An understanding of suicide and self-harm

By Professor Ella Arensman

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Introduction

Dear Readers,

Self-harm and suicide are major public health problems. We asked Professor Ella Arensman, Research Professor at the ***School of Public Health, University College Cork,*** and Chief Scientist at the ***National Suicide Research Foundation***, to share her knowledge so that our members can learn more about the causes of suicide and self-harm in Ireland. This document covers six main topics and at the end you'll find further resources for our readers as well as some relevant help lines and websites.

About the National Suicide Research Foundation:

The ***National Suicide Research Foundation*** is an independent, multi-disciplinary research unit that investigates the causes of suicide and self-harm in Ireland. The diverse research team members come from a broad range of disciplines, including epidemiology, psychology, psychiatry and biostatistics. They undertake research into varying topics relating to suicide and self-harm in Ireland. Based on this research and its findings the foundation provides the knowledge base for suicide prevention, intervention and postvention strategies. They also provide training and positive mental health promotional programmes to a variety of audiences.

Professor Ella Arensman

Professor Ella Arensman is a Research Professor with the School of Public Health, University College Cork and Chief Scientist with the National Suicide Research Foundation, Ireland. She is Vice President of the European Alliance Against Depression, and past President of the International Association for Suicide Prevention.

She is Visiting Professor with the Australian Institute for Suicide Research and Prevention, Griffith University, Brisbane, and an expert advisor for WHO.

Prof Arensman has been involved in research and prevention into suicide, self-harm and related mental health and social issues for more than 30 years, with emphasis on risk and protective factors associated with suicide and self-harm, and effectiveness of suicide prevention and self-harm intervention programmes. In Ireland, she played a key role in developing the first and second National Suicide Prevention Programme: ***Reach Out,*** 2005-2014, and ***Connecting for Life,*** 2015-2020. She has published over 140 papers in peer review journals as well as reports for government departments and policy makers.

Understanding self-harm and suicide in young people

Self-harm and suicide in young people are major public health problems.

In recent years, international research has shown **an increase in self-harm amongst children and adolescents** and that many self-harm acts in this age group remain 'hidden' from health services. Associations have been identified with depression, anxiety, eating disorders, substance abuse, physical and sexual abuse and bullying, including cyberbullying. Suicide ***'clustering'*** is four times more common among young people (15-24 years) than in other age groups, and there are indications of increasing clustering and contagion effects in suicidal behaviour among young people **associated with the rise in social media**. In addition, in small communities, social learning processes can also contribute to clustering of suicide and self-harm.

Recently, the ***National Suicide Research Foundation*** published a new paper on the outcomes of a study examining rates of self-harm among young people in Ireland over a 10-year period, as well as trends in self-harm methods using data from the National Self-Harm Registry Ireland. The study found that peak rates of self-harm during the study period were among **15–19-year-old females and 20–24-year-old males**. Between 2007 and 2016, rates of self-harm increased by 22%, with increases most pronounced for females and those aged 10–14 years. There were marked increases in the use of highly lethal self-harm methods among both males and females. The study indicates that **the age of onset of self-harm is decreasing.** Increasing rates of self-harm, along with increases in highly lethal methods, indicate that mental health promotion and targeted interventions in key transition stages for young people are warranted.

"Suicide 'clustering' is four times more common among young people (15-24 years) than in other age groups"

In recent years, a large-scale study was conducted in Ireland among 1,112 adolescents aged 14 to 17 years, recruited from a European study: ***Saving and Empowering Young Lives in Europe (SEYLE).*** As part of this study, information was obtained on the lifestyles and mental health of adolescents, in order to identify both the risk and protective factors associated with suicidal behaviour. While the majority of adolescents reported high levels of wellbeing and low levels of risk behaviours, **23.7% had anxiety symptoms** and **13.8% had depressive symptoms**.

Suicidal thoughts were reported by 7% of the adolescents, and 3.6% reported having attempted suicide at some time in their lives.

Rates of suicidal thoughts and behaviour were very similar for boys and girls. Subgroups at elevated risk of mental ill-health included young people who had been victims of sexual or physical assault, migrants, and adolescents from the LGBT community. Lifestyle factors associated with lower levels of mental health difficulties included engaging in frequent physical activity and getting adequate sleep, indicating that these behaviours have a possible protective role.

The reasons why young people said they self-harmed were wide ranging and multiple – from wanting to die or self-punishment to wanting to experience a sense of 'relief' from a state of mind.

This clearly indicates the importance of the process of ambivalence underlying self-harm, which should guide health professionals and others involved, both in supporting young people and exploring with them any changes they would like to achieve to improve their emotional wellbeing and mental health.

The young people who participated in this research highlighted the need for school-based individual support, in particular, **the need for guidance counsellors to be available for those in distress.** A second major theme that emerged was the need for **enhanced universal programmes for mental health education.** There is growing evidence for positive mental health promotion programmes in reducing risk factors for self-harm and strengthening protective factors. The ***SEYLE intervention trial*** identified one school-based intervention, ***Youth Aware of Mental Health (YAM),*** which was associated with a significantly lower number of subsequent suicide attempts and suicidal ideation compared to the control intervention. ***YAM*** is a brief, universal mental health awareness programme which was delivered in the classroom over a four-week period and included role-play sessions, interactive lectures and workshops.

The programme aimed to improve the mental health literacy and coping skills of young people, raise awareness of risk and protective factors associated with suicide, and enhance young people's knowledge about mental health issues such as depression and anxiety.

In addition, several specific interventions, including **Cognitive Behaviour Therapy** and **Dialectical Behaviour Therapy,** have demonstrated positive effects in reducing the risk of repeated self-harm among young people. However, there is still a need for more randomised controlled trials in this area.

Professor Ella Arensman

Self-harm and suicide among people in their middle ages

People who engage in self-harm and suicide are a heterogeneous population with many different risk and protective factors associated with these behaviours.

However, in recent years, research has identified subgroups of people who share similar characteristics. **One of these subgroups represents people in their middle ages.** Comparing men and women aged under 40 and over 40 years, important differences have been found in terms of risk profiles associated with suicide and self-harm. The impact of unemployment accompanied by other risk factors (e.g. history of self-harm, alcohol or drug abuse) on suicide rates has been more strongly associated with young men, whereas co-morbid mental health and physical problems were more strongly associated with suicide and self-harm in men aged over 40 years.

Based on just over 300 consecutive cases of suicide, examined by the NSRF developed ***Suicide Support and Information System (SSIS),*** a psychiatric diagnosis was confirmed among 38.3% of the men aged over 40 years compared to 30.5% of the younger men, with depression being the most common diagnosis in both groups, although this was higher among the older men (35.9% vs. 19.5%). A history of alcohol and/or drug abuse combined was more frequently reported for the younger men (38.9%) compared to those aged over 40 years (29.6%). Of those known to have abused alcohol and/or drugs, 76.5% of men aged over 40 had abused alcohol only, compared to 27.5% for younger men. Drug abuse was higher among younger men (29.4 %) compared to those aged over 40 years (2.9 %).

Among both younger men and those aged 40 years and over, about half worked in the construction/production sector (55.8%)

"The trend for middle-aged suicide deaths has remained stable or even increased between 2009 and 2014"

and 41.3% respectively). However, a higher proportion of men aged over 40 years had worked in the agricultural sector (18.8% vs. 6.7%), while a higher proportion of younger men were students (17.6% vs. 0.0%). Among women who died by suicide and who were aged 40 years and older, a relatively large proportion (27%) had worked in a healthcare setting, which indicates the need for more awareness of risk factors associated with suicide, mental health problems, and openness in relation to help seeking behaviour among professionals working in this setting.

Middle-aged adults have a significantly lower percentage of suicidal thoughts and self-harm compared with 15 to 25 year olds, which is the age group with the highest levels of suicidal thoughts and self-harm. In addition to relatively low rates of suicidal thoughts and attempts, the trend for middle-aged suicide deaths has remained stable between 2009 and 2014.

Knowing the differences in risk among the age groups is important for suicide prevention because young adults aged 18 to 25 have the highest rate of self-harm, but those aged 45 to 64 are more likely to have fatal suicide attempts.

Therefore, it is recommended that suicide risk assessment be included as a core element of routine practice within health care services working with people with self-harm, mood disorders, alcohol/drug abuse, and physical illness, in particular men aged over 40 years. Whilst many people in the young and middle age group seem to benefit from evidence based interventions, such as Cognitive Behaviour Therapy and Dialectical Behaviour Therapy, recent research has identified a subgroup of people who engage in self-harm with longstanding Post-traumatic Stress Disorder for whom these interventions are not sufficient. Consequently, there is a need for more targeted and tailored interventions geared to specific risk profiles and needs.

Professor Ella Arensman

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Contagion and clustering of suicide and self-harm

A suicide cluster is defined by Public Health England as **'a situation in which more suicides than expected occur in terms of time, place, or both'** ***(Public Health England, 2015).***

A suicide cluster usually includes three or more deaths; however, two suicides occurring in a specific community or setting and short time should also be taken very seriously in terms of possible links, particularly in the case of young people. **Often, suicide contagion can be the starting point of a suicide cluster.** The impact of suicide contagion and suicide clusters can be devastating on families and communities.

Internationally, there is growing public and professional interest in clusters and contagion in suicidal behaviour (fatal and non-fatal). There are indications of increasing clustering and contagion effects in suicidal behaviour **associated with the rise of modern communication systems and new media.** Yet, the research in this area and information on effective response procedures and prevention strategies is limited.

Research generally **reports on suicide clustering and contagion in adolescents and young adults.** However, research in recent times also shows that suicide clustering and contagion have been found among older adults. In terms of setting, clustering and contagion of suicidal behaviour occurs in a wide range of settings including, communities, psychiatric wards, the military, prison, and work settings.

There is growing evidence supporting **the negative impact of the traditional media, the internet and social media on suicide contagion and clustering.** Information on specific suicide methods on websites is associated with significant increases

in suicides involving these methods and suicide pacts among two or more people. Internet use may exert both positive and negative effects on young people at risk of self-harm or suicide. In terms of positive effects, young people who self-harm or are suicidal, commonly use the internet for seeking support and coping with difficulties. However, there is also evidence indicating that the internet exerts a negative influence by normalising self-harm and potentially discouraging disclosure or professional help-seeking.

In this regard, it is worth mentioning the Netflix series ***'13 Reasons Why',*** which was launched in the US last year, prior to Season 2, launched in May of this year.

The International Association for Suicide Prevention (IASP) prepared a briefing expressing concern about the risks and negative impact on young people, in particular for those who are vulnerable and currently thinking about suicide.

The series is based on the novel by Jay Asher (2007), and it shows the fictional story of a teenage girl who leaves behind 13 audio recordings on tapes after taking her life. She addresses each recording to a person who she says played a role in her tragic decision to end her own life, representing a 'revenge suicide'. The clip in which she ends her life is portrayed in detail. In the months following the release of this series, there was a significant increase in internet searches relating to suicide.

Internationally, there is consistent evidence of the negative impact of detailed and graphic portrayals of suicide in terms of an increased risk of copycat suicides, in particular among young vulnerable people. Across the series of ***'13 Reasons Why'*** there is violation of media guidelines for suicide reporting, including:

- The graphic nature of reporting and the reporting of specific details of the methods involved can trigger copycat cases; the effects of exposure on suicidal behaviour and violence are well-documented.
- There is no consideration of young vulnerable people who may over-identify with the teenage girl in ***'13 Reasons Why'*** who ends her life.
- There are elements of glorifying and romanticising suicide, which may further impact on people who are considering suicide or self-harm.

It would be important for media professionals to include information on helplines and support services for adolescents and concerned parents when reporting about the series, and to adhere to media guidelines prepared by IASP and the World Health Organization, in particular ***'avoiding the explicit reporting of excessive detail of the means of suicide' (WHO, 2017).***

A further issue of concern is that ***'13 Reasons Why'*** does not consider existing evidence of positive mental health promotion and effective strategies to improve mental health difficulties and prevent suicide when topics such as depression, anxiety, and bullying are covered.

Parents, guardians, teachers and others should be aware of the need to talk with adolescents and children who are using Netflix or watching the series, and to discuss their emotions and thoughts.

Professor Ella Arensman

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Effectiveness of interventions for self-harm and suicide

In 2016, two major systematic reviews around suicide and self-harm prevention were published in Lancet Psychiatry. One review reported presented new evidence on the effectiveness of psychosocial treatments for self-harm ***(Hawton et al, 2016)***, and another review reported on the evidence base for suicide prevention initiatives over the past ten years ***(Zalsman et al, 2016)***. Both reviews represent a major resource for stakeholders in health services and policy development relating to suicide and self-harm prevention.

Psychosocial interventions following self-harm in adults

This systematic review found that self-harm (intentional acts of non-fatal overdose or self-injury) is common, particularly in adolescents and young adults aged 15-35 years, often repeated, and strongly associated with suicide, in particular among men. Effective aftercare for individuals who self-harm is therefore important.

The review included 55 randomised controlled trials including 17,699 participants. The most commonly evaluated intervention involved CBT (Cognitive behavioural therapy) - a psychological based therapy with a duration of an average of 10 sessions. At follow-up, people who had received CBT were significantly less likely to have engaged in repeated self-harm compared to those receiving treatment as usual. For people with a history of multiple self-harm episodes, **Dialectical Behaviour Therapy** was identified as reducing the frequency of repeated self-harm, but did not reduce the proportion of individuals repeating self-harm. However, the number of RCTs (Randomised controlled trials) conducted so far is relatively small. It would be important for this new evidence to be integrated in implementing the evidence

"Effective aftercare for individuals who self-harm is important"

based core interventions of the ***Irish National Strategy to Reduce Suicide in Ireland, Connecting for Life, 2015-2020 (Department of Health, 2015).***

Suicide prevention strategies revisited a 10-year systematic review

The purpose of this review was to synthesise and summarise the evidence for the effectiveness of suicide prevention initiatives since the review by Mann et al in 2005. It is timely considering the recommendations from WHO for governments of all WHO member states to develop and implement a national suicide prevention programme ***(WHO, 2014).***

As many countries are developing suicide prevention strategies, up-to-date, high-quality evidence is required.

A total of 164 studies were included in the review. The outcomes from these studies strengthen the evidence base in several areas of suicide prevention, including restricting access to lethal means, school-based awareness programmes in reducing suicide attempts and ideation, psychological treatments, in particular Cognitive Behavioural Therapy and Dialectical Behaviour Therapy, and pharmacological treatment, in particular lithium and clozapine. The review identified emerging evidence for suicide prevention by screening in primary care, general public awareness campaigns and implementing media guidelines for the reporting of suicide.

Implementation of these evidence based interventions has the potential to change public health strategies in suicide prevention plans, strengthen the recommendations of the WHO global report on suicide prevention (WHO, 2014), and significantly reduce the number of deaths due to suicide.

Professor Ella Arensman

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The impact of suicide bereavement on next of kin

Just under 800,000 people take their own lives every year[1]. An estimated 60 people are directly and intimately affected for every suicide, with 1 in 5 people being exposed to suicide during their lifetime[2]. Grief responses to bereavement generally include **shock, sadness, despair, disbelief, guilt and longing for the deceased.** Individuals bereaved by suicide can experience any or all of these grief reactions but may also experience reactions that are unique to suicide bereavement. Reactions to suicide bereavement include feelings of abandonment and anger towards the deceased. They may also experience trauma as a result of finding the body of their loved one. If grieving is prolonged and is not processed adequately by an individual, this may lead to complicated grief which is characterised by intense and long-term suffering.

Mental health outcomes following suicide bereavement

Research shows that people bereaved by suicide have an increased risk of a number of adverse mental health outcomes including self-harm, depression and suicide[3]. A mixed-methods study conducted by the ***National Suicide Research Foundation (NSRF)*** and ***University College Cork (UCC)*** found that 24%, 18% and 27% of suicide-bereaved family members in Ireland had elevated levels of depression, anxiety and stress, respectively. In-depth interviews with suicide-bereaved family members were also conducted, which found that they also experienced other psychological problems including, panic attacks, suicidal thoughts, intrusive images, nightmares and post-traumatic stress disorder (PTSD)[4].

"1 in 5 people are exposed to suicide during their lifetime"

Physical and psychosomatic health outcomes following suicide bereavement

The ***NSRF*** and ***UCC*** also conducted a review of the worldwide international literature on physical and psychosomatic health outcomes in family members bereaved by suicide. The review found that those bereaved by suicide were at increased risk for a number of adverse physical health conditions, including chronic obstructive pulmonary disease (COPD), hypertension, diabetes and cardiovascular disease (CVD). They also experienced more physical health complaints, physical illnesses and physical pain[5]. In-depth interviews with suicide-bereaved family members revealed they experienced adverse psychosomatic health experiences including feelings of nausea, vomiting, chest pains, palpitations, physical pain, abdominal pains, and breathlessness. Sometimes, these symptoms continued in the months after the death and were associated with diagnoses such as hypertension, diverticulitis and type 1 diabetes[4].

Support needs required by suicide-bereaved family members

Due to these health difficulties, **adequate formal and informal support is crucial for family members.** Participants who were interviewed endorsed informal support as being equally important as formal support.

Participants spoke of difficulties accessing formal support services due to grief reactions, being unsure where to access such support and not having the financial means to pay for such support[4].

Implications and recommendations

The findings indicate that **family members bereaved by suicide are a particularly vulnerable group,** and efforts are required to prevent and ameliorate such physical and psychological harm after suicide.
Specific recommendations include:

- **Greater awareness amongst health professionals** of the elevated levels of psychological and physical ill-health is required. Health professionals, coroners and any other professional in contact with those bereaved by suicide should pro-actively facilitate support for those bereaved by suicide.
- **Better availability of formal support services** is crucial, where accessing such support is not dependent on financial status.
- **More longitudinal controlled studies are required**, where studies examine pre-bereavement physical health.

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Guidance for parents, carers and others working with young people

The Royal College of Psychiatrists in the UK have provided evidence informed guidance on self-harm in young people for parents and carers and others working with young people

(https://www.rcpsych.ac.uk/healthadvice/parentsandyoungpeople/parentscarers/self-harm.aspx)

Why do young people harm themselves?

Unfortunately, some young people use self-harm as a way of trying to deal with very difficult feelings that build up inside. This is clearly very serious and can be life threatening. People say different things about why they do it.

- Some say that they have been feeling desperate about a problem and don't know where to turn for help. They feel trapped and helpless. Self-injury helps them to feel more in control.
- Some people talk of feelings of anger or tension that get bottled up inside, until they feel like exploding. Self-injury helps to relieve the tension that they feel.
- Feelings of guilt or shame may also become unbearable. Self-harm is a way of punishing oneself.
- Some people try to cope with very upsetting experiences, such as trauma or abuse, by convincing themselves that the upsetting event(s) never happened. These people sometimes feel 'numb' or 'dead'. They say that they feel detached from the world and their bodies, and that self-injury is a way of feeling more connected and alive.
- A proportion of young people who self-harm do so because they feel so upset and overwhelmed that they wish to end their lives through suicide. At the time, many people just want their problems to disappear, and have no idea how to get help. They feel as if the only way out is to end their lives.

“some young people use self-harm as a way of trying to deal with very difficult feelings that build up inside”

Guidance for parents:

- Notice when the young person seems upset, withdrawn or irritable. Self-injury is often kept secret but there may be clues, such as refusing to wear short sleeves or to take off clothing for sports.
- Encourage them to talk about their worries and take them seriously. Show them you care by listening, offer sympathy and understanding, and help them to solve any problems.
- Keep medicines locked away.
- Get help if family problems or arguments keep upsetting you or the young person.

As a parent it is really hard to cope with a child/young person with self-harming behaviour or who attempts suicide. It is natural to feel angry, frightened or guilty. It may also be difficult to take it seriously or know what to do for the best. Try to keep calm and caring, even if you feel cross or frightened. This will help your child/young person’s understanding that you can manage their distress and they can come to you for help and support.

Healthtalkonline has provided a resource for parents and other family members about their experiences with young people who self-harm by seeing and hearing them share their personal stories on film. You can find out what people said about issues such as why young people self-harm, discovering that a young person is self-harming, how they helped their young person, living with self-harm, support and treatment, and what helped them cope.

Read more: http://www.healthtalk.org/peoples-experiences/mental-health/self-harm-parents-experiences/topics

24/7 Mental Wellbeing Support Programme

Are you worried about a family member, friend or colleague who you feel might be self-harming or experiencing suicidal thoughts?

*Laya healthcare members can access **24/7 Mental Wellbeing Support Services** for immediate advice and support provided by our Case Management Team, who are all fully qualified and experienced psychotherapists based in Ireland.

For more details visit:
layahealthcare.ie/mentalwellbeingsupport

****Available now on a select range of schemes and to all members who renew or join after 1st July 2018***

Where to go for help:

For more articles visit www.layahealthcare.ie/thrive

ChildLine

1800 66 66 66

Suicide Support & Information

www.suicidesupportandinformation.ie

Samaritans

116 123 (free phone)

text: **087 260 9090** (standard text rates apply)

or email: jo@samaritans.ie

Aware

www.aware.ie

1800 804848 (free phone)

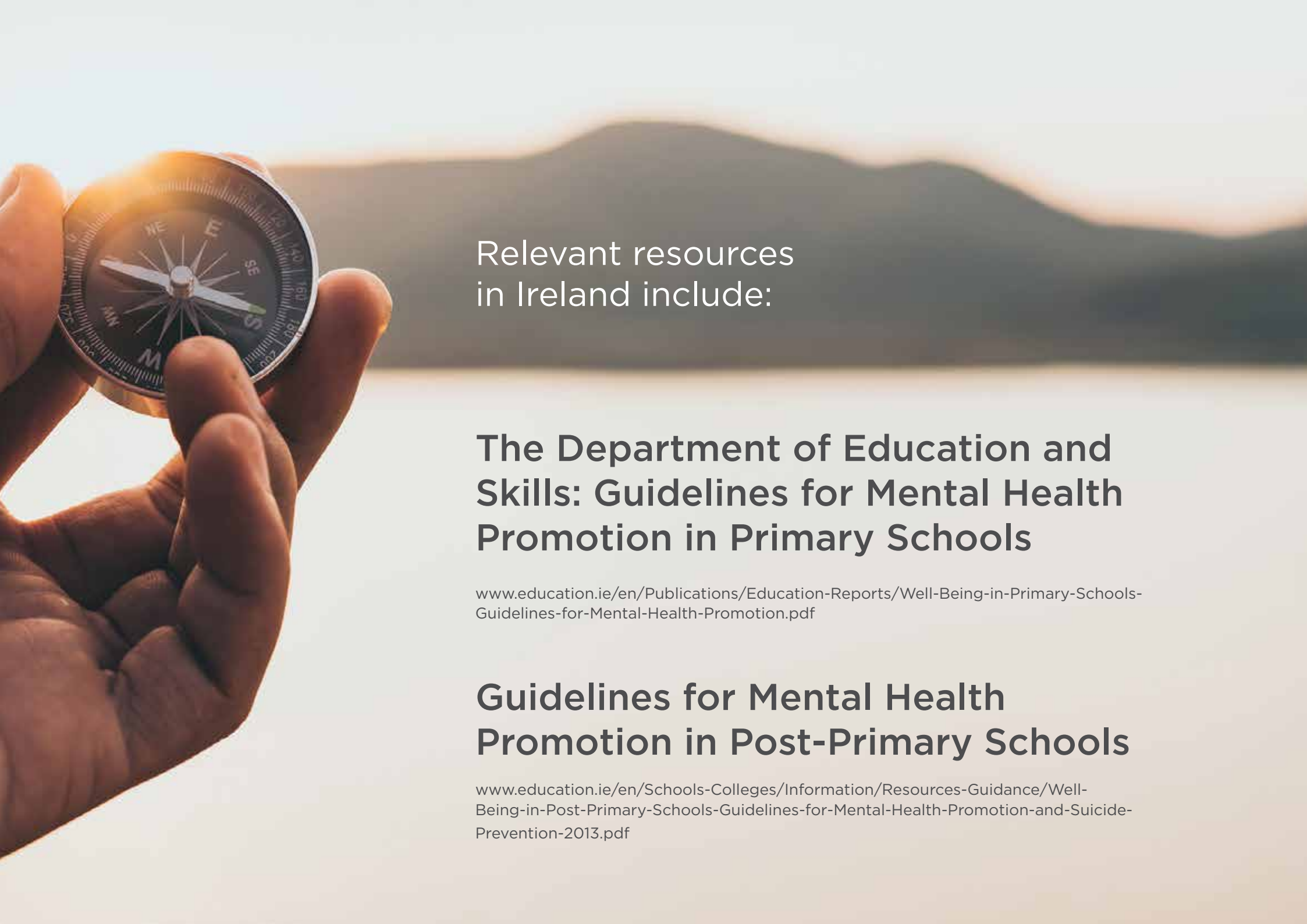
email: supportmail@aware.ie

Your Mental Health

www.yourmentalhealth.ie

Reachout

ie.reachout.com



Relevant resources in Ireland include:

The Department of Education and Skills: Guidelines for Mental Health Promotion in Primary Schools

www.education.ie/en/Publications/Education-Reports/Well-Being-in-Primary-Schools-Guidelines-for-Mental-Health-Promotion.pdf

Guidelines for Mental Health Promotion in Post-Primary Schools

www.education.ie/en/Schools-Colleges/Information/Resources-Guidance/Well-Being-in-Post-Primary-Schools-Guidelines-for-Mental-Health-Promotion-and-Suicide-Prevention-2013.pdf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