total	**104**

6.2 Type Of Abuse	Total
Missing	8
1 Physical	8
1 Physical	2
2 Sexual	7
3 Both	2
-8 Not applicable	76
Bullying/ Mugged (under 21)	14

6.3 Did Abuse Take Place Pre-Fifteen Years Old	Total
Missing	8
1 Yes	16
2 No	74
-8 Unknown	6
Grand Total	**104**

6.4 Any Social Service Involvement	Total
Missing	11
1 Yes	2
2 No	50
-8 N/a	41
Grand Total	**104**

SEPARATION AND LOSS FACTORS

7.1 Deceased Separated From Either Parent	Total
Missing	5
1 Yes	25
2 No	74
Grand Total	**104**

7.2 Deceased Father Alive	Total
Don't know	3
1 Yes	81
2 No	20
Grand Total	**104**

7.3 Deceased Mother Alive	Total
Don't know	3
1 Yes	88
2 No	13
Grand Total	**104**

Suicide Survey: Tables

7.4 Deceased Mother Alive	Deceased Father Alive	Total
Missing		3
Total		3
Yes	Yes	78
	No	10
Yes Total		88
No	Yes	3
	No	10
No Total		13
Grand Total		**104**

SINGLETONS, COUPLETS AND CLUSTERS

8 Suicide Grouping	Total
Singleton	79
Associated Suicide	15
Cluster	10
Singleton	79
Grand Total	**104**

9. Suicide in Ireland Survey: Age-specific life stage factors.

Finance	Career	Relationships	Peers	Support
The fifteen/sixteen year olds were by and large still financially dependent on their parents, while the older age groups were financially independent to a varying degree. Financial independence could bring its own pressures both in terms of earning enough of an income and dealing with consequences when this did not happen.	Even though some of the fifteen/sixteen year olds had been struggling with school they were not facing the immediate challenge of deciding on a 'career' or 'occupation'. Some of those in the older age groups had struggled to find their 'place' in terms of their occupation after leaving school.	Where relationships presented challenges to young people these tended to be parents and friends for the younger age group, and partners for the older age groups. Fights immediately prior to their deaths were with parents for the former, and girlfriends for the latter.	The younger age group were perceived to have been vulnerable to the negative influence of their peers. Parents often disapproved of their friends, especially when they were older. Where they were involved in problematic substance use this was often attributed to these friendships.	The younger age group faced particular challenges in accessing support in terms of age-appropriate services.

10. Suicide in Ireland Survey: Interface with Statutory Services

	Health	Before Justice	After Education	Post-Vention
0	47	80	-	-
1	32	7	6	19
2	24	12	97	83
3	0	2	0	3
4	103	103	103	103

Table key:
0 Absent
1 Negative / Very Negative
2 Neutral
3 Positive / Very Positive

SUICIDE SURVEY FEEDBACK

11.1 Interviewee Experience of Survey	Total
Missing	2
1. Very Positive Experience	73
2. Quite Positive Experience	13
3. Positive Experience	14
6. Very Negative Experience	1
Not Available	1
Grand Total	**104**

12. **Suicide in the Children of Ireland: 1993-1998 vs 2003-2008 Raw numbers and Rates per 100,000 population**				
	5-14 years		15-17 years	
	93-98	03-08	93-98	03-08
Total (Raw)	28	25	77	97 /100k
Male (Raw)	23	18	61	71 /100k
Female (Raw)	05	07	16	26 /100k

13. Poisson Regression Analysis of Age, Sex and Decade Effects on Number of Suicide Deaths in Children of Ireland 1993-2008

Count	Coef.	Std. Err.	z	P |z|	[95% Conf.	Interval]
Decade	.1500607	.1331185	1.13	0.260	-.1108467	.4109681
Age	1.188763	.1568918	7.58	0.000	.881261	1.496266
Gender	-1.164308	.1558809	-7.47	0.000	-1.469829	-.8587865
-cons	2.927644	.159253	18.38	0.000	2.615514	3.239774

14. Poisson Regression Analysis of Age, Sex and Decade Effects on Rate (/100,000) of Suicide Deaths in Children of Ireland 1993-2008

Rate	Coef.	Std. Err.	z	P |z|	[95% Conf.	Interval]
Decade	.3947576	.337327	1.17	0.242	-.2663911	1.055906
Age	1.619323	.4453648	3.64	0.000	.7464237	2.492222
Gender	-1.083345	.3805984	-2.85	0.004	-1.829304	-.3373857
_cons	.5970032	.4641545	1.29	0.198	-.3127228	1.506729

“what’s said
is said, it can’t
be unsaid”