Rapid Assessment and Community Response to suicide and suspected suicide in Dublin South

Summary Report
July 2020

SOLUTIONS

Connecting for *Dublin South*

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Introduction and Overview

1.1 Introduction

In February 2020, the Health Services Executive National Office of Suicide Prevention (HSE NOSP) appointed S3 Solutions Ltd to carry out a rapid assessment of the current situation regarding suicide within the Ballyfermot community.

The purpose was twofold; to efficiently work with key stakeholders to gain insights and understanding about the range of factors that may be affecting suicidal behaviour in the community and to identify how best to support those impacted to minimise any possible contagion. Equipped with this knowledge, the Connecting for Life (CfL) area-level Implementing Team and the local HSE Resource Officer for Suicide Prevention (ROSP) would be well positioned to develop targeted interventions to support the success of all response efforts.

1.2 Objectives

The objectives of research were:

1) To undertake a multisectoral rapid community assessment of the situation and need of the identified community by:

    a) Initiating and planning the project by conducting a community stakeholder mapping exercise to identify existing services

    b) Undertaking community level secondary data review

    c) Engaging in participative primary data collection processes with key stakeholders including facilitated discussions and semi-structured interviews.

2) Triangulate between (primary/secondary) data sources

    a) Present a situation report including

        i) Key findings by sector and/or stakeholder's group

        ii) Conclusions and recommendations for an inclusive rapid response, aligned with Connecting for Life Dublin South.

1.3 Context

A 'suicide cluster' can be defined as a group of suicides or suicide attempts, or both, that occur closer together in time and space than would 'normally' be expected on the basis of either statistical prediction or community expectation[1]". However, often it is unclear what constitutes a 'normal number' of deaths, so for the purpose of this study a narrower definition was used. A suicide cluster was defined as *"a series of 3 or more closely grouped deaths within a three month period that can be linked by space or social relationships*"[2]. The development and maintenance of suicide clusters are often explained by theories relating to contagion and imitation, whereby one person's suicide is thought to influence others to act in the same way[3]. Suicide contagion is a process in which the suicide of one person or multiple people can contribute to a rise in suicidal behaviours among others, especially those who already have suicidal thoughts or a known risk factor for suicide, 'contagion' refers to the process by which one suicide facilitates the occurrence of another[4].Suicide clusters have a significant negative impact on the community they occur in and can cause trauma at an individual, familial and community level[5].

The brief for this research referenced that there have been 26 deaths by suspected suicide[6] in the Ballyfermot and Cherry Orchard community since 2015; many of which, were young women with children. Confidential HSE NOSP data for 2015-2017 relating to the Ballyfermot area (including Cherry Orchard) indicates that women are as likely to die by suicide in the area as men. In contrast, women are three times less likely to die by suicide than men nationally. Between April and July 2019, 8 women aged early twenties to mid-thirties, died by suspected suicide in or close to the area within a 10 week period. Many of these were young mothers. These deaths had a profound effect on the local community. This research is considered a key step in an attempt to respond to these emerging trends.

[1] Gould et al (1989) Suicide clusters: A critical review. Suicide and Life Threatening Behaviour.;19:17–29.

[2] Emerging Survivor Populations: Support after Suicide Clusters and Murder Suicide Events: Arensman E, McCarthy S in Andresen K, Krysinska K, Grad O (Eds.). Postvention in Action: The International Handbook of Suicide Bereavement Support. Hogrefe (2017)

[3] Robinson, et al (2016). Spatial suicide clusters in Australia between 2010 and 2012: a comparison of cluster and non-cluster among young people and adults. BMC Psychiatry 16, 417. https://doi.org/10.1186/s12888-016-1127-8

[4] Insights into the processes of suicide contagion: Narratives from young people bereaved by suicide Jo Bell, Nicky Stanley, Sharon Mallon & Jill Manthorpe, Suicidology Online 2015; VOL.6 (1): 43-52 (2015)

[5] Arensman, E., & McAulifee, C. (2015). Clustering and contagion of suicidal behaviour. In U. Kumar (Ed.), Suicidal Behaviour, Underlying dynamics (pp. 110-120). London, UK: Routledge.

[6] The assessment of whether a death is a suicide in Ireland is determined by a Coroner's inquest. It can be lengthy process from the time of death, through the legal investigation, and the issuing a verdict, depending on the complexity of the case. A Coroner's verdict of suicide is based on legal guidance surrounding the weight of evidence that a person intended to take their life 'beyond reasonable doubt'.

This report will investigate issues which are possibly related to the suicide cluster in the area, based on secondary analysis of data pertaining to the area, the established research on suicide clusters and contagion, and feedback from local stakeholders.

It is important to note here that the individual lives lost to suicide have not been studied, nor did the research endeavour to develop individual case studies of the lives of the young women in the 2019 cluster.

Most respondents have referred to issues present at an area level as opposed to any of the individual cases. The lives lost of these young women has been deeply traumatic to the area and the aim is not to make inferences about individual cases but identify potential risk factors to prevent future suicide clusters in Ballyfermot. Our thoughts and sympathies are with the family and friends of those young women.

1.4 Methodology

This summary research report is informed by the following activity, carried out between February and May 2020.

To guide and oversee the rapid assessment process, the researchers established a Rapid Assessment Response (RAR) Team comprised of representatives of the Ballyfermot service community including Ballyfermot Local Drug and Alcohol Task Force, Ballyfermot Chapelizod Partnership, Ballyfermot Star, HSE Addiction Services, TUSLA and the local HSE Resource Officer for Suicide Prevention (ROSP). In addition, the HSE NOSP attended these meetings. Four meetings of the RAR took place between February and July 2020. RAR members played a key role in providing local intelligence, informing the mapping of local services, encouraging the participation of local groups in the research and facilitating conversations with residents, as well as holding the researchers to account and challenging the findings.

We would like to acknowledge the guidance and counsel provided by this group throughout the research process.

1.4.1 Data Collection

Data was collected through semi-structured interviews. An interview schedule with a series of predetermined, yet open ended, questions was developed by the researchers, alongside members of the RAR. The interview schedule used for these interviews is presented in the appendix.

The following summarises the data collection activities undertaken between 11th March and 19th May:

- 22 semi-structured interviews with service providers from the Ballyfermot and Cherry Orchard communities. Half (n=11) of these interviews, with 14 individuals, took place face-to-face. Due to Covid-19 restrictions which were introduced during the data collection phase, an additional 11 interviews were carried out over Zoom. Research participants included local community and voluntary service providers, statutory agencies, clergy, local councillors and residents. A full list of organisations represented in the consultation process is provided in appendix 2.
- Five semi-structured interviews with local women bereaved by suicide. These participants were identified by local service providers, and aftercare support was provided following the interviews. Four of those interviewed had connections to women involved in the 2019 cluster; one participant has lost children to suicide.
- A desk based review of secondary data and information, including existing qualitative research studies, statistical data and policy documentation relevant to suicide, suicide clusters, and the Ballyfermot and Cherry Orchard areas. The following resources were used to search for relevant research, papers, or statistical information:
    - National Institute for Health and Care Excellence (NICE)[7]
    - Social Care Institute for Excellence[8]
    - National Suicide Research Foundation[9]
    - HSE Publications[10]
    - CSO[11] and Pobal Maps[12]

Online news articles were also accessed and reviewed to gather background information on the 2019 'suicide cluster', and to explore how the media was reporting on events.

- Two online key stakeholder events, one with senior HSE staff working in the relevant community health organisation area (i.e. CHO 7) and a second with relevant HSE national staff (e.g. HSE NOSP, and HSE Addiction Services), were convened by the research team. Members of the RAR attended and participated in both events and represented the local community. The events focused on sharing the learning from the fieldwork including presenting an overview of emerging findings and negotiating recommendations.

[7] https://www.nice.org.uk/

[8] https://www.scie.org.uk/atoz

[9] https://www.nsrf.ie/

[10] https://www.hse.gov.uk/pubns/

[11] https://www.cso.ie/en/

[12] https://maps.pobal.ie/

1.4.2 Data Analysis

Qualitative data analysis was conducted using a thematic approach[13]. Categories were developed, coded, and reduced. Interview data and information from secondary data sources were cross referenced to identify emergent themes and issues and to explore the relationships between issues[14]. The researchers adopted an inductive approach, focused on wide ranging engagements with key stakeholders to build an abstraction and describe the key concepts relating to suicide and suicidal behaviour, specifically for young women in the community. These were transferred into recommendations towards the end of the process – augmented by further engagement with the RAR and HSE.

1.4.3 Limitations

The research was carried out during COVID19 and, considering the intended rapid nature of the assessment, some limitations were inevitable. Several limitations are identified:

- Owing to time restrictions, redeployment and other issues related to the time during which the research was carried out, some key stakeholders were not involved in the study, particularly from a statutory, clinical, primary care background. Further engagement with stakeholders is recommended as part of the implementation of the recommendations in this report.
- Five women from the area were involved in the study, a more in depth engagement and further research with this group would offer a valuable perspective.
- The research did not explore the methods of suicide for those within the 2019 cluster and an analysis of this is an area of further exploration

The rapid assessment is therefore framed primarily from a community perspective, focused on informing intervention at an area-level.

[13] Lewis-Beck, M. S., Bryman, A. & Liao, T. F. (Eds.) (2004). The SAGE encyclopaedia of social science research methods (Vols. 1-3). Thousand Oaks, CA: SAGE Publications

[14] Morgan, D. L. (1997). Focus groups as qualitative research (2nd ed.). Thousand Oaks, CA: Sage.

2

Area Profile

2.1 Introduction

To contextualise findings, this section sets out a brief socio economic profile for the area within which the research was targeted, namely Ballyfermot and Cherry Orchard.

2.2 Suicide and Deprivation

Research for the UK shows a strong association between area level deprivation and suicidal behaviour.

People who are socioeconomically disadvantaged or who live in areas of socioeconomic deprivation have an increased risk of suicidal behaviour. Typically features of this disadvantage include low educational attainment, low income, unemployment, debt and adverse personal and health related experiences[15].

In Ireland, research found that *"overall deprivation had the strongest independent effect on small-area rates of suicide, with the most deprived areas showing the greatest risk of suicide"*. The study also reported *"a weak association between high population density (urbanicity) and increased suicide risk was found among females in the 15–39-year age group"*[16]. The researchers found limited other published Irish research exploring the relationship between poverty/disadvantage and suicide and this is an area for further exploration.

[15] Dying from Inequality: Socio Economic Disadvantage and suicidal behaviour: Samaritans 2017

[16] O'Farrell, I., Corcoran, P. & Perry, I. The area level association between suicide, deprivation, social fragmentation and population density in the Republic of Ireland: a national study. Soc Psychiatry Psychiatr Epidemiol 51, 839–847 (2016)

2.3 Area Level Deprivation

The area profile considers 7 Electoral Divisions that comprise the catchment of Ballyfermot and Cherry Orchard. These include:

Name of Electoral Division	Population[17]	Number of small areas within Electoral Division	HP Deprivation Index
Cherry Orchard A	3254	6	-13.97
Cherry Orchard B (Carna)	2836	9	-14.96
Cherry Orchard C	4545	12	-10.94
Kylemore	2657	10	-16.27
Drumfinn	3588	13	-13.90
Decies	2677	11	-15.18
Kilmainhaim A	2534	12	-9.08
Total	**22,091**	**73**	

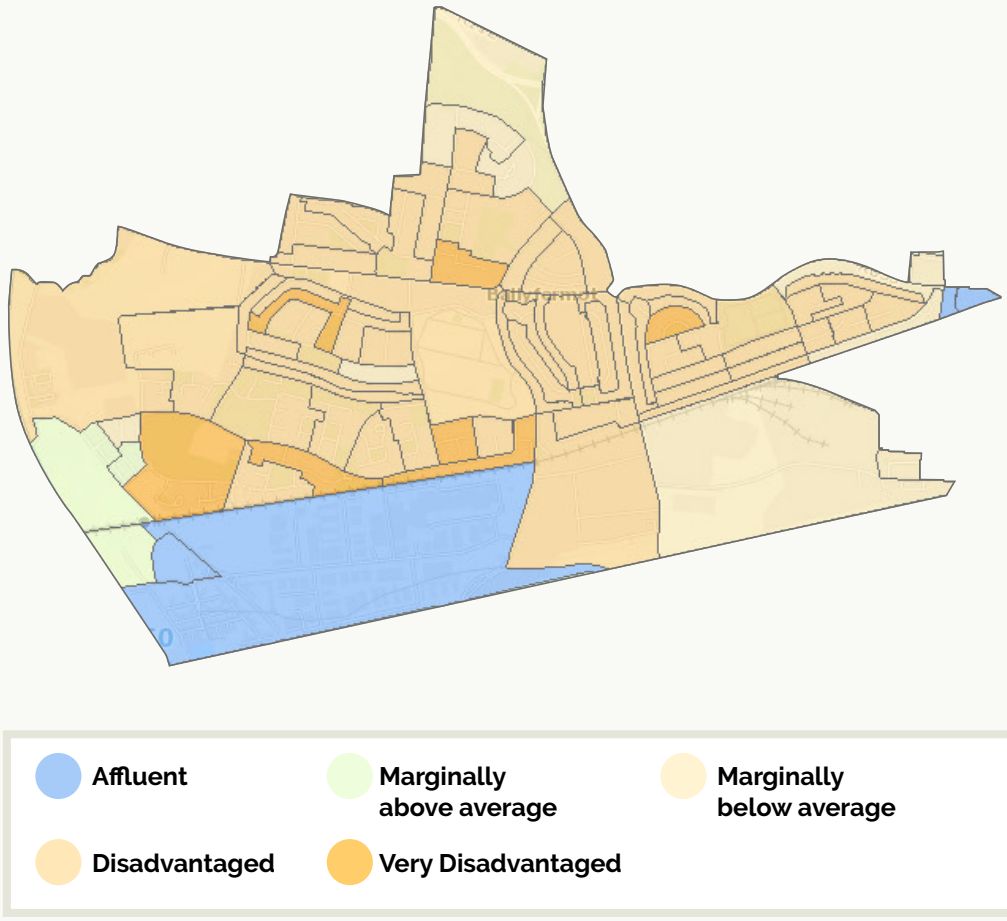
Six of the seven ED's are classified as 'disadvantaged' with one (Kilmainham A) marginally below average levels of disadvantage. Electoral Divisions are comprised of Small Areas (SA's). The 2016 Pobal HP Deprivation Index enables an assessment of overall affluence and deprivation in Ireland across 18,488 SA's. SAs are classified from the most disadvantaged (-40) to the least disadvantaged (+40). SA's are areas of population generally comprising between 80 and 120 dwellings created by the National Institute of Regional and Spatial Analysis (NIRSA) on behalf of the Ordnance Survey Ireland (OSi) in consultation with CSO.[18]

Figure 1 below provides a visual overview of the catchment area, broken down by SA boundaries and mapped against a deprivation overlay. The map shows that the area contains a unique mix of significant deprivation, boundaried by pockets of affluence.

[17] https://maps.pobal.ie/WebApps/DeprivationIndices/index.html

[18] http://airo.maynoothuniversity.ie

Figure 1: Map of the Area with Deprivation overlays



According to the Pobal HP Deprivation Index, of the 73 small areas within the catchment:

- 7 SAs are very disadvantaged (deprivation scores of between -20 and -30)
- 56 SAs are disadvantaged (deprivation scores between -10 and -20)
- 6 SA's are marginally below average (deprivation scores between 0 and -10)
- 4 SAs are marginally above average (0-10) and 4 are affluent (10-20)

The majority of SA's (n = 5) that are classified as 'very disadvantaged' are concentrated in the Cherry Orchard A, B and C Electoral Divisions. Overall, 63 of the 73 SA's (86%) are significantly impacted by deprivation in this catchment.

2.4 How Deprivation Manifests – A Small Area Analysis

An examination of statistics at SA level provides a more intricate analysis of deprivation and how it manifests for people, and specifically in the context of this research, for females. An analysis of the disadvantaged and very disadvantaged SA's was carried out, a number of statistical datasets were sourced and reviewed from the Pobal HP Deprivation Index. These are presented in figure 2, using one 'very disadvantaged' small area as a case study example.

Figure 2: Case Study of Deprivation at SA

Case Study – Very Disadvantaged Small Area

One of the seven SA's classified as 'very disadvantaged' (deprivation index of -22.49) has a population of 358 people, covering around 116 households across 3 distinct streets. According to 2016 Pobal statistics (data source below), 68% of the households in this small area are lone parent (compared to a state average of 25.4%). CSO Statistics (2019) on women and men in Ireland indicates that 86% of all lone parents are female. It is therefore the case that 68-70 households across these 3 streets are likely to be female lone parents. In the same SA, the proportion of people achieving 3rd level education was 3.91% (about 14 people) compared with 33.4% nationally. Further, 30% of this small area have a primary education only, compared to 13% in the state.

Regarding employment, state unemployment for females in 2016 was recorded at 7.8%, corresponding statistics for this Small Area was 35.29%.

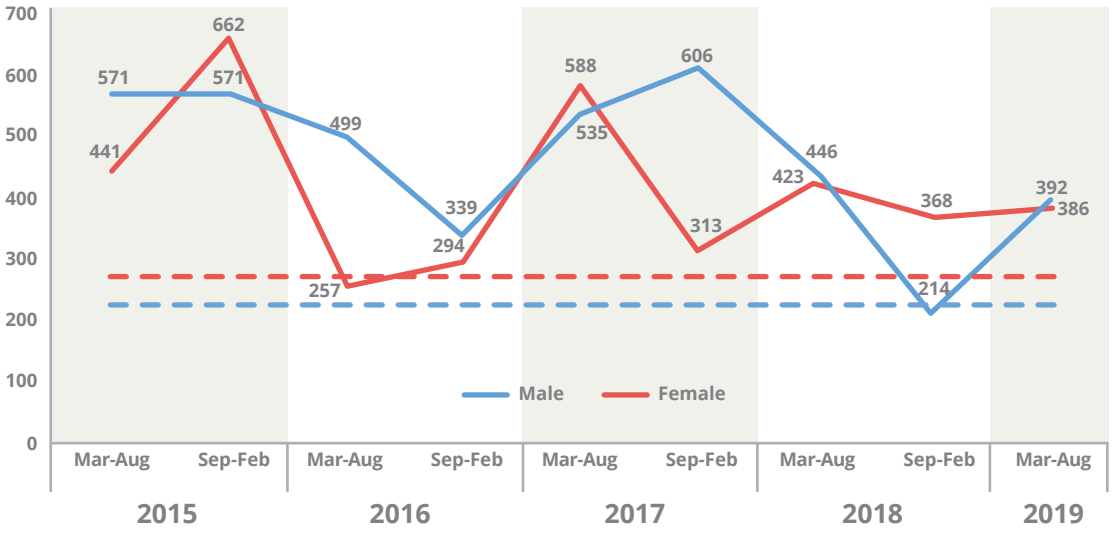
Data sources for Case Study
https://maps.pobal.ie/WebApps/DeprivationIndices/index.html
https://www.cso.ie/en/releasesandpublications/ep/p-wamii/womenandmeninireland2019/

The case study examines one SA within the overall catchment. Six other SA's in this area are classified as 'very disadvantaged', there are similar levels of lone parent families as well as higher proportions of female unemployment and lower educational attainment in some of these SA's. A further 56 SA's are classified as disadvantaged, also presenting statistics beyond those of state averages.

2.5 Hospital Presenting Self-harm

Data provided to the researchers by the National Suicide Research Foundation shows the rates of hospital presenting self-harm from residents of the 7 Electoral Divisions for the Ballyfermot/Cherry Orchard catchment from March 2015 to August 2019. Figure 3 presents the rate of presentation per 100,000 people.

Figure 3: Hospital Presenting Self-harm Rates



Self-harm is the single biggest risk factor for completed suicide, increasing the risk of suicide 40-fold, as compared to the general population. In 2016, more than 11,000 people came to Emergency Departments (ED) in Ireland following self-harm.[19]

The national average rate for males (224) and females (273) over this time period are highlighted by the dotted lines. The graph shows that the hospital presenting self-harm rates were consistently higher than the national average for females (except for Mar-Aug 2016) over the 4.5 year period.

[19] https://www.hse.ie/eng/about/who/cspd/ncps/mental-health/self-harm/

2.6 Service Provision

The image on page 35 provides a visual overview of services and facilities in the area as identified during the rapid assessment consultations. Generally, the view is that there are a lot of services in the area although many reported being under resourced or operating with waiting lists, particularly mental health, counselling and family support services within the community and voluntary sector.

2.7 Summary

This section provides area based information that offers a context for the research findings. The area is characterised by high levels of socio economic deprivation, high levels of lone parent families, low unemployment, and low educational achievement. In addition, rates of hospital presenting self-harm are consistently above the national average. Given the greater risk of suicide and suicidal behaviour in areas of high socio economic deprivation, the statistics for this area provides a useful context for the research findings.

3

Key Findings

3.1 Introduction

The researchers can conclude that there was a suicide cluster[20] in this area in 2019, this relates to 8 women who died by suicide over a 10 week period (April – July 2019). No one research participant could speak with conclusive knowledge about the cluster, however the prevailing view amongst research participants was that only 4 of the young women lived in Ballyfermot/Cherry Orchard. Two were reported as being from Clondalkin, one from Tallaght and one from Palmerstown, however, family ties or childhood connections to Ballyfermot meant that a majority of the funerals took place there. Thus, it was perceived that the Ballyfermot area was disproportionately affected in terms of the presence and visibility of the suicide cluster and contagion.

Research participants spoke of a '*palpable sense of fear and anxiety*' of further suicides, they also spoke about the area, and the characteristics of those that present to services generally, not the individual lives lost to suicide in 2019. In presenting the research findings, the aim is not to make judgements or conclusions about individual cases but to set out the perceived area level factors that may have influenced the cluster, thus informing an area level response. The findings are presented thematically under the following headings:

[20] Emerging Survivor Populations: Support after Suicide Clusters and Murder Suicide Events: Arensman E, McCarthy S in: Andresen K, Krysinska K, Grad O (Eds.). Postvention in Action: The International Handbook of Suicide Bereavement Support. Hogrefe (2017)

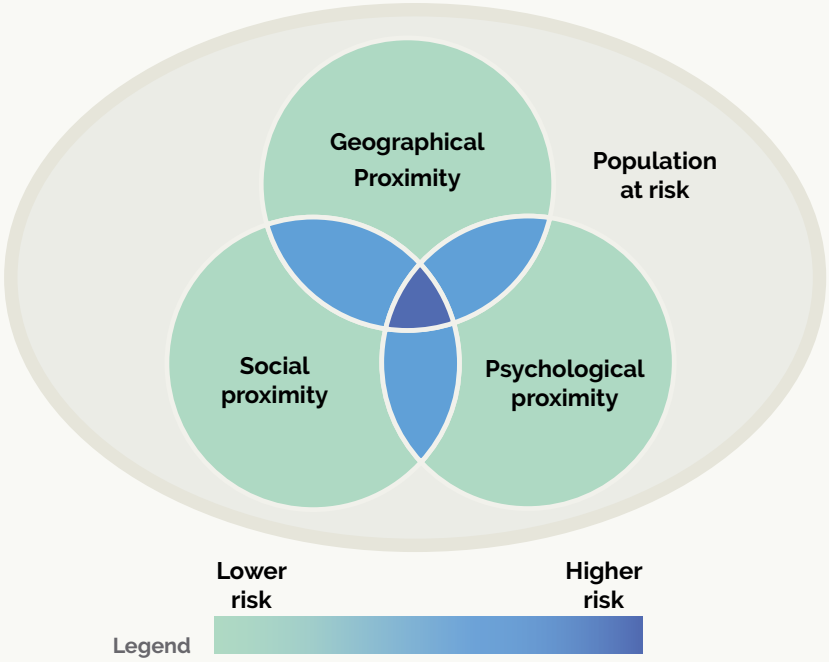
3.2 Perceived factors influencing the suicide cluster and contagion

3.2.1 South Dublin Connection (geographic, social, and psychological)

Research participants indicated that the high incidence of suicide amongst young women extends beyond the Ballyfermot area (focus of this research) and is consistent with a wider group of deprived areas in South Dublin, comprising Ballyfermot and Cherry Orchard[21], Clondalkin, Palmerstown and Tallaght. Research participants described *"similar socio economic circumstances and deprivation"* as the key similarities between the areas whilst also referencing perceived higher levels of social and residential transience between people growing up and settling down in these areas compared with other parts of Dublin.

The Circles of Vulnerability[22] was used as a framework to understand suicide clusters and explore contagion. The Circles of Vulnerability Model is based on the idea that every suicide is akin to a stone being thrown into a pool of water—ripples spread outwards to the edge of the water. The extent of vulnerability to suicide can consist of geographical, social, and psychological proximity to the deceased. The presence of multiple factors can intensify the vulnerability.[23.]

Figure 4: Circles of Vulnerability



[21] Research participants made a clear distinction between Ballyfermot and Cherry Orchard

[22] Public Health England, 2015, Identifying and Responding to Suicide Clusters and Contagion. A Practice Resource

[23] Ailbhe Spillane, Karen Matvienko-Sikar, Celine Larkin, Paul Corcoran & Ella Arensman (2019) How suicide-bereaved family members experience the inquest process: a qualitative study using thematic analysis, International Journal of Qualitative Studies on Health and Well-being, 14:1

Geographical proximity can relate to direct exposure to the death, those in contact/connection with the person shortly before they died are more at risk of contemplating suicide.

Psychological proximity is the extent to which people can relate to the deceased, potentially because of cultural connections or shared experiences, therefore they perceive themselves as similar to the deceased. Research participants reported that young women in particular may be more susceptible or vulnerable to psychological proximity, particularly where there are traumatic underlying issues such as domestic violence, loss of a child and/or sexual abuse. As indicated in the quote from an interview below, there was a feeling amongst research participants that the contagion effect may be stronger in young women, and that when one young mother dies by suicide, the psychological proximity felt, can remove the protective barrier of parenthood for other young mothers against suicide ideation. Knowing that a young mother in similar circumstances in the locality has died by suicide potentially legitimises others to do so.

> ***"Children are usually a protective factor, but this seems to have changed now. Young women committing suicide with young children"***

The relationship someone had with the deceased including in social circles impacts on how close someone feels to the deceased, even if this is a perceived closeness[24], this describes **social proximity.** Research participants were not conclusive about the social proximity of the 8 young women in the 2019 cluster. Whilst at least four were reported to have been in a similar friendship group, it is thought that they all *'would have known of each other'* because of social media connections or indirectly through *'partying and other social circles'*.

In addition, it was perceived by a small number of research participants that some of those in the 2019 cluster were *'connected to services'* and therefore this was a potential source of social proximity.

A fourth dimension of the circles of vulnerability is **time proximity**. Eight suicides took place over a period of 10 weeks, and one of the suicides occurred on the day of one of the funerals.

This was, as described by research participants, heightened further because of the *'close knit'* nature of the Ballyfermot and Cherry Orchard communities.

[24] Headspace (2019) Suicide Contagion School Support

> *Cherry Orchard area is a tight knit community, they all link in socially. You would see the connection, there is so many other people that know someone that has committed suicide. It's a Circle and you can't get off, retraumatising all the time because it's happening so frequently, at least once a month in Cherry Orchard".*

The use of the Circles of Vulnerability model here is an attempt to help understand the circumstances relating to the 2019 cluster and thus to help contextualise findings and shape recommendations.

3.2.2 Funerals monumentalising suicide

Research participants, whilst acknowledging the right of any family to grieve and mourn for their loved one in a way they feel is appropriate for them, consistently referenced the potential negative impact of suicide related funerals which can become *'glorified events'* that result in intensive partying that can go on for days.

> *Funeral happens, celebrate life, they then are on a comedown from the celebration then you hear the next week of another death...(sic)Needs to be a community response".*

> *It is very dangerous how suicide has become normalised now, (sic) particular concern for women that attend the funerals of other women".*

Funerals provide an emotionally charged social outlet and opportunity for collective grieving. There is often a re-kindling with old friends which can lead to excessive drug taking and risky behaviour. While this could apply to any person profile or demographic, it is perceived as prominent in young people, particularly for those who now perhaps live outside of the area, have lost touch with childhood and adolescent friends and whose opportunities to socialise may be restricted due to work, childcare and other commitments.

> *...Drinking and drugs after funerals and then dying that night".*

The need for a specific community response and protocol relating to funerals was frequently referred to, acknowledging that funerals and their aftermath can be distressing for the community and serve as contagion triggers for some individuals. Research participants felt that awareness raising of suicide and its impact on families can be sensitively integrated into the community response pre and post funeral.

Managing the interface between family and the community at funeral times is important in order to respect the family's right to both mourn and celebrate the life of their loved one as they wish.

Family members often become advocates for raising awareness of suicide and its impact and a community response protocol could consider how family members of suicide victims could become part of the community effort at a future point when sufficient time has passed to grieve and adjust.

3.2.3 Monumentalising suicide – the local physical and digital environment

A common view across research participants was the potential negative impact of both social media (through tributes), as well as physical monuments across the streets and estates in monumentalising and glorifying suicide. Research participants again acknowledged the sensitivity of these issues for the grieving families.

The role of the media in providing responsible and informed coverage of suicide to minimise *"glamorising the issue"* is referenced throughout the suicide literature[25]. Whilst this was acknowledged during the research: *'...concern over the suicide being glorified by local press coverage when reporting on local suicides',* the role of the local media received only nominal reference by research participants in comparison to the perceived role of social media:.

The extent to which people are connected on social media is perceived by research participants as a key contributor in broadening the social and geographic proximity, and thus the exposure and impact of the suicide[26].

> ***"...you see the adulation all over Instagram and Facebook, the tributes are all over social media and they probably wonder, is that what people will say about me?"***

Exposure to suicide cluster–related social media is associated with both suicide ideation and suicide attempt during a suicide cluster. Suicide interventions could benefit from efforts to mitigate potential negative effects of social media and promote prevention messages[27].

[25] Niederkrotenthaler T, Voracek M, Herberth A, Till B, Strauss M, Etzersdorfer E, Eisenwort B, Sonneck G. British Journal of Psychiatry. 3. Vol. 197. 2010. Role of media reports in completed and prevented suicide: Werther v. Papageno effects; pp. 234–243

[26] Headspace (2019) Suicide Contagion School Support

[27] Associations Between Social Media and Suicidal Behaviors During a Youth Suicide Cluster in Ohio: Elizabeth A. Swedo et al Published:July 07, 2020 DOI:https://doi.org/10.1016/j.jadohealth.2020.05.049

3.3 Possible area level factors influencing suicide and suicidal behaviour

3.3.1 Underlying Trauma

It was consistently the view of those interviewed that underlying trauma is at the root of anxiety/depression or poor mental health for young women in the area, particularly those from childhood. Adverse Childhood Experiences (ACEs)[28] are more likely to be present in areas of deprivation and those with ACEs are more likely to have attempted suicide in their lifetime than those who had not experienced ACEs.

Women who experience two or more ACEs have significantly increased risk of attempting suicide at least once, compared to women with no ACEs[29]. This was reinforced by many of the local service providers when speaking about the area and young women that live there, all ten counts of ACES's were referenced at least once across the interviews.

> *"A lot of difficulties stem from childhood, (sic) little support for young mothers around how to be emotionally responsive to your children and how to do it when you have limited resources".*

The presence of domestic violence in the family home, abuse (physical/sexual/emotional), the presence of drug and alcohol use in the family, the presence of mental ill health in the family and separation of parents were perceived by research participants as the most common forms of adverse childhood experiences. In addition, research participants described more recent traumas such as for example, the loss of a child or bereavement as contributing to underlying trauma and leading to challenging mental health for young women.

3.3.2 Prevalence of drug and alcohol misuse

Drug misuse was identified across all interviews as an issue for many young women. Where poverty clusters at a neighbourhood level, drug-related harms cluster too[30]. Research participants identified cocaine as the *'main problem drug'* and as especially dangerous at the *"coming down from it'* phase. The use of other drugs such as Lyrica to manage the come down is seen to be problematic and escalates the thinking in suicide ideation towards suicidal behaviour. Alcohol remains an issue and a concern although it is reported as being as cheap to buy drugs as it is alcohol now.

[28] http://www.healthscotland.scot/population-groups/children/adverse-childhood-experiences-aces/overview-of-aces

[29] Choi, N. G., Dinitto, D. M., Marti, C. N., & Segal, S. P. (2017). Adverse childhood experiences and suicide attempts among those with mental and substance use disorders. Child Abuse & Neglect, 69, 252–262.

[30] 'Outcomes: Drug Harms, Policy Harms, Poverty & Inequality 2016 (Aileen O'Gorman, Alan Driscoll, Kerri Moore, Doireann Roantree)

> ***"Alcohol is an issue, drugs is an issue. I know a male that committed suicide had a big coke bill..."***

There are two emerging views on drug misuse:

1) relating to those that died by suicide, the prevailing view of research participants is that where there was drug and/or alcohol misuse, this was likely to be a coping mechanism for a pre-existing trauma, an ongoing trauma, or a challenging circumstance and not the root cause in itself. One research participant, when describing the circumstance behind a local suicide stated, *"extreme violence in the relationship was there, then drugs came into the picture, and it all spiralled from there".*

> ***"In each suicide that happened there was something else involved such as drink or drugs, it has become the impact of drink or drugs that they go off on their own rather than talking to someone.... The cocktail effect"***

> ***"Drug addiction contributes to the suicide not a cause of the suicide..."***

2) More generally, there was a significant concern amongst research participants that the widespread misuse of drugs and alcohol amongst young women could lead to more enduring mental health problems, and potentially suicide ideation and suicide attempt. The sporadic and binge nature of this drug use often means that young women do not identify with drugs services as they do not see their 'recreational' drug use as problematic. One participant highlighted that cocaine and alcohol in particular is a means of escapism that permeates everyday life for some.

> ***...a Monday could just as easily seem like a Saturday now; cocaine and alcohol is an escape from everyday life..."***

A different outreach response for young women is needed particularly in relation to their cocaine and alcohol use and underlying trauma related mental health is a key gap. There is also a persistent and palpable sense of fear in the community because of the intensity of drug related intimidation and violence and services have reported supporting young women that have been sexually exploited, this is another source of trauma.

There is a lack of quantitative data to substantiate qualitative findings on drug and alcohol misuse. The Health Research Board (HRB) produce annual data reports which give a broad overview on the area. However, treatment data at a local level does not capture everyone, or every intervention carried out. Also, the data only relates to individuals who are accessing services, so for women with drug and alcohol issues that are not actually accessing services, they are hidden. National Drug Treatment Reporting Systems[31] data also only relates to specialist drug/alcohol treatment and rehabilitation services, not to the wider family support/child specific services.

The Central Treatment List[32] provides statistics relating to methadone treatment only, so again will only capture people who are accessing HSE Addiction Services to address opiate addiction. The lack of quantitative data is a gap and merits further exploration. It may be useful to explore how data on drug/alcohol use is captured in mental health or other non-specialist addiction services, to get a greater understanding of addiction issues among those not presenting to addiction services.

3.3.3 Social Media

It repeatedly surfaced that social media is perceived by research participants as both amplifying potential contagion through the geographic, social, and psychological proximity, but also in a more persistent way because of the perceived negative impact it can have on mental health – particularly for young women.

According to research participants, young women may feel pressure to *'...look good, be active and popular...',* this emanates from what they see and how they are perceived on social media. Research participants also felt that when young women may observe their peers on social media posting about their social life, which can deepen and entrench feelings of entrapment and isolation. Being distanced from friends and peers may intensify the feeling *"of missing out"*, thus when opportunities to socialise present in the form of family gatherings and funerals, it may potentially lead to excessive partying going on for days with drug taking and risky behaviour.

> ***"...Social media influence, visual of everything being nice, need for 'likes' on social media pages...".***

> ***"...Live in an era where everyone puts up the good times on social media and having a great time, the bad times aren't put out there and no one knows how to deal with the bad times or see the bad times".***

[31] The National Drug Treatment Reporting System (NDTRS) was established as an epidemiological database on treated drug and alcohol misuse in Ireland. It records incidence of drug and alcohol treatment.

[32] Administrative database to regulate the dispensing of methadone treatment.

> ***Women are no longer talking, the picture out there that I have to look the best, be the best and follow the crowd and if I am not doing that then something isn't right".***

3.3.4 Accessibility and Aspirations of Young Women

Research participants highlighted that young mothers/expectant mothers can quickly become "*inaccessible"* during pregnancy and the early years of parenthood leading to increased isolation from their friends and peers and detachment from the community. They can go *"from leaving school or attending a local service or youth club with regular socialising and interaction with friends to relative isolation within a number of months*".

> ***Ballyfermot has good parenting programmes, some of which are home based. Getting a young first time mother to engage with such programmes is critical as such supports may help to address post-natal issues".***

Challenges in relation to access and social connectivity are exacerbated in the event of the young mother being a single parent and perhaps not having a supportive family environment to lean on at such a challenging time.

> ***...Harder for women who are at home, don't link in with the services, a lot of it can be down to stigma, they don't want to be seen going to a service. So, isolating themselves and the mental health is deteriorating..."***

Young mothers struggling in early parenthood and exhibiting some risk factors (abusive relationship, poverty, lack of a support structure and emerging mental health issues) are perceived as unlikely to engage with programmes because they fear that Social Services will intervene. Such fears can also prevent young parents from sending their child to creche which deprives the child of a valuable developmental opportunity and the parent of time for respite or seeking employment opportunities.

Where a young woman is the main carer in the family home or continues to live in the family home in early adulthood, this can also create vulnerability if coupled with unemployment and a lack of opportunity, often resulting from early school leaving and/or poor education attainment. This is particularly the case for a young mother in their late teens/early 20's who may have multiple children and develop feelings of, according to some respondents,*"being stuck"* and *"this is my lot".*

In addition, young women are perceived to be disproportionately affected by early school leaving because of a perceived lack of vocational opportunities which, in the main, are tailored towards young men. Accessing and engaging such young women in employability support and capacity building is a critical consideration.

> *"Girls generally have a higher completion rate to Leaving Cert, but when they do leave school early, their opportunities are limited. Most of the second chance education and employability programmes are tailored towards boys".*

3.3.4 Housing

Research participants frequently referred to the housing challenges in the area, that many single parents are in and out of homelessness. Political contributors identified that the clear majority of those that present at constituency offices for housing support, are young, female lone parents. Research participants offered examples of lone parent families (e.g. a mother of 3) waiting for years for a house. Across the interviews, multiple references were made to young women being *'put up in hotels'* as far away as Kildare (often 25km +) and then having to try and get their kids to school each morning adding significant pressure and strain.

> *"Accommodation, not being able to be on your own and have your own space".*

> *"Living outside of Ballyfermot and have to travel to Ballyfermot to schools because they couldn't get a house in Ballyfermot".*

The pursuit of a new house becomes the primary concern of those supporting young women which, when achieved, signals the end of that support. However, for many, a pre-existing underlying trauma remains and goes unaddressed, potentially surfacing later on. The potential to use housing presentations as a signposting or referral opportunity to bespoke support services for women was identified.

3.3.5 Domestic Violence

The prevalence of domestic violence, much of which is perceived by research participants to be fuelled by drug and alcohol misuse was frequently referred to as a major concern. Almost all of the contributors referenced domestic violence as a key issue faced by young women.

> *"I know for some of the women domestic violence was an issue".*

> *"domestic violence is an issue. Domestic Violence with young women isn't talked about as its seen as with older women. High incidence of young girls being in very DV relationships from a young age".*

Additional fears attached to reaching out to services for vulnerable young women were highlighted if they were in an abusive relationship. It was suggested that *"Manipulative"* partners may block opportunities to engage with services or friends to ensure that they maintain control of their partner's life.

This issue has become even more prominent during the COVID19 lockdown, with the World Health Organisation declaring that member states reported up to a 60 percent increase in emergency calls by women subjected to violence by their intimate partners in April 2020, compared to 2019. Ireland was identified as one of the Countries from which the WHO received 'deeply troubling' reports.[33]

While the perception is that the incidence is high, there is a lack of evidenced based data at area level in Ballyfermot. This lack of evidence and the link between Domestic Violence and Suicide does merit further research.

There are no specific support services for those impacted by Domestic Violence in the area, the closest relevant services would be in Inchicore, Dublin City Centre or Tallaght. It is unlikely that women from Ballyfermot would attend such services outside the immediate area. (See 3.4.2).

3.4 Service Gaps and Connecting for Life

3.4.1 Views of Connecting for Life (CfL) National Strategy

Connecting for Life Dublin South is the area-level C*f*L action plan for HSE Community Health (CHO) Area 7[34]. The CfL vision for Dublin South is:

> **Dublin South will have fewer lives lost through suicide, and communities and individuals will be empowered to improve their mental health and well-being'.**

[33] https://unric.org/en/who-warns-of-surge-of-domestic-violence-as-covid-19-cases-decrease-in-europe/

[34] https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/strategy-implementation/local-action-plans/connecting-for-life-dublin-south.html

The CHO 7 area-level action plan sets out a number of strategic objectives and two primary outcomes.

STRATEGIC OBJECTIVES

1. **To improve the understanding of, and attitudes to, suicidal behaviour, mental health, and wellbeing within Dublin South.**
2. **To support local communities' capacity to prevent and respond to suicidal behaviour.**
3. **To target approaches to reduce suicidal behaviour and improve mental health among priority groups.**
4. **To enhance accessibility, consistency, and care pathways of services for people vulnerable to suicidal behaviour.**
5. **To ensure safe and high-quality services for people vulnerable to suicide.**
6. **To reduce and restrict access to means of suicidal behaviour.**
7. **To improve surveillance, evaluation and high-quality research relating to suicidal behaviour.**

PRIMARY OUTCOMES

1. **Reduced suicide rate in the whole population of Dublin South and amongst specified priority groups.**
2. **Reduced rate of presentations of self-harm in the whole population of Dublin South and amongst specified priority groups.**

Research participants were asked to comment on the implementation of the CfL area level plan in Ballyfermot. The vast majority of those consulted were unaware of CfL, even as a national strategy.

> ***"That's the first I have heard of it".***

> ***"The strategy is out there, but it hasn't been implemented per se here. We don't have a suicide officer in CHO7 at the moment".***

> ***"Hard to tell what the Connecting For Life strategy does for people here".***

Research participants strongly asserted that the community feel let down and require leadership from statutory agencies in both raising awareness of and implementing this strategy and that more *'parity of esteem'* was needed between statutory and community providers. In addition, a greater *'ground up'* or *'grass roots'* involvement in the development of preventative and responsive approaches to suicide and suspected suicide was required.

The findings of this research can easily be aligned to the vision, strategic objectives and primary outcomes from the CfL area-level plan, however, the prevailing view amongst research participants was that the CfL area-level plan is *"not local enough"* and that Dublin South is too big an area[35] comprising too many diverse communities (urban/rural/affluent and deprived) to capture the nuances and idiosyncrasies of each. It was stressed that a more localised approach is required.

Research participants reflected that the consultation attached to this rapid community assessment has provided opportunities for local services to provide insights and local knowledge about a range of factors that affect suicidal behaviour in this area. Thus, this process has enabled local services providers, many suggest for the first time, to offer direction on how to best support the population to reduce their risk through targeted response efforts and interventions.

3.4.2 Perceived Gaps in Service Provision

Part of the rapid assessment process was to map services across the Ballyfermot community. The image on page 26 provides a visual overview of services and facilities in the area. Note, this is not an exhaustive list of services but reflects those that were referenced during the consultations and by the RAR.

Generally, the view is that there are a lot of services in the area although many reported being under resourced or operating with waiting lists, particularly mental health, counselling and family support services within the community and voluntary sector. One service referenced a waiting list of 67 children for intensive child and family support. There is also evidence of "hyper localism" where there is an innate reluctance to go outside immediate localities to access services.

Research participants felt that whilst there are good levels of partnership working between organisations (particularly community and voluntary organisations) there are areas for improvement in relation to referral and case management of service users – however some agency needs to lead and connect all of the services.

The following bullet points provide an overview of the service related challenges that emerged consistently during the consultations, augmented by information from secondary data sources where appropriate:

- Multiple references were made to the negative experience that people have had when presenting to hospital Emergency Departments with mental health concerns. Several interviewees had accompanied at risk individuals to EDs and recounted experiences. The perceived gaps and challenges include:
    - Lack of consideration for mental health difficulties at triage.
    - Long waiting lists to access clinical psychology support.
    - Perceived limited tolerance for people with addiction issues: one contributor noted that 'some people's addictions are so embedded that they need to take drugs or alcohol to get out the door in order to present with a mental health issue'. This is perceived as symptomatic of the mental health vs addiction dual diagnosis vacuum and lack of connectivity between those services.
    - Young people at risk are being "lost" as, even if they present to ED through attempted suicide or self-harm, there is insufficient aftercare and support to mitigate against further incidence.

> ***"...Triage nurse in hospital may not be equipped to deal with someone presenting with Mental Health (sic). Many go, told they are fine and within 48 hour period they have taken their own life. Not enough crisis intervention nurses there".***

> ***"Some services will not link in with someone with mental health problems and will not be seen because they are using drugs or alcohol, one service user was told to come back in 8 weeks when they were doing better in terms of their drug use".***

> ***"...Need around the impact of suicide with the ripple effect, links and services. Mental health services are catered to people with severe mental health problems, a lot of those presenting suicidal do not have a mental health diagnosis".***

- Despite the area having considerably higher rates of self-harm (in part due to her their location in the Dublin city) than the national average, the two hospitals that serve the area, Tallaght and St James are **not** participating in the National Clinical Programme for the Assessment and Management of Patients Presenting to Emergency Departments following Self-harm[36].

- Contributors feel that that mental health[37] and drug and alcohol services[38] in the area for under 18's are inadequate and that a lack of diagnosis and support at an earlier stage results in more embedded problems in early 20's, exacerbated for lone parents and those facing some of the challenges referenced previously in this section. The lack of an U18 rehabilitation and treatment pathway for young people is a considered a key gap, particularly for young mothers.

> *"With adolescents, it's a challenge to get into CAMHS, challenging to getting children into services. There's a gap for children 16 to 18 attaining a service".*

> *"If I am suicidal there is nothing clear out there to say this is what you can do.... If I am feeling or have any idea around suicide, there is no immediate fix to help me. There is no direct route to psychologist. No equivalent to counsellor, have to go to GP to then be assessed and referred on..."*

- Out of hours, evening and weekend interventions are reliant on a gardai response, and there exists an opportunity to develop better community responses in partnership with these services. For example, often a brief intervention can have a really positive impact and the availability of the Pieta House 24-hour helpline could be used in crisis situations.

> *"No immediate fix, I feel that this is missing, it is a huge piece that is missing for people when they have an issue. There is helplines but there is a stigma around them still. I feel that this is something that is needed for people".*

- Contributors from HSE NOSP identified that the level of statutory mental health staff on the ground does not align with the extent and prevalence of need in the area, for example there is no adult primary care psychologists in the area. This is perceived as a major gap.

> *"If you could go with your medical card and see a counsellor it would be great, instead have your medical card go to GP then have to wait 3-4 months to be seen by a service your referred onto by the GP".*

[37] Closest Jigsaw service is in Tallaght

[38] YoDA is the Youth Drug and Alcohol Service based in Tallaght with a catchment area covering HSE Local Health Office (LHO) areas Dublin South-West & Dublin South City

- Whilst some young women are known to services, many won't proactively engage and face significant barriers such as childcare. Research participants feel that more community work is needed to connect with those young women who don't or can't access services. This would assist with drug and alcohol related issues, but also in developing resilience through support networks, wellbeing, and employability pathways.

3.4.3 Community Response

There is a committed Community and Voluntary sector in Ballyfermot and Cherry Orchard and a strong history of community activism. There is a willingness and motivation to define and strengthen the role of the community in addressing the causes and consequences of suicide, but this needs to be matched by statutory services. This can be harnessed and used to advance response efforts based on a community of practice approach to underpin the development of pathways and interventions to support vulnerable young women.

The leadership and passion provided by local community and voluntary sector organisations is reinforced with a deep understanding of Ballyfermot and its history. This innate local knowledge creates strong instincts and insights in identifying and meeting needs. Consequently, community- based services are indelibly connected to and informed as to what is happening on the ground with their insights aligned with those residents and individuals bereaved by suicide.

While services have continuously been cut and have inadequate resources to address the multiple underlying factors of suicide, there remains a commitment to seek out solutions through a community based inter-agency approach. The optimisation of the Ballyfermot community's most important asset i.e. it's people, has helped to shape our recommendation in relation to the identification of a network of local residents who are willing to contribute to the local response as a volunteer peer support network. This network of volunteers would be accessible for people who are seeking support but do not wish to engage a formal service.

3.5 Summary

This section has identified that a suicide cluster occurred in 2019, the perception is that the cluster related to a wider South Dublin area, although it was amplified in Ballyfermot/Cherry Orchard as this is where the majority of funerals took place. One of the key research questions was, **why is this happening in Ballyfermot and Cherry Orchard?**

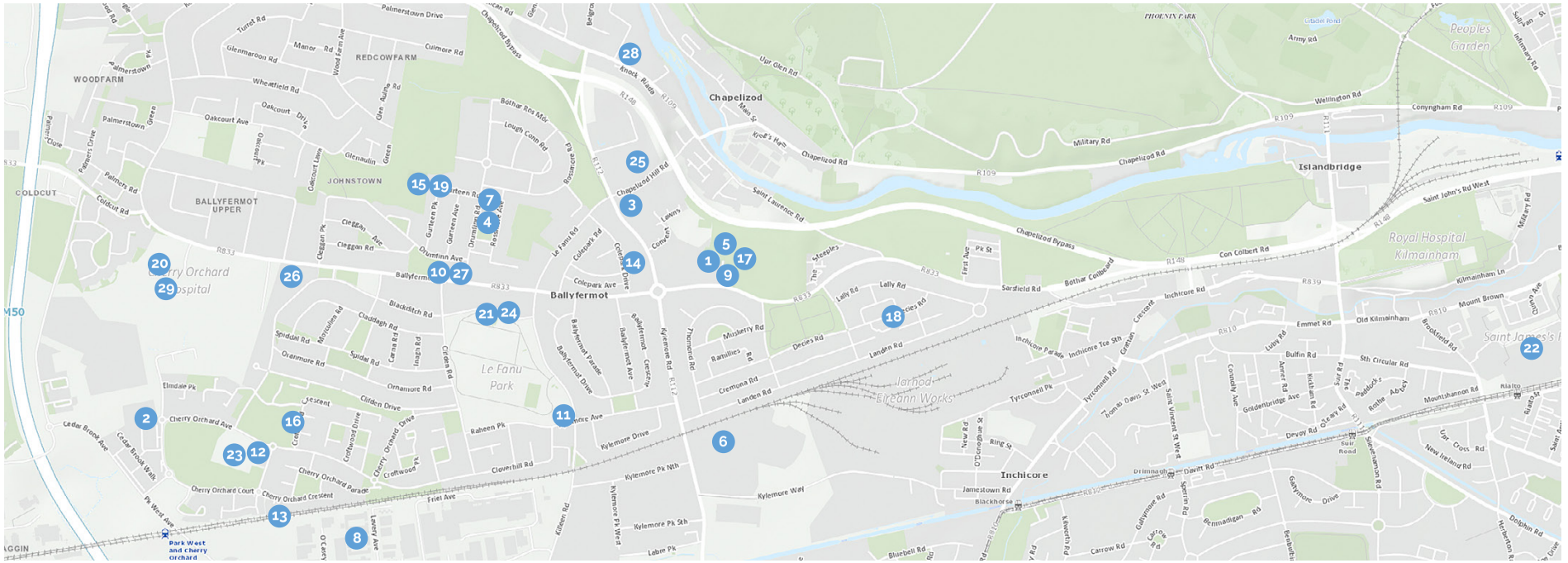
The level of deprivation and poverty, the high prevalence of lone parent families, and the perceived extent of issues relating to drug and alcohol misuse are not unique to Ballyfermot/Cherry Orchard, or the other areas of South Dublin – Tallaght, Palmerstown, Clondalkin, but other communities do not appear to be seeing the same trend. It is not clear why this is the case.

This section has set out a thematic overview of the consultation findings. The findings are reflective of the views put forward by 22 service providers and 6 individuals bereaved by suicide.

Whilst the findings are structured under these headings, there are a number of recurring themes across each. The potential negative impact of social media and the negative impact of drug and alcohol misuse are perceived to be considerable challenges that permeate and exacerbate many of the other enduring issues.

In addition, for the high number of females that are lone parents, emerging issues are often profoundly intensified, creating difficult circumstances and severely impacting on mental health and wellbeing.

The findings have been used to inform a series of recommended actions, presented in the following section.



1. Ballyfermot Family Resource Centre
2. Cherry Orchard Integrated Youth Service
3. Pieta House
4. Ballyfermot Chapelizod Partnership
5. Ballyfermot Traveller Action Project
6. Tusla Ballyfermot
7. Ballyfermot STAR
8. Ballyfermot STAR
9. Ballyfermot STAR
10. Ballyfermot Civic Centre
11. Ballyfermot Advance Project
12. Fusion CPL
13. Ballyfermot Social Intervention Initiative
14. Matt Talbot Community Trust
15. Ballyfermot De La Salle GAA Club
16. Cherry Orchard Community Childcare Service
17. Candle Community Trust
18. Ballyfermot Youth Service
19. Gurteen Youth Club
20. HSE Adolescent Addiction Services
21. Familibase
22. St James Hospital
23. Cherry Orchard Health Centre
24. Ballyfermot Leisure Centre
25. Ballyfermot College ETB
26. Ballyfermot Primary Care Centre
27. Ballyfermot Family Practice GP
28. Chapelizod Medical Centre
29. Ballyfermot Local Drug and Alcohol Task Force

Figure 5: Map of services

4

Recommendations

4.1 Introduction

The following recommendations create resource implications for HSE NOSP and Connecting for Life. There may also be opportunities for collaborative funding proposals by local organisations to support some of the recommendations.

Decisive and swift action is required to respond to the emerging issues in this community particularly in light of the potential harmful impact of COVID19. The pandemic will cause distress and leave many people vulnerable to mental health problems and suicidal behaviour. Mental health consequences are likely to be present for longer and peak later than the actual pandemic[39].

In response to the findings, the following eight recommendations are proposed. The recommendations have been categorised as Short (five), Medium (two) and Long (one) Term.

4.2 Short Term

4.2.1 Recommendation 1: Community Response Leadership Team

It is recommended that a local Community Response Leadership Team (CRLT) for Ballyfermot and Cherry Orchard is established. This is a continuation and evolution of the Rapid Assessment Response steering group.

Rather than seek to establish a new group in the area where many exist already, the development of a CRLT will be an extension of the existing D10 Be Well group. D10 Be Well is an interagency initiative which works to respond to the mental health and well-being needs of the Dublin 10 community. It does this by bringing key stakeholders together to create a space for dialogue, it is led and coordinated by the Ballyfermot Chapelizod Partnership.

Membership of the CRLT will comprise of a core group of:

- Ballyfermot Chapelizod Partnership
- Ballyfermot Local Drug and Alcohol Task Force
- TUSLA
- Ballyfermot Star
- HSE Resource Officer for Suicide Prevention
- HSE Addiction Services

[39] Suicide risk and prevention during the COVID-19 pandemic (May 2020), David Gunnell, Louis Appleby, Ella Arensman, Keith Hawton, Ann John, Nav Kapur, Murad Khan, Rory C O'Connor, Jane Pirkis, and the COVID-19 Suicide Prevention Research Collaboration

The CRLT will call on the input and expertise of a wide range of professionals to respond to emerging issues, to consult on the development of new activities and to lobby for the advancement of new services. This includes but is not limited to: psychiatry services, psychology services, CAMHs, Primary Care Professionals.

The CRLT will have the following key responsibilities:

- To develop and submit a proposal to the CHO area level Implementation Team to employ a Community Response Coordinator for the area.
- To nominate a lead organisation from within the CLRT to employ the Community Response Coordinator.
- To develop a programme of work for the Community Response Coordinator aligned with the recommendations herein and oversee this programme of work.
- To develop a critical incident protocol for suicides in the area including allocating roles and responsibilities around funerals, media, social media and therapeutic/ bereavement and outreach support.
- To disseminate critical incident protocols to various stakeholders across the D10 Be Well Network.
- To mobilise community and voluntary and statutory services to respond to critical incidents via the D10 Be Well Network.
- To take decisions on local issues relating to suicide, suicidal behaviour, and emerging contagion.
- Develop and implement a series of local initiatives to build the capacity of local residents to support those impacted by suicide, minimising possible contagion.
- To share information (adhering to data protection protocols) to provide targeted proactive and reactive supports to the most vulnerable and at risk of suicide.
- To work through the Resource Officer for Suicide Prevention for Dublin South to maximise the impact of Connecting for Life for this community.
- To provide local insights and knowledge that enable emerging needs and trends to be identified and interventions to be developed in response.
- To ensure adequate representation and participation by relevant community, voluntary, political, and statutory agencies as well as local residents.
- To work collaboratively to secure new resources and maximise existing resources in developing and implementing local responses to suicide.
- To identify gaps in service provision, explore the experiences of residents within services and develop opportunities to build better collaboration between community and voluntary and statutory services.

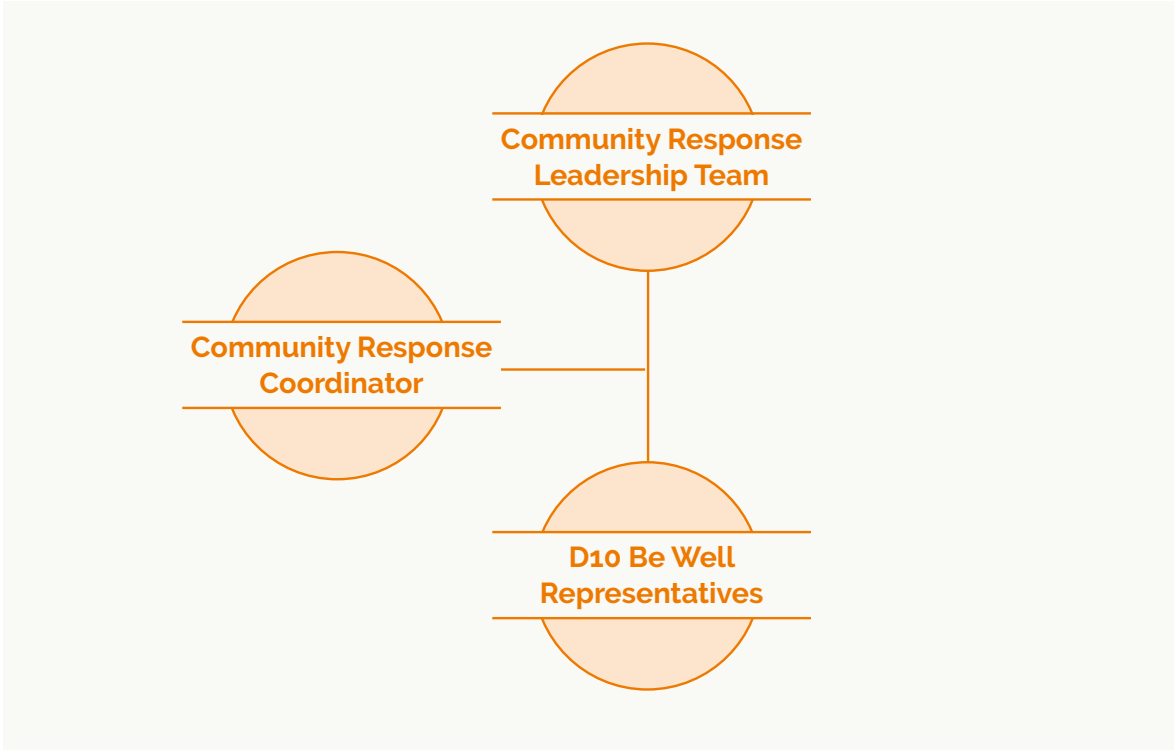
- To engage and lobby statutory services to enhance the availability of and experience of services for people in the Ballyfermot and Cherry Orchard area.
- To connect with other networks across Dublin South to share learning, resources, and experiences to reduce suicide and minimise contagion.

4.2.2 Recommendation 2: Community Response Coordinator

The CRLT will require coordination, both in terms of organising meetings but also in developing and delivering on key actions. In addition, the community response team should have access to a flexible resource budget to enable rapid responses to emerging local issues, particularly to intervene to prevent contagion and to provide tailored supports at critical times. A resource budget is required to support this recommendation.

It is recommended that the Resource Officer for Suicide Prevention for the area, supported by members of the CRLT, develop a costed proposal for the coordination of the local community response team including access to a flexible, annual resource budget. The proposal should set out the roles and responsibilities of the Community Response Coordinator and identify a lead organisation through which the resource will be employed (Ballyfermot Chapelizod Partnership currently coordinate the D10 Be Well Interagency Initiative, and may be best placed to lead).

To enable this role and its work to be embedded locally, it is recommended that the initial proposal is a minimum of 24 months. This should be submitted to the CfL area-level Implementation Team.



4.2.3 Recommendation 3: Critical Incident Protocol

The development of a critical incident protocol relating to suicides is required. This protocol will specifically target funerals, acknowledging that funerals and their aftermath can be distressing for the community and serve as contagion triggers for some individuals. These are seen as critical event requiring attention and intervention.

The HSE is in the process of developing national guidelines on a community response plan. The CRLT should utilise these guidelines to develop a local critical incident protocol for Ballyfermot.

4.2.4 Recommendation 4: Suicide Prevention Training

In partnership with the Resource Officer for Suicide Prevention for Dublin South and local service providers, it is recommended that a comprehensive training programme for local residents, young people, young women, local councillors, front line workers and other key stakeholders is rolled out over the next 12 months. The following training is available through the HSE NOSP, Connecting for Life and local services:

- Stress Control – an online training programme for stress management
- START - an online training programme operating during COVID
- SafeTALK
- ASIST
- Understanding Self-harm Training
- STORM – Skills Training on Risk Management
- Bereavement Training for Communities
- Bereavement Training for Professionals
- Mental Health First Aid
- SAOR (Screening and Brief Intervention for alcohol and substance abuse)
- Domestic Violence response training

4.2.5 Recommendation 5 – Peer Support Network

The comprehensive training programme should be used to identify a network of local residents who are willing to contribute to the local response as a volunteer peer support network. This network of volunteers would be accessible for people who are seeking support but are not currently engaged in formal support. The network can act as a support and signpost people into services if and when needed, but it is important that the volunteer network does not carry a caseload of individuals that require intensive support.

A social media and promotional campaign should follow (similar to an intervention in Jobstown) to make residents aware that local, informal support is available and provide information on how to access them. It is recommended that a Facebook Ad campaign, using specific market segment, is used to target young women in particular. The community response team should explore how ads can be timed to coincide with 'at risk' periods such as evening, early mornings, and weekends.

In addition, the volunteer peer support network should be provided with appropriate support themselves. The community response team should identify an appropriate organisation and allocate appropriate resources to enable this support to be provided regularly. This could comprise, monthly meetings, therapies, and counselling. Any promotional campaign should also raise awareness of online supports such as stresscontrol, esuicidetalk and understanding self-harm.

4.2.6 Recommendation 6 – Under 18 Services

In 2019 the Department of Children and Youth Affairs launched the development of a single fit for purpose funding scheme "UBU Your Space Your Place" which is due to commence in July 2020 through local youth services. The fund targets disadvantaged young people with evidence informed interventions and services to secure good outcomes. This is based on area based action plans which were developed by the local education and training boards.

The CRLT should engage local youth services and ensure that appropriate focus is provided on young women and that signposting, and referral protocols are developed to support young women that may be at risk or vulnerable and that are leaving or disengaging from youth services or that existing referral protocols are promoted and effectively implemented among practitioners and service providers. This should be done in partnership with D10 be Well and the Child and Family Support Network, and the strengthening of the local engagement with the Meitheal Framework could galvanise this piece of work.

4.3 Medium Term

4.3.1 Recommendation 7 – Support and Access programme for young women

Given the findings, the development of a targeted approach to engage young women who may be at risk should be developed in the area. The research points to multiple touchpoints where women could be identified (i.e. housing presentations at local constituency offices, self-harm hospital presentations, targeting specific streets with high levels of lone parent households identifiable through CSO statistics and local insights). Given the perceived impact of social media, this could represent an access point through targeted Facebook ads or keyword searching.

A support and access programme would focus on removing barriers (i.e. by providing childcare) to enable access to Wellness Recovery Action Plan (WRAP), drug and alcohol misuse support, support for domestic violence, employability training, resilience, mentoring and development of peer support. The approach would be needs led.

It is recommended that the CRLT consult with relevant services and directly with women before developing a costed proposal, identify a lead agency, and approach a range of funders to support the development and implementation of a pilot support and access programme for this area. We understand that a similar 'street by street' proposal as part of the Cherry Orchard Local Area Plan has been ratified by Dublin City Council and TUSLA – a joint approach to the development of this initiative is recommended. There is also a piece of work being funded through the Ballyfermot LDATF which is focusing on supporting women to access appropriate treatment. In this regard the initial proposals will need to scope out all existing resources and consider how to connect these pieces of work together.

4.3.2 Recommendation 8: Future Research

This rapid assessment has identified a number of key gaps in the research that would benefit from further exploration. These include:

1) The link between method of suicide and trends amongst young women
2) The relationship between poverty/disadvantage and suicide across other parts of Ireland
3) More in depth analysis and exploration of the experience and perception of young women in the community
4) Quantitative treatment data on drug and alcohol misuse beyond CTL and NDTRS in Ireland and exploring the link between substance use and suicide.
5) The relationship between domestic violence and suicide.

4.4 Long Term

4.4.1 Recommendation 8: Tallaght and St James Hospital

Considering a) the socio economic profile of this area and the risk of suicide and suicidal behaviour in areas of high socio economic deprivation, b) the higher than average rates of self-harm in the area, c) the myriad of challenges faced by young women in particular in the area and d) the perceived lack of adult mental health staff in the area relevant to need: the HSE NOSP should take steps to ensure the participation of both St James Hospital and Tallaght Hospital in the National Clinical Programme for the Assessment and Management of Patients Presenting to Emergency Departments following Self-harm.

5

Implementation Plan

5.1 Introduction

The following table sets out a series of immediate actions to ensure the implementation of the recommendations. The development of a Community Response Leadership Team and the appointment of a Community Response Coordinator are the anchor actions and they stimulate the delivery of others.

Table 2: Implementation Plan

Action	Responsibility	Timeframe
Organise and facilitate a meeting of the RAR in order to develop a costed proposal for a Community Response Coordinator (CRC). The proposal should set out the roles and responsibilities of the CRC and nominate a lead organisation through which the CRC will be employed. This meeting should also be used to nominate individuals to sit on the Community Response Leadership Team and follow up contact made.	Resource Officer for Suicide Prevention All members of RAR	Immediate
Submit the costed business proposal to the CfL area-level implementation group as well as other agencies such as TUSLA, HSE NOSP and Dublin City Council.	Resource Officer for Suicide Prevention	Immediate
Disseminate this report to those consulted as part of the process and to a wider network of community, voluntary and statutory stakeholders	HSE NOSP via members of the RAR	Immediate
Organise a first meeting of the Community Response Leadership Team to agree and sign terms of reference, coordinate meeting schedule and begin to schedule a comprehensive programme of training for local residents, staff key workers.	Resource Officer for Suicide Prevention (or other as agreed in action 1)	Short
Facilitate a meeting of the D10 Be Well network to present findings and to explain the role of the CRLT.	Ballyfermot Chapelizod Partnership	Short
Develop and disseminate a critical incident protocol for the Ballyfermot area – ensuring that all organisations (i.e. D10 Be Well Network) are aware of protocols and response to suicide.	Community Response Coordinator (or CRLT)	Short

Appendix 1 – Interview Question Guide

Thinking about the current situation in respect of suicide and suspected suicide:

1. When you think about the trends in this area in relation to suicide and suspected suicide: can you describe the impact and response?
2. What do you perceive to be the immediate needs in this community?
3. Regarding young women in particular, what do you believe to be the key factors influencing suicide and suspected suicide?
4. What the reasons why this appears to be more evident (2019 cluster) in Ballyfermot compared to other areas?
5. What is your view on the extent of the challenge?
6. Are there certain areas or settings where suicide/suspected suicide or suicide ideation is more prevalent than others?
7. What are the assets and strengths in the community that could assist or enable response efforts?

Thinking about the availability of services in this area:

1. Can you comment on the availability of and access to services (mental health, addictions, suicide)?
2. What is your experience and understanding of Connecting for Life local strategy for this area (CHO7)?
3. How would you describe the level of partnership working and integration of services?
4. What are the gaps in service provision?
5. Do service providers face any barriers and challenges in trying to engage people and make an impact?

Appendix 2 – Contributors

Total of 30 individuals contributed across 27 interviews.

1. Ballyfermot Family Resource Centre
2. Cherry Orchard Integrated Youth Service
3. Pieta House
4. Ballyfermot Chapelizod Partnership
5. Ballyfermot Traveller Action Project
6. TUSLA
7. Ballyfermot Star
8. Dublin City Council
9. Dublin City Councillors
10. Local Clergy
11. 2 x Resource Officers for Suicide Prevention CHO7
12. Ballyfermot Advance
13. Suicide Bereavement Liaison Officer
14. Fusion CPL Cherry Orchard Health Centre
15. Familibase
16. HOME
17. 6 x residents bereaved by suicide

Notes

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Connecting for *Dublin South*