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An Comhchoiste um Shláinte agus Leanaí

An Seachtú Tuarascáil

An Leibhéal Ard Féinmharaithe i Sochaí na hÉireann

Iúil 2006

Houses of the Oireachtas

Joint Committee on Health & Children

Seventh Report

The High Level of Suicide in Irish Society

July 2006

Foreword by the chairman of the Joint Committee on Health & Children, John Moloney, T.D.

The Joint Committee on Health and Children was established in November 2002. As part of its 2005 Work Programme, the Joint Committee established a Sub-Committee on the High Level of Suicide in Irish Society to examine the issue in detail and report back with a series of reasonable and feasible recommendations. The Joint Committee had previously identified suicide as a core priority issue that needed further examination.

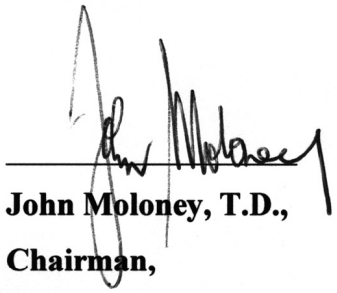
The sub-Committee held its inaugural meeting in October 2005 when it decided to engage the services of a consultant to assist the sub-Committee in the preparation of a draft report.

The sub-Committee appointed Dr. Siobhan Barry MD MRCPsych, Clinical Director of Cluain Mhuire Services to assist it in producing a draft Report containing a series of reasonable and feasible recommendations. A draft report was drawn up by Dr. Barry and agreed by the sub-Committee and referred to the Joint Committee in June 2006. The draft report, as amended, was agreed.

The Joint Committee is grateful to the Members of the sub-Committee for their work on such an important issue. The Joint Committee would like to thank Dr. Siobhan Barry for her assistance in the preparation of the report. The Joint Committee would also like to expresses its gratitude to all those who came before the Joint Committee to give evidence and to those who took the time to make written submissions.

Given that suicide affects all age groups and communities in our society and few people escape being touched by the devastating effects of suicidal behaviour in their lifetime the Joint Committee asks that immediate action be taken to implement the recommendations contained in this report.

The Joint Committee also requests that the issues raised in this report be the subject of a debate in both Houses of the Oireachtas.



John Moloney, T.D.,
Chairman,
Joint Committee on Health & Children.
July 2006.

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Executive Summary

Facts: The sharp increase in rates of suicide in Ireland of the past two decades demands decisive action by Government. This rise is particularly stark in males aged less than 35 years but an emerging trend in young female suicides of those aged less than 25 years is also now apparent.

Social policy: Associated with our increase in suicide has been our economic policy that increases society's wealth but at the cost of society's fragmentation, our family law that is weighted against fathers in non-marital situations or situations of marital breakdown, and our employment law that has lead to less job security but in a climate of negligible unemployment. Being a member of a Church is known to be a protective factor against suicide but our move has been relentlessly towards a more secular lifestyle. Alcohol consumption is strongly associated with accidental deaths including death by suicide but Government has failed, however, to implement its own alcohol policy – Reports of the Strategic Task Force on Alcohol which could curb problem alcohol use.

Mental Health: Those with mental illness are known to be at higher risk of death by suicide but the type of mental health service one can access is a matter of luck. Funding for mental health services is allocated in a random manner with scant regard for need. The provision of mental health services for adolescents is high on aspiration but low on action.

Emergency Services: Our beleaguered A&E Departments have more than 11,000 admissions per year following suicidal behaviour, a significant number of whom will eventually die by suicide. We have not yet put swift and appropriate standardised interventions in place to treat this high risk group and thus reduce repeat acts. This would also relieve pressure on our already over stretched emergency services.

Suicide Prevention: Preventative responses to suicide need to be embedded into a wide range of areas of social policy that include education, criminal justice and health. Our long awaited and recently published *National Strategy for Action on Suicide Prevention 2005-2014* disappointingly has not set out any specific target for the reduction in our suicide rate unlike similar initiatives in other developed countries.

This report by the Joint Oireachtas sub-Committee has, in contrast, set out recommendations, timeframes and the funding required to make inroads into our national suicide epidemic. The Government is urged to cease prevarication and to implement these.

Background to this Report

The sharp increase in the rate of suicide in Ireland over the past two decades is not particular to Ireland as it reflects similar trends in international suicide statistics, but it has led to our launching a number of significant initiatives (*Appendix 1*). Nevertheless, the high rate of suicide has persisted and has led to the formation in October 2005 of the *Joint Oireachtas sub-Committee on High Level of Suicide in Irish Society* to investigate this phenomenon and to report on this matter.

A range of statutory, private and voluntary groups, academics and researchers were invited to appear before the sub-Committee, and additional written submissions were received and considered *(Appendix 2)*. The committee was thus subject to a range of views and opinions from those who have been bereaved by suicide themselves, those who work with those bereaved by suicide and clinicians from the adult and children's mental health services. Presentations were also made by groups whose interest and expertise lie in examining existing national and international statistics and trends of suicide and deliberate self harm in Ireland.

While in writing this report the services of an external consultant were secured, the contents must be seen as the expression of very frustrated politicians who see the neglect of the issue of suicide as one that needs to be immediately addressed by Government.

Submissions to the Committee: Common themes.

Despite the disparity of backgrounds and experience of those who came before the Committee, a number of common opinions emerged from the evidence presented. These included the fact that

1. Suicide, the act of voluntarily or intentionally taking one's own life, is a growing global problem. In itself, **suicide is not an illness** but rather it is a term used to describe the act of the taking of one's own life.

2. **The causes of suicide** are multi-faceted and entail an interaction of biological, psychological, social and environmental risk factors occurring in an individual who may have various socio-demographic vulnerabilities[1] interfacing with life-long susceptibilities[2] that are then usually subject to a precipitating event,[3] with catastrophic consequences.

3. Suicide and suicidal behaviour are **societal problems** and society needs as a consequence to alter social policies to deal with the risk factors for suicide. Effective action to prevent suicidal behaviour requires the cooperation of the whole community, including inputs from the Departments of Education & Science; Justice & Law Reform; Health & Children; Social & Family Affairs; Employer and Voluntary Organisations and agencies committed to positive health promotion.

4. Many suicides occur when the **attachments** between an individual and society are strained or fragmented (Durkheim, 1897). Suicide occurs more frequently when individuals are less engaged in and feel more isolated from their communities, as arises in modern industrial societies were individualism predominates. Consequently an examination of social change and social policy in Ireland is essential to aid one's understanding of the factors associated with the rise in our suicide rates.

5. **Negative emotions** in an individual such as shame, guilt, hostility, despondency, alienation and despair may be triggered by an unfavourable event or a combination of incidents. Closely related to the harmful emotions that lead to suicide in vulnerable people appears to be the conviction that any happiness of the past cannot be recaptured. The loss

[1] Particular vulnerabilities include being of: Male gender; Aged under 35; Single or separated/divorced; Unemployed; Accessibility to lethal means.
[2] Specific susceptibilities include existing: Psychiatric Illness; Alcohol & substance misuse; Gambling problem or other debts; History of Deliberate Self Harm; Family History of Suicide; Poor physical health
[3] Common precipitating events include: Rejection; Interpersonal problems; A recent humiliating event; A loss or bereavement; Work difficulties.

of a job, a relationship or the death of a friend or relative can precipitate states of hopelessness leading to thoughts of suicide in individuals who may already possess long term risk factors (*see footnotes 1-3 of previous page*). Vulnerable individuals' judgement on these occasions is often clouded by recent or current alcohol or drug use. In these circumstances individuals may act in an impulsive self destructive way but ultimately they may be quite ambivalent about whether they want to end their lives, as evidenced by the subsequent report of many of those whose initially very determined attempts at suicide, fail.

6. **Clusters of suicides** in the community in which an individual lives can be a random occurrence or may comprise a significant environmental risk factor. International research indicates that when the protection afforded by family and societal cohesion, and religious beliefs become eroded, a rise in suicide rates follows. There are also well recognised occupations that are at increased risk of suicide such as doctors, vets and those in the armed and police forces. The relatively easy access to lethal means of suicide of these occupations is likely to be the important risk factor rather than the actual occupations themselves.

7. That **there is a well established role of alcohol in completed suicide** and in suicidal behaviour was almost universally highlighted. Alcohol produces a significant fall in mood and facilitates aggressive behaviour towards oneself and others. An individual may not have a history of suffering from depression for this to come about, but those that do are at increased likelihood of a decline in mood. Alcohol impairs problem solving skills and limits an individual's decision making capacity, particularly in a crisis. It is disinhibiting, allowing people to do things that they might otherwise think about but not do. Those who deliberately self harm and who have been found to have alcohol or substance problems should be speedily referred to treatment programmes from the A&E Department. Treatment programmes should provide rapid access in these circumstances. It is conservatively estimated that problem alcohol use costs the Irish national exchequer €2.65 billion annually.

8. While a causal link between mental illness and suicide cannot be made definitively in many instances there is nevertheless a **close relationship between suicide and mental illness,** and the imperative to make mental health services more user-friendly and accessible was emphasised. The poor state of the mental health services, the lack of national planning and chronic underinvestment was raised. The importance of having agreed protocols and guidelines for engaging with people who are themselves assessed to be at high risk for suicidal

behaviour, and for linking in with those who are particularly vulnerable following discharge from in-patient care, was highlighted.
Under funding and the poorly developed services particularly for children and adolescents was referred to in several submissions, as was the procrastination in effectively dealing with this. Integration of the child and adolescent services with adult mental health services at an administrative level would improve the care to those whose vulnerabilities emerge in childhood and ensure that seamless care is provided as these individuals grow into adulthood.
The need to improve mental health services to young people especially those with serious mental illness was emphasised as 10 - 15% of those with psychotic illnesses are at risk of dying by suicide. This risk is at its greatest within the first 5 years after the onset of psychotic symptoms, at a time that these, mostly young adults are completing their education or are at the start of their working life. Programmes of early intervention were advised to be set out to proactively detect and treat serious mental illness early, and in a phase specific way.
Untreated depression and declining intellectual capacity in older people is strongly linked to suicidal thoughts and acts, and these acts tend to be more planned and more likely to result in death than in a younger person, was reported. Sometimes, terminally ill people choose to end their lives rather than to submit themselves to a long and painful decline and expert opinion is divided as to whether this represents a carefully reasoned existential position or that it is an indication of an untreated depression.
The importance of reducing stigma surrounding mental health problems was raised so that when people become aware of such crises arising among their relatives and acquaintances, they know where and how to access help.

9. Prediction of suicide has proved difficult as it is a relatively rare event even in high risk groups whose vulnerabilities are recognised. Approximately 55% of those who die by suicide do so at their first attempt. However, **a systematic approach to the assessment of those who engage in non fatal suicidal behaviour can prevent repeated episodes of self harm,** some of which will have a fatal outcome. Most of those who die by suicide have never been referred to or assessed by the mental health services. One large study has shown that of those who completed suicide in Ireland, 33% had been known to be referred to the Mental Health Services at some point, of whom less than half had been diagnosed as suffering from depression. Post-suicide psychological autopsies however report that between 65 and 95% of those who die by suicide had some form of mental illness. Such high rates may be liable to retrospective over-identification in a desperate but understandable quest

for meaning and motive that follows a suicide and must inevitably be open to influence by the fatal suicidal act itself. Studies of the mental health of completed suicides, for example, largely find, unsurprisingly, that the person was depressed before they died by suicide (Foster *et al*, 1997).

10. Ascertaining **which components of suicide prevention programmes are effective** in reducing rates of suicide and suicide attempt is essential in order to optimise the deployment of limited resources. A rigorous systematic review of all international publications that have examined the effectiveness of specific suicide-preventive interventions[4] published from 1966 to 2005 has recommended from studying the almost 100 papers available, that educating clinicians in recognising depression and its treatment, and restricting access to lethal methods were proven to reduce suicide rates. All other interventions were described as needing more evidence of efficacy (Mann *et al,* 2005).

11. The vulnerabilities of marginalised groups especially those liable to community harassment render these at risk of suicidal behaviour. Young men and women of same-sex orientation have been identified as one of a number of high-risk groups for youth suicide - they being more than 6 times mores likely to engage in suicidal behaviour than their heterosexual peers (Ferguson *et al*, 1999). Those with chronic eating disorders are also more susceptible to suicidal behaviour than the general population.

A further marginalised group that came to the committee's attention were those with Fetal Alcohol Spectrum Disorders. Conditions on this spectrum result from prenatal exposure to alcohol and they are estimated to affect 1% of babies. The consequences for those born with these disorders are life long with impulsivity, a co-morbid mood disorder and substance abuse problems typically arising. These individuals have a many-factor higher than average risk of suicidal behaviour. Levels of general awareness of this preventable condition need to be heightened. As yet unpublished Irish data indicates that people accused of sex offences including those accused of internet paedophile pornography downloading are at extremely high risk of suicide. The sense of shame that is associated with individuals being unmasked for this sort of behaviour, regardless of whether they are eventually convicted or acquitted, appears to be the prime trigger for suicidal behaviour. With

[4] These interventions included a. Education and awareness for the general public and for professionals;
b. The use of specific screening tools for at-risk individuals;
c. Treatment of psychiatric disorders;
d. Restricting access to lethal means ;
e. Responsible media reporting of suicide.

the presumption of innocence until proven guilty seeming to be reversed in these cases, and the protracted legal proceedings that can ensue, putting support in place for these people whose usual social supports are often gone due to the nature of the alleged offence is crucial.

12. **Those who have been bereaved by suicide** refer to the confusion, stigma, shame, anger, and loneliness they experience, and many describe suicidal thoughts themselves that are associated with and complicate their grieving. Many of the voluntary counselling services for those bereaved by suicide have been founded by those who themselves were bereaved by suicide and who through their own experience became painfully aware of the hiatus in generic bereavement services to take into account of their distinct type of loss. There is still not any consistent availability of dedicated services for those in mourning following a suicide, and this must be remedied.
The importance of providing post suicide counselling for those who are experiencing the impact of somebody else's suicide was raised before the sub-committee. The profound impact of an individual's death by suicide on their friends, school or work colleagues, the Gardaí and Emergency Medical Services as well as on their immediate family was outlined. The importance of containing suicide risk and being vigilant about suicidal ideation given the increased risk for people in this situation was emphasised. Attention to very practical matters that concern those who experience loss by suicide was summarised; those included the funeral, inquest, entitlements, how to deal with neighbours, what to say to children or how to connect people with support services if that is their wish.

13. **The need to plan services using reliable and timely information** was emphasised, as was the importance, to this end, of sharing existing data held by statutory, voluntary and other professional agencies. The Central Statistics Office (CSO) uses the information provided by the Gardaí on Form 104 for classifying deaths as suicide as part of their annual reporting of vital statistics. Form 104 has been revised since the *Report of the National Task Force on Suicide* in 1998 now encompassing more detailed information on the deceased than previously. It was felt that further supplementation of this information where possible by contact with, not alone the bereaved family but also the deceased's social network might be of further assistance. Integration and co-ordination of these activities was deemed to be essential to ensure effective implementation of suicide prevention initiatives in the wider community.

Suicide: Facts & Figures

Ireland v EU states

Suicide rates in Ireland were ranked 18th of the 25 EU countries in 2004 with a total (all ages, both genders) suicide rate of 10.2 *per 100,000* of the population.

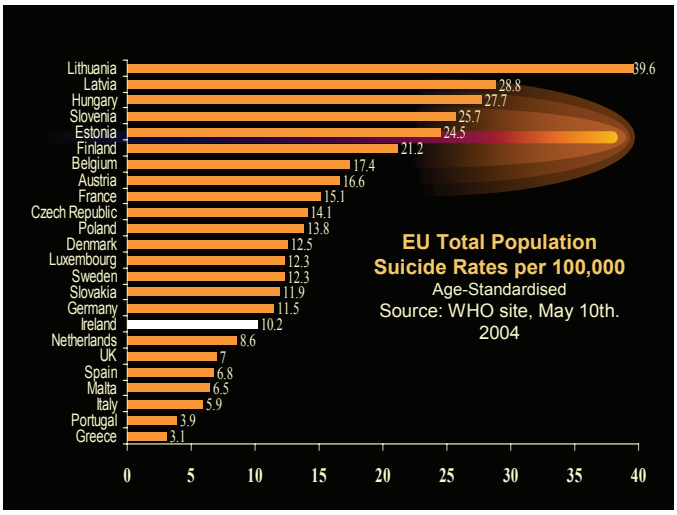

Table 1: EU Total Population Suicide rates *per 100,000*.
This ranks Ireland within the lowest quartile of the 25 EU countries

Despite our low overall ranking, our rate of youth suicide (those aged 15-24 years, both genders) were the 5th highest of the 25 EU countries in 2004 with a rate of 15.7 *per 100,000* of the population, these having risen sharply from 1990 onwards. In this age group, male suicides tend to exceed females by a ratio of 7:1.

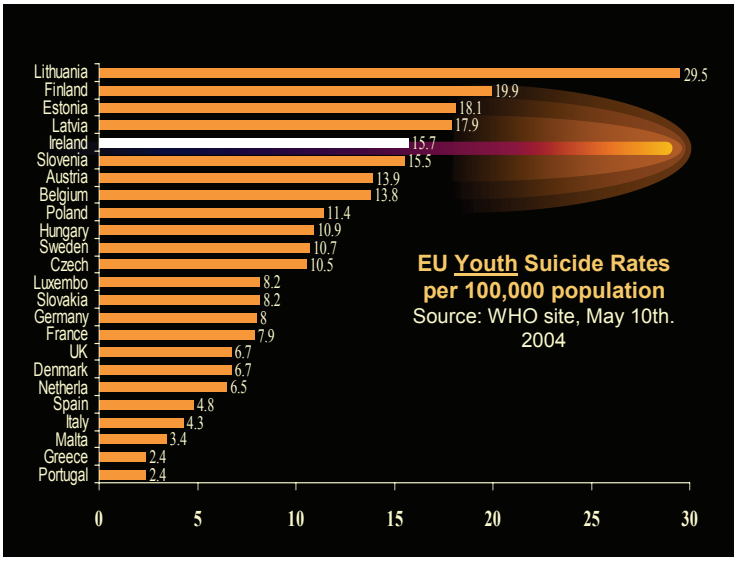

Table 2: EU Youth Suicide (aged 15-24 years) *per 100,000*.
This ranks Ireland within the upper quartile of the 25 EU countries

Suicide in Ireland

Over the past 50 years we have experienced an escalation in the degree of violence in society as evidenced by an almost 9-fold increase in the number of indictable offences from 1952 to 2002, and an almost 6-fold rise in the number of murders during that period.

From the 1890s until 1971, official suicide rates in Ireland were consistently low at 4 per 100,000 of the population (Figure 1). This low figure over that era may, in part, have been due to underreporting.

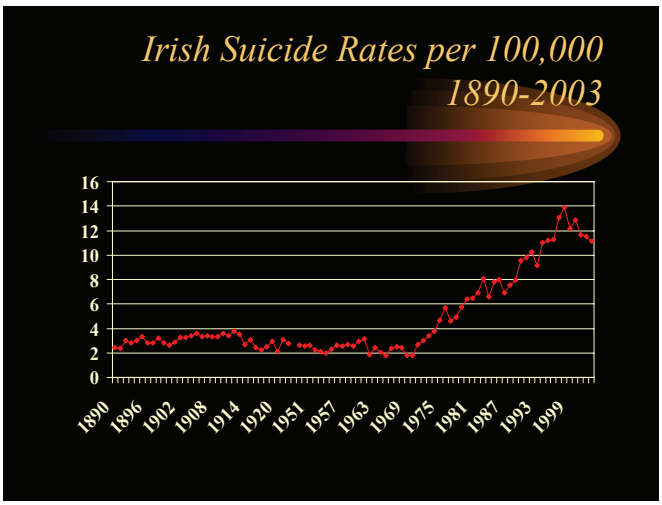

Figure 1: Total Irish Suicide rates *per 100,000* from 1890-2003.

From the 1970s onwards, Ireland has undergone considerable societal change with a population shift from rural to urban areas. In that time suicide rates in this country rose exponentially, peaked in 1998 and have levelled off somewhat since then. While there have been ongoing concerns expressed that official Irish figures for suicide might have been between 15-20% lower than the actual figures (Kelleher, 1991) a subsequent detailed national study of *Suicide in Ireland* have convincingly found this not to be the case and that any discrepancies are likely to be of a very small magnitude. We are nevertheless faced with the spectre of completed suicide that is claimed to be "epidemic" in proportions in the media, and the facts regrettably supporting this contention.

During the twentieth century, Finland, the Netherlands, Norway, Scotland, Spain and Sweden have also experienced a significant increase in deaths from suicide while England & Wales, Italy, Switzerland and New Zealand have experienced a significant decrease (de Leo *et al,* 2002). The fact that some countries have managed to reverse the inexorable upward trend must give rise for hope.

Accidental Deaths:

Since 1998, deaths from suicide have exceeded those lost in road traffic accidents by as many as 100 people per year (Figure 2). It is believed that a number of single vehicle single occupant road deaths reported as road traffic accidents are actually deaths by suicide. The international literature indicates that 6-9% of such deaths have been suicides. Research carried out in Mayo has supported this finding.

Successive Annual Reports of An Garda Siochána for 2003, 2004 and 2005 respectively indicate road deaths of 335, 375 and 399 for those years and the expenditure on road safety by the Department of Transport was **€14.53m** (2003), **€23.55m** (2004) and **€29.45m** (2005)[5]. The CSO vital statistics for death by suicide figure in 2003 was 497, in 2004 there were 457 and in 2005 there were 431 such deaths[6] but ironically, the sum committed to suicide prevention at the launch of the 10-year National Suicide Prevention Strategy in September 2005 was a mere **€0.5m** for the remainder of 2005[7].

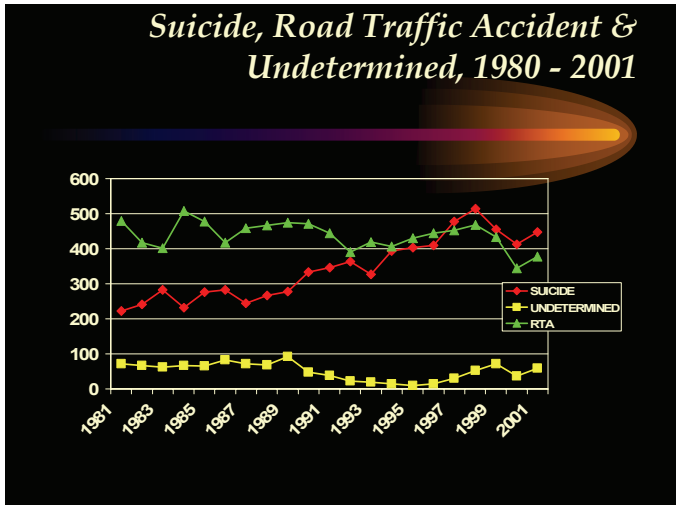

Figure 2: Total number of deaths by Suicide, Road Traffic Accidents and Undetermined Deaths, 1980-2001.

Male v Female Suicide:

The male:female differential in suicide rates holds in all countries suggesting that culturally defined gender roles and expectations may be

[5] Response by the Minister for Transport to a Parliamentary Question on 26, April 2006.
[6] Figures obtained from Central Statistics Office website (yearly national suicide figures).
[7] Press release by the Tánaiste on the 8, September 2005. A sum of €1.2m has been assigned to the National Suicide Prevention Strategy by the HSE for 2006. (HSE website, 13, March 2006)

important variables both across and within different societies. It varies from 1:1 in China to 6.7:1 in the Russian Federation. In European terms, Ireland ranks second to the Russian Federation having an overall male:female differential of 4.7:1 in 2002 (Allen, 2005).

Figure 3: Irish Suicide rates by gender *per 100,000* from 1980 -2003. This shows the continuous rise in overall suicide rate - an increase in male suicides being the major contributor to this phenomenon.

Male Suicides:

An examination of male suicide by age band shows a consistent rise in suicide rates of young males, aged 25 years and under, over the past two decades. Another noteworthy finding is that the suicide rate for males aged 25 to 29 years has more than doubled from 18.3 *per 100,000* of the population in 1989 to 39.9 *per 100,000* of the population in 1999 (Figure 4).

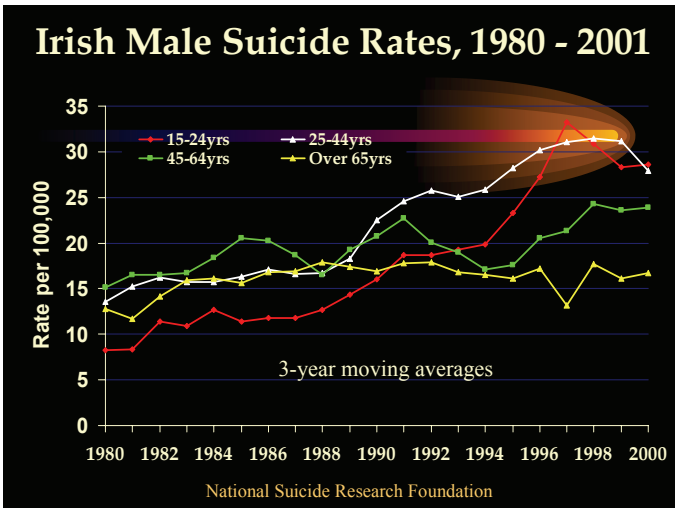

Figure 4: Irish Male Suicides, differentiated by age band 1980-2003.
This figure illustrates a persistent rise in all male suicides with most marked increased in the 15-24 years and 25-44 years age bands.

However a more detailed examination of male suicide by separating and comparing the suicide rate from late 1988 - 1993 to 1994 to 2000 illustrates how rapidly things have disimproved (Figure 5). The huge disparities are particularly marked in the 15-24 years and the 25-34 years age bands:

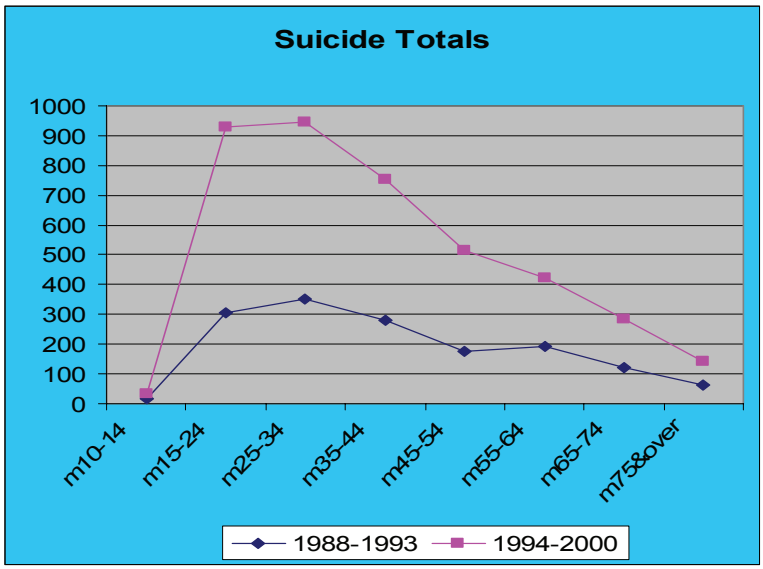

Figure 5: Irish Male Suicides, 1988-1993 compared to 1994 to 2000. This figure illustrates a consistent rise in all male suicides when compared by age band.

Female Suicide:

The total rate of female suicide has remained fairly constant since 1990. However, the number of young women aged 15-24 years who have died by suicide has trebled from 1990 to 2004 (Figure 6). A modest decrease in suicide rates for the over 65 years olds has been reported in Ireland since 1990, possibly due to improved attitudes toward retiring; improved social services; enhanced psychiatric care for older people; greater economic security and greater socio-political activism for the elderly (de Leo, 1998) - suicide among the over-75s being an indication of inadequate support and/or poor medical care (Pritchard & Baldwin, 2002).

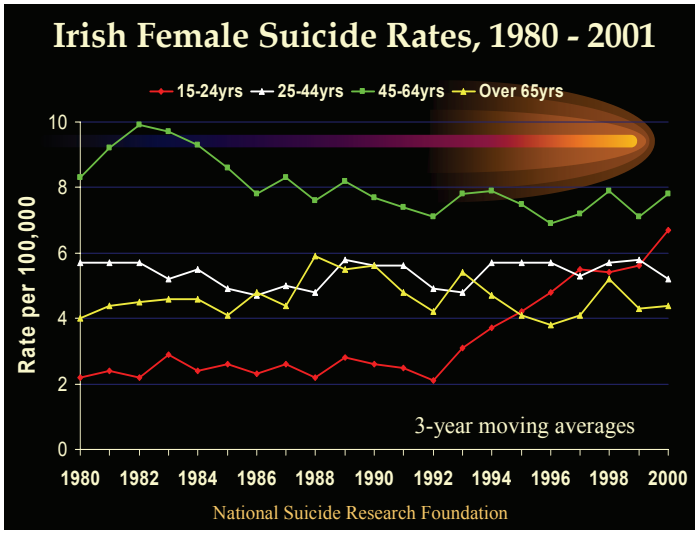

Figure 6: Irish Female Suicides, differentiated by age band, 1980-2001.

Data Collection in relation to Suicide:

Speeding up the reporting process is considered crucial to taking decisive remedial action on suicide. At present an investigating Garda examines all unnatural deaths, and reports those deemed to be due to self harm to the Central Statistics Office on Form 104. It had been estimated that suicide mortality figures are accurate to within 5%, but detailed surveys of coroners' records in two Irish counties in recent times have shown that there may a discrepancy as high as 16% between the official statistics and Coroners Verdicts at Inquest. Additionally, the number of deaths classified as "undetermined" has risen in recent years. A significant number of these deaths might also more properly be added to the number of suicide deaths.

Times of Greatest Vulnerability to Suicide:

An examination of Irish suicide data for the period 1990-1998 found that the male suicide rate was significantly higher on working Mondays and Saturdays, and during April, June and August. Female suicides were high in August but without a day of the week effect. However, when the suicide rates of male teenagers were considered, higher rates were found on Saturdays, Sundays and on both working and bank holiday Mondays (Corcoran *et al,* 2004). This information could be used for targeting responses as well as examining potential causative factors.

Social Fragmentation:

Suicide rates, alcohol misuse, single person households, transient residencies, abstention from voting and declining religious solidarity are all indications of social fragmentation (Congton 1996) - have increased sharply in Ireland since the early 1990s but the rates of serious mental

illness *per se* in society have not correspondingly increased. Research from Bristol indicates that people living in areas which have high levels of social fragmentation have higher rates of suicide than those living in areas of social deprivation or poverty (Whitley *et al* 1999). Subsequent work confirms the relationship of social fragmentation to suicide but did not find a relationship between suicide rates and socioeconomic deprivation or the prevalence of severe mental illness within socially fragmented areas, as measured by psychiatric admission rate (Evans *et al,* 2004). Any targeting of suicide prevention may be more effective if aimed at socially fragmented rather than socially deprived areas. Integration could be achieved through a variety of sources including family support and fostering religious, political and work affiliations. Further research is needed to examine the underlying causes of social fragmentation, in order to assist those making social policy decisions relating to these issues.

The Economic Cost of Suicide:

The economic costs of suicide are significant with the human and indirect costs of suicide in Ireland estimated at €871.5 m in 2001 which was equivalent to approximately 0.5% of the Gross National Product. This is broken down as 72% related to the human cost and 28% mainly to lost productivity to society. Actuarial studies examining Years of Productive Life (YPLs) however indicate a much greater economic loss brought about by suicide given the young age of so many of the victims.

Deliberate Self Harm in Ireland

Suicidal intent at the time of deliberate self harm or non fatal suicidal behaviour is known to be associated with the risk of completed suicide in such individuals in the future. This risk is greatest during the first 12 months after the self harming episode and it remains elevated for many years after the event. It has not been possible, however, to predict with any degree of accuracy which individuals who engage in suicidal behaviour will ultimately die by suicide. However, *the focus of intervention needs to shift from the unreliability of prediction to concentrating efforts systematically on prevention.* Effective suicide preventative strategies include carrying out a detailed and systematic psychiatric assessment in all of those who present following suicidal behaviour, and offering appropriate treatment, support and follow up. In Ireland, in 2003, there were approximately 11,200 deliberate self harm presentations to general hospitals; of these 57% were by women. This represents a statistically significant increase of almost 4% from the previous year with rates of male self harm increasingly disproportionately more than females. The peak presentation with this behaviour is between the ages of 15-19 years for females and between 20-24 years for males (Table 3). Drug overdose has been the most common method of self harm occurring in almost three-quarters of those who present to A&E Departments. **Alcohol** was involved in 47% of male episodes of deliberate self harm with somewhat lower levels for females.

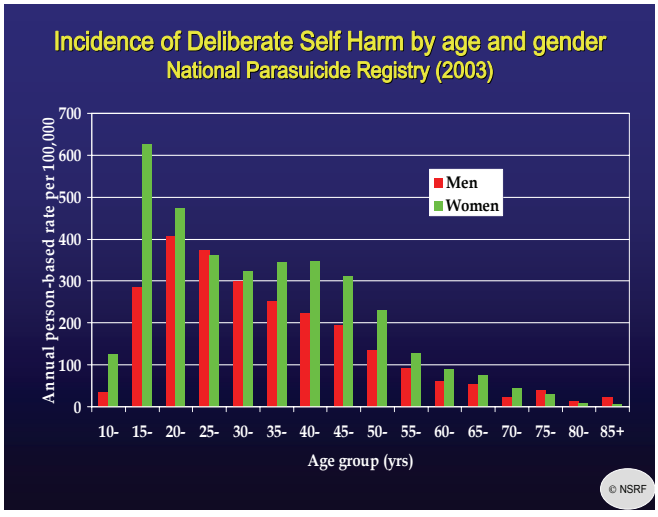

Table 3: Deliberate Self Harm with reference to age and gender, 2003.

The figure of 11,200 annual presentations with suicidal behaviour is widely felt to be the tip of the iceberg and a many-fold underestimate of

true levels of deliberate self harm that occurs in Ireland. For example, community-based research into almost 4,000 teenagers in the 15-17 year old age group in the HSE Southern Region indicated that the vast majority (85%) of the 9% who admitted to having harmed themselves had not been in contact with anybody from the health services, although 50% had confided in a friend and 20% in a family member.

Such studies indicate an enormous hidden number of cases of deliberate self harm and the huge opportunity presented for evidence based health promotion to combat and conquer this form of self abuse that increases the risk for completed suicide for some. An outcome of such public education measures would of necessity result in an increase in the number of people seeking help following deliberate self harm who would have previously hidden their difficulties, in the short term. Ultimately, a reduction in suicidal behaviour and in actual suicide rates would be the goal.

Responses to Deliberate Self Harm

Data from the National Suicide Research Foundation tell us that in 2003 of those that attend hospital following an episode of deliberate self harm, there is quite a disparity in professional response to this event (Table 4). Only 25% of those who present in the HSE Eastern Region were admitted to a general hospital with this figure increasing to 76% in the HSE North East.

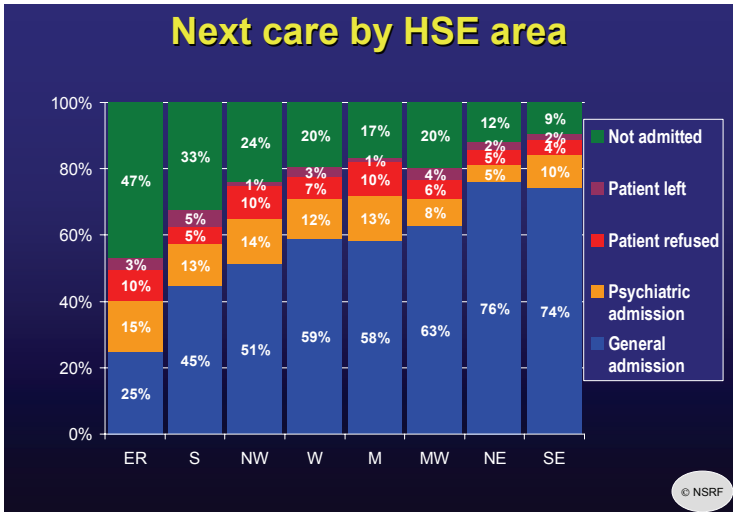

Table 4: The immediate intervention offered by each HSE area to those who presented to hospital following an episode of Deliberate Self Harm in 2003**.**

The immediate intervention offered following an episode of suicidal behaviour is shown in **Table 4**. Whether the individual was admitted to

hospital and whether this was to a general hospital or a psychiatric facility is outlined. There were noteworthy differences of interventions offered following deliberate self harm found in all 8 Health Board Areas. The remarkable difference in what is offered to individuals following suicidal behaviour is likely to be due to a variation in the range of assessment and treatment options available from one area to another. For example were a psychiatric *assessment* in the A&E Department by a dedicated liaison multidisciplinary team an option, would this lead to a reduced necessity for psychiatric *admission*? Is psychiatric admission the intervention of necessity or the only option in areas where specialist liaison psychiatric services have not been developed? The availability of a dedicated liaison multidisciplinary team to assess and intervene in the comprehensive management of those exhibiting suicidal behaviour is likely to be a leading factor affecting the post suicidal behaviour response and effect. A study of regional outcomes should yield information on best practice in this regard.

A recently published French study of more than 600 individuals had presented to A&E following an episode of suicidal behaviour showed that contacting people by telephone one month after being discharged from A&E following an episode of deliberate self poisoning may help reduce the number of reattempted suicides over one year (Vaiva *et al,* 2006).

Social Policy and Social Change in Ireland

The increased wealth that has accompanied the economic boom that Ireland has enjoyed in the 1990s has lead to a greater disposable income spent on leisure time activities but also a surge in suicide especially among young people. Suicide prevention in our society cannot stand in isolation and it needs to be built into our social policies especially those that relate to the Economy, Employment, the Law (particularly Family Law), Alcohol Policy as well as the Mental Health and Education sectors aimed at increasing social cohesion, and ultimately at expanding our social capital (Bourdieu, 1983). Social integration is increased in situations of family support and religious, political and work affiliations and suicide rates tend to be low.

1. **Economy.** Ireland's membership of the European Economic Community in 1973 brought unparalleled social change in its wake. Unprecedented economic prosperity emerged from the late 1980s onwards when we shifted from the European-style social market economy to a US-style free market economy, enabled by successive social partnership agreements. This has come at a price. Urbanisation has increased and is likely to continue into the future. Approximately 60% of the population now live in urban areas compared to 38% in the 1970s. Efforts to secure affordable housing have lead to many couples locating their homes at a distance from work with resultant long commutes on a less than adequate road infrastructure. Their families of origin and traditional support networks have become for many, more distant in the process. Childcare has become a scarce and expensive resource, and pressurised parents are spending less time with their children. This economic growth has resulted in a rise in social inequality with a greater divide between rich and poor. Our economic imperatives to continue this level of growth must be tempered with a recognition that we also need to improve the quality of life for our citizens - the economy should exist to serve society, not the other way round. To quote the late senator Robert Kennedy who in 1968 said: *"The gross national product does not allow for the health of our children, the quality of their education, or the joy of their play. It does not include the beauty of our poetry or the strength of our marriages; the intelligence of our public debate or the integrity of our public officials. It measures neither our wit nor our courage; neither our wisdom nor our learning; neither our compassion nor our devotion to our country; it measures everything, in short, except that which makes life worthwhile".*

2. **Employment.** Changing social roles have led to greater numbers of women, especially those with children, in the workforce and this is expected to increase in future decades. The overwhelming experience from other developed countries is that the greater the female participation in the workforce the corresponding increases in male suicide (Stack, 1998).
   Despite the achievements of job creation, restructuring caused by outsourcing and globalisation has causes job losses in some sectors. Greater mobility of labour in the current economy is coupled with less job security. Experience from other countries indicate that the least skilled individuals in the labour market are at greatest risk of job displacement in a fluid labour market, and are most at risk of suicide (Shortt, 1996). However, the recent Economic and Social Research Institute (ESRI) report (Doyle *et al* 2006) did not find any evidence of Irish worker displacement by migrant workers although anecdotally individuals have reported experiences to the contrary. If workers are exposed to these forces will need to be re-skilled to maintain their employability so that our pursuit of economic progress ensures employment protection for those that are vulnerable.

3. **The Family & Family Law.** The number of single parent, generally and overwhelmingly female, households has increased in Ireland since the 1980s. Research from the US indicates that fatherless children are at dramatically greater risk of suicide (U.S. Department of Health & Human Services, 1993) and that the percentage of families with children present that are female-headed is a strong predictor of suicide among young adult and adolescent white males (McCall & Land 1994). Family law is weighted against fathers and the numbers of fathers not living with their children is growing. Such "detached" adult males are at increased risk of suicide.
   The absence of a consistent male role model for boys as they grow up poses an additional problem - many looking to the lavish and unattainable lifestyles of their sports and music heroes as that to which they aspire. Male children who are raised without paternal involvement have a greater likelihood of youth suicide, becoming involved in crime and tend to have poorer school attainment (Erickson, 2000). Male youngsters who come into residential care cannot look here for role models because of the small numbers of males who enter a career in Social Care.
   Female children brought up without paternal involvement, tend to become sexually active at an earlier age - their lack of experience of non-sexualised relationships with males e.g. their father, likely to be an important contributory factor. Father's access to and involvement

with, their children needs to be protected by law in non-marital situations or in situations of separation/divorce (Tan & Quinlivan 2006).

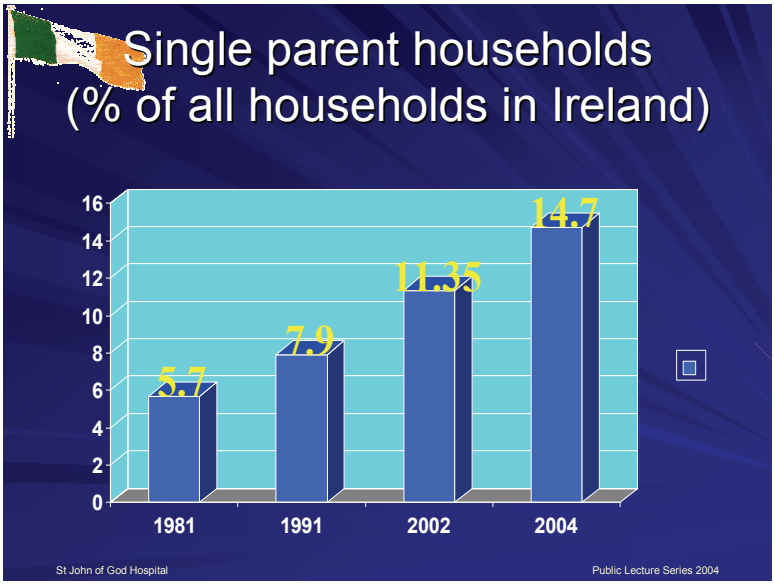

Table 5: This shows the percentage of single parent households from 1981 to 2004.

4. Societal Factors. Our birth rate has steadily fallen from its peak in 1980 and this is expected to plateau out in 2011.

Our life expectancy has increased but the number of older people, aged over 65 years living alone has increased from 1 in 6 in the late 1970s to 1 in 4 today and this trend is expected to continue.

There has been a fall in political engagement as evidenced by a progressive decline in the percentage of those eligible to vote who have turned out to exercise this right in successive general elections. This has been a long established indicator of social fragmentation.

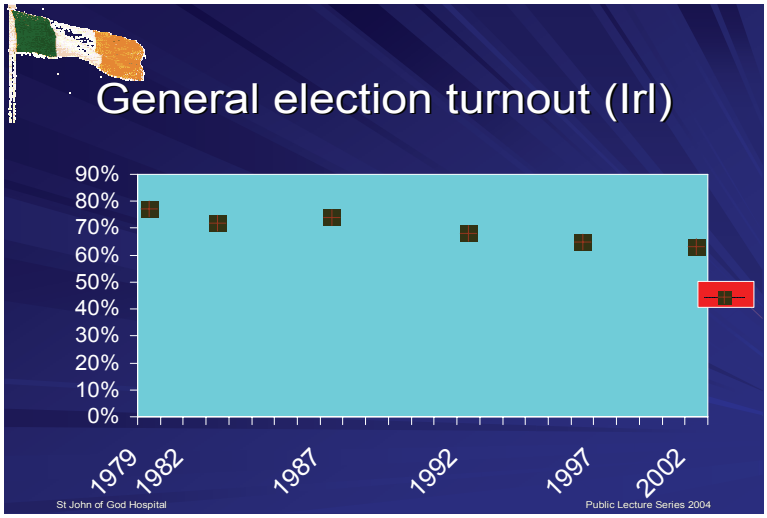

Figure 7: Shows the percentage of the electorate that voted in recent Irish General Elections.

The continuance of these trends indicates that we are becoming more solitary and less engaged in our society. To quote the famous French sociologist, Emile Durkheim who wrote about this in 19th Century France *"Man is the more vulnerable to self-destruction the more he is detached from any collectivity, that is to say, the more he lives as an egoist."* (Durkheim, 1893)

5. Religious Matters

Quantifiable disengagement from formal religion has long been recognised as a significant factor in social fragmentation (Durkheim, 1912) and thus increases in suicide rate (Martin, 1984).

"There is a growing spiritual void at the heart of Irish society which, in its extreme form has produced escapism of various kinds such as drugs, binge drinking, violence and suicide."[8]

Weekly attendance at Church has steadily fallen since the 1980s. A particularly sharp fall-off in church attendance is reported when age, urban-rural location, occupation and gender is taken into account. Younger adult males, particularly among the urban manual occupations, have especially low levels of weekly church attendance.

"Tragically, the young male suicide rate in Ireland is amongst the highest in Europe. The economic boom has brought many fruits to Ireland but there is a growing realisation that growth for growth's sake may not sit

[8] Rev. Professor Vincent Twomey, Professor of Moral Theology, St Patrick's College, Maynooth speaking at the 25th McGill Summer School, Glenties, Co Donegal, July 2005.

well with a caring and an inclusive society. So when policy makers from Central and Eastern Europe visit Ireland to learn about the policies that resulted in the doubling of Irish Gross National Product between 1989 and 2001, they would also do well to learn from our mistakes. There is a growing risk that in the rush to improve our material well being, we are losing sight of our own identity.... While religious identity is still strong in Ireland it is, however, no longer synonymous with regular Church attendance...an Irish opinion poll found that just 44 percent of those who regard themselves as Catholics attend mass once a week."[9]

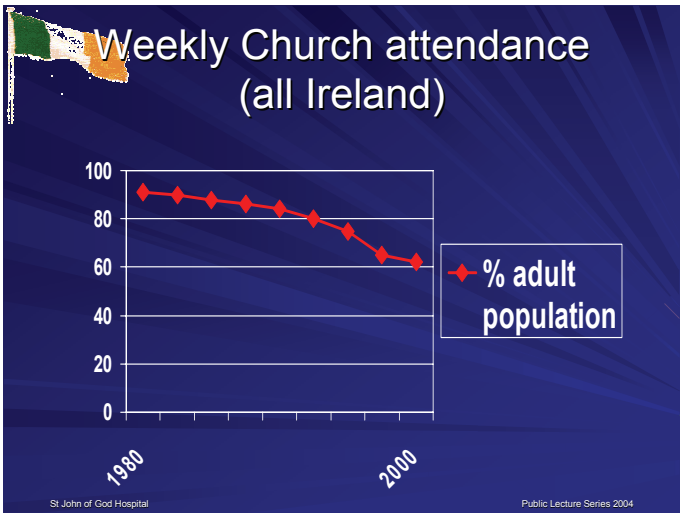

Figure 8: Shows the percentage of the Irish adult population that attend Church on a weekly basis in the years 1980 - 2000.

6. The right to privacy and the presumption of innocence:

The vulnerability of those accused of sexual offences to suicide ought to lead to a restriction of media coverage of such cases and the presumption of innocence until a conviction has been secured, once the safety of children is assured. Victims are already protected in this way and those accused should be offered similar levels of privacy. A mechanism for speeding up the legal process in these cases is also likely to be protective.

[9] Catholic Communications Office Press Release, 29 April 2004. Most Rev Seán Brady's address to the Polish Episcopal Conference, Warsaw on *The Roman Catholic Church in Ireland today*.

7. Mental Health Services in Ireland:

*A. Services for Adults***.** A compact overview of Psychiatric Services in Ireland is provided in successive reports of the Inspector of Mental Hospitals, an office known as the Inspector of Mental Health Services since mid 2003. These reports have attracted fleeting annual interest because of their critical findings but any remedial actions have been painfully slow.

There have been dramatic changes in the structures and delivery of mental health care throughout Europe over the last 50 years and Ireland, following the lead of many European states, has had a policy of moving patient care from long-stay institutions to more acute inpatient facilities and community-based care since 1966[10].

The concept of sectorisation in the Irish mental health services was introduced in 1984 with the publication of a mental health policy document, *Planning for the Future*. As a result, the public mental health service user has no choice in terms of where he can avail of his mental health service - his residence, if he has one, determines the service he is eligible to attend. This lack of choice is unique to the mental health services; no such restriction applies to those seeking other forms of medical care. Despite the service developments that have taken place over the decades, there are "still some locations that were unacceptable for care and treatment of patients because of seriously unsatisfactory conditions"[11]. Therefore, it is still very much a matter of luck as to where and under what kind of conditions, an individual's mental health care needs will be met.

Acute admission facilities have moved from capacious mental asylums, often in rural locations, to smaller psychiatric units in general hospitals. Acute admission beds are known to be a very scarce commodity, particularly in the East of the country (Keogh *et al,* 1999). The original idea of providing asylum for troubled people has been severely curtailed in many areas. Care in the community, although theoretically more humane for the vast majority of those with serious mental illness, is only so in practice if the necessary resources are put in place to sustain this type of relatively staff-intensive treatment.

A study of mental health services in Ireland published in March 2003 examined the association between clinical resources and affluence, and

[10] Report of *The Commission of Inquiry on Mental Illness*. Dublin: Oifig an tSolaithir, 1966.
[11] Report of the Inspector of Mental Hospitals, 2003. Dublin: Government Publication, 2004, page 5.

the availability of specialist services and found that clinical resources are not concentrated in areas of greatest need but paradoxically have been best developed in areas of greatest affluence (O'Keane *et al,* 2003). This study indicates an absence of some of the key speciality services that are likely to impact on suicide prevention. The absence of liaison psychiatry impacts not alone on the safe and rapid assessment of those who present to hospital following suicidal behaviour but it also contributes to the delay in moving people through the Accident and Emergency Services when in the absence of a liaison psychiatric service, assessments have to be carried out by clinical staff who not onsite nor who may not have the training or experience in dealing with suicidal behaviour. Those national findings on subspecialty availability are summarised:

Psychiatry Specialty	**Present**	**Absent**
Rehabilitation	65%	35%
Old Age	53%	47%
Liaison	59%	41%
Forensic	41%	59%
Perinatal	6%	94%
Child	82%	18%
Adolescent	12%	88%
Eating Disorders	12%	88%
Neuropsychiatry	6%	94%

Table 7: Specialist Service availability in Irish Mental Health Services. Legend Table 7: Liaison (General Hospital psychiatry); Perinatal (Psychiatry for women who have given birth); Adolescent (psychiatry for those aged 16 -18 years); Neuropsychiatry (Psychiatry for those with brain diseases or following brain injury).

A report looking at information on regional demography, clinical services and the mental health budget reported in successive Reports of the Inspector of Mental Hospitals from 1998 to 2003 was published in 2005 (O'Keane *et al,* 2005). A 13-fold disparity in funding was found, as were

vast regional variations in the numbers of nursing, medical and administrative staff, as well as acute bed availability. Funding allocated to improve mental health services was not felt to have been allocated as described, and the possibility that it may have been diverted from adult mental health to other service areas raised. Overall, the report showed that financial resources to mental health services were allocated in a random manner.

	Highest provision	**Lowest provision**		**Variation**
Budget (€/*per capita*)	**495.47** (St Brendan's Hosp., Dublin 7)	**37.97** (Kildare Service)		**13-fold**
Nurses[12]	**246** (St Brendan's Hosp., Dublin 7)	**1,802** (Kildare Service)		**7-fold**
Doctors	**2,984** (James Connolly Memorial Hosp., Dublin 15	**13,562** (Tipperary Service)		**5-fold**
Administrative	**2,505** (East Galway Service)	**21,400** (Kildare Service)		**9-fold**
Acute beds	**1,758** (Roscommon Service)	**5,707** (Kildare Service)		**3-fold**

Table 8: This illustrates the range of budget and key clinical resources across 31 catchment area services in Ireland in 2003. Budget is presented as the amount spent per head of population and dividing the population of a catchment area derives the value of the clinical resource.

Further evidence of the random manner of resource allocation comes from the HSE Mental Health Directorate data on the budget allocated for each catchment area, the population size served and the level of deprivation using the SAHRU index.[13] Thus the actual population of an area was adjusted by a factor to reflect the degree of local deprivation areas of relative social deprivation will have the highest rates of psychiatric disorders and the greatest need for services (Table 9, below).

[12] Cluain Mhuire, Dublin has been taken out of this analysis as inpatient services including nursing are purchased from St John of God Private Hospital

[13] The SAHRU index was compiled by the Department of Community Health & General Practice in Trinity College, Dublin and is based geographically on District Electoral Divisions (DEDs). It rates indices of relative poverty on a 1 to 5 scale, where 1 is the most affluent and 5 the most deprived.

Base Population CSO 2002	Burden Pop per Consultant	Burden Pop to Consultant Ranking	Relative Burden Position	Per Capita € Ranking	Per capita spend €
170,262	40,876	Cluain Mhuire	1	Tipperary	35
100,105	40,618	Wicklow	2	Kildare	43
233,753	35,455	Louth/ Meath	3	South Lee	51
242,610	35,440	West Dublin	4	St James' Hosp.,	55
178,515	33,622	Kildare	5	Cluain Mhuire	73
79,121	32,967	Tipperary South	6	Connolly Hosp., Dublin	74
156,036	31,534	North Lee	7	Louth Meath	81
167,479	31,403	South Lee	8	St Ita's Hosp.,	89
122,437	31,326	Laois Offaly	9	West Dublin	91
143,029	30,664	Connolly Hosp., Dublin	10	Vergemount, Dublin 4.	98
100,973	30,099	Vergemount, Dublin 4.	11	West Cork	100
116,596	29,414	Wexford	12	Laois Offaly	116
208,844	28,623	East & West Galway	13	Donegal	118
132,527	28,321	Kerry	14	St Ita's Hosp.,	120
133,095	27,370	St James' Hosp	15	North Lee	124
126,353	25,973	Carlow Kilkenny	16	Kerry	136
104,999	25,837	Longford Westmeath	17	St Ita's Hosp.,	139
133,559	25,376	St Brendan's Hosp.,	18	Wexford	139
129,008	25,186	Donegal	19	Waterford	148
61,010	24,941	Tipperary	20	Limerick	157
210,346	24,827	St Ita's Hosp., Dublin	21	Longford Westmeath	173
103,277	24,151	Clare	22	Cavan Monaghan	189
175,304	23,308	Limerick	23	Mayo	195
73,511	22,426	North Cork	24	East & West Galway	200
107,951	22,134	Cavan Monaghan	25	Clare	211
117,446	20,987	Mayo	26	North Cork	218
101,546	19,468	Waterford	27	Carlow Kilkenny	221
50,803	29,122	West Cork	28	Sligo Leitrim *	221
93,754	16,513	Sligo Leitrim *	29	Tipperary South	240
54,007	16,146	Roscommon	30	Roscommon	243
					Average
					136.58
					Mean
					138.84

Table 9: Consultant Psychiatrist burden population and *per capita* funding (source HSE)

Table 9 was developed by the HSE to examine the ratio of burden population per consultant-lead clinical team i.e. the actual population based on the CSO returns (*left hand column*) was adjusted to reflect the degree of deprivation/burden in each area and then the number of consultant lead teams was divided into this figure given a figure for the burden carried by each team (*second column)*. These services were named (*third column)* and assigned a rank number - the lower the number the higher the work load per team. The last two columns show the *per capita* spend on mental health - taking the budget allocated and dividing this into the size of the population. The extreme variation through out the country in the amount spent becomes apparent form this.

Reports of the Inspector of Mental Hospitals began to reference sudden death among mental hospital inpatients in accordance with *Section 272 of the Mental Treatment Act 1945* from 2001 onwards. Of these 9 were reported as suicide in 2001; 13 suicides in 2002 and 15 suicides reported in 2003. The has been no mention of sudden death or suicide in the *Report of the Inspector of Mental Health Services, 2004* so that it is unclear whether the early trend noted above has continued. It is known from the international literature that those discharged from psychiatric hospitals are at greatest risk of self harm in the days and weeks following discharge. Such figures were they available in Ireland would add considerably to our knowledge.

The long absence of an up-to-date national mental health strategy for service development is one of the main obstacles to equality in clinical resource distribution and the very limited availability and accessibility of specialist services. The publication of *A Vision for Change* in January 2006 is very welcome provided it can remedy these inequities. Rather ominously the introduction to the chapter on the current state of the Irish mental health services in *A Vision for Change* acknowledges that the recommendations of the two previous national mental health policy documents published in 1966 and 1984 were only partially implemented.

B. Services for Children & Young People. Accidents and suicides are the leading causes of death among teenagers and these frequently occur in the context of alcohol and substance use. Psychiatric disorders increase in incidence and prevalence during adolescence - particularly during late adolescent years. It has long been acknowledged in this country that there is considerable potential for overcoming the emotional problems of childhood if the nature of the problem is detected in time and appropriate

corrective action taken[14]. The waiting time for a routine outpatient appointment for our Child & Adolescent Mental Health Services can be between 6 and 18 months while those recognised to be at risk of self harm can be seen as emergencies.

Irish Child & Adolescent Mental Health Services currently provide treatment for children up to 16 years of age only and those over 16 years are provided for by adult mental health services, notwithstanding that the Child Care Act 1991 sets the age of adulthood at 18.

Up to 2% of adolescents display moderate to severe psychiatric disorders. According to the 2002 Census of Population, there are 124,721 young people aged between 16-18 years of age in Ireland, of whom 2,500 are likely to require referral to the mental health services every year. Of these, almost 300 young people will be admitted to an adult mental hospital[15], of which about 25 on an annual basis will be admitted on an involuntary basis.

It has been recognised since the 1980s that children & adolescents need dedicated inpatient facilities and plans to extend existing facilities beyond the meagre total of less than the 20 beds available nationally have been promised. This expansion never took place. As a consequence not alone are older adolescents admitted to adult mental health units, but also 24 children under the age of 16 years, including a child as young as 11, were admitted in 2003, in the absence of dedicated child and adolescent facilities[16].

In June 2000, the Minister for Health & Children, Micheál Martin, established a Working Group on Child and Adolescent Psychiatry. The First Report of the Working Group was presented to the Minister on 1st March, 2001 highlighting the provision of dedicated child and adolescent psychiatric in-patient units as being in need of immediate attention[17]. That Working Group was re-convened in May, 2001 and a subgroup was established with the essential task of making recommendations for the mental health needs of 16-18 year olds in the short, medium and long term.

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[14] *Planning for the Future:* a Report on a Study Group on the Planning of the Psychiatric Services. Dublin: Government Stationary Office, 1984 (PL 3001), (Section 12.11).
[15] Daly A, Walsh D, Moran R & Kartalova O'Doherty Y: Activities of Irish Psychiatric Services 2003. Dublin: Health Research Board, 2004.
[16] Report of the Inspector of Mental Hospitals 2003, page 129.
[17] Department of Health & Children. *First Report of the Working Group on Child and Adolescent Psychiatric Services.* Dublin: Stationery Office.

The Second Report of the Child & Adolescent Psychiatry Working Group was published in July 2003, made 8 recommendations and set a five year review date for those[18]. The lack of progress in implementing those proposals is shameful: the fact that the provision of child and adolescent inpatient units was flagged as in need of "urgent attention" in March 2001 and was emphatically recommended once again in July 2003 being a matter of record. The Expert Group on Mental Health[19] held their inaugural meeting in October 2003 and they were specifically tasked by Minister O'Malley to consider the matter of mental health services for children and adolescents once more notwithstanding the reports of March 2001 and June 2003 that had clear findings but no action taken. The Department of Health & Children and Ministerial inertia to act on the previous explicit recommendations of their Working Group is a matter of grave concern.

The Irish College of Psychiatrists published their own position paper on Child & Adolescent Mental Health Services in Autumn, 2005. This advised more than a doubling of multi-disciplinary teams from that currently available and the development nationally of more than 200 inpatient beds[20].

However, the Report of the Expert Group, *A Vision for Change*, published in late January 2006 advocates a range of expansions to the current mental health service provision for children and adolescents but it falls very short of those of the College. Most worrisome of all is that the urgency of the matter of dedicated inpatient beds was highlighted to Minister Martin in March 2001 and prevarication and procrastination followed. Consequently, no progress can be reported 5 years later.

The lack of progress for the developments of Child & Adolescent Mental Health Services might, under the terms of the Child Care Act 1991 lead to a Redress Board being set up to compensate young people who have failed to have their rights to an age appropriate mental health service met. The families of those who have died by suicide, who can satisfactorily prove State negligence in service provision, might seek redress in this arena. To avoid such heartbreak and the appalling vista of financial compensation due to failure to act on what has been recommended, all

[18] Department of Health & Children (2003). *Working Group on Child and Adolescent Psychiatric Services*. Second Report. Dublin: Stationery Office.
[19] *A Vision for Change*: Report of the Expert Group on Mental Health Policy. Dublin: Government Publications Office, 2006.
[20] *A better future now* - Position statement on the psychiatric services in Ireland. Irish College of Psychiatrists, 2005.

influence must be brought to bear to have the Minister implement the findings of his own Working Group.

The first National Service Plan of the HSE was launched in April 2005 devoted scant attention to the Child & Adolescent Mental Health Services: the section on Mental Health Services (Section 4.4) alluded to the matter by referring one to the section on Children, Adolescents & Families (Section 4.2) as that which would reflect the child & adolescent mental health focus. The section on Children, Adolescents & Families (Section 4.2) makes a mention of Child & Adolescent Mental Health Services solely in the vague context of additional, as "yet to be determined funding" being made available to develop "treatment services over and above the 2004 existed funded levels"[21]. What this means in practice is far from clear but it would take a lot of faith and confidence to see this as indicative of a clear development plan.

8. **Suicide and Alcohol**

Alcohol plays a pivotal role in young male suicide. During the 1990s, Ireland experienced a 41% increase in alcohol consumption, and suicide rates increased by 44%. Are the two connected, and what is the evidence that the increase in alcohol consumption actually increased the increase in suicide?

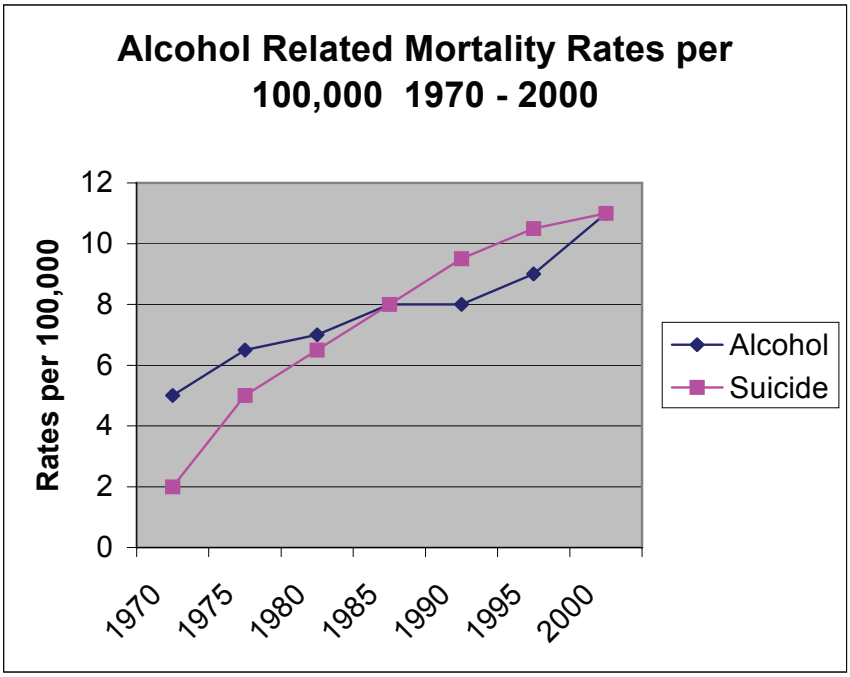

Figure 9: Suicide Rates *per 100,000 v* Alcohol Consumption *in litres pure Alcohol per* head of population.

[21] Health Services Executive National Service Plan 2005, page 41.

The effect of alcohol consumption on the adolescent and young adult brain causes an even greater depletion in important mood stabilising neurotransmitters than occurs in the mature adult brain. High level alcohol consumption such as might occur in a drinking spree can induce a significantly depressed mood state over a subsequent 8-12 hour period. Research has shown that binge drinking[22] is particularly associated with suicidal acts with the relative risk for suicide increasing 10-fold for men and women relative to those of a similar baseline mood state that were not binge-drinking. Liberal licensing laws and a lax regulatory environment contribute further to this situation. States with laws that set the minimum legal age for drinking at 21 years, such as the US have lower youth suicide rates than states where the legal age is 18 years.

Aggressive marketing, political lobbying by the drinks industry and the increase in disposable income of the population has enabled the opportunity of spending money on alcohol with its well described depressant effect on mood and the increase in distorted judgement and impulsivity in its wake. Notwithstanding the numbers of people employed in the Drinks Industry and the huge excise paid on alcohol, our failure to implement the Report of the National Strategic Task Force on Alcohol has a serious negative impact on suicide prevention.

It has been reported by GPs that 20% of their patients who died by suicide had a history of problem alcohol use while psychiatrists reported 27% of their patients lost to suicide had a history of alcohol misuse. Only 46% of those people were known to have attended for alcohol counselling.

A recent Irish study carried out on unnatural deaths in 2001-2002 in Counties Louth, Meath & Cavan (HSE North Eastern Region) found that 93% of young men aged less than 30 years that had ended their lives had alcohol in their system, 58% of these having a blood alcohol level of greater than 160mg% and 25% levels of greater than 240mg%[23]. In comparison, no man over 30 years lost to suicide had the same levels of alcohol consumed.

A 6-year study carried out by the County Louth Coroner Ronan Maguire reported in the media in January 2006 revealed that 48% of the 47 people

[22] 1 unit of alcohol = glass of wine, measure of spirits; half pint of beer. More than 6 units of alcohol for a man and 4 units for a woman in one session constitute a binge but many binges far exceed that minimum requirement.
[23] The legal alcohol limit for driving being under 80mg%

(42 male, 5 female) who died by suicide in his area of inquiry had consumed alcohol prior to ending their lives[24].

[24] RTE News & The Irish Examiner, January 2006.

Achievable Targets in Reducing High Suicide Rates

The Report on the National Task Force on Suicide was published in January 1998 - the year that official rates of suicide in Ireland peaked. Those rates have dropped somewhat since then but they remain unacceptably high. At the launch of the Task Force report, the then Minister for Health Brian Cowen said[25] that the key components of the overall strategy include:-

- The implementation of measures aimed at high risk groups;
- Provision of information and training on suicide prevention to relevant professionals and organisations;
- The improvement of services which would benefit those at risk of suicide and those who attempt suicide.

He said that he planned "to consult with his Ministerial colleagues with a view to the implementation of the Task Force recommendations". However, there was never a stated financial allocation to the actioning of the report nor an implementation deadline, with the result that much of what was recommended continue to to form the key recommendations of *Reach Out* published 7 years later. Nevertheless, there has been some important practical suicide prevention steps introduced in Ireland in recent years, the impact of which is yet to be determined - the *Medicinal Products (Controls of Paracetamol) Regulations* came into effect in October 2001. This restricts the supermarket sales of paracetamol which is highly toxic even in mild overdose, as even an impulsive act of self harm can have very serious consequences. The introduction of Suicide Resource Officers in each health board area has been another useful innovation, as well as the reforms to the Coroners Act flagged in 2000.

Reach Out, the National Strategy for Action on Suicide Prevention 2005-2014 was published in September 2005. This strategy recommended, and has resulted in, the HSE establishing a National Office for Suicide Prevention (NOSP) to drive the implementation of the plan. The approach to the strategy itself was straightforward and based on 4 levels of action categorised as

- Level A: General population approach with particular emphasis on the family, schools, youth organisations and service, 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

[25] Department of Health & Children Press Release, 27, January 1998.

care and general practice.

- Level B: Targeted approach - with particular emphasis on those who have engaged in acts 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.

- Level C: Responding to suicide - support following suicide, coroner service.

- Level D: Information and research.

However, no specific target for the reduction of our national suicide rate was set in the *Reach Out* strategy unlike similar initiatives undertaken in Scotland[26] where, in introducing their national suicide prevention strategies, outcomes in terms of a percentage reduction in the suicide rate within a time frame were unambiguously set out.

The *Joint Oireachtas sub-Committee on High Suicide Level in Irish Society* now sets out a range of detailed costed recommendations in this report that have been based on the submissions to the committee as well as the Actions identified in *Reach Out*. These include practical interventions and research priorities (Table 10). Estimated completion times have been set for these recommendations.

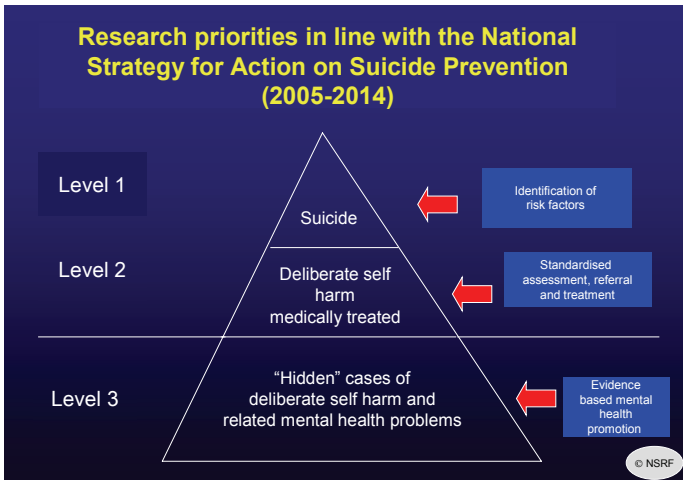

Table 10: Research priorities in line with the National Strategy for Action on Suicide Prevention, *Reach Out.*

[26] *Choose Life:* A National Strategy and Action Plan to Prevent Suicide in Scotland states the key aim of reducing suicide rates by 20% over the 10 year duration of the strategy.

Conclusions

Suicide is largely a societal problem and society needs as a consequence to alter social policies to deal with the risk factors for suicide. Those that are or who perceive themselves to be disenfranchised are at greater risk of suicide. On an individual level we all have a responsibility to be alert and watchful of those at risk.

The close relationship of suicide and mental illness makes it imperative to make psychiatric services more accessible. There is considerable disparity of funding of mental health services. Services for adolescents have tended to be poorly developed notwithstanding the serious mental health issues that emerge at this time in young people's lives. Those with psychotic illnesses are at 10 - 15% risk of dying by suicide. This risk is greatest within the first 5 years after the onset of psychotic symptoms. Programmes of early intervention proactively detect and treat serious mental illness in a phase specific way, and impact on suicide rates in young people.

There is a well established role of alcohol in completed suicide and suicidal behaviour (deliberate self harm). Alcohol produces a significant fall in mood and facilitates aggressive behaviour towards oneself and others. An individual may not have a history of suffering from depression for this to come about, but those that do, are at increased likelihood of a reduction in mood. Alcohol impairs problem solving skills and limits an individual's decision making capacity, particularly in a crisis. It is disinhibiting, allowing people to do things that they might otherwise think about but not do. An opportunity exists of referring those with alcohol or substance misuse issues to treatment programmes from A&E departments following episodes of suicidal behaviour were such programmes to exist.

Suicidal behaviour is largely concealed within the population and engaged in by up to 9% of teenagers as evidenced by one large Irish sample. The vast majority of these have not sought help from the health services. The 11,200 annual presentations to A&E Departments following suicidal behaviour is a gross underestimate of the true extent of this activity - a significant number of whom subsequently go on to die by suicide and thus contribute to our belief that 55% of those who die by suicide do so on their first attempt - it is likely that for some, their previous attempts may not have come to light. Not all of those that present to hospital following an episode of suicidal behaviour are assessed by a trained mental health professional given the haphazard

dispersal of resources and thus an opportunity to reduce repeat acts that will have a fatal outcome for some, is missed.

Support of a practical and emotional nature is not always easily accessible to those bereaved by suicide. Individuals bereaved by suicide describe a hiatus in appropriate service provision.

The absence of a confidential enquiry into accidental deaths including suicide hampers our knowledge and lessens our opportunity of learning from such tragic events, running the risk of the same mistakes being made over and over.

We have a body of statistics about suicide in Ireland that are likely to underestimate the true state of affairs. While accurate data collection is the ideal, avoiding unnecessary duplication of collecting information is also important. The best possible use of the existing data held by statutory and professional agencies relating to suicide deaths in Ireland supplemented when possible by information from the bereaved family and the deceased' social network would also help to build up a picture of the deceased. However, our relentless problem of suicide requires us to engage in preventative programmes and set target for a reduction in self destructive behaviour in parallel as a matter of urgency.

We need to set achievable targets for suicide prevention in Ireland. This committee recommends that **a target of reducing our overall suicide rate by 20% by 2016** be set. This might be a fitting way to commemorate the centenary of the Easter Rising of 1916.

Recommendations

To achieve this target, the following recommendations are made:

Structures:

1. Streamline the training, funding, job descriptions and reporting relationships of Suicide Prevention Officers. These posts should report to the National Office for Suicide Prevention. (To be completed by September 2006, cost neutral).

General Population:

2. Establish a "Health and Education Liaison Group" working group between the Health Services Executive (HSE) and the Department of Education & Science (DES) to develop, implement, monitor and coordinate protocols and policy for mental health promotion and critical incident response in schools. (To be commenced immediately and estimated to cost the HSE **€20, 000** annually.)

3. Appoint a national coordinator in the education sector to work in partnership with appropriate HSE staff to

- Oversee the implementation of mental health promotion activities and critical incident responses in schools.
- Conduct a formal review, making recommendations for service development, of the Guidance and Counselling service to establish staffing levels, training standards and the extent and nature of counselling provided.
- Survey primary and secondary schools to establish information in relation to mental health promotion programmes, critical incident response protocols and the Social, Personal and Health Education (SPHE) module.
- Review and rate the usefulness and effectiveness of the available mental health promotion materials and programmes and the relevant guidelines documents for primary and secondary schools and for students.

(To be commenced immediately and estimated to cost the DES **€120, 000** annually. Outcomes of these initiatives should result in an ultimate reduction of repeat presentations to A&E following deliberate acts of self harm.)

4. Set up an evidence based health promotion programme for all transition year students in a pilot area to combat and conquer deliberate self harm that increases the risk for completed suicide for some. This should be set up in autumn 2006 and the impact evaluated at the end of the Academic Term (May/June), 2009. (Tenders to carry out this work should be advertised by August 2006 with an estimated HSE cost of **€100, 000)**.

5. Building on existing programmes (such as the HSE South Eastern Area schools training programme), and learning from the review and survey described in item 2 above

- Develop and implement a training programme for teachers at all levels and for trainee teachers on mental health promotion and crisis response.
- Agree and deliver, on a partnership basis, a national training programme for volunteers and staff of voluntary and community groups involved in mental health promotion and suicide prevention.
- Agree, plan and deliver in conjunction with the Irish College of General Practitioners a programme of education and training on suicide prevention for all relevant members of the Primary Care Team including GP trainees and community pharmacists.
- Plan and deliver basic awareness training for all levels of hospital staff on suicidal behaviour and develop and deliver specialist intervention, skills-based training for the appropriate staff.
- Plan and deliver a basic awareness training programme for mental health services staff on suicidal behaviour and develop and deliver a specialist skills-based training programme for the appropriate clinical staff.

(To commence immediately and would cost the HSE **€420, 000** to employ 4 National or Regional Training coordinators to deliver the above. In addition programme running costs would be required and the HSE employment ceiling would need to be adjusted to reflect these additional posts.)

6. Organise a consultation with young people to ask them about mental health services and service development. (To commence immediately and would cost the National Office for Suicide Prevention **€30, 000** on a once off basis.)

7. Develop and produce a sustainable anti-stigma and positive mental health promotion campaign in the media.
Develop a system of media monitoring and response for mental health and suicide related issues (learning from existing systems). Allied to this, a panel of media spokespersons within the HSE and voluntary sector should be trained to respond to the media in relation to suicide prevention, mental health promotion and bereavement support. A network of volunteers who have been affected by suicidal behaviour and / or mental health problems and who are willing to engage with the media in a way that is responsible, safe and likely to encourage help-seeking and reduce stigma should be trained. (To be commenced immediately, estimated cost to the Department of Health Children Health Promotion Unit of **€1, 500,000** for the anti stigma tender and **€50, 000** for the media training on a largely once off basis, although trained individuals would need to be replaced over time.)

8. Determine and standardise the provision of support and information provided by primary care services to those who are bereaved by suicide. This would entail working with bereavement support services such as Living Links and Console and with the HSE. (This would entail a once off 6-month HSE work contract estimated at **€50, 000**.**)**

9. Pilot and audit a 'fast-track' priority referral system from Primary Care to community-based mental health services for individuals experiencing a suicidal crisis who contact Primary Care services. (This would entail a 36-month work contract facilitated by the National Office for Suicide Prevention and estimated at **€65, 000** per annum during the pilot phase.**)**

Targeted Approach:

10. Have the National Office for Suicide Prevention, the HSE National Hospitals Office and the Primary, Community & Continuing Care Directorate review, improve and standardise pre-discharge and transfer planning from or between mental health service settings (To be complete by December 2006, cost neutral).

11. Develop, pilot and introduce effective staff guidelines for responding to people presenting to hospitals following deliberate self

harm. (This could be commenced immediately, be facilitated through local Suicide Prevention Officers and entail a once off cost of **€65, 000** to the National Office for Suicide Prevention.)

12. Have the National Office for Suicide Prevention, the HSE National Hospitals Office and the Primary, Community & Continuing Care Directorate collaborate in a study to determine the effectiveness of a minimum standardised nurse-led liaison psychiatric services in A&E compared to a dedicated multidisciplinary liaison team for responding to those who present, following suicidal behaviour. (As per *A Vision for Change*, this could be commenced immediately and entail a minimal annualised cost to the HSE of **€360, 000** plus a flexibility around the employment ceiling.)

13. Determine the risk of engaging in suicidal behaviour associated with belonging to a marginalised group, and review the available services and agencies representing marginalised groups and develop new supports and services as appropriate. (This could be commenced immediately and entail a once off cost of **€65, 000** to the National Office for Suicide Prevention.)

14. Have the HSE Primary, Community & Continuing Care Directorate and the Department of Health & Children develop Child & Adolescent Services by increasing the level of in-patients resources and introducing administrative integration of Child & Adolescent Mental Health services with Adult Mental Health service, thus streamlining and improving service provision in the community. (An annual cost of **€ 40m** + Capital costs.)

15. Recommendations from the Inspector of Mental Health Services must be implemented within a 5 -year period of his/her report or a resignation from either the Inspector on a point of principle or the Minster with responsibility for Mental Health Services because of the failure to support the Inspectorate a matter of course.
(To be complete by September 2006, cost neutral).

16. Implement the National Strategic Task Force on Alcohol, 2nd Report, September 2004 in recognition of the relationship between alcohol and suicide. Specifically

- A national screening protocol for early intervention of problem alcohol use for all sectors of the health care system must be established as a priority. Allied to this, early intervention programmes to be set up in primary care, A&E Departments and through the court system for both juveniles and adults convicted of alcohol related offences, to introduce and establish brief intervention as standard practice to reduce high risk and harmful drinking patterns. (This should commence without delay and is estimated to cost the HSE **€600, 000** on an annual basis.)

- A range of effective, accessible, appropriate and integrated alcohol treatment services must be established in each HSE area with explicit pathways of care for those seeking treatment for alcohol-related problems (Cost will vary depending on the standard of present services but a sum of **€10m** in addition to the current spend should be set aside annually by the HSE to ensure that all services are incrementally upgraded to the highest international standard).

17. Have the National Office for Suicide Prevention, HSE Primary, Community & Continuing Care Directorate and the Department of Health & Children review the current provision of alcohol and addiction treatment services and develop an integrated coherent National Policy on the Treatment of Alcohol and Substance Misuse.

18. Have the Irish Prison Service, the National Office for Suicide Prevention and the Probation & Welfare Service determine the range, extent and quality of psychological support services for prisoners, those on remand and those recently transferred back to prison from hospital. (To be complete by December 2006, cost to the Department of Justice - **€65, 000.**)

19. Have a dedicated skills based training programme for Gardaí and Prison Officers e.g. the Applied Suicide Intervention Skills Training (ASIST) to enable them support someone who is suicidal. (To be complete by December 2006, cost to the Department of Justice - **€120, 000.**)

Responding to suicide:

20. Have the National Office for Suicide Prevention and voluntary groups audit and review the range and quality of general bereavement support services and specific services to support those bereaved by suicide with view to drawing up a service plan for bereavement services nationally (This could be commenced immediately and would incur a once off cost of **€45, 000**).

21. Facilitate and support the formal coordination of the national organisations working in the area of suicide bereavement support including Living Links, Console, the National Suicide Bereavement Support Network and the general bereavement services. (This could be commenced immediately and would incur administrative costs of **€25, 000** + core funding to be agreed).

22. Have the National Office for Suicide Prevention and Suicide Resource Officers develop and implement protocols for the health service response if a community is affected by suicide, learning from the experience of previous crises (such as the suspected cluster in the South East in late 2002) and building on existing critical incident response protocols. (This could be commenced immediately and would incur an annualised HSE cost of **€320, 000**).

23. Initiate formal discussions between the HSE and An Garda Síochána on the possibility of Gardaí notifying the Suicide Prevention Officer of the local health services in a discreet and confidential manner when a suspected suicide death has occurred to facilitate a supportive health service response that would be acceptable to the bereaved. A similar initiative is required between the General Hospital Pathologist and the Suicide Resource Officer following autopsy where suicide has, on the balance of probabilities, occurred. This might take the form of supplying a booklet on entitlements and support access for example modelled on the Scottish Association for Mental Health Information Service *after a suicide*[27]. (This could be commenced immediately and would incur a once off HSE cost of **€20, 000**).

[27] This booklet was written by Sandra McDougall, Legal Officer, Scottish Association for Mental Health, April 2004.

24. Prepare a service plan setting out the evaluation criteria, for the development of pilot mental health promotion and support initiatives for young men. (This could be commenced immediately and would incur an initial HSE cost of **€65, 000**).

25. Determine the risk of suicidal behaviour associated with prescription and over-the-counter medication, with a view to developing, implementing and evaluating recommendations on the availability, marketing and prescribing of these medications. (This could be commenced immediately and would incur a once off HSE cost of **€65, 000**).

26. Provide facilities and promote the safe disposal of unused and unwanted medicines nationally, building on the work in relation to the D.U.M.P. project in the HSE South Western Area, Eastern Region (**D**ispose of **U**nwanted **M**edicines **P**roperly). (This could be commenced immediately and would incur an annualised HSE cost of **€120, 000**).

27. Establish whether there are specific places and types of place that are associated with suicidal acts and, where feasible, implement ways of restricting access, improving safety and promoting help-seeking. (This could be commenced immediately and would incur an annual Office of Public Works cost of **€5m**).

Information & Research:

28. Appoint dedicated Coroner's Officers in the place of Gardaí to act as the link person between the public and the Coroner Service as recommended in *Report of the Working Group on the Coroner Service* (2000). (This could be commenced immediately and would incur an annualised cost of **€600, 000** to be borne by the Department of Justice).

29. Establish a technical group to link and exchange data between relevant national information systems, including the National Register of Deliberate Self Harm, the Hospital In-Patient Enquiry system, the National Psychiatric Inpatient Reporting System, the National Drug Treatment Reporting System, the Drug-related Deaths Index and local

mental health services as and when electronic patient records are developed (This could be commenced immediately and would incur an annualised HSE cost of **€50, 000**.**)**

30. The National Office for Suicide Prevention to commission the establishment of a national confidential enquiry into deaths from unnatural causes including suicide and thus inform suicide prevention and the planning of services. (This could be commenced immediately and would incur an annualised HSE cost of **€80, 000**.**)**

31. The National Office for Suicide Prevention under the auspices of the Directorate of Population Health should set up an Ethics Committee so that all Irish-based suicide research can be registered and receive Ethics Committee Approval from the National Office for Suicide Prevention (This would incur an annual HSE cost of **€5, 000)**

32. The National Office for Suicide Prevention should agree a national programme and plan of research into deliberate self-harm, suicide and suicide prevention, detailing the means of using research findings to inform service provision and health and social policy and establish a Research Register in relation to Suicide Research and Prevention. (This could be commenced immediately and would incur an annualised HSE cost of **€65, 000**.**)**

33. The National Office for Suicide Prevention should publish Suicide Research Guidelines for Donors to which charitable organisations and private donors who might wish to fund suicide research might apply to ensure that the proposed research was relevant, worthwhile and had merit, and thus would add to our national suicide research database. (Cost neutral).

Total cost **€60.09m** (includes Departments of Justice; Education & Science; Office of Public Works and Department of Health & Children costs**)**

Appendix 1

Milestones in Irish Suicide Initiatives

1993	The passing of the *Criminal Law (Suicide) Act* resulting in the decriminalisation of suicidal behaviour.
1995	*The National Suicide Research Foundation* (NSRF) was established.
1996	*The National Task Force on Suicide* was established. *The Irish Association of Suicidology* (IAS) was set up.
1998	*The National Task Force on Suicide Report* was published and the *National Suicide Review Group* was set up.
2000	The *National Parasuicide Registry* (to be known as the *National Register of Deliberate Self Harm)* was established. Department of Justice, Equality & Law Reform published the *Review of the Coroner Service* that expanded the role of the Coroner to include investigation of the circumstances of death.
2005	*Reach Out:* National Strategy for Action on Suicide Prevention (2005-2014) was published and the *National Office for Suicide Prevention* (NOSP) was established.

Appendix 2

List of those who gave evidence to the committee

Date	Presentations	Affiliation	Discipline
4/10/'05	Kevin Malone	UCD	Psychiatrist
	Declan Bedford	Alcohol Action	Public Health
	Conor Farren	"	Psychiatrist
	Norah Gibbons	Barnardos	Advocate
	Marian Rackard	Alcohol Action	Counsellor
11/10/'05	Bairbre Nic Aongusa	DoH&C	Administrator
	Geoff Day	NSO	Administrator
	Ella Arensman	NSRF	Psychiatrist
	Derek Chambers	NSO	Sociologist
	Gerry Hickey	Private Practice	Counsellor
	Dorothy Peel		
	Pat Bowe		
	Dr. Patrick Andrews		
18/10/'05	Michael Egan	Living Links	Rtd-Garda Sgt
	Fran Gleeson	AWARE	Advocate
	Sandra Hogan	AWARE	PRO
25/10/'05	Eadbhard O'Callaghan	DETECT	Psychiatrist
	Gareth O'Callaghan	Console	Counsellor
	Josephine Quinlan	Console	Counsellor
	Siobhan McArdle	Console	Counsellor
	Andrew Gravey	Console	Counsellor
1/11/'05	Carol Fitzpatrick	Mater Hosp	Child Psych
	Nollaig Byrne	Mater Hosp	Child Psych
	Ann Hope	Dept of Health & Children (D/H&C)	Policy Advisor
	Shay McGovern	D/H&C	Civil Servant
8/11/'05	Dan Thompson	Irish Association of Suicidology (IAS)	Vice Chairman
	John Connolly	IAS	Psychiatrist
	Michael Fitzgerald	IAS	Child Psych
	Justin Brophy	IAS	Psychiatrist
	Ann Cleary	IAS	Director
	Niall McElwee	IT Athlone	Lecturer
15/11/'05	Ella Arensman	NSRF	Psychiatrist
	Paul Corcoran	NSRF	Statistician
	Eileen Williamson	NSRF	Business Mgr
	Carmel McAuliff	NSRF	Res. Psychologist
	Seán McCarthy	HSE SE	Suicide Resource Officer.

Written submissions were received from

Organisation:	
BeLong	
Bodywyse	
Fetal Alcohol Ireland	Ms Michelle Savage
Kilkenny Advocacy Team	Mrs Anne Ryan
The Irish College of Psychiatrists	Dr Kate Ganter

Appendix 3

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Appendix 4

Members of the

Joint Committee on Health and Children

Deputies:	Paudge Connolly TD (Ind Beverly Flynn (Ind) Jimmy Devins (FF) (Vice-Chair) Dermot Fitzpatrick (FF) John Gormley (GP) Liz McManus (Lab) John Moloney (FF) (Chair) Dan Neville (FG) Charlie O'Connor (FF) (Government Convenor) Fiona O'Malley (PD) Liam Twomey (FG)
Senators:	Fergal Browne (FG) (Opposition Convenor) Geraldine Feeney (FF) Camillus Glynn (FF) Mary Henry (Ind)
Chairman:	Mr John Moloney (FF)
Clerk:	Ms. Gina Long

Members of the Sub-Committee on
The High Level of Suicide in Irish Society

Deputies:	John Moloney (FF)	Chairman
	Dan Neville (FG)	Vice-Chairman
	Charlie O'Connor (FF)	
	Paudge Connolly (Ind)	
Senators:	Fergal Browne (FG)	
	Camillus Glynn (FF)	

Clerk: **Ms. Gina Long**

Appendix 5

Joint Committee on Health and Children

Orders of Reference

Dáil Éireann on 16 October 2002 *ordered*:

"(1) (*a*) That a Select Committee, which shall be called the Select Committee on Health and Children consisting of 11 members of Dáil Éireann (of whom 4 shall constitute a quorum), be appointed to consider -

(i) such Bills the statute law in respect of which is dealt with by the Department of Health and Children;

(ii) such Estimates for Public Services within the aegis of the Department of Health and Children; and

(iii) such proposals contained in any motion, including any motion within the meaning of Standing Order 157 concerning the approval by the Dáil of international agreements involving a charge on public funds,

as shall be referred to it by Dáil Éireann from time to time.

(*b*) For the purpose of its consideration of Bills and proposals under paragraphs (1)(*a*)(i) and (1)(*a*)(iii), the Select Committee shall have the powers defined in Standing Order 81(1), (2) and (3).

(*c*) For the avoidance of doubt, by virtue of his or her *ex officio* membership of the Select Committee in accordance with Standing Order 90(1), the Minister for Health and Children (or a Minister or Minister of State nominated in his or her stead) shall be entitled to vote.

(2) (*a*) The Select Committee shall be joined with a Select Committee to be appointed by Seanad Éireann to form the Joint Committee on Health and Children to consider -

(i) such public affairs administered by the Department of Health and Children as it may select, including, in respect of Government policy, bodies under the aegis of that Department;

(ii) such matters of policy for which the Minister for Health and Children is officially responsible as it may select;

(iii) such related policy issues as it may select concerning bodies which are partly or wholly funded by the State or which are established or appointed by Members of the Government or by the Oireachtas;

(iv) such Statutory Instruments made by the Minister for Health and Children and laid before both Houses of the Oireachtas as it may select;

(v) such proposals for EU legislation and related policy issues as may be referred to it from time to time, in accordance with Standing Order 81(4);

(vi) the strategy statement laid before each House of the Oireachtas by the Minister for Health and Children pursuant to section 5(2) of the Public Service Management Act, 1997, and the Joint Committee shall be so authorised for the purposes of section 10 of that Act;

(vii) such annual reports or annual reports and accounts, required by law and laid before either or both Houses of the Oireachtas, of bodies specified in paragraphs 2(a)(i) and (iii), and the overall operational results, statements of strategy and corporate plans of these bodies, as it may select;

Provided that the Joint Committee shall not, at any time, consider any matter relating to such a body which is, which has been, or which is, at that time, proposed to be considered by the Committee of Public Accounts pursuant to the Orders of Reference of that Committee and/or the Comptroller and Auditor General (Amendment) Act, 1993;

Provided further that the Joint Committee shall refrain from inquiring into in public session, or publishing confidential information regarding, any such matter if so requested either by the body or by the Minister for Health and Children; and

(viii) such other matters as may be jointly referred to it from time to time by both Houses of the Oireachtas,

and shall report thereon to both Houses of the Oireachtas.

(*b*) The quorum of the Joint Committee shall be five, of whom at least one shall be a member of Dáil Éireann and one a member of Seanad Éireann.

(*c*) The Joint Committee shall have the powers defined in Standing Order 81(1) to (9) inclusive.

(3) The Chairman of the Joint Committee, who shall be a member of Dáil Éireann, shall also be Chairman of the Select Committee.".

Seanad Éireann on 17 October 2002 *ordered*:

"(1) (*a*) That a Select Committee consisting of 4 members of Seanad Éireann shall be appointed to be joined with a Select Committee of Dáil Éireann to form the Joint Committee on Health and Children to consider –

(i) such public affairs administered by the Department of Health and Children as it may select, including, in respect of Government policy, bodies under the aegis of that Department;

(ii) such matters of policy for which the Minister for Health and Children is officially responsible as it may select;

(iii) such related policy issues as it may select concerning bodies which are partly or wholly funded by the State or which are established or appointed by Members of the Government or by the Oireachtas;

(iv) such Statutory Instruments made by the Minister for Health and Children and laid before both Houses of the Oireachtas as it may select;

(v) such proposals for EU legislation and related policy issues as may be referred to it from time to time, in accordance with Standing Order 65(4);

(vi) the strategy statement laid before each House of the Oireachtas by the Minister for Health and Children pursuant to section 5(2) of the Public Service Management Act, 1997, and the Joint Committee shall be so authorised for the purposes of section 10 of that Act;

(vi) such annual reports or annual reports and accounts, required by law and laid before both Houses of the Oireachtas, of bodies specified in paragraphs 1(a)(i) and (iii), and the overall operational results, statements of strategy and corporate plans of these bodies as it may select;

Provided that the Joint Committee shall not, at any time, consider any matter relating to such a body which is, which has been, or which is, at that time, proposed to be considered by the Committee of Public Accounts pursuant to the Orders of Reference of that Committee and/or the Comptroller and Auditor General (Amendment) Act, 1993;

Provided further that the Joint Committee shall refrain from inquiring into in public session, or publishing confidential

information regarding, any such matter if so requested either by the body or by the Minister for Health and Children;

and

(viii) such other matters as may be jointly referred to it from time to time by both Houses of the Oireachtas,

and shall report thereon to both Houses of the Oireachtas.

(*b*) The quorum of the Joint Committee shall be five, of whom at least one shall be a member of Dáil Éireann and one a member of Seanad Éireann.

(*c*) The Joint Committee shall have the powers defined in Standing Order 65(1) to (9) inclusive.

(2) The Chairman of the Joint Committee shall be a member of Dáil Éireann.".

Joint Committee on Health and Children.

Order establishing a sub-Committee on the High Level of Suicide in Irish Society

Ordered on 13 October:-

"That-

a) a sub-Committee (to be called the sub-Committee on the High Level of Suicide in Irish Society) be established to consider such matters as it may think fit in relation to suicide and to report back to the Joint Committee thereon;

b) the sub-Committee shall consist of 6 members of whom 3 shall be Members of Dáil Éireann and 2 shall be Members of Seanad Éireann;

c) the quorom of the sub-Committee shall be 3, of whom 1 at least shall be a Member of Dáil Éireann and 1 a Member of Seanad Éireann;

d) in relation to the matter specifically referred to in paragraph a) above, the sub-Committee shall have those functions of the Joint Committee which are set out in paragraphs 2(a)(i) to 2(a)(iii) (Dáil) and in paragraphs1(a)(i) to 1(a)(iii) (Seanad) of the Joint Committee's Orders of Reference; and

e) the Sub-Committee shall have the following powers of the Joint Committee, namely, those contained in Standing Order 81(1), (2) and (4) to (9) (Dáil) and in Standing Order 65(1), (2) and (4) to (9) (Seanad)."