IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Irish Medical Organisation

Submission to the Health Service Executive on

The New National Framework for Suicide Prevention

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The IMO welcomes the opportunity to submit our views on suicide prevention to aid in the development of the National Framework for Suicide Prevention 2015-2018. 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.

The IMO hopes that the National Framework for Suicide Prevention 2015 – 2018 will acknowledge and implement some of the suggestions made in this submission. However, before turning to a new National Strategy, the HSE should ensure that the recommendations outlined in *Reach Out: The National Strategy for Action on Suicide Prevention 2005-2014* and the *Report of the Joint Oireachtas Sub-Committee on the High Level of Suicide in Irish Society* are fully implemented.

Provisional data shows 525 people died from suicide in Ireland in 2011 of which 95 aged between 15-24 years, the majority (80) were male.[1] While further research is needed, a number of risk factors are associated with suicide and self-harm[2]:

Psychiatric and psychological factors include major depression, other mood disorders such as bipolar disorder, schizophrenia, anxiety and disorders of conduct and personality, impulsivity, a sense of hopelessness and drug or alcohol abuse. A family history of suicide is also a significant risk indicator.

Negative life events can trigger depression, suicidal thoughts or feelings of hopelessness. Examples of such events 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.[3] In young people precipitating negative life events can also include parental separation, divorce or death, or parental mental disorder.

While the evidence base for suicide prevention interventions is poor there are a range of population measures and targeted interventions that can impact positively on mental health and help-seeking among young people. For example means restriction is important and there is also some evidence to suggest that media treatment of suicide can affect suicide rates. As such, the IMO condemns all newspapers who engage in sensational reporting of suicides and do not follow national or international guidelines on the reporting of suicides. The IMO calls on the Minister for Communications to set enforceable guidelines on the reporting of suicide in the media which carry sufficient penalties to prevent the tragic loss of life. All national and local newspapers in Ireland should publically adopt and comply with the National Guidelines on the Reporting of Suicide in all publications.

Hawthorn et al have identified approaches to prevent self-harm and suicide in adolescents.[4]

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[1] CSO Vital Statistics – Yearly Summary 2011

[2] Krug E.G. et al, Self Directed-Violence, *World Report on Violence and Health* World Health Organization (WHO) Geneva 2002 : 183-212

[3] Ibid

[4] Hawton K. Saunders K.E.A. O'Connor R.C, Self-harm and Suicide in Adolescents, Lancet 2012 : 379: 2373-82

Approaches to prevent self-harm and suicide in adolescents **Population measures**	**Measures for at-risk populations**
• School-based psychological well-being and skills training programmes • Gatekeeper training (e.g. school teachers, peers) • Screening to identify those who might be at risk • Restriction of access to means used for self-harm and suicide • Improved media reporting and portrayal of suicidal behaviour • Encouragement of help-seeking behaviour • Public awareness campaigns • Help-lines • Internet sources of help • Reduction of stigma associated with mental health problems and help seeking	• Psychosocial interventions for adolescents at risk of self-harm or suicide (e.g., depressed adolescents, abused individuals, runaway children) • Screening of those at risk (e.g. young offenders) • Psychosocial interventions for adolescents who have self-harmed • Pharmacotherapeutic interventions for adolescents at risk of self-harm or suicide

Hawton K. Saunders K.E.A. O'Connor R.C, Self-harm and Suicide in Adolescents, Lancet 2012 : 379: 2373-82

In addition, a recent study on mental health services in England and Wales found that the provision of adequate community mental health services, in particular the provision of 24-hour crisis care, is associated with a reduction in suicide rates, with the biggest falls in deprived catchment areas. [5]

The enormity of the challenge cannot be underestimated. Suicide fatalities are only part of the problem. For every completed suicide it is estimated that 20 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 from intense grief.[8] In a community of sample of young men in Ireland, 17% had a close friend who died by suicide and 5% a close relative.[9] As such, it is necessary to fund and support services for the bereaved including voluntary bereavement support groups. It is also crucial for the HSE to continue to fund and evaluate public education campaigns that improve recognition of mental health problems, reduce stigma and encourage help-seeking.

Suicide and self-harm in adolescents are major public health problems with devastating impact on individuals, families and communities. While suicide is a rare event in young people, it ranks as a major cause of death because very few young people die from other causes. In Ireland suicide rates are highest among young men and rates of self-reported harm are highest among young females. The peak rate for women was 15-19 years old where one in every 162 women presented to hospital in 2012 as a consequence of deliberate self-harm.[10] The peak rate for men was 20-24 year olds

[5] While D et al, Implementation of mental health service recommendations in England and Wales and suicide rates, 1997—2006: a cross-sectional and before-and-after observational study, Lancet 2012 : 379: 1005-12

[6] World Health Organisation (WHO), 2008, *Suicide Prevention (SUPRE)* – http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/

[7] Krug et al, *World Report on Violence and Health*, eds. 2002, WHO, Geneva, p. 185

[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 p. 45

[9] Begley, Chambers, Corcoran, and Gallagher, The Male Perspective – Young Men's Outlook on Life, Mid-Western Health Board, The National Suicide Review Group and the National Suicide Research Foundation, 2004, p.26

[10] National Office for Suicide Prevention Annual Report 2012, p 62

where one in every 188 men presented to hospital.[11] In order to tackle this problem there should be research, funding and school-based multi-faceted projects which promote self-esteem and improve problem solving amongst young people

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.[12] A previous suicide attempt is however, a strong predictor of eventual suicide. Over 40% of completed suicides are preceded by a previous attempt. One in five people who attempt suicide will attempt again, of whom 10% will succeed.[13] There is also evidence to suggest that only 25% of suicidal acts present at hospital.[14] 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.[15] As such, inequalities in mental health care provision for adults and the under provision of appropriate psychiatric and mental health services for children and adolescents should be addressed by implementing the recommendations in the report of Joint Oireachtas Sub-Committee on the High Level of Suicide in Irish Society.

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. As such, 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

The establishment of the National Office of Suicide Prevention (NOSP) was a welcome step towards tackling the problem. The IMO welcomes the government's commitment to the NOSP. The 8% increase in budget this year to 8.8 million euro illustrates how vital the NOSP is to suicide prevention. It is hopeful that this necessary support provided to the NOSP will be continued in the future.

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 risk factors are common, suicide itself is rare.[16] Some reviewers have commented that the low rate of completed suicide makes it difficult to establish any reduction in suicide rates resulting from interventions.[17] 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. As such, focus on known interventions that encourage early diagnosis and treatment of at-risk individuals for example suicide intervention services in hospital Accident and Emergency departments, training and awareness programmes for primary

[11] National Office for Suicide Prevention Annual Report 2012, p 62
[12] *Begley, Chambers, Corcoran, and Gallagher, The Male Perspective – Young Men's Outlook on Life, Mid-Western Health Board, The National Suicide Review Group and the National Suicide Research Foundation, 2004, p.2*5
[13] Crowley P et al, 2004, p14
[14] Krug EG et al, eds. WHO 2002, p189
[15] WHO 2008, Suicide Prevention (SUPRE)
[16] Walsh D. 2008, p59
[17] Crowley P. et al 2004, p23

care physicians, hospital staff and mental health services staff and gatekeeper education for school teachers and staff of community organisations.

The IMO thus recommends:

- All media outlets in Ireland should comply with the *Media Guidelines for Reporting Suicide and self-harm* (published by the Irish Association of Suicidology and the Samaritans), these guidelines should be legally enforceable with sufficient penalties to ensure compliance;
- Suicide Intervention Teams must be available in all hospitals on a 24 hour 7 days a week basis;
- Pilot the development of community based 24 our crisis mental health provision throughout Ireland.
- 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.
- Research and evaluate other interventions for their possible effect on suicide rates or mental health problems.

The IMO's position on suicide prevention can also be found in The IMO Position Paper on Suicide Prevention (2008) and the IMO Position Paper on Child Health (2012) which contains recommendations on suicide prevention and self-harm among young people as well as recommendations on Child and Adolescent Mental Health Services.