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UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

Profiling a Community led Multilevel Suicide Prevention Intervention

Rebecca Donnachie

CARL Research Project

in collaboration with

Breaking The Silence

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- provide their services on an affordable basis;
- promote and support public access to and influence on science and technology;
- create equitable and supportive partnerships with civil society organisations;
- enhance understanding among policymakers and education and research institutions of the research and education needs of civil society, and
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I would like to dedicate this dissertation to my late mum, Antoinette and brother, Shane who forever give me the passion, courage and drive to pursue my dreams. Finally, I want to also dedicate this dissertation to the late Mike-John who passed away too soon, may he always be an example of how to be humble and enjoy life to the full despite our difficulties in life.

Abstract

This study research was carried out to profile a community led multilevel suicide prevention intervention group, Breaking The Silence. This study examined the main models of suicide prevention intervention being used internationally and located which models are being used within Irish policy. The research explored and identified which of the models is used by the Breaking The Silence and how this fits in with the community context by reviewing models of community work practice. The literature review found that the Irish suicide prevention policy was in line with the models of suicide prevention that are being used internationally. Combing the literature mentioned with the primary data obtained through semi-structured interviews with three members of the group and two community workers who have worked with the group there were several main findings. The research found that the group is located within several different models of suicide prevention and is also is located within several suicide prevention strategies. The group was found to be located within the community development and social planning models of community work.

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List of Abbreviations used

Breaking the Silence = BTS

Community Based Participatory Research = CBPR

Chapter One: Introduction

1.1 Introduction

This research is about profiling a community suicide prevention group, Breaking The Silence and the suicide prevention intervention model that is used by the group. This research will examine this topic through a constructionist's lens. The researcher recognises that everyone's experiences are different and how we perceive something is all based on our prior experiences. This approach has been selected as the researcher recognises that suicide prevention can mean different things to different people. There has been a lot of research on suicide, however, there has been no research carried out on this group. This indicates a constructionist's view, people don't always view suicide prevention from this perspective.

1.2 Research Title

Profiling a community led multi-level suicide prevention intervention

1.3 Background

Despite the extensive amount of secondary and primary research studies worldwide and the variety of intervention developed aimed at preventing suicide, it still remains a global public health issue. The World Health Organisation (2018) reported that every forty seconds a person dies by suicide (World Health Organisation, 2018).To date there has not been any research carried out on the group or the model of suicide prevention intervention that the group uses. Connecting for Life Cork, Cork Suicide Prevention and Self-Harm Prevention Action Plan 2017-2020 is the most recent policy published which is focused on preventing suicide. This document is a plan for suicide prevention in the cork area. This plan highlights the critical role that communities and local structures play in suicide prevention.

1.4 Introduction to Breaking The Silence

Breaking the silence is a community-based organisation which is made of up of volunteers. The group is based in Cobh and was formed in a response to suicide in the town. The groups holds the position that suicide is a community issue and is everybody's business (National Office for Suicide Prevention, 2017).In addition to providing safe-TALK and ASIST training, members of Breaking The Silence intervene with a person who may have thoughts of suicide when asked to do so by a friend or family member. Members of the group then provide support to that person by linking them into supports within the community or with relevant health services. Breaking the silence also provides access to bereavement support services in partnership with other support service in the local area (National Office for Suicide Prevention, 2017).

1.5 Rationale

The rationale for this dissertation is that the researcher has worked in the area of suicide prevention and with this group for the last five years. The researcher's interest to complete a CARL project was first sparked during the Social Work research conference last year. Following conversation with the voluntary group about CARL it was decided that research would be beneficial for the group.

Breaking The Silence has been running as a suicide prevention group for the last ten years and there has been no research on the group to date. There also appears to be a lack of research on this type of community based multilevel intervention. Therefore, it is beneficial to the group and to the wider area of suicide prevention for this research to be carried out. Research on suicide is set out as a goal within the Connecting for Life Strategy 2015-2020, which also makes this a motivating factor to carry out this research as there is a gap in this specific type of suicide prevention research.

The Breaking the Silence has grown as a voluntary group over the last number of years and is now involved in policy implementation with the Connecting for Life Cork Action Plan

2017-2020. This plan is based on the national strategy, Connecting for Life, and sets out a series actions for Cork to implement the strategy locally. One of the aims within these documents is to support local community's capacity to prevent and respond to suicidal behaviour. Therefore, this research could be beneficial in providing research on how the Breaking The Silence has responded to the issue of suicide within their own community for the last number of years and the type of model which has been used.

1.6 Aims of the Research

The aim of the research is to profile the Breaking the Silence community led multi-level suicide prevention intervention.

The research objectives are:

- Identify the main models of community level suicide prevention interventions
- Identify which of these models of community level suicide prevention interventions are located within Irish policy
- Identify which of these models is used by the Breaking the silence
- Explore how this model of suicide prevention fits in with the community context

1.7 Research Questions

1. What are the main models of community level suicide prevention interventions?
2. Which of these are reflected in Irish policies?
3. What model of suicide prevention intervention is used by Breaking The Silence?
4. How does this model of suicide prevention intervention fit in with the community context?

1.8 Reflexive positioning

Mann (2016) states that reflexivity is centred upon self-awareness and taking a stance of being able to locate oneself within the picture where the researcher acknowledges how one's own self influences actions. Reflexivity is also an understanding of the impact identities and interpersonal relationships within the field have on research. The researcher needs to consider how having a certain social identity and particular perspectives impact on the relationship with field work and the research process (Mann, 2016).

To ensure the researcher is objective and applies a reflexive position throughout the research process, it must be noted that the researcher has been a member of the community group being researched for the last five years.

This factor has been stated since the beginning of the research process and has been addressed throughout the research process by journaling and reflecting upon how this may create bias within the research. The potential for bias was discussed during supervision to ensure objectivity within the research.

1.9 Definitions

Suicide

Suicide is defined as 'the action of killing oneself intentionally' (Andriessen, 2006 p.533).

Suicide Prevention

'Suicide prevention aims to diminish the risk and rates of suicide' (National Office for Suicide Prevention, 2017 p.78)

Intervention

The act of intervening with a person who may be suicidal using skills from safeTALK and ASIST and then connecting them in with support to try and prevent the suicide (Wim, et al., 2009).

Person with thoughts of suicide

A person who has suicidal thoughts and has the intentions of ending their life (LivingWorks, 2016).

Safe-TALK

A three and half hour suicide prevention workshop that trains people in how to spot the signs of a person who may be suicidal, how to then intervene and connect them with support (LivingWorks, 2016).

ASIST

A two day follow on workshop from safeTALK which teaches participants to be a support for a person with thoughts of suicide by educating participants on how to reduce the immediate risk of suicide and how to increase support for a person at risk of suicide (Health Service Executive, 2017).

1.10 Overview of Chapters

Chapter One: Introduction

Chapter one introduces the topic and outlines the aim of the study. The research questions and rationale for the study are also presented within this chapter along with the reflexive position of the researcher and key definitions.

Chapter Two: Literature Review

Chapter two is a review of the main literature relevant to the topic and gives a background to the topic. Models of suicide prevention interventions, suicide prevention policies, community interventions and specific models of community work are also explored.

Chapter Three: Methodology

Chapter three sets out the research design used, theoretical underpinnings and details the methods used to undertake the research. The limitation of the study and the challenges encountered during the study will also be discussed.

Chapter Four: Findings and Analysis

Chapter four presents the findings from the data and the key emerging themes. This chapter then has a separate discussion section, where the themes are discussed in relation to literature to answer research question three and four

Chapter Five: Recommendations and Conclusion

The final chapter consists of an overall conclusion of the research, recommendations, limitations of the study and a reflective piece on the research process

Chapter Two: Literature Review

2.1 Introduction

Suicide is a major problem nationally and internationally. Each year close to 800,000 people die worldwide by suicide (World Health Organisation, 2018). For every person who dies by suicide it is estimated that 20-30 people have attempted suicide (Zalsman, et al., 2016). In Ireland an average of 10 people die by suicide every week. Van der Feltz-Cornelis *et al* (2011) states that multilevel interventions were found to be the best strategy for prevention of suicide following a review of systematic reviews on suicide prevention (van der Feltz-Cornelis, et al., 2011).This type of intervention targets several populations or several levels within health care systems (van der Feltz-Cornelis, et al., 2011). Multilevel interventions can take place at a primary care or a public health level and can have more than one focus. Synergistic combinations of interventions at a multi-level have been recommended as best practice when it comes to suicide prevention strategies. However, there currently is no systemic review that identifies the positive synergetic elements of the interventions (van der Feltz-Cornelis, et al., 2011).

The following have been identified as the different levels of interventions for suicide prevention; primary care, population level, general public and gatekeepers, high risk groups, restricting access to means of suicide and targeted groups. (van der Feltz-Cornelis, et al., 2011). A number of interventions have been identified which take place at the different levels. This includes but is not limited to the following; awareness campaigns and education, screening, pharmacotherapy, psychotherapy, follow up care after suicide attempt, restriction of means, individual cognitive behaviour therapy, gatekeeper training for suicide prevention, awareness campaigns, primary care screening, community wide health program, inpatient and outpatient treatment, medication and intermediate care services (van der Feltz-Cornelis, et al., 2011).A systematic review of systematic reviews on suicide multilevel interventions found potential evidence for the following six interventions to be the most effective; training GPs to recognise and treat mental disorders, awareness campaigns that provided a clear pathway to treatment, the training of gatekeepers and community facilitators in recognising suicidality and helping at risk people to access

appropriate services, improvement of health services targeting people at risk and the training of journalists in responsible reporting on suicide (van der Feltz-Cornelis, et al., 2011). Systematic reviews were used to gather information on the topic as it allowed the researcher to examine a large volume of literature which had been synthesized into articles. Systematic reviews were also used as the approach adopts explicit procedures and has been defined as a replicable, scientific process that aims to minimise bias (Bryman, 2012). Systematic reviews of literature are often seen as an accompaniment to an evidence-based approach as their goal is to reproduce advice for clinicians and practitioners based on all available evidence (Bryman, 2012).

2.2 Suicide

The US Centre for Disease Control defines suicide as a *'death arising from an act inflicted upon oneself with the intent to kill oneself'* (Andriessen, 2006 p.533). Rodgers (2010) states that suicidal behaviour consists of a multiple biological, psychological, sociological and spiritual factor which makes suicide prevention difficult (Rodgers, 2010). In recent years suicide has been recognised as a public health priority and public health issue internationally (Zalsman, et al., 2016). When researching the area of suicide prevention in Ireland, it is important to note that in Ireland suicide was a crime up until June 1993 (Osman, et al., 2016). This is important to note as before 1993 there were no suicide prevention services in Ireland. Ireland has moved away from the criminal response to suicide and now focuses on responding to suicide with a public health response, which has led to the development of several policies. The main policy document for suicide in Ireland is The Connecting for Life Strategy (2015). The Connecting for Life Strategy (2015) outlines that the cause for suicide consists of an interplay of biological, psychological and environmental factors(Health Service Executive, 2015). While it is well documented in many research studies that factors such as mental and substance misuse disorders represent a common contributor to suicide risk, it is important to note that they remain poor predictors of suicide as there are many other individual factors to consider (Rodgers, 2010). Because every suicide is different and there are many different reasons as to why a person may take their own life, what may be effective in preventing one suicide may not prevent another (Rodgers, 2010).

2.3 Preventative interventions

Rodgers (2010) states that comprehensive programmes offer the best opportunity to reduce suicide risk. These programmes need to take in to consideration the complexity of individuals who are at risk and the communities in which they live may allow for the greatest opportunity to prevent suicide. These approaches contain multileveled interventions designed to address the varied needs of those at risk and they may also facilitate access to community channels for those at risk (Rodgers, 2010).

Models of suicide prevention intervention strategies can be categorised as primary, secondary and tertiary interventions. The activities which take place within these levels are ones that take place before a suicide occurs, activities during suicidal behaviour and after a suicidal behaviour occurs. Primary prevention interventions are referred to as activities that are intended to discourage or interfere with completion of suicide before the suicidal behaviour occurs (O'Connor, et al., 2011). These activities can include eliminating known risk factors such as eliminating guns or limiting access to locations where suicides frequently take place. Primary factors also include other activities which promote awareness, recognition, empathy and better understanding of mental illness and suicide. The second type of primary intervention activities include promoting protective factors such as; promoting a healthy lifestyle and increasing opportunities for readily available training for gate keepers (O'Connor, et al., 2011). The term gate keeper is defined as person who has been trained to recognise and intervene with those who may be at risk of suicide. This could be any person who has contact with a person who may be at risk of suicide such as a friend or family member (Rodgers, 2010). Gatekeepers are competent in suicide first aid training such as ASIST and safeTALK, they essentially are a first aid responder for a person at risk of suicide, they are trained to identify a person at risk of suicide and refer them to support services. The rationale for the gatekeeper training model is that by training a broad amount of people to recognise the symptoms of suicide and how to intervene with them, the suicide can be prevented, this takes place at a community level among community members.

People at risk of suicide are likely to seek help from a friend or family member rather than a professional (Rodgers, 2010).

Secondary prevention is aimed at identifying illness in its earliest stage. In suicide prevention this includes conducting screening for particular populations considered to be at heightened risk. These screenings use semi-structured interviews protocols and biological tests. Tertiary prevention of psychological or pharmacological treatment of clinically diagnosed patients who show signs of suicidality (O'Connor, et al., 2011).

The Institute of Medicine categories models of prevention as universal, selective and indicated models of suicide prevention. The universal prevention strategies are those that address entire population and are carried out with no prior screening for suicide risk. A universal prevention strategy involves training programmes directed at doctors to enhance recognition and treatment for people who have depression and associated suicidal behaviour. Selective prevention strategies target population sub-sets composed of individuals regarded at risk of suicide solely by virtue of belonging to these sub-sets. Sub-set section is based on known biological, social and or environmental risk factors for suicide such as unemployment, marital dissolution, at risk age, low income and sexual abuse (O'Connor, et al., 2011).

Indicated prevention is aimed at identifying and treating individuals at early signs of behaviour or affiliations often associated with suicidality. This includes; screening, treatment and close follow up of people with a diagnosed mental illness, people who abuse alcohol, a follow up on people who have previously attempted suicide and individuals who exhibit self-harming behaviour (Bertolote, et al., 2004). Individuals may be referred to as indicated preventions not only as a result of targeted screening, but also by lay people in the general population attuned to the signs of risk (Bertolote, et al., 2004) . The more that is known, the more likely at-risk individuals will be referred to them. It is therefore vital to take full advantage of the cumulative and possible synergetic effects of pursuing universal strategies such as the dissemination of mental health information to the general public (O'Connor, et al., 2011).

2.4 Community Intervention

While there is no universal definition of community work there are several different models of community work. Popple (2015) states that despite an extensive review on community work the literature fails to provide an agreed number of models or the exact scope. However, there are several main models that are discussed within the literature such as the community care model, community organisation model, the community education model, community action model (Popple, 2015). While there are many different models of community work, not all will be discussed within this literature. The community development model and the social planning model will be discussed in depth as they are the most relevant to this research and reflect the policies that have been mentioned.

The community development model is one of the best know approaches to community work. This is a fundamentally broad approach to working with groups and individuals within a community. The focus on this approach is helping people to acquire skills and confidence to improve the quality of lives of its member and communities (Popple, 2015). The model focuses on putting in place activities that foster skill-sharing and helps community members to develop skills (Ife, 2013). In addition to this community members are encouraged to use their own existing skills and wisdom to provide services to others with the support of training. Services are not owned by professionals instead they are located within the community. Therefore, the knowledge and skills are owned at the community level and are shared widely among community members (Ife, 2013). This model also places value on local knowledge as the model recognises that it is the community members who have the experience of the community's needs, problems and strengths (Ife, 2013).

Within this model there is a large emphasis on promoting self-help using education and building of neighbourhood capacities for problem solving. In Britain this model is characterised by intervention at the neighbourhood level and community groups are encouraged to articulate their problems and needs. There is an expectation that community members will then engage in civic collective action to meet these needs. Most community development projects are located in areas of high social and economic need. There are three central features of this model which have been identified; informal education,

collective action and organisation development. Informal education is a feature which maintains the idea that people learn new skills through taking on tasks and observing others and then receiving feedback.

The collective action aspect is when people identify the aims they have in common which then results in the mobilisation of community members to develop a joint plan of action such as recruiting allies, activists and then deciding on what needs to be done to make the desired changes (Popple, 2015). The last feature, organisation development, can be described as helping the project to evolve in a way which enables members to achieve their goals, act legally and be accountable to the membership and the wider community (Popple, 2015). Community empowerment is a key value within this model, empowerment informs the practice of this model as there is an emphasis on a grassroots approach to community work. This bottom up approach aims to foster and build empowerment among local communities to make change (Popple, 2015). There is an extensive amount of literature on empowerment within the community context, which highlights the unequal distribution of power and the need re-distribute resources in to the community using this approach (AIEB, 2016).

Self-reliance is an important principle of community development, as there is an emphasis on sustainability within the organisation. This means that the communities rely on their own resources rather than being dependant on external provided resources (Ife, 2013). Ife (2013) highlights that reliance on external support can result in the loss of autonomy and independence, as there can be accountability requirements placed on the community group. The community development approach focuses on identifying and developing all the resources available within the community itself.

An example of the social planning approach is a community group that works directly with policy makers and service providers to sensate them to the needs of specific communities and to assist them to improve services or alter policies (Twelvetrees, 2002). Activities in the social planning approach also involve the groups supporting other community groups in running their own activities and projects. There are also many forms of community work which involves both community development and social planning, as the community worker may be working with local people and service providers (Twelvetrees, 2002).

2.5 Policy

In 1996 a National task force on suicide was established followed by the 1998 final report of the National Task force on suicide, which called for the appointment regional resource officers for suicide prevention (Joint Committee on Health & Children, 2006). In 2005 the national strategy Reach Out: National Strategy for Action on Suicide prevention 2005-2014 was published (Health Service Executive, 2005). This strategy was founded on the review of the implementation of the National Task Force recommendations and a review of a number of international strategies which suggested a broad-based approach to suicide prevention be implemented. This policy aimed to reduce suicide through actions at four levels; general population approach, targeted approach, responding to suicide and information and research. (Health Service Executive, 2005).

The Health Service Executive was established in 2005 by the Health Act 2004 (Irish Statute, 2018). The National Office for Suicide Prevention was formed in 2005 within the Health Service Executive to oversee the implementation, co-ordination and monitoring of the Reach Out strategy (National Office for Suicide Prevention, 2014). In 2015, Connecting for Life: Irelands National strategy to reduce suicide 2015-2020 was launched calling for the development and implementation of a country wide suicide prevention plan (National Office for Suicide Prevention, 2017).

This policy was founded on the suicide prevention work that has taken place in Ireland over the last 10 years as part of the previous prevention strategy, Reach Out. Since the previous policy there has been significant developments in the area of suicide prevention, which have influenced the development of 'Connecting for Life', which influenced the planning of this policy document. The planning process of this documents focused on the process of engagement with a broad range of statutory and non-statutory and community stakeholders, identifying agreed strategic priorities, setting clear goals and objectives. This process created a strong community of people and agencies ready to lead the implementation of Connecting for Life. The policies focus both on preventative and awareness-raising work and supportive work with local communities and targeted approaches for priority groups (Health Service Executive, 2015)

Connecting for Life 2015-2020 is Ireland's current suicide prevention policy. This policy has several goals which aim to prevent suicide through different initiatives and activities. The goals focus on increasing the nations understanding of suicidal behaviour and mental health, improving the community's capacity to respond to suicide, a targeted approach which focuses on suicide prevention among priority groups, including young people and improving pathways to treatment for people who are vulnerable to suicide. The last goals are focused on restricting access to means of suicide and carrying out research (National Office for Suicide Prevention, 2017).

Action 2.1.1 of the 'Connecting for Life' plan states that suicide prevention action plans are to be developed. Most recently the Connecting for Life Cork Suicide and Self-Harm Action Plan 2017-2020 was launched (National Office for Suicide Prevention, 2017). This action plan is specific to the Cork area and is concerned with implementing the national policy within Cork. Within the policy it acknowledges that it is within the community setting that there are many factors which can be protective against suicidal behaviour, which can be developed and effectively implemented (National Office for Suicide Prevention, 2017).

A specific objective of the city plan is to increase suicide awareness in Cork City with accompanying actions such as;

''To continue to work in partnership with other statutory agencies, voluntary and community partners to enhance the existing facilitation of Suicide Prevention Education and Training programmes to empower the people of Cork to become more alert to the signs of suicide risk'' (National Office for Suicide Prevention, 2017 p.21).

Section 1.2.3 HSE Mental Health and Suicide Prevention Supports Services in Cork, refers to Community training in Suicide Prevention. This action focuses on building communities' skills, resilience and confidence in responding to suicide and this is achieved by providing free suicide awareness/prevention training to communities, which is one of the Health Service Executive sustaining initiatives. These training programmes include SafeTALK and ASIST training (National Office for Suicide Prevention, 2017). The training is grounded in the theory of change, which is an outcomes-based approach, which applies critical thinking to the design, implementation and evaluation of initiatives and programmes intended to support

change in their contexts. It is an approach that has been used in grass-root initiatives in developing countries (Vogel, 2012).

The training is a gatekeeper community-based suicide prevention program (LivingWorks, 2018). T1his program is focused on engaging informal helpers. The Philosophy of gatekeeper training is that it is against formal referral as a standard operating procedure. This model holds the belief that people who are suicidal are victims of breakdowns in community channels for help (Rodgers, 2010). The role of the gatekeeper is to re-engage the person with the channels of support within the community. Similar to safeTALK, the ASIST training teaches people to become gate keepers by teaching them Suicide Intervention Model which enable a person to identify, intervene and refer (Rodgers, 2010).This training was developed in Canada by Living Works. Gould, et al (2018) states that ASIST training would be effective in empowering people to help a person at risk of suicide (Gould, et al., 2013). ASIST is widely disseminated as a gatekeeper training programme that has been delivered in Australia, Canada, Ireland, Northern Ireland, Norway and the United States (Gould, et al., 2013).

A study of effective prevention interventions in Ireland identified and assessed interventions which were categorised as the following; Public and doctor education, Media strategies, Screening, Restricting access to means of suicidal behaviour, treatments and internet or helping support (National Office for Suicide Prevention, 2017).

In the early 1990s there was a growing concern in several countries in relation to the rising suicide rates. Subsequently a few of the countries approached the United Nations and the World Health Organisation asking for help in designing a comprehensive national plan to tackle suicide. In 1996 the United Nations published a ‘’Prevention of Suicide: Guidelines for the Formulation and Implementation of National strategies (World Health Organisation, 2012). Within this document it was highlighted that there were key elements required to increase the effectiveness of prevention strategies; Support from government policy, conceptual framework, well-defined aims and goals, measurable objectives, identification of agencies and capability of implementing these objectives and ongoing monitoring. The activities identified as being key to reaching strategy goals were the following; promoting early detection, assessment and treatment, increasing access to information about all

aspects about preventing suicidal behaviour, data collection systems identifying at risk groups and promoting public awareness (World Health Organisation, 2012).

In addition to this document, the European Commission published a Green Paper in response to the World Health Organisation Mental Health Declaration. The purpose of this document was to create communication among relevant decision makers and experts from different states to facilitate and stimulate discussion of prevention measures and public health policies. The Mental Health Declaration and Green Paper was then followed by a high-level European Union conference to launch the 'European Pact for Mental Health and Well-being' which was adopted by twenty seven EU member states. This Pact required states to develop a concerted effort to bring about the reduction in problems such as mental health and suicide. Within the Pact there were five priority areas highlighted to prevent suicide and depression; improving the training of health professionals and key stakeholders, restricting access to potential means of completing suicide, taking measures to raise awareness of mental health in the general public, taking measures to reduce risk factors that contribute to suicide and providing support mechanisms such as support helplines following suicide attempts and for people bereaved by suicide (O'Connor, et al., 2011).

2.6 Conclusion

This chapter has provided a background of the topic and has introduced the community group that is being researched. The rationale for the research has also been clearly explained along with the aims of the research, research questions and the reflexive positioning of the researcher. It was important for the researcher to carefully consider their reflexive positioning within this research, as the researcher is carrying research on a group they are a member of. A brief summary of key definitions were also outlined along with a chapter summary.

Chapter Three: Methodology

3.1 Introduction

The aim of the chapter is to provide an overview of the research process undertaken. This includes the methodology used, epistemology, research methods, ethical considerations and a discussion on community-based research as this is a CARL project.

3.2 Theoretical Perspective

Constructivism holds the positioning that social phenomena and categories are not only produced through social interaction but that they are in a constant state of revision. This perspective also acknowledges that the researcher always presents a specific version of social reality, the researchers constructs their own account of the social world (Bryman, 2012). This perspective views knowledge as being constructed rather than created and is concerned with the nature of how knowledge is constructed. This perspective allows for the researcher to use qualities methods to try and understand the models in which the group uses and the meaning of the group. Constructionism proposes the idea that individuals interpret their meaning as they move within the world which leads to each person constructing their own subjective meaning of their experiences. (Creswell & Poth, 2018)

3.3 Epistemology

A constructivism theoretical perspective then led to use of Interpretivism. Interpretivism is an epistemology which is a contrasting epistemology to positivism. Interpretivism holds the view that the subject matter of social science is fundamentally different to those of the natural science (Bryman, 2012). The approach is more concerned with the theory and methods of interpreting human action, there is a focus on empathic understanding of human action rather than the forces deemed to act on it. Therefore, this approach requires

a different logic of research procedures when studying the social world. One that reflects the distinctiveness of humans against the natural order as this approach is not concerned with explaining human behaviour. (Bryman, 2012).

3.4 Community-Based Participatory Research

This research is a CARL partnership with Breaking The Silence, it is important to note the element of community based participatory research within the study. CBPR is an approach which can be used to engage groups in society that are perceived as 'hard to reach' by professional researchers. There is an ideological rationale in terms of the value placed within this type of research, which is that sharing power with those who are usually the object of research and working towards progressive social change (Connected Communities, 2011). CBPR is collaborative enterprise between academic researchers and community members, where they work together throughout the research process (Bates & Burns, 2012).

3.5 Methodology

Primary and secondary research was used in this study in the form of a literature review and five semi-structured interviews. Qualitative methods were chosen as qualitative research is concerned with words rather than numbers. This fits well with the theoretical underpinnings and the epistemology positioning of the research. Qualitative research is an inductive view of the relationship between research and theory (Bryman, 2012).

3.6 Methods

There were a number of methods used within this study to gather and analyse the data such as; sampling, semi-structured interviews and thematic analysis. These will be discussed as they were used within the research process. The ethical considerations relevant to this research will also be discussed.

3.6.1 Sampling

Purposive sampling is a technique whereby the researcher selects subgroups of the population that are of interest to the study and selects cases from each sub group in a purposeful manner (Teddie & Tashakkori, 2009). This method will be utilised as participants being interviewed are required to be volunteers of the committee group due to their experience of working in the group.

Purposive sampling will also be used for the two non-volunteers of the community who will be interviewed. Purposive sampling will be used for selecting these participant as they are required to have knowledge and experience of the group but are required to not have volunteered with the group. The exclusion criteria will include people who are not volunteers of the Breaking the Silence for the first set of interviews. The exclusion criteria for the second set of interviews will include people who are volunteers of the Breaking The Silence.

3.6.2 Semi-structured interviews

Two semi-structured interview schedules will be used with a mixture of closed and open-ended questions. One interview schedule will be for the members of the group and the second schedule will be for the non-members of the group. It was decided that people from outside the organisation would be interviewed to gain an outsider perspective.

These participants were selected by the organisation. The researcher advised the organisation that participants are required to be selected based on their involvement with the group. The participants selected were community workers who had experience of working with the group. Interview questions were formulated based on the literature review. Each interview lasted under an hour, all interviews were audio recorded and transcribed. Interviews were piloted with peers who worked in the community sector before commencing interviews to strengthen the interview schedule. Following the piloting two questions were rephrased.

3.6.3 Data Collection and Analysis

Thematic analysis will be used to analyse the results. Thematic analysis minimally organises and describes the data in rich detail and will allow the researcher to identify, analyse and report themes within the data (Bryman, 2012). This is a process in which the data is organised by themes and sub themes as they emerge from the literature by reading and re-reading the transcripts. The themes are reoccurring motifs that emerge from the data. A framework described as a matrix-based method for ordering and synthesising data was used. This allowed for the construction of an index which consisted of central themes and sub themes. This type of analysis allowed the researcher to identify, analyse and report themes within the data (Bryman, 2012).

3.7 Ethical Considerations

While this research has been approached by the Social Research Ethics Committee, there were several ethical considerations that were highlighted and reviewed before approval was granted as outlined below.

The researcher is a part of this community group. This is an ethical issue that has been given consideration and factored in to the research. Since the researcher is a part of the community group there is a potential to create bias. Several steps have been taken to mitigate this potential for bias. The researcher has engaged in reflection throughout the research process by utilising the research journal, fully engaged in supervision and has planned time within the research process to take breaks and step back from the research and to help ensure objectivity. The researcher's participation in the group for the duration of the study has been limited and there is a disclosure statement on the information sheet and consent form clearly explaining my role as a researcher as separate from the role I undertake as part of the organisation.

While it was not anticipated that any participants would become emotionally distressed as a result of taking part in this research, this was an issue given ethical consideration due to the sensitive nature of the topic. All participants were debriefed after their interviews and were informed of a named link person from the BTS who was not a part of the research in which they could contact should they feel distressed. Information on support services were also detailed on the information sheet.

The participants being interviewed were known to the researcher. This had the potential to be an ethical issue in terms of the recruitment process. To ensure that no participants felt pressured to be a part of the study the researcher was not involved in selecting or contacting participants. The link person organised the interviews and contacted all participants to avoid any ethical issues of participants feeling pressured to take part. It was also clearly explained to all participants, both verbally and through the information and consent sheet, that participation was voluntary.

3.8 Conclusion

This chapter provided an overview of how the theoretical underpinnings and epistemology relevant to the topic, guided the researcher's methods of collecting and analysing data. The aspect of community based participatory research was also discussed as it is a CARL project. The ethical considerations relevant to this research were examined in depth in order to highlight that the researcher has taken a number of steps to ensure this research is ethical.

Chapter Four: Findings and Analysis

4.1 Introduction

In this chapter the primary themes that emerged from the data will be analysed and presented. The main findings from the literature will also be presented and will be compared to the main findings of the research. For confidentiality purposes all identifying information will be omitted. The findings will be analysed and presented separate from the discussion, in order to give voice to the literature. Participants mentioned locations of groups within the interviews. To protect confidentially, pseudonyms will be used, and the locations will be referred to as 'the town' or 'town'. Participants will be split in to two groups.

Members of the BTS will be referred to as P1 P2 & P3. The Community Workers that have been interviewed referred to as P4 & P5. The main themes that emerged from analysis of the data are the following:

1. Community Ownership
2. Empowerment
3. Maintaining Community Ownership
4. Integrated Regional Response

4.2 Community Ownership

Research participant from the BTS were asked about the purpose of the group and their understanding of why it was set up. Between all three participants there was a consensus that group was set up in a response to suicides. All members felt that the group was a community response. A theme that emerged within all responses was collective community ownership. Participants P4 & P5 were asked about their understanding of the role purpose and function of the group. Their responses were similar to members of the Breaking The silence.

4.2.1 Collective Community Response

Through discussion on the purpose of the group and questions directed at the participants understanding of why the group was set up, the sub theme collective community ownership presented. This sub theme also emerged when participants were asked about ownership of the group. Through discussion it became apparent to the researcher that all the group felt that not only suicide was big issue in their community but that it was a community issue and that it was best approached by the community. P3 highlighted their belief that suicide is a community responsibility and the community need to take ownership of the response to the issue; *'We firmly believe as a group it's a community responsibility not a HSE responsibility….. By education you know own community you can then create, as per the mission statement, a suicide safer community'*(P3). The group felt that the best way to respond to suicide was to get several members trained up in safeTALK and ASIST as this would then allow them to come back and train up members of the community in how to respond to suicide. *'It's a community response, like. It's a member of a community response responding to a community member in need, in crisis that needs real and effective help right now, you know. And that takes many shapes and many forms and a lot of times just a little hope, you know' (P1).* While P1 acknowledge that there are many different ways in which the group responds to the issue. There appeared to be a consensus among all member that the training was the key tool which could be used to try and prevent suicide.

P1, elaborated further on how the training approach is a community response, as people from all occupations are trained, it is not just for mental health professionals, it is an approach that educates an ordinary lay person to become an active participant in preventing suicide by carrying out interventions P2 highlighted this; *'If we take the interventions that happen within the community its people who have done the training like we have. The barmen, the taxi drivers, the hairdressers, the staff in the community, housewives, professionals, all trained in it, so that makes it a complete community response'*(P2). Thus, it is a community response and gives all members of the community ownership over the issue and the skills to respond to it. P5, spoke about the issues of suicide

in the town and how several members of the community came together to respond to the issue using a bottom up approach as opposed to a state response;

'A couple of lads got together and out of their own money went and got trained and brought this training back and rolled it out'(P5).

P6 had a similar response stating that they felt the main reason the group was set up was to prevent suicide locally through training.

4.3 Maintaining Community Ownership

Participants were asked about how they saw the organisation developing in the future which led to the following sub themes emerging; expertise and personal impact and independence. The subject of personal impact was a re-occurring theme across all participants, including the non-members. Throughout discussions and questioning on the understanding of the role, purpose and function of the group these themes also emerged in the interviews with the Community Workers.

4.3.1 Expertise

The challenge of replacing the expertise and uniqueness of the group was a challenge felt by all participants. P3 discussed the need for planning and putting in places measures to overcome this challenge '*We need to have a kind of replacement policy in place because most of three experienced trainers are into fifties and sixties'.* P1 had a similar response and focused on the need for there to be a plan for replacing the chairperson with a person who is willing and will be effective. P5 felt that it would be difficult to replicate the group without the current members due to the passion and authenticity of the current members and the way the group organically evolved. P4 felt strongly on this topic and spoke of the challenges the group faces being a voluntary group in terms of building up the level of expertise within new members;

'Is continuing to find willing volunteers to keep doing the work of BTS. And I'm sure that that's a challenge, because I know it's a challenge is every other sphere of voluntary activity, but particularly when you're looking at building up a level of expertise within members that is quite startling in its level of complexity and which really isn't available in to many places in this country'(P4)

4.3.2 Personal impact

The demand placed on the group as volunteers in terms of personal impact appears to be a challenge within the group. The group spoke about the level of response the group gives to the community and the demand in terms of the training and being on call to respond to a phone call of a person who may be at risk of suicide. This level of demand was not something anticipated by the group, *'The demand on us was bigger than we ever thought it was going to happen' (P2).* In addition to this P2 spoke about the level of commitment required for the delivering training and how the group never cancelled any courses despite the pressure on the group or its members. The demand and pressure on the group was also recognised by the two non-members. P4 acknowledged the amount of work the group does and spoke about self-care and the need for the group to be supported and suggested the group being debriefed or having clinical supervision as a means of support.

P5 discussed their experience of the group's response and highlighted the fact that the volunteers work outside of normal work hours and respond to every call and never say that they are not available;

'You can always count on them to step up. They never say they're too busy. They never say they're not available. They never say they can't get to someone onto it. They're there' (P5)

This level of commitment and the demand placed on the members of the group was well reflected in a similar statement made by P3 where they discussed the level in which the community rely on the group and the feeling of needing to be able to respond; *'I think because the community rely on us to do it we can't say no. it's not just 9 to 5. You're always kind of on standby'*(P3).

4.3.3 Independence

Remaining independent as a community group was important for all members. Members of the group felt that remaining independent allowed the group to work in way that responds to community needs. P1 had a lot to say on this subject and discussed how they felt the group was free to respond to the different needs in the community as they presented and that there is a need to remain independent from the state to continue doing this;

> *I feel the need to maintain our independence and I that that's why it's important that I don't think we ever get financial aid from them…. Like we're very boundaried and we're in safe in everything that we do, but I'm saying it allows us to respond in a way that we think is, you know' (P1)*

There was a consensus across all members that the group worked effectively towards achieving their goals without professionalising or receiving financial aid from the state. P1 elaborated further on this *'I don't know do we ever need to go on a professional footing. I often worry about that..'.* This strong desire to remain independent was again felt strongly by P3 *'we don't receive funding we have our own autonomy to kind of pursue our own aims'.* The model in which the group operate on, being informal, based within the community and remaining independent appear to be important elements that members feel make the group work.

4.3.4 Future of Organisation

There was a discourse in how the participants viewed the future of the organisation. This could be due to a number of factors such as the way in which the researcher asked the questions. There is also a possibility that the participants had different views because of their position with the group. P2 spoke about securing access to training within the HSE in order to ensure younger members get trained in safeTALK and ASISIT to continue the training. P3 spoke about the group becoming a franchise and the model being used in other communities. P3 was focused on developing a free long-term counselling service that the group could provide through developing links with another organisation.

4.4 Empowerment

Following discussions on the purpose of the group and the activities carried out by the group, participants spoke about training and educating people using safeTALK and ASIST. Three of the BTS participants and one Community worker mentioned empowerment. The group focuses on building capacity within the members of the town to address the issues of suicide by teaching skills they can use to prevent it. Participants also referred to interventions that people in the community carried out with a person who has thoughts of suicide.

4.4.1 Education

The group felt that education was the key way in which suicide could be prevented within the community as the group felt that suicide is a community issue so therefore a whole community intervention was required. They aimed to achieve this by delivering the training for free. P1 described how the training teaches people the skills necessary to carry out an intervention, which involves asking a person if they are suicidal and then taking steps to keep them safe;

'It teaches them a skill, you know, that they can ask and they can link…..they can help keep people safe right now, you know….I think it also gives them a part back in that they be aware then, like, you know, from the training of people who are on the committee and who are active.(P1)

One community worker referred to the training as a way in which people are given a vocabulary to have a difficult conversation about suicide, again making reference to the interventions that community members are training to carry out with a person who may be having thoughts of suicide.P3 elaborated further on how people feel equipped to ask people if they are feeling suicidal, after they complete the training;

> *'That you've resources in the town that are trained to spot and intervene with people who are suicidal and also have the information on the different resources that are available'*(P3).
>
> *'They now feel equipped to go home and ask their son or their brother or their uncle, whatever it is, are you suicidal? They feel they can ask the question with the confidence'(P3).*

4.5 Theme Four: Integrated Response

Integrated response was a re-occurring theme that emerged through the research when participants were asked questions on the activities of the group, following discussion on how the aim of the group has changed. The following sub themes emerged under this main theme; People embedded in the community, Capacity building in other communities and Policy development. There appears to be two different levels at which BTS are trying to prevent suicide, in their own community, through supporting other communities. There was also a consensus among the group that while the group was initially set up to prevent suicide, the direction of the group had changed, and the group was now involved in intervening with people who were suicidal on a regular basis and postvention, supporting families after a person had taken their own lives.

The research was able to get a real sense of how the group has grown and adapted its response since it began. The group felt the BTS is embedded in the community and within community members. The group also felt that is has grown as it has now begun to support other communities in creating a similar response to suicide and is involved in policy development. These themes emerged in the Community Workers interviews following discussion on how BTS responds to the issue of suicide. The theme based on policy development emerged from the data during discussions on how the group has changed since it began.

4.5.1 People embedded in the community

All participants agreed that BTS was very much a local group that worked within the town. Participants described how the group worked informally and was based on the local knowledge and how well known the members of the group were within the town. This knowledge appeared to be the basis on how the group functions. P1 described how interventions take place and are supported by this local knowledge;

'Where a family or friend is concerned about an individual, speaks with Breaking The Silence, and someone from Breaking The Silence ends up reaching out to the person that concern is about and having that conversation with them around about, you know,

are you intending to take your own life?'

P5 spoke about the group being active within the community but not being visible as such because the group has no official building. This again adds to how the informality of the group makes it a community response between people in the community who know each other; *'I suppose it's hard to see- not hard to see their role in the community but they're totally entrenched in the community… They're just there'.* P3 & P1 also spoke about how the groups response to suicide is integrated within the community as different voluntary organisations and clubs are involved in either responding to a person who is suicidal or becoming involved in the training;

'We do a huge amount of work with the local family resource centre. We liaise with them, like, especially with their low-cost counselling… we do work with all the sports clubs. There is a few businesses to kind of link in with a liaise with from time to time on different things' (P3)

4.5.2 Capacity Building in other Communities

All of the participants spoke about how the group has now begun to expand and build the capacity in other communities to respond to suicide. The group has tried to do this by supporting other communities in developing a similar response to that of the BTS. Members felt that the group did this by providing training, while the community workers felt it was more than just the training. P2 spoke about a specific community they supported by providing training following a suicide;

'Oh, bigtime, yeah. We've also provided services to other communities where there could be a suicide within the community. Take for instance the 'town'. There was an unfortunate… suicide there and we responded by within a month we had trained over a hundred and fifty people in the town alone'

The Community workers felt that in addition to providing the training they also provide moral support and gave advice in how to respond to this issue at the community level and at individual level. P4 outlined their experience of seeing this capacity building and moral support in action as they had worked with some of the groups involved. P5 spoke directly about their experience of being one of the community groups that the BTS had supported. They felt that it was through training and at an individual level in which they were supported; *'I suppose then on individual levels if I ring for a consultation around something that I'm doing myself, if there's a call comes in here, I'd always ring one of the lads'*

4.5.3 Policy Development

Members from the group and one of the Community Workers spoke about how the group is now involved in the development and implementation of suicide prevention policies. This was a goal the group had for a number of years and now there are several members of the BTS that are now involved in the policy development. One member of the group is chairing the community development committee, while another two members sit on the development and training committee. This shows how the group's response has started at the bottom community level and has worked up to policy development level. P5 outlines this was always a target for the group;

> *'One of the main goals that we set down in 2010 was to at some point get in to influence policy and strategy, which with connecting for Life now I'm chairing the community development. So we're getting there with our achievement to kind of having our own input into national strategy'*

One of the community workers spoke about how the group has always been working towards this goal and had made an effort to always keep pressure on for the issue to be addressed even before they were appointed to the committees;

> *'The fourth is by acting as a prod in the side of the rest of us, whether it's the statutory sector of the reset of the voluntary sector in terms of, you know, look we need to keep the pressure on this, don't give up with this, let's keep talking about training, let's keep talking about working together' (P4)*

4.6 Discussion

The research found that all participants felt that initial aim of Breaking The Silence was to prevent suicide within their town. The participants felt a sense of ownership over of the problem at a local level and therefore felt it required a community response. The group then decided to use the training to try and prevent suicide. This kept the response at a local level, as the training allowed ordinary members of the community to be involved in the response and play their part in preventing suicide. These findings correlate with certain aspects of the literature on the community development model of community work. The literature states that within this approach there is a large emphasis on *'promoting self-help using education and building neighbourhood capacities for problem solving'* (Popple, 2015). P3 describes the groups response to suicide, in similar terms '*By education you know own community you can then create, as per the mission statement, a suicide safer community'.*

The literature states that there are several key features of this model. The collective action feature is described as people identifying the aims they have in common which then results in the mobilisation of community members to develop a joint plan of action. This is strongly correlated with the findings of the research. P4 gave an outside perspective and directly related the groups response to this feature, *'a couple of lads got together and out of their own money went and got trained and brought this training back and rolled it out'*.

Group members felt that they needed to remain independent from the state in order to be able to continue to work that they were doing. This appeared to be both a factor that contributed to the uniqueness of the group but could also be a challenge. This again correlates with the literature, as remaining independent is a principle of the community development approach. Self-reliance is outlined as an important principle of community development, as there is an emphasis on sustainability within the organisation. This means that the communities rely on their own resources rather than being dependant on external provided resources (Ife, 2013). Ife (2013) highlights that reliance on external support can result in the loss of autonomy and independence as there can be accountability requirements placed on the community group. (Ife, 2013)

These findings from the research show that the key tool the group has used to prevent suicide is empowerment through educating members of the community in how to respond to a person who may be suicidal. The group educates members of the community using safeTALK and ASIST training to be active participants in trying to prevent suicide. This finding is again similar to the literature which described empowerment as a key element and value in the community development model. Ife (2013) states that valuing local knowledge is an essential part of community work, as it is the community members who have the experience of the community, of its needs and problems its strengths and positives (Ife, 2013). These findings have identified that it is activities that educate members of the Community, which is the group's main suicide prevention strategy. This has a strong correlation with the literature on the gatekeeper training. The literature states that a gate keeper is defined as person who has been trained to recognise and intervene with those who may be at risk of suicide. This can be done through use of safeTALK and ASIST training in the community which is what the BTS has done (Rodgers, 2010).

This type of intervention also correlates with several aspects of the literature on models of suicide prevention. Such as the primary intervention activities, which are aimed at promoting a healthy lifestyle and increasing opportunities for readily available training. The primary prevention is described as activities that are designed to discourage or interfere with completion of suicide, which is the aim of the safeTALK and ASIST training as described by P3 *'…people would be aware of the signs that young people have in the build up to suicide ideation…they would be trained in how to approach them in a direct manner...'* O'Connor (2011) states that primary prevention encompasses activities that promote the awareness, recognition, empathy and better understanding of mental illness and suicide. There is a strong correlation with this type of prevention and the one used by Breaking The Silence (O'Connor, et al., 2011).

All participants mentioned the group's activities in terms of interventions, prevention and postvention. The findings presented show that the activities are focused on several different levels on suicide prevention; preventative work, interventions and postventions. The finding correlates with different aspects of the literature in models of suicide prevention. P1 outlines this *'We started out about suicide intervention and it's become a lot more than that.*

Like it's become prevention, intervention, and postvention' The literature refers to the three stages of prevention through three different types of activities. The activities are one that take place before a suicidal behaviour occurs, as a suicidal behaviour occurs, and after a suicidal behaviour occurs (O'Connor, et al., 2011). This would suggest that the BTS model is a primary, secondary and tertiary model of suicide prevention.

Elements of the literature on the social planning approach correlate with the findings within the sub theme policy development and capacity building in other communities. The social planning approach is characterised by community groups that work directly with policy makers and service providers to sensate them to the needs of specific communities and to assist them to improve services or alter policies (Twelvetrees, 2002). The findings from the research showed that the group has three members who are now actively involved in policy development and implementation.

The research findings also showed that the group is involved in building the capacity of other communities to respond to suicide. As P2 highlighted; *'We've also provided services to other communities where there could be a suicide within the community'.* The literature states that social planning approach is involved in assisting groups to run their own activities and projects (Twelvetrees, 2002).

4.7 Conclusion

In this chapter the primary research explored questions three and four and through thematic analysis. The data was presented under several main themes and sub themes. The data was then discussed within the literature at the end of the chapter. The research question one and two will be explored within the next chapter of the study. This chapter has outlined why the BTS was set up and has located the group within models of suicide prevention and models of community work. This chapter also examined the personal impact, which did not correlate with any literature. This could be due to limitations in the study, which will be examined within the next chapter. While the researcher aimed to give an equal amount of discussion to each theme that emerged, a limitation of the study is that is a small-scale study and the researcher is limited to the word count

Chapter Five: Conclusion and Recommendation

5.1 Introduction

This chapter will provide a summary of the overall findings of the research. It will consist of several conclusions and recommendations which are based on findings and analysis of the primary and secondary research that has been carried out. The first two research questions will be answered using the literature review and the third and fourth research questions will be answered using the primary research and the literature. This chapter will also include the limitations of the study, my reflection on the research process and the implications of this piece of research for Social Work practice.

5.2 Conclusions

5.2.1 International models of community level suicide prevention interventions

The main models of international suicide prevention interventions were found to exist within several levels. The primary care model included an improvement of depression recognition and suicide risk evaluation by GPs (van der Feltz-Cornelis, et al., 2011). The population model interventions focus on the general public and gatekeepers. High risk groups is a model that focuses on people who are risk of suicidal behaviour and depression. Restriction to access to means of suicide, for example gun control. The last model of intervention found was, targeted population where the intervention is focused on specific groups of society such as psychiatric patients, older people and ethnic minorities (van der Feltz-Cornelis, et al., 2011). The literature did not find any specific model of community level suicide prevention intervention, rather the models of community interventions take place within all levels. These models can be categorised into three levels of suicide prevention strategies; activities before the suicide occurs such as primary prevention, activities as the suicidal behaviour occurs such as secondary and activities after the suicidal behaviour occurs which would be tertiary.

5.2.2 International models of suicide prevention reflected in Irish Policies

The main goals within Ireland's most recent suicide prevention strategy, Connecting for Life 2015-2020 reflect aspects of all the levels of the international models of suicide prevention interventions (Health Service Executive, 2015). Goal one focuses on increasing the nations understanding of suicidal behaviour and mental health. This is a population level intervention as outlined above. The second goal is focused on improving the community's capacity to respond to suicide and also to provide training which also relates to population level intervention, specifically the gatekeeper aspect. Goal three is a targeted approach which focuses on suicide prevention among priority groups, including young people. This goal reflects the targeted population model. Goal four is concerned with improving pathways to treatment for people who are vulnerable to suicide, this is reflected within the primary care model. Goal 6 is the same as the restriction to access of means of suicide model. This policy was developed based on the previous suicide prevention document, Reach out 2015-2014 which has similar goals (Health Service Executive, 2015).

5.2.3 Breaking The Silence Model of Suicide Prevention Intervention

The Breaking the Silence aims to prevent suicide by carrying out a number of activities. The main activities of the group focus on interventions, postvention and prevention through training while also contributing to policy development and implementation. Because of the variety of activities carried out by the group, there are several levels of suicide prevention interventions identified within the literature which the group uses. The BTS uses multiple levels of intervention; prevention, intervention and postvention, this correlates with the literature of suicide prevention models, which indicates the BTS uses all three models; primary, secondary and tertiary. The findings also located the BTS strongly within a specific prevention model gatekeeper training.

5.2.4 Location of Breaking The Silence Model within the community context

This model of suicide prevention in which the BTS uses fit in two community work models; community development and social planning. There was a strong correlation between the theme community ownership and empowerment and many elements of the community development model of community work. Integrated response was a theme which also arose and linked the BTS with the social planning approach in community work.

5.3 Research Recommendations

5.3.1 Self-Care and Sustainability

One theme that presented itself within the research which did not present in the literature was, personal impact. In light of this finding, I recommend that further research is carried to locate a model of self-care that can be used for the BTS in order to sustain themselves in their work as volunteers.

The findings under the theme, expertise, showed that members of the group felt concerned about sustaining the group and re-creating the level of expertise that would be lost as members leave the group and new members are recruited. For the reason, I recommend that further research is carried out on the areas of recruitment and sustainability within voluntary community groups in order for the group to develop or find a framework which enables them to sustain the group. Which may include training and mentor processes for new members.

5.3.2 Policy

As highlighted within this research the BTS is a multilevel community level suicide prevention group. There is a large emphasis in the current suicide prevention policies, Connecting for Life and Connecting for Life Cork that it is within the community that protective factors against suicide can be developed and implemented (National Office for Suicide Prevention, 2017). Considering this I recommend that similar further research is carried out in the literature and on the BTS to develop a framework for a model that can be used to foster these protective factors by developing community suicide prevention groups. A similar point was mentioned by P1 under the future recommendation theme.

5.3.3 Social Work Practice

Within the primary and secondary research that was carried out, there appeared to be a gap or lack of Social Work involvement. It is important to note that this could be due to the limitations of the research, being that it is a small-scale study and only selected literature was reviewed. However, given that it is stated in the CORU standards that a Social Worker must, 'Demonstrate intervention skills of planning, implementation, evaluation and closure, contracting, negotiating and formulating plans with service users and providers' (CORU, 2014 p.16). it is also important to have knowledge of the concepts and explanatory frameworks that underpin a range of theory's including community work theory and practice. It would be beneficial that there is research carried out on the role or contribution Social Work has in community suicide prevention interventions. Suicide is still a major public health issues and addressing the issue within communities is a large focus of the Ireland suicide prevention polices.

5.4 Limitations & Strengths

There were a number of limitations that the researcher noted throughout the research process and upon reflection. As this was a small-scale study the amount of literature the research could review on the levels of suicide prevention intervention were curtailed. This influenced the researcher as there is an extensive amount of research on suicide prevention. The researcher was limited to which literature could be reviewed. Again, due to timeframe and limits on the small-scale study, not all members of BTS were interviewed. If this research were carried out again a more extensive literature review would be carried out, which would include models of self-care for volunteers and frameworks for recruitment volunteers. All members of the BTS would be interviewed to provide a more in-depth study of the group.

5.5 Implications for Social Work practice

This research is important in terms of Social Work practice as it serves as source of information on suicide prevention and different models and levels in which suicide prevention occurs internationally and nationally. The research highlights the importance and weight placed the community response to suicide within policies on suicide prevention. This research is beneficial to Social Work in general as suicide is a public health issue and Social Workers and work with clients who are affected by these types of issues. More specifically the research serves as guide to Community Social workers in how to support communities in preventing suicide and how to develop an evidence-based community response to suicide.

5.6 Reflection

I initially thought about selecting a different topic that a community had presented to be researched. However, after watching the presentation on the dissertations; 'Evaluation of the Cork Parent Infant Network Group' and **'***An Exploration of Anticipatory Grief in Families of Children with Mitochondrial Disease and the Role of Social Work'* I became inspired to

carry out research on the community group I was involved with, BTS. The area of suicide prevention has always been something I have been very interested in and upon reflection I can see that it is the passion for the area that gave me the motivation to pursue and complete this project. I discussed the possibility of carrying out this research with my tutor and several other lecturers on the course. I contacted the chairperson of the BTS and discussed the CARL project and how it could benefit the group. Following this conversation, I then set about starting my dissertation.

When carrying out the literature review I realised the importance of journaling and using supervision. I found that I was focused on finding a specific model of suicide prevention that explained the group rather than looking at all the models and locating which one was similar to the group. I realised through reflecting and following discussion with my supervisor that I was looking at the literature as a member of the group rather than a researcher. This was a moment for me in which I realised the difference and that I needed to view the topic from a research perspective and put aside what I knew. I did this by journaling and constantly reflecting upon what I researched and questioning myself and my choices.

At this stage in the research process I was concerned that because of my involvement in the group that I may not be able to carry out the research. However, following discussions with my tutor I realised that this was not a reason that would prevent me from carrying out the research, rather it was a strength I could foster throughout the research process as I had an insider's perspective. Looking back upon the research process I can see how it has supported my professional development as a Social Worker. Suicide prevention work is something I do voluntarily. Taking a step back from the work and looking at it as a researcher has allowed me to further develop the skill of being objective and developing an ability to look at my own work using different lenses. I also feel that carrying out this dissertation has enabled me to develop my interviewing skills. Upon reflection my first interview I realised I prompted too much and needed to interview as a researcher. I can see now that I was trying to use to skill of reflecting too much. I have learned from this experience that it is important to reflect upon the purpose of the and interview before meeting with a client to select the correct interview skills to gather the information that is needed. A Social Worker may need to adapt their questioning style

depending on the context and purpose of the interview. I can see now that I was drawing on therapeutic interviewing skills I learnt on placement when I should have been using research interview skills.

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Appendices

Appendix 1: Confirmation of Ethical Approval

Dear Rebecca
The Social Research and Ethics Committee has reviewed and approved your application Log 2018-003 entitled "Profiling the Breaking the Silence's community lead multilevel intervention for suicide prevention".

The committee wishes you every success with your research and thanks you for your patience during the application process.

All the best

Liz

Appendix 2: Information Sheet

INFORMATION SHEET



Purpose of the Study. As part of the requirements for the Masters in Social Work at University College Cork, I have to carry out a research study. This study is a CARL project which will aim to profile a community lead multilevel intervention for suicide prevention. The community group that will be profiled is the Breaking the Silence. Please see the attached information sheet for further information on CARL projects.

What will the study involve? This is a qualitative study which means participants will be interviewed using a semi-structured interview schedule to obtain data needed to carry out the research. The research will take approximately nine months to complete. Participants will be interviewed for a minimum of 60 minutes and a maximum of 90 minutes. Participants will be asked approximately 6 questions.

Why have you been asked to take part? You have been asked to take part because of your experience of being a member of the group or because you have experience of working with the group. You are suitable to provide data for this study based on your experience.

Do you have to take part? You do not have to take part in this study. Participation in this study is completely voluntary. You will get a copy of this information sheet and the consent form. As stated on the consent form if you agree to take part you still have the option of withdrawing before the study commences. After data collection you have a two-week period to choose to withdraw your data and have it destroyed. After the two-week period I cannot guarantee that your data will not be used in the study.

Will your participation in the study be kept confidential? The research will try to protect anonymity ensuring that there no clues to your identity appear in the thesis. Membership of the group will make it difficult to protect your anonymity in this project. Your name will not be mentioned in this research. Any extracts from what you say that are quoted in the thesis will be entirely anonymous. However, as this research is focused on a specific community group which will be named in the thesis I cannot fully guarantee confidentiality.

What will happen to the information which you give? The information will be kept confidential for the duration of the study, available to only me and my research supervisor. The physical data will be kept in a locked office in University College Cork and the electronic copy will be stored on a password protected laptop in an encrypted file. On completion of the project, the data will be retained for a further 10 years and then destroyed.

What will happen to the results? The results will be presented in the thesis. They will be seen by my supervisor, a second marker and the external examiner. The thesis may be read by future students on the course. The study may be published in a research journal and may also be viewed by the National Office for Suicide Prevention and by the Health Service Executive. This is a CARL project and may also be published on the CARL website.

What are the possible disadvantages of taking part? I don't envisage any negative consequences for you in taking part. It is possible that talking about your experience in this way may cause some distress. If this happens all participants will be offered a debriefing after the study and will be provided with details of supports that are available to them.

What if there is a problem? At the end of the procedure, I will discuss with you how you found the experience and how you are feeling. If you subsequently feel distressed, you can contact the supports below or ask the researcher for a list of alternative supports.

Samaritans: 116123 Pieta house: 02143431400 Pieta house helpline: 1800247247

Who has reviewed this study? Approval must be given by the Social Research Ethics Committee of UCC before studies like this can take place.

Any further queries? If you need any further information, you can contact me or my

supervisor: Rebecca Donnachie, 0852345646, 16221798@umail.ucc. Eleanor Bantry White,

021490228, E.BantryWhite@ucc.ie.

***Disclosure: The researcher is a member of the Breaking The Silence community group. For the purpose of this project, the researcher will be acting as an independent researcher and not as a member of the group.**
If you agree to take part in the study, please sign the consent form.

Appendix 3: Consent Form

CONSENT FORM

University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

I……agree to participate in Rebecca Donnachie's research study.

The purpose and nature of the study has been explained to me in writing.

I am participating voluntarily.

I give permission for my interview with Rebecca Donnachie to be audio-recorded.

I understand that I can withdraw from the study, without repercussions, at any time, whether before it starts or while I am participating.

I understand that I can withdraw permission to use the data within two weeks of the interview, in which case the material will be deleted.

I understand that anonymity will be ensured in the write-up by disguising my identity.

I understand that disguised extracts from my interview may be quoted in the thesis and any subsequent publications if I give permission below by signing this

(Please tick one box:)

I agree to quotation/publication of extracts from my interview ☐

I do not agree to quotation/publication of extracts from my interview ☐

***Disclosure: The researcher is a member of the Breaking The Silence community group. For the purpose of this project, the researcher will be acting as an independent researcher and not as a member of the group.**

Signed: …… Date: ……..

PRINT NAME: ……

Appendix 4: Interview Schedule One

1. What is the purpose of Breaking the Silence
   Why was the group set up?
   How has this changed since the group began?
   In what way is this a community response?

2. In what way do you think this is reflected in the activities carried out by the group?
   What are the activities?
   What does this look like?
   What does this mean for members of the community?
   Do you think people now feel empowered from these activities?
   What supports the activities of the group?

3. Do you think that the aims of the Breaking The Silence fit in with the Connecting for Life Strategy goals?

4. If you have been involved in the implementation of the Connecting for Life Cork Action Plan could you tell me a bit about this?

5. What are the links between Breaking the Silence and the National Office for Suicide Prevention?

6. Do you feel that people have ownership of the group at a local level?

7. Do you think that the group meets local needs?

8. How do you see the group developing in the future?

Appendix 5 Interview Schedule Two

1. What do you think are the needs in your community? (Issues related to suicide)
2. How do you think Breaking The Silence respond to these issues?
3. What do you think is the contribution of Breaking The Silence?
4. What is your understanding of the work carried out by Breaking the Silence in the community?

   Probe: Role, Function, Purpose