Report of the National Task Force on Suicide

DEPARTMENT
OF HEALTH AND CHILDREN
AN ROINN
SLÁINTE AGUS LEANAÍ

Report of the National Task Force on Suicide

January 1998

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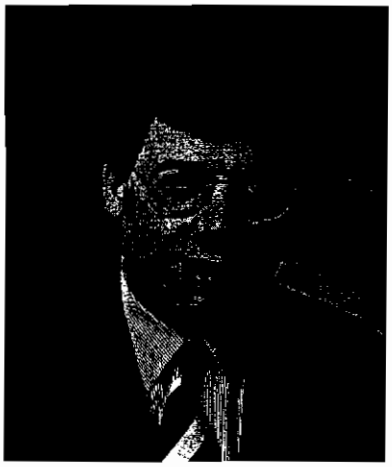


I welcome the publication of the final Report of the National Task Force on Suicide which is the culmination of detailed analysis, discussion and consideration of the factors and causes of suicide and attempted suicide. The publication of this Report will complement the Interim Report of the National Task Force on Suicide which was published in September, 1996. The Interim Report defined numerically and qualitatively the nature of the suicide problem and also the problems of attempted suicide and parasuicide in Ireland.

I attach great importance to the formulation of a suicide prevention/reduction strategy as outlined in this Report. In order to tackle this growing tragedy in our society it is essential that a clear, systematic approach aimed at the prevention of suicide and suicidal behaviour is put in place. I am glad that this Report identifies the various authorities with jurisdiction in suicide prevention strategies and their respective responsibilities. The Report will also serve as a valuable guide to the general public on how it is intended to attempt to reverse increasing rates of suicide in this country.

I wish to record my appreciation of the time, effort and expertise of members of the Task Force in the preparation of this important document and I urge that the recommendations of the Report be acted upon and implemented without unnecessary delay.

Brian Cowen TD
Minister for Health and Children
January 1998

Introduction

1. Terms of Reference

The Interim Report of the National Task Force on Suicide was published in September, 1996. The Report addressed the first two terms of reference of the Task Force – to define numerically and qualitatively, the nature of the suicide problem in Ireland and to define and quantify the problems of attempted suicide and parasuicide in Ireland including the associated costs involved. The remaining terms of reference of the Task Force will now be addressed–

- to make recommendations on how service providers can most cost effectively address the problems of attempted suicide and parasuicide;
- to identify the various authorities with jurisdiction in suicide prevention strategies and their respective responsibilities and
- to formulate, following consultation with all interested parties, a National Suicide Prevention/Reduction Strategy.

2. Membership

The members of the Task Force were:

- Mr Noel Usher, Principal Officer, Department of Health and Children (Chairman) succeeded by Mr Brian Howard, Assistant Principal Officer on 12 November, 1996
- Ms Myra Barry, Clinical Psychologist, Eastern Health Board
- Dr Rosaleen Corcoran, Director of Public Health, North-Eastern Health Board
- Dr Anne Cullen, Senior Registrar in Psychiatry, Mallard Lodge, Newport Road, Castlebar, Co Mayo
- Ms Norita Griffin, Statistician, Central Statistics Office succeeded by Ms Mary Heanue, Statistician on 27 February, 1997
- Superintendent Michael Guiney, Garda Headquarters succeeded by Superintendent John Kelly on 12 September, 1996
- Ms Mona Halligan, The Samaritans
- Mr Francis W Hutchinson, Solicitor, Coroner, Waterford
- Dr Elizabeth Keane, Director of Public Health, Southern Health Board

- Dr Michael Kelleher, Principal Investigator, National Suicide Research Foundation and Clinical Director, Southern Health Board
- Mr Patrick Rooney, Casemix Co-ordinator, Letterkenny General Hospital, North Western Health Board, Co Donegal
- Mr Joseph Treacy, Senior Statistician, Central Statistics Office
- Dr Dermot Walsh, Clinical Director, Eastern Health Board and Inspector of Mental Hospitals
- Ms Geraldine Kelly, Administrative Officer, Department of Health succeeded by Ms Margaret McDonnell, Higher Executive Officer on 26 June 1996, and Ms Caitríona Ryan, Executive Officer (Secretariat to the Task Force)

3. Consultative Process

In formulating a National Suicide Prevention/Reduction Strategy the Task Force has been engaged in a major consultative process. This involved considering in detail over seventy written submissions received from a range of interested individuals and organisations, both statutory and voluntary. The list of bodies/persons who made written submissions to the Task Force is at Appendix 5. We also met with representatives of a number of these and other organisations to further discuss and elaborate on the issues raised. We were very pleased and grateful at the impressive response from interested parties who submitted views and comments. Careful consideration has been given to the views expressed by all interested parties and this material has been of enormous benefit in the preparation of the National Strategy.

4. Number of Meetings

Members of the Task Force met on a total of sixteen occasions inclusive of six occasions the members of the Task Force convened in the preparation of the Interim Report.

5. Suicide Research Foundation

The Task Force is grateful to the Suicide Research Foundation for providing data and assistance in the preparation of the Report and the Interim Report.

Summary of Recommendations

Chapter 2 The Provision and Structures of Services relating to Suicide and to Attempted Suicide.

The Task Force recommends that:

- the study and management of suicidal behaviour be an integral part of both the training of general practitioners and their continued medical education;
- all members of the primary care team be trained in the recognition and response to the suicidal patient. This should also involve instruction in how to deal with their own and other's reactions to a completed suicide;
- the recommendations of the report on the development of mental health services, **Planning for the Future**, be implemented in full. In particular the Task Force recommends the provision of an extensive network of community-based psychiatric services, bringing specialised, multi-disciplinary psychiatric services within easy reach and accessibility of all citizens and referral agencies so that psychiatric services are readily available and acceptable to all. This will lead to more frequent and earlier referral of potentially suicidal patients and enable them to receive earlier and more effective treatment;
- all clinical personnel receive postgraduate and continued education in matters relating to suicidal behaviour;
- all undergraduate training should include a module on suicidal behaviour;
- relevant health care personnel be trained in matters relating to suicidal behaviour;
- relevant health care personnel receive continued education in matters relating to suicide;
- each health board establish a directory of names and telephone numbers of appropriate voluntary groups who contribute caring services to those in need and at risk of suicide in their own jurisdiction. The directory should also include details of statutory services in order to fully inform the public on all services;
- in consultation with the agencies, each health board develop measures to assess the efficacy and reliability of the delivery of these voluntary services

and where appropriate make recommendations for the subvention of these services;

- the directory of services should be distributed to all appropriate statutory and voluntary services and general practitioners. This information be made available, on request, to members of the public and be kept up to date;
- the Department of Justice, Equality and Law Reform ensures that coroners be offered special training in psychological management of highly sensitive issues with particular reference to adjudicating on such matters;
- coroners be made aware of where the bereaved may obtain help and that they give the bereaved this information where appropriate;
- the premises in which inquests are held be of a standard in keeping with the work involved;
- inquests be held as soon after death as is legally and psychologically appropriate;
- inquests be scheduled to take place at an appointed time so that relatives may not be unwelcome witnesses to the grief of strangers attending the earlier inquests;
- suicide awareness be part of the in-service training for members of an Garda Síochána;
- that the mentally ill in prison be given appropriate treatment;
- that in view of the marked association between drug abuse and both self-injury and death (including suicide) in prison, particular effort and resources be devoted, in conjunction with community strategies, towards addressing the drug dependency problems of prisoners;
- that the medical and caring services within prison be developed to a level which would ensure equivalence with similar community services;
- that prison officers receive appropriate training in the recognition and response to suicidal behaviour;
- that every effort be made, where possible to prevent access to illicit drugs in prisons;
- teachers, at all levels, be supported in respect of the psychological and social dimension of their work, through undergraduate and continued professional educational courses;
- programmes should be initiated aimed at teaching children about positive health issues including coping strategies and basic information about positive mental health at an early stage as a natural part of their health care curriculum;
- guidance counsellors be available in all schools;

– the psychological services delivered to schools by the Department of Education and Science be extended so that the needs of all students can be met without undue delay.

Chapter 3 The Prevention of Suicide and Parasuicide

The Task Force recommends that:

– the recommendations contained in the National Alcohol Policy be implemented in full;

– national alcohol consumption levels be stabilised and preferably reduced;

– all centres and services, voluntary and statutory, providing services for addiction include a model for treatment and awareness on the matter of suicide;

– the Department of Education and Science in conjunction with the Health Promotion Unit of the Department of Health and Children introduce a broad based Social and Personal Health Education (SPHE) Programme in our primary and secondary schools to be implemented throughout the school cycle;

– Department of Health and Children work with youth services to develop a Social and Personal Health Education (SPHE) Programme for our young out of school sector;

– Social and Personal Health Education (SPHE) Programmes include modules on depression awareness and anger control skills;

– greater collaboration take place in schools between staff, pupils, parents' associations and the local health boards to promote positive health;

– third level educational institutions pilot and evaluate the concept of peer support or "student council" as envisaged by the Department of Education and Science;

– the media, in general, and journalists, in particular, establish a code of good practice applicable to reporting matters relating to suicide and that the headline writers (editors and sub-editors) and newspaper photographers follow the same stringent code as journalists writing the particular articles;

– the reporting of individual suicides be limited to particular cases where it is thought to be in the public interest to do so. The coroner may decide to address the Press in this regard. The report should not include specific details as to the mode of the death. Nothing should be written or said that might encourage others to end their lives;

– television and radio programmes dealing with suicide and related issues be accompanied by helpline numbers and referral information;

– the two documents produced by the Samaritans entitled, 'Suicide – Fiction and Fact' and 'Signs of Suicidal Intent' be distributed to appropriate health

service personnel and to each voluntary group concerned with suicide for distribution and discussion among its members;

- suicide deaths be treated in an honest, open, caring manner recognising the loss and pain of relatives without glorifying or denying the manner of death;

- the possibility of suicide should be considered when treating people with mental health problems. In particular, pre-discharge assessments on patients leaving in-patient care should have regard to the high risk of suicide in newly discharged patients. Such assessments should therefore be thorough and comprehensive and each examination should be the subject of appropriate case note entries;

- consideration be given by statutory and voluntary carers to the potential for suicide in persons suffering from depression, alcohol abuse, schizophrenia, substance abuse and personality disorder;

- steps be taken to make the health services, including mental health services, more accessible to the public, particularly the young, who may at present perceive them as not being readily available to address their needs at times of crises;

- all suicides occurring in psychiatric hospitals and units or soon after discharge be audited so that the services and their responses can be modified where appropriate;

- young peoples suicides (i.e. those aged between 15 and 24 years) be further researched with a view to identifying and understanding the reasons why they occurred so that society may respond appropriately;

- youth mental health needs to be recognised at an early stage and interpreted correctly;

- children and young people, at a time of crisis, have access to appropriate support services and a comprehensive range of psychological and counselling services should be available;

- there be improved recognition of the risk of suicide in older people and improved treatment of depression in older people;

- the psychological needs of older people, whether due, for example, to isolation or bereavement, be specifically addressed by counselling and social intervention, and that specialised psychiatric services for older people be expanded;

- health boards put in place programmes aimed at improving coping capabilities among older people and helping them to take responsibility for their own lives. Such programmes should help older people identify mental disorder in themselves and explain the potential benefits of receiving treatment. They should also aim to familiarise younger relatives, friends and carers of the signs of mental disorder in old age;

- it be established whether suicide varies between occupational groups in Ireland and if so, whether specific work related stress is a contributory factor;
- professional organisations and occupational groups consider the provision of information on the facilities and referral services available specifically for the mental health needs of their members;
- all children be taught to swim as part of their general education with a view to enhancing health and preventing accidental drowning as well as suicide;
- life saving apparatus be available along appropriate places where there is easy access to water;
- all applications for firearms licences should be carefully scrutinised;
- the licensing authorities produce and make available for distribution a code of practice for the safe storage and disposal of firearms. Individual parts of all weapons should be stored separately;
- the availability of medicines harmful in overdose be restricted;
- appropriate regulations be made under the Irish Medicines Board Act, 1995 to give statutory effect to the recent recommendations of the Irish Medicines Board on the control of sale and supply of paracetamol containing products and the Department of Health and Children publish these changes;
- public safety information should be disseminated about commonly used drugs. In the case of paracetamol, the information should encourage early hospital treatment after overdose – emphasising the high efficacy of the antidote in the case of early interventions;
- prescribing practices which help to prevent the possibility of suicide by overdose should be included in the continuing medical education programme for general practitioners;
- consideration may have to be given in future to restricting the sale of paracetamol containing products to pharmacies depending on the impact of the recommendations of the Irish Medicines Board in reducing suicide by drug overdose;
- planning authorities, insofar as it is possible, shall endeavour to avoid possible overcrowding of accommodation in the planning, designing and location of residential accommodation;
- planning authorities, insofar as it is possible, shall endeavour to allocate housing with an objective of having a varied age structure in the local community;
- health boards put in place a range of comprehensive support services including social work services for vulnerable families or families experiencing difficulties.

Chapter 4 Intervention

The Task Force recommends that:

- all individuals who engage in acts of parasuicide should be encouraged to seek professional help, as soon as possible, after the event and, where necessary, emergency transfer arranged to the accident and emergency unit of the local general hospital;
- all relatives and friends see that appropriate health professional contact is established immediately following the act of parasuicide or as soon as possible thereafter;
- the individual's general practitioner, if known, be contacted, by telephone as soon as possible;
- every case of parasuicide seen in general hospital accident and emergency departments be examined by the liaison psychiatric team;
- every case of parasuicide be referred to the appropriate psychiatric team if such is different from the liaison psychiatric team;
- each sector psychiatric team nominate a health professional to oversee the future management of the parasuicidal patient, if this is thought appropriate, and that the parasuicidal patient be made aware who this professional is;
- the patient's general practitioner be kept informed of every step of the management of his/her patient by the psychiatric team;
- where appropriate the general practitioner be encouraged and supported in looking after both the immediate and long term needs of the parasuicidal patient;
- the underlying diagnosis in parasuicidal patients be treated by the appropriate professionals;
- where relevant, and with his or her permission, the individual be put in touch with appropriate self-help or other support groups;
- the social and psychological, as well as the medical (both physical and psychiatric) needs of parasuicidal patients be catered for;
- those with a previous history of deliberate self-poisoning be prescribed drugs which are safe in overdose;
- where only drugs, toxic in overdose, are perceived as being essential in treatment, the drugs be given in quantities that would not be life threatening if all were taken together, i.e. that those at high risk be given prescriptions restricted in time and to a particular pharmacist;
- arrangements be made either by a specific person from the psychiatric team or the general practitioner to see each parasuicidal patient again at an agreed appointed time as deemed clinically appropriate;

– the specific person from the psychiatric team or the general practitioner contact the parasuicidal patient should he or she fail to keep his or her appointment.

Chapter 5 Aftermath and Aftercare

The Task Force recommends that:

– relevant professionals whether nurse or doctor, garda, prison officer or priest be given special training in confronting and responding to traumatic situations and, in particular, in how best to communicate 'bad news', balancing truthfulness and openness with sensitivity and support;

– relevant professionals be made aware of what are the appropriate steps for distraught relatives to take should they feel they cannot cope, bearing in mind that the best solution is often to find the resources within one's own personality and social network;

– when professionals themselves have been traumatised, counselling should be made available for them by the relevant professional organisation.

Chapter 6 Research and Evaluation

The Task Force recommends that:

– the proposed new Form 104 be adopted by the Garda Síochána and the Central Statistics Office (C.S.O.);

– a nominated Garda Inspector within each Garda Division be made responsible for overseeing the use and completion of the new form;

– a Suicide Research Group be established by the Chief Executive Officers of the health boards, comprising of Psychiatrists, Directors of Public Health, and relevant researchers, to review ongoing trends in suicide and para-suicide, to co-ordinate research into suicide and to make appropriate recommendations to the CEOs;

– the C.S.O. grant the status of Officer of Statistics to a researcher appointed by the Suicide Research Group, who will assist with analysing the new information collected on Form 104, evaluate on an ongoing basis the C.SO.'s procedures for classisfying deaths as suicides and will report on these matters to the Suicide Research Group;

– the Chief Executive Officers of each health board nominate a resource officer(s) with responsibilities, in the broad field of suicide;

– the resource officer(s) shall act as a contact point with voluntary groups and facilitate research into all aspects of suicidal and parasuicidal behaviour and their consequences in the health board area.

CHAPTER 1

Extent of Suicide and Attempted Suicide in Ireland

1.1 Suicide in Ireland

1.2 Attempted Suicide in Ireland

1.3 Ascertainment of Statistics on Suicide and Attempted Suicide in Ireland

CHAPTER 1

Extent of Suicide and Attempted Suicide in Ireland

1.1 Suicide in Ireland

1.1.1 Between 1945 and 1995 the rate of suicide in Ireland rose from 2.38 per 100,000 population to 10.69 per 100,000. In the preparation of the Interim Report the Task Force examined Irish male and female suicide rates, classified by gender, in Ireland at 5 year age group intervals for the years 1991 to 1993. It found that suicide is the second most common cause of death among 15 to 24 year old males in Ireland equal to a rate of 19.5 per 100,000 population compared with 2.1 per 100,000 among 15 to 24 year old young women. During the same period from 1991 to 1993 young male suicide deaths increased from a position where they were as frequent as cancer deaths in 1976 to greatly exceeding cancer deaths by 1993.

1.1.2 A psychological autopsy of suicides in Cork between August, 1989 and January, 1993 found that only 18% of young men aged 15 to 24 years who had committed suicide had received psychological treatment in the year before their death even though almost 75% of this group were regarded as being mentally ill. Most persons who are mentally ill, however, do not kill themselves. It is thought that about 15% of those who suffer from major mood disorders end their lives.

1.1.3 In the case of older people, men aged 65 years and over have shown a significant increase in their rate of suicide from 9.4 per 100,000 population to 17.9 per 100,000 population between 1976 and 1993. In the age group 65 to 74 years there is a far greater incidence of suicide for both men and women than in the 75 years of age plus age group.

1.1.4 The increase in suicide in recent decades has been primarily a male phenomenon. The overall rate of suicide among men in 1995 was 17.17 compared with a rate of 4.32 among women per 100,000 population.

1.1.5 Slight regional variations were recorded. While all provinces have experienced a rise in male suicide, the rate for Leinster, although doubling from 7.5 to 15 per 100,000 since 1976, has risen less steeply and has consistently been the lowest since 1983. The rates of the other three, predominately rural, provinces have almost trebled, rising from approximately 7.5 to 21 per 100,000.

1.1.6 Social factors such as certain occupations, unemployment, alcohol and drug dependency and changes in family life have been identified which appear to be correlated with changes in the suicide rate. However, further research is required before a cause and effect relationship can be definitively established.

1.1.7 As regards suicide in prison the Advisory Group on Prison Deaths published in 1991 recommended that a suicide awareness group be established in each prison under the Chairmanship of the Governor of each prison. In the years 1975 to 1990 the number of deaths per annum attributed to suicide in prison in Ireland ranged from 0-5. From January 1990 to April 1997 there were a further 35 deaths in custody. The circumstances of each death in custody are examined by a Suicide Awareness Group which has been established in each prison. These examinations cover the background and circumstances of each death. Their objective is to identify, where possible, measures which might be taken to contribute to the prevention of tragic deaths of this nature. The Awareness Groups also review each suicide attempt and ensure appropriate action is taken at local level.

The National Steering Group which oversees the local Awareness Groups was established by the Minister for Justice, Equality and Law Reform in mid 1996 continues to meet on a monthly basis. It has almost completed its review of the 57 recommendations contained in the Report of the Advisory Group on Prison Deaths, published in August, 1991. The Steering Group hopes to submit a report to the Minister for Justice, Equality and Law Reform shortly.

1.1.8 In terms of lost economic productivity, the cost of 280 young adult suicides between 1991 and 1994, is estimated to amount to approximately £75,600,000. If suicides among those in older age groups are added the cost would be considerably more.

1.2 Attempted Suicide in Ireland

1.2.1 The Suicide Research Foundation has done and is currently doing extensive work in the analysis of attempted suicides in Cork. Over the years 1982, 1988 and 1992 three major surveys of self poisoners referred to casualty departments of general hospitals in Cork City have been undertaken. The results of the surveys indicate that parasuicide is most common in the late teens and early adulthood. When the rates of parasuicide are calculated it can also be seen that parasuicide is a major problem right into middle age for Cork City residents showing a fall off after 45 years. In Cork City parasuicide rates are characterised by the following social factors – domestic units mainly rented from the local authority, high density of people per room and per hectare, the majority of persons have minimum education and most are unemployed.

1.2.2 A ten year follow up study of self poisoners seen at casualty departments of general hospitals in Cork City in 1992 indicated that most of the females had multiple disadvantages in childhood; over 40% describe their childhood as unhappy and almost 50% had significant disadvantages; over 60% of women had a current mental illness and over 40% had major personality difficulties. In the

case of men alcoholism, personality difficulties and current psychiatric illnesses were factors in over half the cases. In contrast over 60% of the women and about 44% of men said that things were generally better than at the time of attempted suicide.

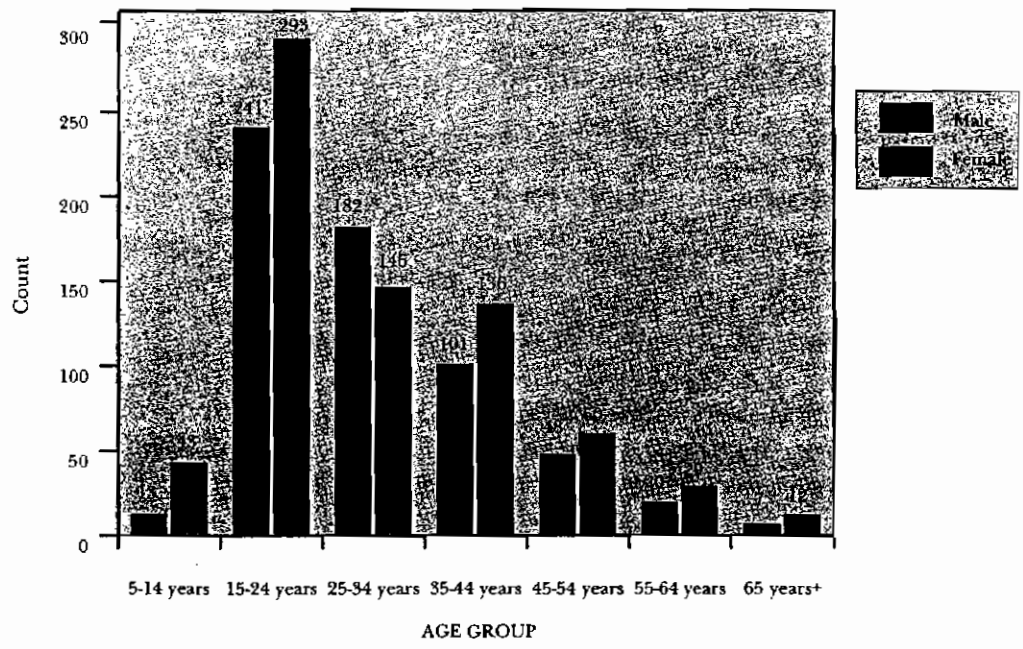
1.2.3 During 1995, with the full co-operation of the Cork City Faculty of General Practitioners, every listed family doctor within the city, the suburbs and satellite towns was contacted to ascertain the number of parasuicides that the practice had to deal with in the previous twelve months. The results are currently being analysed .

1.2.4 Since 1995, every act of parasuicide occurring within the Southern Health Board area and referred to casualty departments of general hospitals is being monitored. Since 1st July, 1995, every such act occurring in the Mid-Western Health Board has also been the subject of enquiry. An analysis of the data is now available since the publication of the Interim Report.

The number of individuals, in each age group and sex, who exhibited parasuicidal behaviour in the first twelve months of monitoring in the combined Southern and Mid-Western Health Board area is shown in Figure 1.1. The rate of parasuicide is shown in Figure 1.2.

FIGURE 1.1

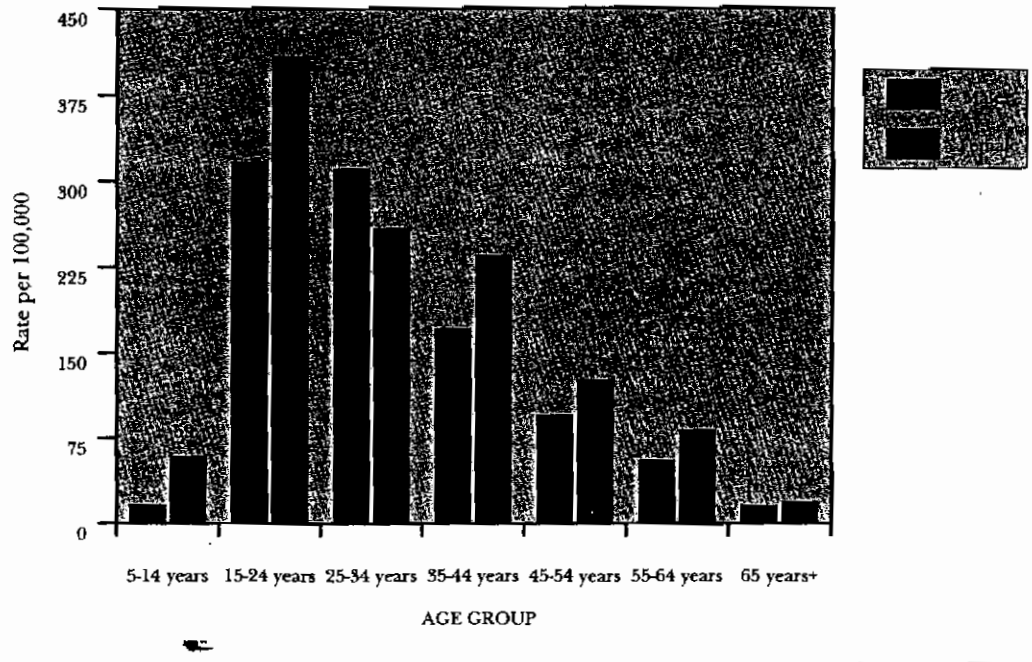
Age/Sex Distribution of Parasuicidal Individuals, Southern and Mid-Western Health Board Areas, 1995-96



Source: National Suicide Research Foundation

FIGURE 1.2

Rate of Parasuicide, Southern and Mid-Western Health Board Areas, 1995-96



Source: National Suicide Research Foundation

It is clear from Figures 1.1 and 1.2 that parasuicide is most common among those in their late teens and early adulthood.

1.2.5 As regards the cost to the health services of parasuicide, if it is assumed that each casualty referred parasuicide act on average costs the services £300 it suggests an estimated cost in excess of £100,000 per annum for the immediate response to the act of parasuicide for Cork City residents. Since the publication of the Interim Report further data has become available.

In 1995, 814 Southern Health Board residents (population 546,000) were referred to casualty with 979 acts of parasuicide (some repeating within the year). Between July 1, 1995 and June 30, 1996, 529 Mid-Western Health Board residents (population 317,000) accounted for 680 referrals to casualty due to parasuicide. This suggests an estimated total cost of £500,000 per annum for the immediate response to parasuicide in these areas. Considering that this relates to almost one quarter of the Irish population, the national cost is likely to be in excess of £2 million per annum. The final and long-term costs would be considerably in excess of this. Methods of estimating the cost of parasuicide to the Irish economy are currently being examined by the National Suicide Research Foundation.

1.3 Ascertainment of Statistics on Suicide and Attempted Suicide in Ireland

1.3.1 The Interim Report outlined how the incidence of suicide in Ireland is recorded by the Central Statistics Office (C.S.O.) and we referred to the fact that

an accurate record of the incidence of suicide is hindered by a lack of certainty in the law relating to verdicts of suicide at inquest. This has led to different applications of the law in the various coroners districts. Under the Coroners Act, 1962, the duty of a coroner is to enquire into all sudden, unexplained and unnatural deaths. Until 1984 some coroners recorded verdicts of death by suicide notwithstanding that under Section 30 of the Coroners Act, 1962 a coroner is precluded from returning a verdict of suicide as he/she is prohibited from making anyone civilly or criminally liable consequent on death. Prior to the enactment of the Criminal Law (Suicide) Act, 1993 suicide was deemed to be a criminal offence. In the **McKeown and Scully** High Court case (1984) such a verdict was quashed on the grounds that since suicide was then a criminal offence, it was not in law permissible for a coroner to return such a verdict at inquest. As a result of the **McKeown and Scully** decision, a verdict of suicide at inquest was not considered lawful until the enactment of the Criminal Law (Suicide) Act, 1993 which abolished the crime of suicide.

1.3.2 With the enactment of the Criminal Law (Suicide) Act, 1993 it was thought that coroners were free to return verdicts of suicide. However, confusion has arisen on foot of a High Court decision in the **Greene and McLoughlin** case in 1989, subsequently appealed to the Supreme Court which adjudicated on the case in 1995. One interpretation has been that the Supreme Court decision in the **Greene and McLoughlin** case in 1995 precludes a coroner from bringing in a verdict of suicide. A further interpretation, widely supported on the basis of case law and statute law, is that the powers of coroners to return verdicts of suicide following the enactment of the Criminal Law (Suicide) Act, 1993 is not affected by virtue of the **Greene and McLoughlin** case relating to facts at issue at a time when suicide was a criminal offence (i.e. prior to the enactment of the Criminal Law (Suicide) Act, 1993).

Given the obvious need to clarify this whole issue, in the Interim Report, the Task Force recommended that the Coroners Act, 1962 be reviewed in order to facilitate coroners in returning verdicts of suicide, when appropriate. Since the publication of the Interim Report, the Department of Justice, Equality and Law Reform announced its intention to establish a working group to review this and other issues relating to the coroners system. This Group is expected to be established soon.

1.3.3 The classification of deaths as suicide for statistical purposes is done by the Vital Statistics Section (V.S.S.) of the C.S.O. on the basis of information provided by the Garda Síochána on Form 104. This form is completed in respect of all deaths from external causes and includes medical evidence, information on how relevant injuries were sustained and whether the death was considered to be accidental, suicidal, homicidal or undetermined. Where the C.S.O. is satisfied that the cause of death is suicide, the death is classified as suicide for statistical purposes. The residual number of deaths classified as undetermined provides a measure of the extent to which suicide could be understated in the statistics. In recent years this understatement has probably amounted to less than 5% of all suicides. The

Task Force considered the procedures of the C.S.O. in detail in its interim report and is satisfied that the system determines accurately the incidence of suicide.

1.3.4 The Task Force recognises that research had taken place and is continuing on various aspects of suicide. Current research into suicide is outlined in Chapter 6.

1.3.5 It is recognised that gaining accurate data on the incidence of attempted suicide in Ireland is difficult. However, the Suicide Research Foundation, is currently compiling data on attempted suicide in the Southern and Mid-Western Health Board areas. Developments since the publication of the Interim Report relating to this research are outlined in Paragraph 1.2.4.

1.3.6 The Task Force recommended in the Interim Report the expansion of the current Form 104 to include the social and personal circumstances of each case of suicide which would facilitate a better understanding of the causes of suicide. Since the publication of the Interim Report representatives of the Garda Siochana and the C.S.O. have drafted an expanded Form 104 providing greater detailed sociological and medical information compared with the current Form 104. The representatives of the C.S.O. and Garda Síochána and other members of the Task Force are satisfied that the expanded Form 104, at Appendix 4, will further assist the research into suicide.

CHAPTER 2

The Provision and Structure of Services Relating to Suicide and to Attempted Suicide

CHAPTER 2

The Provision and Structure of Services Relating to Suicide and to Attempted Suicide

2.1 Introduction

Many of those whose working lives impinge on the recognition and care of the suicidal are normally not members of organisations specifically engaged in the field of assisting and supporting those at risk of suicide. Among these are teachers, clergy, gardaí, youth leaders, prison officers, coroners and many others. This chapter will outline the contribution of some of these so that the subsequent chapters on prevention, intervention and aftercare of the bereaved and those who have survived suicide attempts, may be better appreciated.

The ordering of the succeeding paragraphs should not be taken as indicating any perceived hierarchy of importance. In the final analysis, suicide affects us all, in particular those who have been in direct contact with the deceased. Closest among these are family, relatives and friends whose plight will be discussed in the later chapter on aftercare.

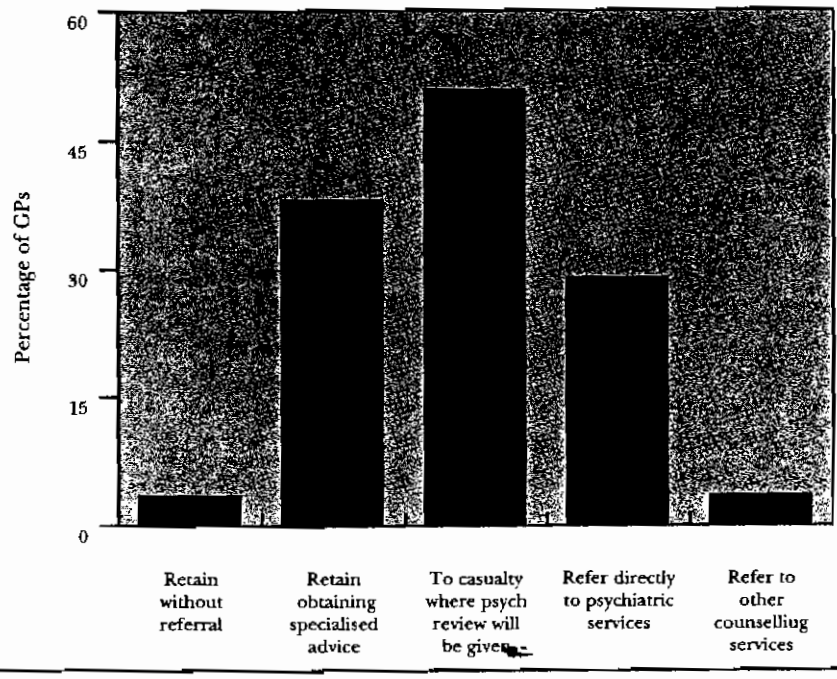
2.2 Primary Care Service

As the general practitioner is frequently the first point of contact with the health services, it is important that he/she has the professional skills necessary to deal with the management of suicidal behaviour. Other members of the primary care team such as public health nurses and social workers also have an important role in relation to the management of suicidal behaviour. In its submission to the Task Force, the Irish College of General Practitioners has expressed a willingness to be more involved in the clinical management of the suicidal patient. A survey of Cork general practitioners confirms this view (Figure 2.1).

In the past any fully registered medical practitioner could enter general practice, without further training, once he/she had completed his/her intern (pre-registration) year in a recognised hospital. This has been changing over the years. It is now recommended that each prospective general practitioner, as part of the three year vocational training scheme, spend at least six months in psychiatry. Afterwards they are encouraged to attend advanced and refresher courses each year, as part of their continued medical education.

FIGURE 2.1

GP's Opinion of how they would respond to an act of parasuicide in an ideal health service



Source: National Suicide Research Foundation

A key recommendation of the Working Party Report on the development of Psychiatric Services – **Planning for the Future**, published in 1984 is the integration of psychiatric services with general practitioner services and this is being achieved through recognition by consultant psychiatrist led multi-disciplinary teams of the central role of general practitioners in the prevention and treatment of mental illness. While progress has been made towards integration of general practitioner and psychiatric services, it is recognised that increased communication and mutual confidence between general practitioners and psychiatric service personnel needs to take place.

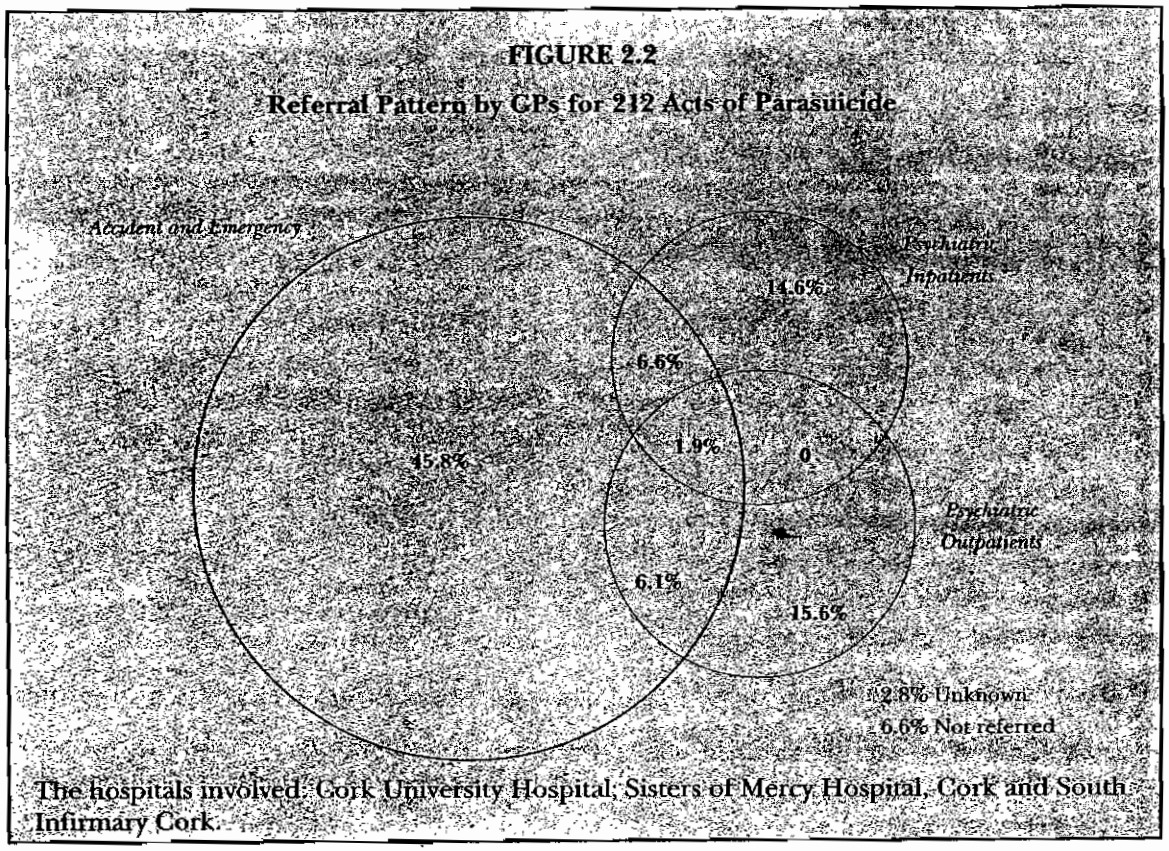
The Task Force recommends that:

- ***study and management of suicidal behaviour be an integral part of both the training of the general practitioners and their continued medical education;***
- ***all members of the primary care team be trained in the recognition and response to the suicidal patient. This should also involve instruction in how to deal with their own and other's reactions to a completed suicide.***

2.3 The Accident and Emergency Services of General Hospitals

Many people who have attempted suicide attend the accident and emergency departments of general hospitals. Psychiatrists attached to acute psychiatric units of general hospitals normally provide a liaison psychiatric service within a general

hospital, in particular the accident and emergency department where the majority of the parasuicidal are referred. Where an acute psychiatric unit is not located in a general hospital the liaison psychiatric service is normally provided by a consultant led multi-disciplinary team from within the catchment area served by the general hospital. Figure 2.2 below illustrates the referral pattern by general practitioners in Cork of parasuicidal patients over the period October 1994 to September 1995.



Source: National Suicide Research Foundation

2.4 The Psychiatric Services

The psychiatric services in Ireland have seen many changes in recent years and this has been accelerated since the publication of **Planning for the Future** in 1984. Previously the psychiatric services were predominantly reliant on in-patient services located in many instances in large Victorian hospitals. More recently, psychiatric units have been incorporated into general hospitals. Additionally, different functions of the old mental hospitals have been built into modern community psychiatric care. These include community residences which provide residential accommodation with varying levels of support for the residents; day hospitals providing therapeutic services including group and individual psychotherapy on a nine to five, five-day week basis and day centres. The Task Force endorses and supports the recommendations of **Planning for the Future** towards development of a modern psychiatric service.

The Task Force recommends that:–

- *the recommendations of the report on the development of mental health services, Planning for the Future, be implemented in full. In particular the Task Force recommends the provision of an extensive network of community-based psychiatric services, bringing specialised, multi-disciplinary psychiatric services within easy reach and accessibility of all citizens and referral agencies so that psychiatric services are readily available and acceptable to all. This will lead to more frequent and earlier referral of potentially suicidal patients and enable them to receive earlier and more effective treatment.*

The Task Force endorses:–

- *the policy outlined in Planning for the Future of establishing acute psychiatric units at general hospitals which will facilitate early intervention for people who attend Accident and Emergency Departments having attempted suicide.*

2.5 Health Care Professionals

Psychiatrists, nurses, social workers, psychologists, occupational therapists, physiotherapists, rehabilitation officers, clinical administrators, public health community care professionals and clerical staff at clinics will, from time to time, come in contact with patients and clients who are psychologically distressed and potentially suicidal. Their sensitivity and awareness of the possibility of suicidal behaviour should be enhanced so that they can better serve the needs of patients.

The Task Force recommends that:–

- *all clinical personnel receive postgraduate and continued education in matters relating to suicidal behaviour;*
- *all undergraduate training should include a module on suicidal behaviour;*
- *relevant health care personnel be trained in matters relating to suicidal behaviour;*
- *relevant health care personnel receive continued education in matters relating to suicide.*

2.6 The Voluntary Sector

There are many voluntary organisations contributing to the well-being of distressed people, whether the distress arises from physical or psychological problems or through social disadvantage. Often the ordinary citizen is unaware of the existence of such organisations unless he or she is a relative of the distressed person who develops a particular need. The professionals themselves and the local statutory services may lack comprehensive knowledge of all that is available to the distressed and disadvantaged within their own geographical area.

2.6.1 Preserving Diversity in the Voluntary Sector

The Task Force received submissions, both written and oral, from voluntary groups in Ireland who extend care, time, support and special insight to those

troubled by suicidal thoughts, feelings, impulses, acts as well as those surviving such painful occurrences. The level of commitment and understanding overall is clearly apparent.

The Task Force recommends that:–

- *each health board establish a directory of names and telephone numbers of voluntary groups who contribute caring services to those in need and at risk of suicide in their own jurisdiction. The directory should also include details of statutory services in order to fully inform the public on all services;*
- *in consultation with the agencies, each health board develop measures to assess the efficacy and reliability of the delivery of these voluntary services and where appropriate make recommendations for the subvention of these services;*
- *the directory of services should be distributed to all appropriate statutory and voluntary services and general practitioners. This information be made available, on request, to members of the public and it be kept up to date.*

2.6.2 Voluntary Care Approaches

The work of some voluntary organisations has a direct bearing on the care of the suicidal, either because they were originally set up with the suicidal in mind, as is the case with The Samaritans or because they focus on helping the psychologically disturbed who are known to have a greater disposition towards suicide. Examples of the latter are Aware, Grow, the Mental Health Association of Ireland and Schizophrenia Ireland. More recently, in particular parts of the country, groups have been set up focusing on the care of those bereaved by suicide.

The resources of these groups include the skills and time given by their organisers and members. The latter may be current or former sufferers as in the case of Alcoholics Anonymous, Grow and Aware. They may also be relatives and friends as are some of the members of Schizophrenia Ireland, or they may have selected themselves to help others out of a sense of social and psychological concern as is the case with The Samaritans.

2.6.3 The Samaritans

The Samaritan movement in Ireland provides a 24-hour emergency, listening and befriending service for everyone passing through a personal crisis and at risk of committing suicide. Since the formation of the Dublin branch in 1970, eleven further branches have been established in the principal towns and cities, their trained volunteers serving local communities in designated catchment areas. The introduction of their single telephone number in 1992 – 1850 609090 – now means that for the price of a local call, anyone, anywhere in the country can have immediate contact with a Samaritan volunteer who will offer a confidential, supportive, listening ear at any hour of the day or night to those who feel they have no one to talk to and who are in danger of taking their own life. The Samaritans also are involved in the training of personnel from various statutory and voluntary agencies in suicide awareness and listening skills.

2.7 Church and Community

Traditionally social and pastoral care was delivered by churches of all denominations and while social changes have occurred affecting the practice of religious beliefs, nevertheless clergy of all denominations are in daily encounter, through their pastoral work, with those who are psychologically as well as spiritually stressed.

The Task Force acknowledges the role of the clergy in the recognition and response to the suicidal.

2.8 Justice and Law Enforcement

Suicide, canon law and civil law are historically intertwined. In 1993 suicide was decriminalised in Ireland. Every case of 'unnatural death' (deaths due to external causes which include accidents, drownings, suicides and homicides) are adjudicated upon in the coroner's court which is held in public. Those present are usually relatives of the deceased, witnesses and officers of the court. Several cases may be heard on the same day and journalists do have a right to be present.

Coroners, gardaí and prison officers come face to face with suicide and the suicidal in their daily professional lives. Their training should take cognisance of this. Coroners preside over a situation in which much distressing information is brought to light. Key witnesses are often bereaved relatives, some of whom report that they are upset by having to wait while other cases are being discussed.

The Task Force recommends that:–

- ***the Department of Justice, Equality and Law Reform ensures that coroners be offered special training in psychological management of highly sensitive issues with particular reference to adjudicating on such matters;***
- ***coroners be made aware of where the bereaved may obtain help and that they give the bereaved this information where appropriate;***
- ***the premises in which inquests are held be of a standard in keeping with the work involved;***
- ***inquests be held as soon after death as is legally and psychologically appropriate;***
- ***inquests be scheduled to take place at an appointed time so that relatives may not be unwelcome witnesses to the grief of strangers attending the earlier inquests.***

2.9 An Garda Síochána

There are many aspects to police work outside of their perceived social function of law enforcement. They are often the first to face many distressing situations including tragic accidents and suicides. Often it is they who must break the news of suicide to relatives. They must also investigate each case of 'unnatural' death with a view to preparing a report and giving evidence in the coroner's court.

Often criminals, particularly petty criminals, are psychologically disturbed, engaged in addictive behaviour, or living in stressful situations.

The Task Force endorses:–

- *the training given to members of an Garda Síochána in matters of suicide awareness at the garda college;*

The Task Force recommends that:–

- *suicide awareness be part of the in-service training for members of an Garda Síochána.*

2.10 The Prisons

The Task Force is concerned about the level and organisation of mental health services provided within the prison system. There is a need to significantly augment the existing provision of what might be broadly considered the "caring" services within the prison environment, e.g. medical including psychiatric and psychological services.

The Task Force endorses:–

- *the recommendations of the Report of the Advisory Group on Prison Deaths' (published August 1991). This Group examined the level of suicide in Irish prisons and considered that a more positive and intensive approach to suicide prevention was required. The Group made recommendations concerning the provision of medical, psychiatric, psychological, welfare and counselling services in prisons. In addition, a number of recommendations in relation to the physical design of prisons and cells and the collection and analysis of prison data were made.*

The Task Force recommends:–

- *that the mentally ill in prison be given appropriate treatment;*
- *that in view of the marked association between drug abuse and both self-injury and death (including suicide) in prison, particular effort and resources be devoted, in conjunction with community strategies, towards addressing the drug dependency problems of prisoners;*
- *that the medical and caring services within prison be developed to a level which would ensure equivalence with similar community services;*
- *that prison officers receive appropriate training in the recognition and response to suicidal behaviour;*
- *that every effort be made to prevent access to illicit drugs in prisons.*

At present all drug misusers committed to prison are offered a 14 day detoxification programme. An intensive therapy programme was introduced in prisons in September, 1996. This involves a multi-agency approach, which is co-ordinated

by a Senior Probation and Welfare Officer. Each programme deals with 12 offenders and runs for 8 weeks. The therapy programme is a follow-up to detoxification.

A new drug-free unit, which can accommodate 96 prisoners, opened adjacent to Mountjoy Prison in June, 1996.

The main problem area for drug misuse is Mountjoy prison. Eastern Health Board service planners are working closely with the Department of Justice, Equality and Law Reform to develop a co-ordinated service to drug misusers both in prison and in the community. This issue was addressed by the Ministerial Task Force on measures to reduce the demand for drugs. The Task Force recommended the establishment of an Expert Group to determine the effectiveness of the current supports available to offenders who misuse drugs and to make appropriate recommendations to integrate them more effectively. It is understood that steps are now in train to establish the Expert Group.

2.11 Teaching and Education

The Task Force endorses the principles enunciated in the Government White Paper on Education – **Charting our Education Future,** published in 1995 that each child is entitled to an education and learning environment, which facilitates the nurturing of his/her full educational potential, in all its richness and diversity; all schools should aim to create such an environment for their students. To the greatest extent possible the school environment should be a caring one in which each child's right to a joyful and safe childhood is guaranteed at all times.

Next to the home and peer group, teachers have the greatest influence on the developing child. For some children school provides the greatest stabilising force in an otherwise unstable world, therefore the potential for guidance and help extends far outside narrowly defined schooling. Throughout secondary and tertiary education the problems may change but the students' needs remain much the same.

The Task Force is concerned about the adequacy of educational school psychology services for the assessment of children attending national schools. This responsibility falls to the Department of Education and Science. The Report of the Special Education Review Committee (1993) recommended, inter alia, that an expanded school psychological service, staffed by psychologists with appropriate qualifications under the Department of Education and/or the proposed intermediate educational structures, should be established on a countywide basis without delay. It is understood that the Department of Education and Science has recently established a planning group to produce proposals for the extension of a national school psychological service to all schools.

The Task Force recommends that:–

- ***teachers, at all levels, be supported in respect of the psychological and social dimension of their work, through undergraduate and continued professional educational courses;***

- *programmes should be initiated aimed at teaching children about positive health issues including coping strategies and basic information about positive mental health at an early stage as a natural part of their health care curriculum;*
- *guidance counsellors be available to all schools;*
- *the psychological services delivered to schools by the Department of Education and Science be extended so that the needs of all students can be met without undue delay.*

CHAPTER 3

The Prevention of Suicide and Parasuicide

3.9 Prevention of Parasuicide

- 3.9.1 Unemployment
- 3.9.2 Education
- 3.9.3 Housing
- 3.9.4 Mental Illness
- 3.9.5 Age and Gender
- 3.9.6 Childhood
- 3.9.7 Adult Family Life

CHAPTER 3

The Prevention of Suicide and Parasuicide

3.1 Introduction

Suicide is a major social problem and is a potentially preventable form of mortality accounting for over 1% of deaths in this country annually equal to the number of people who were killed in road traffic accidents in 1995 (C.S.O. provisional figures). The National Health Strategy – **Shaping a Healthier Future** calls for action in reducing premature mortality related to cardiovascular disease, cancers and accidents. The establishment of the National Task Force on Suicide has been an important step towards addressing the problem of suicide by providing a detailed analysis relating to suicide and attempted suicide (outlined in the Interim Report) and also in the formulation of a national suicide prevention/reduction programme.

We will attempt to discuss deliberate self-destructive behaviour in three chapters covering broadly the concepts of prevention, intervention and aftercare. In each chapter, suicide will be dealt with first but here again, there will be an overlap between suicide, failed suicide, where lethality and intent are high, and parasuicide, where both lethality and intent may be uncertain or low.

3.1.1 The Setting of Targets

The World Health Organisation (WHO) and the European Union (EU) have called for health for all (HFA) by the year 2000 for all regions, health being defined as "a state of complete physical, mental and social well-being". In order to make progress towards this goal targets were set for member states. The target set for mental health was as follows:–

> **"by the year 2000 there should be a sustained and continuing reduction in the prevalence of mental disorders, an improvement in the quality of life of all people with such disorders and a reversal of the rising trends in suicide".**

Since the publication of the working party report on the development of mental health services – **Planning for the Future** – in 1984, there has been significant development of mental health services with a corresponding improvement in the quality of life of people with mental disorders. Mental health services are increasingly delivered to persons with the least disruption where possible, to their daily lives. For example, in 1984 there were 32 day hospital/day centres in operation compared with 159 in 1995 and 121 community residences in 1984 as against 377

in 1995. The total number of admissions to psychiatric hospitals and units in 1984 was 28,330 compared with 22,221 in 1995.

The Task Force considered in great detail the appropriateness of setting specific targets as part of a suicide prevention strategy. The setting of targets, i.e. stating what the level should be by a certain year does not necessarily address the real problem. It is of far greater importance that we should continue to get improved information and to use this in open discussion when planning our responses into the future. Our overall aim must be to reduce suicides to the lowest possible level. Addressing social and cultural factors as well as improving education and training and reducing access to means has the potential to influence the suicide rate. Suicide rates should be susceptible to influence by:–

- general public health measures;
- well managed and responsive health services which can recognise mental illness early and make timely interventions and
- comprehensive community based services which are accessible, appropriate and reach out into the community to provide more sensitive care for mentally ill patients.

3.2 Reduction/Reversal in Trends of Suicide and Parasuicide

The aim of preventing suicide must be tempered with realism. There is weak evidence supporting the effectiveness of suicide prevention/reduction programmes. No specific intervention has been found to be universally effective. Prevention has been hampered by a lack of knowledge or consensus regarding the natural history or causation of suicide, the contributing factors most amenable to preventive effort and the most appropriate target population.

The formulation of a preventive strategy must be based on the factual knowledge that we have. In efforts to obtain detailed information on the suicide victim's state of mind prior to suicide and on the person's past medical history, some research has included interviews with friends, relatives and professionals. High risk groups have also been studied to determine the factors associated with and contributing to suicide. However, we do not know within these groups which individuals will kill themselves and which will not. There is a link between certain mental disorders and suicidal behaviour. However, mental disorder is not a sufficient causative factor of suicide given the large numbers of mentally ill individuals who do not take their own lives. The Task Force acknowledges that suicide cannot be reduced at a single stroke. The preventive approaches which are presented in this report must involve all sectors of society in a multiplicity of interrelated activities and responses. It is only in this manner that the possibility of solutions to the suicide problem will evolve.

3.3 Improving General Suicide Prevention and Education Programmes

3.3.1 Promoting Positive Mental Health

Mental illness can be the subject of stigmatisation. However, much can be done to address this problem through promoting positive mental health. Health promotion is a long term strategy and it is important that the appropriate balance in

resource allocation be found to support such programmes. Increasing awareness about mental illness, changing public attitudes and developing strategies to prevent illness may:–

- counter the fear, ignorance and stigma which still surround mental illness and thereby help people to talk about their feelings, emotional problems and to seek help without fear of being labelled or feeling a failure;
- prevent the progression of a mental illness by improving coping abilities in stressful situations;
- lead towards earlier and more appropriate usage of available services;
- improve the quality of life of people with long standing recurrent or acute mental health problems and that of their families and friends and
- maintain and improve social functioning.

3.3.2 Promoting Healthy Lifestyles

People should be encouraged to take responsibility for their own health. A co-ordinated and integrated approach to health promotion is required with support from the various agencies both statutory and voluntary. Informed public discussion about the potential of each person to strengthen his/her own self-esteem and ability to cope with life should be promoted. The adoption of healthy lifestyles and healthy choices should be encouraged.

Many studies have found a correlation between rates of suicide and rates of alcohol consumption and alcohol problems. Although the contribution that alcoholism in itself makes to the overall suicide risk is still unclear, the adverse affects of alcohol are pervasive throughout Irish society. Alcohol abuse can result in harm to physical and emotional health, in economic loss, in violence and disruption of family life. The National Alcohol Policy of the Department of Health (September 1996) encourages moderation for those who choose to drink and outlines strategies to enable people to acquire and develop personal skills to enable them to make positive decisions in relation to their health. The key areas in the policy include promoting awareness of healthy alcohol use through sensible drinking guidelines, the detection of early signs of alcohol dependency as well as a wide range of health promoting initiatives.

There has been a substantial increase in non-alcohol drug abuse in recent years. While association between suicide and drug abuse can not yet be determined it is clear that large scale drug addiction has a close relation to social and economic disadvantage and deprivation.

3.3.3 Education of our Youth

A particularly urgent aspect of the suicide problem is the increasing frequency of suicides and parasuicides by young people. School-based programmes offer an ideal opportunity for reaching the largest number of young people. However, school-based educational programmes focusing primarily on suicide in other

countries have generated controversy and lack conclusive empirical evidence for their effectiveness. The causes of suicide are multiple and complex and there exists a wide diversity of risk factors. This suggests the need to integrate suicide prevention into programmes that address a wide range of health issues both physical and mental.

3.3.4 School Sector

Currently there exist some excellent health promotion programmes in our schools (e.g. Substance Abuse Prevention Initiatives, AIDS Education, Child Abuse Prevention Programmes, etc.) in addition to, for example, a North Western Health Board publication – **In the Event of Tragedy** – dealing with sudden unexpected death of a student(s) or staff member(s). However, the development of some programmes has been on an ad hoc basis and their provision is unevenly distributed throughout the country. Some schools have very developed and sophisticated programmes while others have practically no health education component. In this context a new Social and Personal Health Education Programme (SPHE) is to be implemented in primary schools in the next school year. Ideally this Programme should be continued in secondary schools. This would allow for a broad based health education programme to be implemented in our schools throughout the school cycle incorporating education on suicide and parasuicide.

3.3.5 Young People Out of School

Many young people at high risk of suicide and parasuicide have multiple problems – e.g. early school drop out, disturbed family backgrounds, substance abuse, physical or sexual abuse, depression, unemployment, homelessness, etc. Specialist "Social and Personal Health Educational Programmes" need to be incorporated into Youthreach programmes to reach and serve them. These programmes could be used with young people in many different settings.

3.3.6 Third Level Education Sector

The third level education sector has expanded greatly in recent years with increased numbers of young people going on to further education at a range of third level institutions. Many of these institutions provide specialised student health services including psychiatric services, counselling services and a variety of other support services. It is vitally important that all professionals working in these services are aware of the high risk of suicide that exists in this age group, particularly young males, and are appropriately skilled to deal with this risk.

The Task Force endorses:–

- ***guidelines for youth workers dealing with suicide published by the National Youth Federation in 1995. These guidelines offer possibilities for youth workers to take a proactive role in suicide prevention. They propose responses for youth workers at three levels:–***

  (a) general preventative measures which involves befriending and actively listening to young people and being unafraid to ask about suicide;

(b) dealing with suicide risk which involves recognising danger signs, identifying young people at very high risk and making appropriate interventions on behalf of these young people;

(c) post suicide intervention which involves taking responsibility for managing the sequence of events in a youth project or group after a young person has committed suicide.

– *the National Alcohol Policy and its recommendations.*

The Task Force recommends that:–

– *the recommendations contained in the National Alcohol Policy be implemented in full;*

– *national alcohol consumption levels be stabilised and preferably reduced;*

– *all centres and services, voluntary and statutory, providing services for addiction include a model for treatment and awareness on the matter of suicide;*

– *the Department of Education and Science, in conjunction with the Health Promotion Unit of the Department of Health and Children, introduce a broad based Social and Personal Health Education (SPHE) Programme in our primary and secondary schools to be implemented throughout the school cycle;*

– *Department of Health and Children work with youth services to develop a Social and Personal Health Education (SPHE) Programme for our young out of school sector;*

– *Social and Personal Health Education (SPHE) Programmes include modules on depression awareness and anger control skills;*

– *greater collaboration take place in schools between staff, pupils, parents associations and the local health boards to promote positive mental health;*

– *third level educational institutions pilot and evaluate the concept of peer support or "student council" as envisaged by the Department of Education and Science.*

3.3.7 The Media

How the media reports suicide is important. If the language or description of the report glamorises the act, this may encourage other vulnerable people to follow suit. This is said to occur particularly in the case of the young where it has been estimated in the USA that one in five suicides are 'copy-cat' in origin, i.e. the second suicide was in part imitative of the first.

However, the positive effects of the media in Ireland cannot and should not be underestimated. In recent years, they have for the most part drawn attention to the problem in a way that has forced society and concerned individuals to make a practical response.

Careful reporting of suicides in the popular media may be helpful in reducing suicide rates particularly suicide by imitation. Several studies show that the more publicity there is the more imitative suicide results. The provision of a timely flow of accurate appropriate information by the media about the warning signs of suicide (how to help, who to call and where to get help from) could help to prevent potential suicides by providing a positive and preventive message to balance the story.

The Task Force recommends that:–

- ***the media, in general, and journalists, in particular, establish a code of good practice applicable to reporting matters relating to suicide and that the headline writers (editors and sub-editors) and newspaper photographers follow the same stringent code as journalists writing the particular articles;***
- ***the reporting of individual suicides be limited to particular cases where it is thought to be in the public interest to do so. The coroner may decide to address the Press in this regard. The report should not include specific details as to the mode of the death. Nothing should be written or said that might encourage others to end their lives;***
- ***television and radio programmes dealing with suicide and related issues be accompanied by helpline numbers and referral information.***

3.3.8 Prevention of Suicide at the Individual Level

In the final analysis suicide is an act and not an illness. If we could recognise the individual likely to commit such acts, we might be successful in suicide prevention. The Samaritans have the experience of dealing with the suicidal individual. They have prepared for their members a resume of Facts and Fiction concerning Suicide as well as Signs of Suicidal Intent, copies at Appendices 2 and 3. The Task Force considers that the information set out is of important value.

The Task Force recommends that:–

- ***the two documents produced by the Samaritans entitled, 'Suicide – Fiction and Fact' and 'Signs of Suicidal Intent' be distributed to appropriate health service personnel and to each voluntary group concerned with suicide for distribution and discussion among its members.***

3.3.9 Prevention of Suicide Imitation at Local Level

Suicide sometimes occurs in a local area where young people know each other and have socialised together. Often a second suicide comes from the same parish, club or school as the first. For this reason, the response of local society to suicide may be of crucial importance. Nothing must be said that glamorises the act or bestows hero status on the person for what he or she did. Pain and distress may be shared. Other deaths, however, will not be prevented by rushing head long into ill considered explanatory poses or by the unfair attachment of blame.

The Task Force recommends that:–

- *suicide deaths be treated in an honest, open, caring manner recognising the loss and pain of relatives without glorifying or denying the manner of death.*

3.4 Suicide Prevention in Primary Care – Increasing Awareness

Detection of suicidal behaviour in the individual depends on the recognition of change in mental state or alteration in customary behaviour on the part of a relative or friend of the person at risk. Peer groups and school friends have a similar need for such awareness and the realisation of the need to communicate stress, change or other significant psychological change to a wider group, i.e. relatives of the individual detected to be at risk or, in the school setting, teachers who themselves are particularly well placed to detect change in psychological status, work performance or output and to pursue the matter further. The important role of health care professionals in this area is referred to in Chapter 2.

3.5 Suicide Prevention in Secondary Care

All categories of psychiatric illness carry an increased risk of suicide. Research indicates that there is a greatly increased risk of suicide amongst psychiatric patients shortly after discharge from in-patient care. It is important that such patients have easy access to aftercare services.

Efforts should be made to improve access to health services for those who are suicidal. Such measures could include the provision of emergency contact telephone numbers, easy access to out-patient consultation and care. Services need to be made available which are appropriate to particular target groups such as young males.

The Task Force recommends that:–

- *the possibility of suicide should be considered when treating people with mental health problems. In particular, pre-discharge assessments on patients leaving in-patient care should have regard to the high risk of suicide in newly discharged patients. Such assessments should therefore be thorough and comprehensive and each examination should be the subject of appropriate case note entries.*

3.6 Vulnerable Groups

The risk of suicide is not equally spread throughout our society. The following groups are known to be particularly vulnerable:

3.6.1 The Mentally Ill

The most vulnerable are the mentally ill. Although many who are severely psychologically distressed never attempt suicide, others who may appear objectively less ill sometimes engage in suicidal behaviour.

It is therefore very important that such persons have easy access to the mental health services and that the services are acutely aware and responsive to the risk of suicide.

The Task Force recommends that:–

- *consideration be given by statutory and voluntary carers to the potential for suicide in persons suffering from depression, alcohol abuse, schizophrenia, substance abuse and personality disorder;*
- *steps be taken to make the health services, including mental health services, more accessible to the public, particularly the young, who may at present perceive them as not being readily available to address their needs at times of crises;*
- *all suicides occurring in psychiatric hospitals and units or soon after discharge be audited so that the services and their responses can be modified where appropriate.*

3.6.2 The Young

The rates of male suicides in all age groups and in most countries has shown a striking increase in recent years. This is most marked in the younger age group. In addition young men are almost four times more likely to commit suicide than young women. There are a number of possible explanations advanced for the gender difference in completed suicide rates among young people – e.g. there are substantial differences between boys and girls in their susceptibility to risk factors such as aggressive and anti-social behaviour, alcohol abuse and depression. Also the fact that boys have a higher rate of risk taking behaviour leading them to greater familiarity with lethal techniques.

The Task Force recommends that:–

- *young peoples suicides (i.e. those aged between 15 and 24 years) be further researched with a view to identifying and understanding the reasons why they occurred so that society may respond appropriately;*
- *youth mental health needs to be recognised at an early stage and interpreted correctly;*
- *children and young people, at a time of crisis, have access to appropriate support services and a comprehensive range of psychological and counselling services should be available.*

3.6.3 Older People

Suicide among those aged between 65 and 70 years is rising. There were thirty seven deaths by people aged sixty five years and over registered as suicides in Ireland in 1996 (C.S.O. provisional figures). An older person who regards his/her situation as intolerable may be at risk of suicide although this situation can often

be alleviated through appropriate practical re-arrangement and support. The strong role of depression in suicides later in life has been shown repeatedly.

The Task Force recommends that:–

- *there be improved recognition of the risk of suicide in older people and improved treatment of depression in older people;*
- *the psychological needs of older people, whether due, for example, to isolation or bereavement, be specifically addressed by counselling and social intervention, and that specialised psychiatric services for older people be expanded;*
- *health boards put in place programmes aimed at improving coping capabilities among older people and helping them to take responsibility for their own lives. Such programmes should help older people identify mental disorder in themselves and explain the potential benefits of receiving treatment. They should also aim to familiarise younger relatives, friends and carers of the signs of mental disorder in old age.*

3.6.4 Occupational Groups and Suicide

League tables have been constructed in other countries purporting to show that some professions and vocations have a higher suicide rate than others. Often the differences are not great and, on closer inquiry, the apparent high association may diminish, if not disappear. Professional groups often emphasise stress arising from their work. Other influences, however, such as particular factors in the profession, access to methods and familiarity with death may be of equal importance. Because we are, numerically, a small nation, these matters are particularly difficult to research in Ireland.

The Task Force recommends that:–

- *it be established whether suicide varies between occupational groups in Ireland and, if so, whether specific work related stress is a contributory factor;*
- *professional organisations and occupational groups consider the provision of information on the facilities and referral services available specifically for the mental health needs of their members.*

3.6.5 Improving Social Conditions

A variety of social conditions have been associated with suicide rate such as poverty, unemployment, marginalisation, particularly in groups such as people with mental disorders, learning disabilities or chronic diseases and victims of physical or sexual abuse. However, such factors are associations and cannot be viewed as direct causes of suicide. Nevertheless the Task Force believes that measures which may ameliorate social conditions for such groups would impact particularly on the suicide rate.

3.7 Reducing the Availability and Means of Suicide

There has been much discussion about the possible connections between suicide rates and the availability of means of suicide. The methods of suicide employed in this country include hanging, drowning, firearms and drug overdose, with the more violent approaches being employed by males. Firearms account for a relatively small percentage of suicides. Access to firearms is controlled in this country and this should continue.

The Task Force recommends that:–

- *all children be taught to swim as part of their general education with a view to enhancing health and preventing accidental drowning as well as suicide;*
- *life saving apparatus be available along appropriate places where there is easy access to water;*
- *all applications for firearms licences should be carefully scrutinised;*
- *the licensing authorities produce and make available for distribution a code of practice for the safe storage and disposal of firearms. Individual parts of all weapons should be stored separately.*

3.8 Over the Counter and Prescribed Medication

All over the counter and prescribed medication should be reviewed as regards warnings, labelling and availability in relation to improving safety. This is particularly so in relation to analgesics such as paracetamol, anti-depressants and other drugs. Safer prescribing should be considered by health professionals. It is estimated that 50% of suicidal overdoses used commonly prescribed medication. There is good evidence to show that the prescription of less toxic drugs, reducing the quantity of drugs and limitation of the amount of drugs available on a single prescription may reduce suicide by drug overdose. Limiting the availability of certain drugs by reducing pack size or limiting prescriptions for larger amounts of medication may reduce the number of serious overdoses.

The Task Force recommends that the availability of medicines harmful in overdose be restricted.

The Task Force supports the recent recommendations of the Irish Medicines Board on the control of sale and supply of paracetamol containing products as follows:–

- *the pack size of all paracetamol tablets should be restricted and packaged in blister packs;*
- *the unprescribed sale of paracetamol tablets should be normally restricted to one pack per person;*
- *in relation to labelling the statement "contains paracetamol" should be clearly stated on red bold type on the label together with the following warning "do not take any other paracetamol containing products";*
- *the labelling warning should be further strengthened to state the following "immediate medical advice should be sought in the event of overdose because of the risk of irreversible liver damage".*

The Task Force recommends that:–

- *appropriate regulations be made under the Irish Medicines Board Act, 1995 to give statutory effect to these recommendations and the Department of Health and Children publicise these changes;*
- *public safety information should be disseminated about commonly used drugs. In the case of paracetamol, the information should encourage early hospital treatment after overdose – emphasising the high efficacy of the antidote in the case of early interventions;*
- *prescribing practices which help to prevent the possibility of suicide by overdose should be included in the continuing medical education programme for general practitioners;*
- *consideration may have to be given in future to restricting the sale of paracetamol containing products to pharmacies depending on the impact of the above recommendations of the Irish Medicines Board in reducing suicide by drug overdose.*

3.9 Prevention of Parasuicide

Some of those who deliberately injure themselves in a suicidal manner do not intend to end their lives: others do, but fail. Collectively, they are called parasuicide. However, the difference in lethality and intention is one of degree. Many persons attempting suicide, if not most, are ambivalent in intent. We have already dealt with suicide in this chapter. Here we will describe parasuicide which encompasses both failed suicide and those, perhaps the majority, who are merely uttering a cry for help. Once again, as far as is relevant, we will consider prevention at society, sub-group and individual level.

3.9.1 Unemployment

Unemployment is a serious social problem. It steals status, diminishes autonomy and takes power from the individual. It defines the level of hardship within an area and underpins all the other disadvantages. Parasuicidal patients are more likely to come from urban areas of high unemployment and have a history of personal unemployment.

The Task Force endorses the report of the Task Force on Long-term Unemployment and supports the aims and objectives of the Government strategy on the labour market as incorporated in the strategy paper titled "Growing and Sharing our Employment".

3.9.2 Education

Parasuicide is influenced by young persons leaving school with minimum education. It is important that pre-school educational groups (nursery schools) be available particularly in urban areas involving both children and parents.

An important facet of school education in relation to parasuicide is programmes which help young people to develop their interpersonal and problem-solving skills

in order to recognise and deal with various life tasks including mental health issues. This issue has previously been addressed in Section 3.3.4.

3.9.3 Housing

In the past century, it was realised that overcrowding was a potent factor in the spread of infectious diseases. Overcrowding, however, also adversely affects our emotional health. We all need personal space. Even within the home, we need privacy. This is not possible with overcrowding.

Re-housing is often by age group because particular age groups may have the greatest need e.g. young parents with children. One negative effect of this is that the age structure of local societies becomes unbalanced, so that older, more mature people, who might act as leaders, are relatively unavailable in the locality. The transfer to new housing may also attenuate the protective influence of extended families.

The Task Force recommends that:–

- *planning authorities, insofar as it is possible, shall endeavour to avoid possible overcrowding of accommodation in the planning, designing and location of residential accommodation.*
- *planning authorities, insofar as it is possible, shall endeavour to allocate housing with an objective of having a varied age structure in the local community.*

3.9.4 Mental Illness

As with suicide, mental illness is associated with the parasuicide rate in Ireland. This association adds further weight to the recommendations made earlier for the management of mental illness and substance abuse which are such a costly burden on the individual, the immediate social network and society itself.

3.9.5 Age and Gender

Ireland is unlike much of Europe in that parasuicide occurs almost as frequently among men as among women. Furthermore, it is not just the population of young adults and adolescents that are affected but rather all the adult age groups up to 45 years, after which the frequency rapidly falls off.

3.9.6 Childhood

Whereas parasuicide, like suicide, may be comparatively rare in childhood, the seeds of future unhappiness and maladaptation are often sown at that time of life. Certainly, the childhood of most adult parasuicidal patients, men and women, have been dismal. Although disadvantage is usually multiple, the high level of reported sexual and physical abuse is both striking and unacceptable.

3.9.7 Adult Family Life

Like their childhood, the adult family life of many parasuicidal patients is both unhappy and dysfunctional. Substance abuse, mental illness as well as physical abuse dominate the scene.

Given that the incidence of suicide and attempted suicide is significantly increased among adolescents and young adults in families vulnerable to stresses in a variety of functional areas and that such individuals need to learn improved coping skills, comprehensive and supportive social work services to such families is essential. The Task Force therefore recommends that community-based and primary care professional workers, identify such families and individuals at risk. Once individuals and families in this situation become known to the services every effort should be made to make life skills programmes available for them on a continuing basis. In addition continuing social work support to deal with crises and ongoing social and familial problems are, in view of the Task Force, a necessity.

The Task Force recommends that:–

- *health boards put in place a range of comprehensive support services including social work services for vulnerable families or families experiencing difficulties.*

CHAPTER 4

Intervention

4.1 Intervention in Parasuicide

4.2 Responding to the Act of Parasuicide

4.3 Direct referrals to Accident and Emergency Departments of General Hospitals

4.4 Intervention and the General Practitioner

4.5 Intervention Procedures -- Multiple Problems

CHAPTER 4

Intervention

4.1 Intervention in Parasuicide

This chapter deals with the pathways into care of those who engage in parasuicidal acts including how and where the services might best intervene.

4.2 Responding to the act of Parasuicide

Unless he or she falls unconscious, the parasuicidal individual is the first to realise what he or she has done. Often, and indeed, usually the event has a cathartic effect by which the individual sees himself or herself differently after the event compared to before. He or she may go for professional help or inform a relative or friend. He or she may also have performed the act in the presence of another or in response to an emotional disagreement, or he or she may have done it at a time when discovery was likely. A minority, of course, seek to avoid discovery before death intervenes. Whatever the circumstances, all parasuicidal acts should be professionally assessed where they come to the attention of the health services.

The Task Force recommends that:–

- *all individuals who engage in acts of parasuicide should be encouraged to seek professional help, as soon as possible, after the event and, where necessary, emergency transfer be arranged to the accident and emergency unit of the local general hospital;*
- *all relatives and friends see that appropriate health professional contact is established immediately following the act of parasuicide or as soon as possible thereafter;*
- *the individual's general practitioner, if known, be contacted by telephone as soon as possible.*

4.3 Direct referrals to Accident and Emergency Departments of General Hospitals

Many parasuicides are brought directly to accident and emergency departments of general hospitals without intervention by general practitioners. The reasons for these direct referrals include the perceived urgency of the situation, not having a general practitioner and familiarity with the hospital services, often because of previous attempts.

The Task Force recommends that:–

- *every case of parasuicide seen in general hospital accident and emergency departments be examined by the liaison psychiatric team;*
- *every case of parasuicide be referred to the appropriate psychiatric team if such is different from the liaison psychiatric team;*
- *each sector psychiatric team nominate a health professional to oversee the future management of the parasuicidal patient, if this is thought appropriate, and that the parasuicidal patient be made aware who this professional is.*

4.4 Intervention and the General Practitioner

As many parasuicide patients will revert to the care of their general practitioners, it is important that they be fully informed of the patient's management while in the accident and emergency department and in the care of the psychiatric team. Thereafter, management may be a joint matter between the general practitioner and the sector psychiatric team and its nominated professional. It is essential, therefore, that there be satisfactory communication between all concerned. When the general practitioner is managing a patient on his or her own, he or she should have ready and rapid access to the sector psychiatric professionals as required.

The Task Force recommends that:–

- *the patient's general practitioner be kept informed of every step of the management of his/her patient by the psychiatric team;*
- *where appropriate the general practitioner be encouraged and supported in looking after both the immediate and long term needs of the parasuicidal patient.*

4.5 Intervention Procedures – Multiple Problems

Most parasuicidal patients have multiple problems which must be tackled from a broad base whether medical (physical and psychiatric), psychological or social. Most of all they need a dependable, predictable service relationship even though they themselves may remain both unpredictable and often not able or willing to maintain consistent professional contact.

When prescribed medication has been used in overdose, special precautions must be taken with future prescriptions. Both the type and amounts of medicines to be prescribed should be given serious consideration particularly if they are harmful in overdose. The patient should be encouraged not to stock-pile medicines, whether over-the-counter preparations or prescribed drugs. Unused medicines should be either destroyed or returned to the service. With the patient's permission, where appropriate, medicine may be given for safe keeping to relatives.

The Task Force recommends that:–

- *the underlying diagnosis in parasuicidal patients be treated by the appropriate professionals;*

- *where relevant, and with his or her permission, the individual be put in touch with appropriate self-help or other support groups;*
- *the social and psychological, as well as the medical (both physical and psychiatric) needs of parasuicidal patients be catered for;*
- *those with a previous history of deliberate self-poisoning be prescribed drugs which are safe in overdose;*
- *where only drugs, toxic in overdose, are perceived as being essential in treatment, the drugs be given in quantities that would not be life threatening if all were taken together, i.e. that those at high risk be given prescriptions restricted in time and to a particular pharmacist;*
- *arrangements be made either by a specific person from the psychiatric team or the general practitioner to see each parasuicidal patient again at an agreed appointed time as deemed clinically appropriate;*
- *the specific person from the psychiatric team or the general practitioner contact the parasuicidal patient should he or she fail to keep his or her appointment.*

CHAPTER 5

Aftermath and Aftercare

5.1 Aftercare in Suicide

CHAPTER 5

Aftermath and Aftercare

5.1 Aftercare in Suicide

Relatives and friends of the deceased may have mixed and confused emotions ranging from shock to grief, anger to guilt consequent on the event. Each participant in this unwelcome drama finds himself/herself cast in a role for which he/she has been ill-prepared. The unexpected suddenness of it all confounds the situation further.

There is no universally right way of handling the aftercare of those affected by suicide. Each step in the process may require a different response. No two deaths are precisely the same. Because of this, only guidelines, and not instructions, can be given. Sometimes carers, whether teachers, nurses or doctors, are almost as much affected, in the initial stages, as the bereaved themselves. In order to understand the complexity of the diverse interactions, each phase will be briefly examined in sequence and where appropriate, recommendations made.

5.1.1 Missing Persons

The first prelude to a suicide may be when a person goes missing. For some families the situation is resolved by the return of the individual; for others the body is discovered. In a few cases no trace is ever found. Each family has been inordinately stressed. Grieving is especially difficult in the last case.

5.1.2 Discovering the Deceased

The discovery of a dead person under normal circumstances and particularly, unexpectedly, is traumatic. Sometimes the person who makes the discovery is a relative, a close friend or at other times a professional, whether nurse, prison officer or garda.

5.1.3 Breaking the News

The sad news must be broken to all those who have a right to know. It can be beneficial for the person if he or she is allowed to comprehend himself/herself the reality of the situation. It is therefore, crucial that a sensitive and caring approach is used when breaking the news. By this approach it is as if the person being informed is making the discovery which may aid him or her in the bereavement process.

5.1.4 Who Should Break the News?

There is no one right person. It usually depends on the circumstances of the case. If the death occurs in care, then a nurse, doctor or in the case of a person in custody, a prison officer would take on the task. Most suicides, however, take place in the community. If outside the home, then a garda, doctor or priest may be involved. If within the home, then a relative may be the primary informant. The professional should have training in breaking the news.

The Task Force recommends that:–

- *relevant professionals whether nurse or doctor, garda, prison officer or priest be given special training in confronting and responding to traumatic situations and, in particular, in how best to communicate 'bad news', balancing truthfulness and openness with sensitivity and support;*
- *relevant professionals be made aware of what are the appropriate steps for distraught relatives to take should they feel they cannot cope, bearing in mind that the best solution is often to find the resources within one's own personality and social network;*
- *when professionals themselves have been traumatised, counselling should be made available for them by the relevant professional organisation.*

5.1.5 The Announcement

Death is never a private matter only. An announcement is made before the funeral. In modern society, this may be done through newspapers and more recently, local radio. In the past, it was by word of mouth. Whatever the method, the nature of the language used is important. Neither denial or stark insensitivity is appropriate. Announcements often have a coded format. Words such as 'sudden' or 'unexpected' without the addition such as 'after an accident' or 'after a brief illness', offer clues as to cause. Falsehoods do not protect and may make mourning more difficult.

5.1.6 The Funeral Service

Words spoken at the funeral, either by private mourners, or clergy should be well chosen. A distinction should be made between the life and the death, including the manner of death. Nothing should be said that could be construed as praising the choice of suicide. There may be other vulnerable persons present whose life pressures are similar. It goes without saying that nothing should be said or done that would add to the distress of the bereaved themselves.

5.1.7 The School, the Club and the Work Place

People have many contacts, whether occupational, recreational or through education. Each or all of these may have a tradition of how best to respond to the death of a member and associates. The normal practice for any bereaved associate in the school, place of work etc. should be followed in the case of death due to suicide. If it is usual for the class, or the school to attend the funeral then that

should be done, subject to the wishes of the family. If it is usual for a guard of honour to be assembled, then that also should be done, subject to the wishes of the family. All of these matters, and their implications, must be thought of at the time.

Decisions concerning burial or cremation must be made in a short space of time to decide where and when. Many contribute to the decision making process. Undertakers, friends, other relatives, clergy and doctors may inform such decisions.

5.1.8 After the Burial/Cremation

Mourning, for those most intimately affected, does not end with burial. In the period after the funeral, aspects of the problem may begin to manifest themselves more clearly. There is the loss itself, as well as the manner of the loss. Sometimes, the death occurred in the face of pressing social or financial problems which must now be addressed. Many households operate on an internal division of labour. The person who died may have been competent in a particular area of family life for which the bereaved has no experience or is ill-prepared.

The support of the health and social services, both voluntary and statutory, may now be necessary. If appropriate, these must be called into play. The key contact person is likely to be the general practitioner. The challenge for the doctor is to support and offer guidance without, if possible, resorting to medication.

CHAPTER 6

Research and Evaluation

CHAPTER 6

Research and Evaluation

6.1 Research and Suicide

More information is needed in Ireland with regard to suicide – risk, protective factors and preventative strategies. Funding is required for research to develop and progress. The importance of co-ordination of research programmes must be emphasised in order to avoid overlap or duplication of research projects.

6.1.1 Health Board Research

Important research into suicide is currently underway in this country. The Chief Executive Officers of the eight health boards initiated a study on suicide which commenced in October 1995. This study is ongoing and aims to address concerns expressed about the rising trends in suicide and the need to gain information on factors and circumstances relating to each case of suicide. This will facilitate a better understanding of the causes of suicide and allow for a more appropriate prevention/reduction programme to be developed.
The aims of the study are:–

(a) to establish the incidence and associated factors of suicide nationally on a health board basis and inform the present knowledge base on suicides;

(b) to provide information in order to facilitate future planning for a suicide prevention/reduction programme.

The study involves Coroners, Directors of Public Health, Gardaí, General Practitioners, Pathologists, Psychiatrists and Specialists in Public Health Medicine. The Director of Public Health in the North Eastern Health Board has been designated by the Chief Executive Officers of the health boards to co-ordinate the study nationally.

The information gathering process for the study begins with the Gardaí who have been asked to notify the Director of Public Health in the relevant health board of all unnatural deaths requiring an inquest via a form (Form C71) which is sent by Gardaí to Coroners. The designated specialist in public health medicine with responsibility for suicide in each health board examines the C71 forms to identify all definite suicide cases, based on the information contained in the form, the clinical judgement of the specialist, whether there is evidence that death was self-inflicted and whether the deceased expressed an intention to commit suicide. In the case of undetermined causes of death, a panel of specialists in public health medicine examine all relevant information surrounding the person's death. Where the evidence points beyond reasonable doubt to suicide, it is recorded as suicide

for the purposes of the study. The deceased's general practitioner involved in each case is identified through the C71 form and a detailed anonymized questionnaire is filled out by the general practitioner on each case. Where the deceased has been a patient of the mental health services a detailed anonymized questionnaire is also completed by the relevant consultant psychiatrist. Further information is obtained from pathologists, coroners and attendance at inquests.

The study was carried out initially in the North Eastern Health Board (N.E.H.B.) area on a pilot basis for a period of one year from October, 1995 to October, 1996 and was extended nationally for a two year period, from 1st January, 1997 to 31st December, 1998.

To date the study has revealed that:–

- the pilot study demonstrated that this research is feasible and the professionals concerned are very anxious to co-operate;
- the incidence of suicides in the N.E.H.B. was higher than the "official rate" but could not be taken as significant given the small numbers involved and
- all logistical problems identified in the pilot study have been addressed and the national study appears to be progressing smoothly.

6.1.2 National Suicide Research Foundation and Irish Association of Suicidology

The National Suicide Research Foundation based in Cork has also been involved in suicide research in recent years and many of its findings have been presented in this report and the Interim Report. The Task Force also welcomes the recent establishment of the Irish Association of Suicidology. The Association's aim is to promote public awareness of the problems of suicide and suicidal behaviour.

6.2 Future Research

It is very important that research workers in the future break out of a repetitive mould. Rather than replicating previous work, attempts should be made to employ new methodologies likely to generate innovative responses to the problem of suicide. In particular, work is needed to clarify different approaches in responding to suicide. Methods of intervention also need to be researched further. To date, one of the most important advances in suicidology has been the development of psychological autopsy studies.

6.3 Psychological Autopsy Studies

A psychological autopsy study is analogous to a post mortem examination. Obviously the mind of the deceased cannot be dissected. Valuable clues to his/her mental state and make-up can, however, be discovered by speaking to those who knew him/her before he/she died and by reviewing any medical records and

contacts available. Such techniques allow the making of a diagnosis where appropriate. They also allow assessment of the contributions made by various psychological stressors prior to death. The results of such enquiries can contribute greatly to the better understanding of intervention and prevention as has been outlined in previous chapters.

This is very expensive work to do, however, requiring as it does attendance at different coroners' courts and then contacting relatives, gardaí, doctors, hospitals and others. Ideally, in the case of the young, one should speak to friends as well, as they may know more about the social life of the deceased, including whether there were any unknown pressures relating to drugs, alcohol, sexuality or legal matters.

It is recognised that psychological autopsy studies are likely to give us the most compelling insights into the minds and habits of persons who commit suicide. This new understanding can then be used to inform the development of future national policy. We have an obligation to find out if there are preventable circumstances contributing to the recent rise in suicide in Ireland.

6.4 Gathering of Information for Suicide Research Purposes

Each year in Ireland, coroners adjudicate on approximately 400 cases of suicide. Those giving evidence include relatives, witnesses, doctors, gardaí, pathologists and on occasion friends. The evidence includes previous medical and psychiatric history, his/her occupation, domestic living relationships, usage of drugs, alcohol and other attendant circumstances.

As explained earlier, recording of the incidence of suicide by the C.S.O. is dependent on information set out on Form 104 completed by the Garda Síochána in respect of each inquest and forwarded to the C.S.O. The questions listed on Form 104 are designed to assist the C.S.O. in the statistical classification of deaths, the subject of inquests, as either accidental, suicidal, homicidal or undetermined. The Form does not cover all of the information available at the time of the coroner's inquest but only the details that are relevant to the classification. The use of Form 104 for suicide research purposes is impeded on two levels – the information given on Form 104 is confidential under the terms of the Statistics Act, 1993 and may only be used for statistical purposes and, secondly, the medical details concerning the deceased are sparse.

The Interim Report of the Task Force recommended that the C.S.O. and the Garda Síochána consider amending Form 104, for the purpose of collecting more detailed sociological and medical information relating to suicide. Since the publication of the Interim Report representatives of the Garda Síochána and the C.S.O. have drafted an expanded Form 104 (copy at Appendix 4). The revised form seeks additional information on, inter alia

- marital status
- domestic living arrangements
- employment situation

- drug/alcohol dependency
- medical history
- known contributory factors
- name and address of the deceased's general practitioner

6.5 Use of Form 104 in Suicide Research

The proposed new Form 104 addresses the deficiency of the lack of detailed medical or psychiatric information relating to the deceased.

The Task Force recommends that:–

- *the proposed new Form 104 be adopted by the Garda Síochána and the C.S.O.;*
- *a nominated Garda Inspector within each Garda Division be made responsible for overseeing the use and completion of the new form.*

6.6 Suicide Research and Surveillance

The National Study on Suicide currently underway in each health board will provide important epidemiological information on suicides which will facilitate the development of reduction/prevention strategies relevant to each region. While there is uncertainty as to the effectiveness of any single intervention in reducing suicide rates, a combination of measures will be needed to bring about a reduction. Strategies aimed at improving the quality of services generally should be central to any prevention/reduction programme. It is important that whatever suicide reduction strategies are developed and introduced they should be subjected to careful evaluation before their widespread adoption is advocated.

The Task Force considers it important to establish a Suicide Research Group to monitor ongoing trends in suicide and to examine the effectiveness of specific interventions on suicide rates. This group should have available, where possible, all data, including the additional information proposed in the expanded 104 form, as well as reports and publications of independent bodies in the field of suicide and suicide reduction.

The Task Force recommends that:–

- *a Suicide Research Group be established by the Chief Executive Officers of the health boards, comprising of Psychiatrists, Directors of Public Health and relevant researchers, to review ongoing trends in suicide and parasuicide, to co-ordinate research into suicide and to make appropriate recommendations to the C.E.O.s. The Task Force envisages the ongoing work of the studies and research referred at 6.1 be fed into this Group.*

It will be necessary for the C.S.O. to provide the Suicide Research Group with a regular analysis of the information contained in Form 104. In order not to breach the provisions of the Statistics Act, 1993 relating to the use of information available to the C.S.O., *the Task Force recommends that:–*

– *the C.S.O. grants the status of Officer of Statistics to a researcher appointed by the Suicide Research Group, who will assist with analysing the new information collected on Form 104, evaluate on an ongoing basis the C.S.O.'s procedures for classifying deaths as suicides and will report on these matters to the Suicide Research Group.*

6.7 Future Response to Suicidal Behaviour

In order to have an effective response to suicidal behaviour, the Task Force considers that each health board should designate a person or persons with specific responsibilities in the broad field of suicide. The designated person(s) or resource officer(s) should advise all statutory caring personnel within the health board area in matters relating to suicide and parasuicide and compile a directory of the voluntary and statutory services concerned with suicidal behaviour in the health board area. The person(s) will assess the ongoing needs and evaluate the services which are concerned with suicidal behaviour including the area psychiatric team and liaise with and advise, on request, all voluntary services within the health board area on clinical aspects of the care of the suicidal and those affected by suicidal behaviour.

The Task Force recommends that:–

– *the Chief Executive Officers of each health board nominate a resource officer(s) with responsibilities, as set out heretofore, in the broad field of suicide;*

– *the resource officer(s) shall act as a contact point with voluntary groups and facilitate research into all aspects of suicidal and parasuicidal behaviour and their consequences in the health board area.*

APPENDICES

APPENDIX 1

Form 104

CONFIDENTIAL STATISTICAL RETURN IN RESPECT OF INQUEST

This return will be used solely for the purpose of supplementing the information on the Coroner's Certificate for the better statistical classification of cause of death and will be treated as strictly confidential. It should be forwarded to the Director, Central Statistics Office, Vital Statistics Section, Skehard Road, Cork, on the adjournment or completion of the inquest.

1. Coroner's District	2. Date of adjournment or completion of inquest

3. Date on which death occurred

4. Place at which death occurred (full address)

5. Name, surname and home address of deceased

6. Sex	7. Marital condition	8. Age of deceased

9. Occupation of deceased

10. Medical evidence as to cause of death

11. How injuries were sustained (In case of a traffic accident, please state whether deceased was a driver, passenger, or pedestrian, the vehicle(s) involved and the circumstances of the accident. If a tractor was involved, please state whether this was agricultural or road haulage.)

12. In the case of an accident, please state the place where accident occurred. (Please indicate whether at home, on farm, in factory, on public road etc.) and the date of the accident.

13. Was deceased at work at time of accident.

14. Please state (where applicable) whether death was accidental, suicidal, homicidal or undetermined

Signature of Sergeant in Charge _____

Sub District _____

Date _____

APPENDIX 2

Suicide — Fiction and Fact

Fiction	*Fact*
People who talk about it don't commit suicide.	Most people who kill themselves have given definite warnings of their intention.
Suicidal people are absolutely intent upon dying.	Most suicidal people are ambivalent about living and dying; they gamble with death but may retain the desire to live.
Suicide happens without warning.	Suicidal people often give indications of thoughts (sometimes before the thoughts become intentions) by words or actions.
Once a person becomes suicidal, he/she is suicidal forever.	Suicidal thoughts may return, but they are not permanent, and in some people, they may never return.
After a crisis, improvement means that the suicide risk is over.	Many suicides occur in a 'period of improvement' when the person has the energy and the will to turn despairing thoughts into self-destructive action.
Suicide occurs mainly among the rich/the poor.	Suicide occurs in all groups in society.
Suicidal behaviour is a sign of mental illness.	Suicidal behaviour indicates deep unhappiness but not necessarily mental illness.
You are either the suicidal type or you're not.	It could happen to anybody.

Appendix 3

Signs of Suicidal Intent

Suicide risk is greater where there is:

- Recent loss or the break-up of a close relationship.
- Current or anticipated unhappy change in health or circumstances, e.g. retirement or financial problems.
- Painful and/or disabling physical illness.
- Heavy use of, or dependency on alcohol/other drugs.
- History of earlier suicidal behaviour.
- History of suicide in the family.
- Depression.

People often show their suicidal feelings by:

- Being withdrawn and unable to relate.
- Having definite ideas of how to commit suicide, and maybe speaking of tidying up affairs, or giving other indications of planning suicide.
- Talking about feeling isolated and lonely.
- Expressing feelings of failure, uselessness, hopelessness or loss of self-esteem.
- Constantly dwelling on problems for which there seem to be no solutions.
- Expressing the lack of supporting philosophy of life, such as a religious belief.

APPENDIX 4

Proposed Form 104

CONFIDENTIAL STATISTICAL RETURN IN RESPECT OF INQUEST

This return will be used solely for the purposes of supplementing the information on the Coroner's Certificate for the better statistical classification of cause of death and will be treated as strictly confidential. It should be forwarded to the Director General, Central Statistics Office, Vital Statistics Section, Skehard Road, Cork, on the adjournment or completion of the inquest.

Reference Information:

1. Coroner's District	2. Date of adjournment or completion of inquest
3. Member of An Garda Síochána and station investigating the death	

Information on deceased:

4. Date on which death occurred.									
5. Address at whch death occurred (*if not at home*).									
6. Name, surname and home address of deceased.									
7. Sex	Male ☐	Female ☐	8. Date of Birth						
9. Marital Status	Single ☐	Married ☐	Divorced ☐	Widowed ☐	Separated ☐				
10. Most recent domestic living arrangements (*e.g. living alone, with parents, with spouse/partner etc.*)									
11. Employment status at time of death	Employee ☐	Self-employed ☐	Retired ☐	Student ☐	Unemployed for last 12 months ☐	Unemployed for longer than 12 months ☐	Worked in the home ☐	Other, specify..... ☐	
12. Main occupation (*If person was unemployed or retired, gove last previous occupation*)									

Medical Details:

13. Medical evidence as to cause of death
14. How injuries were sustained– (Describe events surrounded death. (*In the case of a traffic accident, please state (i) whether deceased was a driver, passenger, cyclist or pedestrian; (ii) type of vehicle(s) involved etc.*)

Medical details (contd.)

15. Please state the place where the incident occurred. (*For example, at home, residential institution, school, sports area, street/road, trade/service, industrial construction area, farm, other*)

16. Is there any evidence of deceased being drug or alcohol dependent? Yes ☐ No ☐
If drug dependent please specify:
(i) type of drug(s).....
(ii) were the drugs prescribed? Yes ☐ No ☐

17. Deaths caused by poison:
Please state type of poison.
How and where stored.

Other Information:

18. Cases of shooting: How was the firearm obtained?
Was it licensed/unlicensed?

19. Please state if any written note etc. was left at the scene
(*For example suicide note*).

20. Any known medical history
(*mental/physical, previous contact with medical or social services*).

21. Any other known contributing factors.
(*For example stress, family/relationship problems, etc.*)

22. Name and address of G.P., hospital doctor or medical attendant (*if known*).

23. Is Post Mortem report available? Yes ☐ No ☐

24. Please state, in your opinion, whether death was: Accidental ☐ Suicidal ☐ Homicidal ☐ Undetermined ☐

Signature of Sergeant in Charge _____

Sub District _____

Date _____

Appendix 5

List of bodies/persons who made submissions to the National Task Force on Suicide

1. Mr Colm de Bhaldraithe, Dublin 6.
2. Mr Christopher Deely, Co Longford.
3. Sergeant Tim O'Leary, Co Kerry.
4. Ms Martina Kelly, Secretary, Clonberne ICA Guild, Cogaula, Clonberne, Ballinasloe, Co Galway.
5. Mr Donal Murphy, Co Mayo.
6. Mr Patrick O'Connor, Solicitor/Notary Public, Coroner for Mayo East.
7. Egan Daughter & Company, Solicitors, Parliamentary Agents, Castlebar, Co Mayo.
8. Mr John P Goff, Coroner, Nolan Farrell & Goff, Solicitors & Notaries, Waterford.
9. Mr John T D O'Dwyer, Coroner, Crean O'Cleirigh & O'Dwyer, Solicitors, Co Mayo.
10. Mr Cathal Louth, Coroner, C J Louth & Son, Solicitors, Co Wicklow.
11. Mr James J Kelly, Coroner, James J Kelly & Son, Solicitors, Co Tipperary.
12. Mr Declan Madden, Director – Social Affairs and Specialist Services, Irish Business and Employers Confederation, Confederation House, 84/86 Lower Baggot Street, Dublin 2.
13. Mr Frank O'Connell, Coroner, C F O'Connell & Company, Co Cork.
14. Mr William Ryan, Co Limerick.
15. Ms Anne McCarthy, Co Cork.

16. Ms Lorna Meldrum, Chairperson, and Ms Alve Bevan, Committee Member, The Bereavement Counselling Service, Dublin Street, Baldoyle, Dublin 13.

17. Ms Joan Lahiff, Co Clare.

18. Mr Ger Murphy, Chairperson, Irish Council for Psychotherapy, 17 Dame Court, Dublin 2.

19. Ms Pauline Áine Harkin, Dublin 14.

20. Mr Peter Gaughan, Co Dublin.

21. Mr J R Madden, Coroner, Donegal North-East.

22. Mr Brendan O'Donnell, Former Coroner, Co Kildare.

23. Mr Dermot Kavanagh, Acting Secretary, Homelessness and Mental Health Action, C/O The Franciscan Friary, 4 Merchants Quay, Dublin 8.

24. Ms Sheila Vereker, Administrator, Waterford Rape Crisis Centre, 33 Georges Street, Waterford.

25. Mr S Molloy, Chairman, Association of Administrative Psychiatric Nurses, St Loman's Hospital, Palmerstown, Dublin.

26. Mr Brendan Goldsmith, President, Dublin Institute of Technology, Fitzwilliam House, 30 Upper Pembroke Street, Dublin 2.

27. Dr Brendan M Doyle, Deputy Coroner for County Carlow.

28. Dr Margaret Barry, Department of Health Promotion, University College, Galway.

29. Mr Michael Walsh, Deputy Chief Executive Officer, Eastern Health Board, Dr Steeven's Hospital, Dublin 8.

30. Ms Siobhan Mc Grory, Health Education Officer, National Youth Health Programme, National Youth Council of Ireland, 3 Montague Street, Dublin 2.

31. Dr David Thomas, Student Health Service, Trinity College, Dublin 2.

32. Ms Pauline Beegan, President, The Psychological Society of Ireland, 13 Adelaide Road, Dublin 2.

33. Ms Suzy Byrne, Co-Chairperson, Gay & Lesbian Equality Network, Glen, Hirschfeld Centre, 10 Fownes Street, Dublin 2.

34. Mr Tim O'Riordan, College Chaplain, Waterford Regional Technical College, Cork Road, Waterford.

35. Mr Vincent McCarthy, Registrar, Regional Technical College, Limerick.

36. Mr Eamon O'Brien, Limerick Corporation, City Coroner's Office, Limerick.

37. Dr Denis A Cusack, Barrister-at-Law, Coroner for County Kildare.

38. Mr John Dunne, Chief Executive, National Youth Federation, 20 Lower Dominick Street, Dublin 1.

39. Ms Theresa Millea, Assistant Secretary, Irish Friends of the Suicide Bereaved, PO Box 162, Cork.

40. Mr Padraic Cuffe, Sligo Regional Technical College, Ballinode, Sligo.

41. Mr Bob Carroll, Secretary, National Council on Ageing and Older People, 22 Clanwilliam Square, Grand Canal Quay, Dublin 2.

42. Ms Moira Leydon, Education/Research Officer, Association of Secondary School Teachers in Ireland, ASTI House, Winetavern Street, Dublin 8.

43. Ms Marion Quinn, Member of National Executive, Institute of Guidance Counsellors, 45 Clonmore Road, Mount Merrion, Co Dublin.

44. Mr Donal O'Shea, Chief Executive Officer, North Eastern Health Board, Kells, Co Meath.

45. Dr Brian J Farrell, Coroner for the City of Dublin.

46. Mr Owen Metcalfe, Chief Education Officer, Health Promotion Unit, Department of Health and Children, Dublin 2.

47. Ms Ann McCarthy, South Eastern Health Board.

48. Dr P A Carney, Chairman, Irish Psychiatric Training Committee, Corrigan House, Fenian Street, Dublin 2.

49. Dr Bartley Sheehan, Coroner for the County of Dublin.

50. Ms Orla O'Neill, Administrator, Schizophrenia Ireland, 38 Blessington Street, Dublin 7.

51. Judge Catherine McGuinness on behalf of the Circuit Court Judiciary.

52. Ms Caroline Mc Inerney, and Ms Mary Egan, Co Galway.

53. Dr John F Connolly, R.M.S./Chief Psychiatrist, St Mary's Hospital, Castlebar, Co Mayo.

54. Dr Patrick McKeon, Aware, 147 Phibsborough Road, Dublin 7.

55. Mr Maurice Mahon, Combat Suicide, C/O Calms, 1st Floor, 32 Shipquay Street, Derry.

56. Professor Marcus Webb, Chairman, The Royal College of Psychiatrists, Irish Division, Whitaker House, 37 Carysfort Downs, Blackrock, Co Dublin.

57. Mr John Cregan, Programme Manager, Special Hospital Care, Midland Health Board, Arden Road, Tullamore, Co Offaly.

58. Ms Ann Walker, Dublin Lesbian Line, Carmichael House, North Brunswick Street, Dublin 7.

59. Mr Fionan O'Cuinneagain, Chief Executive, Irish College of General Practitioners, Corrigan House, Fenian Street, Dublin 2.

60. Dr R F Chute, Coroner for West Kerry.

61. Mr Rory M Hogan, Coroner for Co Kilkenny.

62. Ms Fiona Hynes, Secretary and Mr Mike Scully, Chairman, APTI-SR, Association of Psychiatrists in Training in Ireland — Southern Region, Psychiatric Unit, General Hospital, Bantry, Co Cork.

63. Sr Eileen Fahey, Director, Aiséirí, Townspark, Cahir, Co Tipperary.

64. Mr Jim Byrne, Chairperson, Irish Association of University and College Counsellors (IAUCC), c/o Student Counselling Department, University College, Galway.

65. Dr F X Flanagan, Co Kildare.

66. Mr Mike Watts, National Coordinator, Grow Community Mental Health Movement, South East Region, Ormonde Home, Barrack Street, Kilkenny.

67. Ms Ruby Morrow, Psychologist, Psychological Service, Department of Education, Marlborough Street, Dublin 1.

68. Mr Matt Lynch, Programme Manager, Special Hospitals, South Eastern Health Board, Lacken, Dublin Road, Kilkenny.

69. Mr Eoin Ronayne, Irish Secretary, National Union of Journalists, 9th Floor, Liberty Hall, Dublin 1.

70. Mr Frank Lyons, Co Dublin.

71. Mr Eugene Donoghue, Chief Executive Officer, An Bord Altranais, Nursing Board, 31/32 Fitzwilliam Square, Dublin 2.

72. Mr Finbarr Fitzpatrick, Secretary General, Irish Hospital Consultants Association, Heritage House, Dundrum Office Park, Dublin 14.

73. Mr Brion Sweeney, Consultant Psychiatrist in Substance Misuse, Eastern Health Board, Baggot Street Clinic, 19 Haddington Road, Dublin 4.

74. Dr Enda Dooley, Director of Prison Medical Services, Department of Justice, Equality and Law Reform, 72-76, St Stephen's Green, Dublin 2.

Wt. P60030. 700. 2/99. Cahill. (M33412). G.Spl.