AfterWords: A survey of people bereaved by suicide in Ireland

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Acknowledgements

This report is part of a collaboration between the National Suicide Research Foundation (NSRF) and HUGG (Healing Untold Grief Groups). The project is funded by the HSE National Office for Suicide Prevention (NOSP) through the Collaborative Research Grant Scheme 2021. On behalf of all authors, we would like to thank NOSP for their support of this important study.

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Finally, we want to extend our sincere thanks to the many people who completed the survey and shared their experiences so generously with us.

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Foreword

Each year more than 60,000 people are impacted by suicide and the necessity to continue to work tirelessly to support these people grows greater by the day. This first-of-its-kind survey aimed to examine and understand the profile and needs of those bereaved by suicide and with over 2,400 people contributing to the survey, it is evident that those bereaved by suicide want to tell their story and have their voice heard. Now that peoples' experience of suicide bereavement supports and services in this country are on the record, the important first step has been taken. The second, equally important step, is to ensure everything possible is done to provide the range of supports and services required are responsive and tailored to individual needs.

With these needs in mind, and in a policy context, HSE Mental Health Operations and the HSE National Office for Suicide Prevention (NOSP) have lead responsibility for actions 4.3.1 and 4.3.2 related to suicide bereavement supports, outlined in *Connecting for Life*, Ireland's National Strategy to Reduce Suicide 2015-2024. These actions focus on the delivery of enhanced bereavement support services to families and communities that are known to mental health services and affected by suicide and the commissioning and evaluation of bereavement support services. To progress the implementation of these actions, HSE Mental Health established a service improvement project in 2018 which was supported by a working group comprised of key HSE staff and representatives of partner agencies in the area of suicide bereavement support.

In late 2019, a project report entitled *Improving Suicide Bereavement Supports in Ireland* was finalised. This report set out 10 core action areas that encompassed 21 actions identified as essential for the improvement of supports.

The report also identified the ownership of the actions that will allow for the improvement and sustainability of services in this area, with a National Suicide Bereavement Support Coordinator subsequently appointed to lead on the implementation of the actions in the report.

The workshop component of the launch of this report will generate important action points and priority recommendations to inform service development and, will inform an updated iteration of the aforementioned *Improving Suicide Bereavement Supports in Ireland* report.

This survey and its findings underline the need to rethink what we mean by suicide bereavement and highlight the significant and enduring impacts on friends, work colleagues and professionals experiencing a loss by suicide. These findings will be used to enhance services for people who have been affected by suicide in Ireland and the results will help to identify things that help or hinder people in accessing support so that these can be addressed by services in the future.

On behalf of HSE Mental Health Operations, I would like to extend my sincere thanks to each and every person who worked on this report but I'd particularly like to commend and thank all those people bereaved by suicide who stepped forward in such numbers to share the experience of their deeply personal loss.

Oliver Skehan
HSE National Suicide Bereavement Support Coordinator

Key findings

Demographics

2,413 ADULTS completed the survey (72% female)

Participants commonly reported loss of a

Family member	Friend
62%	35%

1 in 2 experienced multiple losses

Impacts

93% stated that the loss had a moderate or major impact on their lives

The most common impacts were:

- Mental health challenges
- Relationship or family problems
- Prolonged use of alcohol

Wellbeing

2 in 3 reported some symptoms of depression

1 in 2 reported some symptoms of anxiety

1 in 5 had current thoughts of self-harm or suicide

Barriers to accessing supports

31%	Nothing was offered
30%	Reluctance to ask for help
22%	COVID-19 restrictions
21%	Feeling undeserving of help
20%	Low mood

Factors that helped access supports

- Realising the severity of mental health impact
- Information and encouragement from others
- Financial and practical ease of access
- Positive past experiences

Supports

91%	Family, friends, neighbours
47%	Work/school environment
49%	Information resources
42%	Professionals in the community
30%	Specialised supports
43%	Mental health professional

Findings in context

For the first time in Ireland, we have had the opportunity to hear from those in our community who have known someone who has died by suicide, including family members, friends, work colleagues and professionals. The findings from this survey provide invaluable insight into the experiences of people bereaved and affected by suicide, the impacts on their lives and the supports received following their loss. The findings also illustrate the specific challenges unique to suicide bereavement and have important implications for support and service provision.

Rethinking what we mean by the 'suicide bereaved'

Half of adults in Ireland have known someone who has died by suicide and 13% have experienced the loss of someone close to them.[1] Furthermore, almost half of those who participated in our survey had experienced multiple losses to suicide. Generally speaking, those closest to the person who has died will experience the most profound impacts, as evidenced in this report, with two-thirds of participants reporting to have lost a family member. The remaining participants reported losing a friend, partner, colleague or other acquaintance, or had experienced suicide loss as part of their professional role. The vast majority reported that the death had a moderate or major impact on their lives. The findings of this report suggest that relationship to the deceased is only one marker of the grief experience and impacts felt following a suicide, underlining the importance of understanding and providing supports to those outside the immediate family.

1. **Suicide bereavement extends beyond the immediate family, with friends, colleagues and professionals also deeply impacted**
2. **Young adults and professionals experiencing suicide loss as part of their roles are key priority groups for tailored supports**

The findings of this report have highlighted two important sub-groups who may have specific needs following a suicide loss – young adults (18-24 years) and those experiencing suicide loss as part of their professional role. Young adults – many of whom had reported losing a friend to suicide – reported more pronounced mental health impacts as a result of their bereavement than other age groups. They also reported to have experienced more perceived stigma, shame and guilt, which were also reflected in their reasons for not seeking help. While our survey was limited to adults, these outcomes may also be reflected in young people under 18 years. Approximately 15% of participants were professionals who experienced suicide within their professional roles, most commonly healthcare professionals and members of An Garda Síochána. Many had experienced multiple losses along with suicide loss in a personal capacity. They were less likely to access formal supports for their loss, which is of concern, given that their role may also involve supporting people bereaved by suicide.

Impacts of suicide on those bereaved

The findings of this report highlight the broad impacts that suicide can have on those who knew the person. Multiple adverse impacts were often reported, relating to both mental and physical health, interpersonal and family relationships and financial or employment problems. The reported mental health impacts are also reflected in the higher prevalence of current depressive and anxiety symptoms among our participants, relative to the general population. These outcomes were, broadly speaking, similar for all participants, but more pronounced for young adults aged 18-24 years.

3. **The impacts of suicide are wide-ranging and complex, and needs may be practical as well as health-related**

4. **There is a need for increased awareness about the high prevalence of thoughts of self-harm or suicide among people bereaved by suicide**

Most strikingly, one-in-five reported having some thoughts of self-harm or suicide in the two weeks prior to completing the survey and one-third indicated that they had such thoughts following their loss. These outcomes again were more common among young adults. This underlines the need to raise awareness of the significant impacts of suicide bereavement on mental health and risk of suicide and self-harm.

It is also important to highlight that poor mental wellbeing was more pronounced for those more recently bereaved and improved according to time since loss. Most people reported some positive changes as a result of the loss (personal or post-traumatic growth), including increased compassion and empathy for others, a better ability to cope with life, along with having more good days than bad.

Developing services and supports for suicide bereavement

The predominant finding from this report is that a range of services and supports, from information resources to specialised care,[2] are needed. These may need to be tailored to the people accessing help, to reflect specific patterns of help-seeking behaviour.

Approximately one-third of participants did not access any formal supports (support from a professional or specialised service) following their loss. While not everyone will require such support, there is a clear need for timely access to high-quality and specialised services. In addition, the wide-ranging and often complex needs of those bereaved denotes the need for specialised services, which should be standardised[3] and trauma-informed. Services that are delivered by professionals together with trained peers with lived experience show the most promise in terms of effective supports.[4]

All individuals involved in providing supports should receive specialised suicide bereavement support training and should have empathy, understanding and active listening skills.

The majority of participants felt that the availability of services in their local area was poor and a barrier to accessing help. Nevertheless, those who did access supports and services generally found them helpful, particularly when they were specialised for suicide bereavement. Many of these people found supports within one month of their loss, but 57% reported waiting more than one month to access supports. While there have been developments in recent years within *Connecting for Life*, Ireland's National Strategy to Reduce Suicide, 2015-2024,[5] participants still reported significant barriers in accessing supports including awareness, availability, waiting times and financial costs.

Most people reported accessing informal support from close social networks (e.g. family and friends) and professionals working in the community following their loss, with these supports being rated as very helpful. Many also accessed information resources such as websites, books and applications, but reported them to be less helpful when the information was generic. These types of informal supports were also identified as a route to accessing further formal support, with family members and professionals in communities offering information or encouragement to seek further help. This type of signposting, along with proactive outreach by organisations who offer supports, is one of the key factors to facilitating help-seeking.[6]

5. **There is a need for a range of high-quality supports and services, tailored to the specific needs of those bereaved by suicide**
6. **Proactive outreach and signposting are key elements of facilitating access to formal supports**
7. **Those providing formal supports should receive sufficient suicide bereavement and grief training, and services should operate to national standards**
8. **Family members, friends and community gatekeepers are a valued source of (informal) support**

Reducing stigma and social isolation

Many of the experiences reported by participants reflected underlying perceived stigma (perceptions of others' avoidance and lack of concern)[7] and personal shame, with participants feeling increased social isolation following the death as well as avoiding speaking to others about the death. Despite this, most participants reported receiving valuable support from their immediate family and friends. Perceived stigma and personal shame were often cited as reasons for not accessing formal supports, with people often feeling reluctant to ask for help or feeling that they did not deserve help. Perceived stigma and shame were also more often reported by young adults, both in their experiences and as reasons for not accessing support. This has important implications for messaging that encourages help-seeking, as well as for broader activities to reduce stigma and shame among those bereaved. Given the key role of informal support from social networks and community gatekeepers, enabling people to be comfortable and confident in talking about suicide may be a crucial element in providing social support. These groups require ongoing support and training on how to talk about suicide, how to provide support which is compassionate and how best to facilitate signposting where required. This is particularly important for social networks of family and friends, who themselves may also be impacted by the death.

9. **Raising awareness around suicide prevention is important. Equally important is enabling people to support each other and feel comfortable in speaking about suicide**
10. **Efforts to reduce social isolation for people bereaved by suicide require a collaborative approach to which community gatekeepers are integral**

Generalisability of findings

The findings cannot be generalised to represent the experiences of all adults bereaved by suicide, as there are elements of inherent bias in the data including the outcomes being self-reported, the survey being accessible online only and the sampling strategy used. The proportion of those reporting to have accessed supports for example could be a result of better engagement and uptake from participants already engaged with supports.

We endeavoured to offset some of these sources of bias by distributing the survey through a wide network of organisations, professional and community groups, as well as promoting the survey through social media and traditional media channels. Our sample of 2,413 people reflected broad representation according to age and area of residence. There was over-representation of females in the survey, although the proportion of males participating is higher than what might be expected in research of this nature. Overall, 7% of our sample identified as being LGBTQ+. Despite wide distribution of the survey, we did not have good representation from some marginalised and hard-to-reach groups, including members of the Traveller community and those experiencing homelessness. Understanding suicide bereavement and supports for people in these groups remains a key research priority.

Background

Approximately 500 people die by suicide in Ireland each year.[8] For each person who dies, six close family members and up to 135 individuals may be affected by the death.[9, 10] This equates to more than 3,000 close family members and 60,000 individuals who may be impacted by suicide in Ireland every year.

People who are bereaved by suicide experience impacts on their mental and physical health that can be long lasting.[11-13] They are also at increased risk of suicidal thoughts and behaviours.[7, 14] Many of those bereaved or affected by suicide need support in order to deal with their grief. A range of supports are needed from informal support provided by family and friends to formal support such as support provided by healthcare professionals, support groups or counselling.[15, 16]

Previous research indicates that access to appropriate supports remains a challenge. Studies in the United Kingdom show that many of those bereaved by suicide did not access formal supports following their loss, including 40% of people bereaved of a close relative or friend and 60% of people affected within the immediate or wider circle.[17, 18] A number of barriers to accessing support have been identified including stigma, awareness of supports, cost of support, lack of standardised referral pathways and variation in availability in different locations.[17, 18] Differences in the support services available across Ireland have impacted negatively on the grieving process of bereaved family members.[15]

Connecting for Life, Ireland's National Strategy to Reduce Suicide,[5] sets out steps to standardise the supports available for people bereaved by suicide in Ireland. However, there has been limited research on the experiences of supports following suicide bereavement in Ireland.[19] Research is needed to understand what supports are helpful and how to improve access to supports.

The specific objectives of this survey were to:

1. Examine the profile, characteristics and wellbeing of adults bereaved or affected by suicide in Ireland
2. Determine the types of suicide bereavement supports accessed
3. Examine the experiences of receiving or engaging with supports, the barriers and facilitators, the perceived gaps and unmet needs in supports.

Methodology

This is a brief overview of the methodology of this study, the Irish Suicide Bereavement Survey. It outlines the definitions used, methods of recruitment, questions included and the standardised measures used in the survey. For further information on the survey, please refer to the published protocol.[20]

Survey design

The Irish Suicide Bereavement Survey was a cross-sectional online survey, using Qualtrics software (**www.qualtrics.com/uk/**). The survey was open for participation between October 2021 and February 2022. The following people were eligible to take part in the survey:

1. Adults aged 18 years and over
2. Current residents of Republic of Ireland (including Northern Ireland)
3. People who identified as being bereaved or affected by suicide

A small number of participants (n=43) were excluded due to not meeting the above criteria.

As the survey was online only, participants were recruited in a number of ways – through social media messaging and advertisements, disseminating the survey in print and digital media and through organisations involved in providing supports and services for people bereaved by suicide.

Definitions and terminology

A broad definition of suicide bereavement was used in the survey, to include both people directly bereaved and affected by suicide[17, 21, 22] and the term 'bereavement' is used in this broad sense throughout this report. In order to encourage wide participation across these groups, we used example definitions from McDonnell et al.[17] to ensure that the survey is inclusive to those directly bereaved (e.g. *family and close friends*) and those affected by a suicide (e.g. "*if you knew a neighbour who has lost their partner, son or daughter, if you were the passer-by who witnessed the death or found the person, if you are front line staff who respond to an emergency … prison officers, train drivers, health professionals responsible for their care, and other people who may have had regular social contact with the person who died …*" (p. 59).

Survey questions

The survey contained five main sections: demographic information, current psychosocial wellbeing, details about the death(s) by suicide, impact of the bereavement and information on the use of support services following bereavement. Some of these questions follow similar wording and design to a survey undertaken in the UK[17] to allow for a comparison of findings.

Standardised measures

Several standardised measures were used in the survey to quantify the impact of suicide bereavement on mental health, wellbeing and participants' experiences of grief.

Table 1. Standardised measures used in survey

Construct	Measure	Number of items	Reliability in this sample (Cronbach's Alpha-α)
Wellbeing	The World Health Organisation - Five Wellbeing Index [WHO-5] [23, 24]	5	0.896
Depression	Patient Health Questionnaire – Anxiety and Depression Scale [PHQ-ADS] [25]	9	0.895
Anxiety	Patient Health Questionnaire – Anxiety and Depression Scale [PHQ-ADS] [25]	7	0.921
Grief Experience	Brief version of the Grief Experience Questionnaire [GEQ] [26, 27]	16	0.855
Personal Growth	Personal Growth Subscale from the Hogan Grief Reaction Checklist [HGRC] [28]	12	0.908
Perceived Social Support	Brief version of the Multidimensional Scale of Perceived Social Support [MSPSS] [29]	3	0.788

Notes on statistics and analysis

While we endeavoured to include a wide range of demographic information and experiences of the participants of the survey, there were small numbers in some response categories. Therefore, response categories including fewer than 20 participants are not presented in this report.

Some participants did not answer all survey questions. Therefore, when we note proportions or percentages in this report, we endeavour to present these in relation to the proportion of respondents answering that question.

Participants who had experienced multiple losses due to suicide were asked to identify one loss to focus on for most of the survey questions.

We analysed the content of participants' comments and identified the central themes within these comments. We have provided quotes from participants to contextualise the statistics in this report.

Ethical approval and data confidentiality

Ethical approval for the survey was obtained from the Clinical Research Ethics Committee of the Cork Teaching Hospitals (CREC), reference number: ECM 4 (j) 10/8/2021 & ECM 3 (rr) 07/09/2021. Furthermore, no personally identifiable information was recorded in the survey. The National Suicide Research Foundation is registered with the Data Protection Agency and complies with the Irish Data Protection Act of 1988, the Irish Data Protection (Amendment) Act of 2003 and the General Data Protection Regulation (GDPR) 2018.

Project governance and lived experience representation

The survey was undertaken as a collaboration between researchers at the National Suicide Research Foundation and the School of Public Health, University College Cork and Healing Untold Grief Groups (HUGG). The project was funded by the Health Service Executive's National Office for Suicide Prevention, as part of the Collaborative Grant Scheme 2021. The project steering group consisted of the report authors. An independent project advisory panel was established and met quarterly for the duration of the project.

The involvement of people with lived experience was central to this survey and we sought to receive feedback and input at all stages of the research process from design to dissemination. We worked with two independent Lived Experience Representatives who provided invaluable input and insights across the project, including reviewing the survey tool and supporting documentation. These representatives also contributed to the interpretation and dissemination strategy of research findings and the content of this report. The research team and advisory panel for the study included people with lived experience of suicide bereavement and providers of services for those bereaved or affected by suicide. These project members provided feedback on the survey content and associated materials. In addition, the online survey was reviewed by a small number of individuals with lived experience of suicide bereavement and researchers working in the area of suicide prevention.

Who took part in the survey?

A total of 2,413 people participated in the survey. Almost three-quarters of participants were women (73%), 27% were men and fewer than 10 participants* identified as other gender or non-binary. The mean age of participants was 43 years (range: 18-85 years; standard deviation: 12 years). Over half of the participants (58%) were aged between 35-54 years.

2,413

Adults took part

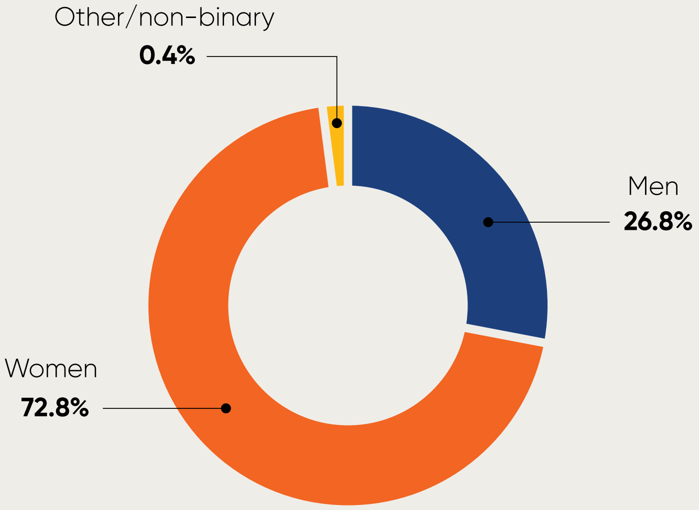


Figure 1. Gender of participants

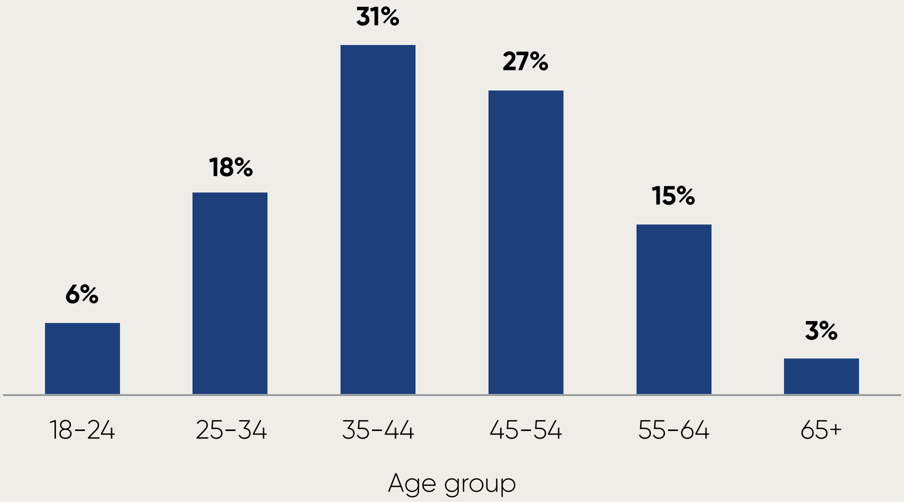


Figure 2. Proportion of participants in each age group

There was participation from residents in all counties across Ireland. Half (51%) of participants were from Leinster, 30% from Munster, 12% from Connacht and 6% from Ulster. A minority were residents of Northern Ireland (1%).

*As there were fewer than 10 participants in this group, we use the categories of men and women when making gender comparisons.

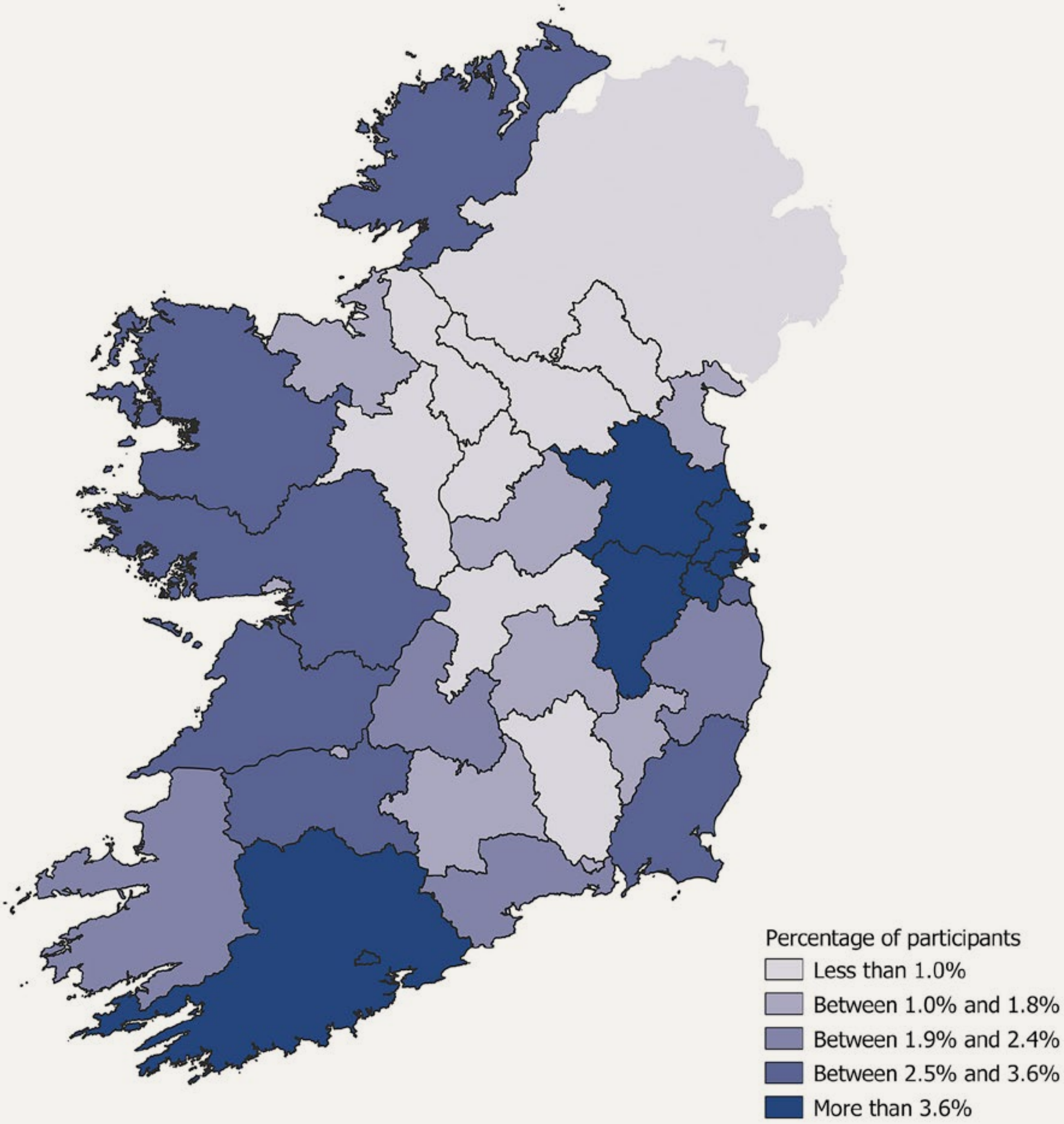


Figure 3. Proportion of participants represented according to county of residence
Note: Categories range from areas representing less than 1.7% of the responses received (light shade) to areas representing more than 3.6% of the the responses received (dark shade).

Most participants reported that they were working full-time or part-time (82%), 8% were studying full-time/part-time; 6% were engaged in home duties; 4% were retired; 4% were unable to work due to disability/illness; while 2% were full-time/part-time carers and 2% were unemployed/seeking work.

Of those participants who provided additional sociodemographic information (82%), most identified as White Irish (96%) while 3% were from a white background other than Irish. Fewer than 2% of the respondents identified with other ethnicities including (Irish) Asian, Mixed background, Irish Traveller, (Irish) Black and Roma.

Almost two-thirds (64%) of participants reported being members of Christian faiths and 4% had other religious affiliations. A considerable proportion of participants identified as atheist (15%) or agnostic (11%). A minority specified 'other' religious beliefs (7%) in which participants described themselves as spiritual, non-practicing/lapsed from previous religion; or having 'none'/no religion.

The majority (92%) of participants reported heterosexual orientation. The remainder of participants identified with bisexual (2%), gay (2%) and lesbian (1%) or other sexual orientations (3%), including asexual, pansexual, queer and not sure/questioning.

Almost half (48%) of participants were married/in a civil partnership, while 23% were in a relationship and a further 20% were single. The remaining participants were separated/divorced (5%) and widowed (4%).

Relationship to the deceased

Most people who participated in the survey had lost a family member (62%) or a friend (35%) to suicide. A smaller proportion had lost an (ex-) partner/spouse (9%), a colleague (10%), a classmate (9%) or an acquaintance (6%). Approximately 15% reported experiencing a suicide as part of their professional role (e.g. as a first responder, health professional, Garda or teacher).

Women were more likely to report the loss of a family member, (ex-) partner/spouse or acquaintance while a greater proportion of men reported loss of a friend (47%), colleague (15%), classmate (13%) and as part of their professional role (18%).

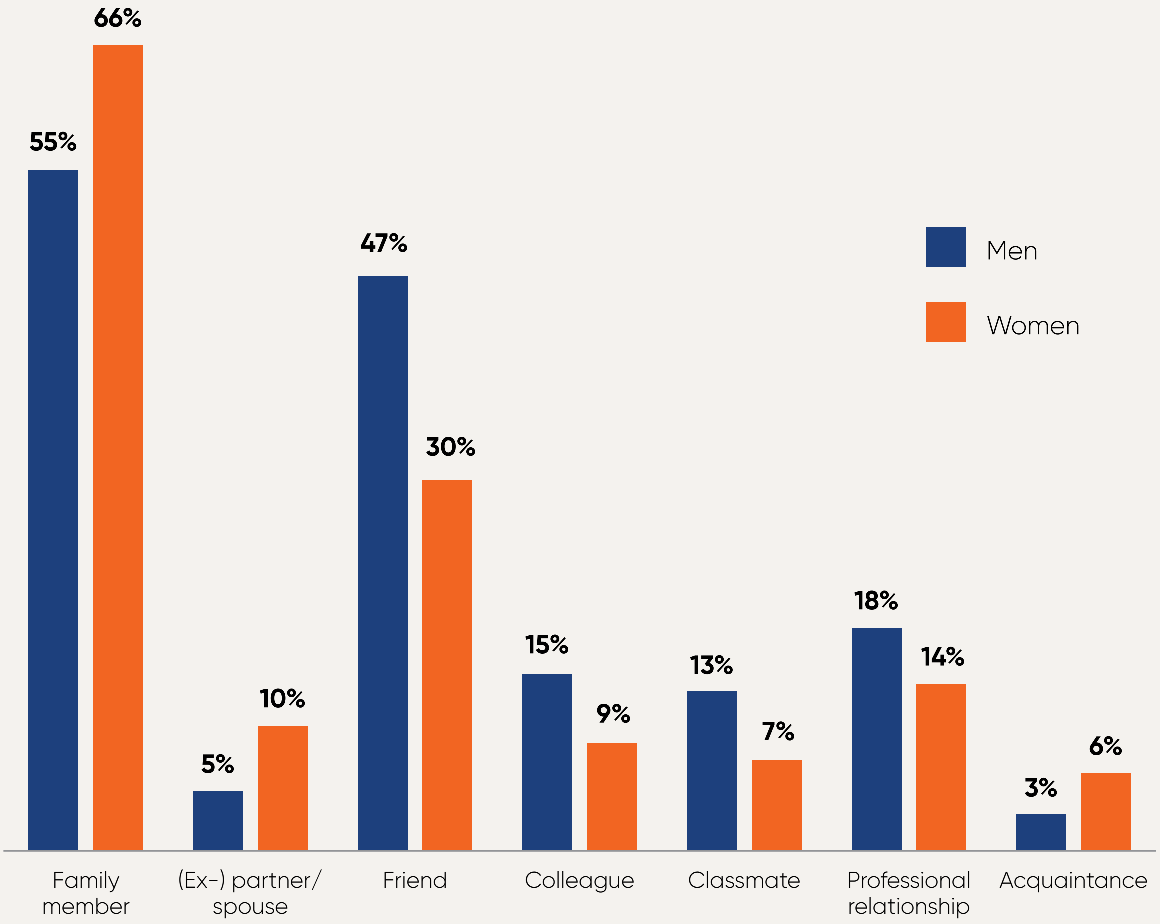


Figure 4. Relationship to the deceased by gender (n=2,393)

54%

Experienced multiple losses

Half of participants (54%) had been affected by more than one death by suicide. Furthermore, one-in-ten were affected by four or more deaths.

For most questions in the survey, participants were asked to focus on one person when answering. Where there were multiple bereavements, participants were asked to reflect on 'the loss that has been most on your mind lately/that you have been most impacted by'. Over half of participants (58%) focused on the death of a family member, most commonly a sibling (23%) or parent (10%). Within the family, others focused on the death of a cousin (7%), child (5%), aunt/uncle (5%) or other family relationship (8%). Approximately one-fifth (21%) focused on the death of a friend, with the remainder responding about an (ex-) partner/spouse (9%), acquaintance (6%), client/service user in their professional role (4%) or colleague (2%).

Time since bereavement

There was considerable variation in the length of time since participants had lost someone to suicide, with almost one-third of participants bereaved in the past two years (31%), 37% between three and ten years, and 32% bereaved more than 10 years. Of those recently bereaved, one-quarter (25%) were bereaved during the COVID-19 pandemic.

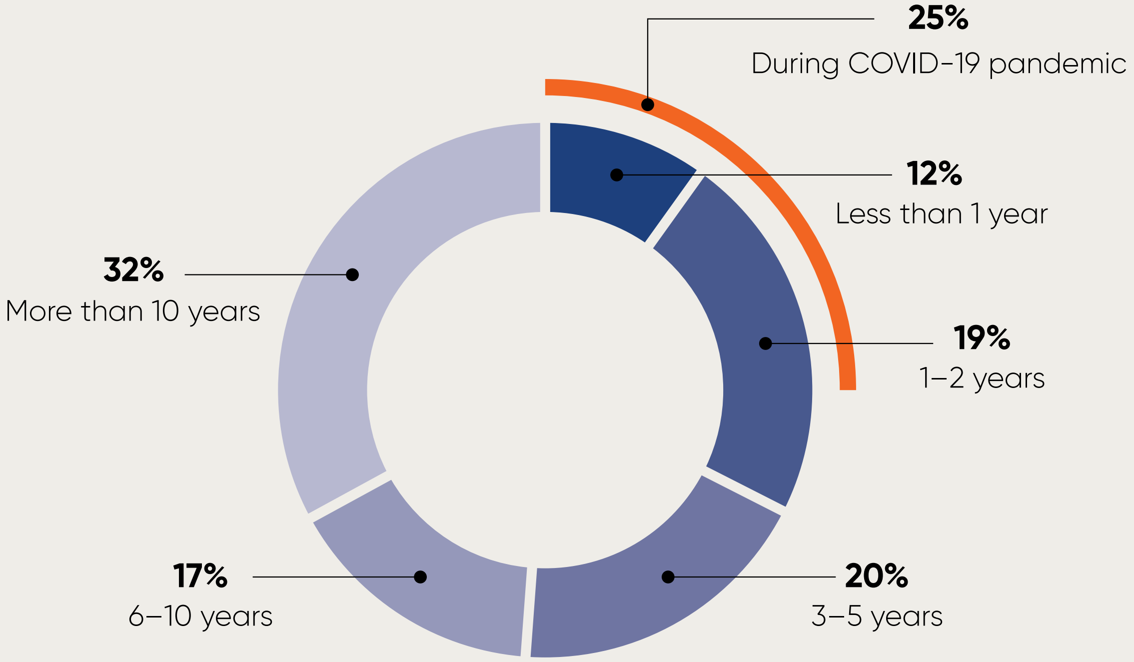


Figure 5. Length of time since bereavement (n=2,413)

Age at bereavement

There was also variation in the age of participants at bereavement. Approximately half of participants (49%) were aged between 25-44 years when the death occurred, while one-quarter (25%) were aged under 25 years and 26% of participants were aged 45 years or over.

What was the experience and impact of bereavement?

The vast majority of participants (93%) reported the loss to have had a **moderate** or **major impact on their lives**. This was consistent across participants regardless of the reported relationship to the deceased person. However, a greater proportion of participants who lost an immediate family member or a (ex-) partner/spouse reported that the death had a major impact on their lives (90% and 88% respectively).

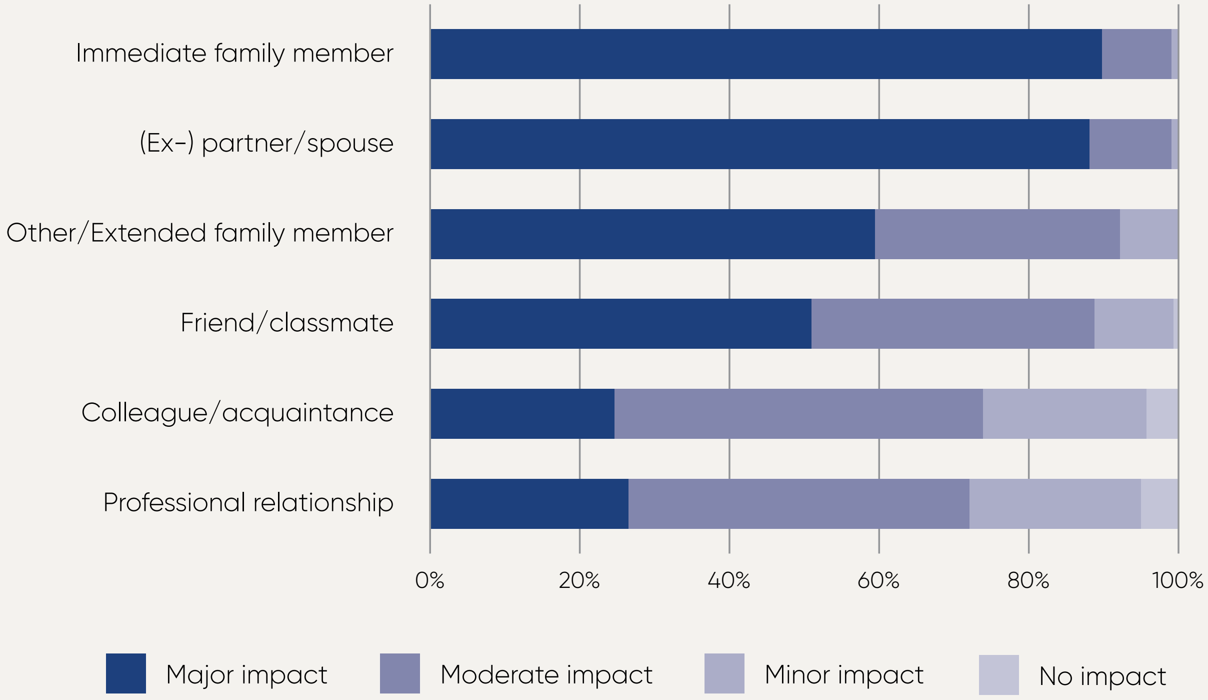


Figure 6. Reported impact of death according to relationship to deceased (n=2,375)

93%

Stated the loss had a moderate/ major impact

Participants were asked about their experiences of grief in the period following the death, via the *Grief Experience Questionnaire*.[26, 27] Participants were also asked to further describe their experience in their own words.

Most commonly, participants reported searching for an **explanation for the death**, with approximately 70% reporting to have experienced these feelings and thoughts often or almost always in the period after the death (e.g. 'questioning why the person had to die'). **Feelings of rejection** were also common e.g. 'wondering about the person's motivation for not living longer', reported by 62% of participants.

> It is the most soul-destroying thing that anyone can go through. The guilt you feel afterwards is enough to drive a person over the edge or to the edge of insanity. The questions NEVER stop. They won't go away. The Why and the what if's are daily. It's exhausting and weights very heavy on your heart and health.

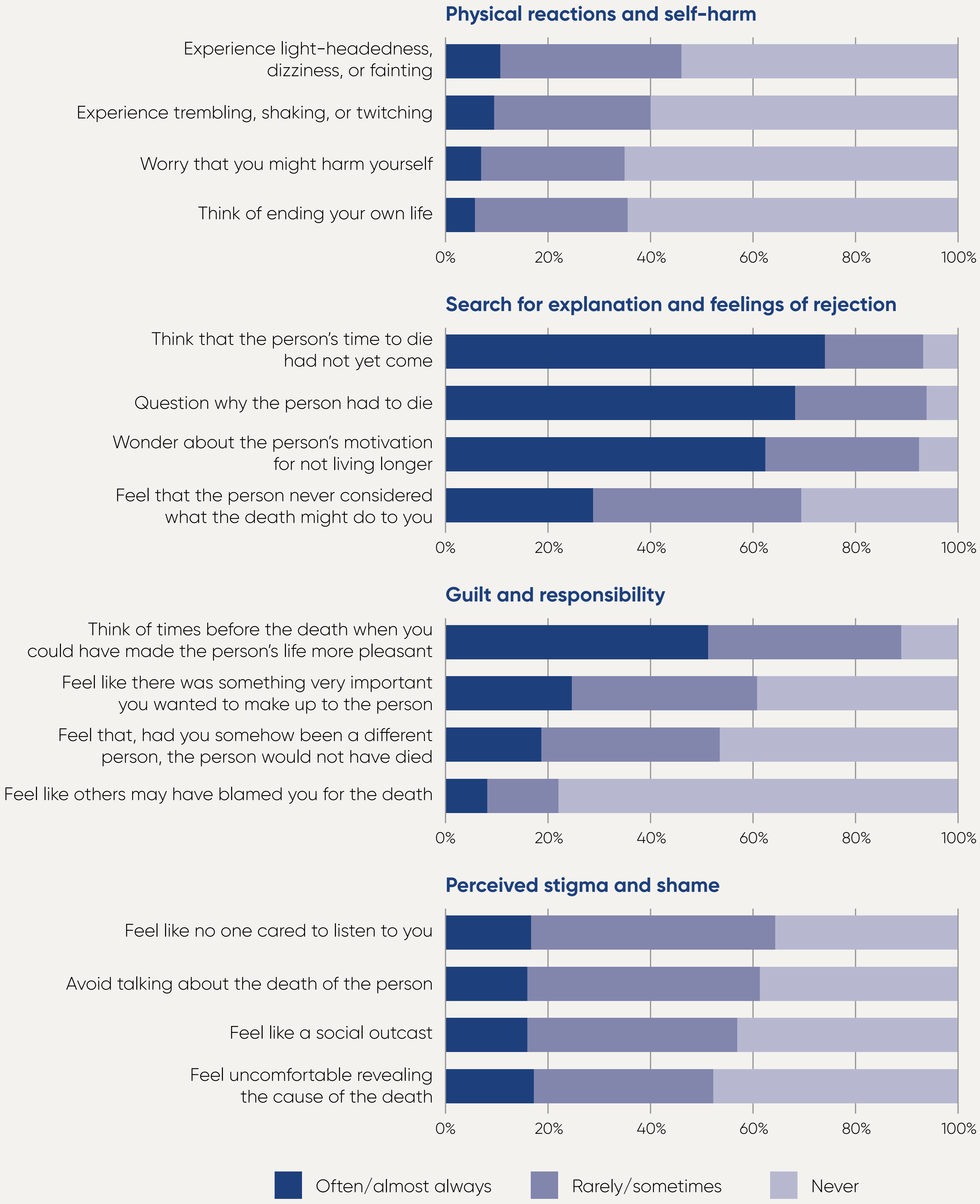
> You always ask yourself the question "why did he do it?" It is such a waste of a precious life and leaves a gaping hole in your chest when you think of them and what might have been.

> I, as a best friend felt I had no right to be hurting as much as I did compared to what the family were going through. I felt very selfish for feeling the way I did. I bet myself up every day over that. I also bet myself up because I couldn't save my friend, I felt I should have been able to.

Experiences of guilt were also common, with 'thinking of times before the death when you could have made the person's life more pleasant' reported by 52% of participants. **Feelings of perceived stigma and shame** were also common, with two-thirds (65%) of participants reporting to feel that no-one cared to listen to them.

While physical reactions were less commonly reported by participants, 40% or more had some physical reactions, including feeling light-headed, shaky, twitchy or dizzy.

More than one-third (35%) of participants reported having some thoughts of self-harm ('worry that you might harm yourself') or thoughts of suicide ('think of ending your own life') as a direct result of the death. For self-harm, 30% of participants stated that they had thoughts of self-harm 'rarely/sometimes', while 5% stated that they had these thoughts 'often/almost always'. Similarly, 31% of participants stated that they had thoughts of suicide 'rarely/sometimes' and 4% had these thoughts 'often/almost always'.


Physical reactions and self-harm

Search for explanation and feelings of rejection

Guilt and responsibility

Perceived stigma and shame

Figure 7. Grief experiences following the death – Grief Experience Questionnaire (n=2,302)

Impacts of the bereavement

More than two-thirds (69%) of participants provided information on specific impacts of their loss. A wide range of impacts were reported, with many participants reporting multiple impacts (three or more: 45%). Broadly speaking, physical and mental health impacts were most commonly reported (74%), followed by relational or family problems (58%). Almost one-fifth of participants reported financial or employment-related impacts.

The most frequently reported specific impacts were mental health challenges (67%) followed by family problems (40%), relationship problems, including avoidance of relationships (33%), use of alcohol (30%) and deterioration of physical health (28%), all lasting for more than three months.

Some differences in reported impacts were observed between men and women. The use of alcohol, use of illegal/non-prescription drugs and gambling were more prevalent for men, while family problems were more commonly reported by women.

Table 2. Impacts of bereavement reported by participants (n=1,599)

Impact	Men	Women
Mental health challenges	65%	68%
Family problems*	33%	42%
Relationship problems*	30%	34%
Use of alcohol*	40%	26%
Poor or deterioration in physical health*	28%	28%
Financial problems	16%	13%
Use of prescription drugs*	14%	14%
Change of residence (e.g. moved house)	12%	13%
Use of illegal/non-prescription drugs*	16%	6%
Unemployment/job loss	11%	8%
Divorce/relationship breakdown	11%	8%
Hospitalisation for mental health problems	7%	6%
Gambling*	6%	1%
Homelessness/loss of family home	2%	1%

*for more than three months (as specified in question wording)

> “Suicide is like an implosion and an explosion of shock anger disbelief isolation and guilt [...] the impact was absolutely devastating. My mam and dad suffered serious relationship problems after decades of a steady marriage [...] I have long term serious [health condition]. [...] I had a nervous breakdown and became so ill. I felt I crawled out of a black hole to try and survive.”

> “The grief we endured all those years turned us into different people and people [we] were not meant to be. Each family member has isolated them self in order to move past such horrid years of grief, and barely speak, as to be together is just unbearable now. [...] That suicide not only impacted all remaining [...] members of my family, but our partners & their families. And that’s not to even mention generations now of children who will never even know their first cousins or meet them.”

Current mental wellbeing of participants

Participants were asked to complete a series of measures about their mental wellbeing at the time of completing the survey.

Overall mental wellbeing

Participants were asked to complete a short measure of their overall mental wellbeing. Scores range from 0-100, with a higher score indicating better mental wellbeing.

Approximately half (56%) of respondents reported negative mental wellbeing (a score of 50 or less).

Mental wellbeing measure:
WHO-5 Index

This measure consists of five statements and participants indicated on a scale how often they have felt that way over the past two weeks (e.g. I have felt cheerful and in good spirits).

There is information on where you can find support on **page 45**

Symptoms of depression and anxiety

Participants also completed a scale measuring symptoms of depression and anxiety. Most participants indicated some symptoms of depression (64%) or anxiety (59%), ranging from mild to severe.

For depression, participants were categorised as having mild (33%), moderate (17%) or severe (15%) symptoms. For anxiety, participants were categorised as having mild (33%), moderate (14%) or severe (12%) symptoms. Reported symptoms of depression and anxiety were similar for men and women.

Depression and anxiety measure: PHQ-ADS

This measure consists of 16 statements and participants indicated how often they had been bothered by a problem over the past two weeks (e.g. little interest or pleasure in doing things or not being able to stop or control worrying).

Suicidal ideation

One-in-five participants reported some degree of current suicidal ideation in the previous two weeks (21%) and this was more often reported by men than women (27% vs. 18%).

Current suicidal ideation

Participants were asked to indicate on a five-point scale (ranging from ‘not at all’ to ‘nearly every day’) how often, over the past two weeks, they had ‘thoughts that you would be better off dead or of hurting yourself in some way’, which we refer to as current suicidal ideation.

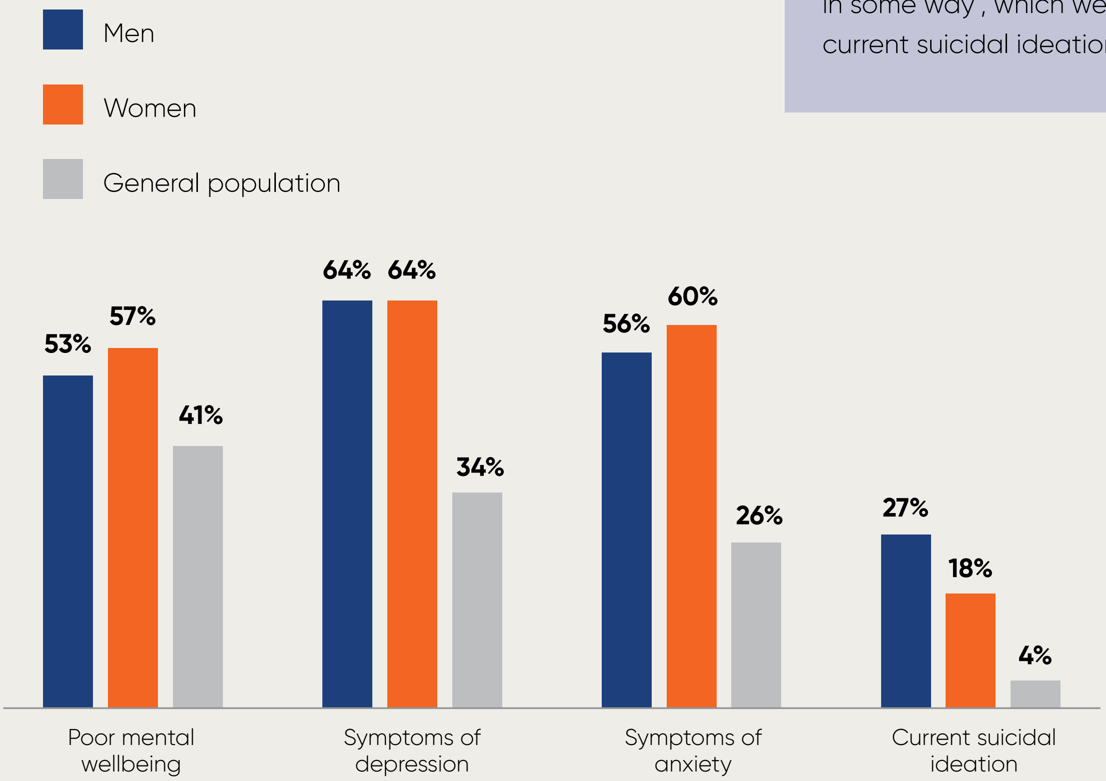


Figure 8. Current reported wellbeing of participants

Note: General population prevalence data used for comparison of mental wellbeing,[30] symptoms of depression and anxiety and suicidal ideation.[31]

Experiences of personal growth

Personal growth after a suicide bereavement (also known as post-traumatic growth) is a positive, enduring psychological change as a result of the loss, whereby people who experience grief may also experience positive impacts in different ways, including better interpersonal relationships or life perspectives.

Participants who had been bereaved for at least one year were asked to respond to a series of statements describing personal growth. Of those, most participants agreed with the statements, with agreement ranging from 56% to 93% across items. Over 80% of participants agreed with the statements 'I have more compassion for others', 'I care more deeply for others' and 'I have more good days than bad days'.

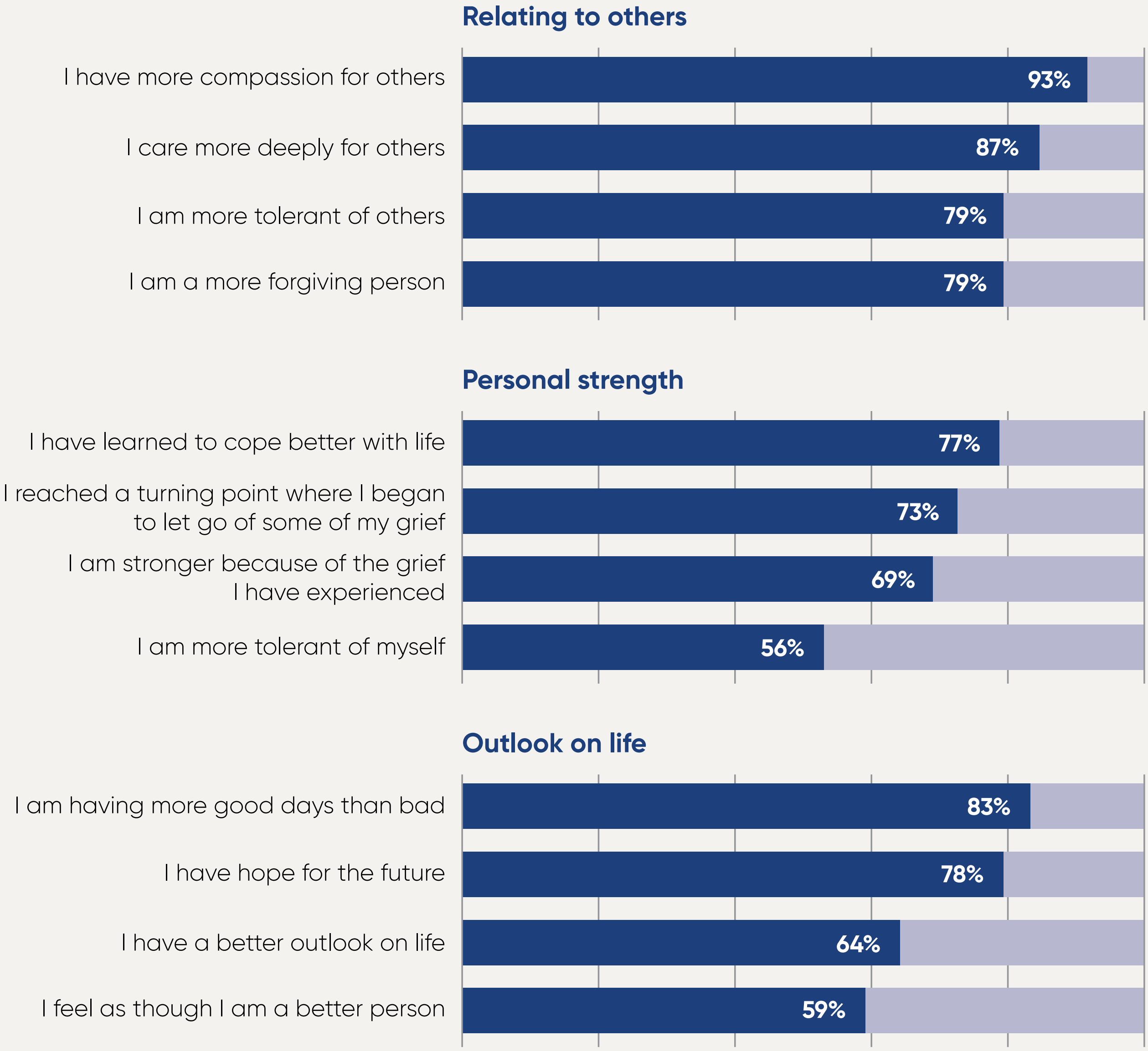


Figure 9. Agreement with statements of personal growth (n=1,646)

What support did people access following their bereavement?

Broadly speaking, there were two types of support identified by participants following their bereavement. **Formal supports** include supports from an employer, school/college, funeral director, Gardaí, Coroner, charity support organisations and all health and social care professionals. **Informal supports** include supports from family, friends, neighbours, colleagues and faith leaders as well as information resources. Almost two-thirds (66%) of participants reported having accessed some type of formal support, which means that approximately one-third of participants (34%) did not access any formal supports.

Considering specific sources of support, most participants (91%) reported receiving support from someone in their close circle of family, friends or neighbours. Almost half (47%) reported receiving support from the work/school environment including from classmates, teachers, colleagues and employers while 42% received support from a range of professionals in the community. Half of participants (49%) had accessed information resources and just under one-third (30%) had accessed specialised supports such as those from peer support groups, helplines or other support charities. Counselling, therapy or other support from a mental health professional was accessed by 43% of participants.

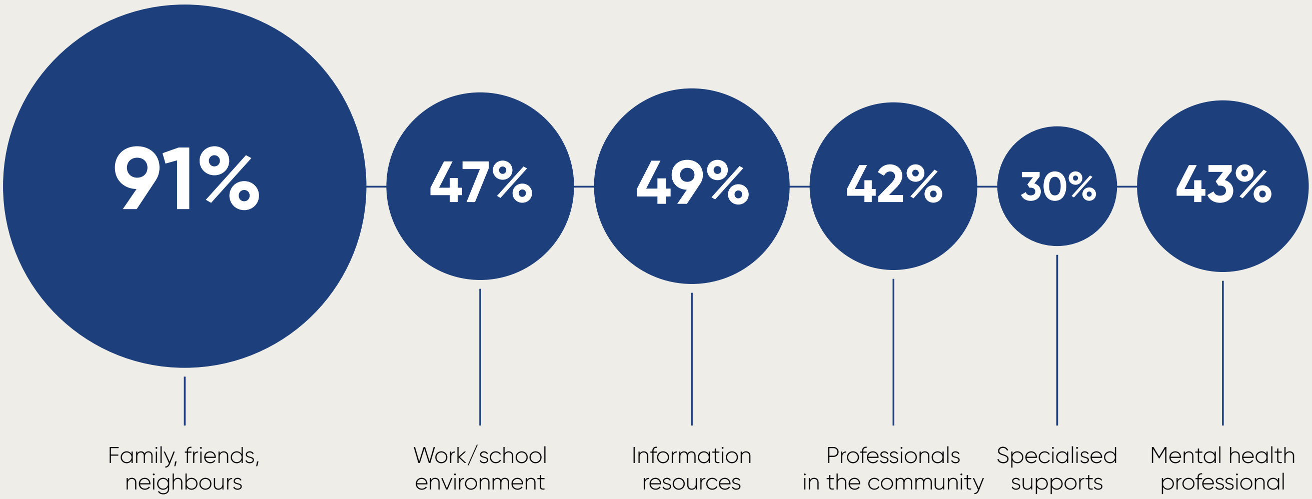


Figure 10. Frequency of accessing support groups (n=2,158)*

The type of supports accessed by participants varied according to time since loss. In general, participants who were bereaved in more recent years, particularly in the past five years, were more likely to access formal supports, which is likely a reflection of increased provision of services. However, the recent COVID-19 pandemic negatively impacted access to supports, in particular access to support from professionals in the community and therapeutic supports. Nevertheless, participants reported that they continued to access information resources and support in the work/school environment during the pandemic.

*For specialised supports and information resources, frequencies of accessing supports are presented only for those who experienced loss less than five years ago (n=947). We do this to provide accurate representation of support access because many support services/resources within these groupings only became operational in recent years.

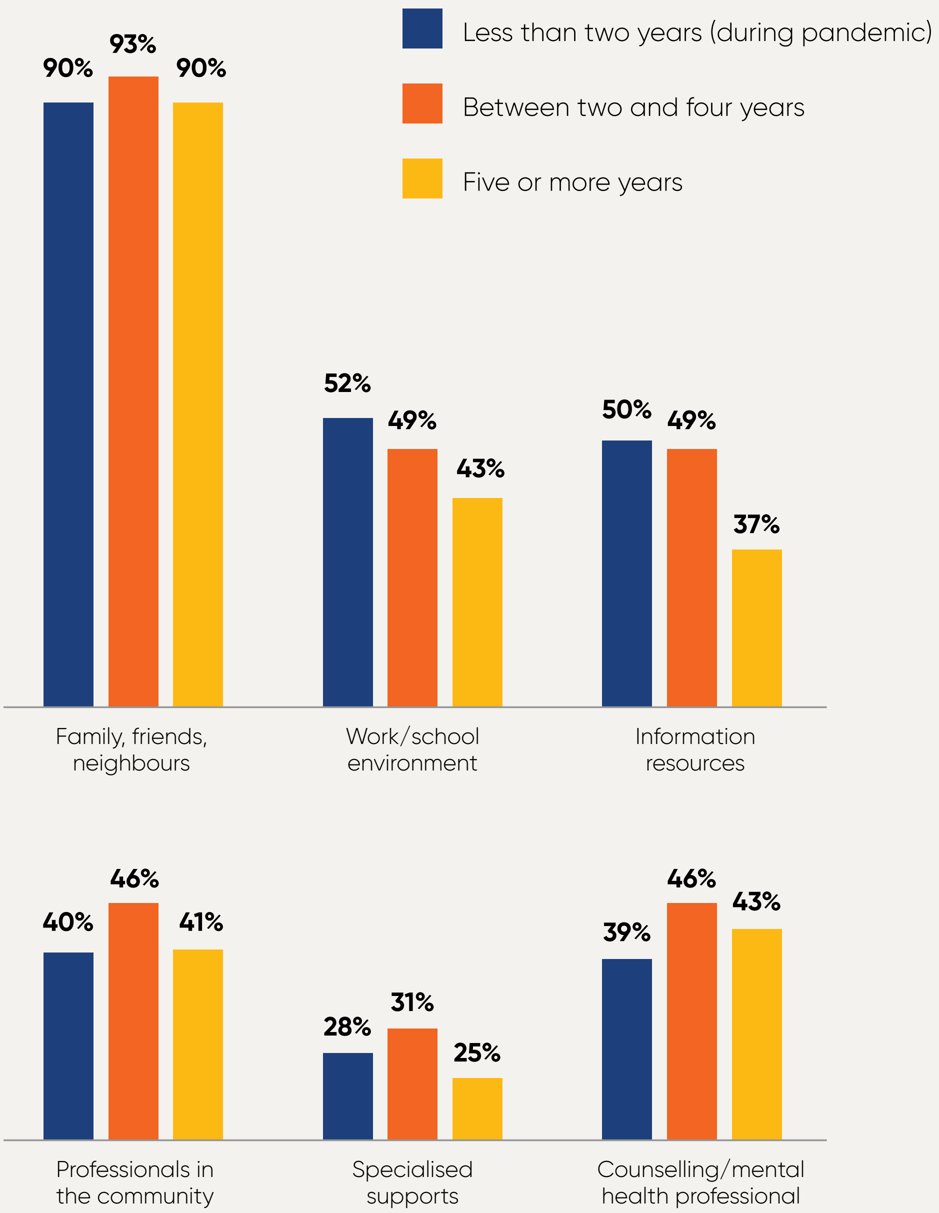


Figure 11. Supports accessed according to time since loss

Men and women reported similar patterns of accessing informal and local supports including support from family/friends (88% men, 92% women), professionals in the community (39% men, 43% women) and support in the school/work environment (43% men, 48% women). However, men accessed fewer information resources (39% men, 53% women), specialised supports (21% men, 32% women) and counselling/mental health professionals (33% men, 46% women).

Friends, family and neighbours

Within the close circle, friends were the most commonly cited source of support (69%) while just under half received support from siblings (46%), parents (43%) and partners (45%). One-third (33%) received support from extended family, 20% from neighbours and 16% from children.

Participants were asked to rate the helpfulness of the supports accessed. Support sources in this group were predominantly rated as helpful (82%).

Many participants described the value of friends or family **"being there"** for them. The presence of another person or the knowledge that they could be easily reached was comforting. Some participants also described close ones checking-in on them as helpful. **Listening** was a prominent and valued feature of support from family, friends and neighbours. Participants valued when others 'just' listened to them talk about whatever was on their mind, including difficult feelings and emotions. They valued when those close to them did not judge them, empathised with them and showed compassion. Many participants also spoke of **practical assistance** from friends, family or neighbours. These involved help with caring for children, providing food, or organising aspects of the funeral.

Table 3.

Access to support from family, friends and neighbours (n=2,158)	
Friends	69%
Siblings	46%
Spouse/partner	45%
Parents	43%
Extended family	33%
Neighbours	20%
Child/children	16%

> “They were there for me whenever I needed them, they listened to me, they let me cry.”

> “My college friends saved me, I didn’t know how to deal with the anger and hurt and they stood by me and listened.”

> “They took care of all practical matters for several months; shopping, cooking, housekeeping; I would not have been able to organise these at that time.”

91%

Supported by family, friends and neighbours

Participants strongly valued feeling **understood**. Participants mainly described feeling understood by others with experience of being bereaved by suicide, or those who had lost the same person. This was sometimes reported as being challenging with close family members whom participants felt were processing their grief differently or where participants feared adding further to the burden of their grief.

> **My siblings and I understood each other's grief best. It felt good to have someone reflect my feelings and thoughts.**

> **One of the single most helpful supports came from someone I was not close with, and hadn't seen in years, but knew from a wider circle of friends. He had lost his own brother to suicide [...] we met up a number of times to talk about our siblings and that support from someone who understood was invaluable.**

> **My family members each had their own extreme pain to deal with, so it was hard to ask them for support. Also, there was a feeling that we were all to blame, and then some more than others.**

In a few instances, support from family, friends and neighbours was rated as unhelpful. While non-judgemental listening was a valued aspect of support, some participants reported perceived stigma and feeling others were uncomfortable speaking about suicide or unsure how to help. Some participants spoke about how they found it difficult to engage with support, either because they felt they needed to be strong for others or they found it difficult to talk about their experiences and feelings. Other unhelpful aspects were when friends/family encouraged the bereaved person to return to normal which the participant experienced as dismissive of their grief, or where the support was present in the immediate aftermath of the death but did not continue into the long-term.

Work/school environment

Many participants reported support from colleagues (35%) and to some extent from employers (17%). A small number of participants reported support from school/college sources (7%) and classmates (6%).

Most work/school environment supports were rated as helpful (83%). Support from employers was viewed as being largely positive, with many participants highlighting that employers were very understanding and facilitated as much time off work as was needed. Participants also reported that employers/colleagues reduced work pressure in other ways such as allocating work to others/providing cover, or temporarily shifting roles.

Table 4.

Access to work/school support (n=2,004)	
Colleagues	35%
Employer	17%
School/college supports	7%
Classmates	6%

> **“They stayed in contact with me, there was no pressure on me to feel like I had to return to work they let me take it at my own pace.”**

> **“They let me take as much time off as I wished. I went back after 3 weeks but I was useless, no-one said anything. It took me 6 months and then by year 1, I was back on track.”**

Colleagues and classmates were also there to support the bereaved person in many ways such as listening and talking about what happened. People bereaved within their professional role noted the value of support from colleagues:

> **“Speaking to Peers/Colleagues team members who shared the loss of the death of the patient and our questioning of ourselves was helpful and supportive. Everyone worked very hard to provide a high level of care and availability.”**

Professionals in community

Table 5.

Access to professionals in community (n=2,004)	
GP	24%
Gardaí	15%
Funeral director	13%
Faith leaders	8%
Coroner	5%
Hospital staff	4%

Within the community, support from general practitioners (GPs) (24%) was commonly reported. Other sources of support were Gardaí/police (15%), funeral directors (13%) and faith leaders (8%). Social workers, public health nurses and social welfare staff were also included in this group, though less commonly accessed. Community supports were generally seen as being helpful (83%).

Participants valued the **care and concern** shown by professionals or people with designated roles in the community. These points refer to employers and teachers also. Generally, participants valued support that was caring, compassionate and sensitive. Participants appreciated the regular calls and visits from community professionals and knowing these support sources were accessible to them.

> **“The local priest was a great source of support to my parents when my brother died. He visited them often in the months after the death, even just for a cup of tea and to sit with them.”**

> **“The Garda who attended the scene after my brother died was so kind and compassionate. He visited us several times and was very gentle with my parents.”**

Empathy was a prominent feature of the compassionate support that spanned across the wider community. Support in the form of **listening** was also mentioned as a feature of support from professionals in the community.

> **“All of these people showed empathy, were not trying to pry, and showed compassion.”**

> **[GP] was the only person I was able to talk to that understood. My mother didn't know why I was so upset [...]. My dad isn't good at talking about feelings, emotional stuff etc. [...]. So, my doctor was literally the only one who offered me emotional support.**

To a lesser extent, participants noted the value of **advice and assistance with practical tasks** received from these support sources. They valued the time taken to give advice by community professionals, often referring to funeral directors with regard to funeral arrangements and other queries around the death and legal/inquest-related matters. Faith leaders and funeral directors were valued for their role in providing a ceremony that was appropriate to commemorate the deceased.

GPs were a common source of support. Many identified how GPs had shown them great care and concern and had been there to listen. Overall, 15% of all participants were prescribed medication. Participants had mixed experiences of this. Some found benefit in the medication, including reduced anxiety and improved focus, while a minority reported negative side effects. More generally, some participants felt the prescription was inadequate or inappropriate, particularly when receiving "just" a prescription and no other emotional support or follow-up.

Other participants reported that GPs referred them to or informed them of more specialised help/counselling that was available.

> **The first line of treatment was medication. I didn't like that. However just having one person to talk to although briefly was good.**

42%

Accessed community professionals

The coronial inquest

Many participants referred to the inquest when describing the support of Gardaí and Coroners. Participants had varied experiences of support during the inquest. On one hand, some people described being kept informed and were supported in the lead-up and throughout the inquest process. Speaking about the Gardaí, participants said they:

> **“Kept contact. Explained what was happening in terms of autopsy funeral arrangements, inquests etc.”**

> **“The gardai were amazing. They dealt with us so sympathetically. They were so patient with all our questions in the weeks that followed and through the inquest. Unbelievably supportive. The coroner again had such empathy and patience with all the questions I had about the inquest process.”**

On the other hand, some participants described a very difficult process in which they were unable to get the information they wanted. They had to engage in a lot of independent searching and contacting to obtain information and felt isolated in handling the inquest:

> **“It was incredibly difficult to find information from the authorities. We could never get anyone on the phone, we were told conflicting information, no one would give us a clear overview of the process and the role we, as the family, played in it. [...] We felt like we were a burden and an irritation on the system.”**

> **“There is no one there to help with the whole thing. You are just on your own trying to piece the steps together.”**

Information resources

Focusing on people bereaved in the past five years, the most commonly used information resources were websites and books (42%) and online resources (17%), while 11% of participants reported accessing the HSE Booklet 'You Are Not Alone'.

Table 6.

Access to information resources (n=947)	
Websites/books	42%
Online resources/apps	17%
You Are Not Alone Guide	11%

Compared to other forms of support, information and resources had more varied ratings of helpfulness, with 70% of participants rating information resources as being helpful. The particular areas in which participants valued information were related to understanding suicidal behaviour, learning about the grief process and information to assist other bereaved loved ones. The latter was prominent for parents who sought information on how to communicate with and support children in dealing with the loss.

Information resources were valued when they included detail of other peoples' experiences of suicide bereavement, which validated their own experiences and helped reduce feelings of isolation, with one participant stating that:

> “ **Listening to podcasts/reading helped me understand other peoples' suicide related grief and I learned I wasn't alone.** ”

Two common challenges relating to written resources were reported. Many participants were frustrated when information was perceived as being not relevant to them or their situation (e.g. the type of relationship they had with deceased, religious beliefs or cultural background).

> “ **These resources are helpful but at the same time they are not catered specifically to everyone's individual needs and give a more common answer to problems.** ”

Secondly, even with these information sources, active engagement with another person was often seen as necessary to provide tailored and meaningful support:

> “ **I imagine each loss is unique, so the books & online information was not as helpful as the human connection.** ”

Specialised supports

Overall, 16% of participants who experienced loss in the past five years received support from a Suicide Bereavement Liaison Officer (SBLO). Charity organisations (14%) encompassed a wide range of individual and group-based supports with many providing emotional and informational support. Specifically, 4% accessed a telephone/text helpline or drop-in support.

Approximately 71% of these support ratings were positive, while 15% of ratings were 'unhelpful'.

Suicide-specific peer support groups were accessed by 10% while online forums and other bereavement support groups were accessed by 4% and 3% respectively. In relation to peer support, participants valued engaging with other people bereaved by suicide and the shared understanding that exists between them which validated their experience and reduced isolation. This point was raised in terms of support groups as well as online forums:

Table 7.

Access to specialised supports (n=947)	
Suicide Bereavement Liaison Officer	16%
Charity organisation	14%
Suicide-specific support group	10%
Helpline/drop-in	4%
Online forum	4%
General bereavement support group	3%

A Suicide Bereavement Liaison Officer or SBLO provides one-to-one support to family members or wider community in the aftermath of a suicide. The support may be emotional or practical such as communicating about the inquest or may involve referral to further services if needed.

Peer support is where people who share similar experiences come together to support one another based on their common experiences.

> **"It was a good support because you are speaking & listening to people who have been through the same thing as you not just people who are trained in the area. I didn't feel/still don't feel ready to go to a therapist so this was a better option for me."**

Across support providers such as SBLOs, peer-support sources and counsellors (described below), participants identified valued features of support. Having the opportunity to **speak openly about their experiences and feelings** and having someone to listen were the most commonly reported benefits. Specifically, they reported the following helpful features:

- A designated safe space to talk
- Confidential and non-judgemental
- With a person external to the situation with skills to provide support
- Avoided upsetting or burdening family or friends.

Counselling, therapy and mental health professionals

More than one-third of participants (37%) reported accessing some form of counselling which may have been individual or family/couples counselling while 23% accessed support from mental health professionals. Support from counsellors, therapists and mental health professionals was predominantly rated as being helpful (76%). Participants highlighted a number of features of counselling or therapy that were seen as helpful. One participant noted about their experience of counselling:

Table 8.

Access to counselling/mental health professionals (n=2,026)	
Counselling/therapy	37%
Mental health professional	23%

> **“It was nice to have someone non-judgemental and not trying to make me feel like I needed to be ok again. Many of my friends didn’t want to ask or talk about the suicide anymore and so I found the impartial nature of therapy really helpful.”**

With regard to counselling, there were a number of features that determined how useful the counselling was to participants. Broadly speaking, this might be described as ‘finding the right counsellor for them’. Specifically, the type of approach to therapy or specialised skills of the counsellor were identified as important.

> **“I was fortunate to find the right counsellor for me, who specialised in bereavement and trauma. I went to her about six-eight months after my sister’s death and she was pivotal in helping me to cope and process much of the trauma associated with the death.”**

Positive counselling experiences were reported to contribute to the following outcomes for participants: insight into their feelings, ability to connect with emotions, process the grief and to manage powerful emotions. Some participants highlighted negative experiences where the professional did not provide the above features of support, particularly the specialised skills tailored to their situation. The perceived helpfulness also depended on whether participants felt they had a good relationship with the counsellor and ability to attend the same counsellor over time.

43%

Accessed
a counsellor/
mental health
professional

What factors affected accessing supports?

Timing of supports accessed

Of participants accessing specialised supports, counselling or therapy, more than one-third (35%) reported accessing valued support in the first month following the death, while 28% accessed support between one and six months and over one-third (37%) accessed support after six months.

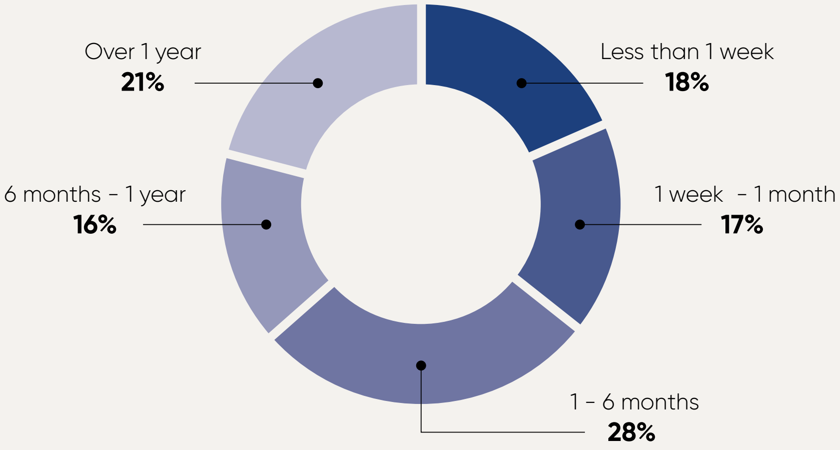


Figure 12. Timing of support access following death

Participants who engaged in counselling, therapy or support groups were asked about the waiting time to access these supports. A substantial proportion (43%) were waiting less than one month from initial contact. A further 27% were waiting between one and six months, while 30% were waiting six months or more.

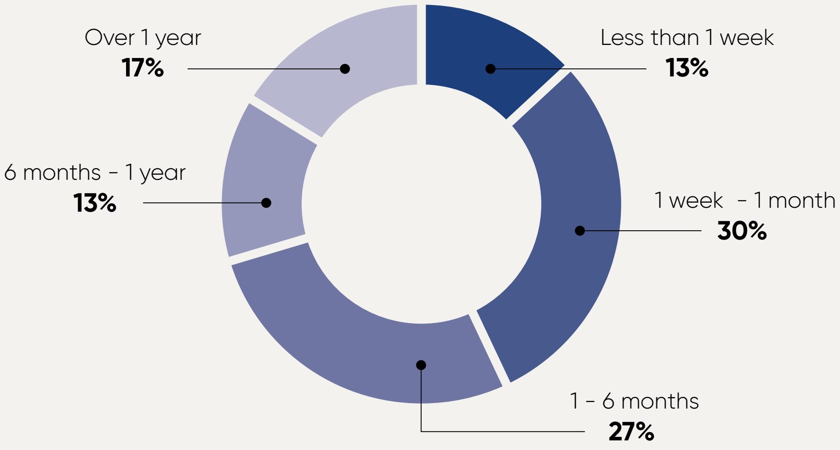


Figure 13. Waiting time from initial contact to first appointment

Most participants who accessed counselling, therapy or support groups engaged with these supports for more than one month (79%) while 21% engaged with these supports for less than one month.

Barriers to accessing support services

There were several reasons as to why people did not access support services for their grief. Broadly speaking, these were categorised into two groupings: *individual perceptions* and *service accessibility*. Most participants who identified a reason for not accessing support services stated that they felt that they could cope themselves (45%). However, many reported that they were reluctant to ask for help (30%), that they didn't feel their grief was important enough or that they deserved help (21%).

One-fifth of participants (20%) felt that low mood prevented them from accessing help. Other personal factors related to perceived stigma – including their grief not being recognised by others (14%), personal shame/concern about what others would think (14%), a fear/distrust in services (11%), a fear it would make things worse (10%) or a lack of confidence in professionals (9%).

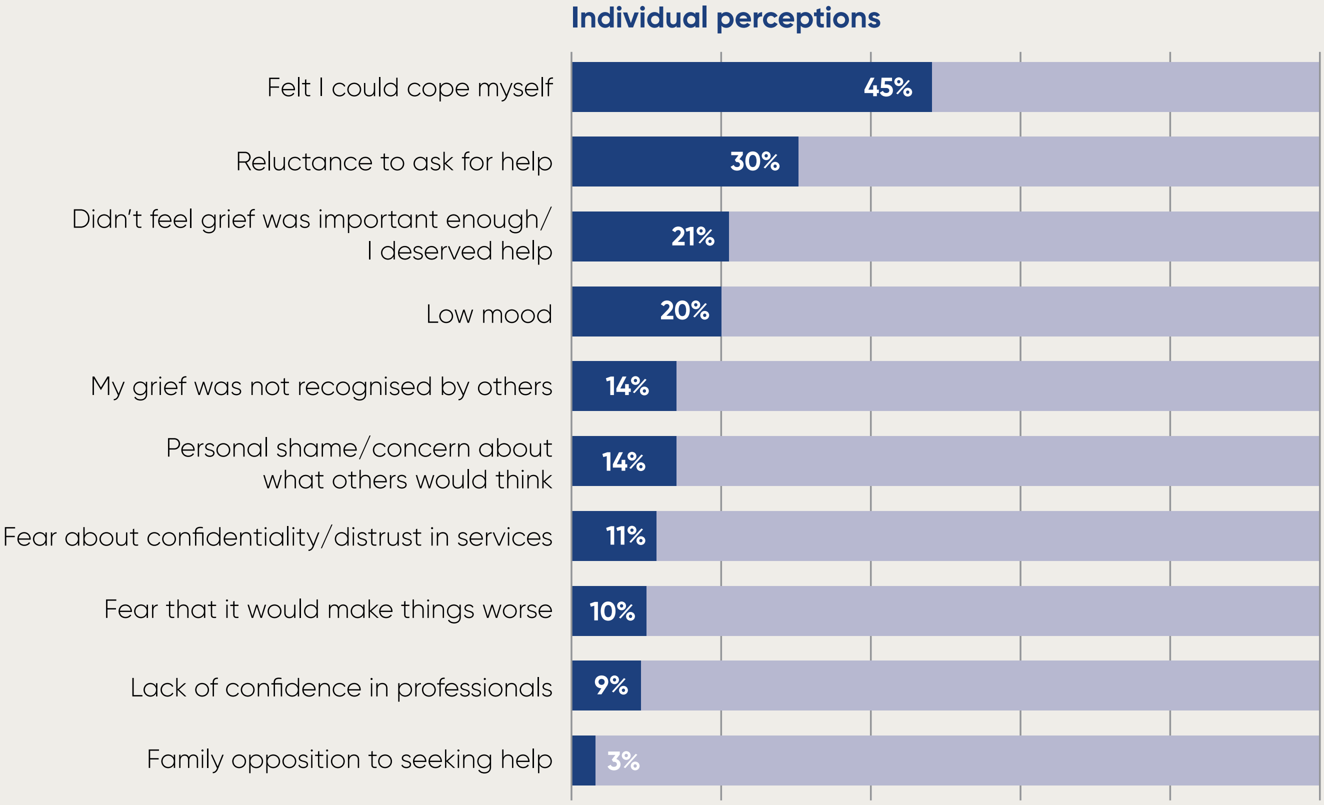


Figure 14a. Reported barriers to accessing support (n=1,830)

There were several barriers related to service accessibility, with participants indicating that nothing was offered to them (31%) or that they had difficulty finding information about accessing services (14%). Other barriers included the associated financial costs (19%) and a lack of time (17%) – including taking the necessary time off work. For participants bereaved during the COVID-19 pandemic, 22% indicated that the public health restrictions impacted on them accessing support and services.

31%

Felt no services were offered to them

> **We were all very much left to get on with the grief ourselves … I feel strongly that someone needs to be assigned to families and individuals to guide them through all the various options at home. When you are feeling low the last thing I personally didn't want was to have to travel for a service I was unsure of and then sit in a waiting room. That was too much of an ask.**

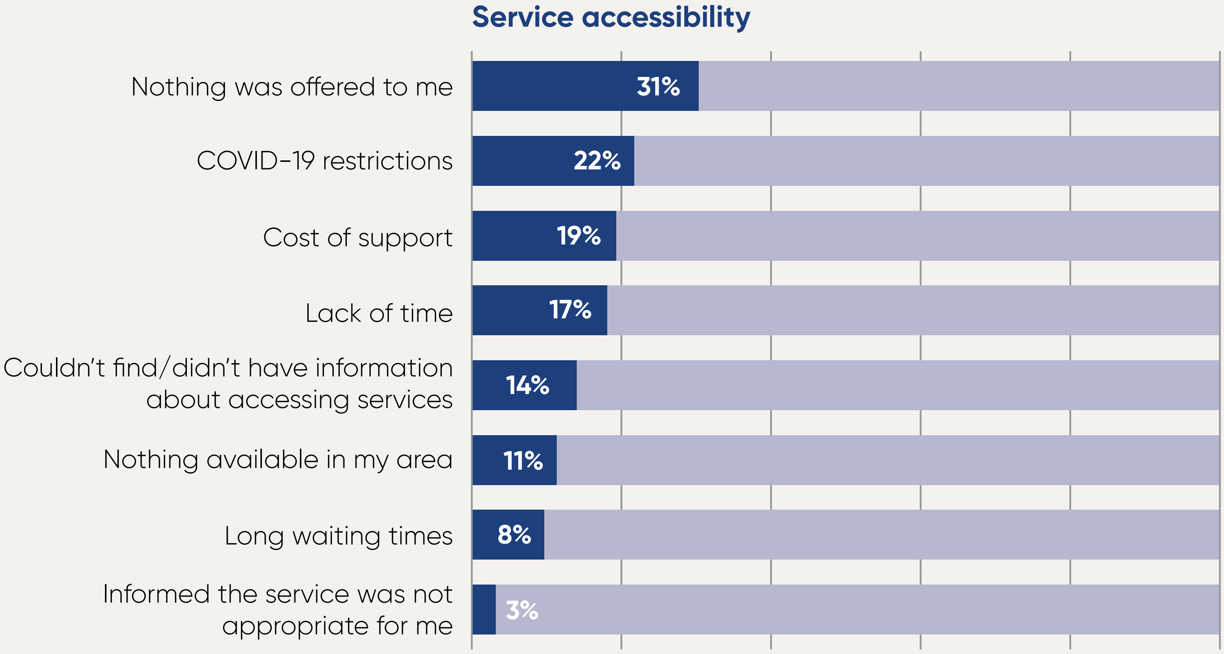


Figure 14b. Reported barriers to accessing support (n=1,830)

More than one-in-ten participants indicated that there was no service in their local area (11%). When asked further about the availability of supports in their local area, 14% reported availability as being good/very good. Almost two thirds (65%) felt that availability of supports in local area was poor while 21% felt the supports in local area were acceptable.

Factors that helped in accessing supports

Participants were asked to describe what helped them to access supports. These can be grouped into four main areas: realising the severity of the mental health impact, information and encouragement from others, financial and practical ease of access and positive past experiences.

Realising the severity of the mental health impact

One of the main factors that encouraged people to access support was the realisation that they were not coping and were struggling with mental health issues following the death. Participants spoke of seeking help when it got to a point that it felt too much to handle, at various times following the loss:

> “I wasn’t coping. I was in shock. I physically lost 2 stone in 6 weeks. I didn’t sleep or eat. [...] I hated feeling so emotionally unstable, so I reached out for help.”

> “I was having difficulties with my then boyfriend so sought help. Was still carrying the grief ([many] years later) & needed help to let go & allow someone else in.”

For many, they were aware of the severity of the situation themselves while, for some, those around them also echoed this:

> “I felt overwhelmed at the time. I just wasn’t coping with what happened. I thought I was losing my mind. I went off one day to my friends and my phone died. I was late home and my husband was distraught. That was when he told me that every time I was out he was afraid I would do what my [family member] did.”

Information and encouragement from others

Many participants described engaging in their own research and searching to find support services. This was mainly conducted online via internet searches:

> **“Googling services helped and when I done that, I then learned how much was support was out there for young people that I just never knew or heard of as, I often feel it’s a raw subject to discuss sometimes around people.”**

Social support was a prominent facilitator of access to support. Many participants highlighted that someone close to them such as friend, family or partner had informed them about support available or recommended a specific support. Furthermore, participants also frequently described how someone close to them highlighted the need to get help and encouraged them to access support.

> **“My husband brought the service to my attention. He was struggling to support me but knew I needed something.”**

> **“A colleague recognised that I was struggling with everything (work, health issues, family life, social isolation, etc.) and she suggested I think about getting some counselling.”**

Many participants were informed about the services available via their routine healthcare provider, predominantly their GP. This spanned from being informed about the services available, being advised/encouraged to reach out, through to being referred to a service and an appointment arranged:

> **“My GP told me about the counselling service and she also applied for the funding for it. It came through fairly swiftly once the application was sent. It was a godsend for me, and I deeply appreciate the skills of that very compassionate kind lady.”**

Some participants also described being informed or encouraged by a range of other professionals working in the community such as Gardaí or liaison officers. In other cases, participants described how they had knowledge about the supports due to advertisements in the wider media or information in local community bulletins/newsletters. For others, they had knowledge of what supports were available from their own education and training, such as those who were health or social care professionals.

Financial and practical ease of access

Some participants reported financial factors affecting access. These included being able to engage in support such as counselling because it was provided free of charge through various schemes and arrangements, though they would have been otherwise unable to afford it. Others noted that being financially able to pay for private counselling enabled them to access the support they needed. One participant noted how their family supported them financially:

> **My Dad lodged some money into my account and told me never to let the financial outlay to get in the way of my seeking that support.**

A small number of participants noted ease of access in a practical sense such as availing of support locally or remotely or having someone call to the house. Employee assistance programmes were commonly mentioned as facilitators to accessing further support such as counselling. These were highlighted to be useful in terms of being free of charge but also easily arranged.

Positive past experiences

A number of participants described how they were already engaged with support such as counselling or had recently been engaged and could easily resume sessions:

> **I was already seeing a counsellor before the death occurred so I was able to link in with them quite quickly afterwards.**

Furthermore, those who had previously or currently engaged with supports described how this encouraged them to access further supports because they had experienced benefits of support and many specifically valued the continuity and trust with the same provider.

> **I was already seeing the counsellor and she had supported me through his health issues, so as I felt really comfortable with her, I continued to see her.**

There is information on where you can find support on **page 45**

Young adults bereaved by suicide

53%

Of young people reported suicidal ideation

A minority of participants of the survey were young adults aged between 18-24 years (n=152; 6%), of which 122 (81%) were women.

Young adults reported poor mental wellbeing at the time of completing the survey, whereby they reported more negative outcomes across all measures and this was apparent for both men and women. The vast majority of young people reported some symptoms of anxiety (89% for both young men and women) and depression (82% for young men, 92% for young women). Of concern, a large proportion of young people reported current suicidal ideation – 43% of young men and 55% of young women. However, fewer than 30 young men aged 18-24 years completed the survey.

Experiences and impacts of suicide bereavement

Young adults were more likely to have lost a friend (45%) or classmate (20%) to suicide and 49% had experienced more than one death.

For the most part, young adults reported more pronounced experiences of grief following their loss. Most strikingly, more than half of young adults reported to have had some thoughts of self-harm or suicide in the period following the death(s) (59% and 57%, respectively), in comparison to 38% of all participants.

Young adults also experienced more physical reactions to the death(s) than other participants, with almost one-third reporting to have experienced trembling, shaking or twitching (30%) often or always in the period after the death. This compared with 9% of all participants. Young adults also reported more pronounced feelings of guilt and responsibility, with 38% feeling often or always like there was something important they wanted to make up to the person (compared with 26% of all participants).

Young adults also reported more experiences of perceived stigma and shame, with approximately one-third (35%) indicating that they felt uncomfortable revealing the cause of death, compared to 17% of all participants.

These experiences were also reflected in the types of impacts reported by young adults following the death, which mostly related to health and relational problems. The most commonly reported impact among young people was mental health challenges (91%). One-quarter (25%) reported poor or a deterioration in physical health. Ongoing family problems (42%) and relationship difficulties (37%) were also commonly reported by young adults.

Supports accessed by young adults

There was little variation in the type of supports accessed according to age, with 69% of young adults accessing formal supports following their loss.

Barriers to accessing support for young adults

While 38% of young adults reported feeling that they could cope themselves without additional support from services, a number of barriers to accessing support services were reported. These reflected feelings of perceived stigma, including a reluctance to ask for help (50%), not feeling their grief was important enough or that they didn't deserve help (40%), low mood (38%) and personal shame (32%).

Approximately one-third (31%) reported that nothing was offered them. A lack of time (37%), the cost of support (36%), long waiting times (21%) and difficulty finding information about services (17%) were more often reported by young adults.

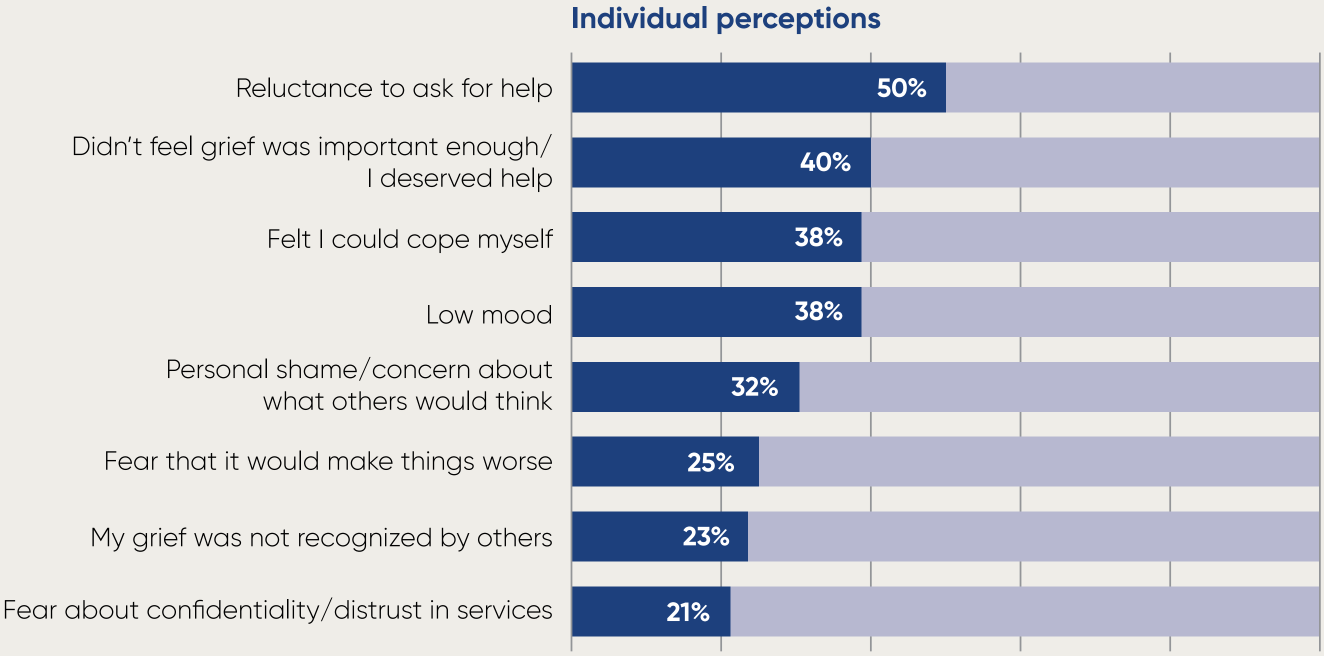


Figure 15a. Barriers to accessing support for young people

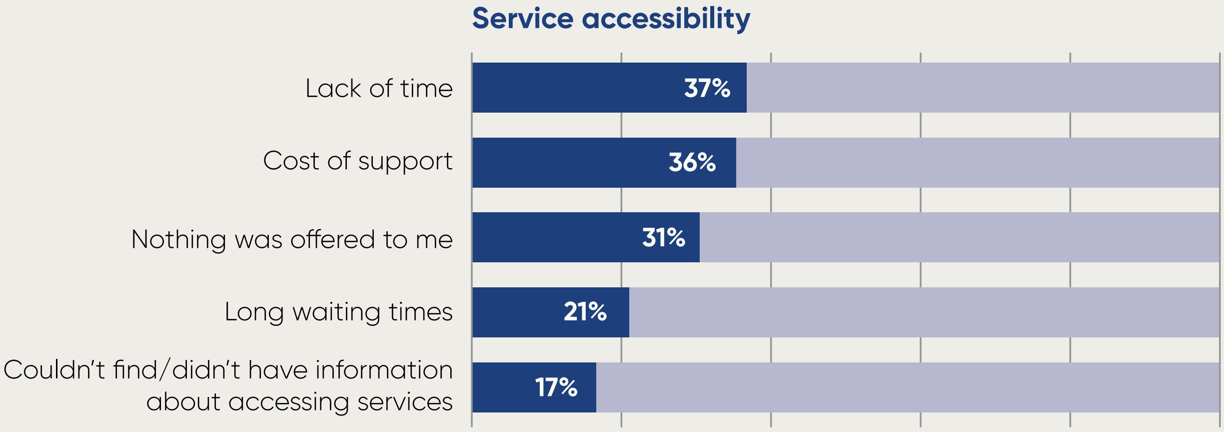


Figure 15b. Barriers to accessing support for young people

Suicide bereavement in a professional role

15%

Were bereaved within their professional role

Overall, 354 participants (15%) reported being bereaved by suicide as part of their professional role, of whom 67% were female. The majority of these participants (95%) were aged 25-64 years. Of those who provided details of their occupation (n=294), the most common sectors were healthcare (34%; of whom 53% were nurses), security, defence & law enforcement (20%; of whom 93% were Gardaí) and psychology and social care (16%; of whom 45% were social workers).

Table 9. Occupations associated with loss in a professional role

Industry	% affected
Healthcare	34%
Security, Defence & Law Enforcement	20%
Psychology & Social Care	16%
Education & Teaching	8%
Community & Voluntary	7%

A large proportion of this group (63%) had also experienced loss to suicide in a personal capacity such as family members, friends, colleagues and acquaintances. Over half (63%) of these participants had lost between one and five people to suicide in their professional role. Approximately 14% had experienced 16 or more deaths by suicide.

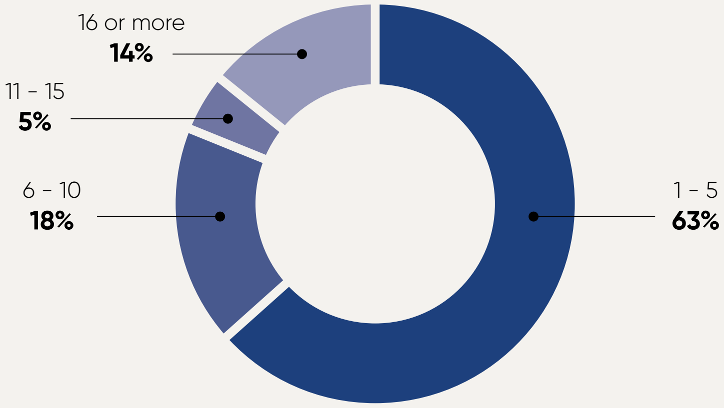


Figure 16. Number of bereavements reported by professionals

These participants reported a similar prevalence of impacts of the death compared to all participants, with mental health challenges being most prominent. Just under half (46%) reported the loss had a moderate impact on their lives while over a quarter (27%) felt the loss had a major impact on their lives.

Table 10. Common impacts of loss in professional role

Impact	%
Mental health challenges	73%
Use of alcohol*	36%
Relationship problems, including the avoidance of relationships*	35%
Family problems*	32%
Poor or deterioration in physical health*	28%

*for more than three months.

Compared to all participants, those experiencing loss in professional role tended to access fewer supports including from friends and family (81%). Overall, 44% did not access formal supports. However, they accessed more support in the work environment (60%). This was largely accounted for by support from colleagues (56%), while support from employer was accessed by 17%.

In terms of reasons for not accessing support services, more than half of professionals (54%) felt they could cope themselves. The most common barriers to accessing support services were nothing being offered (22%); reluctance to ask for help (22%); lack of time/ unable to take time off work (20%); not feeling grief was important enough or that they deserved help (19%); grief not being recognised by others (17%); personal shame/ concern about what others would think (17%) and cost (14%). Of those bereaved during the pandemic, 18% felt the COVID-19 restrictions were a barrier to accessing support services.

Support information

Support for people in crisis

- If you, or someone you know, needs support or is in crisis, contact your local GP.
- In an emergency, go to/contact the Emergency Department of your nearest hospital or ring 999 for Emergency Services.

Pieta provides services to those who are thinking about suicide and those who have been bereaved by suicide. Free Phone 1800 247 247 (24-hour) or text HELP to 51444 (standard message rates apply). **www.pieta.ie**

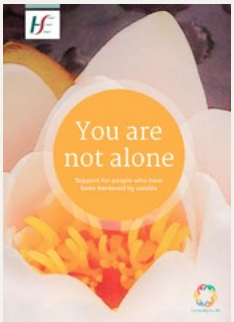
50808 is a free 24-hour anonymous messaging service for people in crisis.
Text YMH to 50808. **www.text50808.ie**

Samaritans provide a 24-hour listening service, free of charge.
Phone 116 123 or email **jo@samaritans.org**

Support for people bereaved by suicide

The following resources contain a range of information and support options:

You are not alone: Support for people who have been bereaved by suicide
A guide which provides information on suicide bereavement and the supports available in Ireland. The guide was developed by people who have lost loved ones through suicide in conjunction with the HSE.



Access the booklet online here:

www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/news/national-suicide-bereavement-support-guide.pdf

A list of support organisations and organisations for people bereaved by suicide can be found on the HUGG website: **www.hugg.ie/find-support**

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