

# **Responding to murder suicide and suicide clusters**

## **Guidance document**



April 2011



## 1. Foreword

Suicide remains a significant public health issue in Ireland. However in the last few years in Ireland the relatively rare events of murder suicide and suicide clusters have become more prevalent. When such events occur they have often attracted high profile media coverage. There is therefore a need for a consistent and coordinated health and social care response.

This guidance document is designed to be an accessible resource for local service managers when responding to such tragic events as murder-suicide and suicide clusters.

Murder suicides occur when one person, or persons, kill others and then take their own lives. Suicide clusters emerge when a number of apparent suicides, which may appear to be unrelated, occur in a particular area over a particular time period and have common or similar method. These are sometimes referred to as 'copycat' suicides.

Whilst the HSE has a significant and often lead role to play there are many other organisations, both statutory and voluntary, which can make an important contribution. The coordination of all these efforts is therefore critical.

This document sets out our current understanding of murder suicide and suicide clusters, the evidence about their occurrence, prevention approaches and the practical steps which can be taken to respond when such a tragedy occurs. The best international evidence has been brought together in a concise and accessible format. The document offers practical steps to proactively prepare for such eventualities and sets out the responses necessary in the immediate aftermath of a murder suicide and suicide clusters.

Both murder suicide and suicide clusters require more intense and coordinated approaches within communities. As such the response is

markedly different from the ongoing efforts of many regarding individual suicides.

This guidance sets out how the key organisations need to work together to ensure that family, friends and communities receive the most appropriate and timely support.

I want to thank both the steering group and the wider reference group for their input into the production of this important guidance document.

Laverne McGuinness,  
National Director,  
Integrated Services Programme.

## **2. Executive Summary**

Murder suicide and suicide clusters are relatively rare events in Ireland.

When they occur they have a significant impact on families and communities and are subject to a high level of public and media interest.

The HSE at local level, in conjunction with other statutory and voluntary organisations, has a key role in the coordination and provision of services.

International evidence has best practice has been assessed in preparing this guidance document.

Each local health area needs to prepare a response plan so that any murder suicide or suicide cluster can be responded to quickly and effectively.

The coordination of our efforts is critical in ensuring the response in comprehensive and appropriate bearing in mind the sensitivities of families and communities.

The media has an important role to play in sensitively reporting such occurrences and the timely flow of appropriate information is critical.

The response to any such occurrence needs to be properly evaluated and assessed for future learning.

### **3. Background:**

Reach Out – The National Strategy for Action on Suicide Prevention was launched in September 2005 following extensive consultation with the public and many organisations. The 10 year strategy built on the important work of the Task Force on Suicide which reported in 1998. Both reports seek to address the increase in the numbers and rate of self harm and suicide through the 1990's and early 2000's.

Reach Out sets out 96 actions in 26 action areas across population approaches, targeted approaches, responding to suicide and research/information. The full strategy can be accessed on [www.nosp.ie](http://www.nosp.ie) .

The causes of suicide are complex and are likely to involve psychological, biological, social and environmental factors. However the act of suicide is largely one based on an individual's decision to end their own life. The impact of any suicide on family, friends or communities is substantial. Occasionally the connections between friends, family and community can have a 'contagion' effect leading to, clusters or emerging clusters, of suicides.

Research evidence shows that these contagion effects are negatively reinforced by inappropriate media reporting of suicide.

However, rarely, is suicide either directly or indirectly associated with the death of others.

Rationale:

In the last few years the phenomena of suicide clusters and murder-suicides have become more prominent in Irish society. Whilst numbers involved are small, the impact can be devastating on family networks and communities. Such tragedies are of significant public interest and are reported as such by the media.

Many organisations both statutory and voluntary become involved at local level in developing a response to support communities and raise awareness about the signs of potential suicidal behaviour. Often a senior HSE manager in the local area is called upon to coordinate a multi agency response.

In September 2008 Dr. Patrick Doorley, National Director of Population Health and Ms. Laverne McGuinness, National Director of Primary, Community & Continuing Care agreed to the establishment of a time limited group to further explore this phenomenon. A small steering group was established to lead the work. This was headed by Geoff Day, Director of the HSE National Office for Suicide Prevention. A larger reference group of key stakeholders was also established, chaired by Martin Rogan, National Care Group Manager for Mental Health.

Terms of reference and membership are attached at Appendix 1.

The steering group held regular teleconferences and meetings to progress the work. The reference group met on 2 occasions.

#### Aim of the Guidelines

- They will be used as a planning tool to guide the HSE and its partners in preparing an effective response to critical events where there has been the loss of a life or lives through murder suicide or suicide clusters;
- They will set out the actions that need to be considered in order to develop a psychosocial response plan which will be followed in order to ensure a timely, appropriate and co-ordinated response to critical events

#### 4. Prevention

Research shows that in most cases of suicide, it is a combination of risk factors, listed below, that contributes to increased suicide risk. Rarely is one single factor associated with suicide risk. Similarly with regard to prevention of suicide, the more protective factors that are present, the greater the likelihood of preventing suicide.

Key elements of prevention

##### Risk Factors

Mental illness  
Attempted suicide (deliberate self harm)  
Substance misuse  
Chronic Physical Illness  
Personality traits  
Unemployment  
Socio Economic Deprivation  
Pregnancy and abortion

##### Protective Factors

Coping skills  
Reasons for living  
Physical activity and health  
Family connectedness  
Supportive schools  
Social support/values  
Religious participation  
Employment  
Access to treatment by a health professional



[Summary taken from Risk & Protective Factors for Suicide and Suicidal Behaviour: A literature review published by Scottish Government Social Research 2008. [www.scotland.gov.uk/socialresearch](http://www.scotland.gov.uk/socialresearch)]

Research had identified a number of interventions with positive outcomes in terms of reduced rates of deliberate self harm and suicide.

- Physician education in depression recognition and treatment
- Restricting access to lethal means
- Gatekeeper education and training (clergy, school, military, Gardaí, pharmacists, HSE personnel)
- Identification of at risk individuals e.g. youth screening
- Treatment of psychiatric disorders
- Psychotherapy in particular Cognitive Behaviour Therapy and Problem Solving Interventions for self harm patients
- Follow up care after suicide attempts
- Appropriate media reporting

[Suicide Prevention Strategies – A Systematic Review. J. John Mann et. al. Journal of the American Medical Association Vol. 294, No. 16. October 26, 2005. [www.jama.ama-assn.org](http://www.jama.ama-assn.org)].

## **5. Murder suicide and suicide clusters – some definitions**

In this document we use various terms to explain those suicides which also involve the death of others, either directly or indirectly.

In Ireland, as in most other countries, such occurrences are rare.

When they occur they can be described as being in one of the following categories.

### **Direct consequence:**

These events are often described generally as murder suicides (sometimes called homicide suicide) as they involve one person killing others and then ending their own lives.

- i) Familial suicide – The killing of one’s child(ren) and spouse/partner, followed by suicide.
- ii) Filial suicide – The killing of one’s child(ren) followed by suicide.  
Such deaths may also be referred to as follows:
  - filicide – involving children aged 1 to 18 years
  - infanticide – involving children up to 1 year
  - neonaticide – involving children within the first 24 hours of birth
- iii) Extra familial suicide – the killing of one or more others (usually not related) followed by suicide.

### **Indirect consequence:**

- i) Suicide Clusters (sometimes referred to as contagion suicides or copycat suicides) – a number of suicides which may appear to be unrelated but which occur in a particular area and time, have common method or are in response to defined stimuli.

- ii) Suicide Pacts – a mutual agreement between two or more people to kill themselves at about the same time.

Whilst direct and indirect consequence events may differ this report discusses both as in addition to clear differences, there are also common factors to take into account in risk assessment, intervention, prevention and responding after an incident.

However it is also clear that in responding to these events local differences in the approach taken may be required based on the individual circumstances and the services available. This document can only set out a framework within which local responses can take place.

## 6. Suicide mortality

The Central Statistics Office (CSO) is responsible for collecting and analysing data on suicides. This is provided in the form of annual data by year of occurrence and annual data by year of registration. The latter is regarded as provisional data which usually is lower (both in number and rate of suicide) than year of occurrence data.

The latest data for suicide deaths is available on [www.cso.ie](http://www.cso.ie) and is also included in the National Office for Suicide Prevention Annual Report available on [www.nosp.ie](http://www.nosp.ie)

**Table 1**

Suicide, undetermined death, death by external cause, death by all causes, 2002-2007, per 100,000 total population

Year	Suicide		Undetermined		Death by external cause (ICD9: E800-E999)		All deaths	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
2002	478	12.2	88	2.2	1768	45.1	29683	757.8
2003	497	12.5	87	2.2	1601	40.2	28823	724.4
2004	493	12.2	81	2.0	1594	39.4	28665	708.9
2005	481	11.6	134	3.2	1745	42.2	28260	683.6
2006	460	10.8	82	1.9	1664	39.2	28488	671.9
2007	458	10.6	119	2.7	1759	40.5	28117	648.0

Provisional death data by year of registration

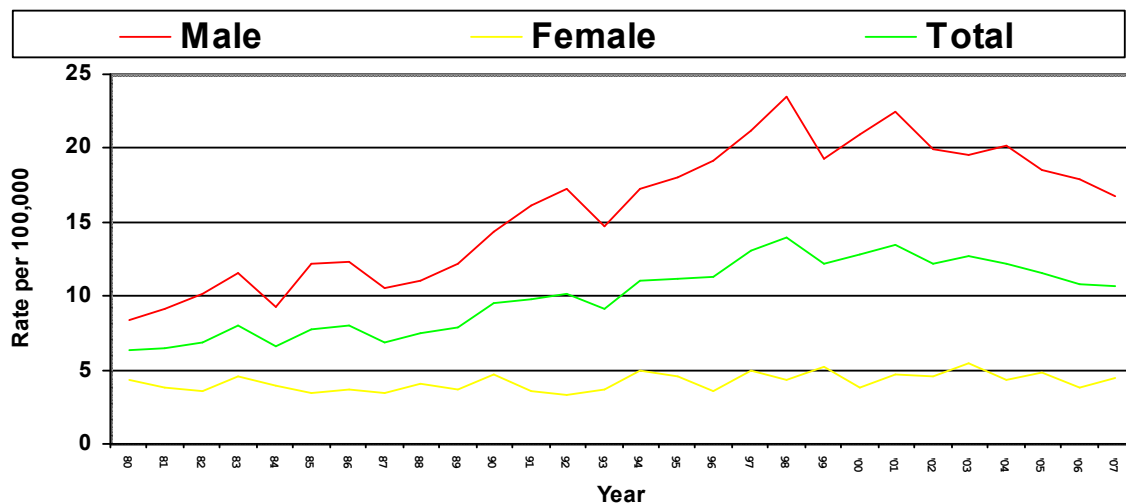
2008	424	9.6	181	4.1	1663	37.6	28192	637.5
2009	527	11.7	195	4.3	1894	42.2	28898	643.7

Points of note:

- The suicide rate has declined in recent years, from 12.5 per 100,000 in 2003 to 10.6 per 100,000 in 2007.
- Deaths by suicide account for 26% of all deaths by external causes
- Over twice as many males (n = 1252) died due to external causes compared with females (n = 507). The gender difference is more significant in deaths by suicide, where almost four times as many males (n = 363) died by suicide compared with females (n = 96).
- Caution is urged in comparing the deaths registered in 2009 with those registered in 2008, particularly deaths from an external cause. The increase from 2008 to 2009 in suicides (from 424 to 527), undetermined deaths (from 181 to 195) and all external causes (from 1663 to 1894) is likely in part to be due to a change in methodology employed by the CSO to record deaths registered in a calendar year. Specifically, the 2009 data includes deaths with a provisional cause of death. The 2008 data does not include these deaths.

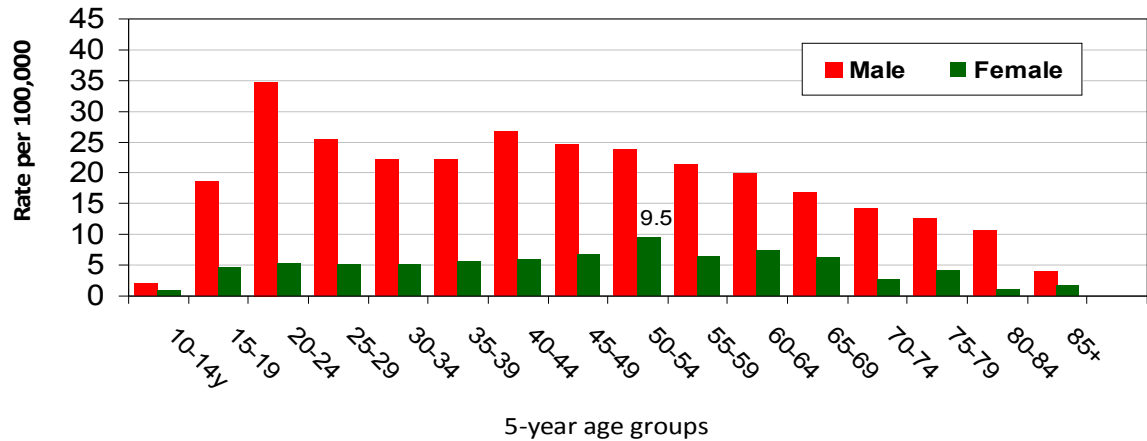
**Figure 1**

Suicide rate per 100,000 population by gender, 1980 to 2007



**Figure 2**

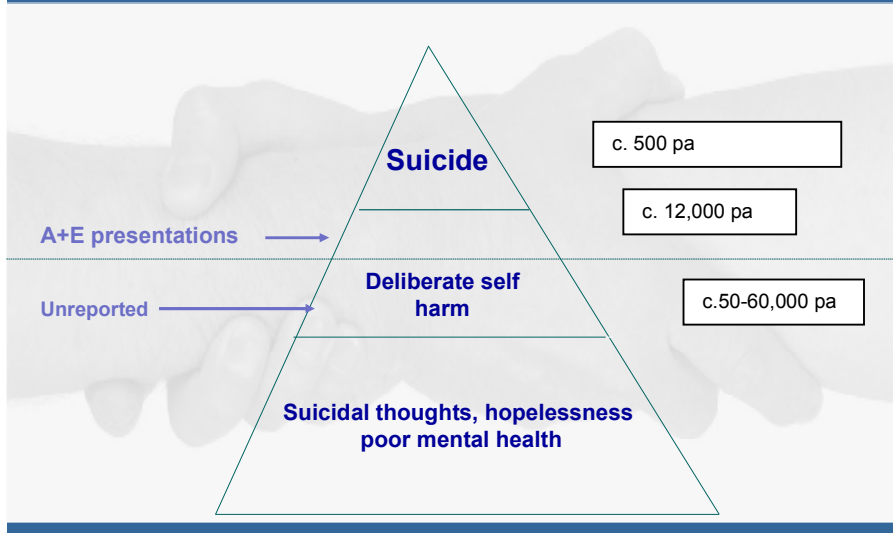
Average annual suicide rate per 100,000 by age and by 5-year age groups (2002-2007)



CSO figures for undetermined deaths may also include deaths which a Coroners inquest has been unable to conclude as a suicide 'beyond all reasonable doubt'.

Presentations of deliberate self harm to hospital emergency departments have remained stable at around 11,000 until 2006. Since then numbers of presentations have increased to nearly 12,000 in 2009. The Annual Report of the Registry of Deliberate Self Harm is available on [www.nsrh.ie](http://www.nsrh.ie). It has been estimated that annually a further 60,000 cases of deliberate self harm are not brought to the attention of the health services in Ireland.

## Extent of potential suicidal behaviour



A suicide can only be classified following a coroner's inquest. Where a murder has taken place these figures will be separately classified by the CSO i.e. not as a suicide.

The Central Statistics Office does not separately classify murder-suicides or clusters.

From anecdotal information throughout Ireland we estimate that there have been over 10 murder suicides in the last 7 years. As clusters are also difficult to quantify our best estimate is that there could have been up to 10 clusters in the same period.

## 7. Research Evidence

Suicides which involve the killing of others (family or non family) are rare occurrences worldwide. However, when they do occur they impact greatly on families involved and on their local communities. They also attract significant public and media interest.

Due to the small numbers involved in any one country systematic research in this area has been difficult, the most relevant research being retrospective analysis of such events.

Coid (1983) in a review of 17 studies from 10 nations concluded that murder suicide (including familial and filial) occurred at an average rate of 0.20 to 0.30 per 100,000 population. A recent review of the worldwide literature shows an incidence rate of murder suicide under 0.001 % (Eliason 2009).

The National Suicide Research Foundation has further examined the research literature in this area by looking at 21 published studies and 3 reviews, 15 of which were published after 2000.

Findings from this review of the literature indicate

- Perpetrators of murder suicide are most commonly male
- The mean age of perpetrators is between 40 and 50 years (age range 19-86 years)
- Fathers are the main perpetrators of filicides involving more than one child
- Fathers are the main perpetrators of filicide in age range 4-15 years
- Fathers rather than mothers are more likely to take their own life/attempt suicide
- Two-thirds of fathers killed or attempted to kill their spouse/partner (none of the mothers did so)



- Fathers who kill their children are usually older (mean age 38.2 years) than mothers (mean age 31.8 years).

(Eliason 2009; Shackelford et al 2008; Bourget et al 2007; Hatters et al 2005; Palermo 2002; Collins 2001; Wilson et al 1995).

The most significant factor associated with familicide/filicide was that 80% of parents had a history of psychiatric symptoms (particularly mood disorder) (Eliason 2009; Bourget 2007; Hatters et al 2005; Collins 2001). Seventy per cent of mothers and thirty per cent of fathers had previous contact with psychiatrist or other mental health care professional (Bourget 2007; Harper et al 2007; Hatters et al 2005). In terms of previous suicidal behaviour, parents involved in filicide show higher rates of prior non-fatal suicide acts compared to those who take their own lives but not the lives of others (Bourget 2007; Hatters et al 2005; Collins 2001).

Non-fatal suicidal behaviour is more common among adults involved in filicide compared to those who engage in suicide and who do not take the lives of other.

Other relevant factors from the available research

- 30% of fathers had recently experienced a decrease in status at work or job loss.
- 90% mothers and 60% fathers identified a desire to alleviate real or imagined suffering in their children
- Substance abuse is frequently reported in relation to murder suicide cases (range 10-31%).

(Eliason 2009; Bourget 2007; Hatters et al 2005; Collins 2001).

It is rare that a murder-suicide victim is unknown or unrelated in some way to the perpetrator. However, in extrafamilial suicide perpetrators often kill fellow employees, students, doctors, etc., before killing themselves. They may know them personally or be present at a particular location when the perpetrator

acts. Such events are often precipitated by a perceived rejection or humiliation. Such events are virtually unknown in Ireland, where they do occur they are often to be associated with the availability or use of firearms e.g. Dunblane school killings in Scotland, killings in Hungerford, England and Columbine killings in the U.S.A.

### Suicide Clusters:

Suicide clusters are sometimes referred to as contagion suicides or copycat suicides, denoting imitative behaviour.

There is significant research on imitative behaviour as a risk factor for suicidal intent. This is especially so amongst children, adolescents and young adults (Insel & Gould 2008; Johansson et al 2006; Gould et al 1994; Gould et al 1990). All forms of communication can be effective in influencing imitative behaviour, but of particular relevance are TV/radio, newspapers and more recently the internet (Biddle et al 2008; Stack 2005; Stack 2003).

Clustering is more common amongst adolescents and young adults. However defining any particular set of events as a cluster is difficult, firstly because the available data may not be reliable and secondly because of the relatively low numbers involved. It may be more appropriate therefore to refer to 'emerging' clusters and put in place a response strategy accordingly. Gould suggests such a strategy is threefold

- convene a multi agency coordinating committee
- deliver a public response which is balanced and appropriate
- evaluate the counselling/treatment needs of close friends and high risk persons.

The most publicised recent 'emerging' cluster took place in Bridgend, South Wales where 17 suspected suicides of young people took place within 1 year. The media coverage over the period was substantial. An enquiry has been established to examine these deaths of young people.

### Suicide Pacts:

A suicide pact is a mutual agreement involving pairs of individuals or large groups, who agree to kill themselves at the same time and usually in the same place. However, the recent emergence of cyber-based suicide pacts, in which individual pact members agree to die by suicide at about the same time, but not necessarily at the same place, means that a more liberal definition may need to be borne in mind to take these current trends into account (Canterbury Suicide Project 2005). There appear to be two types

- Death is mutually agreed upon and both parties act independently.
- One person coerces the other into being killed, or to kill the instigator first and then kill themselves. Such relationships can be regarded as having a dominant and submissive member.

Like murder suicides, pacts contain an element of aggression in one of the parties. In recent years suicide pacts have become more common among young people and there have been a number which have been agreed through the internet and in particular through social networking sites.

In England/U.S.A. suicide pacts account for 0.28 to 1% of all suicides. There appear to be common characteristics (Fishbain & Aldrich 1985; Brown & Barraclough 1999).

Specific factors associated with suicide pacts:

- Mental disorders, in particular mood disorders and substance abuse are common among people who enter suicide pacts
- Chronic physical illness is frequently reported in relation to suicide pacts

- There is a union between those involved, described by Hemphill & Thomley (1969) as the encapsulated unit.
- Members of this unit become isolated from society, communicating only with each other.
- If the unit is threatened by dissolution, for example by loss of a partner due to illness, members agree to die rather than be separated.

(Brown & Barraclough 1999; Brown & Barraclough 1995; Milin & Turgay 1990; Fishbain et al 1984; Hemphil & Thornley 1969).

More recently in Ireland the phenomenon of internet suicide pacts has emerged whereby two or more people meet on the internet and agree to take their own lives, at or around the same time, but not necessarily in the same place.

## 8. Learning from our own and others' experience

The group considered the recent experiences in Ireland of responding to murder suicides e.g. Wexford and emerging clusters e.g. Wexford, Meath, Mayo, Cork.

These were achieved through relevant presentations to the group and examination of written material where available.

Three Irish reports are relevant here

- Redacted Report of the Monageer Inquiry 12/5/09 – [www.dohc.ie](http://www.dohc.ie)
- Report of the Independent Inquiry Panel, Madeleine & Laura O'Neill – May 2007 (27/3/08) [www.whssb.n-i.nhs.uk](http://www.whssb.n-i.nhs.uk)
- Responding to Critical Incidents - January 2008 [www.education.ie](http://www.education.ie)

Other relevant reports

- Surgeon General's call to action (US) [www.surgeongeneral.gov](http://www.surgeongeneral.gov)
- Centre for Disease Control (US) [www.cdc.gov](http://www.cdc.gov)
- Critical Incident Psycho-social Response Services Framework for Donegal – HSE
- Psycho-social Care Response for Major Emergencies in the Counties of Cork and Kerry – HSE
- Community Response Plan for Omagh District Council Area following Suicide – Omagh District Public Health Agency (2010).

## **9. Guidance for the Management of Murder-Suicide and Suicide Clusters at Local HSE Level**

National and international good practice has shown that critical incident planning must be based on the local organisation and culture. Plans must be tailored and localised. The response required for a murder suicide is different to a suicide cluster and cognisance must be paid to this in the development of response plans. It is not possible to take a plan from another service and just change the names. Each part of the organisation must develop its own plan.

Any plan will be underpinned by the relevant actions referred to in the Reach Out Strategy. The activity of developing this response plan may be managed by the Steering Group on Suicide Prevention/Mental Health Promotion if such a group is operating in the area. If no such group exists a new group will need to be established to develop a response plan.

### **Leadership:**

Any complex enterprise needs a clear leading control structure. At such a fraught and sensitive time staff and the members of the affected community will require leadership and reassurance. This is likely to be provided by a local senior HSE manager.

The senior HSE Manager locally or their nominee will be responsible for the development of the action response plan in their area. This includes:

- development of the plan
- the identification of resources
- activation of the plan
- the establishment of a response team
- the engagement and utilisation of other statutory, voluntary and community supports
- reviewing the response with a view to scaling down or deactivating the plan
- the deactivation and stand down of the response plan

- reporting significant national or strategic issues

### Development of the Response Plan

The immediate aftermath of a tragedy is not the time for introductions. Statutory, community, and voluntary leaders need to meet in advance to discuss their roles in the event of community trauma.

### Who will be involved in developing this plan?

It is well recognised that suicide is a very complex problem and that no single agency or group has the resources to tackle this problem alone. A multi-agency response is required.

An advisory group should be established including relevant HSE staff and appropriate representation from other statutory and voluntary organisations. This will need to be locally determined. Some initial planning by key HSE staff will be required before establishing an advisory group.

### Within the HSE:

The response plan must reflect the statutory and other responsibilities of the HSE including

- Major Emergency and Planning Policy
- The Serious Incident Management Policy & Procedure
- Developing and Populating a Risk Register
- Child Protection policies – when involving children under 18
- Health and Safety policies
- HSE Risk Management policy
- Protocol on the management of suspected suicides in an inpatient Psychiatric Unit.

### Interagency Protocols

It is important to foster a sense of working together for the benefit of all concerned. If they are not already in place, this may be an opportune time to develop interagency protocols to explore good practice and the best way in which to respond to issues such as:

- The referral process – making and receiving referrals
- Confidentiality
- Information sharing
- Maintaining specific agency responsibilities

In many situations where death requires further explanation or analysis agencies will be required to preserve evidence, make technical examinations and conduct difficult enquiries. Active HSE personnel should be aware of the obligated roles of Gardaí, Coroner Services and others and facilitate colleagues from other agencies in their duties.

#### The role of Specialist staff:

The Resource Officer for Suicide Prevention has a key role.

They will be able to provide advice and information to the Advisory Group about the likely impact of a suspected suicide or cluster, the resources likely to be required and the organisations at regional and local level which may be in a position to support HSE services.

They should also

- Provide advice to the local response team on best practice in prevention and response after a tragedy
- Act as a support to statutory, voluntary and community groups when responding to a crisis
- Ensure that information and resource materials are up to date and easily available



- Deliver or organise appropriate and relevant education and skills-based training programmes
- Work with HSE Communications to indicate the potential media impact and best practice

### National Office for Suicide Prevention

The National Office for Suicide Prevention has a strategic role in the delivery of the actions laid out in Reach Out - The Strategy for Action on Suicide Prevention, 2005-2014. The NOSP role is to commission services and provide research and information in relation to all aspects of suicide and mental health promotion. The Office should also be informed of the long term implications of actions taken so that future policy can be influenced.

### Devise a response plan

Based on the identified risks and needs, a range of initiatives may need to be put in place. These include:

#### Support Services:

- immediate practical help
- information on existing helplines e.g. Samaritans
- psychological support
- bereavement support
- Fast track referral to specialist clinical services.

### Develop framework and plans prior to an incident

For the purposes of planning practical care, it has been found useful to do so in terms of three phases. These are:

The Immediate aftermath (0-24 hours)

The Reactive Period (12 hours to one week)

The Outreach Period (weeks, months, years).

It is important that the response plan identifies both the immediate, short-term needs, as well as the ongoing medium to long term needs of those affected.

#### Cultural Differences & Other Needs:

In preparing guidance cognisance needs to be taken of cultural differences, working in a language other than English, working with individuals with disabilities, etc.

#### Training Requirements:

Identify the skills required by the Team in order to respond effectively e.g.

- Psychological First Aid (a set of skills that help communities care for their families, friends, neighbours and themselves by providing appropriate psychological support)
- Screening for Post Traumatic Stress Reactions, suicide risk, risk of self-harm, other psychological reactions
- Bereavement Support Skills
- Note taking and record keeping
- Dissemination of key consistent messages e.g. availability of support services, response to traumatic events, advice to parents, dispelling myths, etc.
- Children First Guidelines
- Media & communication skills training

Establish what training needs to be put in place to develop and sustain these skills. Induction sessions should be conducted to clarify expectations of skilled volunteers should they be required.

### Working with the Media:

The media in all its forms has a powerful role to play in responding to suicide events. They can support communities by sensitively reporting the issues and providing approved information.

However the media can equally be unhelpful by sensationalising the event and by inappropriate reporting. At its worst, inappropriate media reporting can lead to imitative suicidal behaviour. (See section 10 Role of the Media).

A communications plan needs to be put in place providing a timely flow of accurate, appropriate information. It must include:

- a) An internal notification system in the event of a suspected murder suicide or suicide cluster.
- b) A plan for communicating information to the HSE, external agencies, the wider community and the media. This will often dispel rumours and help put the situation into perspective. It will allow the opportunity to publicise sources of help and useful information. Identify a spokesperson(s) to communicate information to the print and other communications media. Explore suitable mediums of communication i.e. the print media, television, radio, internet, intranet, etc.

### Helplines:

There is little current evidence for the effectiveness of crisis helplines (Youth Suicide Prevention, Health Development Agency, 2004, [www.nice.org.uk](http://www.nice.org.uk)). However such helplines can be useful in reassuring the public that there is professional help available. Existing helplines should be used unless there is a clear need for a new and separate helpline. In previous similar situations Console, the bereavement support organisation, has staffed its phone line (1800 201 890) for extended hours so that the number can be made available to the public. An appropriate grant will need to be made available to Console to cover the extra costs of counsellors on the phone line.

### Working with schools:

Insufficient evidence has been found to recommend universal (non-targeted) school based suicide prevention programmes or programmes applied to high-risk groups. In fact some studies have found that classroom based suicide prevention programmes can have potential negative effects, especially among at-risk males (Youth Suicide Prevention, Health Development Agency, The Institute of Public Health in Ireland, 2004). A whole school approach to promoting positive mental health is recommended instead.

Research on the effectiveness and safety of psychological intervention following traumatic events in schools is very limited. Critical incident stress debriefing and critical incident stress management are often used in schools for students affected by suicide, accidental death and trauma.

There is a lack of controlled studies to prove the effectiveness or safety of these interventions in schools. Given our current knowledge, the following is recommended:

- A sense of safety
- Calmness
- A sense of self and community efficacy
- Connectedness
- Hope

The role of the National Educational Psychological Service (NEPS) is critical here and any suspected suicide in a school setting must involve NEPS.

A number of good practice guidelines are available to support work with schools. These include:

- Responding to Critical Incidents: Guidelines for Schools (NEPS) – available on [www.education.ie](http://www.education.ie)

- Draft Guidelines for Schools Selecting Programmes from External Providers (NOSP) – available on [www.nosp.ie](http://www.nosp.ie)
- Guidelines for Mental Health Agencies Working with Schools (NOSP) [www.nosp.ie](http://www.nosp.ie)

#### Evaluation & Review:

Put in place a system in which to record activities.

Review the effectiveness of the response by identifying:

- What worked well?
- What areas need improvement?
- What could be done differently in the future?

Revise the plan in light of the community's experiences of using the plan or new knowledge or information.

## **10. Implementing the Plan**

### Monitoring the situation

It is important to remember that any developing incident can only be described as a 'suspected' suicide, as it is the Coroners Inquest which determines the actual nature of death and records a death as suicide as appropriate.

### Murder-suicide:

As this is likely to be a once off dramatic event, the HSE is likely to be notified by the Gardaí without much advance warning. There may be initial media speculation or more likely indications from within the local community. The local HSE senior manager or nominee should keep in close contact with the Gardaí. They will initially assess the incident as a crime scene but may very quickly require HSE or other agency support. The extent of the support offered to family and community will need to be determined locally but is likely to be intense and over a relatively short period of time. Where extended family require to be offered support this may be in another HSE area or abroad.

### Suicide clusters:

The very nature of suicide clusters is that they develop over time. This may take many months or even longer. Information will almost certainly be gleaned from a variety of sources, including communities, schools, HSE staff (Resource Officer for Suicide Prevention, Clinical services, etc.), and voluntary organisations as well as from the Gardaí. Unlike murder-suicide the HSE and community response is likely to be more extensive e.g. a number of families, friends and community networks and over a longer period of time.

In both situations it will be important to try and define the extent of the incident so that the response plan, when activated, can meet the needs of those identified.

#### General:

The overall response should be conducted in a manner that avoids glorification of the suicide and minimises sensationalism. To do otherwise might increase the likelihood that someone who identifies with the deceased or who is having suicidal thoughts will also attempt suicide, in order to be similarly glorified or to receive similar positive attention.

It is important also to avoid vilifying those who have died by suicide in an effort to decrease the degree to which others might identify with them. In addition to being needlessly cruel to bereaved families, such an approach may only serve to make those who do identify with those who have died more isolated and friendless.

People at risk should be identified and offered support. This must be given in a professional and sensitive manner bearing in mind that the family in particular may not recognise the death as a suspected suicide. This may include:

- The immediate family(s) bereaved by a suspected suicide
- Close friends, relatives, work colleagues
- School community
- Witness to the event or person(s) involved in the discovery of body(s)

#### The Wider Community:

- Other people in the community who may be vulnerable at this time e.g. families who have lost relatives to suicide in the past, others who are mentally unwell, actively suicidal, etc.

- Concerned parents seeking advice on how to support their young people

Support for these individuals may already be provided by the HSE and if not such support will need to be prioritised within the resources available. Local GPs and Voluntary agencies may be able to assist in the support of individuals not requiring HSE support.

### The 3 Phases of Response

#### The Immediate Aftermath (0-24 hours)

- If it has been established that a cluster is emerging through an agreed reporting mechanism the co-ordinating committee will need to be convened. At this meeting the committee will decide whether it is appropriate to implement the agreed community response plan.
- Immediately notify those agencies whether voluntary community based or statutory who will have a role in implementing the response plan and who may not be part of the co-ordinating committee.
- Review and agree the responsibilities and roles of each of the key participants in responding. This will provide clarity as to what each individual and agency is doing.
- Consider and put in place the provision of supervision to support the committee and responders to the cluster. This will be particularly important should other suicides occur during the response period
- Nominate one person from the co-ordinating committee who will act as media spokesperson/liaison
- People considered to be at high risk in the community should be identified where possible by local services and appropriate responses/interventions be put in place.

It may be helpful to assess the level of trauma in a community and identify those most at risk by using the “circles of vulnerability” model. The model identifies 4 groups who could potentially be vulnerable follow suicide(s):



- Geographical proximity: This is the physical distance a person is from the location of the incident. It also includes eye witnesses, those discovering or exposed to the aftermath of the event.
- Psychological proximity: This relates to the level of identification an individual has with the victim(s). Examples include classmates, members of a football team, etc. It also includes those who view the deceased as a role model e.g. celebrity, prominent athlete, etc.
- Social proximity: This refers to the relationship with the deceased e.g. family, friends, and those part of the same social circle.
- Population at risk: These include individuals exposed to the traumatic event who also have pre-existing vulnerabilities e.g. mental illness, prior suicidal behaviour, etc.

Other factors which may lead to someone being of greater risk include:

- Facilitation of the suicide through supportive actions
  - Failure to identify the signs of suicidal intent
  - Feeling responsible for the death
- Identify relatives of the deceased and provide them with an opportunity to meet with an appropriately trained support person.
  - A similar support structure should be available to boyfriend/girlfriend, close friends, school friends, fellow workers and others who are impacted by the suicides.
  - At the end of the immediate period review actions taken and plan for the next stage

#### The Reactive Period (12 hours to 1 week)

- Advertise the existence of help line support that may be currently available in the community. In some circumstances a special help line may have to be set up for a defined period of time.

- If counselling services are not available to the community it may be necessary to consider the use of accredited counsellors supported by local mental health professionals in drop in centres which are easily accessible to the public (schools, church's, community centre) who may be impacted by the recent deaths.
- Consider the provision of a community meeting event (Crisis Management Briefing, CMB) during which information on signs and symptoms of stress/distress can be provided along with information about local services both statutory and voluntary and how they may be accessed.
- It may be appropriate to provide support to appropriate groups during this period e.g. sporting organisations, clubs, associations, school friends, etc which have been impacted.
- Engage the local media proactively in publishing information relating to available supports and other relevant information e.g. bereavement information, concerned about suicide leaflets etc.
- Ensure that critical incident stress debriefing/counselling/supervision is available to all responders to the suicide cluster
- Consider the provision of fast track expert mental health service support and advice to primary care services who may be dealing with an increase in presentations with of people in severe distress and appear at risk.
- Continually monitor uptake of services and adapt or modify plan as appropriate to the local requirements
- Review the actions taken and knowledge gained from the implementation of the actions in the reactive period.

#### The Outreach Period (weeks, months, years)

- Ensure continued support for those persons who have presented for support during the reactive period

- Implement relevant training at a community/voluntary and statutory level relating to suicide prevention and postvention to equip the whole community in addressing suicide prevention at a local level.
- Develop local suicide prevention action plans at a cross community level providing local responses to local issues
- Develop and support appropriate services which may have been identified as lacking during the reactive period e.g. bereavement counselling

#### Clarity about Role and Function:

Each person on the team needs to be clear about their role and function, to avoid confusion and/or possible conflict. The Senior HSE Manager or their nominee will:

- Convene the group and select its core membership
- Chair the group or agree another agency to chair
- Ensure implementation of agreed actions through HSE or other agencies
- Resource the HSE delivery of these actions where appropriate
- Activate and de-activate the response plan
- Monitor, evaluate and review local responses to an actual event
- Convene a review meeting on an annual basis to update information and test systems and plans

The core response team will comprise could include:

#### HSE:

- Senior HSE Manager locally or nominee – to chair
- Resource Officer for Suicide Prevention
- Psychological services
- Mental Health Services – Adult and/or Child & Adolescent
- Primary Health Care Services

- Social Work Service
- Health Promotion
- Internal Communications

#### Possible External Agencies

- Gardaí
- NEPS (if response is required in a school setting)
- Bereavement Support Services (HSE or voluntary organisation)

These are the key services /agencies most likely to be involved in the initial crisis response. Other statutory, voluntary and community services may be involved depending on the nature of the crisis and in meeting the medium and longer term needs of the community. These could be any of the following depending on circumstances;

- Parents groups
- Local voluntary sector/community organisations
- Education
- Youth services
- Clergy
- Funeral Directors
- Local sporting organisations e.g. GAA
- Student representatives e.g. USI Welfare Officers
- Military personnel
- Local government
- Office of Public Works
- Irish Rail
- Irish Water Safety

## Confidentiality

Even though the events surrounding murder-suicide or suicide clusters are often very much in the public domain it is still important to ensure that the policy on confidentiality is maintained. This is particularly important regarding publicising details of any contact with HSE services by the family or individuals.

## Impact on existing services:

In responding to an adverse event, local managers will almost certainly need to divert existing resources to respond on an emergency basis. A decision may be made to ask appropriately skilled staff to focus on providing an effective response. This may impact on scheduled and routine service provision in the short term. The relevance of such transfers will need to be closely and regularly monitored so that scheduled routine services can resume as soon as possible.

Having a predefined plan at area level will identify community resources that can also be utilised to avoid the sole diversion and dependence on the resources of the HSE local area.

## Support for Responders:

### Ethical & Practical Issues:

It is important to be mindful that in a country the size of Ireland, it is possible for professionals, especially those working in smaller teams, to be personally affected by death(s) by suicide in their area i.e. having a direct relationship (e.g. family member, close friend, etc) or indirect relationship to the deceased (e.g. deceased attended same school as own children, neighbour in the community person grew up in, etc.). Consideration needs to be given as to whether it is appropriate and ethical for responders who have been affected to become involved in the plan, or not, or to change their role within the team. Other roles to consider include:

- Taking on a co-ordination rather than front-line role e.g. information dissemination, communicating specific key local knowledge such as using direct links with the community as a way of “gauging the temperature” of what is going on for people during this time.
- If possible and practical, to avoid being a direct key worker with persons known personally.

If a situation arises where a person is personally affected by a suicide (e.g. son, daughter, husband, wife) consideration may have to be given to the area that he or she works in and its relevance to the area of suicide.

Ensure that support services are available to persons involved in responding to the crisis if not available through their own organisations e.g. Priest, Gardaí, HSE workers.

#### Scaling down the Response

Local HSE management will need to constantly review the response to the incident to ensure the appropriate level of resources is available. Consideration will need to be given to scaling back the response at an appropriate time and in consultation with other key agencies.

#### Deactivate the Plan

The senior HSE Manager locally has the authority to deactivate the response plan. A debriefing session should be held as part of the deactivation process in order to:

- Support staff who have been involved in the response
- Consider and review the experiences of all involved
- Review the resources and effectiveness of the plan
- Identify any particular difficulties that were encountered

- Identify any training, response needs or wider implications and act on these appropriately

#### Evaluation of Response & Capturing the Learning:

Extended suicide/familicide and suicide clusters are rare events and their unexpected nature can make it difficult for responders to mobilise an ideal approach. Services should always document their experiences to continuously review practice and improve responses to supporting communities and affected families. Such material can be anonymised and made available to skilled colleagues working within an ethically monitored framework. Whilst it is fully recognised that all responders will be doing their best in the immediate situation, this information can help improve practice in responding to similar tragic events in the future.

## 11. Role of the media

The media in all its forms, print, TV, radio, internet can be helpful in responding to the tragedies described in this document by

- Raising awareness of the complexity of the issues surrounding suicide and factors contributing to the problem
- Challenging stigma associated with mental illness and suicide
- Opening discussion about suicide in the public arena to challenge the idea of it as a taboo subject
- Providing information about local or national support services
- Offering advice to families and friends about warning signs for people at risk
- Promoting the message that suicide is preventable given appropriate supports
- Considering the impact on family, friends and communities

However research also indicates that inappropriate media reporting can have a negative effect on vulnerable individuals or encourage contagion or imitative behaviour. The following should be avoided

- Sensational reporting or headlines
- Reporting which glamorises the suicide
- Front page reporting or photographs
- Mentioning suicide as a way of solving personal problems
- Inappropriate language such as 'commit' suicide or 'successful' suicide
- Explicit detail of method or location
- Simplistic explanations

The media should be requested to follow the IAS/Samaritans media guidelines – revised Guidelines were launched in October 2009. [www.ias.ie](http://www.ias.ie) or [www.samaritans.org](http://www.samaritans.org) or [www.nosp.ie](http://www.nosp.ie) - see Appendix 2 for summary.



A communications plan should be drawn up for each intervention, specifically designed to the local situation. It should include

- Regular briefings for the media with timely accurate information
- Agree identified person to contact media
- Agree media spokesperson(s)
- Ask the media to adhere to the evidence based guidelines on report suicide
- Monitor local/national coverage
- Use Press Ombudsman for complaints as appropriate.

## 12. Appendices

### Appendix 1

#### National Working Group Terms of Reference

To examine the international evidence in this area, incidence, antecedence, associated factors, context and effective responses.

To understand protective mechanisms which have proven useful in the international context.

To examine the role or potential role of the HSE and key identified partners in intervening to prevent/respond to such actions.

Develop relevant expertise within the HSE and with key identified partners in addressing these phenomena

Develop a uniform response in the event of such tragic events to support survivors, traumatised communities, HSE staff, and the wider public.

#### Working Arrangements

A two tier structure will be established to coordinate the work and to ensure the maximum input from key stakeholders

- i) A Steering Group will coordinate the work and be responsible for sourcing appropriate material, including preparation of drafts, for consideration by the Reference Group.

The Steering Group will comprise

- Geoff Day, Director, National Office for Suicide Prevention
- Martin Rogan - Asst. National Director, Office of the CEO
- Catherine Brogan - Specialist in Mental Health
- Pauline Bryan – Local Health Manager, Wexford
- Mary O’Sullivan - Resource Officer for Suicide Prevention, HSE West

The Steering Group will undertake the bulk of its work by email and teleconferencing. It may need to meet occasionally on a face to face basis.

(Sean McCarthy, Resource Officer for Suicide Prevention, HSE South deputised for Pauline Bryan on a number of occasions).

- ii) A Reference Group will offer advice and expertise to the Steering Group. Specifically they will be requested to
  - Examine/comment on the relevance and impact of international evidence

- Examine/comment on appropriate Irish documentation
- Draw on their own expertise in responding to local crises regarding extended suicides
- Comment critically on draft documents provided by the Steering Group
- Agree a process for wider consultation
- Agree a process to ensure HSE approval of agreed documentation

The Reference Group will comprise members of the Steering Group and the following

- David Gaskin, Local Health Manager, Dublin NE
- Frank Murray, Local Health Manager, Co Mayo
- Martina Queally, Local Health Manager, Co Kildare
- Peter Kieran, Specialist Child Protection, HSE South
- Angela Dooley, Person with Lived Experience – Irish National Service Users Executive
- Dr. Ella Arensman, Research Director, National Suicide Research Foundation
- Sean McCarthy, Console, Organisation supporting those bereaved through suicide (left Console March 2009 to return to HSE)
- Dr. Ann Shannon, Public Health Specialist, HSE West
- Mr. Pearse Finnegan, Project Manager, Irish College of General Practitioners
- Prof. Harry Kennedy, Clinical Director, National Forensic Mental Health Service
- Ashling Culhane, Psychiatric Nurses Association - Representative of Health Partnership

Martin Rogan has agreed to chair the Reference Group

## **Appendix 2**

### Media guidelines for reporting suicide

Summary taken from Irish Association of Suicidology/Samaritans – Media Guidelines on Reporting Suicide.

- Avoid explicit or technical details of suicide methods
- Include details of further sources of information and advice
- Avoid simplistic explanations for suicide
- Challenge the common myths about suicide
- Remember the effect on survivors of suicide
- Look after yourself
- Don't romanticise or glorify suicide
- Don't imply that there are 'positive' results to be gain by suicide
- Seek expert advice
- Use appropriate language

#### *Avoid phrases like:*

- A successful suicide attempt
- An 'unsuccessful' suicide attempt
- Commit suicide
- Suicide 'victim'
- 'Just a cry for help'
- Suicide prone person
- Stop the spread/epidemic of suicide

#### *Use phrases like:*

- A suicide
- Die by suicide
- A suicide attempt
- Take his/her life
- Kill oneself

## Appendix 3

### Websites and information resources

<i>Website</i>	<i>Organisation</i>	<i>Description</i>
<a href="http://www.aware.ie">www.aware.ie</a>	Aware	Helping to Defeat Depression
<a href="http://www.barnardos.ie">www.barnardos.ie</a>	Barnardos	Bereavement Counselling for Children is a service for children and young people who have lost someone close to them
<a href="http://www.belongto.org">www.belongto.org</a>	BeLonG To	An organisation for Lesbian, Gay, Bisexual and Transgendered (LGBT) young people, aged between 14 and 23
<a href="http://www.bodywhys.ie">www.bodywhys.ie</a>	Bodywhys	Provides support to people affected by eating disorders
<a href="http://www.cso.ie">www.cso.ie</a>	Central Statistics Office	
<a href="http://www.console.ie">www.console.ie</a>	Console	Supporting those bereaved by suicide
<a href="http://www.crosscare.ie">www.crosscare.ie</a>	Crosscare	The Social Care Agency of The Dublin Diocese
<a href="http://www.dhsspsni.gov.uk">www.dhsspsni.gov.uk</a>	Department Health, Social Service & Public Safety, Northern Ireland	
<a href="http://www.education.ie">www.education.ie</a>	Department of Education & Skills	
<a href="http://www.dohc.ie">www.dohc.ie</a>	Department of Health & Children	
<a href="http://www.glen.ie">www.glen.ie</a>	GLEN	Gay and Lesbian Equality Network
<a href="http://www.grow.ie">www.grow.ie</a>	Grow	Mental Health Movement in Ireland
<a href="http://www.hse.ie">www.hse.ie</a>	Health Service Executive	
<a href="http://www.healthpromotion.ie">www.healthpromotion.ie</a>	Health Service Executive	Online ordering service for HSE publications
<a href="http://www.inspireireland.ie">www.inspireireland.ie</a>	Inspire Ireland Foundation	An online information service to help young people aged 16-25
<a href="http://www.iasp.info">www.iasp.info</a>	International Association for Suicide Prevention	
<a href="http://www.irishadvocacynetwork.com">www.irishadvocacynetwork.com</a>	Irish Advocacy Network	
<a href="http://www.ias.ie">www.ias.ie</a>	Irish Association of Suicidology	
<a href="http://www.lenus.ie">www.lenus.ie</a>	Lenus	Irish Health Repository
<a href="http://www.livinglinks.ie">www.livinglinks.ie</a>	Living Links	Supporting those bereaved by suicide
<a href="http://www.livingworks.net">www.livingworks.net</a>	Living Works	Information on ASIST training (suicide intervention) and other programmes
<a href="http://www.mentalhealthireland.ie">www.mentalhealthireland.ie</a>	Mental Health Ireland	

<a href="http://www.nosp.ie">www.nosp.ie</a>	National Office for Suicide Prevention	
<a href="http://www.yourmentalhealth.ie">www.yourmentalhealth.ie</a>	National Office for Suicide Prevention	Website promoting positive mental health
<a href="http://www.letsomeoneknow.ie">www.letsomeoneknow.ie</a>	National Office for Suicide Prevention	Website promoting positive mental health for young people
<a href="http://www.nsrif.ie">www.nsrif.ie</a>	National Suicide Research Foundation	
<a href="http://www.pieta.ie">www.pieta.ie</a>	Pieta House	Centre for the Prevention of Self-Harm or Suicide
<a href="http://www.publichealth.hscni.net">www.publichealth.hscni.net</a>	Public Health Agency, Northern Ireland	
<a href="http://www.samaritans.org">www.samaritans.org</a>	Samaritans	
<a href="http://www.seechange.ie">www.seechange.ie</a>	See Change	To reduce stigma and challenge discrimination associated with mental health
<a href="http://www.seniorhelpline.ie">www.seniorhelpline.ie</a>	Senior Helpline	A confidential listening service for older people by older people
<a href="http://www.shineonline.ie">www.shineonline.ie</a>	Shine	Supporting People Affected by Mental Ill Health
<a href="http://www.sphe.ie">www.sphe.ie</a>	SPHE	Social, Personal and Health Education, as part of the curriculum, supports the personal development, health and well-being of young people
<a href="http://www.spunout.ie">www.spunout.ie</a>	SpunOut	An interactive website providing health, lifestyle information and signposting to support services.
<a href="http://www.teenline.ie">www.teenline.ie</a>	Teenline	
<a href="http://www.3Ts.ie">www.3Ts.ie</a>	3ts	Turning the Tide of Suicide
<a href="http://www.who.int">www.who.int</a>	World Health Organisation	

<b>Organisation</b>	<b>Web</b>	<b>Phone</b>	<b>Email</b>	<b>Text</b>
<b>AWARE:</b> <i>A service for people who experience depression and concerned family and friends</i>	<a href="http://www.aware.ie">www.aware.ie</a>	1890 30 33 02	<a href="mailto:wecanhelp@aware.ie">wecanhelp@aware.ie</a>	
<b>Barnardos:</b> <i>Bereavement Counselling for Children is a service for children and young people who have lost someone close to them</i>	<a href="http://www.barnardos.ie">www.barnardos.ie</a>	01 473 2110	<a href="mailto:bereavement@barnardos.ie">bereavement@barnardos.ie</a>	
<b>Bodywhys:</b> <i>Provides support to people affected by eating disorders</i>	<a href="http://www.bodywhys.ie">www.bodywhys.ie</a>	1890 20 04 44	<a href="mailto:alex@bodywhys.ie">alex@bodywhys.ie</a>	Text 'SUPPORT' to 53305
<b>Console:</b> <i>Supporting and helping people bereaved through suicide.</i>	<a href="http://www.console.ie">www.console.ie</a>	1800 20 18 90	<a href="mailto:info@console.ie">info@console.ie</a>	
<b>GROW:</b> <i>A Mental Health Organisation which helps people who have suffered, or are suffering, from mental health problems</i>	<a href="http://www.grow.ie">www.grow.ie</a>	1890 47 44 74	<a href="mailto:info@grow.ie">info@grow.ie</a>	
<b>Health Service Executive:</b> <i>Ireland's national health and social care provider</i>	<a href="http://www.hse.ie">www.hse.ie</a>	1850 24 18 50		
<b>Living Links:</b> <i>Providing assertive outreach support to the suicide bereaved</i>	<a href="http://www.livinglinks.ie">www.livinglinks.ie</a>	087 412 2052	<a href="mailto:info@livinglinks.ie">info@livinglinks.ie</a>	
<b>Pieta House:</b> <i>Centre for the Prevention of Self-Harm or Suicide</i>	<a href="http://www.pieta.ie">www.pieta.ie</a>	01 601 0000	<a href="mailto:mary@pieta.ie">mary@pieta.ie</a>	
<b>Rehabcare:</b> <i>A mental health promotion project which aims to contribute to suicide prevention efforts by providing timely,</i>	<a href="http://www.headsup.ie">www.headsup.ie</a>	01 205 7200	<a href="mailto:info@headsup.ie">info@headsup.ie</a>	Text "HEADSUP" to 50424

<i>appropriate information and support to young people</i>				
	-		-	
<b>Samaritans:</b> <i>A confidential 24 hour emotional support service for people who are experiencing feelings of distress or despair, including those which may lead to suicide.</i>	<a href="http://www.samaritans.org">www.samaritans.org</a>	1850 60 90 90	<a href="mailto:jo@samaritans.org">jo@samaritans.org</a>	
			-	
<b>Senior Helpline:</b> <i>A confidential listening service for older people by older people</i>	<a href="http://www.seniorhelpline.ie">www.seniorhelpline.ie</a>	1850 44 04 44		
<b>Shine:</b> <i>The national organisation dedicated to upholding the rights and addressing the needs of all those affected by enduring mental illness</i>	<a href="http://www.shineonline.ie">www.shineonline.ie</a>	1890 62 16 31		
<b>Teenline Ireland:</b> <i>A confidential listening service for young people</i>	<a href="http://www.teenline.ie">www.teenline.ie</a>	1800 83 36 34		

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