Towards Understanding

A Suicide Information Booklet

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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Foreword

Suicide is always a tragedy, for the life that has ended and for the family, friends and community left behind.

The increase in the number of people, particularly males, taking their own lives in Ireland in recent years is a major cause for concern as is the increase in the numbers of people, particularly females, engaging in self harm behaviour (Parasuicide).

The prevention of suicide is an important issue for us here in Ireland. The reasons why people die by suicide are wide and varied. Having basic information and awareness on the issues surrounding suicide is very important if we are to tackle the problem of suicide in our country.

This booklet is designed and written to give you that basic information about suicide in Ireland. It is written in the hope that by increasing awareness of the risk factors and warning signs to look out for and by knowing what to say in a supportive manner to a person in distress may support you in helping others who may well be in crisis.

Regional Suicide Resource Office
January, 2006

AN OVERVIEW OF SUICIDE/PARASUICIDE

Introduction

Suicide is a major public health issue. Both the United Nations (UN), and the World Health Organisation (WHO) consider suicide to be a significant threat to public health. The tragic reality of suicide is enormously difficult and deeply traumatic for families, communities and society as a whole. Death by suicide is complex, and its covertness and unpredictability can leave the individuals and communities left behind, grappling with a frightening sense of helplessness.

In 2005 the Tánaiste launched the "Reach Out – A National Strategy on Suicide Prevention 2005-2014". This strategy contains actions to be implemented under the heading of General Population, Targeted Approach, Responding to Suicide and Information & Research.

In Ireland, suicide rates were relatively low by international standards until the early 1970's. Unfortunately, the rate of death from suicide has doubled since 1976 from 5.7 per 100,000 to 11.5 per 100,000 in 2002. While the number of deaths attributed to suicide in 1945 was 71, the number in 1998 was 514. Most striking is the rise in male suicides, (378 males in 1997), particularly young males in the 15-24 and 25-34 age groups. The rates for females have remained relatively stable over the past 20 years in all age groups except the 15-24 age groups which has been steadily rising since the early 1990's. Suicide numbers are highest for females in the 45-64 age group. The registered number of suicide deaths in 2003 was 444.

The most common method of suicide in Ireland is hanging, followed by drowning. A consistent trend has been that females use the less lethal / violent methods. Over a five year period (1997-2001), data from the CSO confirms that hanging was the most commonly used method by males in all age groups and by females in the younger age group. Poisoning and drowning were the other common methods used by females.

Parasuicide is a term broadly used to describe 'attempted suicide'. It refers to a deliberate act of self-harm not resulting in death. Neither of the terms are accurate in that, in some cases, where there is deliberate self-harm, suicidal intention may be absent. The person's behaviour may simply be a cry for help and they may have no real intention of ending their life. Common to these behaviours is that individuals inflict acute harm upon themselves, poisoning or injuring themselves with non-fatal

outcome.

The National Suicide Research Foundation Parasuicide Register covering the year 2003 recorded 9,839 deliberate self harm presentations made by 7,825 individuals over the period from January 1st to December 31st 2003. Of the 9,839 presentations in 2003, 42.6% were by men and 57.4% were women. I n most age groups the number of acts by females exceeded the number by men particularly in the 10-19 yr age group. A notable exception to this was in the 30-34 year age group where there were marginally more episodes by men than by women. Almost half of all presentations (46.9%) were by people under 30 and 88.9% were by people aged less than 50 years.

The two main methods of parasuicide nationally are overdose and cutting. 73.1% of all episodes involved overdose, 64.1% male and 79.8% female with 42.6% of all cases involving alcohol. The other main method, cutting accounted for 23% men and 14.3% females. The more lethal methods, such as hanging, drowning and firearms are rarely used in parasuicide.

Suicide attempt is our strongest predictor for possible repeated behaviour and between 10-15% of attempters will eventually complete a suicide.

Parasuicide is a growing phenomenon in our society particularly among our adolescents. The behaviour seems to reflect the degree of helplessness and hopelessness of young people coping with life stresses, their impulsiveness in relationship breakdown, and the vulnerability of those with low education, income and unemployment.

SUICIDE – FACT & FICTION

There are a number of commonly held misconceptions or myths about suicide. Some of these can hinder those who attempt to identify and ultimately help people who may be suicidal. By removing these myths and by having possession of the facts we can strive to remove the stigma associated with suicide. This may ultimately lead to a greater recognition of people in distress. It may also assist in providing people with the knowledge they require in order to assist people in accessing help and treatment when required.

The myths listed below are a sample of the types of statements commonly heard in relations to suicide. They are not listed in any particular order.

Fiction: People who talk about suicide don't die by suicide.

Fact: Evidence suggests that most people who die by suicide have given definite warnings of their intention. These may be verbal or non-verbal. An ability to recognise the warning signs, risk factors and situations is therefore important.

Fiction: Talking about suicide or asking someone if they feel suicidal will lead to suicide attempts.

Fact: Talking or asking about suicide will not cause a person to kill him/herself. For a person who is in distress the opportunities that can be opened for them by simply asking the questions can be immense. It can provide them with an opportunity to discuss the difficulties in an open and frank manner. The questions can be asked in a manner of ways such as:
"Do you feel like harming yourself?"
"Do you feel like ending your life?"

Fiction: Suicidal people are absolutely intent upon dying.

Fact: Suicide can be prevented. People can be helped. Most suicidal people are ambivalent about dying. The immediate objective of the person is to be released from the pain and suffering that they are enduring. Many people who have experienced suicidal thoughts or who have engaged in suicidal behaviour, no longer have the desire to die by suicide, once they have received help.

Fiction: People who attempt or threaten suicide are merely attention seeking.

Fact: All threats or attempts at suicide should be taken extremely seriously. Do not dismiss them as merely attention seeking. Remember that this may be the only way that the person in distress can ask for help. The attention they are seeking may well save his/her life.

Fiction: After a crisis, improvement means that the suicide risk is over.

Fact: Research indicates that the period following a crisis, such as that period following discharge from hospital may be a high-risk period. A sudden apparent lifting of a person's mood may in fact be the result of the person having finally made a decision to die by suicide.

Fiction: Suicidal behaviour is a sign of mental illness.

Fact: Mental illness is indicated in a large percentage of suicide deaths. However not all deaths by suicide are a result of having a mental illness. Suicidal behaviour may indicate deep unhappiness. The expression of hopelessness in a person is another strong indicator of an individual at risk.

Fiction: You are either the suicidal type or you are not.

Fact: Suicide can happen to anyone. The phenomena of suicide crosses all boundaries, it is no respecter of age, religion, socio-economic grouping, culture or perceived standing in the community. Any person who is in distress, this distress should it impact deeply enough on that person may lead then to suicidal behaviour.

Fiction: There is no connection between alcohol and suicide.

Fact: Alcohol/drug abuse and suicide do have a correlation. Such substances cloud our judgement. Alcohol on its own has a depressant effect. Its consumption when one is already feeling low can lead to greater feelings of depression. Alcohol and drug taking can also lead to greater impulsivity, which can be a factor in suicide and attempted suicide at times.

Fiction: Suicide is painless

Fact: Many methods of suicide are very painful both to the individual and to those left behind. The bereaved are left to cope with a very traumatic bereavement and will experience a wide range of emotions such as shock, guilt, shame, blame, anger, suicidal thoughts themselves, loss of trust, loss of self esteem and confidence and much more. These emotions can last for a very long period of time and for some people, lead to a protracted painful bereavement process.

CAUSES OF SUICIDE

Suicide is a tragic event. It is also a behaviour that is very complex. The factors that impact on an individual that lead to choosing suicide as an alternative are multi-dimensional. Numerous factors frequently occur simultaneously providing a bio-psycho-social model for the causes of suicide. Such a model indicates that biological, psychological and sociological factors in combination can have an adverse on an individual and can lead to suicide. To look for one particular cause and state that it was the reason for the person's death can be simplistic and wrong in the vast majority of cases.

"Suicide is not a disease. It is an expression of a host of emotions, hopelessness, guilt, sorrow, loneliness, rage, fear, shame, that have their root in psychological, social, medical and biochemical factors" (Psychological Society of Ireland 1992).

Research has shown that depression or other diagnosable mental illnesses or substance abuse disorders play an important role in suicide. Other research indicates that alterations in neurotransmitters, such as serotonin, are associated with increased risk. Reduced levels of this brain chemical have been found in the post mortems of people who have died by suicide. Along with this, adverse life events associated with factors such as depression can lead to suicide. These would include sociological and psychological factors.

The table below outlines some, but not all, of the causative factors under three headings.

Sociological	Psychological	Biological
Changing family structure	Mental well-being	Genetics
Marital breakdown	Personality	Psychiatric illness
Changing cultural values and religious practices	Psychosocial	Physical illness
Unemployment/employment		
Alcohol and substance misuse		
Increased availability of methods of suicide		

THE MEDIA

There have been many studies made on the reporting of suicidal behaviour by the media, in an effort to establish whether there may be a link between the reporting of suicide and copycat suicidal behaviour. There is ample evidence, as Pirkis and Blood (2001) and others have shown, that media portrayal and reporting can contribute to suicidal behaviour. Added to this is the growing evidence that the reporting of specific methods of suicide can shape the behaviour of individuals who are already at risk (Veysey et al.,1999 and Ashton & Donnan 1981). There is also a body of evidence that links the fictional portrayal of specific methods of suicidal behaviour in television drama for instance, to a considerable increase in the use of those particular methods (Schmidtke & Hafner, 1988).

A number of organisations have responded to this evidence, by compiling guidelines to help journalists report sensitively and appropriately on suicidal behaviour. The World Health Organisation is one example of such an organisation, and in our own country, the Irish Association of Suicidology have also produced guidelines regarding media reporting. It also follows that positive portrayals of individuals coping with difficult circumstances in fictional television drama might prove to be a powerful influence in the prevention of suicide. All of this points to the importance of harnessing the potential of the media for positive prevention.

RISK FACTORS FOR SUICIDE

To recognize a person who is feeling suicidal it is necessary to have knowledge of the potential risk factors and warning signs of suicide. The next two sections look at this information and it may be helpful to you if you are concerned about a person in distress.

Risk factors are stressful events, situations and/or conditions that may increase the likelihood of a person completing a suicide. Risk factors may be present at birth e.g. family history of suicide/genetic predisposition: they may develop as the person goes through life e.g. depression/alcohol use: these are sometimes referred to as long term risk factors. Risk factors may also be present at the time the person is suicidal acting as a triggering or precipitating factor e.g. a stressful life event such as a relationship break-up, loss events such as bereavement/financial and a humiliating experience such as imprisonment (or threat of). These precipitating factors are also referred to as short term risk factors. Other risk factors are of a sociodemographic nature and include sex, age and marital status. If we have knowledge of these risk factors and warning signs of suicide we may be able to recognize a person in distress and encourage the person to get help. The risk factors for suicide are shown in the table below:

Long-term factors	Short-term/precipitating factors	Sociodemographic factors
Psychiatric illness	Interpersonal problems	Sex
Alcohol and substance misuse	Rejection	Age
Previous suicide attempt	Loss events	Marital status
Family history of suicide	Work problems	Occupation
Physical illness	A humiliating life event	Unemployment
Loss		Access to the means

LONG-TERM FACTORS

Psychiatric illness – International studies reveal that approximately 90% of all suicides show symptoms of mental illness (Barraclough 1974). Depression is the most common diagnosis in completed suicides accounting for more than half of all suicides. It has a high prevalence in the general population but is often not detected and goes untreated. This occurs because people are often embarrassed to admit that

they are depressed as they see it as a sign of weakness and also it may present as a wide variety of vague aches and pains. Depression is a treatable illness and anti-depressant medication has a 60-70% response rate. Some of the symptoms of depression are: feeling sad most of the day every day, losing interest in usual activities, losing/gaining weight, sleeping too much/little, feeling tired all the time, feeling worthless and guilty, feeling irritable, having difficulty in concentrating and making decisions and having thoughts of suicide. Approximately 10% of people with schizophrenia die by suicide and it is the single largest cause of premature death among people with schizophrenia (Tsuang et al, 1980). Research findings indicate that people with personality disorder represent a major risk for suicide, particularly people with borderline and antisocial personality disorders.

Substance misuse – Alcohol has been recognized for 40 years as a major contributor to suicide. Overall, substance abuse (alcohol included) is found in 25-55% of suicides (Rich et al, 1986). Alcohol acts as a depressant, impairs problem solving ability and increases the likelihood of acting impulsively on suicidal thoughts. Further negative consequences of substance misuse include damaged social relationships, poor work performance, deterioration in personal care and health. About one-third of suicides in this group appear to have been precipitated by loss or disruption of a close personal relationship (Murphy and Robins, 1967). The occurrence of depression along with substance misuse increases the risk significantly.

Previous suicide attempt – Past suicidal behaviour is a significant risk factor for suicide. 1-3% of people who attempt suicide will die by suicide within one year and 10-15% of people who attempt suicide may eventually die by suicide. Two-thirds of suicides have a history of a prior attempt, yet at least half have had no contact with a mental health professional in their final year of life (The International Handbook of Suicide and Attempted Suicide). It may be possible to prevent many suicides if the underlying psychiatric and social conditions of people who attempt suicide are treated more effectively.

Family history of suicide – Research from family, twin and adoption studies show that there is a genetic susceptibility to suicide. This susceptibility is only likely to manifest itself in a person at times of severe stress or when ill with a major psychiatric illness. Non genetic factors may also play a part as in the case of a family model of suicidal behaviour.

Physical illness – Physical illness especially those of a chronic nature are common among suicides. Cancer, multiple sclerosis, stroke, spinal cord lesions and epilepsy are associated with increased risk. Having a physical illness may be accompanied by pain, disability, worry, limitations in social behaviour, loss of ability to work etc all which may result in disillusionment and development of suicidal behaviour.

Loss – Research shows that the death of a parent during childhood may increase the risk of suicide in adulthood (Roy, 1983). Recent bereavement, particularly of a spouse or parent is also a risk factor. Losses may also include loss of status, identity or finance as perceived by the person.

SHORT-TERM/PRECIPITATING FACTORS

The majority of people who die by suicide have experienced a number of stressful life events prior to the suicide which may have triggered the suicide, such as:

- Interpersonal problems e.g. quarrels with spouse, family, friends
- Rejection- e.g. separation from family and friends, by a significant other
- Loss events- e.g. financial loss, bereavement
- Work problems- e.g. job loss, retirement, disappointment with performance
- A humiliating life event e.g. being arrested, legal problems, being found guilty

SOCIODEMOGRAPHIC RISK FACTORS

Sex – More males complete suicide than females

Age – The elderly (above 65) and the younger (15-30) are at increased risk of suicide

Marital status – Divorced, widowed and single people are at increased risk of suicide

Occupation – Certain occupational groups such as veterinary surgeons, pharmacists, dentists, farmers and medical practitioners have a higher risk of suicide.

Unemployment – There are fairly strong associations between unemployment rates and suicide rates although the nature of these associations is complex.

Access to the means – the risk of suicide is increased when a person has access to the means to carry out the suicide. Reducing access to methods of suicide has been identified as a way of reducing numbers of suicides. Suicide by firearms accounts for 1 in 8 young male suicides (15-24 years) and 1 in 10 older male suicides. The Task Force Report on suicide recommends safe storage of firearms and scrutinizing of applications for firearms. Poisoning accounts for 17% of suicides and in 2001 statutory regulations placed restrictions on the sale and supply of paracetamol in shops and chemists.

PROTECTIVE FACTORS

Protective factors are the positive conditions, personal and social resources that promote resiliency and reduce the potential for suicide. The absence of risk factors is protective in itself. The following have been found to be specific protective factors:

- Hopefulness
- Current mental health care
- Responsibility for children
- Strong social supports (actually feeling supported)
- Remaining in education

CONCLUSION

Risk factors that describe something about the person (depression, communication of intent) are more predictive than sociodemographic factors (divorce, unemployment). The presence of depression with other risk factors considerably increases the risk. Risk factors may be long term e.g. presence of psychiatric illness: and they can be short term e.g. a precipitating life event such as interpersonal problems. If you are concerned about a person it is useful to consider both long term and short term factors and any factors that might protect the person.

WARNING SIGNS OF SUICIDE

Warning signs are changes in a person's behaviors, thoughts, physical appearance feelings and in what they are saying which are considered unusual for that person and out-of-character. The warning signs for suicide can be very similar to the signs of depression. In some cases it is possible for a person not to show signs of suicidal behaviour and to mask their emotional distress. However it is thought that the majority of people give signs and communicate their intent before taking their life. The signs can be very direct in some situations and other times they are covert and difficult to detect. Some warning signs can be associated with everyday behaviour and should be looked at in the context of the overall picture of the individual. The following are common signs that may be noticed:

Warning signs – behaviour

- Difficulties in school/work
- Dropping out of activities
- Sleeping/eating disturbances
- Isolating self from friends/family
- Drug/alcohol abuse
- Disinterest in usual activities
- High risk behaviours

Warning signs – physical

- Neglect of appearance
- Personal hygiene/dress neglected
- Persistent physical complaints

Warning signs – thoughts

- Pessimistic
- Inability to find solutions to problems
- Overly self-critical
- Difficulty in concentrating

Warning signs – feelings

- Restless/agitated/irritable
- Feelings of hopelessness
- Expressing feelings of low self-esteem
- Feeling depressed (sad/angry)
- Feeling life is meaningless
- Sudden improvement in mood

Suicide specific warning signs –

- Ideas and themes of depression and death
- Writing/speaking about suicide
- Listening to music with a suicide theme/art work
- Threats and statements about suicide
- Life threatening risk taking behaviour
- Tidying up affairs (giving away possessions, making a will)

WARNING SIGNS OF SUICIDE

Direct verbal clues	Less direct verbal clues
q "I wish I were dead"	q "You'd be better off without me"
q "I'm going to end it all"	q "I'm so tired of it all"
q "If x doesn't happen, I'll kill myself"	q "What's the point of living?"
	q "You won't have to worry about me soon"

While some warning signs may typically indicate greater risk than others, a less obvious sign may be particularly telling for a given individual. Also, while a greater number of signs might seem to indicate greater potential for suicidal behaviour, there will be cases in which a few or only one could help to recognise suicide risk. A person may experience a number of these warning signs and not have thoughts of suicide.

To find out if a person is feeling suicidal, we need to ask the person about thoughts of suicide directly and clearly, "Are you having thoughts of suicide?" The next section 'Responding to the Suicidal Person' looks at this in more detail.

RESPONDING TO THE SUICIDAL PERSON

Introduction

All suicide threats should be taken seriously. To respond to such a situation is very difficult because we feel inadequately trained or prepared to respond to something so serious. This is very natural and it's good to keep in mind that even those who are trained to respond find it difficult also.

The following are guidelines around how best to respond to someone who is in distress or suicidal.

Guidelines in Responding

There are two basic skills involved in responding to a person who is in distress or suicidal.

1. Attending
2. Active Listening

Attending

F.L.O.W.E.R.

- ❖ Face the person
- ❖ Lean forward
- ❖ Open posture
- ❖ Watch the person
- ❖ Eye contact
- ❖ Relax

Active Listening

Dos	**Do not**
Give the person your full attention	Argue
Show interest	Make value judgements
Be warm and supportive	Give advice
Pay attention	Find the solution
Ask for clarification	Give out platitudes
Be silent	Interrupt
Allow time	Burden the person

The following suggestions offer some direction on how best to respond to someone that you have become aware of, who may be at risk, or someone who indicates to you that they may have intent of suicidal behaviour. These are adapted from A. Leenars, 'Helping your suicidal student', (University of Leiden, Netherlands).

- **Believe it**: Always take threats seriously. Do not presume that they are looking for attention: "I noticed changes in you lately".
- **Listen**: Take time to listen to the person. Encourage them to talk about their thoughts and feelings. Paraphrase what the person is saying. This involves playing back or feeding back to the person what they have said to you; eg. "so what I'm hearing, is that you're drinking a lot, and that there's a lot of rows at home, and that it's causing you a lot of distress". This helps the person to feel that they are being listened to, and also gives the person the chance to add more detail, or to say more about their distress and difficulty. Use mainly <u>open ended</u> questions, ie. questions that illicit information and details from the person rather than a yes/no response, and <u>closed</u> questions when a definite response is needed.
- **Check it out**: You may want to check it out with another person, eg. parent, friend or school principal. You may want to check with the person themselves if they have intent. It's important to remember that asking the person if they are thinking about hurting themselves or if they have suicidal intent, does not put the idea into their head. Enquire, clearly and directly, about suicidal thoughts and feelings; use the persons own phrase for suicide; " Do you feel that life is not worth living?", "Are you thinking of harming yourself ?" Find out if they have plans; "Have you made plans to end your life?" or if they have the means or method; "do you have an idea of how you are going to do it?" If they have the method at hand do not leave them alone.
- **Be calm and understanding**: Don't panic or sound shocked by anything the person may say. Do not debate whether suicide is right or wrong. This will only increase the person's own sense of anxiety and frustration and affect your own ability to respond.
- **Do not promise confidentiality**: Do not promise to keep such talk or behaviour secret. This is one secret you should not keep. Try to lead the person down the road of accepting help, letting them know that you are there for them and can find them help.
- **Show you care**: Make it clear to the person that you understand and that you are concerned and that you want to help them and that help is available: "I'm worried about you and I want to help". Focus on the person's strengths; "how have you resolved difficulties before?" Explore alternatives to suicide.
- **Be honest**: Do not give false reassurances; " Everything will be all right", or trivialise their situation or their distress; "now things can't be that bad".
- **Seek help**: Encourage the person to seek professional help. If the risk remains high and they refuse to seek help, contact someone for them. Remember that you do not have to cope with this on your own and that it's not wise to do so. It's important to involve others, parent/guardian, spouse, G.P. or counsellor. Know the services in your own community area. If you discover the person while the suicidal act is in progress, call an ambulance and the Gardai immediately in case the person has taken some life threatening action.

THE IMPACT OF SUICIDE ON RELATIVES AND FRIENDS

Each individual's grief is unique to himself or herself however there are some common emotions that people experience at different stages following a death. You may feel some or all of these emotions as you grieve for your loss. You may also feel these at different stages over time.

Shock

- Of discovering the body
- That the person killed him/herself

Distress

- That the person is dead
- That suicide is the cause of death

Guilt

- For in some way contributing to the suicide
- For not preventing the suicide
- For poor parenting, the breakdown of the relationship or for sibling rivalry with the deceased before death
- For not identifying the suicidal behaviour before the death
- Using the guilt to punish oneself for the suicide
- About a death wish
- At the sense of relief following the death
- From the content of the suicide note

Anger

- At the deceased for the emotional pain and added responsibilities, at being cheated out of the relationship, at not being able to retaliate
- At the system, self, press, therapist, doctor, God

Questioning

How?

- What method and substances were used

Why?

- The events and relationships leading to the death

- The state of mind of the deceased before the death

Shame

- About mental illness, the suicide, blame, guilt

Blame

- Towards other people for their contribution

Fear of Another Suicide

- Over protection of family members

Suicidal Thoughts

- To join the deceased
- From the loss of meaning and purpose in life, clinical depression

Loss of Trust

- Difficulty in maintaining old or forming new relationships
- Loneliness and social isolation

Wasted Life

- Remorse at unfulfilled talents and opportunities

Crisis of Values

- Fall of self-esteem
- Confusion in personal and religious values and beliefs

Unfinished Business

- Wishing the deceased had known how much he/she was appreciated and loved
- About past disputes

Grief Recovery

- Reasoning that the deceased is out of emotional pain
- Discerning a peaceful expression on the deceased’s face after death
- Fulfilment of the deceased’s wish
- The strength of the deceased
- Relief that the suicide is over
- Recognising that there may be few answers
- Developing a new spiritual relationship with the deceased
- Finding reason for the loss

Alcoholics Anonymous
Tel: 01 4538998

Aware (Defeat Depression)
Tel: 01 6617211
Helpline: 1890 303302
E-mail: aware.se@o2.ie

Bodywhys
(Support Group for Eating Disorders)
Helpline: 1890 200 444
Web: www.bodywhys.ie
E-mail: watbodywhys@eircom.net

Childline (24 hours)
Tel: 1800 66 66 66

Comhairle (social services information)
056 7765176

Citizens Information
1890 777 121

Cura (unplanned pregnancy)
1850 622 626

Garda Confidential Line
Tel: 1800 666 111

Gay Switchboard
01 8721055

GROW
Tel: 1890 474474
Kilkenny Tel: 056 7761624
Web: www.grow.ie
E-Mail: info@grow.ie

Mental Health Ireland,
Mensana House, 6 Adelaide Street,
Dun Laoighre, Co.Dublin
Tel: 01 2841166
E-mail: info@mensana.org
Waterford Office: 051 848659

Narcotics Anonymous
086 3791784

National Pregnancy Helpline
1850 49 50 51

Out and About Association
140 St Laurence Rd
Clontarf, Dublin 3
Tel: 01 8338252

Parentline
1890 92 72 77

Rainbows, Loreto Centre,
Crumlin, Dublin 12
Tel: 01 4734175
www.rainbowsireland.com

Rape Crisis Helpline
1800 32 32 32

Schizophrenia Ireland
Helpline: 1890 621 631
Kilkenny office: 056 7756210
Web: www.sirl.ie

Senior Helpline
Tel: 1850 44 04 44

Solas-Barnardos
Child Bereavement Services
01 4732110
www.barnardos.ie

'Talk It Over'
Suicide Bereavement Support Group
(South East)
Tel: 1850 201 249

The Samaritans,
Tel: Helpline 1850 60 90 90
E-mail: jo@samaritans.org

Carlow Women's Aid
Tel: 1800 444 944
Tel: 059 9130720

Console (Bereavement)
1800 201 890

Kilkenny Women's Refuge Project:
(Amber)
056 7771404
1850 424244

Women's Refuge
Cuan Saor, Clonmel.
052 27557

Oasis House Women's Refuge,
Waterford
051 370367

Wexford Women's Refuge Project:
053 9121876

Contacts:
National Suicide Research Foundation, 1 Perrott Avenue, College Road, Cork
E-mail: nsrf@iol.ie
Web: www.nsrf.ie

Irish Association of Suicidology, 16 New Antrim Street, Castlebar, Co.Mayo
E-mail: joscott@eircom.net

Irish Association of Counselling and Psychotherapy
8 Cumberland Street, Dun Laoghaire, Co. Dublin
Tel: 01 2300061

Websites:
www.nsrg.ie National Suicide Review Group
www.ias.ie Irish Association of Suicidology
www.suicidology.org American Association of Suicidology
www.afsp.org American Foundation for Suicide Prevention
www.wfmh.com World Federatrion of Mental Health
www.mentalhealthireland.ie Mental Health Association of Ireland
www.nsbsn.org National Suicide Bereavement Support Network
www.samaritans.org Samaritans
www.aware.ie Aware
www.indigo.ie/ala Alcoholics Anonymous
www.bodywhys.ie Bodywhys
www.sirl.ie Schizophrenia Ireland
www.rainbowsireland.com Rainbows organisation
www.barnardos.ie Barnardos
www.cidb.ie Comhairle

READING & CONTACT LIST

Reading & Resource Material:

- *A Special Scar* – 2nd edition The experiences of people bereaved by suicide Alison Wertheimer Published 2001 by Brunner-Routledge
- *Cultivating Suicide* – destruction of self in a changing Ireland, Caroline Smyth, Malcolm Machachlen and Anthony Clare. Liffey Press.
- *Death: Helping children understand*. Barnardos
- *Living After a Death* by Mary Paula Walsh, Columba
- *Mental Health Matters* - a resource pack. Mental Health Ireland
- *Reach Out* - A National Strategy for action on suicide prevention 2005-2014, Dept. of Health & Children 2005
- *Responding to Youth Suicide and Attempted Youth Suicide in Ireland*" Barnardos
- *Suicide and the Irish* by Michael J.Kelleher. Mercier Press, 1996
- *Suicide in Ireland. A global perspective and a national strategy*. Aware Publications
- *Suicide in Ireland: A national study* (2001). Departments of Public Health on behalf of the CEOs of the Health Boards.
- *Suicide in Ireland* by Fergal Bowers. Irish Medical Organisation, 1994.
- *Suicide Prevention:* a resource handbook for your organisations. National Youth Federation.
- *Suicide Prevention in Schools*: Best Practice Guidelines. Irish Association of Suicidology and National Suicide Review Group
- *Suicide: The Irish Experience* by Seán Spellissy. On Stream Publications Ltd, 1996.
- *When someone close dies*. Beaumont Hospital
- *Bereavement Information,* Information for people bereaved through suicide or other sudden death – Regional Suicide Resource Office, HSE South East.
- *Towards Understanding* – A Suicide Information Booklet – Regional Suicide Resource Office, HSE South East.

REGIONAL SUICIDE RESOURCE OFFICE

The objective of the Regional Suicide Resource Office is primarily to support local services throughout the Health Service Executive (HSE) South East region, through close collaboration with local area teams on issues relating to suicide and parasuicide.
The office also works closely with the various voluntary community groups in the development of community based initiatives aimed at increasing awareness of the issues associated with suicide and para-suicide.
The aim of the service is to seek a reduction in the incidence of suicide and para-suicide in the south east region.

Training And Development
The Regional Suicide Resource Office has a Training and Development Section attached to it. There are two Training/Development Officers one of which provides services in the Wexford and Waterford community service areas with the other Officer providing services to the Carlow/Kilkenny and Tipperary S.R. community care areas.
The role of the Training/Development Officer is to develop and deliver training programmes relating to suicide issues at the level of prevention, intervention and postvention to both the statutory and voluntary sectors in the region. Four priority groups have been identified as the main focus of training and development work.

- Health Service Staff
- Schools and Third Level Colleges
- Youth Workers
- Community

The range of training they provide is as follows:
- Applied Suicide Intervention Skills Training (A.S.I.S.T)
- Community Gatekeeper Training (Concerned About Suicide)
- Concerned About Suicide - One Day Programme in Suicide Awareness
- Older Adults: Depression and Suicide
- Suicide Awareness in Schools - An Education Programme for Teachers

Resource Publications
The '***Help and Health for you***' information cards were updated and reprinted in 2006. These cards contain information relating to HSE services and local support

groups along with regional and national support numbers.
Three Resource Publications were published by the Suicide Resource Office in 2003.

The Bereavement Information Booklet and Towards Understanding Booklet are available on the HSE intranet www.hse.ie

The '***Bereavement Information Booklet***' is an information support resource for people bereaved through suicide or sudden death.

Towards Understanding A Suicide Information Booklet provides detailed information on suicide in Ireland.

'**Suicide Awareness – An Information Pack for Post-Primary Schools'** provides guidance to principals, guidance counsellors and teachers so they are best able to respond to and address issues of suicide prevention in the three areas of prevention, intervention and postvention. This is not a stand alone pack and is distributed to staff who attend the 14 hour teacher training programme only.

Our contact details are as follows:
Regional Suicide Resource Office,
Front Block, St. Patrick's Hospital,
John's Hill,
Waterford.

Tel: 051 874013
Fax: 051 853037

Email: sean.mccarthy@maila.hse.ie
john.kennedy1@maila.hse.ie
agatha.lawless@maila.hse.ie

Our opening hours are:
Monday - Friday: 9am - 1pm, 2pm - 5pm

If you have any suggestions/comments about this publication please contact:

Suicide Resource Office,
Front Block,
St. Patrick's Hospital,
John's Hill,
Waterford.

PERSONAL CONTACT LIST

Please fill in your own local support numbers:

Contact	Name	Phone Number
Family Member/ Friend		
Doctor/CareDoc		
Local Hospital		
Gardai		
Health Service		
School Principal		
Other School Contacts		
Clergy		
Local Bereavement Support Group		
Other Relevant Numbers		
Self Help Group		
Samaritans		1850 60 90 90
Aware		1890 30 33 02

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