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## **An Overview of Suicide Prevention Strategies: A Case Study of Knocknaheeny, Cork**

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### **Abstract**

Suicidal behaviour has increasingly become recognised as a major health problem in this country. This paper sets out to explore suicide prevention strategies in place to tackle this problem. It concentrates on the area of Knocknaheeny in Cork which has all risk factors for suicidal behaviour. Data was collected from national and international policies and agency publications. Theories of prevention were explored and prevention strategies which exist in other countries studied. The research was approached as a case study, with data generated from both qualitative and quantitative methodology. The research gives an insight into the activities of workers in the community and the frustrations they encounter in their daily working lives in relation to suicide prevention services. The general consensus from the findings suggested a major awareness of the need for targeted suicide prevention services. Participants all agreed that they would like to run programmes to facilitate further awareness among young people and the community at large but were hesitant as they did not have the necessary training. Formal suicide prevention services do not exist in an area which provides so many community services and has such a high rate of suicide. Though a lot has been done nationally to address the issue there is no concerted approach to tackling this problem which affects so many families in the area.

**Key words:** Suicide; risk factors; prevention; suicide prevention services



## **Introduction**

This paper reports the findings of an exploratory study relating to suicide prevention services, examining how the problem of suicide is acknowledged and addressed in a local community. Though this study was a case study of the Knocknaheeny area and the services there in relation to suicide prevention, it was conducted in a manner to give an overall view of service provision in Ireland and worldwide. Cooper and Kapur (2005; 37) suggest that some of the risk factors for suicide and suicidal behaviour include; being male, coming from a disadvantaged area, unemployment, early school leaving. A Northern Ireland Study conducted in 2003 notes that social class is also a factor with rates in class V four times as high as class I. (Dept of Health, Social Services and Public Safety). In 2001 Knocknaheeny was identified as having higher than average social welfare dependency and a higher rate of children living in poverty and a high number of early school leaving. (O'Toole; 2002; 25). With this in mind I chose the area of Knocknaheeny to conduct my study. If suicide prevention is not addressed in an area of high risk for suicidal behaviour such as Knocknaheeny, and given that it has so many service providers in the area, then it gives an indication as to how the problem is acknowledged on a national level.

## ***Statistical Report***

Statistics tell us that Ireland has one of the highest rates of suicide in Europe at the moment with the majority of deaths occurring with young males aged 15-25 years (Central Statistics Office, 2007). No one seems to be able to explain the surge in the statistics. Herbert (in Davies, 2005; 360) notes that it does not seem to relate to drug use or liberal prescriptions of medication by doctors though it might relate to the increase in alcohol consumption among this age group. He goes on to state that it is most likely attributed to marriage breakdown, unemployment and criminality. Though the actual number of suicides over the last few years has remained relatively stable - from a peak of 519 in 2001 to 409 in 2006, the number of self-harm presentations to our A&E departments in Ireland remains at around 11,000 per annum. (National Office for Suicide Prevention, 2008)



A lot has been done by the government since the mid 1990's to create awareness of suicide. Reach Out - a National Strategy for Action on Suicide Prevention 2005-2014' states: "Information on suicidal behaviour is vital in order to guide the planning of effective services and supports." Agencies have been set up to provide statistics and a lot of research has been done but the rates still remain high.

The aim of this research was to examine the provision of services in the Knocknaheeny area, to investigate whether appropriate suicide prevention courses were implemented from a national policy framework, to assess the efficacy of these programmes and explore the service providers' opinions. A further objective of the research was to examine statistics in other countries and assess what methods of prevention they have used and their effectiveness and how they could be adapted here to address the issue of suicide.

### **Literature Review**

The provision of efficient suicide prevention programmes is not possible without understanding the theory and causes of suicide. And in understanding the theory and causes of suicidal behaviour it is essential to identify what in the suicidal process itself and in its dynamics that enables the reversing of this self destructive behaviour. Orbach (2003; 235) states that one of the intrinsic features of self destruction which opens possibilities for intervention is the understanding of suicidal behaviour as embedded in a multidimensional conflict. The intense feelings of despair, pessimism and perception of death that the person sees as the only solution are usually short lived. If a person can be helped to live through the suicidal state of mind he or she may come out of immediate danger. This fact makes it possible to intervene successfully.

### ***Prevention Theory***

The majority of the literature around suicide prevention seems to agree that the best approach to suicide prevention is through a three dimensional primary prevention approach. Weisberg and Kumpfer's (2003; 4) model of prevention is based on the



concept that prevention is now a multidisciplinary science that draws on basic and applied research from many disciplines including psychology, public health, education, psychiatry, social work, medicine, sociology, criminal justice and law. They assert that these interdisciplinary origins have given strength and credibility to the field. They divided preventive interventions into three subcategories: (1) universal preventive interventions that target the general public or a whole population group; (2) selective preventive interventions that focus on individuals or population subgroups who have biological, psychological, or social risk factors, placing them at higher than average likelihood of problematic behaviour; and (3) indicated preventive interventions that target high-risk individuals. Duffy and Ryan (2004; 323) concur and inform that primary prevention refers to ‘interventions designed to prevent a disorder or problem occurring.’ National and international policies also favour the above approaches with the recommendations of the 2005 Reach Out Strategy, and the 2006 Oireachtas report directing provision of services towards universal and targeted means of suicide prevention.

### ***National Policy on Suicide Prevention***

In the years since suicide was decriminalised in 1993 with the passing of the Criminal Law (Suicide) Act, Ireland seems to have done a tremendous amount of work in the area of suicide prevention. The introduction of this Act facilitated efforts to research suicide openly and to develop strategies for suicide prevention. According to a study carried out by Begley et al for the Mid-Western Health Board in 2002 the following timeline sketches some of the major developments in suicide prevention in Ireland in recent years:

**1995:** a National Task Force on Suicide was appointed.

**1995:** the National Suicide Research Foundation (NSRF) was established with the aim of investigating the extent of suicidal behaviour and its possible causes.

**1996:** the Irish Association of Suicidology (IAS) was established to promote public and professional awareness of suicide prevention.

**1998:** the Final Report of the Task Force was published making 86 recommendations.



**1998:** the National Suicide Review Group (NSRG) was appointed by the Chief Executive Officers of the Health Boards.

**1998:** Health Boards began appointing Resource Officers for Suicide Prevention, supported by Regional Steering Committees.

**2000:** the National Parasuicide Registry was implemented by the NSRF.

**2001:** Suicide in Ireland: a national study 2 was published providing in-depth information on 2 years of suicide data in Ireland.

**2001:** the Health (Miscellaneous Provisions) Act 2001 was passed, requiring the Minister for Health and Children to report annually on the activities of Health Boards in the area of suicide prevention.

**2001:** the Medicinal Products (Controls of Paracetamol) Regulations came into effect in October .

**2005:** Reach Out, the National Strategy for Action on Suicide Prevention was launched by the Minister for Health and Children, Mary Harney TD.

**2005:** The Joint Oireachtas sub-Committee on High Level of Suicide in Irish Society was set up to investigate the phenomenon of suicide and to report on the matter.

**2006:** Seventh Report: The High Level of Suicide in Irish Society. The Joint Committee on Health and Children was established in November 2002.

**2007:** National Office for Suicide Prevention commissions a study through the HSE to inform a national mental health awareness campaign.

As shown above there has been a considerable mobilisation of resources and organisations set up nationally and regionally in the area of suicide prevention given the relatively short time frame involved. However, given that Ireland has the fifth highest rate of suicide of young males there is clearly a need to examine these responses if meaningful prevention policy is to be developed further.

### ***Risk Factors***

Before examining the preventive strategies put in place to address this crisis, it is necessary to look at the range of contributing factors believed to increase the risk of suicide. Appleby et al. (1999; 1235) assert that 'high suicide rates are particularly

associated with acute episodes of illness, recent hospital discharge, social factors such as living alone, and features of clinical history such as substance abuse and non-fatal self harm'. Hassan (1996; 2) notes that social factors that have been linked to suicide include marital status, economic cycles, occupation, and migration and ethnicity, while De Leo and Evans (2005;2) argue that detecting and treating mental illness is the key to preventing suicide. They state that the risk of suicide is highest with depression, schizophrenia, substance abuse and personality disorder. Cooper and Kapur (2005; 20) assert that assessing suicide risk involves knowledge of what makes an individual more vulnerable to suicide.

### ***Prevention Strategies***

O'Connor and Sheehy (2000;120) tell us that potential suicides come in many different guises and that healthcare professionals are not often aware of the degree of diversity within the suicidal population. They assert that suicidal people do not always present with the traditional risk factors and therefore may remain untreated and that many GP's believe wrongly that talking about suicide to these patients can increase the likelihood of the patient committing suicide.

Miller and Barber (2002; 224) tell us that existing suicide prevention programmes can be classified into two groups; clinically based casework, conducted by trained therapists and broader community based programmes conducted by 'gatekeepers' such as teachers, youth workers, medical practitioners and others. This study further notes that 80% of people who have thoughts of suicide will have communicated their intention to someone. With direct case finding they suggest screening as a cost effective way of identifying young people at risk in schools and involves systematically screening 15-19 year olds for previous suicide attempts or recent serious suicide ideation, depression or complications with alcohol or substance abuse. They maintain that young people will truthfully reveal such information. This statement is backed up by a Cork study done by the Cork Counselling Centre (2007) which surveyed 16-19 year olds about their lifestyle and coping skills. The findings surprised the agency when they discovered that 11% of adolescents had thought of ending their lives



Developing an evidence base for prevention strategies has been complicated by the complex and varied risk factors for suicide and the lack of information on the effectiveness of possible interventions. Campbell and Fahy (2004; 1) inform that the picture is further marred by the ‘conceptual difficulties such as the hypothesized continuum between non-fatal and fatal suicidal behaviour and the extrapolation of findings from those who have attempted suicide to those who go on to complete suicide.’ Indeed the previously mentioned study done by the National Suicide Research Foundation (2004;19) confirms this and found that 9% of the 4,000 students surveyed in schools reported that they had self harmed and sought no medical advice as a result. Dr. Arensman, director of the NSRF noted that a large proportion of the deliberate self-harm adolescents remain hidden from the services and, for example, teachers. She said her agency had examined the possibilities of using this information to estimate how many adolescents could engage in deliberate self-harm nationally and who, at the same time, would be hidden from the services. In their extrapolation, they came to a figure of another 10,000 cases nationwide on an annual basis. The NSRF already has a para-suicide registry which accounts for 11,000 patients who presented for deliberate self harm in the A&E departments across the country.

Suicide is a major problem and its prevention is a worldwide priority. In recent years, significant steps have been taken to reduce the incidence of suicide. Prevention initiatives have been launched in the U.S, Canada, Australia, the U.K, France, Finland and others. Appleby (2005; 2) notes that the U.K has identified a reduction in the rate of suicide by 20% by the year 2010 as a measure by which it is prepared to be judged. Duffy and Ryan (2004, 13) tell us that the first ever national Suicide Prevention Strategy for England was developed in 2002 to promote a co-ordinated approach to meeting this target. They note further that the latest available rates for 2001-3 show a rate of 8.6 per 100,000. If this trend continues, the target will be met. In Australia since the late 1990s there has been a sharp downward trend in Australian young male suicide. Morell et al (2007; 747) note that it is possible that a major government youth suicide prevention initiative, the National Youth Suicide Prevention Strategy



(NYSPS), implemented during 1995–1999 may have influenced the decline. Research in Scotland showed a 42% reduction in suicide rates among 15-29 year old men. Numerous suicide prevention policy initiatives have been implemented by the Scottish government, focussing on social exclusion and deprivation.

### **Method and Methodology**

At present there are approximately 14 service providers in Knocknaheeny working with the families and schools in the community. These services range from family support to juvenile justice schemes and are funded by the relevant government agencies. In this study the aim was to interview the coordinators of eight of these agencies and the local G.P and examine their opinions on the delivery and targeting of suicide prevention services in the area.

### ***Case study as a research strategy***

This research is best defined as a case study, where the ‘case’ is the provision of services related to suicide prevention in the geographical area of Knocknaheeny. Yin (in Holt 2005;58) states that an important strength of case study data collection is the ‘opportunity to use many different sources of evidence, a technique called triangulation, allowing the researcher to get a ‘fix’ on something by looking at it from two or more places.

### ***Data collection***

Data collection methodologies included a literature review, a review of the documents, ie, national strategies and reports, evaluation of reviews and personal interviews.

The research examined documentation relating to national strategies and policies on suicide prevention such as Reach Out, the National Strategy on Suicide Prevention, The Mental Health Act 2005, The Vision for Change Document 2006. It also analysed reports and studies commissioned by the National Office for Suicide Prevention to oversee the implementation of the national strategy and the National



Suicide Research Foundation studies on mental health difficulties of young people. Conference papers from the Irish Association of Suicidology.

Interviews were conducted with the coordinators of the service providing centres, including Springboard, Ógra Chorcaí, Youth Diversion Programmes, NICHE, (Northside initiative for Community Health and Education) along with the Gardaí, Youthreach, school completion programme and the Home School Liaison Officer from the secondary school. An interview was also carried out with the local G.P as primary care would seem to be an obvious focus for suicide prevention. Interviews, asking open ended questions, rather than questionnaires were chosen. These were carried out on a semi-structured basis asking mostly open ended questions. A few broad questions were asked about suicide prevention programmes, whether the agencies had any training in suicide prevention, whether they ran programmes in relation to suicide prevention, whether they saw the need for them, had they come across young people with suicidal behaviour and if they were aware of the Suicide Resource Officer for their area. The answers given led to asking further questions to get a true concept of the provision of services and the problems which arose.

### ***Qualitative and quantitative data***

In this project both qualitative and quantitative methods of research were used. Here the different methodological perspectives complemented each other. Oevermann et al (in Flick, 1998; 258) note that quantitative methods are research economic short cuts to process the data collected whereas qualitative methods are able to provide the actual scientific explanations of facts. The data was analysed on the basis of quantifying the percentage of agencies who had awareness of the problem of suicide, calculating the number of those who have had training in suicide prevention and examining the amount of agencies who had already provided services for suicide prevention. With this information it was possible to assess the qualitative information and explore in detail the situation in regard to suicide prevention in the area and what aspects need to be addressed.



## **Data analysis / Findings**

### ***Quantitative data***

Of the eight agencies and G.P. surveyed 100% of those interviewed had come in contact with people at some time who would have had mental health issues.

The quantitative data analysis arising from the information collected from the questionnaires showed that:

- 55% of the service providing agencies (including the G.P) had no training in suicide prevention.
- Of these agencies two were funded by the Department of Education (Home School Liaison and Youth Reach - Early School-leaving project) and two were funded by the Department of Justice (Youth Justice Project and Juvenile Liaison Programme). The G.P. was employed under the HSE.
- All of the agencies have come in contact with young people every day.

Of the 45% who had suicide training two were employed by HSE funded agencies (the Community Health Worker and a project worker from Springboard family support agency) and two worked in community run programmes (Ogra Chorcai and the Northside Initiative in Health and Community Education ). These workers were offered training in suicide prevention and awareness if they wished to avail of it.

### ***Qualitative Data***

Four dominant themes emerged as a result of the interviews around the issue of suicide prevention services in the Knocknaheeny area. Firstly, all the workers interviewed were aware of the problem of suicide in the area and wanted to help. One worker noted that she had come across a young person lately who was having suicidal thoughts and she dealt with it as best she could but she went home worrying if she had dealt with the situation properly.

Secondly, the issue of formal training was high on the agenda. Almost all of the workers (75%) had heard of the ASIST programme (Applied Suicide Intervention Skills Training). This is a programme provided by the HSE which tackles 'suicide



first aid'. Four of the eight agency workers had received this training but it seems this was only because they were connected in some way with health, either through community health programmes (the Health Action Zone worker) or HSE funded agencies like Springboard (the HSE funded Family Support Centre).

The third theme that emerged was that though formal training was not available a lot of alternative programmes were implemented by most of the community groups. In the Social, Personal and Health Education class in the secondary school the local community health worker developed a programme as a result of a student dying by suicide a few months earlier. This programme wasn't a suicide awareness programme per se but through photography, activities and discussions they got the students talking about their emotions and personal problems and the students found this very beneficial.

In relation to the interview with the G.P. he noted that he also had not received any formal training in suicide prevention though he would come in contact with people regularly suffering from depression and other mental health problems. He noted he was not aware of what programmes existed in this regard and also that there is a 'serious lack of communication between G.Ps and the HSE'. His examination of the patient would begin with an assessment and then a decision is made on whether to treat with medication, refer further or both. This has been his usual practice. He also was not aware of the Suicide Resource Officer for his area and had never been approached to take part in any training.

The fourth emergent theme was in relation to the area Suicide Resource Officer. This post was set up as part of the 'Reach Out' Strategy. Some of its functions were to direct people to support services and co-ordinate delivery of education and training programmes. The research through the interviews suggests that the majority of service providers (7 of the 9) did not know about this officer or the work she does.

### ***Findings from the Document Research***

One of the most significant findings in my research was in relation to the available suicide statistics. The Central Statistics Office website offers a breakdown of the national suicide rate. It gives a further breakdown of the Munster area, the Cork County area and then the Cork City area. It notes that in 2006 25 people died from suicide in Cork city. The Sergeant I interviewed stated that he could obtain a further breakdown which would encompass the area of Knocknaheeny and immediate surrounding areas. This would enhance my research but when he accessed this information it reported a total of 2 suicides in the area for last year. He knew this could not be correct as he had personally known of many more. It seems that after the coroner's report is finalised and the death by suicide confirmed the figures don't get conveyed back to the Gardaí. This presents as a major discrepancy in the study of the suicide rates.

Overall, the service providers are aware of the problems in the community in relation to suicide and at some level have experienced these. They all agreed that they would like to run programmes to help the situation but are hesitant because a lot of them don't have relevant training. The research suggests there is not much communication between the Suicide Resource Officer and the service providers in the area. A lot of the service providers do run programmes such as personal development which might include a module on suicide prevention if they felt it necessary though these seem to be informal and dependent on the resources on offer.

### **Discussion / Recommendations**

It seems though the willingness is there on the part of the community providers the direction is not coming from top-down in relation to national policies. There is no national action plan that can be implemented across the board and it seems if agencies want to implement a programme they do it themselves rather than seeking out their local suicide resource officer. Most agencies did not know who their resource officer was or how the National Office for Suicide Prevention could help.



A coordinated national response to suicide needs to be in place with all the various government departments involved from the Department of Health and Children to the Department of Education to the Department of Justice rolling out relevant evaluated programmes. Various suicide prevention programmes run by the HSE have been piloted around the country but these seem to be done on an ad hoc basis rather than targeting the whole country.

In this country we spent €29 million last year in relation to road safety with television campaigns running constantly. And while this is very worthwhile and necessary why is the trauma of suicide not as high on the agenda? The National Office for Suicide Prevention gets approximately €4.5 million per year to tackle the problem. Compare that with Northern Ireland which devotes £6 million (sterling) per year to suicide prevention. As a result latest figures in the Irish Times (14/04/08) show a reduction of 17% in the suicide rate in Northern Ireland in the past year. We must remember also in this comparison that Northern Ireland's population is approximately only one quarter Ireland's!

We need a massive publicity campaign like those in the U.S. with recognisable figures such as sports stars to promote awareness of depression, to destigmatize the problem and to encourage people to seek help.

We need to educate the educators, peers and parents to enable them to recognise signs and to respond when they are approached or confided in so they know how to tackle the situation effectively. The HSE runs the ASIST programme which is an excellent course in tackling these areas and shows how not to be afraid to talk about suicide.

We need to utilise the bereaved families and ask them if they are willing to talk to parents, schools, colleges, post leaving cert programmes, sports groups and any other groups that deal with young people and relate to them first hand the devastation this problem causes to families for the rest of their lives not just around the time of the funeral.



Our besieged A&E Departments have more than 11,000 admissions per year following suicidal behaviour, a significant number of whom will eventually die by suicide. Ireland has not yet put swift and appropriate standardised interventions in place to treat this high risk group and therefore reduce repeat acts. This group is an excellent base to study suicidal behaviour and to develop competent prevention strategies as a result.

Our National Strategy for Action on Suicide Prevention 2005-2014 disappointingly has not set out any specific target for the reduction in our suicide rate unlike similar initiatives in other developed countries. England aimed at reducing their rate by 20% in their 2002 National Plan and are well on the way to achieving it.



## **Bibliography**

- Appleby, L. Foreword in Duffy, D. and Ryan, T. (2004) *New Approaches to Preventing Suicide, A Manual for Practitioners*. London: Jessica Kingsley.
- Barry, M. and Connolly, J. (2002) *Suicide Prevention in Schools, Best Practice Guidelines*, commissioned by the Irish Association of Suicidology and the National Suicide Review Group. Mayo: Connaught Telegraph.
- Beautrais, A (2005) 'National Strategies for the Reduction and Prevention of Suicide Crisis', *Journal of Crisis Intervention and Suicide Prevention*, Vol 26, 1, pgs, 1-3.
- Begley et al (2002) *The Male Perspective: Young Men's Outlook on Life*, Study undertaken by the Mid Western Health Board, National Suicide Review Group, and the National Suicide Research Foundation.
- Boland R (1985) *Phenomenology: A Preferred Approach to Research*. Amsterdam: North Holland.
- Campbell, C. and Fahy, T. (2004) 'Suicide and its Prevention: Current medical Literature', *Psychiatry*, 2004, Vol. 15, Issue 1, pgs 1-5.
- Clare, A., MacLachlan, M. and Smyth, C. (2003) *Cultivating Suicide? Destruction of self in a changing Ireland*. Dublin: Liffey Press.
- Conner, K. and Goldston, B. (2007) 'Rates of suicide among males increase steadily from age 11 to 21: Developmental framework and outline for prevention', *Aggression and Violent Behavior*, Vol 12, Issue 2, pgs 193-207.
- Crowley, P., Kilroe, J. and Burke, S. (2004) *Youth suicide prevention: evidence briefing*. Dublin: Institute of Public Health in Ireland; Health Development Agency.
- De Leo, D. and Evans, R. (2005) 'International suicide rates; recent trends and implications for Australia, in *Suicide in Australia: A Public Health Perspective*', *Health Issues* 2005, Number 85, pgs 28-31.
- Department of Health, Social Services and Public Safety, Northern Ireland (2003) *Promoting Mental Health – Strategy and Action Plan 2003-2008*. Belfast: Department of Health, Social Services and Public Safety, Northern Ireland
- Department of Health and Children (2005) *Reach Out -National Strategy for Action on Suicide Prevention*. Dublin: Stationery Office.



- Department of Health and Children (2006) *Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: Stationary Office.
- Duffy, D. and Ryan, T. (2004) 'Assessing Suicide Risk' in *New Approaches to preventing Suicide; A Manual for Practitioners* London, Jessica Kingsley
- Flick, U (1998) *An Introduction to Qualitative Research*, London: Sage Publications
- Goldney, R.D. (2005) 'Risk Factors for Suicidal Behaviour' in Hawton, K, (ed.) *Prevention and Treatment of Suicidal Behaviour: From Science to Practice*. Oxford: Oxford University Press.
- Fisher, L.J. (2002) 'Population attributable risk of major depression for suicidal ideation in a random and representative common sample', *Journal of Affective Disorders*, Vol. 7, pgs 267 -272.
- Gurnee, M. (2007) *Report of Teenage Mental Health Problems, selected at random from seven schools across Cork*. Cork: Counselling Centre.
- Harrington, R. and Saleem, Y. (2003) 'Cognitive Behavioral Therapy after Deliberate Self Harm', in King, R. and Apter, A. (eds.) *Suicide in Children and Adults*. Cambridge: Cambridge University Press.
- Hassan, R (1996) 'Social Factors in Suicide in Australia; Trends and Issues', *Crime and Criminal Justice*, No. 52, Camberra: Australian Institute of Criminology.
- Herbert, M. (2005) 'The Human Lifecycle' in Davies *The Blackwell Companion to Social Work*. Oxford: Blackwell Publishing.
- Houses of the Oireachtas (2006) Joint Committee on Health & Children Seventh Report: The High Level of Suicide in Irish Society. Dublin: Stationary Office.
- Holt, S (2003) 'Child Protection Social Work and Men's Abuse of Women: an Irish Study', *Child and Family Social Work*, Vol. 8, pgs. 53-65.
- Kapur, N., Cooper, J., Rodway, C., Kelly, J., Guthrie, E., Mackway-Jones, K.(2005) 'Predicting the Risk of Repetition after Self Harm: Cohort Study', *Brithish Medical Journal*, , pgs 394-395
- Leenaars, A. (2002) Speaker at the Irish Association of Suicidology's 6<sup>th</sup> National Conference, Sligo, Suicide Prevention: School as a Place of Healing.
- Mann et al (2005) Suicide Prevention Strategies, A Systematic Review, *Journal of American Medical Association*, Vol. 294, Issue 16, pgs 2064-2074.



- McQueen, R and Knussen, C (2002) *Research Methods for Social Science: An Introduction*. Essex: Pearson Education.
- Miller, K. and Barber, J. (2002) 'Brief Intervention Strategies for the Prevention of Youth Suicide', *Brief Treatment and Crisis Intervention*, Vol. 2, Issue 3.
- Morrell, S., Page, A., and Taylor, R. (2007) 'The Decline in Australian Young Male Suicides', *Social Science and Medicine*, Vol. 64, Issue 3, pg. 747.
- National Parasuicide Registry Ireland (2003) *Annual Report*. Cork: National Suicide Research Foundation.
- National Strategy for Action on Suicide Prevention 2005-2014 (2005) Reach Out. Dublin: Stationery Office.
- O'Connor, R. and Sheehy, N. (2000) *Understanding Suicidal Behaviour*. Leicester: BPS Books(British Psychological Society).
- O'Sullivan, P. (2007) *Farranree and Knocknaheeny Springboard Project Cork: Evaluation Report*. Dublin: Child and Family Research Centre.
- O'Toole, S. (2002) North Lee Springboard Initiative'. Report compiled for the Child Care Manager's Office and North Lee Community Work Department.
- Orbach, I. (2003) 'Suicide prevention for adolescents' in King, R. and Apter, A (eds), *Suicide in Children and Adults*. UK: Cambridge University Press.
- Redfield, K. and Hawton, K. (2005) The Burden of Suicide and Clinical Suggestions in Hawton, K, (ed) *Prevention and Treatment of Suicidal Behaviour; From Science to Practice*. Oxford: Oxford University Press.
- Saraceno, Dr. (2004) Suicide huge but preventable public health problem, says WHO- World Suicide Prevention Day- 8 September 2004 -Geneva  
|<http://www.who.int/mediacentre/news/releases/2004/pr61/en/> accessed on 30/03/08
- Sarantakos, S. (1988) *Social Research*. Hampshire: Palgrave.
- Schifano, F. and DeLeo, D. (1998) Pharmacological Treatment of Suicidal Behaviour in DeLeo, D., Schmidtke, A., and Diekstra, RFW (eds) *Suicide Prevention, A Holistic Approach*, The Netherlands: Kluwer Academic Publishers.
- Sullivan, C. Arensman E, and Keeley, H.S. (2004) *Young People's Mental Health; A report of the findings from the Lifestyle and Coping Survey*, Cork: National Suicide



Research Foundation.

Walsh, Dr. D (2008) Press Release on Review of Suicide and Suicide Prevention

Thursday 6 March 2008, [www.hrb.ie](http://www.hrb.ie) accessed on 10/03/08

Weissberg, R. Kumpfer K. and Seligman, M. (2003) 'Prevention that works for Children and Youth', *American Psychologist*, Vol. 58, No. 6/7 pgs. 424-432.

Yin, R. K. (1994) *Case Study Research: Design and Methods*. London: Sage Publications.

### **Websites:**

AWARE (2008) Suicide in Ireland - A Global Perspective and a National Strategy, accessed on 01/03/08.

CONSOLE (200) Suicide Bereavement and Coping: An Exploratory Study. Trinity College Dublin: [www.console.ie](http://www.console.ie) accessed on 01/03/08 .

The Counselling Centre (2008) [www.thecounsellingcentre.ie](http://www.thecounsellingcentre.ie) accessed on 29/03/08

GROW (2008) [www.grow.ie](http://www.grow.ie) accessed on 29/03/08

Health Service Executive (2008) Guidelines for Media in relation to Suicide Prevention: [www.hse.ie](http://www.hse.ie), accessed on 27/03/08

International Association for Suicide Prevention (2008) Guidelines for suicide prevention, [www.iasp.com](http://www.iasp.com), accessed on 3/03/2008

Irish Times (2007) Tough Times: New Mental Health Campaign Reaches Out to Young People in Distress - 50% of those who die by suicide in Ireland are under 25 years old (19/06/07)

Irish Times ( 2008) Suicide prevention appeal- April 10<sup>th</sup> 2008

NOSP (2006) Annual Report 2006, [www.nosp.ie](http://www.nosp.ie) - accessed on 10/04/08