IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

IMO Position Paper on

Suicide Prevention

September 2008

Irish Medical Organisation
10 Fitzwilliam Place
Dublin 2
tel (01) 676 72 73
fax (01) 661 27 58
email imo@imo.ie
website www.imo.ie

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Mission Statement

The role of the IMO is to **represent** doctors

in Ireland and to **provide** them with all relevant services.

It is committed to the **development** of a caring,

efficient and effective Health Service.

Suicide Prevention

Suicide prevention is a major public health challenge both in Ireland and worldwide. The underlying factors that contribute to suicidal behaviour are complex and interlinked and while the risk factors are common, fatal suicide is relatively rare. There are few evidence based interventions that have any impact on suicide rates, there are however promising initiatives that impact on mental health in other ways that need to be researched, implemented and evaluated further.

In Ireland approximately 500 people die from suicide annually (2000-2004), representing 1.7% of all deaths and 29% of deaths from external causes.[1] According to the World Health Organisation (WHO) approximately one million people die each year from suicide[2] and it is the thirteenth leading cause of death worldwide.[3] Rates vary from country to country but of particular concern in Ireland is the high rate of suicide among young people, particularly young males. More than a quarter (26%) of deaths by suicide occurred in young adults in their 20s[4] and men under 35 years account for up to 40% of all suicide deaths in Ireland.[5]

Suicide fatalities are only part of the problem. For every completed suicide it is estimated that 20 other people attempt suicide.[6] Furthermore, each person who dies by suicide leaves behind family and friends whose lives are profoundly affected.[7] On average six people suffer intense grief.[8] In a community sample of young men in Ireland, 17% had a close friend who died by suicide and 5% a close relative.[9]

Suicide and undetermined death in Ireland - number and rate per 100,000 population

Year	Suicide		Undetermined death	
	Number	Rate	Number	Rate
2000	486	12.8	69	1.9
2001	519	13.5	78	2.0
2002	478	12.2	88	2.2
2003	497	12.7	87	2.2
2004	493	12.2	81	2.0
Deaths by Year of Registration				
2005	432	11.0	89	2.3
2006	409	9.6	66	1.6

Source: CSO and NOSP 2006

1 National Office for Suicide Prevention (NOSP) 2007, *Annual Report 2006,* Health Service Executive (HSE)… p21
2 World Health Organisation (WHO) 2008, *Suicide Prevention (SUPRE)* downloaded from http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/
3 Krug EG et al, eds. 2002, *World Report on Violence and Health* World Health Organisation (WHO) Geneva. p185
4 NOSP 2007, *Annual Report 2006*, …p20
5 Begley M, Chambers D, Corcoran P, and Gallagher J, 2004, *The Male Perspective – Young Men's Outlook on Life,* Mid-Western Health Board, The National Suicide Review Group and the National Suicide Research Foundation…p3
6 WHO 2008, *Suicide Prevention (SUPRE)*
7 Krug EG et al, eds. WHO 2002…p185
8 Health Service Executive (HSE), National Suicide Review Group (NSRG) and the Department of Health and Children (DOHC) 2005. *Reach Out. National Strategy for Action on Suicide Prevention*. HSE and DOHC: Dublin…p45
9 Begley M et al, 2004…p26

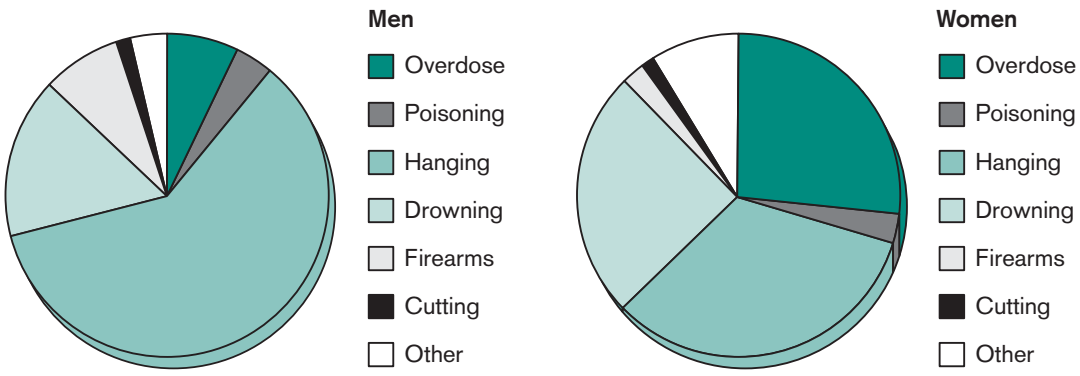
While suicide rates appear to have dropped in 2005 and 2006, these figures represent year of registration and not occurrence. Because registration of death from external causes takes place after an inquest, there is an inevitable delay in the registration of suicide.[10]

Rates of suicide, in general, may be under-reported by between 30% and 200%.[11] In the absence of proof of intent (a suicide note for example), a coroner may be reluctant to call the death a suicide and may instead give a verdict of undetermined cause.[12] Family members may also deny or conceal knowledge of intention to avoid stigmatisation or to benefit from insurance policies. Also many suicides may officially go unrecognised - for example in the case of a drug overdose or in car crashes involving one person where the act was deliberately masked as an accident.[13]

Suicide was decriminalised by the Criminal Law (Suicide) Act 1993. Prior to that suicide was further under-reported because of criminal implications and a religious ban on the burial in church grounds of those who died by suicide.[14] Trends in suicide are therefore difficult to establish.

Methods of suicide vary according to culture and environment[15] for example suicide by firearm is most common in the US and self-poisoning by pesticide is the most common method in China. Method chosen is a clear indication of whether suicidal behaviour will be fatal or not.[16] In Ireland, in all age groups hanging (55% of suicides) is the most common method of suicide in Ireland followed by drowning (18%) then poisoning (14%). In young men of 15-24 years 71 % of suicides were by hanging followed by 10% by firearm.[17]

Method of suicide for men and for women



Source: NSRF 2005

According to the National Registry of Deliberate Self Harm Ireland approximately 11,000 episodes of deliberate self-harm are recorded in Accident and Emergency departments annually.[18] Drug overdose is the most common method of self-harm, (involved in 76% of all acts registered in 2005) followed by self-cutting (21%).[19] The female rate of self-harm is 37% higher than the male rate. Almost half of all presentations (46%) were by people under 30 years of age. The highest rates of deliberate self-harm are among females aged 15-19 years.[20]

Not all episodes of self-harm are necessarily an attempt at suicide, but rather a cry for help, self-punishment or a loss of control.[21] A previous suicide attempt is however, a strong predictor of eventual suicide. Over 40% of completed suicides are preceded by a previous

10 NOSP 2007, *Annual Report 2006,* …p20
11 Crowley P, Kilroe J and Burke S, 2004, *Youth Suicide Prevention.* London: Health Development Agency. p9
12 Walsh D. 2008, *Suicide, Attempted Suicide And Prevention In Ireland And Elsewhere*. HRB Overview Series 7. Dublin: Health Research Board p25
13 Krug EG et al, eds. WHO 2002…p189
14 Walsh D. 2008…p25
15 Begley M. et al 2004…p8
16 Krug EG et al, eds. WHO 2002…p196
17 National Suicide Research Foundation (NSRF) 2006, *National Registry of Deliberate Self Harm Ireland: Annual Report 2005*. p12
18 NSRF 2006, *Annual Report 2005*…p3
19 NSRF 2006, *Annual Report 2005*…p7
20 NSRF 2006, *Annual Report 2005*…p13
21 NOSP 2007, *Annual Report 2006* …p25

attempt. One in five people who attempt suicide will attempt again, of whom 10% will succeed.[22] There is also evidence to suggest that only 25% of suicidal acts present at hospital.[23]

Mental disorders, particularly depression and substance abuse, are generally associated with suicide, however, suicide results from many complex sociocultural factors and is more likely to occur particularly during periods of socioeconomic, family and individual crisis situations, for example unemployment or bereavement.[24]

Depression and Suicide

"Psychological autopsies" - where researchers have interviewed surviving parents, close relatives or friends - have estimated that 65-90% of suicides displayed symptoms of depression prior to their death. However these figures have been contested. One study of completed suicide in Ireland found that one third were known to Mental Health Services at some point prior to their death, of which less than half had been diagnosed with depression.[25]

However there is a causal link between mental illness and suicide.[26] Research shows that people diagnosed with major uni-polar depression have a 20-fold increased risk of suicide compared to the general population while those diagnosed with bipolar disorder (or manic depression) are 15 times more at risk. Several studies show that schizophrenia is associated with a suicide risk which is 8.5 times higher than that observed in the general population. Studies also show that those who suffer from anxiety disorders including 'anxiety neurosis', agoraphobia, obsessive-compulsive disorder and panic disorder have a 6 to10-fold increased risk of suicide.[27] Among patients with depression, the risk seems to be higher when they do not follow their treatment, consider themselves untreatable, or are considered by specialists to be untreatable.[28]

A family history of suicide is a recognised marker for increased risk of suicide, however it is thought that it is a psychiatric disorder that is inherited rather than a genetic predisposition to suicidal behaviour.[29] Genetic factors are thought to account for up to 40% of the risk of depression.[30]

There is also evidence that stressful life events can trigger depression, suicidal behaviour or feelings of hopelessness in one in twelve cases.[31] Life events as precipitating factors include:

- loss of a loved one through death, divorce or separation
- interpersonal conflicts
- domestic violence
- physical or sexual abuse in childhood
- social isolation
- disabling illness (particularly in old people)
- financial difficulties
- job loss leading to poverty or a socially diminished role.[32]

Women are three to four times more likely to suffer from depression than men,[33] however, an unknown number of people (both male and female) are undiagnosed. The HSE estimates up to a million people in Ireland or one in four persons will develop suicidal thoughts, a feeling of hopelessness or poor mental health during their lifetime.[34]

There is still a certain amount of stigma attached to mental illness in Ireland. According to the Survey of Lifestyle, Attitudes and Nutrition

22 Crowley P et al, 2004…p14
23 Krug EG et al, eds. WHO 2002…p189
24 WHO 2008, *Suicide Prevention (SUPRE)*
25 Oireachtas Joint Committee on Health & Children 2006, *Seventh Report: The High Level of Suicide in Irish Society*…pp13-14
26 Oireachtas Joint Committee on Health & Children 2006,…p12
27 Samaritans 2008, *Mental Health Problems and Suicide* Samaritans Information Sheet p7…downloaded from http://www.samaritans.org/your_emotional_health/publications/mental_health_and_suicide.aspx
28 Krug EG et al, eds. WHO 2002…pp192-193
29 Krug EG et al, eds. WHO 2002…pp193-194
30 Walsh D. 2008…p52
31 Walsh D. 2008…p52
32 Krug EG et al, eds. WHO 2002…p194
33 Aware leaflet, *A Better Understanding of Depression* http://www.aware.ie/information.php
34 HSE 2007, *Mental Health in Ireland: Awareness and Attitudes* pp.5-10

(SLÁN) Report 2007, 66% of respondents reported that they 'agree' or 'strongly agree' with the statement 'If I was experiencing mental health problems, I wouldn't want people knowing about it' with more men (68%) agreeing than women (63%).[35]

Alcohol Abuse and Suicide

There is also a strong link between both chronic and acute alcohol abuse and suicide and a positive association has been found between rising alcohol consumption and suicide rates.[36] The lifetime risk of suicide among people dependent on alcohol is 7%[37] and is more likely to occur later on in the condition. Chronic alcohol abuse and depression are closely linked, and it is often difficult to determine which is the leading condition, for example alcohol abuse may lead to depression through the sense of decline and failure that many alcohol dependents experience, or alcohol abuse may be a form of self-medication to alleviate depression. Furthermore both depression and alcohol abuse may be the result of specific stresses in the person's life.[38]

Acute alcohol abuse is also related to suicide in a number of ways. Some individuals may consume large quantities of alcohol in order to turn suicidal ideation into action or acute intoxication may impair decision making and emotional and cognitive reasoning prompting a person to see suicide as a solution to their problems and acting on it.[39]

While alcohol is rare as a method of suicide or self-harm, a study of alcohol levels in accidental deaths and suicide in Ireland found 56% of suicides tested positive for alcohol. In suicides under 30 years of age, association was far higher with 92% testing positive for alcohol.[40] Alcohol consumption was also evident in 41% of all episodes of deliberate self-harm registered in 2005, and more common in male episodes (46%) than in female (38%).[41]

Ireland ranks among the highest consumers of alcohol in Europe. Alcohol consumption per adult (15 years and over) rose from 9.8 litres of pure alcohol in 1987 to 13.3 litres in 2006, peaking at 14.3 litres in 2001. Ireland ranks third highest in alcohol consumption in the enlarged Europe where the average annual consumption per adult is 10.2 litres of pure alcohol.[42] Young Irish men (18-29 age group) reported the highest consumption of alcohol and had more binge drinkers than any other population group.[43]

According to the National Drug Treatment Reporting System alcohol is the main problem substance in Ireland with 16,020 cases of problem alcohol use treated between 2004 and 2006, of which 68% were male.[44]

Young Males and Suicide

In the 15-24 year age group suicide accounts for 30% of deaths worldwide and in Ireland is one of the leading causes of violent death in this age category along with road accidents. Suicide is still a rare event in young people, but ranks as a major cause of death because very few young people die from other causes.[45]

In Ireland, on average, four times more men die from suicide than women. In the 20-29 year age group suicide rates are highest and male deaths in this age category outnumber female deaths by six.[46]

The reasons why more young men than young women kill themselves are unclear.[47] Rates for self-harm and depression are higher amongst females than males, although men are more likely to report hazardous levels of alcohol consumption and alcohol dependence compared with women. Depression is often difficult to detect in men, who generally seek medical help less often than women,[48] however,

35 Morgan K, McGee H, Watson D, Perry I, Barry M, Shelley E, Harrington J, Molcho M, Layte R, Tully N, van Lente E, Ward M, Lutomski J , Conroy R, Brugha R. 2008, *SLÁN 2007: Survey of Lifestyle, Attitudes & Nutrition in Ireland.* Main Report. Dublin: Department of Health and Children p48

36 Mongan D, Reynolds S, Fanagan S and Long J. 2007, *Health-Related Consequences of Problem Alcohol Use.* Overview 6 Dublin: Health Research Board p61

37 Mongan D. et al, 2007..p61

38 Krug EG et al, eds. WHO 2002…p193

39 Mongan D. et al, 2007…p61

40 Bedford D, O'Farrell A and Howell F (2006). *Blood Alcohol Levels in Persons who Died from Accidents and Suicides*. Irish Medical Journal, Vol.99. No.3. pp80–83.

41 NSRF 2006, *Annual Report 2005*…p7

42 Hope A. 2007, *Alcohol Consumption In Ireland 1986-2006,* HSE – Alcohol Implementation Group…p5

43 Department of Health and Children (DOHC) 2004, *Strategic Task Force on Alcohol, Second Report*…p9

44 Fanagan S, Reynolds S, Mongan D and Long J (2008) *Trends In Treated Problem Alcohol Use in Ireland, 2004 to 2006.* HRB Trends Series 1. Dublin: Health Research Board p25

45 Crowley et al 2004…p9

46 NOSP 2007, *Annual Report 2006*…p23

47 Walsh D. 2008, …p41

48 Krug EG et al, eds. WHO 2002,…p192

excessive drinking, particularly in men, is thought to be a symptom of "masked" depression.[49] Suicidal young men are also more likely to use drugs to relieve stress.[50]

A study examining attitudes among young men aged 18 to 34 in the mid-west of Ireland found that almost half (47%), experienced at least one form of suicidal ideation and one in nine (11.4%) had seriously considered suicide at some point. 4.6% indicated that they had deliberately taken an overdose or tried to harm themselves in some way, although less than 40% of those had been treated in hospital, indicating that the majority of deliberate self-harm acts by young men are not hospital-treated.[51]

The study also found that 70% of the men indicated that they sometimes or often "have a drink" when worried or upset.[52] One in eight (12%) men reported having a problem in the past year for which they felt they needed professional help but they didn't try to get it because it was too expensive or they felt they could handle it themselves or that no-one could help them. Barriers to seeking help for psychological problems in general included a dislike of talking to strangers, embarrassment and shame, concerns about confidentiality and stigma.[53]

Durkheim's theory suggests that an increase in anomie, that is a breakdown in social norms and values, have left some young men feeling excluded from or pessimistic about today's society.[54] The increase in suicide rates among young Irish men during the 1990s has corresponded to an increase in social fragmentation brought about by the rapid changes in Ireland's economy during the same period.[55] The increases in Ireland's economic prosperity has resulted in a rise in social inequality, high cost of living, less job security, increased urbanisation accompanied by long commutes. Church attendance has dropped as has the number of people who turn out to vote. Single parent households have increased and family law is heavily weighted against fathers.[56]

Suicide by young people has been associated with a number of social and interpersonal factors including unemployment and social isolation. Suicidal young men are 8 times more likely to be living alone, in care or hostels or without a family structure. They are also more likely to have a father who is absent.[57] In addition to the life events that trigger depression or suicidal behaviour in general, the following can also affect young people:

- bullying or being bullied
- physical or sexual abuse
- sexual orientation
- parental divorce
- problems with parents or friends.[58]

While the evidence is conflicting, media treatment of suicide is believed by some experts to affect suicide rates particularly amongst young people. For example publicity around the suicide of a famous person or exposure of suicide methods may encourage individuals to imitate. Romanticising suicide or presenting suicide as the inexplicable act of an otherwise healthy or high-achieving person may also encourage identification with the victim.[59]

The internet is of increasing concern, while some sites can provide advice to young people on where to seek help, a rising number of websites exist that promote suicide, the most lethal methods, and facilitate suicide pacts among strangers.[60]

Suicide Prevention Strategies

While many countries have devised suicide prevention strategies, there is disagreement over their value and effectiveness as the evidence base is poor for the majority of interventions. The roots of suicide are complex, diverse and poorly understood and while the

49 Samaritans 2008, *Mental Health Problems and Suicide*…p5
50 Eden-Evans V. 2004, *Young People and Suicide*, Samaritans Information Sheet downloaded from http://www.samaritans.org/your_emotional_health/publications/young_people_and_suicide.aspx …p9
51 Begley et al, 2004…p18
52 Begley et al, 2004…p20
53 Begley et al, 2004…p23
54 Begley et al, 2004…p5
55 Oireachtas Joint Committee on Health & Children 2006,…p11
56 Oireachtas Joint Committee on Health & Children 2006,…pp29-33
57 Eden-Evans V. Samaritans 2004, *Young People and Suicide*…pp10-12
58 Krug EG et al, eds. WHO 2002…p195
59 Eden-Evans V. Samaritans 2004, *Young People and Suicide*…pp13-14
60 Biddle L, Donovan J, Hawton K, Kapur N. and Gunnell D. 2008 *Suicide and the Internet* British Medical Journal Vol. 336 pp800-802

risk factors are common, suicide itself is rare.[61] Some reviewers have commented that the low rate of completed suicide makes it difficult to establish any reduction in suicide rates resulting from interventions.[62] While their impact on suicide rates are generally unproved there is evidence that some interventions have a positive impact on mental health and help-seeking. The following is an overview of the principle interventions:

Treatment Approaches

Research shows that a number of mental disorders are significantly associated with suicide. Depression is untreated or under-treated in general even after a suicide attempt.[63] Therefore early identification and appropriate treatment of disorders is an important strategy for preventing suicide.[64]

Pharmacotherapy works on the neurobiological processes that underlie certain psychiatric conditions related to suicidal behaviour.[65] Trials indicate an antisuicidal effect for lithium in major mood disorders and clozapine in schizophrenia. Suicide rates fell in 27 countries with a high increase in selective serotonin reuptake inhibitor (SSRI) prescriptions. Also certain geographic regions or demographic groups with high SSRI prescription rates have the lowest suicide rates in the United States and Australia. However, studies in Iceland, Japan and Italy do not show the same results, possibly due to; lack of compliance; pre-existing low suicide rate; high rates of alcoholism or the effect may be confined to women because too few men seek and comply with treatment.[66] There are concerns about over-identification of depression as distinct from transitory unhappiness leading to unnecessary anti-depressant prescriptions and that SSRI administration to adolescents may precipitate suicide rather than prevent it.[67]

Psychotherapy relies on verbal and non-verbal communication with the patient and alone or combined with antidepressants can be an effective treatment of psychiatric disorders. Research shows that depressive symptoms and feelings of hopelessness improved with problem solving therapy, suicidal ideation decreased with interpersonal psychotherapy, cognitive behavior therapy, and dialectical behavioral therapy, repeat suicide attempts halved with cognitive therapy and suicidal behaviour in people with borderline personality disorder was reduced with dialectical behavioral therapy and psychoanalytically oriented partial hospitalisation.[68]

Follow-up Care After Suicide Attempts

Because many depressed people who survive a suicide attempt, reattempt or comply poorly with treatment, improved follow-up care is needed including psychiatric hopitalisation where needed.[69] Follow-up interventions have shown mixed results. Issuing an emergency contact green card or use of a suicide intervention counsellor to coordinate assessment and long-term treatment have resulted in fewer suicides compared to a control group. On the other hand, interventions including telephone follow-up, intensive psychosocial follow-up, and video education plus family therapy, resulted in no difference compared with standard aftercare.[70]

Awareness and Education

Public education campaigns are aimed at improving the recognition of suicide risk, reducing the stigma associated with mental illness and encouraging help-seeking. So far their has been no detectable impact on suicide acts or on intermediate measures such as treatment seeking, however their possible longer term impact on suicide has yet to be assessed.[71]

School-based education programmes which have a universal approach or are targeted at high-risk groups, so far lack evidence to support them. However, interventions aimed at promoting self-esteem were found to have a positive impact on young people's mental well-being. Further evaluation of current interventions is still needed.[72]

---

61 Walsh D. 2008, …p59
62 Crowley P. et al 2004…p23
63 Mann J.J, Apter A, Bertolete J et al. 2005, *Suicide Prevention Strategies. A Systematic Review.* Journal of the American Medical Association, Vol.294. No.16. pp2064–2074.
64 Krug EG et al, eds. WHO 2002,…p199
65 Krug EG et al, eds. WHO 2002,…p199
66 Mann J.J.et al 2005,…p2069
67 Walsh D. 2008,…p63
68 Mann J.J. et al. 2005,…p2069
69 Mann J.J. et al. 2005,…pp2069-2070
70 Mann J.J. et al. 2005,…pp2069-2070
71 Mann J.J. et al. 2005,…p2067
72 Crowley et al 2004,…p39

Primary care physician education campaigns aimed at improving physician recognition of depression and suicide risk. Research has shown that many suicides have had contact with a primary care physician a month prior to their death although their depression may not have been diagnosed.[73] Primary care education programmes have been successful in Sweden, Hungary, Japan and Slovenia where prescription rates for antidepressants have increased and suicide rates have lowered.[74]

Societal Interventions

Media Restriction

While the media may help suicide prevention by providing an avenue for public education, media restrictions on suicide reporting have had mixed results. A total black-out of reporting of underground (metro) suicide reporting on Austria saw an 80% reduction in such suicides. However educating journalists and establishing guidelines for the responsible reporting of suicide have had mixed results and need to be evaluated further.[75]

Means Restriction

Interventions restricting access to lethal methods decrease the number of suicides by those methods. Where the method is common, restriction of means has led to overall reductions in suicide, for example firearms restriction in Canada and Washington DC, barbiturate restriction in Australia and domestic gas detoxification in Switzerland and the United Kingdom.[76] However the effectiveness of means restriction interventions has been contested because substitution of method has been observed in some cases,[77] or effectiveness has not been assessed in the long-term.[78] Furthermore, hanging and drowning are the most common methods of suicide in Ireland and restriction to these means is difficult. Restriction on the sale of paracetamol was introduced in Ireland in 2001 and is a rare example of means restriction in the State.[79]

Alcohol Restriction

Studies have shown that, particularly amongst young people, the percentage change in alcohol consumption has the single highest correlation with changes in suicide rates.[80] In the United Kingdom, the Department of Health has stated that "focusing on drug and alcohol abuse would have a greater impact on adolescent suicide rates than any other primary prevention programme"[81] In the former USSR a major anti-alcohol campaign - which included raising prices of alcoholic beverages, fewer retail outlets and reduced tolerance of public drunkenness - resulted in significant reductions in alcohol consumption and suicide rates (19% for women, 32% for men).[82] In Iceland following a change in alcohol laws, a decrease in consumption of spirits was accompanied by a decrease in the suicide rate.[83] In France where television advertising is forbidden and no graphic content can feature in other media, alcohol consumption has progressively halved, [84] however the impact on suicide rates is unknown.

Community-Based Interventions

Suicide prevention centres which provide emotional support by telephone 24 hours with occasional face-to-face counselling and outreach work[85] have never been properly evaluated,[86] however this is not to say that they do not have an effect. There is evidence however, to suggest that they attract the high-risk population that they are aiming to help.[87]

Gatekeepers are community or institutional members –such as clergy, caregivers, teachers, prison officers and military leaders - who are trained to identify high-risk individuals, encourage help-seeking and reduce stigma associated with mental health issues. So far

---

73 Mann J.J. et al. 2005,…p2067
74 Mann J.J. et al. 2005,...p2067
75 Mann J.J. et al. 2005,…p2070
76 Mann J.J. et al. 2005,…p2070
77 Crowley et al 2004,…p40
78 Mann J.J. et al. 2005,…p2070
79 NOSP 2006,…p39
80 Eden-Evans V. Samaritans 2004, *Young People and Suicide*…p10
81 Eden-Evans V. Samaritans 2004, *Young People and Suicide*…p9
82 Foster T. 2001, *Dying for a Drink*, British Medical Journal Vol. 323 pp817-818
83 Lester D. 1999, *Effect of Changing Alcohol Laws in Iceland on Suicide Rates*. Psychological Reports Vol. 84 p1158
84 Walsh D. 2008, …p66
85 Krug EG et al, eds. WHO 2002…p201
86 Walsh D. 2008,…p60
87 Krug EG et al, eds. WHO 2002,…p201

evaluation has largely been limited to multilevel interventions in institutional settings such as the military where success has been reported in lowering suicide rates.[88]

Reach Out: The National Strategy for Action on Suicide Prevention 2005-2014 was published in 2005, taking a broad-based approach to prevent suicide, self-harm and suicidal ideation in the general population by tackling contributing factors.[89] The strategy is comprised of 4 levels of action:

A general population approach – to promote positive mental health and well-being and bring about positive attitude change towards mental health, problem solving and coping in the general population – with action outlined in areas of the family, schools, youth organisations and services, third level education settings, the workplace, sports clubs and organisations, voluntary and community organisations, church and religious groups, the media, reducing stigma and promoting mental health, primary care and general practice.[90]

A targeted approach - to reduce the risk of suicidal behaviour among high risk groups and vulnerable people – with action outlined in the areas of deliberate self-harm, mental health services, alcohol and substance abuse, marginalised groups, prisoners, members of An Garda Síochána, unemployed people, people who have experienced abuse, young men, older people, restricting access to means.[91]

Responding to suicide - to minimise the distress felt among families, friends and in a community following a death by suicide and ensure that individuals are not isolated or left vulnerable so that the risk of any related suicidal behaviour is reduced – with action outlined in support following suicide and in the coroner service.[92]

Information and research - to improve access to information relating to suicidal behaviour and on where and how to get help, and to encourage suicide research and improve access to research findings.[93]

The 2006 report of the Joint Oireachtas Sub-Committee on the *High Level of Suicide in Irish Society* further recommends a range of detailed, costed measures based on submissions and the actions identified in *Reach Out.* The report set out a goal of reducing overall suicide rates by 20% by 2016.[94]

The report also highlighted two areas of concern regarding mental health services in Ireland that need to be addressed: 1) the continued inequality and lack of choice in adult mental health services throughout the country and 2) the lack of psychiatric inpatient units for children and adolescents.[95]

Conclusion

There is a wealth of international research on suicide which indicates some of the possible causes and remedies but in Ireland there is a dearth of information. The establishment of the National Office of Suicide Prevention (NOSP) is a welcome step towards tackling the problem. However the IMO is concerned at the removal of funding from the programmes related to suicide prevention. This has been highlighted in the recent reports about the failure to increase funding in line with inflation for this work. According to Mr. Dan Neville, retiring President of the Irish Association of Suicidology speaking to Irishhealth.com, 'the allocation to NOSP in 2008 is €3.5 million, which is identical to 2007. When inflation is taken into consideration, there is a reduction of support from the Government', Mr Neville said.[96] According to Geoff Day of the NOSP, the NOSP received only €3.5m of the promised €5m for funding its prevention strategy *Reach Out*. This has forced the voluntary sector to raise funds from other sources.[97]

88 Mann J.J. et al. 2005,…pp2067-2068
89 HSE, NSRG and DOHC 2005, *Reach Out. National Strategy for Action on Suicide Prevention*…p8
90 HSE, NSRG and DOHC 2005, *Reach Out*…p20-32
91 HSE, NSRG and DOHC 2005, Reach Out…p33-44
92 HSE, NSRG and DOHC 2005, Reach Out…p45-47
93 HSE, NSRG and DOHC 2005, Reach Out…p48-50
94 Oireachtas Joint Committee on Health & Children 2006,…p48
95 Oireachtas Joint Committee on Health & Children 2006,…p34-41
96 www.irishhealth.com 10/4/2008
97 *Irish Independent* 31/3/08

IMO Recommendations

The IMO calls for the full implementation of the recommendations outlined in *Reach Out: The National Strategy for Action on Suicide Prevention 2005-2014* and the recommendations detailed in the report of the Joint Oireachtas Sub-Committee on the *High Level of Suicide in Irish Society.*

At each level of action proposed, the IMO further recommends:

General Population Approach

- Focus on known interventions that encourage early diagnosis and treatment of at-risk individuals for example training and awareness programmes for primary care physicians, hospital staff and mental health services staff and gatekeeper education for school teachers and staff of community organisations.
- Continue to fund and evaluate public education campaigns that improve recognition of mental health problems, reduce stigma and encourage help-seeking.
- Research, fund and evaluate school-based multi-faceted projects which promote self-esteem and improve problem solving amongst young people.

Targeted Approach

- Again focus on known interventions that improve follow-up care after suicide attempts, for example suicide intervention services in hospital Accident and Emergency departments.
- Address the inequalities in mental health care provision for adults and the under provision of appropriate psychiatric and mental health services for children and adolescents[98] by implementing the recommendations in the report of Joint Oireachtas Sub-Committee on the *High Level of Suicide in Irish Society.*
- Given the relationship between alcohol abuse and suicide the IMO calls for the full implementation of the recommendations of the National Strategic Task Force on Alcohol.
- Continue to fund and evaluate community-based initiatives such as suicide prevention centres, and initiatives that attempt to reduce social isolation.

Responding to Suicide

- Fund and support services for the bereaved including voluntary bereavement support groups.

Information and Research

- Further research is needed into the cause of suicide including:
  - better data collection on suicide and social indicators, divorce, migration, increased alcohol consumption rates etc.
  - the relationship between alcohol, depression and suicide particularly amongst young men
  - media influence on suicide and young people
- Monitor those programmes that improve mental health and protective factors for their long-term impact on suicide rates
- Research and evaluate other interventions for their possible effect on suicide rates or mental health problems

98 Since 2003 the IMO has called for the adequate resourcing of inpatient psychiatric services for children and adolescents.

Position Papers published by the Irish Medical Organisation are available on www.imo.ie

Lifestyle and Chronic Disease	Sep 2008
Protecting the Vulnerable – A Modern Forensic Medical Service	Mar 2008
Disability, Ages (0–18 years)	Nov 2007
Co-location and Acute Hospital Beds	Jul 2007
Role of the Doctor	Apr 2007
Medical Schools	Aug 2006
Obesity	Apr 2006
Care of the Elderly	Jan 2006
Health Service Funding	Mar 2005
Acute Hospital Bed Capacity	Mar 2005
Medical Card Eligibility	Mar 2005
Road Safety	Mar 2005
Accident & Emergency	Mar 2005
Manpower	Mar 2005