Developing a Community Response to Suicide

A resource to guide those developing and implementing an Inter-Agency Community Response Plan for incidents of suspected suicide, particularly where there is a risk of clusters and/or contagion.

HSE National Office for Suicide Prevention

September 2021

Connecting for Life

Contents

Section 7

Section 8

Appendices

Foreword

On behalf of colleagues, we are very pleased to introduce these Guidelines - *Developing a Community Response to Suicide: A resource to guide those developing and implementing an Inter-Agency Community Response Plan for incidents of suspected suicide, particularly where there is a risk of clusters and/or contagion.*

These guidelines have been developed because we know of the potentially devastating impact a death by suicide, or series of suicides, can have in any given community. These deaths are usually sudden, can be very traumatic and can leave individuals and groups with a wide range of difficult emotions and reactions.

A compassionate and coordinated response within the community is imperative if we are to provide timely and appropriate bereavement support, minimise the harmful impact on others and reduce the potential for contagion elsewhere in the community. While there are many common practices and approaches that can help in these situations, we need to remember that every individual, family, social and community situation is unique.

These guidelines take this into careful consideration and are designed to complement other relevant frameworks such as psychosocial structures and supports or the HSE Incident Management Framework. They are aligned with specific objectives and actions in *Connecting for Life, Irelands National Strategy to Reduce Suicide and reflect many principles in Sharing the Vision, a Mental Health Policy for Everyone* - which focuses on the provision of recovery-focused integrated mental health services and approaches in Ireland.

By using these guidelines, and developing/activating a Community Response Plan we can ensure;

1. **Foremost involvement and engagement with bereaved individuals or communities**
2. **A bottom-up approach committed to serving the expressed needs of the community and building on the community's own strengths**
3. **Robust links to existing appropriate services, supports and information sources**
4. **A coordinated multi-agency approach with due regard for the contribution that all stakeholders can make**
5. **A commitment to ongoing learning and the review and improvement of all practices.**

A prevailing theme in these guidelines is one of preparedness. It is critical that early opportunities for prevention, postvention intervention are not missed, especially when a situation is rapidly evolving. It is important that we invest time and attention up front – to improve readiness to deliver rapid responses with coordinated approaches and careful thinking, whenever the need might arise.

We would like thank Eustace Patterson Limited and TMA Consultants who drafted guidelines after a comprehensive review and consultation process in 2019, and the Working Group of Resources Officers for Suicide Prevention and NOSP Staff who developed this final resource document in 2020.

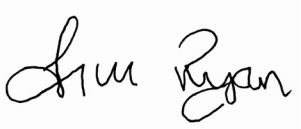
We are also very appreciative to all others who shared their experiences and insights along the way. While research into response interventions continues to evolve, these guidelines are primarily grounded in sound practice informed by your vast experiences and expertise.

By providing a safe and workable roadmap for how we can proactively support communities who have experienced a loss (or multiple losses) through suicide, we hope this resulting set of guidelines will make a meaningful difference in our communities and across our wide range of mental health services nationwide.

John Meehan

HSE Assistant National Director

Mental Health Planning and Head of the
National Office for Suicide Prevention (NOSP)



Jim Ryan

HSE Assistant National Director

Head of Operations,
HSE Mental Health Services

1. Introduction

These guidelines are intended to support the development of a Community Response Plan (CRP) for your area. While other related plans (for example, psychosocial responses) may already be in place in a particular area, these guidelines support the development of a CRP specifically for cases of suspected suicide(s). They are a practical resource for anyone involved in the preparation, writing, implementation and review of a new or existing plan. They inform how appropriate teams, roles, responsibilities and systems should be established. They give clear criteria for activating and deactivating a CRP and guidance on how it can be evaluated and reviewed.

Some areas may have a plan which has been activated in the past, other areas may have a plan in development and some may not yet have a plan at all. These best practice guidelines can be used either to update an existing plan or to develop one from the beginning.

Given that a wide representation from various sectors of the community may be involved in a response to suicide, these guidelines aim to promote cross-community and inter-sectoral collaboration and partnership working. Ultimately, they aim to promote safety, hope and resilience in communities that have been impacted by suicide(s).

Preparedness is key to the successful response to incidents of suspected suicide and this can be achieved through the process of preparing and developing the plan, as well as learning from its activation.

These guidelines are divided into two processes:

1. **Developing a CRP:** This process is set out in Section 4. It involves developing a CRP for your region. The CRP sets out the steps that should be taken when addressing suspected suicide(s).

2. **Activating a CRP:** This process is set out in Section 7. It involves the four steps taken once a suspected suicide(s) has been identified. The four steps are: monitoring and decision-making, activation, deactivation and evaluation.

The diagram on the following page sets out the detail of these two processes.

Developing and activating a CRP

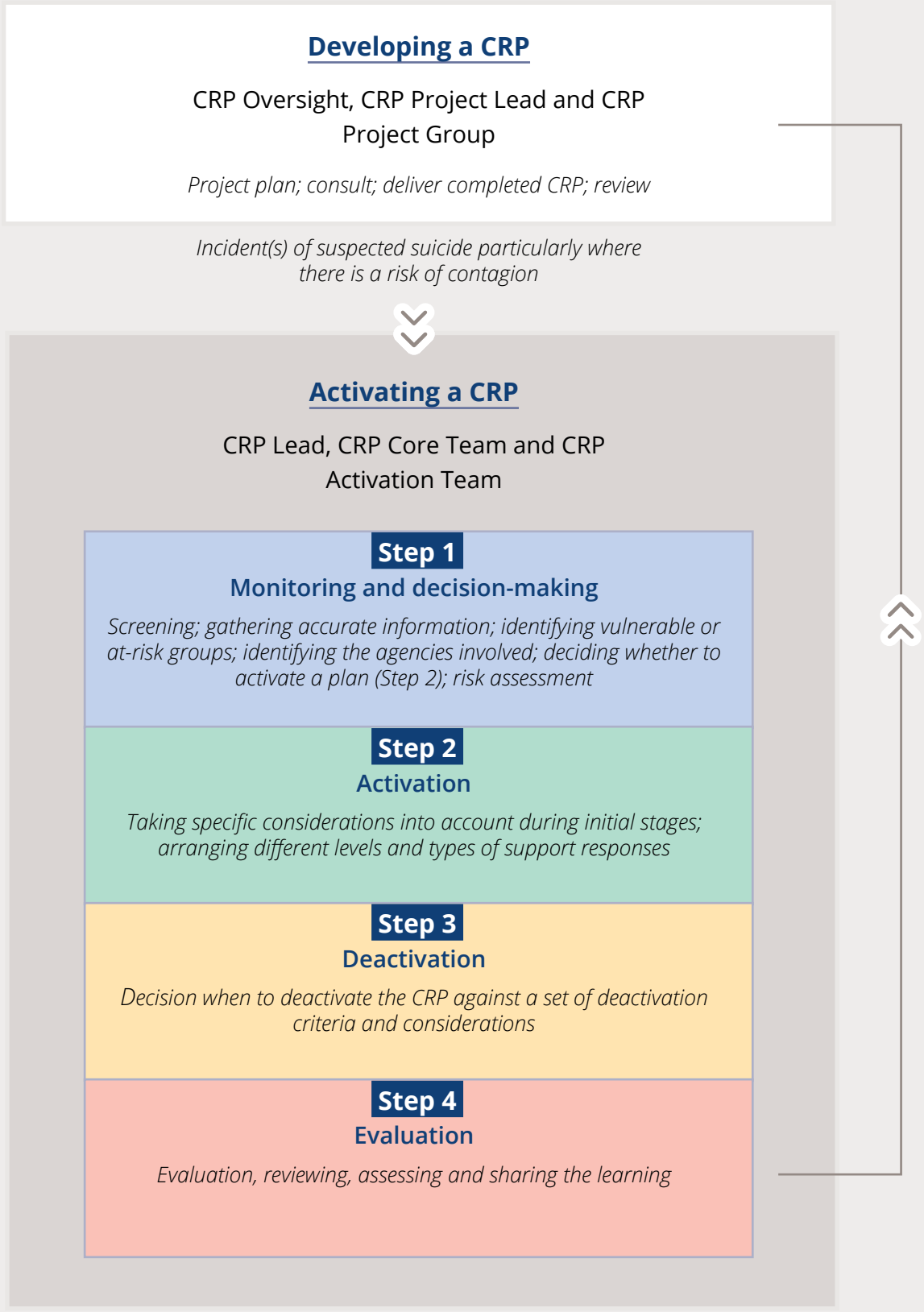


Figure 1: Developing and activating a CRP

2. About these guidelines

To inform the development of these guidelines, in 2019 the HSE National Office for Suicide Prevention (NOSP) engaged Anne Eustace and Ann Clarke (Eustace Patterson Limited) and Tom Martin (TMA Consultants), who developed draft guidelines through a process of:

- Reviewing literature, practical experience and learning from elsewhere.
- Reviewing a sample of critical incident plans developed and implemented in different settings.
- Conducting workshops with Resource Officers for Suicide Prevention (ROSPs).
- Consulting with other stakeholders, including HSE Mental Health Services in CHO 4, CHO 7, and CHO 9, the National Educational Psychological Service (NEPS), Tusla, Children and Young People's Services Committees (CYPSCs), Pieta, the Samaritans, the GAA and the Mayo Suicide Bereavement Liaison Service (SBLO).

In 2020, a working group comprising NOSP staff and ROSPs developed the final guidelines. Membership of the working group was as follows:

- Ciarán Austin - Communications Manager, HSE National Office for Suicide Prevention
- Niamh Crudden - HSE Resource Officer for Suicide Prevention, CHO 7.
- Tracy Nugent - HSE Resource Officer for Suicide Prevention, CHO 5.
- Mary O'Sullivan - HSE Resource Officer for Suicide Prevention, CHO 2.
- Sarah Woods - Lead for Strategy Coordination, Quality and Education, HSE National Office for Suicide Prevention.

The working group was supported by the wider NOSP office and ROSP network. The guidelines incorporate evidence-based findings, as well as the real-life experiences of those working in the area. They have been reviewed by HSE Heads of Service (Mental Health), the Heads of Psychology Services Ireland (HPSI) Group, HSE Quality and Patient Safety and the National Suicide Research Foundation at University College Cork.

These guidelines supersede the 2011 HSE publication, ***Responding to murder suicide and suicide clusters***. They are aligned with ***Connecting for Life, Ireland's National Strategy to Reduce Suicide***. This strategy sets out a vision for Ireland where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health and wellbeing. It provides increased supports for suicide prevention, intervention and postvention.

For more information on Connecting for Life, visit **www.connectingforlifeireland.ie.**

3. Commonly used terms

Community Response Plan

A Community Response Plan (CRP) is a coordinated response, in this case to suspected suicide(s) and/or where there is concern about contagion (the 'copycat' effect). A CRP aims to facilitate the early detection of potential related suicides and provide guidance and support in the provision of a timely and coordinated response amongst a number of agencies, as existing services are unable to effectively respond in isolation to the situation. A CRP is also a form of postvention activity that seeks to promote healing after a death by suspected suicide (or suspected murder-suicide) and to reduce the risk of subsequent suicides. Research suggests that effective intervention in response to a suicide cluster is more likely if a response group is established than if no such group exists (Hawton, Hill, Gould, John, Lascelles & Robinson, 2019).

Community

From a health promotion perspective, a ***community*** is typically defined as "a specific group of people, often living in a defined geographical area, who share a common culture, values and norms, are arranged in a social structure according to relationships which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group and share common needs and a commitment to meeting them." (World Health Organisation, 1998). Therefore, the particular setting and size or type of community can vary.

Suicide, self-harm, clusters and contagion

The World Health Organisation (WHO, 2020) provides the following definitions:

Suicide: "The act of deliberately killing oneself". Suicide was de-criminalised in Ireland in 1993, an act that precipitated Ireland's suicide prevention activities (National Suicide Research Foundation (NSRF), 2020).

Suicide attempt: "Any non-fatal suicidal behaviour and refers to intentional self-inflicted poisoning, injury or self-harm which may or may not have a fatal intent or outcome."

Suicidal behaviour: "A range of behaviours that include thinking about suicide (or ideation), planning for suicide, attempting suicide and suicide itself."

Self-harm: "An act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or expected physical consequences."

Murder-suicide

Murder suicide is murder followed by the suicide of a perpetrator, within one week. It may involve:

- **Familial suicide***:* The killing of one's child(ren) and spouse/partner, followed by suicide.
- **Filial suicide***:* The killing of one's child(ren) followed by suicide. Such deaths may also be referred to as ***filicide*** (involving children aged 1 to 18 years), ***infanticide*** (involving children up to 1 year) or ***neonaticide*** (involving children within the first 24 hours of birth).
- **Extra familial suicide***:* The killing of one or more others (usually not related) followed by suicide (Marzuk, Tardiff & Hirsch, 1992, cited in NOSP, 2011).

Please note

The response required for a murder-suicide is different to that required for a suicide cluster. Cognisance must be paid to this in the development of response plans (Arensman & McCarthy, 2017). Each area should decide who should lead on this as part of developing the CRP. See Appendix 5.6 for further information

Suicide cluster

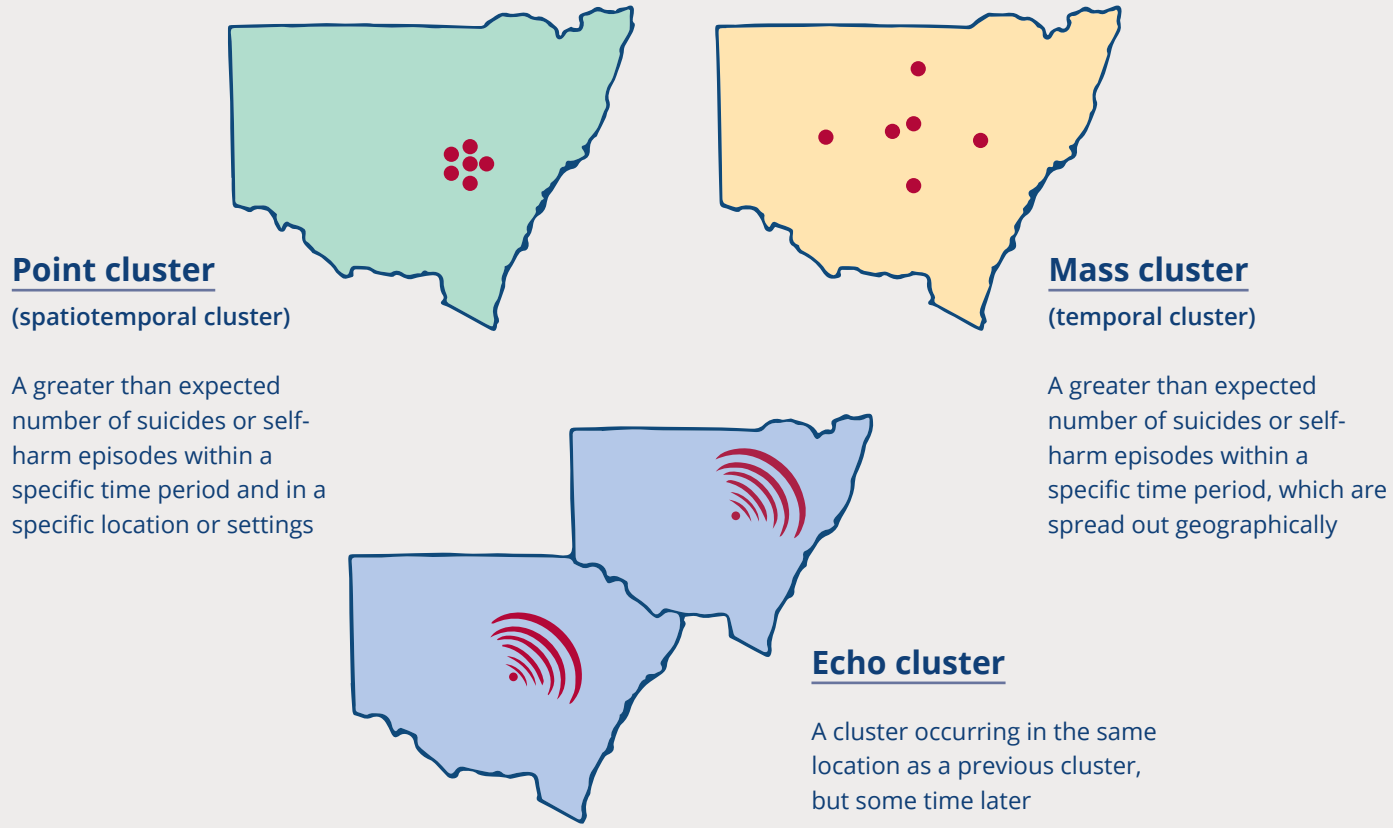


Figure 2: Types of suicide clusters (Hawton et al., 2019)

A suicide cluster refers to a series of three or more closely grouped suicides that are linked psychologically and/or by locality and/or by social relationships. Types of suicide clusters include:

1. **Point clusters (or spatial-temporal clusters)**: A greater than expected number of suicides that occur within a time period in a specific location. This might be in a community or an institution (for example, school, university, psychiatric inpatient setting).
2. **Mass clusters (or temporal clusters)**: A greater than expected number of suicides within a time period, which are spread out geographically.
3. **Echo cluster:** A cluster occurring in the same location as a previous cluster, but some time later.
4. **Clusters involving a specific method of suicide:** Sometimes clustering can involve a particular method of suicide. This can occur in point, mass and echo clusters.

It is important to recognise that self-harm can also occur in clusters (as can mixed clusters of suicide and self-harm) and that linked episodes of self-harm may be a precursor to a suicide cluster (Hawton et al., 2019). In Ireland, data from the National Self-Harm Registry has shown that this link would be more likely to occur among men than women (Arensman, 2014).

Suicide contagion

Suicide contagion is the risk associated with the knowledge of another person's suicidal behaviour, either firsthand or through the media. Not all suicides that occur in clusters are the result of contagion. Suicide contagion is more likely to occur when:

- A suicide involves a person with similar characteristics (such as gender, age, social circumstances) to other people who have died. Such deaths may have occurred within an individual's social network or in people they became aware of through media or other influences.
- New or unusual methods of suicide are publicised or become known, including through social media.
- There is a death of a celebrity or high profile person by suicide (or other cause). This includes someone considered to be high profile within the community (including online influencers).
- A suicide involves a young person.

Literature highlights that there are varied definitions and potential uses of the term suicide contagion. For example the category 'contagion-as-cluster' labels acute occurrence of similar behaviours among a group of people, who often share some sort of proximity. The 'contagion-as-mechanism' category has four different but related mechanisms to explain how suicide clusters occur, including: transmission (contagion-as-transmission); imitation (contagion-as-imitation); contextual influence (contagion-as-context); and affiliation (contagion-as-affiliation). (Cheng et al, 2014).

Suicide pacts

A suicide pact is a mutual agreement made between two or more people to kill themselves at about the same time and usually in the same place. However, in the case of suicide pacts made online (cyber-based suicide pacts), they may not necessarily occur at the same place. There are two types: death is mutually agreed upon and both parties act independently, or one person coerces the other into being killed, or to kill the instigator first and then kill themselves. Most pacts involve an individual who is coercive and another who is extremely dependent (Holland Barnes, 2010). The essential feature of suicide pacts is the consent of two or more people. They must be differentiated from;

- consecutive suicides, also called 'suicide clusters,' occurring as a phenomenon of 'contagion'
- accidental deaths of relatives caused by a gesture of the person who dies by suicide
- simultaneous suicides, when people close decide independently to die by suicide
- mass suicides, for example those involving cults. (Prat et al, 2013).

An additional glossary of terms used in this document is available in Appendix 1.

4. Process to develop a CRP

This section includes recommendations regarding the structures and individuals who should be involved in leading and supporting the process to develop a CRP. It also includes information on the roles and responsibilities of key stakeholders and guidance on how to involve local communities in the development of your plan, while taking cognisance of existing critical incident or psychosocial response plans (see page 15).

4.1 Oversight

The Connecting for Life (CfL) Implementation Oversight Group is a local structure established to coordinate the implementation of CfL Local Action Plans. The group has a key role in overseeing the development of suicide prevention initiatives in the local area and the development of guidelines, including the CRP.

	Role	Responsibilities
CfL Implementation Oversight Group	▷ Define the objectives of the project to develop a CRP. ▷ Ensure that the CRP has been developed. ▷ Ensure that the CRP is reviewed in line with actions laid out in the local CfL plan. ▷ Appoint the members of the planning group.	▷ Initiating the development of a community response plan. ▷ Nominating a project lead and planning group. ▷ Supporting the planning process to completion. ▷ Signing off on the completed CRP. ▷ Reviewing the CRP annually, as well as following each activation. ▷ Recognising the need for their own self-care.

4.2 Leadership and structures

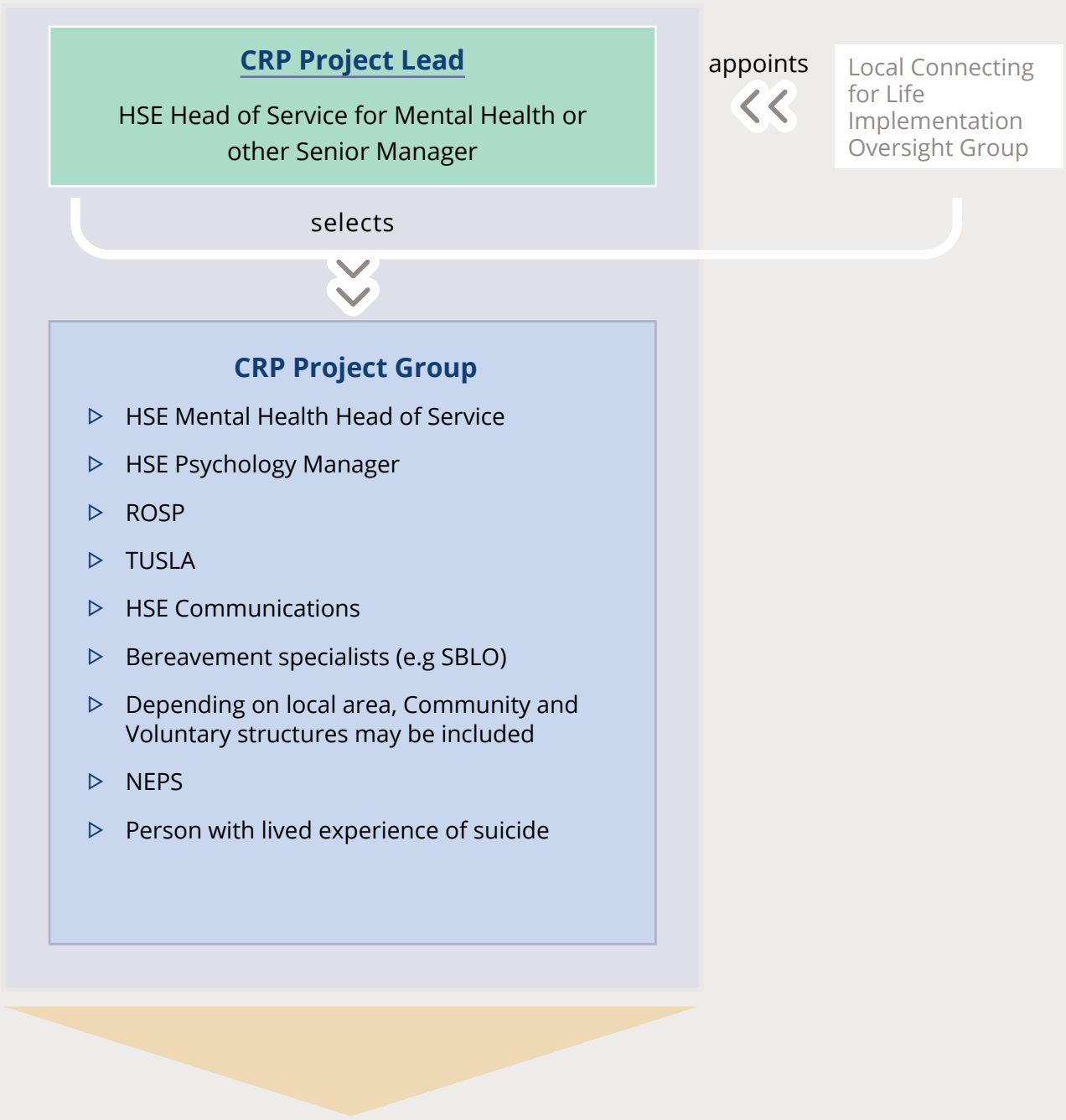


Figure 3: CRP Project Lead and Project Group

Appointing a Project Lead and Project Group

The project to develop a CRP will be managed by the Project Lead and the Project Group. The Project Lead should be appointed by the local CfL Implementation Oversight Group. The members of the Project Group should be selected by the CfL Implementation Oversight Group and the Project Lead together. The establishment of this structure is the first step in the process to develop a CRP.

Project Lead

It is recommended that the Project Lead is the Head of Service for Mental Health or another senior manager in the HSE. The work of the Project Lead will be supported by the ROSP.

	Role	Responsibilities
Project Lead	▷ Nominate members for the project group. ▷ Design the project plan to develop a CRP. ▷ Convene and chair all meetings of the project group. ▷ Ensure all actions in the project plan are completed within the timeframe agreed.	▷ Fostering collaboration. ▷ Ensuring that the work of the group is grounded in national and international evidence, as per NOSP guidance. ▷ Delivering a completed CRP for the local area. ▷ Recognising the need for their own self-care.

Project Group

The project group should be a small group of professionals and should include senior managers in relevant agencies. The members of this group should be able to provide expertise in the areas of suicide prevention and bereavement.

This group could include:

- HSE Mental Health Head of Service
- Executive Clinical Director
- HSE Psychology Manager
- ROSP
- Tusla
- HSE Communications
- Bereavement specialists (for example, SBLO)
- NEPS or the Education and Training Board (ETB)
- Person with lived experience of suicide (for guidance please consult with the HSE Area Lead for Mental Health Engagement and Recovery)

	Role	Responsibilities
Project Group	▷ Agree the project plan to develop a CRP. ▷ Execute this plan. ▷ Deliver a completed CRP.	▷ Providing expertise to guide and support the development of the CRP. ▷ Supporting the ongoing engagement of stakeholders. ▷ Removing obstacles to the successful delivery of a CRP. ▷ Maintaining the focus on the agreed scope and outcomes of the project plan at all times. ▷ Recognising the need for their own self-care.

Note: Once the plan has been developed, the Project Group will not have a role in the implementation of the CRP when an activation is required. However, individual members of the group, depending on their role and geographical location, may be involved in its subsequent implementation.

4.3 Consult

Community responses to suicide, suicide clusters, and murder suicide are multi-agency endeavours. The project group should consider consulting with key community stakeholders as part of the process of developing the CRP.

4.4 Other local plans

Where there are concerns about suicide/suicide clusters in other settings, for example, educational, youth, sporting or mental health settings, other organisational response plans will need to be considered. In such cases close collaboration between the CRP Lead and the relevant organisational lead will be required to establish clarity of roles, to avoid confusion and to ensure implementation of the most effective response.

The CRP guidelines do not replace or negate existing critical incident or psychosocial response plans devised by other organisations. There are many effective policies, protocols and guidelines in place that can complement the development of a CRP, but few are specific to suicide. The CRP guidelines are a roadmap to providing a coordinated, inter-agency and community-led response in the aftermath of a suspected suicide, particularly where there is a risk of a cluster and/or contagion.

4.5 Write and finalise the CRP

The final CRP should be concise and written in Plain English. It should include as much specific, local information as possible. A sample contents page can be found in Appendix 2. Once the document has been signed off, it should be published and circulated to key stakeholders. The document should be reviewed annually (this is the responsibility of the CfL Implementation Oversight Group) as well as after each activation, as part of the deactivation process. As the document will be updated frequently, it should not be designed or printed externally but can be printed in-house.

Resources to support this section

See Appendix 2 for:

- Information on other relevant plans
- A sample contents plan for a CRP

For further project management support please contact your local PMO (Programme Management Office).

The HSE National Framework for developing Policies, Procedures, Protocols and Guidelines (PPPG):

https://www.hse.ie/eng/about/who/qid/use-of-improvement-methods/nationalframeworkdevelopingpolicies/hse-national-framework-for-developing-policies-procedures-protocols-and-guidelines-pppgs-2016.pdf

For guidelines on communicating clearly using Plain English see:
https://www.hse.ie/eng/about/who/communications/communicatingclearly/

5. Who is involved in the activation of a CRP?

This section sets out the roles and responsibilities of the CRP Core team. It also discusses membership of the CRP Activation Team, which is established for each response.

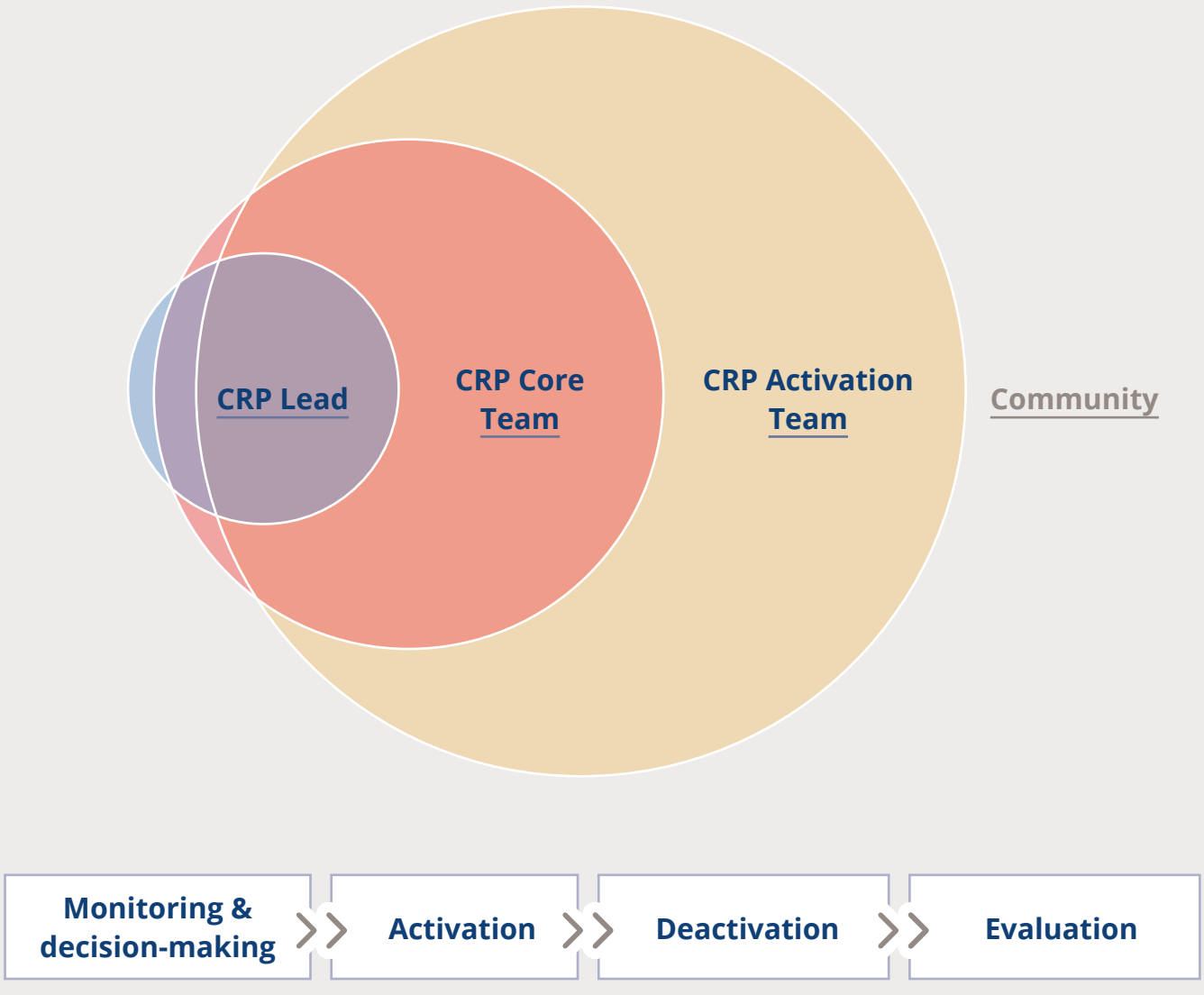


Figure 4: The CRP Team

5.1 The CRP Lead

The role of CRP Lead should be assigned to a particular person within senior management of the HSE. This will be decided during the development of the CRP. It is important that this person has the capacity to make decisions quickly and has ready access to resources.

	Role	Responsibilities
CRP Lead	▷ Oversee the monitoring process. ▷ Convene and chair meetings of the Core Team and CRP Activation Team. ▷ Link with team members and other stakeholders to ensure alignment of the CRP with other plans and activities. ▷ Maintain regular contact with the nominated media spokesperson to ensure a timely and accurate flow of information to the media. ▷ Ensure all agreed actions are completed within the timeframe agreed. ▷ Put support in place for members of the CRP Core Team, Activation Team and any others involved in the response. ▷ Lead the review/evaluation process.	▷ Fostering collaboration. ▷ Guiding and supporting the activation of the CRP. ▷ Removing obstacles to the successful delivery of a community response. ▷ Ensuring that the work of the group adheres to the process that is laid out in the local CRP. ▷ Recognise the need for their own self-care.

5.2 The CRP Core Team

Members of the Core Team will be of appropriate seniority to be able to make rapid decisions and access resources, if required. Where possible, the membership of the Core Team should remain the same for each activation of the CRP. See Section 8 for further information on building the capacity of the Core Team.

Membership should include:

- Head of Service for Mental Health
- Principal Psychology Manager
- Chief Superintendent/Garda representative for the region
- ROSP
- SBLO
- HSE Communications

Others who could be included in the Core Team:

- District Coroner or Deputy Coroner.
- Clinical Director for Mental Health Services (where suspected suicide(s) is of an adult mental health service user).
- Clinical Director for CAMHS (where suspected suicide(s) is of a CAMHS service user).
- Executive Clinical Director who can engage with the relevant Clinical Directors (CAMHS/AMHS).
- Tusla Area Manager (where suspected suicide(s) is of a young person or young people are at heightened risk).
- NEPS (where the suspected suicide is linked to a school).
- Education and Training Board – ETB (where the suspected suicide is linked to Youthreach or other ETB training initiatives).

	Role	Responsibilities
Core Team	▷ Monitor (watchful waiting). ▷ Determine if a CRP needs to be activated. ▷ Determine who is best placed to inform the family that a response plan has been activated and agree who will maintain communication with the family throughout the process. ▷ Determine if there is a requirement to include other organisations or individuals in the CRP Activation Team. ▷ Review the activation of the plan, the learning and the outcomes.	▷ Ensuring that the approaches/interventions used by the CRP Core Team are grounded in national and international evidence of what works in terms of bereavement in the aftermath of suicide and suicide/self-harm prevention. ▷ Declaring conflict of interest/ proximity to situation/ person who is deceased.

5.3 HSE Resource Officers for Suicide Prevention (ROSPs)

The role of the ROSP (as a member of the Core Team) can include:

- Gathering relevant information about an incident and bringing it to the attention of the Core Team.
- Deciding, in consultation with the Core Team, who and what organisations need to be involved, if they are not already on the Core Team.
- Supporting the Core Team to implement the CRP by providing up-to-date information and insights on local services and resources and providing advice on best practice in prevention and responses (in consultation with NOSP).
- Being a point of contact, as appropriate, for the community.
- Determining the need for and organising appropriate and relevant information and training, including the NOSP programme, ***Supporting people who are bereaved through suicide in the community***, which can be delivered from two weeks after a tragedy.
- Helping, as appropriate, to manage community expectations in the aftermath of an incident.
- Participating in the review process for each CRP and supporting evaluation (including sharing learning with and from other areas).

5.4 HSE Psychology

The role of the HSE Principal Psychology Manager (as a member of the Core Team) can include:

- Being available to attend Core Team meetings in the event of a suicide requiring a Community Response Plan or nominating a deputy to support this work in their absence.
- Working with the core team to consider what additional organisations or individuals might be involved in providing a response.
- Working with the core team to consider which individuals and groups might need to be prioritised for follow up response based on international evidence on at risk/ vulnerable groups.
- Supporting and planning for the delivery of a proportionate community, based response with due consideration to the psychological impacts of loss or trauma on individuals and groups.
- Offering support and guidance to key stakeholders in the community normalising acute emotional adjustment responses and offering guidance on monitoring typical or atypical psychological adjustment short, medium and longer term.

- Being available to mobilise relevant psychology staff to provide direct intervention to community groups or individuals as part of a planned community response.
- Providing clear information to signpost those in the community affected by suicide to access appropriate psychological supports as required.
- Participating in the review process for each CRP and support evaluation (including sharing learning with and from other areas).

5.5 HSE Communications

A communications member of the Core Team should be from relevant communications networks or structures already in place, primarily the Community Health Organisation (CHO) or Hospital Group. This may be a local HSE Communications Manager or member of the local Press Team.

Additional support or input may be sought from national communications teams, for example the HSE National Office for Suicide Prevention, or HSE National Communications (which includes National News and Media, Internal Communications, Digital, and others).

The role of the communications member of the Core Team can include:

- Supporting the Core Team to determine how communications approaches and solutions can address challenges (and avail of opportunities) related to the CRP, as detailed in Section 6.2 Media and Communications.
- Leading the development of a media communication protocol, by and with agreement from the Core Team, and taking on a central role in activities related to the protocol.
- Participating in the review process for each CRP and supporting evaluation (including sharing learning with and from other areas).

5.6 The CRP Activation Team

The CRP Activation Team will include all Core Team members and any additional organisations or individuals that the Core Team deems critical to the activation of a response. Membership of the team (beyond the Core Team) will be specific to each activation and is likely to vary depending on the circumstances of individual suicide(s), resources available in the local community and geographical location (this could cross CHO borders).

	Role	Responsibilities
CRP Activation Team	▷ Agree the appropriate inter-agency interventions and communications. ▷ Identify and remove obstacles to the successful delivery of a CRP. ▷ Maintain the focus on the agreed scope and outcomes of the CRP at all times. ▷ Make timely decisions and take action to avoid holding up the response.	▷ Attending all scheduled meetings of the CRP Activation Team (each organisation should also ensure consistent representation from the same individual, where possible). ▷ Sharing relevant and up-to-date information. ▷ Maintaining confidentiality ▷ Supporting the delivery of aspects of the response if required. ▷ Taking part in a review of the CRP activation. ▷ Recognising the need for their own self-care.

6. Surveillance

This section sets out the national surveillance process to monitor cases of suspected suicide. It also discusses the role of the media. Note that here the national process is referred to as surveillance, whereas monitoring is the preferred term for the local process.

6.1 Surveillance process

In Ireland, mortality statistics (including data on deaths by suicide) are published by the Central Statistics Office (CSO) two years after the calendar year in which they took place.

The importance of real-time data and timely flow of information has been highlighted in the literature. It has the potential to facilitate:

- Timely support for bereaved families and affected communities.
- Identification of and appropriate responses to emerging suicide clusters and contagion.
- Identification of emerging trends, for example, locations where people frequently take their lives and other patterns.
- Response to increasing rates of suicide within institutions.
- Verification of anecdotal evidence or public statements on suicide statistics.

As part of the process to develop a CRP, the Project Team should also establish a process for monitoring suspected suicides and identifying potential clusters.

The development of a national surveillance protocol – inter-agency data sharing

Some Community Health Organisation (CHO) areas have data sharing arrangements with local Gardaí, through the Garda Victim Liaison Office (GVLO). In Cork, the Suicide and Self-Harm Observatory is an emerging system that works directly with local Coroners to access real-time data before the inquest has taken place.

The National Self-Harm Registry Ireland (www.nsrf.ie) is a national system of population monitoring for the occurrence of hospital-treated self-harm. The registry collects data on persons presenting to hospital emergency departments as a result of self-harm in the Republic of Ireland. Data is also being gathered as part of the National Clinical Programme for the Assessment and Management Programme for Patients Presenting to Emergency Departments following Self-harm.

Many CHO areas currently have no access to real-time data. This can delay the response to critical situations. At the time of publication, the HSE NOSP is working on a national data sharing protocol between the HSE and GVLO. According to the protocol, the GVLO would inform NOSP of any suspected suicides identified by their PULSE computer system. NOSP would in turn send

the data to the relevant ROSP. The purpose of this data would be to help local teams to identify support service needs and to help the CRP Core Team to monitor potential clusters and inform decisions around CRP activation.

According to the draft protocol, the GVLO would also send the National Suicide Bereavement Support Guide (***You Are Not Alone***, NOSP 2020) to the investigating officer (to provide to the bereaved, if appropriate), as well as the option of a referral to the local SBLO service.

General Data Protection Regulation (GDPR)

In September 2020 advice was sought from the HSE Data Protection Officer in relation to data sharing specific to suicide prevention and postvention. The full response can be found in Appendix 3. In summary:

- A data sharing agreement should be developed with any external agencies with which personal data will be shared.
- GDPR is silent on retention periods other than to say that data should only be retained for as long as it is required to fulfil the purpose for which it was originally collected. The retention period needs to be agreed within the team (and the team should be able to justify the period agreed).
- GDPR does not apply in the case of the deceased. However, the HSE is always bound by the principle of confidentiality for current and former patients/clients.
- In the case of people considered to be at an increased risk of suicide, the processing of personal data could be considered to be in the public interest. A decision to share the personal data of an individual in the public interest should not be taken lightly.
- In some cases, de-identified (or anonymous) data will be sufficient and must be used in preference to identifiable personal information.
- At all times good data privacy principles should be followed (see **www.hse.ie/eng/gdpr/**).

Confidentiality

Even though the events surrounding high profile tragedies are often very much in the public domain, it is still important to ensure that the policy on confidentiality is maintained. Although the data of a deceased person is not subject to GDPR, the highly sensitive nature of the data and need to maintain confidentiality (particularly in relation to the bereaved family) must be considered at all times. This is particularly important regarding publicising details of any contact with HSE services by the family or other individuals (NOSP, 2011).

Care should be taken in the terminology used in emails and other messages, for example, 'suspected suicide' should be used, as 'suicide' is a legal ruling by a coroner.

This should be overseen by a Senior Manager within the HSE, to be nominated by the CRP Lead.

Ongoing local monitoring

Once a CRP has been activated, ongoing monitoring by the Core Team is essential. Monitoring of suspected suicides should be continuous, to ensure that increases in incidents within a particular group, team or geographical area are picked up at an early stage. Noting significant increases in self-harm could be part of monitoring (Public Health England, 2015) as they may be a precursor to suicide clusters (Hawton et al., 2019). Close collaboration and ongoing communication with other state agencies (for example, NEPS or Tusla) also help the monitoring process.

6.2 Media and communications

Media channels (including print, radio, television, social media and online) are a potential source of helpful information when a suspected suicide(s) has occurred.

These channels provide an opportunity to encourage a better understanding of suicide, reduce stigma and raise awareness of the wider issues associated with it, such as risk factors. They also provide a space to highlight specific supports or services that are in place to support people bereaved by suicide, or who might be at risk.

However, unhelpful media reporting or communications may cause undue worry, distress or even additional harm, such as an association with the development of a suicide cluster. The proliferation of misinformation, inaccurate information and 'hear say' can be particularly harmful and cause significant hindrance to people who have been impacted by a loss, those working to support them, and others who might be vulnerable or at risk of harm.

In all communications related to a suspected suicide(s) or cluster, particular care should be taken to:

- Remain sensitive to the privacy and needs of those impacted.
- Consider the potential harmful impact of any communications on the audience, particularly on those who may be more vulnerable.
- Exercise caution when publicly referring to the methods and context of a suspected suicide. There is a possibility that people may over-identify with detailed descriptions, and increase the risk of imitative behaviour.
- Avoid over simplification of the perceived factors or causes related to the suspected suicide(s). This can be misleading and potentially upsetting for others.
- Avoid melodramatic depictions of suicide or its aftermath.
- Be clear, consistent, reliable and respect the rights and wishes of individuals and families. All communications and messaging should reflect HSE values of trust, care, compassion and learning.

Media communication protocol

The CRP Core Team should agree a media communication protocol to be used at times when media engagement is required. The protocol should include information on:

- The agreed person to handle media and communications queries in the first instance. This should be the HSE Communications Manager (in areas where there is one) or Press Team.
- The required level of sign-off or approval for any messaging.
- Who should act as a spokesperson, if required.
- What information is to be shared, or not shared.
- The key messages on the response, services or supports that can be relayed.
- The most appropriate time to deliver a particular message.
- The channels that should be used to ensure effective and appropriate dissemination of messages.
- Which audiences should be targeted, for each particular message (for example, the community, stakeholders, service providers, internal HSE).

Social media

Most of the time, social media platforms provide a place where we can connect with others and widely share positive messages or information. Encouraging a constructive social media discourse on suicide related issues, supports and services is always helpful.

However, responding to inappropriate or potentially harmful content on social media can be challenging. On these platforms, the sharing of incorrect, reactive, misleading or inappropriate information can potentially undermine coordinated efforts to deliver a sensitive and safe community response.

Most major social media platforms recognise the hurt that content like this can cause and do not allow pro-suicide or potentially harmful content on their platforms. There are many ways to report such content directly with the platform.

Wherever possible, it can be helpful to raise awareness of these issues and share and promote information and guidance with the community, stakeholders and members of the CRP Core and Activation Teams.

Suicide clusters, social media and young people (Hawton et al., 2019)

Young people generally use social media to memorialise, reminisce and share experiences about the person(s) who has died. It can also be used as an effective and powerful way to circulate helpful information.

The public nature of social media creates uncertainty about who is entitled to grieve and also social pressures to grieve. For example, young people who knew the deceased well may feel angry that others who knew them less well are posting information about them. Other young people report feeling obliged to feel sad or are uncertain about when it is acceptable for the mourning period to end.

Young people may also potentially be more vulnerable in small, close knit communities, as they may feel under greater pressure to meet cultural expectations. This is heightened by the speed with which information can spread in these areas. In addition, there may be greater reluctance to seek help due to stigma and fear of public disclosure. It may be helpful to encourage young people to safely participate in the development and promotion of suicide prevention messages though social media sites that they frequently use.

Resources to support this section

The DPC's guidance document on legal bases in the GDPR: **https://www.dataprotection.ie/en/guidance-landing/guidance-legal-bases-processing-personal-data**

The period of storage of associated records should be in line with Record Retention Periods Health Service Policy (2013): **https://www.hse.ie/eng/services/list/3/acutehospitals/hospitals/ulh/staff/resources/pppgs/rm/recret2013.pdf**

Training on establishing a surveillance system for suicide attempts and self-harm can be found here:

https://suicideresearchpreventionelearning.com/?sfwd-courses=establishing-and-maintaining-surveillance-systems-for-suicide-attempts-and-self-harm

Further guidance and information on interacting with the media/social media on suicide, is available at:

- **https://www.samaritans.org/ireland/about-samaritans/media-guidelines/media-guidelines-ireland/**
- **www.headline.ie**
- **https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/reporting-social-media-content.html**

See Appendix 3 for a sample media release.

7. Activation steps

This section sets out the steps involved in a CRP activation: Monitoring and decision-making; activation, deactivation and evaluation.

Step 1 – Monitoring and decision-making

Ensure there is an established monitoring process in your area (see Section 6 above).

Local monitoring

Local monitoring refers to the gathering of accurate information, establishing the facts, identifying vulnerable or at-risk groups and identifying agencies involved in supporting communities.

The monitoring process should be carried out by the Core Team, which would be overseen by the CRP Lead. Monitoring will most likely continue throughout the activation phase of a CRP.

Figure 5: Local monitoring

Allowing time for monitoring and clarifying the situation will help to inform the type of interventions required. Also this time will allow any information received about a suspected suicide(s) to be checked and verified. be checked and verified. However, it is also important to make sure that any interventions needed are carried out in a timely manner. It may also be important to address misinformation in relation to suicide contagion and clustering. This may be done via a media statement (see Appendix 3.2 for an example).

Gathering accurate information

It is important to obtain accurate information about the nature and circumstances of the incident; otherwise, anecdotal information may begin to circulate and add further to the distress of those involved. The key information to gather about a person who has died by a suspected suicide is listed in Box 1 below. This information will support the monitoring process.

Box 1 **Key information on the person who has died**
(developed by the HSE Resource Officers for Suicide Prevention)

- Name (encrypt)
- Gender
- Age
- Marital status
- General information on family (please be mindful of GDPR)
- Address and relevant addresses such as school and workplace
- Date of death
- Location of death
- Manner, cause and method of death
- Current links to services, such as HSE, Tusla
- Number and ages of children (if applicable)
- Any other relevant information, for example, member of priority or at-risk group

Establishing the facts

It is important to review available data from reliable sources in order to understand the circumstances of the suspected suicide(s). Examples of the key information to gather are listed in Box 2 below. This will also help to inform the screening process.

Box 2 **Key information on the circumstances of the death**
(developed by the HSE Resource Officers for Suicide Prevention)

- What is known about the affected family in terms of support networks, previous or recent crises or deaths, any immediate needs or concerns identified?
- Are there any particular individuals or families for whom the team or the community have immediate concerns?
- What responses are already being provided and are they adequate?
- Are those directly impacted by the suspected suicide in education, employment or are they unemployed? Where is their place of education or employment and has contact been made with them?
- Does the person who died by suspected suicide have a high profile in the local community?

- Was the person linked in with young people in the community?
- Was the person linked into any sports clubs, community groups or community services?
- What activity, if any, is happening on social media about the suspected suicide?
- Has there been, or is there likely to be, a sudden increase in referrals or requests for support?
- Has the community asked for support?

Establishing the facts about a possible suicide cluster must be carried out as soon as possible. In addition to recording the information outlined in Boxes 1 and 2 above, it is also useful to:

- Establish a timeline of events surrounding suspected suicides (to identify if there are more suspected suicides than expected within a time period in a specific location or in a wider geographical area).
- For example, identify any similarities and possible links between the deaths (for example, in terms of method used, possible contagion through exposure to other suicides, community issues, occupation, social connections).
- Plot information about suspected suicides on a map, as this can also help to identify potential connections (geographical, psychological and social).
- Establish if there has been a rise in self-harm presentations, which may be a precursor to suicide clusters. This can be done with data from the National Self-Harm Registry Ireland or the National Clinical Programme for the Assessment and Management of Patients Presenting to Emergency Departments following Self-Harm.

Identifying vulnerable or at-risk groups

Death by suicide is an overwhelming loss for those closest to the person who has died, for example, family and friends. It can also have a devastating ripple effect on the wider community, especially in areas where there are strong social networks. The Continuum Model shows how people can be impacted on four different levels, depending on their reaction to the death (See Figure 6 on page 32). It emphasises the need to focus on a broader group of people who may require support as a result of exposure to suicide.

The Circles of Vulnerability can help to identify those who may be vulnerable or at risk following a suspected suicide. It can be used to determine the degree of emotional impact a death by suspected suicide can have. It highlights that individuals who may be most at risk are those socially, psychologically and geographically close to the person who has died, which is represented by three interlocking circles (See Figure 7 on page 32). Risk may be higher for those closest to the person on all three levels. While it may not be possible to identify everyone who may be at risk, the Circles of Vulnerability can help the CRP Core and/or Activation Teams to consider those who may be potentially at greater risk.

Examples of how at-risk groups can be identified using the Circles of Vulnerability model can be found in Appendix 4.1

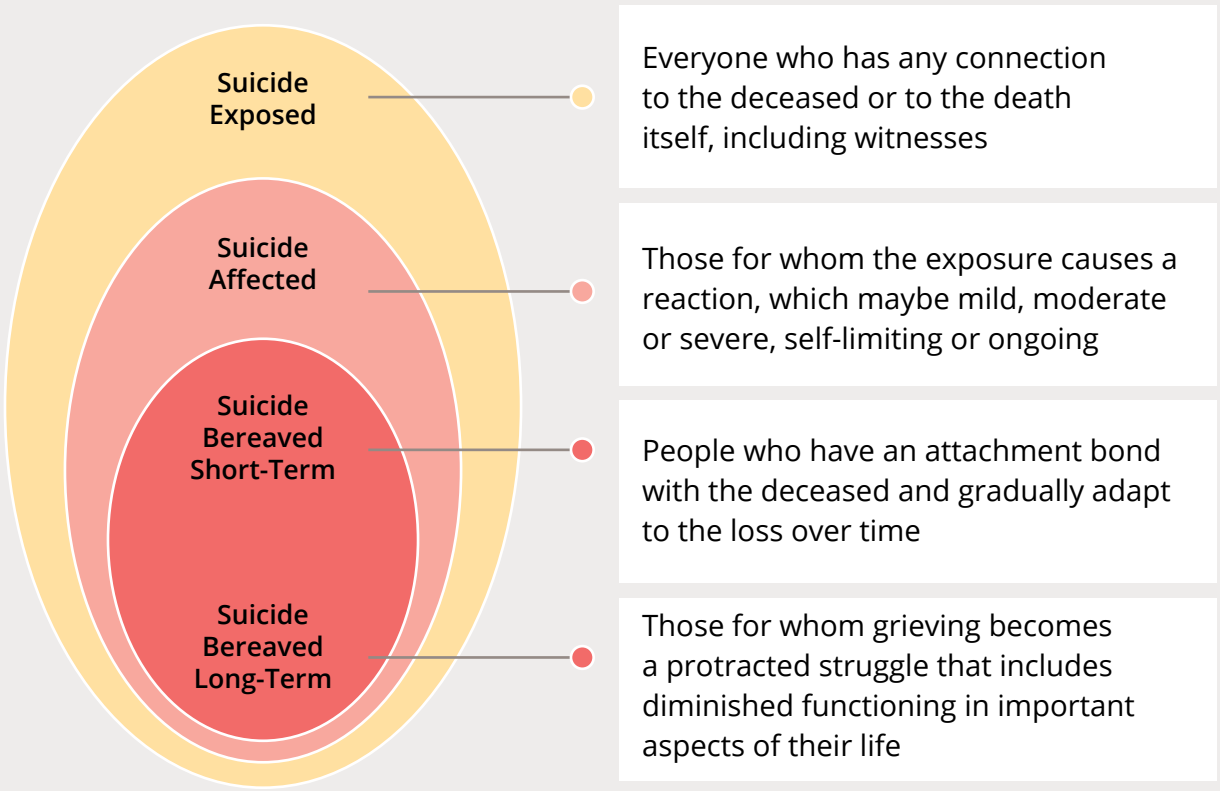


Figure 6 The Continuum Model: Effects of Suicide Exposure (Cerel et al, 2014)

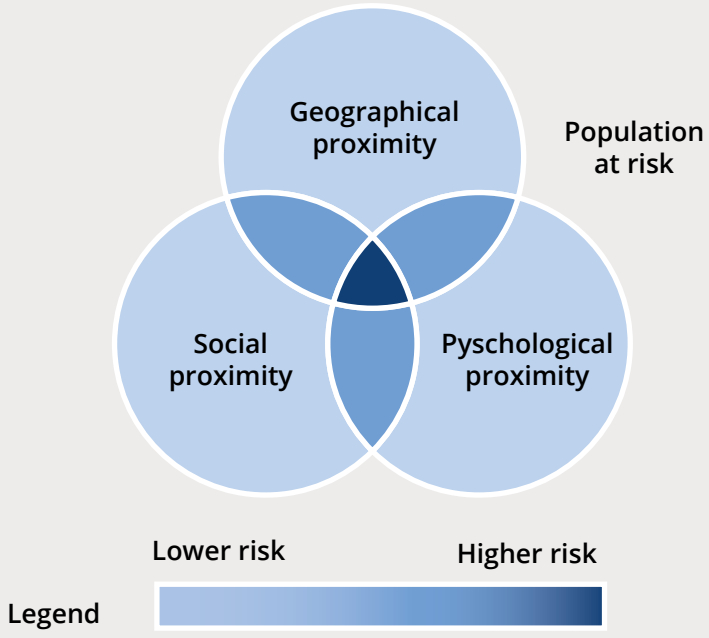


Figure 7: Circles of Vulnerability (Public Health England, 2019)

Identifying the agencies involved

It is also helpful to identify any agencies that may already have established links with the family or community. Key information to gather includes: what agencies, if any, are linked with the family or the wider community affected by the suspected suicide in that area? How have they responded to date to the situation? For example, have they activated any formal plans?

Examples of other critical incident plans and guidelines can be found in Appendix 2.1

For more details on surveillance in relation to murder suicide, see Appendix 5.6

Deciding whether to activate a plan

Activation criteria

Based on information gathered through the monitoring and screening processes, the CRP Lead should convene a Core Team meeting(s) to decide whether to activate a CRP. This decision is based on a number of factors (see Box 3). These may change over time as ongoing monitoring, review and research informs the process, and as teams become more experienced in dealing with cases of suspected suicide.

Box 3 Factors influencing the decision to activate a CRP

Circumstances of the death(s)	▷ How an individual is perceived within a community, for example, the death of a high-profile person by suspected suicide. ▷ The number of people (young people) affected. ▷ Any unusual circumstances surrounding the death ▷ If the death occurred in a public place. ▷ Murder-suicide.*
Impact of the death(s) at community level	▷ Perception by the community that there has been a rise in suicide deaths over a relatively short period of time. ▷ There is a sense that an individual's death is seen as losing identity because of being part of a suspected suicide cluster (Public Health England, 2019). ▷ The cumulative effect of a number of suspected deaths by suicide occurring within a short period of time is creating a sense of ongoing fear. ▷ The cumulative effect of a number of confirmed suicide deaths over a number of years is having an ongoing impact. ▷ Rumours circulating in a community, impacting on further risk. ▷ Content being posted on social media sites that may pose a threat to vulnerable individuals.

* Since 2019 the Garda National Bureau of Criminal Investigation and the National Suicide Research Foundation have established a collaboration to conduct systematic indepth reviews of cases of murder-suicide.

(continued on next page)

Impact of the death(s) at community level	▷ There is a sense that the community is overwhelmed and finding it difficult to cope. ▷ Collective anger may be directed towards an organisation regarding its perceived contribution to the deaths and the organisation's response (Public Health England, 2019). ▷ The community has already put a number of measures in place in response to suspected suicide deaths in the past and now feels disheartened because of the rise in the number of new deaths. ▷ The community's ability to cope has been eroded by the accumulated stress of a number of tragedies (for example, murder, car accidents), and now a suspected suicide adds to that.
Impact of the death(s) at individual level	▷ Serious concern being expressed about particular individuals affected by the death(s). ▷ Reports emerging of any worrying behaviour by any person(s) in the community.
Support required	▷ Direct requests for support being made by individuals/agencies/ community groups. ▷ There is an increase in the number of referrals to existing services in the area. ▷ There is a concern that one single agency would not have sufficient capacity to respond and that a coordinated inter-agency response is deemed necessary.
Emerging data	▷ A number of suspected suicide deaths have occurred in a specific geographical area or community. ▷ There is a risk of further deaths by suicide or copycat suicides. ▷ There is information to indicate that a relationship exists between a number of suspected suicides. ▷ A number of self-harm or attempted suicide incidents have occurred in a specific geographical area or community.
Media interest	▷ Potential or actual media interest. ▷ Negative impact of inappropriate media reporting. ▷ Negative impact of the spread of misinformation.

Other risks	▷ A specific, usually public, site is in the CRP area, which is frequently used as a location for suicide and which provides either the means or opportunity for suicide. ▷ Other traumatic deaths have occurred in the community at the same time as the suspected suicide death. ▷ Other suspected deaths by suicide have occurred in another geographical area that may impact locally.

Risk assessment

When deciding whether a CRP should be activated, it may be helpful to assess the likelihood of an event occurring (if interventions are not taken), combined with its impact (consequence). Some elements of the general risk assessment tool used by the HSE can be applied to assess suicide risk within the community.

See risk matrix in Appendix 4.2

Reasons for not activating a CRP

The decision not to activate a plan may be made for a number of reasons. The following are some examples:

- The death might be outside the scope of the CRP (for example, not a suspected suicide death).
- The family may not acknowledge or accept the cause of death to be by suicide.
- The organisation affected by the death(s) may wish to offer internal and/or individual supports only rather than an external or public response.
- The cause of death may not be clear.
- The person may be classified as a missing person and not pronounced dead.
- A single agency has the capacity and is deemed the most appropriate to provide support to those affected.

The activation of a suspected suicide CRP implies that the person has died and that their death is in some way suicide related. Making this assumption may further compound the pain in an already distraught or grieving family or in others affected within that community such as friends, neighbours, work colleagues, club members. There may also be facts that families may not wish to share, and this should be respected as much as possible. In these situations, it may be more appropriate to implement a broader psychosocial response plan, as opposed to a suicide specific one.

The activation of a CRP also implies that a coordinated response by a number of different agencies is required, as opposed to the situation being managed by one single agency.

If a decision is made not to activate the CRP, then the CRP Lead should:

- Ensure relevant support is still being offered.
- Advise relevant agencies that a decision has been made not to activate a CRP, giving the reasons why.
- Consider re-assessing this decision at a later date, if necessary.
- Document the decision and undertake the evaluation process (Step 4).

RESOURCES TO SUPPORT STEP 1

See Appendix 4 for:

▷ Example of Circles of Vulnerability

▷ Details of a risk assessment tool

Further information on managing risk in the HSE:

https://www.hse.ie/eng/services/publications/mentalhealth/riskmanagementinmentalhealth.pdf Please note that this document is dated but the principles it contains remain relevant and applicable today. However, some of the other generic documents referenced within that document have been superseded by new / updated policy documents.

https://www.hse.ie/eng/about/who/oqr012-20081210-v4-risk assessment-tool-and-guidance-incl-guidance-on.pdf

Step 2 – Activation

Once a decision has been reached to activate a CRP, then the Core Team will decide what other agencies or individuals should be invited to become part of the Activation Team. Membership will vary depending on the location and circumstances of the deaths. Steps 2–4 should then be followed.

Considerations during initial stages

- **If the person died while under the care of HSE Mental Health Services,** either as an in-patient or while under the care of a community team, an incident review should be undertaken. Incident reviews involve an analysis to determine what happened, how it happened, why it happened, and whether there are learning points for the service, for the wider organisation, or nationally. A member of the mental health services team should contact the bereaved family and ask them for their views to be included in the review. The family should be kept fully informed throughout the process unless they ask not to be. There should be an identified person within the mental health services that that can be contacted if the family have questions or concerns. The ***HSE Incident Management Framework*** takes the needs of families and loved ones into account by promoting open disclosure and by appointing a family/service user liaison person to inform the family of the review process following a serious incident.

  In addition, the report ***Improving Suicide Bereavement Supports in Ireland***, includes guidance on communicating with families following a suspected suicide death occurring within a mental health service setting. The purpose of the guidance is to assist HSE Mental Health Services to reach out to families with an appropriate and consistent response and to ensure signposting to relevant bereavement supports. The guidance recommends that a letter should be sent to the bereaved family within two weeks of death and that this letter should include contact details for the local Suicide Bereavement Liaison Officer (SBLO).

- **Specific needs**
  Any additional needs must be taken into consideration in the response required. For example, cultural differences, working in a language other than English, working with individuals with disabilities or coordinating efforts with another HSE area if the death(s) took place in that location or if the person is from another or if they have connections in other areas.

- **Recognise staff as community members**
  It is important to be mindful that in a small country such as Ireland, it is possible for professionals, especially those working in smaller teams, to be personally affected by death(s) by suicide in their area. They may have a direct relationship (family member, close friend, and so on) or an indirect relationship to the deceased (for example, deceased attended same school as own children, neighbour in the community person grew up in). Therefore, there is a need to manage both professional and personal boundaries. Consideration needs to be given as to whether it is appropriate and ethical for responders who have been affected to become involved in the plan or if their role within the team should be changed. It also highlights the need to support staff who are also members of that same community.

- **Specific challenges**
  There may be challenges in terms of providing support, depending on when the death(s) occurred, for example, over a weekend/long weekend or during bad weather conditions (see ***Severe Weather Planning Guidance for HSE Services***). See also Appendix 5.5 for Covid-19 challenges.

Level and type of support response

The level and type of support offered and how long it will be needed for varies from person to person. The point at which individuals decide to seek help differs too, it could be right away, several months after their bereavement or further down the line around significant anniversaries or family events. Care must be taken in the response process, because if services intervene without invitation this can disempower the bereaved family's own networks.

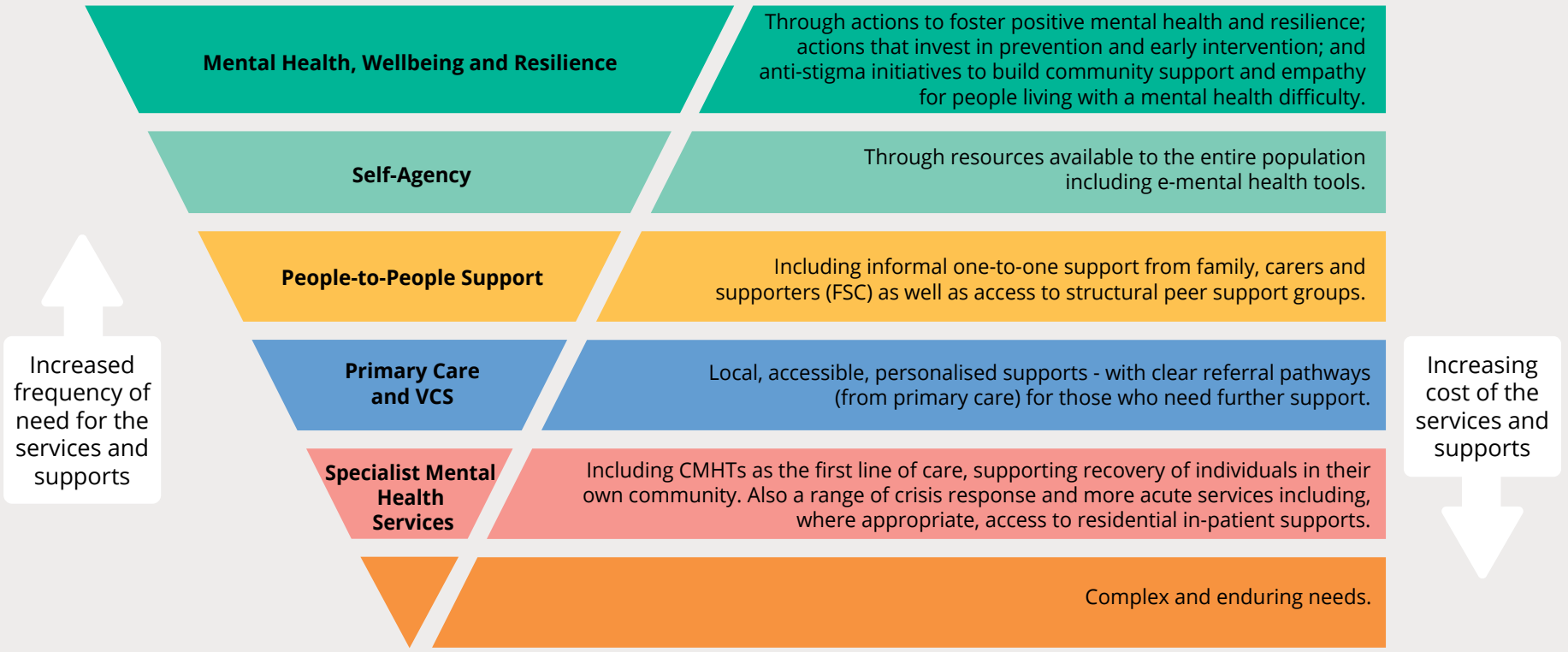
A range of different responses may be required, depending on the situation. These include:

Active measures: Vulnerable individuals are actively sought out and offered support.

Passive measures: Creating awareness of and access to various services and supports, which may encourage vulnerable individuals, who may not directly seek support, to look for help themselves or with the support of concerned third parties.

The response should comprise a number of elements. For example, whole population approaches, such as proactive engagement with the media and ongoing long-term suicide prevention initiatives, working with priority groups who may have specific needs and individual approaches, such as bereavement support and providing information and support to vulnerable individuals.

These responses can be provided at six different levels, in line with the population based planning approach set out in ***Sharing the Vision: A Mental Health Policy for Everyone*** (Department of Health 2020). The approach helps to guide the distribution and development of mental health services and supports in Ireland in response to need. Individuals move through different levels of support and services, from informal care and support in their own community to primary care, to specialist mental health services, all based on their mental health needs.



Mental health is not a matter for the health sector alone. It sits in a much broader context of how society views mental health and how decisions can be made right across the spectrum of relevant public services to invest in the wellbeing of the population and support individuals living with a mental health difficulty on their recovery path. Good mental health for the population of Ireland cannot be achieved without measures being taken by other government departments as well as by the Department of Health.

Figure 8: Population-based planning approach – For effective and efficient person-centered system

Step 3 – Deactivation

The Activation Team decides when to scale back and then deactivate the plan, having carefully considered needs within a community. Each situation will be unique, and the team must decide when and how to withdraw and what supports, if any, should remain in place. Sometimes communities will need ongoing services and supports over many months or years, for example, at the time of an inquest, anniversaries or due to the cumulative effect of a number of suspected suicide deaths in the area. In other situations, the usual support structures in place in the community will be sufficient to support their needs.

The CRP Lead should convene a meeting to discuss deactivating the plan.

Deactivation criteria

Timing is an important consideration when deciding to deactivate a CRP. This decision should be based on a number of factors, for example:

- The risk assessment has been completed again and the level of impact and likelihood of risk occurring has reduced.
- No new data is emerging to indicate further actual or potential risk in the community as a result of suicide, attempted suicide, self-harm or other traumatic incidents.
- There is a greater sense of calm and containment within the community.
- Any potential risk associated with media interest has decreased.
- Existing supports and services or single agencies have the capacity to support individuals or groups within the community.

Once it is agreed that the CRP will be deactivated, the following actions may be taken:

- Arrange to tell those directly affected or wider community groups about the decision to deactivate the plan, signpost to available supports in the community and communicate that ongoing monitoring of suspected suicide(s) will take place.
- Agree a plan on how to respond and support the community in relation to medium or long-term support needs.
- Ensure that agencies continue to work together to support communities affected by suicide.
- Discuss whether any/further supports are required by the team.
- Schedule a meeting to carry out the evaluation (Step 4).

Step 4 – Evaluation

Evaluation and sharing of learning

An overview of the CRP implementation process should take place and the following should be considered:

- Review the process, including updating any information that would support future activations of the CRP.
- Assess and review the appropriateness of the actions taken.
- Examine the effectiveness of the response, for example, the level of engagement, uptake of supports and its timing.
- Identify and respond to any emerging training and/or support needs in the community
- Review the adequacy of the resources.
- Establish if there are any wider implications or actions needed over the medium to long-term, for example, planning for anniversaries.
- Identify any particular difficulties encountered and how they could be addressed
- Identify if any changes need to be made to the plan, based on what has been learned.
- Share the learning and good practice with colleagues in other agencies, HSE areas and with HSE NOSP (see Appendix 5.7 for a template).

Role of NOSP

ROSP should notify the Head of NOSP and the NOSP Lead for Strategy Coordination, Education and Quality if a CRP has been activated within their CHO and send a final anonymised report once the response has been deactivated. NOSP will use this information to monitor national trends and to update these guidelines and share examples of best practice.

8. Building the capacity of the Core Team

Ongoing staff support

Responding to suspected suicide deaths can be challenging and can place additional strain on those involved. The response phase of a CRP can span several months or in some cases years. Because of this, it is very important to ensure that the self-care and welfare needs of those who are either directly or indirectly involved are met during the delivery of a CRP; support should not be left to the end of the process, after the CRP has been deactivated. All supports provided should be in line with the HSE ***Policy for Preventing and Managing Critical Incident Stress***:

www.hse.ie/eng/staff/resources/hrppg/policy-for-preventing-and-managing-critical-incident-stressdecember-2012.pdf

Areas of focus may include:

- Discussing the experiences of all those involved in implementing the plan.
- Identifying and responding to emerging training needs of team members.
- Identifying and responding to emerging support needs of team members, by providing information on supervision and support for staff involved in postvention support.

The following are some examples of supports available to HSE staff; other organisations may have access to others:

- The ASIST Me Model of Supporting Staff following an adverse event:**https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/opendisclosure/opendiscfiles/bookletsuppstaffadverseevent.pdf**
- The Schwartz Rounds, which provide an opportunity for staff from all disciplines across a healthcare organisation to reflect on the emotional aspects of their work: **https://www.hse.ie/eng/about/who/qid/staff-engagement/schwartzrounds/an-introduction-to-schwartz-rounds.html**
- Employee assistance programmes: **https://www.hse.ie/eng/staff/workplace-health-and-wellbeing-unit/employee-assistance-and-counselling-service/**
- Psychological First Aid
- Critical Incidence Stress Management (CISM)

Preparedness

Immediately after the local area CRP has been developed and before an activation might be required there are a number of steps that the CRP Lead and the Core team can undertake to up skill the team and to ensure that they are prepared for an activation.

Training for the Core Team

It is essential that members of the Core Team have the skills, capacity and resources to activate and implement a CRP. It is recommended that the CRP Lead completes an audit of the skill set of the Core Team members and matches each individual with training opportunities that will allow them to enhance their skills in particular areas. The Core Team members will be required to increase their knowledge in the areas of suicide and self-harm prevention, intervention and postvention.

Mapping local services

It is imperative that the Core Team carries out a local mapping exercise to support the activation of the CRP (at county or CHO level or both). This exercise should map supports that are currently available and how those supports can be accessed. The map of supports and services should be maintained as a live document that is reviewed and updated on an ongoing basis. The ROSP will be a valuable resource when completing this exercise.

Using the population-based planning approach set out in ***Sharing the Vision*** (Department of Health 2020) (see Figure 8), general and suicide specific services can be tiered into levels.

Conducting tabletop exercises

A tabletop exercise is an activity in which members of the Core Team gather to discuss various simulated situations. The purpose of the exercise is to evaluate and support the team's preparedness for a particular situation. It allows participants to become familiar with their roles in the response, the variety of interventions that can be used and what organisations could be called upon to join the Activation Team in particular circumstances.

Cultural awareness

Some people bereaved by suicide benefit from understanding and support from their community. Community support can make a difference in dealing with the emotional distress of a suspected suicide. However, there are some cultures with strong views on suicide. This may complicate grief and mourning for those bereaved.

Some cultures also have different mores and norms in relation to death and grieving.

It is important that the Core Team takes the time to understand differences in attitudes to suicide and to develop an understanding of bereavement within a cultural context. Where there is a large population of a cultural group in an area, it is recommended that the Core Team should undertake to meet with representatives of these communities and avail of any cultural awareness training that might be available.

RESOURCES TO SUPPORT THIS SECTION

See Appendix 6 for:

- Examples of different levels of supports
- A list of relevant training programmes (including those on cultural awareness)
- Guidance on conducting tabletop exercises

Framework for Quality Improvement

The framework for quality Improvement and the HSE Change Model may be useful for the Core Team to frame and develop quality improvement actions, should they be identified as an area of need. While the framework is focused on healthcare, it is transferrable to other settings: **https://www.hse.ie/eng/about/who/qid/framework-for-quality-improvement/**

The Change Guide has many practical tools included on the resource page and there is also a HSE training module: **https://www.hse.ie/eng/staff/resources changeguide/resources/**

Appendices

Appendix 1 Glossary

Term	Explanation
ASIST	Applied Suicide Intervention Skills Training
Bereavement	Bereavement refers to the loss of a close relationship through death. Grief is an individual's emotional response to the death, and mourning is the social expression of that grief.
CAMHS	Child and Adolescent Mental Health Services.
CHO areas	The HSE has established nine Community Healthcare Organisation (CHO) areas across the country as a new means of delivering health services outside of acute hospitals, such as primary care, social care, mental health and other health and well being services.
Critical incident	An incident or sequence of events that overwhelms the normal coping mechanism of a community (or a school or a workplace).
CIMT	The role of a Critical Incident Management Team (CIMT) is to coordinate an inter-agency response to a critical incident; to decide upon and coordinate the interventions required and to involve the relevant agencies needed to address the issues.
CISM	Critical Incident Stress Management (CISM), is an intervention protocol developed specifically for dealing with traumatic events. It is a formal, highly structured and professionally recognised process for helping those involved in a critical incident to share their experiences, express emotions, learn about stress reactions and symptoms and to access referral pathways for further help if required. It is a confidential, voluntary and educative process, sometimes called Psychological First Aid.
CYPSC	Children and Young People's Services Committees are county level committees that bring together the main statutory, community and voluntary providers of services to children and young people. They are chaired by Tusla.

Employee assistance and counselling programmes (EAP/EAS)	Employee assistance/support and counselling programmes (EAP/EAS) are available, free of charge, to employees in the HSE and in many other statutory, community and voluntary and private sector organisations.
First Responders	Emergency services personnel who attend to the scene or the aftermath of an accident or death (usually ambulance and/or fire brigade personnel/ paramedics, hospital staff, An Garda Síochána, coast guard personnel).
First Response Teams	First Response Teams comprise trained volunteers from the community as well as medical and mental health professionals who respond to the practical and emotional needs of the suicide bereaved.
Garda Victim Liaison Office (GVLO)	The GVLO is part of the Garda National Protective Services Bureau (GNPSB). The GVLO liaises with government funded victim support organisations and criminal justice and other state agencies regarding issues of mutual interest to improve services to victims of crime. The GVLO also provides support to the Family Liaison Officers (FLOs) who are appointed to victims of crime and their families in serious cases such as murder, fatal road traffic accidents or false imprisonments.
Monitoring	Monitoring refers to the systematic collection, tracking and reporting of information at a local level.
NEPS	The National Educational Psychological Service (NEPS) is a division of the Department of Education and Skills. NEPS Psychologists work with both primary and post-primary schools and are concerned with learning, behaviour, social and emotional development.
NOSP	The role of the HSE's National Office for Suicide Prevention (NOSP) is to effectively support, inform, monitor and coordinate the implementation of ***Connecting for Life***.
Person with lived experience of suicide	People with lived experience of suicide are individuals who have experienced a suicide attempt, suicidal thoughts and feelings, or a suicide loss. They have firsthand knowledge of suicidal thoughts and behaviours because they have lived through one or more suicidal experiences.

Postvention	An organised response in the aftermath of a suspected suicide to accomplish one or more of the following: ▷ To facilitate the healing of individuals from the grief and distress of suicide loss ▷ To mitigate other negative effects of exposure to suspected suicide ▷ To prevent suicide among people who are at high risk after exposure to suspected suicide.
Psychological First Aid	Psychological First Aid describes a humane, supportive response to a fellow human being who is suffering and who may need support. Psychological First Aid is a simple and in-the-moment response that involves the following themes: providing practical care and support, which does not intrude; assessing needs and concerns; helping people address basic needs; listening to people and not pressurising them to talk; comforting people and helping them to feel calm; helping people to connect to information, services and social supports; protecting people from further harm.
ROSP	HSE Resource Officers for Suicide Prevention (ROSPs) work across nine Community Healthcare Organisations (CHOs). They are the designated lead for coordinating the implementation of ***Connecting for Life*** at CHO level. The ROSP is considered an integral resource, a central point of contact and a key contributor in the CRP.
safeTALK	A three and a half hour suicide alertness programme that trains people to spot the signs of a person who may be suicidal and how to intervene and connect them with support.
Self-harm	The various methods by which people harm themselves, including self-cutting and taking overdoses. Varying degrees of suicidal intent can be present and sometimes there may not be any suicidal intent, although an increased risk of further suicidal behaviour is associated with all self-harm.
Start	A 90 minute e-learning suicide prevention training programme.
Suicide Bereavement Liaison Officers (SBLO)	The HSE funded Suicide Bereavement Liaison Service provides a high quality and proactive support to families and communities in the aftermath of a loss by suspected suicide, within a defined framework and protocol to the geographical area.

Suicide cluster	A suicide cluster refers to a series of three or more closely grouped suicides that are linked by locality and psychologically as in the Circles of Vulnerability .
Suicide contagion	There are many definitions and potential uses of the term suicide contagion. It describes the risk associated with the knowledge of another person's suicidal behaviour, either firsthand or through the media. 'Contagion-as-cluster' refers to the acute occurrence of similar behaviours among a group of people, who often share some sort of proximity. The 'contagion-as-mechanism' category has four different but related mechanisms to explain how suicide clusters occur, including: transmission i.e. spreads based on proximity (contagion-as-transmission); imitation i.e. exposure to publicised suicide serves as a stimulus for action (contagion-as-imitation); contextual influence e.g. peer influence and group norms (contagion-as-context); and affiliation e.g. with others who share like-minded attitudes (contagion-as-affiliation). Not all suicides that occur in clusters are the result of contagion.
Suicide pacts	A suicide pact is a mutual agreement made between two or more people to kill themselves at about the same time and usually in the same place.
Suicide prevention	The science and practice of identifying and reducing the impact of risk factors associated with suicidal behaviour and of identifying and promoting factors that protect against engaging in suicidal behaviour.
Tusla	The National Child and Family Agency.
Vicarious trauma	Vicarious trauma, also known as secondary trauma or compassion fatigue, can be described as indirect exposure to a traumatic event through hearing a firsthand account or narrative of that event. It includes the trauma that can be experienced when a person, who has a significant relationship with a survivor of trauma, is exposed indirectly or second hand to the experience. This can include exposure to difficult and disturbing images and stories related to the trauma.
Watchful waiting	Watchful waiting is often used to describe a strategy that includes frequent observation rather than immediate intervention or action.

Appendix 2.1 Other relevant plans

HSE Psychosocial Response to Covid-19

The HSE is co-ordinating a comprehensive psychosocial response programme to the current Covid-19 crisis in Ireland. It aims to bring together the different strands of existing service, to ensure that there is a fully integrated, strategic psychosocial response to Covid-19 for both the immediate and long-term for members of the public and health sector staff.

https://www.hse.ie/eng/services/list/4/mental-health-services/psychosocial-response-group/

Breaking the Silence in the Workplace: A Guide for Employers on Responding to Suicide in the Workplace

This guide is designed specifically with employers in mind. It aims to help organisations to increase their understanding and confidence in responding to suicide in the workplace.
Through this understanding, employers can be helped to reduce or minimise impacts on workplace outcomes such as absenteeism, sick leave and/or reduced performance.

https://www.sprc.org/resources-programs/breaking-silence-workplace-guide-employers-responding-suicide-workplace

Children and Young People's Services Committee (CYPSC) Critical Incident Protocols

CYPSC inter-agency Critical Incident Protocols have been developed in many, but not all, counties/regions nationally. The protocols are unique to each specific area and they may be activated when an incident overwhelms a local community's capacity to support children or young people and their carers affected by critical incidents. The protocol is implemented where existing services are unable to effectively respond in isolation to the outcome of the incident and a coordinated response amongst a number of agencies is required. The incident can be a suspected suicide/suicide cluster.

www.cypsc.ie

Guide to Developing a Local Coordinated Crisis Response Plan for the Traveller Community

This guide provides a framework for developing a local coordinated crisis response plan for the Traveller community in partnership with relevant organisations and services, which is activated for 4-6 weeks following the occurrence of an attempted suicide, suicide or unexpected death.

https://otm.ie/a-guide-to-developing-a-local-co-ordinated-crisis-response-plan-for-the-traveller-community-2018/

HSE Guidance Document, Psychosocial and Mental Health Needs following Major Emergencies

The HSE Psychosocial Response to the Covid-19 pandemic (2021) builds on this report. The guidance document complements major emergency planning from a psychosocial perspective and requires

collaboration between the HSE, local authorities, An Garda Síochána, as well as a broad range of other organisations including the Defence Forces, the Irish Coast Guard, the Voluntary Emergency Services and community organisations. Psychosocial refers to the full spectrum of psychological, emotional, social, relationship, behavioural, cognitive and physical experiences. These can occur within individuals and within groups in the context of particular social and physical environments, for example, during and after major emergencies.

https://www.hse.ie/eng/services/list/3/emergencymanangement/psychosocial/

HSE Incident Management Framework (IMF)

If an incident of suspected suicide relates to a person in receipt of publicly funded health or social care services, the HSE's IMF should be applied to determine if a patient safety incident has occurred (i.e. the preliminary assessment). If the preliminary assessment identifies a potential patient safety incident, then this should be reviewed in line with the IMF. The framework places a particular emphasis on supporting the needs of service users, families and staff in the aftermath of an incident.

www.hse.ie/eng/about/qavd/incident-management

Responding to Critical Incidents: NEPS Guidelines and Resource Materials for Schools

These guidelines outline how schools can be proactive in developing policies and procedures that promote mental health. They offer templates, advice and information on how schools can prepare for critical incidents by identifying a Critical Incident Management Team and having a Critical Incident Management Plan. They also give a practical step-by-step guide to schools on how to respond effectively when an incident occurs in order to minimise the potential traumatic effect on the school community:

Responding to Critical Incidents: NEPS Guidelines and Resource Materials for Schools:
https://assets.gov.ie/40700/21b5193521d147c890b4309fe4bfce9d.pdf

Responding to Critical Incidents during School Closures and Public Health Restrictions arising from COVID-19: Information Booklet for Schools.

https://www.education.ie/en/Schools-Colleges/Services/National-Educational-Psychological-Service-NEPS-/responding-to-critical-incidents-covid19.pdf

CRPs in Higher Education Institutions

Higher Education Institutions may also have developed their own critical incident response protocols, as recommended in the HEA National Student Mental Health and Suicide Prevention Framework (2020).

https://hea.ie/assets/uploads/2020/10/HEA-NSMHS-Framework.pdf

Appendix 2.2 CRP: Sample contents

Community Response Plan: Sample contents

1. How the CRP was developed: Include a short background piece on the development process.
2. The CRP Team: Identify members of the Core Team, who will be involved in coordinating the response (roles and responsibilities, including the named lead). Also note who else may need to be included in the response, depending on the circumstances.
3. Monitoring process: Outline the agreed process for ongoing monitoring, information gathering and reporting suspected suicide(s) and concern of risk of contagion to the CRP Team. Include details of how data will be verified, tracked and stored and how additional information will be sought, where necessary.
4. Agreed process for screening by the Core Team.
5. Activation of the CRP. Set out the agreed activation criteria, the decision making process and process for contacting stakeholders (i.e. a single, common communication platform). Include the process for when a decision is made not to activate the CRP.
6. Process for identifying those at risk within the community and delivering targeted suicide prevention/postvention support.
7. Local information sharing protocol (inter-agency).
8. Media engagement protocol.
9. Details of care pathway for the bereaved and details of local bereavement services.
10. Guide on communication with family if deceased was in care of HSE Mental Health Services.
11. Process for communicating with bereaved family/families.
12. Specific protocols and special considerations for priority groups, including under 18s.
13. Details of access to and storage arrangements for resource materials.
14. Details of additional training and support: bereavement training for first responders, National Suicide Bereavement Support Guide, community presentation, other support services.
15. Deactivation criteria.
16. Process for reviewing and updating the plan. This should include organisational changes, for example, updating contact details due to personnel changes or their working hours.

Appendix 3.1 GDPR advice from HSE Data Protection Officer

In September 2020, the HSE Data Protection Officer offered the following advice in relation to data sharing specific to suicide prevention and postvention. This will assist CRP Teams with local surveillance:

The HSE's lawful basis for processing of personal data for the purposes of providing care and treatment to service users is the legal obligations outlined in the Health Act 2004 and is underpinned by GDPR Article 6(1)(c) & Article 9(2)(h) in terms of consent and special-category data.

In other words, where data processing is required to provide care and treatment to individuals, in any HSE service, explicit consent of the data subjects is not a legal basis for doing so and is therefore not required. The HSE will regularly share personal information with external organisations in the course of that care and treatment. The HSE has agreements in place with such organisations (e.g. voluntary hospitals and organisations under Section 38 & 39 contracts). The roles and responsibilities of all parties to these agreements are usually outlined in a data sharing agreement, which sets out the terms and conditions regarding each party's roles and responsibilities with respect to data protection and the GDPR.

Importantly, where the HSE does not have an agreement (or contract) in place with a body and data sharing is necessary with that body, regardless of the legal basis for the processing, a data sharing agreement should be in place.

In relation to the remaining relevant legal bases in the GDPR, processing of personal data in the public interest, (Article 6(1)(e) and Article 9(2)(g) for special category (health) data) may be considered in these circumstances.

A decision to share the personal data of an individual in the public interest should not be taken lightly. In some cases, de-identified (or anonymous) data will often be sufficient for many purposes and must be used in preference to identifiable personal information. Professional judgment is, of course, a factor. Professionals should discuss cases with colleagues (perhaps anonymously) or seek advice from legal teams where necessary in making a decision. In all cases, the controller should document the circumstances around the reliance on a legal basis and ensure they can justify their reasoning.

This document can be accessed here: **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/271792/Consensus_statement_on_information_sharing.pdf**

This document pre-dates GDPR but the principles align to GDPR principles. In relation to data sharing in the public interest, the following paragraph in this document is useful:

"Disclosure may also be in the public interest because of the far-reaching impact that a suicide can have on others. For example, the method of suicide could cause potential serious harm to others. The practitioner will need to make a judgement about whether the benefits to an individual or society in disclosing information without consent outweigh both the individual's and the public interest in keeping it confidential. Determining where to draw the line is a matter for professional judgement in each individual case".

The Data Protection Commission (DPC) has advised that "...processing should be a reasonable and proportionate method of achieving a given goal, taking into account the overarching principle of data minimisation, and that personal data should not be processed where there is a more reasonable and proportionate, and less intrusive way to achieve a goal". The decision on processing (sharing) of personal data should always be made on a case-by-case basis, and the decision to share personal information, in the absence of a sound legal basis and/or in the absence of explicit consent, should not be taken lightly. The DPC goes on to point out that "... controllers should make sure that any processing of personal data which they undertake, or propose to undertake, is more than simply convenient for them, or potentially useful, or even just the standard practice which they or their industry have used up to now. Instead, controllers should ensure that each processing operation is necessary as a specific and proportionate way of achieving a transparent stated purpose or goal, which could not reasonably be achieved by some other less intrusive means, or by processing less personal data. Controllers also need to keep in mind that for more intrusive processing, a stronger justification will be required".

Article 6(1) (d) - processing is necessary in order to protect the vital interests of the data subject or of another natural person.

Controllers are most likely to rely on this legal basis where the processing of personal data is needed in order to protect someone's life, or mitigate against a serious threat to a person, for example a child or a missing person. If you can reasonably protect the person's vital interests in another less intrusive way, this basis will not apply. You cannot rely on vital interests for health data or other special-category data if the individual is capable of giving consent, even if they refuse their consent. You should consider whether you are likely to rely on this basis and, if so, document the circumstances where it will be relevant and ensure you can justify your reasoning.

Appendix 3.2 Sample press release

Response to claim being widely circulated on social media about a large number of deaths within a short time and a request for the number of people who have died

Response: In Ireland, the decision as to whether someone has died by suicide is a legal determination made by coroners, not a medical decision by doctors or the HSE. Following some time (to allow for the coronial investigation, inquest and registration processes) the Central Statistics Office (CSO) publishes national mortality data, including data on deaths by suicide. All CSO data on suicide deaths is provided annually and is publicly available on their website **www.cso.ie**

A summary of current data from the CSO, is available from the HSE National Office for Suicide Prevention (NOSP) here: **https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/nosp-briefing-on-suicide-figures.html**

The HSE NOSP does not report or comment on cases described as suicide that have not been published as official mortality data (i.e. "suspected suicides") for the following reasons:

- Out of respect, sensitivity and confidentiality for those bereaved.
- To reduce the potential for harm to others within any given community who may be also be vulnerable.
- To avoid the proliferation of misleading or inaccurate information, which could also be harmful to vulnerable individuals or communities.
- So as not to undermine the investigatory processes involved in any sudden, unexplained, violent or unnatural death.

Appendix 4.1 Circles of Vulnerability

This has been adapted from Identifying and responding to suicide clusters, a practice resource (Public Health England, 2019).

Type of proximity	Individuals/Groups affected	Description of risk
Psychological proximity refers to those who: ▷ Had a relationship with the person who has died ▷ Identify with the person who has died ▷ Perceive themselves to be similar in some way through cultural connections or shared experiences ▷ View the person who has died as a role model, such as a celebrity or prominent sports person There may also be people experiencing hidden loss or grief as they feel their loss cannot be openly acknowledged. This might happen, for example, in the case of relationships that are not recognised.	Spouse, partner, ex-partners, extra-marital affairs Peer group Professional staff who had contact Social media connections People with pre-existing vulnerabilities, such as mental ill health or prior suicidal behaviour	Psychological trauma, grief/ loss, mental ill health Loss, grief, mental health, contagion Psychological trauma, loss, stress, mental health Contagion Mental health, contagion

Social proximity refers to those who: ▷ Had a relationship or connection with the person who has died ▷ May have been unaware/ aware of the signs of suicidal intent ▷ May feel responsible in some way for the death The degree of perceived closeness a person feels towards the person who has died has been found to significantly influence their level of risk (even if, looking from the outside in, they did not appear to have had a strong relationship). In the short term, a high-risk period is immediately after the funeral. In the medium term, a high-risk period is around the time of anniversaries.	Children within family or local friendship group Close family and friends Workmates or college peers Pupils at same school Club or group members Social media connections Individuals who were in recent contact (text messages, social visits that day)	Grief/loss, psychological trauma, mental health Grief/loss, psychological trauma, mental health Grief/loss, contagion Grief/loss, psychological trauma, mental health, contagion Loss, contagion Contagion Psychological trauma, loss
Geographic proximity refers to those who: ▷ Have witnessed the death ▷ Were exposed to it ▷ Had contact with the person shortly before they died Suicide contagion can also occur via the internet, mobile phones and the mass media. Social media can substantially broaden the exposure and impact of the suicide.	Individual(s) discovering the body Professionals on the scene Neighbours Members of household Local population (through media reporting)	Psychological trauma, mental health, grief/loss Psychological trauma, mental health Exposure, loss, mental health Psychological trauma, grief/ loss, mental health Potential to broaden exposure in community, contagion

Appendix 4.2 Risk assessment

Risk matrix

Risk matrix	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Almost certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Possible (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare/Remote (1)	1	2	3	4	5

High risks are scored between 15 and 25

Medium risks are scored between 6 and 12

Low risks are scored between 1 and 5

For further guidance and training on using this tool see: https://www.hse.ie/eng/about/qavd/riskmanagement/risk-management-documentation/risk%20management%20support%20tools.html

Impact table

Completing this risk assessment tool will help to determine the current level of risk within the community.

Impact	Negligible	Minor
Injury	Adverse event leading to minor injury. No impaired psychosocial functioning.	Minor injury or illness. Impaired psychosocial functioning for more than 3 days and less than one month.
Service user experience	Reduced quality of service user experience related to inadequate provision of information.	Unsatisfactory service user experience related to less-than-optimal treatment and/or inadequate information, not being talked to & treated as an equal or not being treated with honesty, dignity & respect – readily resolvable.
Adverse publicity or reputation	Rumours, no media coverage. No public concerns voiced. Little effect on staff morale. No review/investigation necessary.	Local media coverage – short term. Some public concern. Minor effect on staff morale / public attitudes. Internal review necessary.
Compliance with standards (statutory, clinical, professional & management)	Minor non- compliance with internal standards. Small number of minor issues requiring improvement.	Single failure to meet internal standards or follow protocol. Minor recommendations, which can be easily addressed by local management.

Moderate	Major	Extreme
Significant injury requiring medical treatment and/ or counselling. Impaired psychosocial functioning for more than one month and less than six months.	Major injuries/long-term incapacity or disability requiring medical treatment and/or counselling Impaired psychosocial functioning for more than six months.	Incident leading to death or major permanent incapacity. Event which impacts on large number of patients or member of the public. Permanent psychosocial functioning incapacity.
Unsatisfactory service user experience related to less-than-optimal treatment resulting in short-term effects (less than 1 week).	Unsatisfactory service user experience related to poor treatment resulting in long-term effects.	Totally unsatisfactory service user outcome resulting in long-term effects or extremely poor experience of care provision.
Local media – adverse publicity. Significant effect on staff morale & public perception of the organisation. Public calls (at local level) for specific remedial actions. Comprehensive review/ investigation necessary.	National media/ adverse publicity for less than 3 days. News stories & features in national papers. Local media – long-term adverse publicity. Public confidence in the organisation undermined. HSE use of resources questioned. Minister may make comment. Possible questions in the Dáil. Public calls (at national level) for specific remedial actions to be taken. Possible HSE review/investigation.	National/international media/ adverse publicity for more than 3 days. Editorial follows days of news stories & features in national papers. Public confidence in the organisation undermined. HSE use of resources questioned. CEO's performance questioned. Calls for individual HSE officials to be sanctioned. Taoiseach/Minister forced to comment or intervene. Questions in the Dail. Public calls (at national level) for specific remedial actions to be taken. Court action. Public (independent) inquiry.
Repeated failure to meet internal standards or follow protocols. Important recommendations that can be addressed with an appropriate management action plan.	Repeated failure to meet external standards. Failure to meet national norms and standards / regulations (Mental Health, Child Care Act etc). Critical report or substantial number of significant findings and/or lack of adherence to regulations.	Gross failure to meet external standards Repeated failure to meet national norms and standards / regulations. Severely critical report with possible major reputational or financial implications.

Appendix 5.1 Sample agenda for initial meeting

This has been adapted from Identifying and responding to suicide clusters, a practice resource (Public Health England, 2019).

Instructions:

- The Lead of the Core Team communicates with Activation Team members about a suspected suicide and convenes a meeting, teleconference or online meeting.
- This meeting addresses the items on the proposed agenda for the initial meeting.
- A template setting out the agreed actions and lead responsible for their delivery is completed, based on the Circles of Vulnerability matrices.

1. Identify an individual to take notes of the meeting and provide ongoing administrative support

2. Confirm purpose of meeting is to:

- Agree leadership/co-leadership of the CRP Activation Team and clarify working and communication arrangements.
- Establish facts surrounding suspected suicides and determine possible links between deaths.
- Agree appropriate level of escalation and intervention.
- Review membership of the CRP Activation Team, identify additional members (those required to attend meetings and those with whom links should be established) and clarify roles.
- Agree and record actions and timescales.

3. Monitoring

- Gather information on the details and circumstances of deaths: data from real-time monitoring or coroners.
- Understand the events in the context of the organisation concerned; for example, is there something going on in the wider community that is affecting the organisation, or vice versa?
- Identify anniversaries of previous suicides.
- Identify any reported increases in non fatal self-harm.
- Systematically record details and circumstances to aid identification of similarities and possible connections between deaths.

4. Information-sharing

- Identify further investigations: what additional information is required and from whom?
- Identify who needs to be informed of concerns and agree communication processes.
- Agree confidentiality and information sharing processes.

5. Media

- Identify media communication lead of CRP Team.
- Identify media communication leads within affected organisations.
- Agree communication strategy between organisations and with internal and external media.
- Agree content for media/press statement.
- Identify possible social media concerns.
- Agree process for monitoring known social media memorial sites and responding to concerning posts with supportive statements and signposting.

6. Bereavement support

- Identify bereavement support that is already in place or has been provided.
- Identify additional support needs (using Circles of Vulnerability).
- Identify bereavement support agencies.
- Identify any shortfall and make contingency plans.
- Identify any additional support requirements for bereavement support providers.

7. Prevention

- Identify individuals and groups who may be at risk (using Circles of Vulnerability).
- Agree whole population, targeted and individual strategies for support and prevention activity and identify provider agencies.

8. Monitoring of plan

- Agree monitoring (including record-keeping and storage) and evaluation strategies.
- Agree frequency of CRP Team meetings.

SUBSEQUENT MEETINGS:

- The team should arrange to hold regular updating, monitoring and progress review sessions through meetings, email or teleconference. These may have to be held frequently, especially at the early stages, with dates agreed and scheduled. This will allow decisions to be made if and when more targeted or broader responses are necessary to support a community. The sessions should include identifying any gaps that emerge as the response progresses and agreeing how these will be addressed.

- Together with the HSE CHO Communications Manager, the Activation Team develops a set of messages that are accurate, safe and non-sensational and can be delivered to anyone with whom they interact. Communication should be consistent, reliable and respect the rights and wishes of individuals and families. It may be necessary to issue a joint statement between the HSE and the Gardaí, Department of Education and Skills, Tusla or other agencies. Links between these and other relevant organisations must be formed to ensure consistency of messages and approach to the media. It may also be useful to agree communications that can be issued at high-risk periods such as in the weeks just after the funeral.

- The team reassesses the need for continuing support, particularly if other incidents occur or in light of any other upcoming events (e.g., the inquest, anniversary). There is a need to continue to identify needs and respond, as appropriate.

Appendix 5.2 Checklist of core actions

This has been adapted from Identifying and responding to suicide clusters, a practice resource (Public Health England, 2019).

- Convene CRP Team meeting and if concerns are identified activate the pre-prepared CRP, according to the circumstances of the suicide(s) concerned.
- Agree confidentiality and information sharing arrangements.
- Identify organisational leads and agree links between internal response and CRP Team.
- Ensure clear communication, recording and administration arrangements are in place.
- Ensure appropriate bereavement support and signposting are offered to family and friends of the deceased.
- Identify vulnerable individuals and groups using the Circles of Vulnerability model as a guide.
- Document identified concerns, actions and responsible leads.
- Agree CRP monitoring and review arrangements, including ongoing suicide monitoring.
- Ensure support is in place for staff providing bereavement support activity.

Appendix 5.3 Examples of supports that may be offered

This has been adapted from Identifying and responding to suicide clusters, a practice resource (Public Health England, 2019).

Individuals/Groups affected	Description of risk	Possible supports
Psychological proximity Spouse, partner, ex-partners, extra-marital affairs Peer group Professional staff who had contact Social media connections People with pre-existing vulnerabilities, such as mental ill health or prior suicidal behaviour	Psychological trauma, grief/ loss, mental ill health Loss, grief, mental health, contagion Psychological trauma, loss, stress, mental health Contagion Mental health, contagion	National Suicide Bereavement Support Guide, Suicide Bereavement Liaison Service Distribute supportive signposting literature with helpline numbers, in line with NEPS if within school context Signpost to supports and services, Employee Assistance Programme Use social media positively to signpost and distribute supportive literature Signpost to supports and services
Social proximity Children within family or local friendship group Close family and friends Workmates or college peers Pupils at same school Club or group members Social media connections Individuals who were in recent contact (text messages, social visits that day)	Grief/loss, psychological trauma, mental health Grief/loss, psychological trauma, mental health Grief/loss, contagion Grief/loss, psychological trauma, mental health, contagion Loss, contagion Contagion Psychological trauma, loss	Suicide Bereavement Liaison Service, HSE Child Psychology Service National Suicide Bereavement Support Guide, Suicide Bereavement Liaison Service Signposting to information, supports and services, Psychological First Aid In line with NEPS critical incident plan Community information session, signposting to supports and services As above Signpost to supports and service, psychoeducation

Geographic proximity Individual(s) discovering the body Professionals on the scene Neighbours Members of household Local population (through media reporting)	Psychological trauma, mental health, grief/loss Psychological trauma, mental health Exposure, loss, mental health Psychological trauma, grief/ loss, mental health Potential to broaden exposure in community, contagion	Psychoeducation re: responses to trauma, signpost to Suicide Bereavement Liaison Service, GP advised CISM, EAP Information on bereavement, signposting to community supports Suicide Bereavement Liaison Service, National Suicide Bereavement Support Guide Support media to report sensitively Support community to respond appropriately to media requests

Appendix 5.4 Blank template for vulnerability matrices

Area:

Deceased:

This has been adapted from Identifying and responding to suicide clusters, a practice resource (Public Health England, 2019).

Geographic proximity Individuals discovering the deceased or exposed to the aftermath				
Circles of Vulnerability : Individuals or groups	Identified	Description of risk	What has been done to help this person?	What remains to be done?

Social proximity Identification with, relationship to or connection to the person who died				
Circles of Vulnerability : Individuals or groups	Identified	Description of risk	What has been done to help this person?	What remains to be done?

Psychological proximity Identification with, relationship to or connection to the person who died				
Circles of Vulnerability : Individuals or groups	Identified	Description of risk	What has been done to help this person?	What remains to be done?

Appendix 5.5 COVID-19

Many changes have occurred as a result of COVID 19. These may impact upon the way in which a CRP can be activated and implemented. This should be taken into account in Step 1 as part of the preparatory stage. Some considerations include:

- Convening CRP meetings: Meetings may have to carried out by telecall or online rather than face-to-face.
- Supporting individuals/communities: Fundamental changes have happened to the traditional funeral arrangements and rituals that have been observed in Ireland for generations. This has impacted on the way in which we mark our grief as individuals and as part of a community.
- Face-to-face supports may not be possible and other options may have to be considered instead, such as telephone or online support.
- Some suicide prevention/postvention programmes can only be delivered in a face to face setting.

Support services: Services have adapted the way in which they are being delivered and are instead being offered by phone, text or online. Some new supports have been developed specifically in response to the COVID 19 pandemic: **https://www2.hse.ie/services/mental-health-supports-and-services-during-coronavirus/mental-health-supports-and-services-during-coronavirus.html**

This may place additional challenges on response teams to ensure that any supports are offered in a safe manner, particularly if some of the usual supports cannot currently be accessed or are not available in their usual format. However, some of the learning and support structures put in place as part of the psychosocial response to COVID 19 may also be used to inform the CRP.

Appendix 5.6 Specific considerations when responding to murder-suicide

Murder-suicides are rare events. However, when they do happen, they can have a long lasting and traumatic effect on the families involved, as well as on the communities in which they take place (Arensman & McCarthy, 2017).

There are many factors that make this grief different, including the sudden and often violent nature of the death(s), the fact that the death(s) occurred at the hand of another, losing more than one loved one at the same time in such a manner and making sense of the loss. Families left behind may have to be involved in legal investigations if the perpetrator has attempted but not died by suicide. Extensive coverage by the media almost always causes additional stress and trauma and can increase the risk of copycat behaviour.

Other factors that can add to the trauma are:

- Witnessing the murder or events leading up to the murder
- Relationship of the victim to the survivor
- Relationship of the victim to the perpetrator
- Type of murder
- Attributes of the victim
- Attributes of the perpetrator
- Proximity of the family of the murder victim to the site of the murder
- The shift in family dynamics brought about by the change in the functional position or role of the person(s) who has died had in the family

Murder-suicide can evoke a range of emotions in affected families, which can include:

- Recurrent nightmares about the actual murder (whether they know what happened or not)
- Rage toward the person responsible
- Anger toward the victim for being in the wrong place at the wrong time
- Depression and helplessness/powerlessness
- Loneliness and isolation (National Coalition to Abolish the Death Penalty (NCADP), 2010)

In the grief process, there may be anger expressed about the way in which the family feel they have been treated by the State. Some may describe being re-traumatised by their experiences of the criminal justice system. There may also be conflict among families around gaining custody of the children.

Professionals either directly or indirectly involved in the aftermath of a murder-suicide, for example, healthcare professionals or other first responders, may be at increased risk of developing Post Traumatic Stress Disorder (PTSD), if they have not received training or cannot avail of the supports they need (Jordan, 2008, cited in Arensman & McCarthy, 2017). It is important to be mindful that focusing on the murder can mask the suicidal aspects of the act.

The Circles of Vulnerability model can be used to identify those who are at increased risk of developing mental health difficulties or engaging in suicidal behaviour as a result of the murder-suicide.

Use of language relating to murder-suicide

When engaging with families of murder victims, it is most important to use the language that they use to identify themselves. When in doubt, ask how they would like you to refer to the parties involved and get their permission. This will help to build trust.

- Call the deceased by their name (they are not the murder victim).
- Call the act murder – "I am sorry to hear that John was killed". Avoid the words "incident". or "event".
- Never use the word "alleged". Do not use legal words (National Coalition to Abolish the Death Penalty (NCADP), 2010).
- Be mindful of different triggers and different cultural experiences.

Media reporting of murder-suicide

There is a need for the sensitive and factual reporting of murder-suicide to increase awareness, while reducing harm, for example, copycat behaviour.

The following best-practice guidelines have been recommended when reporting on murder-suicides (NSRF, 2020):

- Be extremely careful not to report graphic detail, particularly in relation to specific methods involved. Methods used in murder-suicide can be copied.
- When reporting on the actions of the perpetrator leading up to or during an incident, be extremely careful not to sensationalise or dramatise events.
- Think ethically and carefully before approaching witnesses, victims or others affected by a murder-suicide. For those experiencing complicated grief, it is not usually helpful for them to engage with the media. While some people may be visibly emotional, others may not be. Please do not assume this means they are in a position to be interviewed. If a witness or victim volunteers to be interviewed, double check they understand that what they say will be broadcast or printed and show them the report before it is published.
- Question if it is necessary to report from the scene of a murder-suicide. For example, is it essential to have footage of the street or area where a familial murder-suicide occurred when relatives, neighbours and whole communities may be in shock and distressed?

- Be extremely careful not to fuel panic when reporting live on an unproven murder-suicide. Publicising premature estimates of the number of people who died or were injured will cause undue stress to families and communities. There is a further likelihood that sensational media reporting of murder-suicide will distort the facts and contribute to fear.
- Avoid speculation about the motives behind the perpetrator's behaviour. Unfounded conjecture will influence other people in difficulty and can trigger their suicide acts.
- Media professionals must consider the vulnerable reader who might be in personal or family crisis when they read the story; coverage must not be lurid or sensationalised. It should emphasise the severe consequences of the event for those involved and others affected and list sources of help.

In addition, there is a tendency to report on murder-suicide cases solely in a mental health context, with the appropriate suicide and mental health helplines offered. However, in many cases where a woman has been murdered, the killer has been her partner or ex-partner. The reporting of these cases will impact on other women affected by domestic violence. The 24hr Women's Aid National Freephone Helpline should also be listed in reports on murder-suicide cases (Women's Aid, 2019, Femicide Watch Report Republic of Ireland).

Gathering accurate information

Key information to gather includes:

- Date when the murder-suicide occurred.
- Names and ages of all victims and the alleged perpetrator.
- Names and ages of children (if applicable).
- Location where the murder-suicide took place and the location of residence, if different (Georgia Commission on Family Violence, 2020).

Establishing the facts

It is important to review available data from reliable sources, in order to understand the circumstances of the suspected murder-suicide(s). Examples of the key information to gather are listed in Box 4 below. This will also help to inform the screening process.

Box 4: Key information on the circumstances of the death(s)

- What is known about the affected family(s) in terms of support networks, previous or recent crises or deaths, any immediate needs or concerns identified?
- Are there any particular individuals or families for whom the team or the community have immediate concerns?
- What responses are already being provided and are they adequate?
- Are those directly impacted by the murder-suicide in education, employment or are they unemployed? Where is their place of education or employment and has contact been made with them?

- Do the people who died by murder-suicide have a high profile in the local community?
- Was the person(s) linked in with young people in the community?
- Was the person(s) linked into any sports clubs or community groups or community services?
- What activity, if any, is happening on social media about the suspected murder-suicide?
- Has there been, or is there likely to be, a sudden increase in referrals or requests for support?
- Has the community asked for support?

Establishing the facts around concerns about a possible murder-suicide must be carried out as soon as possible. In addition to recording the information outlined above, it is also useful to:

- Establish a timeline of events surrounding the suspected murder-suicides(s).
- Identify any similarities and possible links between other cases (in terms of method used, possible contagion through exposure to other suicides, community issues, occupation, social connections, for example).
- Plot information about the suspected murder-suicide on a map, as this can also help to identify potential connections (geographical, psychological and social).

Identifying the agencies involved

It is important to establish if a particular agency or individual already knows the victim(s), alleged perpetrator or family(s) affected. Contact should be made with the families affected as soon as possible, ideally within seven days, to ensure that they are connected with services. However, it is also important to consider the personality, professional affiliation, competency, trauma expertise or other relevant factors of those carrying out this role.

If no one has an established connection with the affected family(s), then other ways to connect with them with support services must be sought.

Circles of Vulnerability in murder-suicide

Surviving parents

Mothers and fathers who have lost a child due to murder-suicide are at increased risk of developing complicated grief symptoms. They may struggle to make sense of how a parent can take the life of their own child(ren). They may also feel very angry that their child(ren) has/have been taken from them.

It is important to be mindful that in some cases both the perpetrator and the victim are from the same family, for example, a son killing his mother. In that situation, parents may struggle to make sense of how one of their children could take the life (lives) of another (other) family member(s).

Surviving children

Surviving children not only lose their victim parent, but often both parents simultaneously. Children who experience this type of loss grapple with the complicated grief that comes with losing their parents suddenly and tragically. They may feel angry and confused as they try to comprehend how one parent or caregiver could take the other's life. They may feel conflicted as they experience anger and blame towards the perpetrator, combined with the love they have for them as a parent. Conversely, they may blame the victim for doing something, or not doing something, to "cause" their own death. They may worry that they have inherited "badness" from a parent. In addition to the loss of their parents and possibly other family members, they may also experience secondary losses, such as the loss of their home or school (Georgia Commission on Family Violence, 2020).

Other survivors

In the wake of a domestic violence murder-suicide, it is not uncommon for survivors to question their own role in the circumstances and what they may have been able to do differently to change the outcome.

Support offered

Each situation is unique, and the response provided will need to reflect that. There is a need to recognise and acknowledge what has happened and where the family are at. A tailored approach in terms of the support needed is generally recommended.

Some families may be ready to talk and take up support, others may not. It is important to offer support at intervals, immediately and later on, with services emphasising that they are there when they are needed by the family and others affected.

Care must be exercised on how to approach the domestic violence component of the response, if that needs to be considered, as it may not always be obvious.

In terms of the wider community, guidance may be needed on how to talk to children about murder-suicide in a safe and age-appropriate way.

Resources

The following resources are available:

- Advocacy After Fatal Domestic Abuse (AAFDA) (UK-based organisation): **https://aafda.org.uk/**
- **https://aafda.org.uk/resources/**
- **https://aafda.org.uk/help-for-families/**
- **https://aafda.org.uk/domestic-homicide-reviews/how-to-include-families-and-loved-ones-properly/**

A number of factsheets have been developed in the United States, which include:

- Family Dynamics Following a Domestic Violence Murder-Suicide
- Talking to Children About Domestic Violence Murder-Suicide
- Self-Care and Healing for Children After Domestic Violence Murder-Suicide

See: **https://gcfv.georgia.gov/support-survivors-murder-suicide**

Note: The first systematic review of murder-suicide in Ireland is currently being undertaken by the Garda National Bureau of Criminal Investigation, working in collaboration with the NSRF.

Learning from other responses to murder-suicide

- **Clarity:** Clarity regarding leadership, direction and coordination of agencies involved is vital. There is also a need to decide whether a murder-suicide should be managed through the HSE Psychosocial and Mental Health Needs following Major Emergencies plan, rather than the CRP.
- **Inter-agency working**: Governance needs to be absolutely clear and established in advance, as inter-service or boundary issues cannot delay the response. Inter-agency working needs proactive support to ensure that all the appropriate agencies are clear on roles and responsibilities, communication processes and are working together to provide a cohesive and timely community response.
- **Caring for the carers:** It is important to ensure that staff care is to the forefront. Systems need to be in place to respond, as opposed to placing the onus on individuals.
- **Communications:** Briefing and support may need to be provided to the wider affected community on how to manage the media. There is also a need to monitor and report on negative media coverage and report breaches, as necessary.

Appendix 5.7 CRP feedback template

CHO area(s) in which the incident(s) occurred	
CRP Lead	
Template submitted by	
CRP activation date	
CRP deactivation date	

1 Give a brief overview of the incident(s)

Include: background (do not include any personal data); monitoring and screening process; decision on activation.

2 Give a brief overview of the response

Include: Who was involved (within and external to HSE); an overview of the main activity (eg media engagement, community events); what community support was provided (eg. bereavement presentation, referral to SBLO service).

3 Deactivation criteria

Include: The reasons why the CRP response was deactivated.

4 Lessons learned

Include: What worked well?; What would you do differently?; Are there any additional training or up skilling needs for the core team?

Please send the completed template to the NOSP Lead for Strategy Coordination, Quality and Training.

Appendix 6.1 Examples of different supports

Information and support	
Examples of responses	**Examples of resources/services**
Distribute resource materials.	See leaflets available on **www.healthpromotion.ie** including: ▷ Concerned about suicide. ▷ If someone is thinking of suicide. ▷ National Suicide Bereavement Support Guide. ▷ Suite of bereavement leaflets (such as, "If you have been Bereaved by Suicide").
Promote mental health, well-being, self-care and messages of hope, unity and compassion.	Campaigns promoting **Yourmentalhealth.ie**
Signpost to supports and services, including out-of-hours and 24/7, and to other geographical areas, if applicable.	**www.yourmentalhealth.ie** Local supports and services cards/leaflets.
Encourage help-seeking in the community by reducing self-stigma and public stigma, which can act as barriers; encourage preparation in advance of where and how to access support, if needed.	Green Ribbon campaign trained ambassadors sharing true stories of seeking help and benefitting from it. HSE Mental Health Engagement and Recovery Forums.
Promote safe, effective and evidence-based responses in the community.	See resources on **www.healthpromotion.ie** including: ▷ Responding to a person in suicidal distress: A guidance document. ▷ Reporting social media content that promotes suicide. ▷ Suicide prevention in the community: A practical guide.

Extra support	
Listening and support services.	Helplines and services available 24/7 such as Pieta on 1800 247 247, the Samaritans on 116 123 and Text 50808. **ISPCC Support Line and Childline Crisis line** **Support Line: 01 6767960** The ISPCC support line is available Monday to Friday from 9am – 1pm and is contactable on 01 6767960. This is not a Freephone service but is available to parents all year round to support them in their parenting role. This support line has also been utilised and advertised in local areas in times of a local tragedy where parents may wish to seek out additional support on how to talk to and support their own children through a particular crisis/tragedy. This support line is staffed on a rota basis by the Childline therapeutic support staff team each of whom have a lot of experience supporting parents in their parenting role. **Childline Crisis Line: 1800 400 100.** Childline can provide a designated crisis helpline to schools and communities where there has been a death by suicide if requested to do so within a couple of hours of the request. Currently this special crisis line is operated through the Childline phone system and therefore is accessible nationally and on a 24 hour Freephone and can be reached by all children and young people up to the age of 18 by calling **1800 400 100.** All calls to this number are answered as "You are through to the special line", Childline is never identified. It is an active listening line which is non-directive in nature. The purpose of the line is to offer support and a listening ear to children and young people who may be struggling with feelings of loss and or confusion.

Organise an information and support event in a community centre, parish hall, sports hall or school, which may be for a specific group or for the wider community affected by the death(s).	Providing: ▷ 'Tea, talk and tissues' ▷ Information on the grief response, signs and symptoms of distress/self-harm and suicide risk and local services. ▷ Psychological First Aid. Note: There is a growing body of research that supports an emphasis, in the aftermath of a critical incident, on focusing on the strength and resilience of the individuals involved to cope with the given situation, rather than assuming pathology. Hobfoll et al. (2007) notes that people's reactions in the aftermath of a disaster should not be regarded as pathological or even as a precursor of subsequent illness. Instead they recommend promoting a sense of safety, calm, connectedness and hope. ▷ An opportunity to answer specific questions that need to be addressed (identifying these issues in advance of a gathering can be useful in terms of being better prepared with agreed clear messages and support materials). Note: Organising the HSE NOSP "Supporting people bereaved through suicide in the community" programme would be a more formal way of addressing this support need.
Organise and promote drop-in clinics in the local area.	Provided by services already working in the area to those seeking advice and support.
Professional therapy	
Provide fast-track expert mental health service advice and support.	HSE Primary Care and Mental Health Services.
Provide therapeutic services.	Specialist, therapeutic and counselling services.

Caring for the carers	
Ensure that support systems are put in place for those working directly with those affected at any or all of the levels above.	▷ Promoting self-care among professionals. ▷ Linking in with peers who have been through a similar experience and who can offer informal support and share how they came to terms with the loss. ▷ Providing line management and clinical supervision (if applicable). ▷ Building capacity and skills by attending the HSE NOSP workshop for "Professionals and key contact people providing support to those bereaved by suicide". ▷ Providing professional support.
Communication methods	
Communicate important information through proactive engagement with traditional local media.	Traditional methods including newspapers, public posting, door to door distribution within a particular community; radio, education and training programmes, some of which may have a higher reach with an older audience.
Disseminate information and promote a sense of social connection and mutual support.	▷ Online methods include social media, email communication and websites. ▷ These can be used effectively, particularly for those in marginalised or remote communities who cannot readily access to face to face support.
Provide information about bereavement supports available via the extended family, friends or community leaders.	This can empower the community and instil a message of confidence and resilience for the bereaved family and the larger community.

Longer-term interventions	
Provide ongoing bereavement support to those who continue to require it.	▷ Suicide bereavement support groups. ▷ Remembrance services.
Deliver relevant suicide prevention and intervention training in the area (but not in the immediate aftermath of a death).	See Appendix 6.2 for more detail.
Develop and support appropriate services, which may have been identified as lacking early on, including identifying ways to make services more accessible and culturally appropriate.	See examples cited in HSE NOSP annual reports, **https://www.hse.ie/eng/services/list/4/mental-health-services/nosp/about/annualreports/**
Build new natural support networks by empowering families and communities/local services to receive and harness support from within their own existing networks.	This can be achieved by increasing a community's capacity and confidence by assisting them to be better prepared in the event of a suspected suicide by, for example, supporting local community groups involved in mental health promotion and suicide prevention, in line with good practice.
Continue to deliver on identified actions in Connecting for Life local actions plans that may be relevant for the community affected by the death(s).	See **https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/connecting-for-life-local-action-plans.html**

Appendix 6.2 – Relevant training programmes

Relevant training programmes include:

Suicide, self-harm and bereavement

www.nosp.ie/training

- START, Online Suicide Prevention Training
- safeTALK, Suicide Alertness Training
- ASIST, Applied Suicide Intervention Skills Training
- STORM, Skills Training on Risk Management
- Understanding Self-Harm
- Bereavement training for professionals supporting people bereaved through suicide
- Supporting people bereaved through suicide in the community

Others

- CISM, Critical Incident Stress Management
- Psychological First Aid (PFA) or Mental Health First Aid (MHFA)
- Women's Aid training and development programmes https://www.womensaid.ie/about/training.html
- Training on coercive control
- Bereavement training delivered on an ongoing basis by the Irish Hospice Foundation www.hospicefoundation.ie
- Working therapeutically with grief, including traumatic memories, delivered by The Loss Foundation (UK charity) www.thelossfoundation.org/training
- Complicated grief, PTSD training, Trauma-informed care/approaches
- Barnardos, who provide support for children, young people and families, offer training in two ways: through training events open to staff and volunteers and also tailored training with a group of staff from an organisation to address specific issues. www.barnardos.ie

Cultural awareness

Relevant documents/Literature

- The HSE's Multilingual Aid Box: **https://www.hse.ie/eng/services/publications/socialinclusion/ema.html**
- Good practice guidelines for HSE staff on working with interpreters: **www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/translation-hub/translation-interpreting-companies/**
- A Health Services Intercultural Guide: **https://www.hse.ie/eng/services/publications/socialinclusion/interculturalguide/**
- Multilingual resources: **www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/translation-hub/multilingual-resources-and-translated-material/**

Organisations that could provide advice

- Doras – **doras.org**
- Nasc Ireland – **nascireland.org**
- The Immigrant Council of Ireland – **www.nwci.ie**
- The Irish Refugee Council – **www.irishrefugeecouncil.ie**
- MASI – The Movement of Asylum Seekers in Ireland – **www.masi.ie**
- Pavee Point – **www.paveepoint.ie**
- Exchange House – **www.exchangehouse.ie**
- Directory of Migrant Organisations and Supports in Dublin: **https://www.newcommunities.ie/assets/files/pdf/20130812153718.pdf**
- HSE National Social Inclusion Office: **https://www.hse.ie/eng/about/who/primarycare/socialinclusion/**

Relevant training

- Pavee Point: Cultural Awareness/Diversity Training with a focus on Travellers & Roma **http://www.paveepoint.ie/wp-content/uploads/2009/05/Pavee-Training-Brochure.pdf**
- National Youth Council of Ireland youth training **www.youth.ie/training-and-events/**
- TENI transgender awareness training **www.teni.ie** and **www.hseland.ie**
- LGBT Ireland awareness training **https://lgbt.ie/training/** and **www.hseland.ie**
- BelongTo LGBTI+ training **www.belongto.org/professionals/training/**
- HSELand Intercultural Awareness eLearning programme: **www.hseland.ie**

6.3 Tabletop exercises

Tabletop exercises can be carried out to make sure that plans are feasible, comprehensive and workable when activated during an actual event.

This usually involves a number of steps:

Step 1 – Setting objectives

Objectives set standards for measuring the success of the exercise. It is recommended that they are based on the mnemonic SMART (simple, measurable, achievable, realistic and task-orientated). Examples include:

- Determining how effective the plan was when responding to a suicide cluster, murder-suicide, etc. by identifying and understanding any gaps
- Evaluating the adequacy of the resources, for example, training of personnel, information, service provision, etc
- Determining the ability to provide timely and accurate information to whole population or specific groups

Step 2 – Selecting a scenario

Present a realistic scenario that will engage participants to test the exercise objective. When identifying a likely scenario, it is important to consider:

- Geographic-specific contexts
- Specify timing (day of the week, time of the year)
- The stage of the CRP on which the exercise will focus

Step 3 – Selecting people to facilitate, participate and observe

- **Facilitator:** The facilitator is responsible for setting the ground rules, leading the discussion, helping to answer participant questions and resolving any problems that may arise
- **Participants:** These include individuals from organisations who are likely to be involved in the response
- **Observer:** The observer ensures participant feedback is accurately recorded, takes notes and recounts observations during the review process. Observers should not take part in scenario discussions but should provide input at the review stage. It is recommended that there is at least one observer for every 10-15 participants

Step 4 – Create an environment conducive to participation

- **Room setup**: Ensure that the room is sufficiently large so that all participants can easily see one another. Decide how to how to divide up participants, for example, with each department together, different departments mixed, by geographical location
- **Timing:** Set time frames for discussing each scenario
- **Materials:** Provide participants with the following materials: an agenda, a copy of the scenario (particularly if you are not using a PowerPoint presentation), relevant policies or plans, pens and notepads and evaluations of the exercise
- **Ground rules:**
  - This is an open, low stress, no-fault environment
  - Varying viewpoints, even disagreements, are expected
  - Responses are based on your knowledge of current plans and capabilities involving existing assets as well as insights derived from training
  - This is an opportunity to discuss and present multiple options and possible solutions.
  - Assume cooperation and support from other responders and agencies
  - Issue identification is not as valuable as suggestions and recommended actions that could improve response and preparedness efforts
  - The focus is on problem-solving
  - There are no hidden agendas or trick questions
  - All participants receive information at the same time
  - This exercise assumes that agencies not present will conduct their roles appropriately

Step 5 – Conduct a review and evaluation

Once the exercise has been completed, the facilitator should allow participants and observers to share their thoughts on the discussions. Provide every participant and observer with an opportunity to comment on what worked well, what did not work well and areas for improvement. Have someone take notes during the review. After the review, ask participants to complete evaluations of the exercise.

Step 6 – Write an after action report

The after action report records the results of the tabletop exercise by analysing the information from the review, evaluations and exercise notes. Any recommendations from the evaluations and review should be noted.

Step 7 – Meet to discuss follow up actions once the after action report is complete

Schedule a meeting with the exercise participants to:

- Review the after action report and its recommendations
- Determine what actions are necessary to address these recommendations
- Identify those responsible for delivering on these recommendations
- Develop a plan with timelines for completion

Scenario 1 – Suspected point cluster suicide

This is assuming that a CRP is already in place.

The ROSP has been made aware that a point cluster may have occurred in an area. There has been the death of a young man aged 15 years by suspected suicide. This took place four weeks ago. There has also been a death of another young man aged 16 years by suspected suicide in an adjoining parish, which took place two weeks ago. We have just heard of another death. The girlfriend of the young man who died four weeks ago has also died by suspected suicide. Both young men were connected through GAA. A senior member and mentor to the young lads of the GAA club took his own life two years ago. The information has been given to the CRP Lead.

Objective 1 – To evaluate step one in the CRP, monitoring and screening, and to evaluate the CRP Lead and Core Team's familiarity with the plan.

Prompting questions:

What are the first steps the CRP Lead needs to take in organising a meeting of the Core Team?

What are the roles and responsibilities of the Core Team?

How can the Core Team establish that the information they have received is reliable? How does the team get additional reliable information to assist them in establishing the facts about the deaths to allow them to make a decision about activation?

What steps need to be taken to ensure that all the relevant documentation generated from the response has been captured, recorded and stored?

How does the Core Team use the tools (risk assessment, Circles of Vulnerability) in the CRP to identify vulnerable or at risk groups?

How does the Core Team get information about organisations/supports in the community?

How does the Core Team establish what has happened already in the community and what organisations have already provided support to the community?

What process does the Core Team use to make a decision about activation?

What does the Core Team need to consider in relation to media and communications?

What other additional supports, if needed, should be offered to team members?

Objective 2 – To evaluate step two, activation of the CRP, and to evaluate the CRP Activation Team's level of preparedness for the activation process, specifically focusing on the initial meeting.

Prompting questions:

What are the first steps the CRP Lead needs to take when organising an initial meeting?

What are the Activation Team members' roles and responsibilities?

If any members of the team have been personally affected by the death (for example, if it occurred in their own community), how will this impact on their role or on additional supports they may require?

What are the principles of partnership working that will lead to a more effective response?

What steps need to be taken to ensure that all the relevant documentation generated from the response has been captured, recorded and stored?

Can the team identify the tools and processes needed to respond and how they can be used (sample agenda, core actions, Circles of Vulnerability matrices)?

In what way would the team mobilise and manage the resources and services needed to respond (levels of response needed)?

Can the team demonstrate how best to establish and maintain communications internally as a group, with other agencies and with the media?

What, if any, knowledge gaps or training requirements have the team identified to provide a safe, sensitive and timely response?

What other additional factors should the team take into account at the first meeting when activating a CRP? Additional factors that you may wish to build in when planning your response:

Additional considerations	Examples to select
Location	City Town Rural Remote or island community
Timing	Friday before a bank holiday weekend Week before Christmas holidays Second week in August (schools and many businesses closed)
Special needs	Priority group impacted People with disabilities impacted (physical/learning) Requirement to provide resources and supports in a language other than English
Other challenges	Severe weather warning in place Covid-19 restrictions in place
Other	Person who died under the care of the HSE Mental Health Services

What other additional supports, if needed, should be offered to team members?

Objective 3 – To evaluate step three, deactivation of the CRP, and to evaluate the Activation Team's level of preparedness for the deactivation process.

Note: This exercise may be difficult to complete if a team has not gone through the process of activating a plan.

Prompting questions:

What steps need to be taken to ensure that all the relevant documentation generated from the response has been captured, recorded and stored?

What factors should the team consider when making a decision about deactivation (for example, timing, current status of the community, ongoing monitoring)?

Can the team identify the tools needed to inform the decision regarding deactivation (for example, risk assessment)?

Can the team members identify the wider implications and actions that need to be put in place in the more medium to long term in the community following deactivation of the CRP?

What does the team need to consider in relation to media and communications?

What can be done to ensure that agencies continue to work together to support communities affected by suicide?

What other additional supports, if needed, should be offered to team members?

Objective 4 – To evaluate step four, evaluation, and to evaluate the CRP Activation Team's familiarity with the plan.

Prompting questions:

What is the team's understanding of the importance of evaluation?

Can the team identify the two elements of the evaluation stage?

Who has responsibility for supporting the Core Team and the wider Activation Team?

What are the elements involved in this process?

Who has responsibility for the evaluation of the CRP?

What should be addressed as part of an evaluation?

How should the results of the evaluation be used?

Scenario 2 – Suspected murder-suicide

Reports are emerging in the media about a suspected murder-suicide. It involves a family of six, the parents and four children aged 15, 12, 8 and 3 years. It appears that the father had recently been made redundant from his job.

Work through objectives 1-4 above

Appendix 7 - References

Arensman, E. & McCarthy, S. (2017). Emerging survivor populations: Support after suicide clusters and murder-suicide events. In K. Andriessen, K. Krysinska & O.T. Grad (Eds.), **Postvention in action: The International Handbook of Suicide Bereavement Support (pp. 225–236). Boston: Hogrefe Publishing.**

Arensman, E. (2014). **Clustering and contagion of suicide and self-harm: Bridging the gaps in research and prevention.** Keynote lecture, 15th European Symposium on Suicide and Suicidal Behaviour, Tallinn, Estonia. August 27–30.

Cerel, J, McIntosh, J.L., Neimeyer, R.A., Maple, M. & Marshall, D. (2014).The continuum of "survivorship": Definitional issues in the aftermath of suicide. **Suicide & Life-Threatening Behavior. Available from:** https://doi.org/10.1111/sltb.12093

Cheng, Q., Li, H., Silenzio, V. & Caine, E.D. (2014). Suicide contagion: A systematic review of definitions and research utility. **PLoS ONE,** 9(9), e108724 [online]. Available from: https://doi.org/10.1371/journal.pone.0108724 [accessed 25 January 2021].

EduRisk. (2016). **Crisis response planning: A guide for conducting tabletop exercises.** United Educators: USA.

Georgia Commission on Family Violence. (2020). **Support for survivors of murder-suicide** [online]. Available from: https://gcfv.georgia.gov/support-survivors-murder-suicide [accessed 12 June 2020].

Hawton, K., Hill, N.T.M., Gould, M., John, A., Lascelles, K. & Robinson, J. (2019). Clustering of suicides in children and adolescents. **Lancet Child Adolescent Health** [online]. Available from: https://doi.org/10.1016/S2352-4642(19)30335-9

Higher Education Authority. (2020). **National student mental health and suicide prevention framework**.

HSE National Office for Suicide Prevention. (2011). **Responding to murder-suicide and suicide clusters guidance document**.

Hobfoll, S., Watson, P., Bell, C., Bryant, R., Brymer, M., Friedman, M., Friedman, M., Gersons, B., Jong, J., Layne, C., Maguen, S., Neria, Y., Norwood, A., Pynoos, R., Reissman, D., Ruzek, J., Shalev, A., Solomon, Z., Steinberg, A. & Ursano, R. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. **Psychiatry**, 70, pp. 283–315.

Holland Barnes, D. (2010). Media coverage. In R.N. Golden & F.L. Peterson (Eds.), **The truth about suicide** (pp. 62–67). New York: Facts on File, Inc.

National Action Alliance. (2020). **Our strategy: Lived experience** [online]. Available from https://theactionalliance.org/our-strategy/lived-experience [accessed 23 November 2020].

National Coalition to Abolish the Death Penalty (NCADP). (2010). **The impact of homicide on families of murder victims** [online]. Available from: https://b.3cdn.net/ncadp/0345dbc8bb192096d8_w6m6bh8oz.pdf [accessed 12 June 2020].

National Suicide Research Foundation. (2020). **Briefing: Murder-suicide and media reporting** [online]. Available from: https://www.nsrf.ie/wp-content/uploads/2020/10/Briefing_Murder-suicide_NSRF.pdf [accessed 23 November 2020].

National Suicide Research Foundation. (2020). **What is suicide?** [online]. Available from: https://www.nsrf.ie/our-research/what-is-suicide/ [accessed 23 November 2020].

Prat, S., Rérolle, C. & Saint-Martin, P. (2013). Suicide pacts: Six cases and literature review, **Journal of Forensic Science**, 58(4), pp. 1092–1098. https://doi.org/10.1111/1556-4029.12056

Public Health England. (2019). **Identifying and responding to suicide clusters. A practice resource.** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/839621/PHE_Suicide_Cluster_Guide.pdf

Samaritans Ireland. (2020). **Media guidelines for reporting suicide.** Available from: https://www.samaritans.org/ireland/about-samaritans/media-guidelines/

World Health Organization (2020). **Health topics: Suicide** [online]. Available from: http://www.emro.who.int/health-topics/suicide/feed/atom.html [accessed 23 November 2020].

Women's Aid (2019). **Femicide watch report Republic of Ireland: A legacy of loss for women, family and community.**

Published by:

The HSE National Office for Suicide Prevention (NOSP)
Stewarts Hospital, Palmerstown, Dublin 20

September 2021 / Version 1.0

info@nosp.ie | www.nosp.ie

Connecting for Life