Policy Briefing

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Responding To Youth Suicide and Attempted Youth Suicide in Ireland

Barnardos

Children, their rights and their needs

Responding To Youth Suicide and Attempted Youth Suicide in Ireland

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ABOUT THIS SERIES

Recent years have brought significant growth in both public interest and government response to concerns relating to children and young people. Yet by international comparisons a serious deficit remains in Ireland's provision for children and their needs.

Barnardos is a major voluntary provider of services to children and young people –and their families – in Ireland. This imposes a responsibility to share our developing expertise with a wider audience as a contribution to the development of awareness and knowledge, legislation and policy, provision and practice in the interest of responding ever more appropriately and effectively as a community to the rights, needs and interests of our younger citizens. This task must also be underpinned by a vision of what we ultimately hope to achieve. It is Barnardos view that Ireland should aspire to nothing less than the achievement of standards of provision for children that match the best in the world. It may take a long time to achieve – perhaps even a generation – but it is no less relevant for that.

Primarily a service providing agency, Barnardos has been keen to draw lessons for policy and provision from our practice experience. In 1998, we established a Policy Advisor post supported by a Policy Steering Group representative of childcare practitioners for this purpose. Crucially, our policy positions are both informed by, and inform our direct work with children and families in Ireland.

These policies are being published as an occasional series of papers which we hope will be of interest and benefit to a broad range of professionals, parents, media, policy-makers, academics, students, legislators, and, of course, the general public. More than anything though, we hope they will make a difference, however small, to the lives of children and young people.

Owen Keenan
Chief Executive
Barnardos

RESPONDING TO YOUTH SUICIDE AND ATTEMPTED YOUTH SUICIDE IN IRELAND:

"Each day in the Republic of Ireland at least one person ends his life by suicide"[1]

"Suicide is now the second most common cause of death, after road traffic accidents, among 15 to 24 year old Irish males."[2]

1. INTRODUCTION

Facing the tragic reality of a suicide is enormously difficult and stressful for families, communities and, indeed, society as a whole. A suicide, which is often committed by someone with a family and friends who care, can evoke not only the normal emotions associated with bereavement, but also feelings of anger, confusion and the unanswerable question, why?

In the case of a youth suicide the stresses it places on family, friends and communities can be multiplied. Young suicides provoke many questions – Why would a teenage boy want to take his own life? How could he be allowed take this ultimate step without anyone being able to help? – but few easy answers.

Through Sólás, its bereavement counselling service for children, Barnardos has come into contact with youth suicides and its impact on families. While in statistical terms the problem is not large it is an important issue of social concern. Youth suicide is a growing reality in Ireland as is attempted suicide. While it is difficult for society to acknowledge, never mind respond to this problem, that is exactly what must happen.

This paper has been prepared to share information about the nature of the problem in Ireland, to examine factors and 'causes' associated with youth suicide and attempted suicide and to suggest appropriate responses. There is a clear need to plan appropriate services and interventions and Barnardos hopes that this paper will contribute to what should be a rapidly developing debate.

2. SUICIDE IN IRELAND

The number of suicides in Ireland has been increasing steadily. Total number of suicides for the period 1980 – 1982 were as follows:

1980	–	216
1981	–	223
1982	–	241

[1] M.Kelleher, H.Keeley, C.McAuliffe (1998) – Suicide in Adolescents, Modern Medicine 28(I)-27-36

[2] M.Kelleher (1996) – Suicide and the Irish, Mercier Press

Figure 1 below shows the total number of suicides for the 1994 – 1997 period. Between 1980 and 1997, therefore, the total number of suicides increased by over 100%. The Report of the National Task Force on Suicide[3] noted that between 1945 and 1995 the rate of suicide in Ireland rose from 2.38 per 100,000 population to 10.69 per 100,000. The Task Force points out that this increase has been primarily a male phenomenon with, in 1995, the rate for male suicides being 17.17 per 100,000 population compared to 4.32 per 100,000 for women.

Since the enactment of the Criminal Law (Suicide) Act 1993, suicide has been decriminalised. The Central Statistics Office is the body which compiles statistics on the numbers of suicides, and this is done on the basis of information supplied by the Gardai. The recording of suicides was examined by the National Task Force and it considered itself satisfied with the accuracy of the recording procedures, although it acknowledged that there may be an underestimation of less than 5%

Papers prepared by the National Suicide Research Foundation[4] have examined the rates of suicide in different parts of the country between 1976 and 1994/95. Somewhat surprisingly, the analyses have shown that the male suicide rate in Dublin remained steady while the national male rate has more than doubled. They note that "*the rise in suicide has been shown to be a rural rather than an urban phenomenon, a male rather than a female phenomenon affecting the young and the young elderly .....*" This has implications for service provision and is considered in more detail in subsequent sections.

FIGURE 1: **SUICIDES REGISTERED IN IRELAND 1994 – 1997**

	1994	**1995**	**1996**	**1997**	**Summary 1994-1997**
Male	280	305	310	355	1250
Female	73	78	68	78	297
Total	**353**	**383**	**378**	**433**	**1547**

[3] Department of Health and Children (1998) – Report of the National Task Force on Suicide, Dublin, The Stationery Office

[4] M.Kelleher, H.Keeley, P.Corcoran (1997) – The Service Implications of Regional Differences in Suicide Rates in the Republic of Ireland, IMJ 90(7)262-264
M.Kelleher, H.Keeley, P Corcoran (1998) – Variation in Suicide Rates Between Health Board Areas, IMJ 91(2) 53 – 56

3. YOUTH SUICIDE IN IRELAND

Figure 2 below shows there has been an increase in the number of young suicides over the past four years. As can be seen there has been just one recorded suicide below the age of ten years. In considering this particular aspect of young suicide one commentator has noted that *"there is evidence from a number of sources and countries that children as young as ten years or even younger – do occasionally kill themselves or make suicide attempts".*[5]

FIGURE 2: **YOUNG SUICIDES REGISTERED IN IRELAND 1994 – 1997**

Age Range	**1994**		**1995**		**1996**		**1997**		**Summary 1994-1997**
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	
5 – 9	0	0	1	0	0	0	0	0	1
10 – 14	6	0	2	1	1	1	8	0	19
15 – 19	20	4	30	5	20	7	26	7	119
20 – 24	48	5	42	5	53	6	61	9	229
Total	**83**		**86**		**88**		**111**		**368**

The statistics show that young suicide in Ireland is predominantly a male phenomenon. Commentators have noted that suicide is a main cause of death in young people, among young men in Ireland second only to road traffic deaths. This is supported by a Samaritans report for England and Wales which estimates that *"suicide accounts for 20% of all deaths among young people aged 15 – 24 and is the second most common cause among young men, claiming more lives than cancer."*[6]

4. ATTEMPTED YOUTH SUICIDE

There is no national system for collating and publishing details of the extent of attempted suicide in Ireland. The National Suicide Research Foundation has been monitoring the extent of parasuicidal behaviour in the Southern Health Board and Mid-Western Health Board regions. The numbers of individuals, by age band and sex, who exhibited parasuicidal behaviour in the first twelve months of monitoring is illustrated below.

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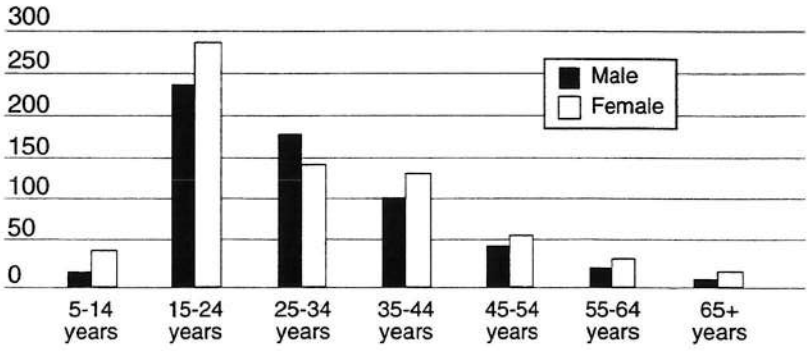
[5] N.Madge (1996) – Suicidal Behaviour in Children and Young People Highlight No.144, N.C.B./Barnardos

[6] The Samaritans (UK) (1997) – Exploring the Taboo: A Samaritans Report, The Samaritans, London

FIGURE 3: **AGE AND SEX DISTRIBUTION OF PARASUICIDAL INDIVIDUALS**

Southern and Mid-Western Health Board Areas, 1995 – 1996



*Source: National Suicide Research Foundation

This analysis demonstrates that attempted suicide is most common among those in their late teens and early adult years. It illustrates also, in contrast to the statistics for actual suicide, that more females than males exhibit parasuicidal behaviour. This gender difference has been noted internationally with one writer commenting that *"while statistics show, for almost all dates and in most countries, that young males complete suicide more often than young females and are alone responsible for recent upward trends, it remains true that the vast majority of individuals involved in deliberate self-harm are female".*[7]

5. FACTORS ASSOCIATED WITH YOUTH SUICIDE

Many writers and researchers have attempted to analyse the factors and 'causes' associated with youth suicide. Identifying 'causal' relationships is always difficult and in this situation it is even more difficult as people who commit suicide obviously cannot be interviewed and many do not leave a suicide note. Notwithstanding this, some of the more important factors associated with those who commit suicide are as follows:

5.1. There appears to be a close relationship between mental illness and young suicide

A Finnish study,[8] which analysed 53 adolescent suicides, established that one year before the suicide 44% of the girls and 18% of the boys had had one or more mental health visits. A study of over 200 youth suicides in Minnesota[9] established that 50% had shown clear evidence of multiple psychiatric

[7] N.Madge (1996) op.cit

[8] M.Marttunen, H.M. Aro, H.K.Lonnguist (1992) – *Adolescent Suicide: End point of long term difficulties* in Journal of the American Academy of Child and Adolescent Psychiatry.

[9] H.Hakerman, B.D.Garfunkel (1988) – *Completed Suicides in Children and Adolescents* in Journal of the American Academy of Child and Adolescent Psychiatry.

disorders. The National Task Force Report[10] refers to a psychological autopsy of suicides in Cork which found that of young men aged 15 to 24 years who had committed suicide, almost 75% were regarded as mentally ill. More starkly, Irish researchers have claimed that *"approximately 90% of those who end their lives by suicide are suffering from mental illness, most commonly depression."*[11]

5.2. A previous suicide attempt is a significant factor

In the Minnesota study referred to above 18% of suicides were known to have made a prior attempt, in the Finnish study it was 33%. In contrast to this Kelleher has written that the proportion of parasuicides who ultimately end their lives in the subsequent 10 to 15 years is somewhere between 10 and 15%.[12]

5.3. There is some evidence of a link between alcohol and substance misuse and youth suicide

Looking at the overall situation, the National Task Force noted that many studies had found a correlation between rates of suicide and rates of alcohol consumption and alcohol problems. It cautioned, however, that the contribution that alcoholism in itself makes is unclear. Looking specifically at youth suicide, the Samaritans in Britain have observed more forcefully that *"many research studies have shown that alcohol and substance misuse are significant factors in youth suicide – approximately one in three adolescent suicides is intoxicated at the time of death."*[13] More cautiously, Kelleher reports that *"a significant number of male suicides have taken moderate amounts of alcohol in the hours before going to their deaths"*.[14]

While these are just some of the causal factors, the evidence is not definitive nor can it be. It has been suggested, for example, *"that adolescents of all socio-economic groupings commit suicide. The successful or high achieving adolescent is just as vulnerable as the one who is angry or a loner"*.[15]

However, while it is not possible to predict suicides the brief review presented here indicates that suicides do not just happen 'out of the blue'. In his book Kelleher suggests that *"most of those who die by suicide have given signals and hints of varying clarity before they come to their end"*.[16] The relationship between mental illness, previous suicide attempts and actual suicide lend weight to a conclusion drawn by the Finnish study already referred to – *"The results strongly suggest that in most cases adolescent suicide is an end point of a long term risk path of development"*.[17]

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[10] Department of Health and Children (1998) – op. cit

[11] M.Kelleher, H.Keeley, C.McAuliffe (1998) – Suicide in Adolescents, Modern Medicine 28(I)27 -36

[12] M.Kelleher (1996) – op.cit

[13] The Samaritans (U.K.) (1997) – op. cit

[14] M.Kelleher (1996) – op. cit

[15] J.L.Fleming M.D. – (updated) – Understanding Youth Suicide: A Report to the community, Laureate Saint Finnas Behavioural Services

[16] M.Kelleher (1996) – op.cit

[17] M.Marttunen et al (1992) op.cit

6 FACTORS ASSOCIATED WITH ATTEMPTED YOUTH SUICIDE

Writers and researchers have highlighted the following as important in considering attempted youth suicide:

6.1. The physical location of the suicide attempt has importance

One analysis[18] has suggested that up to 90% of attempted suicides are made at home, 70% while the parents are there.

6.2 Interpersonal and relationship problems are significant.

Irish researchers[19] have suggested that "*interpersonal arguments in the preceding 72 hours is the commonest reason given for a suicide attempt in male adolescents*". The Samaritans in Britain suggest that "*relationship problems are the most common persistent problems of suicide attempters, both adolescent and adult*".[20]

6.3. There appears to be a relationship between social and family background and attempted suicide

A study[21] of over 500 adolescent and child attempted suicides found that they came from families beset by medical, mental heath, alcohol and employment problems. This is supported by the Samaritans' report which suggests that adolescent 'attempters' came from homes where there is parental unemployment, mental illness or addiction.[22] Kelleher[23] refers to a study of 245 self poisoners, conducted in Cork in the 1980's, which found that most had come from a background of appalling childhood disadvantage with 15% having experienced physical abuse and 10% having experienced sexual abuse.

6.4 Issues of sexuality and identity may also be important.

A small study[24] of 7 adolescent attempted suicides established that all seven young people felt they were sexually abnormal in some way. Another writer[25] has suggested that "*the core concept of sexual identity ...is missing from many studies.*" And three Irish researchers in their paper write that "*gay youth are said to be two or three times more likely to attempt suicide than other young people*".[26]

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[18] quoted in B.Frankel & R Kranz (1994) – Straight Talking About Teenage Suicide, New York, Facts on File.

[19] M.Kelleher, H.Keeley C.McAuliffe (1998) op cit

[20] The Samaritans (UK) (1997) op.cit

[21] Quoted in B.Frankel & R Kranz (1994) op.cit

[22] The Samaritans (UK) 1997) op cit

[23] M.Kelleher (1996) op.cit

[24] M.E.Laufer (1995) – *A Research Study into attempted Suicide in Adolescence* in M.E.Laufer (ed) 1995 – The Suicidal Adolescent, Karnac Books, Brent Adolescent Centre

[25] R.McCarthy (1996) – Identity Formation in Early Adolescent Suicide (Unpublished Masters in Social Science dissertation)

[26] M.Kelleher, H.Keeley and C McAuliffe (1998) op.cit

7. RESPONDING TO YOUTH SUICIDE AND ATTEMPTED YOUTH SUICIDE

7.1 Introduction

The Report of the National Task Force on Suicide was published in January 1998 and recommended a comprehensive range of actions designed to address the problems of suicide and attempted suicide. A Suicide Review Group was subsequently established to monitor the progress in each health board area toward achieving the objectives set out by the Task Force. One of the important recommendations of the Task Force, that health boards appoint suicide resource officers with broad responsibilities in the field of suicide, is being pursued. In addition a national epidemiological study, on all suicides in the period January 1997 to December 1998, is being carried out through the Department of Public Health in each health board. This study will assist in increasing understanding of the causes and factors associated with suicide. Indeed, the varied and detailed work of the National Suicide Research Foundation has already made a substantial contribution in this respect.

While, both in Ireland and internationally, there is increasing research into the problem there is also considerable debate as to how, if at all, suicide can be prevented or its frequency reduced. While it seems to be the case that it is not possible to predict a suicide, available research does point the way toward the range of services which can help in the areas of prevention and in responding to the problem of attempted suicide. One area where there is little debate or research is in the range of services needed by families bereaved by a youth suicide.

Given the work of the National Task Force, the Suicide Research Foundation and other bodies it is not necessary for Barnardos to detail all possible services and responses required to address these problems. Instead we focus on some areas and issues which seem particularly relevant to the issue of young people. In this we have benefited from discussions with various experts in this field who have helped shape our thinking.

Apart from the clear need to develop various services it is also necessary that these important issues are debated within society as a whole. In particular Barnardos feels that we need to discuss, debate and consider three key questions – questions which do not have any easy answers but which need to influence our thinking on this whole issue.

Firstly, ***why is the rate of young suicide on the increase?*** An extremely difficult question to answer that may be better asked as follows – why is it that now more young people turn to suicide or attempted suicide as a way of dealing with the difficulties in their lives? In the course of preparing this paper it was suggested to us that the issue of suicide as a violent act remains under-recognised. Do we live in a society where violence is tolerated more? It was suggested also that increasing pressure on young people to 'succeed' – in school, in university, at work – may be an important factor. Are these pressures significant? Similarly, it is appropriate to consider whether the freer availability of alcohol, illegal drugs and prescribed drugs are contributing factors.

We cannot provide answers to these questions but what we can do as a society is consider whether there are broader societal changes which contribute to the increase in youth suicide, and if so how they may be counteracted.

Secondly, ***why do many more young men than young women kill themselves?*** Again, while there are no easy answers it is vital to consider what it is about the situation of young men which predisposes them to this ultimate act. It has been suggested that young men are more likely to engage in aggressive or violent acts. One person, who has experience of dealing with actual and attempted suicides, has suggested to us that 'as a society we are very hard on men' – meaning that we demand a lot from men in terms of responsibilities but do not encourage emotional expression.

It is particularly necessary, therefore, to consider the situation of young men and how they can be supported and helped.

Thirdly, ***why are more people from rural Ireland committing suicide?*** There does not appear to be any research or other data available which can offer answers to this question. Some commentators have expressed surprise at this trend, noting that urban areas are more likely to encompass a range of social problems. Whatever the causal factors there are implications for the way services are delivered to all parts of the country.

These central questions should be an important influence in the development of service responses. In the following sections Barnardos considers in more detail the issue of service development under four headings –

- Health Promotion and Prevention;
- Strategies targeted at 'at risk' young people;
- Intervention: Dealing with suicide attempts
- Post suicide: Therapy, support and aftercare.

7.2 Health Promotion and Prevention

"The preventive approaches ... must involve all sections of society in a multiplicity of inter-related activities and responses"

(Report of the National Task Force)

While it is difficult to measure the success of health promotion strategies it is important that ongoing efforts are made to develop such strategies and to monitor their effectiveness. Because of the connections identified already between substance misuse and suicide there is a particular challenge to develop programmes which promote a healthy use of alcohol and reduce the demand for drugs.

Developing effective programmes of this type is particularly challenging. A study conducted by the Mid-Western Health Board, which surveyed 4000 teenagers, found that over 25% of 13 year olds and 75% of 17 year olds have been drunk at some stage.[27] Alcohol is an accepted part of youth culture and promoting healthier alternatives requires creativity and a range of responses involving the education, youth work and community sectors.

In the development of preventive strategies, high self esteem, better interpersonal and coping skills and better relationships with peers have been identified as important 'protective' factors for young people. At least some of these can be enhanced within the school setting and the National Task Force Report has suggested the need for broad based social and personal health education programmes which would incorporate addressing issues such as suicide, anger control and depression awareness.

The Department of Education has approved a new primary school syllabus which will incorporate a new Social and Personal Health Education (SPHE) programme within it. This new syllabus will be introduced into all primary schools over the next three years. In the post primary sector a SPHE module for inclusion in the Junior Cycle syllabus awaits Department of Education approval. Accordingly Barnardos considers it important that:

- Continued investment is made in school and community based health promotion programmes for young people.
- Programmes such as these should be developed in ways that will be relevant to young males in particular.
- The SPHE programmes should be introduced without delay and properly resourced so they can be developed in a proper manner.
- The SPHE programmes, particularly at post primary level, should be developed in a way that allows it to be responsive to the needs of young males.

7.3. Strategies targeted at 'at risk' young people

"The Task Force recommends that ... children and young people, at a time of crisis, have access to appropriate support services and a comprehensive range of psychological and counselling services should be available"[28]

"Another aspect of care delivery which should be mentioned is the very low level of attendance at services of young male suicides prior to their deaths.... It is necessary that (services) should be altered to make them more accessible and acceptable to younger male members of our community"[29]

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[27] Reported in The Irish Times 23/3/99

[28] Department of Health and Children (1998) op.cit

[29] M.Kelleher, H.Keeley, P.Corcoran (1997) op.cit

While it is not possible either to predict suicide or to guard against all situations it is important that a range of professional, and accessible, services are developed which can support young people when they are experiencing considerable stress. The following, which is by no means exhaustive, appear important.

- There is an ongoing need to develop the counselling and the educational psychological service available to schools. Schools are often in a position to identify students who are under stress but the difficulty has often been the absence of appropriate specialised services to which students can be referred. A report on The Department of Education's eductation psychology service is being expanded following publication of a report which recommended the appointment of an additional 131 psychologists over the next five years[30]. Clearly the service is significantly understaffed. Equally, the development of the relatively new posts of teacher/counsellor in schools should be pursued. With the development of these services it will be possible for young people to more easily access support services via the school system.
- Apart from school based supports there is also a need to develop more community based and accessible youth counselling services. While the more formal medical or quasi-medical services do reach young people 'at risk' this model, with its formality and appointment procedures, is not always the one young people will access. Services which are more informal, based in local communities and specifically geared toward young people can be a useful complementary addition to mainstream services. In this context options such as the development of a 'buddy' type system, where trained young adults could support teenagers, might usefully be explored.
- In addition to the development of specialised services there is a need to provide accessible information to parents, and others who come into contact with young people, which could help them identify the 'warning signs' associated with suicide or attempted suicide and encourage them to refer young people to appropriate services.
- Given the prevalence of young suicides in rural Ireland there is a particular challenge in developing services which can reach less populated parts of the country. In addition to the services mentioned above there may be a value in developing telephone helplines targeted particularly at teenagers. The work of the Samaritans in this area is acknowledged and it may be worth complementing this with a service more focused on young people.

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[30] Reported in The Irish Independent 30/7/98

- There is an ongoing need to target awareness strategies at young people about services that are already available to assist them. A study[31] of ninety three university students in Cork found that over 50% did not know where they would turn if they were in trouble. The most striking message from this study, consider the authors, is the lack of information about services even among a relatively advantaged group of young adults.

If such a lack of information is prevalent throughout the country then there is a clear need for the health and social service agencies to promote clear public awareness among young people about the type of services available to them.

7.4 Intervention: Dealing with Suicide Attempts

".... Every suicide attempt in an adolescent is a sign of serious disturbance and its importance should never be minimised. It is a demand for help from an emotionally disturbed and very vulnerable person and it requires very careful assessment"[32]

An attempted suicide requires speedy, effective and co-ordinated responses at a number of levels. The following approaches, many of which are identified in the Report of the National Task Force, appear important:

- As most parasuicides are first admitted to accident and emergency departments in hospitals there is a need for smooth linkages between A &E departments and the appropriate psychiatric services.
- In addition to the availability of appropriate specialised psychiatric and counselling services there is a need for these services to link with G.P's and other local agencies so that ongoing support is provided to the parasuicidal person.
- As the risk of actual suicide is greatly enhanced after a suicide attempt there is a need for these services to be in continued contact with the young parasuicides and also for these services to be sufficiently flexible so that they can be accessed without undue delay.

7.5 Post Suicide: Support, Therapy and Aftercare

"Relatives and friends of the deceased may have mixed and confused emotions ranging from shock to grief, anger to guilt consequent on the event.... There is no universally right way of handling the aftercare of those affected by suicide. Each step in the process may require a different response".[33]

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[31] H.Keeley, M.Kelleher (1998) – Youth Attitudes to services in Ireland, Psychiatric Bulletin 22(4):257

[32] M.Kohl (1995) – *A Suicidal Girl from a Loving Home* in The Suicidal Adolescent M.E.Lawfer (ed)

[33] Department of Health and Children (1998) op.cit

As noted in the introduction, the suicide of a young person, at an early stage of his or her life, can be a hugely traumatic time for family, friends, neighbours and communities. It impacts also in a very real way on the young person's school and other organisations such as sports and social clubs, where the young person may have been involved.

Post suicide services, therefore, should attempt to recognise the wide range of people affected and that these people may be affected in quite different ways.

Bereavement services are underdeveloped in Ireland. While parish run bereavement services exist along with various support groups the importance of this work has not always been fully appreciated. Barnardos own bereavement counselling service was established in 1996 specifically as a bereavement service for children who have lost a parent, sibling, close relative or friend. Approximately 300 referrals are received each year with 28 % of these being in respect of a suicide.

From this experience Barnardos believes that the following strategies and supports are required.

- Firstly the importance of families being able to talk about and come to terms with a young suicide needs to be recognised. Families often need help with this difficult task and individual members of the family can need different types of help. There is a need, therefore, to develop the range of bereavement counselling services which will support families both as a unit and their individual members.
- There is also a need to provide links between services so that families can begin to understand and get answers to their many questions. Therefore if an individual or family is attending a bereavement service it may be very necessary for them to meet with a doctor/counsellor/ psychiatrist where such a person was dealing with their son or daughter prior to the suicide. Meeting with these professionals can allow families to seek answers and also express their frustration at the inability of services to protect the young person. While difficult, creating networks between services is very necessary.
- As a suicide can have a 'wider' impact it is important that the specialist counselling services are able to offer guidance to schools and youth organisations as to how they can appropriately deal with the aftermath of a suicide.
- It is also important for organisations which deal with individuals bereaved by a suicide to assist in the development of appropriate support groups where the demand exists.

SUMMARY OF KEY POINTS

Youth suicide is a growing reality in Ireland. In the period 1994 – 1997 over 360 young people, aged 24 years and under, took their lives. The large majority of young people who commit suicide are male. There is no national system for collecting data on the extent of attempted suicide, but we do know that more females than males engage in suicide attempts.

The "causes" and factors associated with youth suicide are complex. Various studies have shown a relationship between suicide and mental illness, and some links between alcohol and substance misuse and suicide. With regard to attempted suicide, interpersonal problems are significant as is coming from a disadvantaged or troubled family background.

Youth suicide, and attempted youth suicide, can have a lasting impact, not only on the person's family but on his/her friends and local community. These problems need to be tackled in a comprehensive manner and a range of services are required.

It is essential that concerted efforts are made to provide appropriate education and awareness programmes in schools. Specialist counselling and psychological services are required for young people who are under stress and are deemed to be at risk. Statistics show that in Ireland youth suicides occur more frequently in rural rather than urban areas and there is a need, therefore, to develop accessible services such as a telephone helpline for teenagers. Through Sólás, its bereavement counselling service for children, Barnardos has already recognised the importance of providing specialised services to bereaved families. And where a youth suicide occurs bereavement services should also be able to offer support to friends and schools.

The numbers of young people committing suicide is on the increase in Ireland. Barnardos believes it is necessary now to develop a concerted response to this growing and tragic social problem.

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