National Task Force on Suicide

INTERIM REPORT

DEPARTMENT
OF HEALTH
AN ROINN
SLÁINTE

rce

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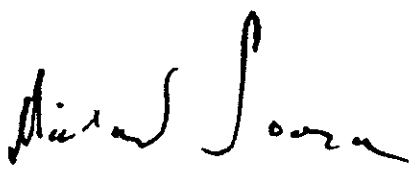
Foreword

The increase in the numbers of reported suicides and parasuicides in Ireland over the past two decades is an issue of growing national concern. If help is to be made available to those at risk, it is essential that reliable information should be available on the occurrence of, and factors associated with, suicidal behaviour.

In order to address this issue I established a National Task Force on Suicide in November 1995. This Interim Report, which I am pleased to introduce, contains a detailed analysis of statistics relating to suicide and attempted suicide in Ireland, and includes a preliminary analysis of the factors which might possibly contribute to changes in the incidence of suicide.

The contents of this Interim Report addresses the first two terms of reference of the Task Force, which are outlined in the body of the Report. The Task Force will now concentrate on addressing the other terms of reference. It has already commenced the national consultative process, the outcome of which will play an important role in the formulation of a National Suicide Prevention/Reduction Strategy.



Michael Noonan TD
Minister for Health
August 1996

Introduction

1. Background to establishment of the National Task Force on Suicide

The numbers of reported suicides and attempted suicides in Ireland have increased over the past twenty years. Investigation and detailed research into the causes of suicide has not been easy at national and international level. In the past there has been an understandable reluctance to even discuss the issue and this made the compilation of accurate data on the frequency and pattern of suicide more difficult.

The factors giving rise to suicide in society have been the subject of debate for many years. Changes in the fabric of society, depression, social isolation and a sense of hopelessness are factors which can contribute to individual distress.

The **World Health Organisation** in its **Targets for Health for All** has recommended action to reverse the rising trend in suicide by the year 2000. It highlights the importance of early detection and treatment for schizophrenia, depression and alcohol misuse. The **European Commission** has also recently established a committee of national experts to formulate a programme of Community action on injury prevention. This programme will be set in the context of the framework for action in the field of public health and it has been decided that one of the topics the programme must focus on is that of suicide.

The Health Strategy – Shaping a Healthier Future – expressed concerns about the increase in the rate of suicide, especially among young people in Ireland. Although not all persons who commit suicide suffer from mental illness, the mental health service has a particular responsibility to prevent suicide and, in particular, to the follow up of cases of attempted suicide.

Planning for the Future – the policy document on the development of the mental health services recommended a shift in the delivery of services from an institutional to a community-based setting. This re-orientation, including the making of services more accessible and user friendly, is continuing in line with the Health Strategy.

Given these developments, and the need to ensure the availability of reliable information on the occurrence of suicidal behaviour if help is to be made available to those considered to be at risk, the Minister for Health, Mr Michael Noonan TD, established the National Task Force on Suicide.

2. Terms of Reference

We were appointed as a Task Force by the Minister for Health, in November 1995, with the following terms of reference:

- to define numerically and qualitatively, the nature of the suicide problem in Ireland,
- to define and quantify the problems of attempted suicide and parasuicide in Ireland including the associated costs involved,
- to make recommendations on how service providers can most cost effectively address the problems of attempted suicide and parasuicide,
- to identify the various authorities with jurisdiction in suicide prevention strategies and their respective responsibilities and
- to formulate, following consultation with all interested parties, a National Suicide Prevention/Reduction Strategy.

3. Membership

The members of the Task Force are:

- Mr Noel Usher, Principal Officer, Department of Health (Chairman)
- Ms Myra Barry, Clinical Psychologist, Eastern Health Board
- Dr Rosaleen Corcoran, Director of Public Health, North-Eastern Health Board
- Dr Anne Cullen, Mallard Lodge, Newport Road, Castlebar, Co Mayo
- Mr John Dolan, Regional Director of Samaritans, Limerick (represented by Ms Mona Halligan)
- Ms Norita Griffin, Statistician, Central Statistics Office
- Superintendent Michael Guiney, Garda Headquarters
- Mr Francis W Hutchinson, Solicitor, Coroner, Waterford
- Dr Elizabeth Keane, Director of Public Health, Southern Health Board
- Dr Michael Kelleher, Clinical Director, Southern Health Board
- Mr Patrick Rooney, North-Western Health Board, Co Donegal
- Mr Joseph Treacy, Senior Statistician, Central Statistics Office
- Dr Dermot Walsh, Clinical Director, Eastern Health Board and Inspector of Mental Hospitals
- Ms Geraldine Kelly, Administrative Officer, Department of Health (Secretary to the Task Force)

4. Work Programme of Task Force

The Task Force was asked to submit an interim report to the Minister, by July 1996, containing detailed analysis of all existing data relating to suicide, attempted

suicide and associated factors. We were then to initiate a major consultative exercise involving all interested parties leading to the formulation of a National Suicide Prevention/Reduction Strategy by the end of 1996.

5. In the formulation of this Interim Report to the Minister the Task Force has met on six occasions, including four full day meetings.

We considered all relevant data available, together with a study of the mechanisms for compiling suicide statistics in Ireland.

6. The Task Force is grateful to the Suicide Research Foundation, Cork, for conducting the literature review and for making the results of its ongoing investigations available.

7. This Interim Report addresses our first two terms of reference. The Task Force will now be addressing our other terms of reference and are currently considering, in detail, the numerous submissions received from interested individuals and organisations. We have already commenced the consultative exercise required to formulate the National Suicide Prevention/Reduction Strategy. We confidently expect to complete the preparation of this Strategy for submission to the Minister by the end of 1996.

Summary of Main Conclusions & Recommendations

Chapter 1 Ascertainment of Statistics on Suicide & Attempted Suicide in Ireland

There were 383 suicides recorded in 1995, an increase of 30 on the 1994 figure.

The Task Force provisionally recommends that the Coroners Act, 1962 be reviewed in order to facilitate coroners in returning verdicts of suicide, when appropriate.

The Task Force is satisfied with the accuracy of the Central Statistics Office (CSO) statistics on suicide. However, we believe that additional information is needed on the attendant social and personal circumstances of each case of suicide. This additional information would facilitate a better understanding of cause and a more effective way of looking at prevention. **The Task Force recommends that the CSO and the Garda Síochána consider amending Form 104, which provides the current basis for the completion of statistics on the number of suicides, in order to elicit this additional sociological information.**

Whilst there are major difficulties in ascertaining and defining the true rate of attempted suicide in Ireland, information is available on a limited geographic basis.

Chapter 2 Suicide in Ireland

Between 1976 and 1992 the rise in the rate of suicide was particularly remarkable among young males (15-24 age group). The increase in the young male suicide rate during this time may not be because of any factors peculiar to Ireland. Rather, it was in line with international trends.

Between 1976 and 1992 the suicide rate among women remained low.

Chapter 3 Attempted Suicide in Ireland

Cork is one of sixteen European Centres participating in a World Health Organisation study of attempted suicide. Of the study areas Cork has the highest male rate and the third highest female rate.

CHAPTER 1

Ascertainment of Statistics on Suicide and Attempted Suicide in Ireland

1.1 Introduction

1.1.1 Suicide
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1.1.3 Research

1.2 Procedures for Classifying Deaths as Suicide in Ireland

1.2.1 General Overview – Processing of Birth and Death Statistics
1.2.2 Classification of Causes of Death
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1.3 Completeness of Statistics

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CHAPTER 1

Ascertainment of Statistics on Suicide and Attempted Suicide in Ireland

1.1 INTRODUCTION

In addressing our first two terms of reference the Task Force looked at the range of procedures and research projects in place for gathering statistics on suicide and attempted suicide in Ireland.

1.1.1 Suicide

Statistics on suicide in Ireland are compiled by the Central Statistics Office (CSO) and the procedures used by the CSO are outlined in succeeding paragraphs. Basically, the process commences with the discovery of a death thought to be due to external causes i.e. as distinct from natural causes, and the medical practitioner is not prepared to issue a death certificate. In such a situation the Gardaí inform the coroner who orders a post mortem examination. If the examination reveals that the death is due to external causes, the coroner may then, and usually does, order an inquest. A verdict is returned and the Coroner's Death Certificate is sent to the Registrar of Deaths, the deceased's relatives and the CSO. At the same time the local Gardaí complete a confidential statistical form – Form 104 – for submission to the CSO, which gives the medical evidence in the case in question, information on how the relevant injuries were sustained and on whether the death was accidental, suicidal, homicidal or the residuary category of undetermined. It is the information supplied in Form 104 upon which the CSO relies heavily in coding the cause of death, and in turn, determining the number of suicides in Ireland.

1.1.2 Attempted Suicide

The difficulties of ascertaining and defining the true rate of attempted suicide are considerable in Ireland, as elsewhere in the world. These difficulties arise because, at national level, persons who attempt suicide are not recorded in our national statistics. It is well known that many persons attempt suicide and are only seen by their general practitioners and there are others who never come to medical attention. However, information is available on a limited geographic basis and, as outlined in Chapter 3, the Suicide Research Foundation has done extensive work in the area of attempted suicide in the Southern Health Board (Cork and Kerry) and Mid-Western Health Board (Clare, Limerick and Tipperary North Riding).

1.1.3 Research

A number of research projects is underway on different aspects of the suicide problem and with particular reference to the incidence of suicide and the associated factors involved. In relation to attempted suicide the Suicide Research Foundation's research in the Southern Health Board and Mid-Western Health Board is continuing.

1.2 PROCEDURES FOR CLASSIFYING DEATHS AS SUICIDE IN IRELAND

1.2.1 General Overview – Processing of Birth and Death Statistics

Vital Statistics (births, deaths and marriages) are compiled by the CSO on behalf of the Department of Health. Quarterly reports give initial information on vital events registered during each quarter while more detailed annual reports contain information on the births, deaths and marriages which occurred in a given year.

Vital statistics are a by-product of the Civil Registration System. Registrars (of whom there are about 300) send birth and death returns for their areas to the CSO on a monthly basis. The birth and death forms received by the CSO are divided into area batches for processing – which involves clerical coding of the information returned on the form; keying the information into computer; data editing/examination of outliers; and correction of errors. When the quarterly file is clear of errors, tables are compiled and published.

1.2.2 Classification of Causes of Death

Coding the cause of death involves relatively complicated decision rules, mainly in relation to the correct choice of an underlying cause from the information given on the death certificate. In line with international practice, the CSO classifies deaths according to the WHO's (World Health Organisation) International Classification of Diseases 9th Revision (ICD-9). At its most detailed level, ICD-9 is a four digit classification of the cause of death. Codes 001.0 to 799.9 relate to natural causes of death while 800.0 to 999.9 are the codes for deaths due to external causes (all such deaths are subject to inquests). In 1998, the CSO plan to introduce ICD-10, the latest revision of cause-of-death coding.

For all deaths with an external cause, a supplementary code, known as the E-code, is also required. While the ICD-9 code indicates the nature of an injury which caused the death, the E-code provides additional information on whether the death was an:

- Accident
- Homicide
- Suicide
- Undetermined

Deaths registered in 1995 classified by cause of death, using the ICD-9 classification, are given in Table 1.1. Of the 31,494 deaths registered in 1995, injuries and poisonings accounted for 1,355 deaths while natural causes accounted for the remainder. Using the supplementary E-code there were 949 accidental deaths, 383 suicides, 17 homicides and 9 deaths due to other external causes (undetermined).

1.2.3 Identifying Deaths due to Suicide

In the normal course, the Medical Cause of Death Certificate and Form 102 – the standard statistical return on deaths – contain sufficient information to allow the cause of death to be coded. However, further information supplementing the medical cause of death is required to code suicides and other external cause deaths. This information is recorded on Form 104 which is completed by the Gardaí. Whenever a Coroner's Certificate is received, the CSO asks the relevant Garda station to complete a copy of Form 104 in relation to the death.

A blank copy of Form 104 is given in Appendix 1. In addition to the medical evidence, the form seeks information on how the relevant injuries were sustained; in the case of accidents – where the accident occurred; whether the deceased was at work at the time of the accident; and whether the death was accidental, suicidal, homicidal or undetermined.

Form 104 is normally completed by the Garda who attended the scene of the death. The information given on whether the death was accidental etc. is the opinion of the Garda completing the form. The information on Form 104 is assessed by the CSO along with the Coroner's Certificate.

Coding of the cause of death is done within the Vital Statistics Section of the CSO and all cases of death by external causes are reviewed. The following are the procedures for coding a death caused by injury or poisoning:

- The underlying ICD-9 code is assigned on the basis of the medical evidence.
- If the Garda's opinion on Form 104 is that death was due to suicide and this concurs with the other circumstances described on the form, the E-code for suicide is chosen.
- If the form says 'undetermined' then the CSO initiate follow-up procedures to clarify the situation. The death may still be classified as suicide if the circumstances described by the Garda on Form 104 obviously point to this conclusion.

Form 104 has been in use since the late 1960s and provides a sound basis for the compilation of statistics on the number of suicides. The information provided by the Gardaí directly to the CSO on Form 104 is confidential under the Statistics Act, 1993 and may only be used for statistical purposes. This confidentiality is an important part of the statistical system for causes of death, in that it assures the Gardaí that the opinions stated cannot be disclosed to relatives or used as evidence.

The Statistics Act also precludes researchers from having access to the information on Form 104. This is unlike the situation for other Vital Statistics forms (e.g. Form 102) which are collected as part of the Civil Registration System and for which access by bona fide researchers to individual records is legally permitted, subject to the consent of the Minister for Health.

1.3 COMPLETENESS OF STATISTICS

The Task Force is satisfied with the accuracy of the current CSO statistics on suicide. Although the recording mechanisms have not changed, in the past it was suggested that the Irish suicide rate was significantly higher than official figures would indicate.

A measure of the completeness of the suicide statistics is how many deaths are coded as undetermined. Table 1.2 shows the number of suicides in each year since 1971, the number of undetermined deaths and the number of suicides expressed as a proportion of suicides-plus-undetermined.

In 1971, there were more undetermined deaths than suicides, thus suggesting that the figure for suicides in that year could have considerably understated the situation. The number of deaths coded as suicide has changed considerably in the intervening years. During most of the 1980s suicides represented 75% to 80% of suicides-plus-undetermined. Since 1990, the number of deaths coded to the residual undetermined category has fallen considerably. While it is practically impossible to correctly identify every suicide when compiling statistics, the current understatement of the number of suicides probably amounts to no more than 5%.

It is likely that the statistical figures for suicide produced by the CSO in Ireland are now more dependable than those of other countries. For example, in England and Wales, the official male suicide rate has increased slightly at a time when the English male undetermined rate has more definitely increased (Figure 1.1).

The opposite holds for Irish women (Figure 1.2). The Irish female suicide rate appears, in recent years, to be slightly higher than that of England and Wales. However, when allowance is made for the marked decrease in the Irish female undetermined death rate, and for the increase in English female undetermined deaths, it is very likely that the true female suicide rate in Ireland is significantly lower than that of England and Wales. Put differently, the underestimates of suicide, due to the misclassification of suicides as undetermined deaths, is up to five times higher for males and up to thirteen times higher for females in England and Wales than it is in Ireland (Figures 1.3 and 1.4).

FIGURE 1.1

Male Suicide and Undetermined Deaths

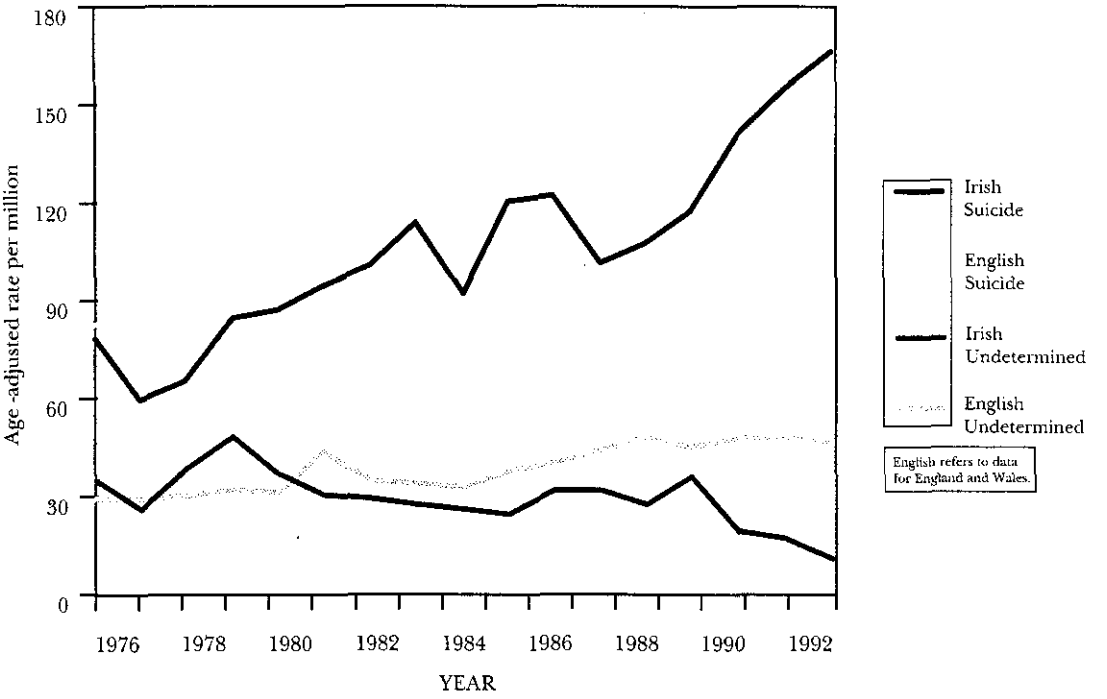
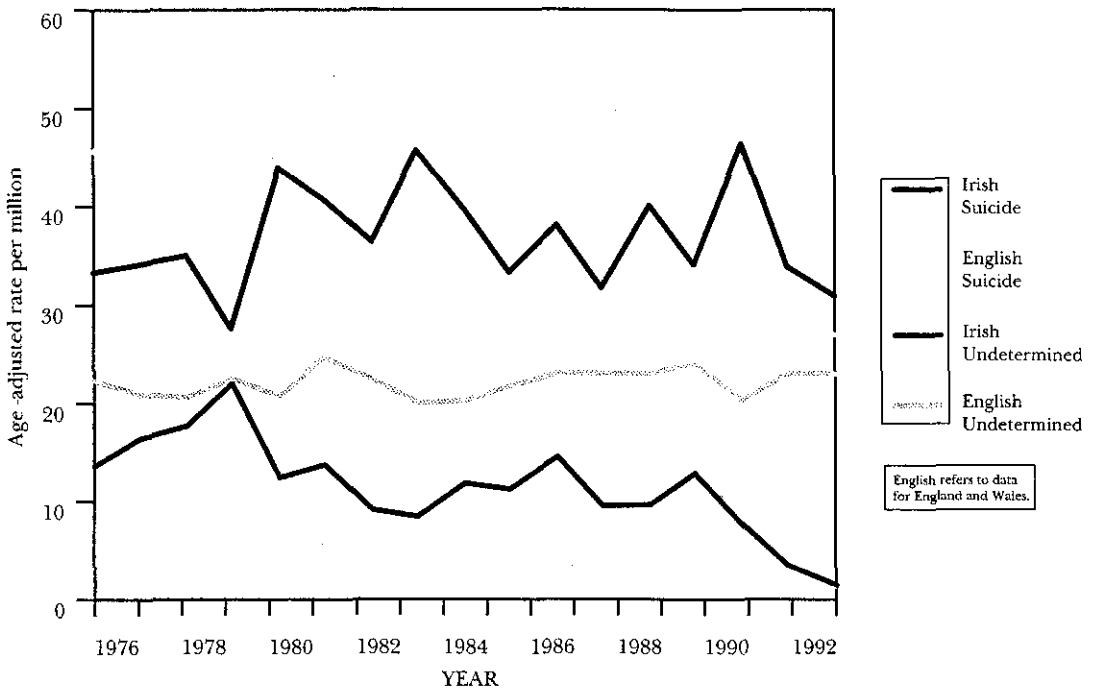


FIGURE 1.2

Female Suicide and Undetermined Deaths



Source: Suicide Research Foundation, Cork.

FIGURE 1.3

Male Ratio of Undetermined Death to Suicide

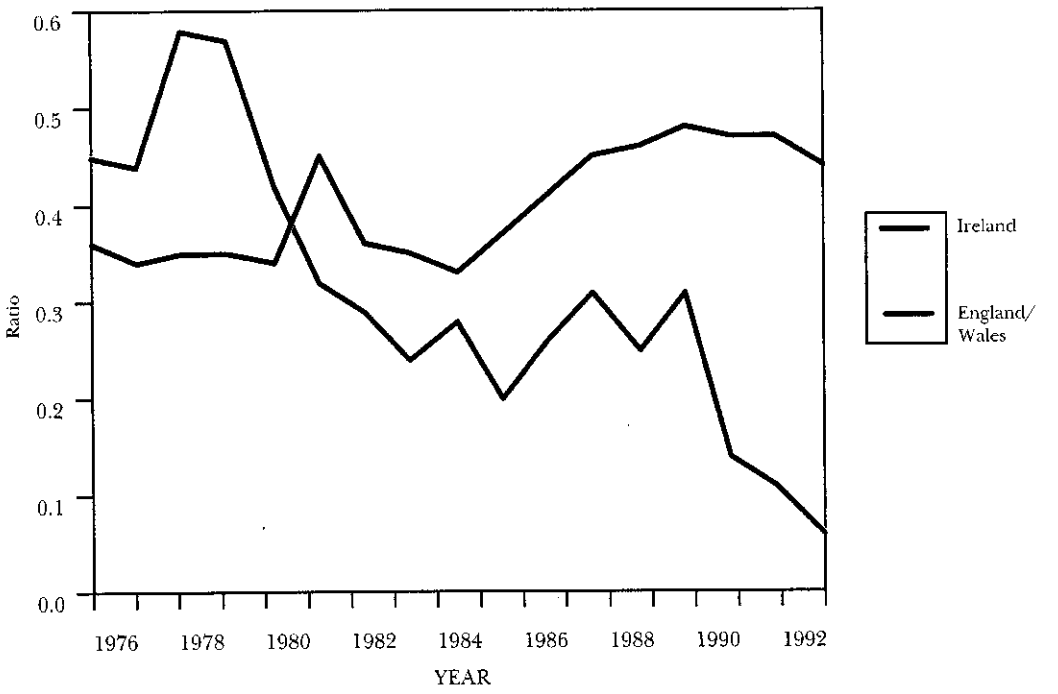
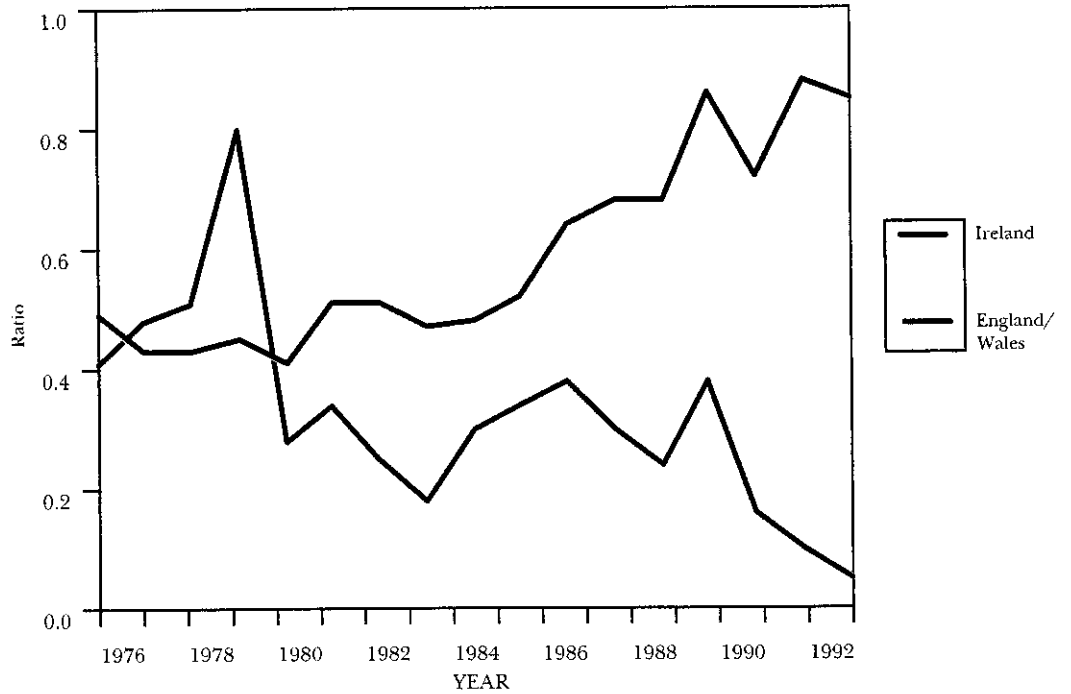


FIGURE 1.4

Female Ratio of Undetermined Death to Suicide



Source: Suicide Research Foundation, Cork.

The improvement in recent years may be connected with the decriminalisation of suicide in 1993, which has made coroners free (technically at least) to return verdicts of suicide. Notwithstanding this development, the Coroners Act, 1962, inhibits any inquiry into civil or criminal liability at any inquest and the implications of the case law in this area need to be fully clarified. **The Task Force provisionally recommends that this legislation be reviewed in order to facilitate coroners in returning verdicts of suicide, when appropriate.** Until this is done, coroners may continue to return open or undetermined verdicts. The Task Force will be consulting the Department of Justice about this matter and will return to it in our final report.

All of this means that a confidential return such as Form 104 is an essential source of supplementary information required for the identification of suicides, as coroners may still be reticent about returning suicide verdicts.

1.4 CONCLUSIONS

The CSO assigns two codes to deaths due to external causes: the ICD-9 code relating to the underlying medical cause; and the E-code stating whether the death was accidental, suicidal, homicidal or undetermined. The E-code depends on information provided confidentially by the Gardaí on Form 104, which was designed exclusively for statistical purposes and the present system succeeds in identifying, for inclusion in the statistics, the vast majority of suicides.

The Task Force is satisfied with the effectiveness of the CSO recording mechanisms in accurately quantifying, to the greatest extent possible, the number of suicides in Ireland each year. However, we believe that additional information is needed on the attendant social and personal circumstances of each case of suicide. This additional information would facilitate a better understanding of cause and a more effective way of looking at prevention.

The Task Force considers that the best way of securing this valuable social information would be to amend Form 104 to elicit more information on the circumstances leading up to the suicide. **We recommend that the CSO and the Garda Authorities consider amending Form 104 for this purpose and examine the technical, organisational and legal implications of such an amendment.** However, in making this recommendation, the Task Force acknowledges that any changes which are proposed would need to have regard to the following basic requirements:

- **Confidentiality:**
  Respondents – be they Gardaí or coroners – would need to be assured that the information they provide will not be made public and, in particular, that, in order to respect the sensitivities involved, no individual will be identified and no relative contacted in any follow-up process.

- **Use of information:**
  The uses to which information may be put should be clearly stated and observed. In general terms, the information would be used to quantify the problem of suicide and to clarify attendant social and personal circumstances. Towards this end, it is considered that these circumstances should be examined by accepted clinical experts in the field, subject to appropriate legal and institutional arrangements. Any other use would undermine the co-operation of respondents and the quality of information they provide.

- **Respondent burden:**
  Gardaí and coroners should only be asked for information which they are reasonably able to provide.

- **Timeliness:**
  There is already a greater time lag in the recording of statistics on deaths by external causes than for other deaths. This would be expected as there are no inquests for natural deaths. The difference is usually two to three months but can, in some cases, be longer. The system should not slow things down further by complicating the reporting procedure.

- **Continuity:**
  The current system works well in that it includes the vast majority of suicides in the statistics. The statistics on suicide and on all other deaths from external causes depend critically on Form 104 being completed by Gardaí and it is essential that confidential Garda returns continue to be part of the reporting system.

The Task Force will be liaising with the CSO and the Garda Authorities on the options available for gathering additional sociological information on suicides, and the possible legal implications thereof, and will return to this issue in our final report.

Table 1.1

Deaths registered during 1995, classified by sex, cause and age group

Sex and Cause of Death	All Ages	Age Group							
		0-14	15-24	25-34	35-44	45-54	55-64	65-74	75 and over
MALES									
All deaths	16,680	274	284	291	398	865	1,964	4,528	8,076
Natural causes	15,732	225	78	124	255	764	1,877	4,432	7,977
Injuries and poisonings	948	49	206	167	143	101	87	96	99
External Causes (E-codes):									
Accidents	623	46	129	92	75	60	63	68	90
–traffic	274	21	88	49	36	24	17	21	18
–falls	110	3	1	4	11	7	18	21	45
Suicide	305	3	72	70	64	38	23	27	8
Homicide	14	–	5	5	2	1	–	1	–
Undetermined	6	–	–	–	2	2	1	–	1
FEMALES									
All deaths	14,814	211	87	130	237	541	1,050	2,914	9,644
Natural causes	14,407	189	45	92	197	497	1,018	2,874	9,495
Injuries and poisonings	407	22	42	38	40	44	32	40	149
External Causes (E-codes):									
Accidents	326	20	31	22	20	30	25	31	147
–traffic	109	10	23	13	8	15	7	16	17
–falls	133	1	4	–	1	3	8	6	110
Suicide	78	1	10	16	19	14	7	9	2
Homicide	3	–	1	–	1	1	–	–	–
Undetermined	3	1	–	–	–	1	1	–	–
TOTAL									
All deaths	31,494	485	371	421	635	1,406	3,014	7,442	17,720
Natural causes	30,139	414	123	216	452	1,261	2,895	7,306	17,472
Injuries and poisonings	1,355	71	248	205	183	145	119	136	248
External Causes (E-codes):									
Accidents	949	66	160	114	95	90	88	99	237
–traffic	383	31	111	62	44	39	24	37	35
–falls	243	4	5	4	12	10	26	27	155
Suicide	383	4	82	86	83	52	30	36	10
Homicide	17	–	6	5	3	2	–	1	–
Undetermined	9	1	–	–	2	3	2	–	1

Source: Central Statistics Office.

Table 1.2

Number of suicides each year since 1971, number of undetermined deaths and number of suicides expressed as proportion of suicides – plus – undetermined

Year	Suicides E950-959	Undetermined E980-989	Suicides as a % of (suicides-plus-undetermined)
1971	81	119	40.5
1972	90	68	57.0
1973	105	79	57.1
1974	118	73	61.8
1975	148	68	68.5
1976	183	79	64.9
1977	151	73	67.4
1978	163	94	63.4
1979	193	120	62.3
1980	216	84	72.0
1981	223	72	75.6
1982	241	67	78.2
1983	282	62	82.0
1984	232	67	77.6
1985	276	65	80.9
1986	283	83	77.3
1987	245	71	77.5
1988	266	71	79.6
1989	278	92	75.1
1990	334	48	87.4
1991	346	38	90.1
1992	363	22	94.3
1993	361	26	93.3
1994	353	12	96.7
1995	383	9	97.7

Note: 1971 to 1992 (inclusive) data are based on the number of suicides occurring in those years; 1993, 1994 and 1995 figures relate to suicides registered in those years. A death can be legally registered up to one year after its occurrence (up to two years in cases where an inquest is held).

Source: Central Statistics Office.

CHAPTER 2

Suicide in Ireland

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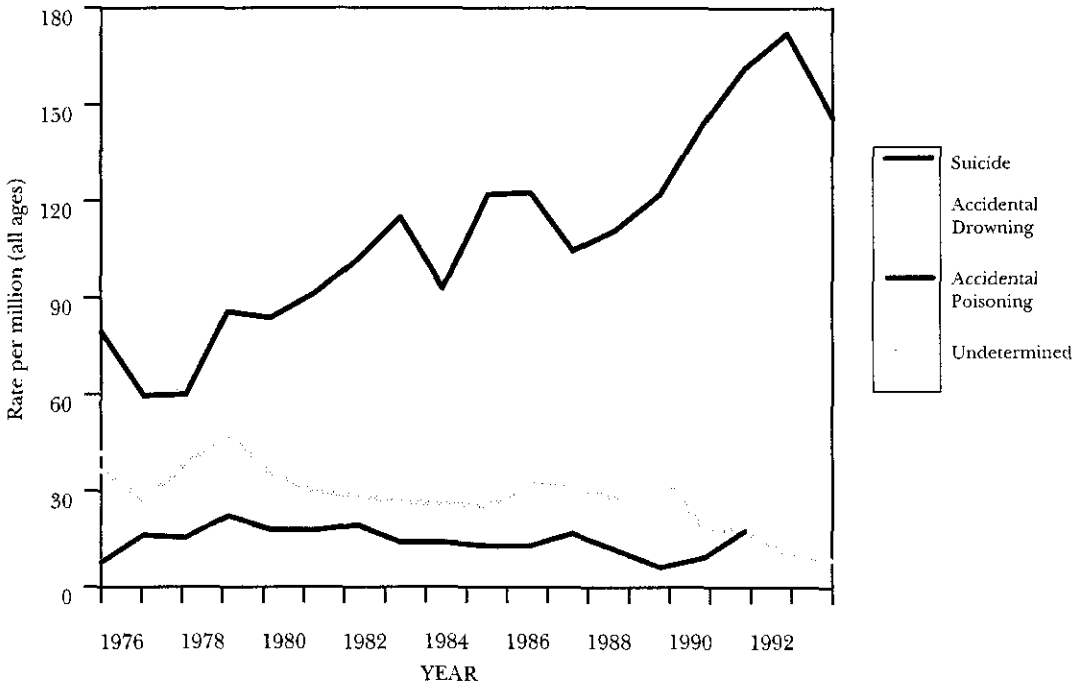
Suicide in Ireland

2.1 INCIDENCE OF SUICIDE IN IRELAND

Between 1945 and 1995 the number of deaths in Ireland attributed to suicide rose from 71 to 383. Apart from looking at the absolute numbers of suicides in any year, it is necessary to examine the suicide rate (i.e. the number of suicides per 100,000 population)* to enable valid comparisons be made. For the purpose of this Report, the Task Force examined the suicide rates in Ireland between 1976 and 1992. From Figures 2.1 and 2.2 it is evident that there has been a significant rise in the male suicide rate but no increase in the female suicide rate in this time period.

FIGURE 2.1

Irish Male Rate of Suicide, Accidental Drowning, Accidential Poisoning and Undetermined Death, 1976-1993

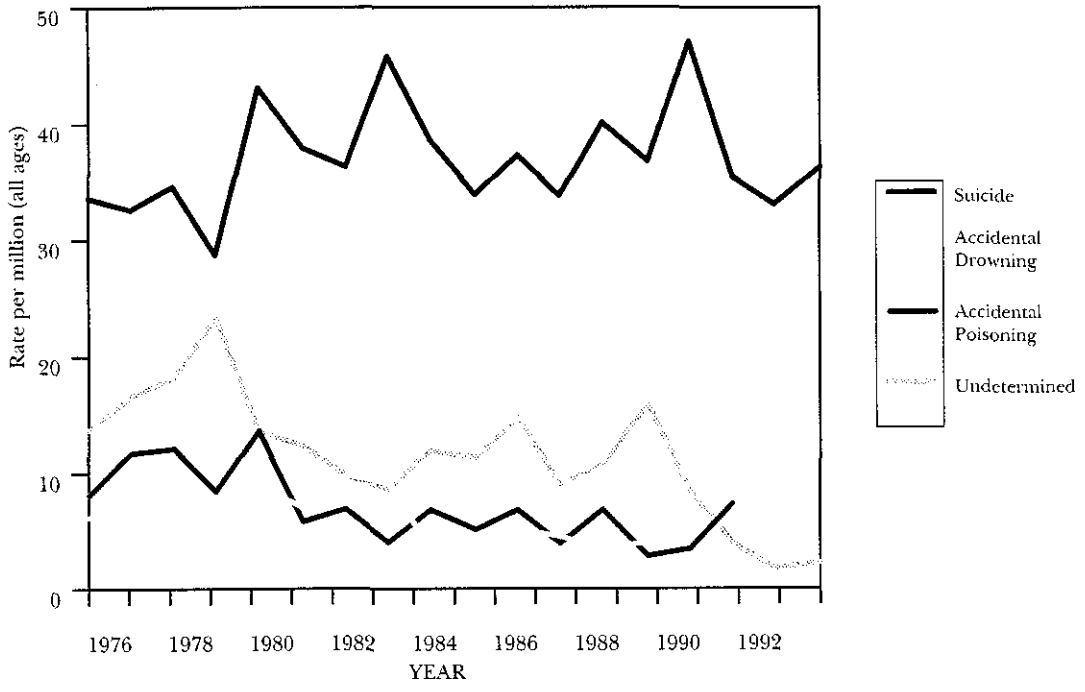


Source: Suicide Research Foundation, Cork.

*For the purposes of graphical illustration it has been necessary in some cases to represent rates per million of the population.

FIGURE 2.2

Irish Female Rate of Suicide, Accidental Drowning, Accidential Poisoning and Undetermined Death, 1976-1993



Source: Suicide Research Foundation, Cork.

The increase in the male suicide rate is not explained by a fall in other causes of unnatural deaths such as 'accidental drowning' and 'accidental poisoning'. This increase is, therefore, regarded as genuine.

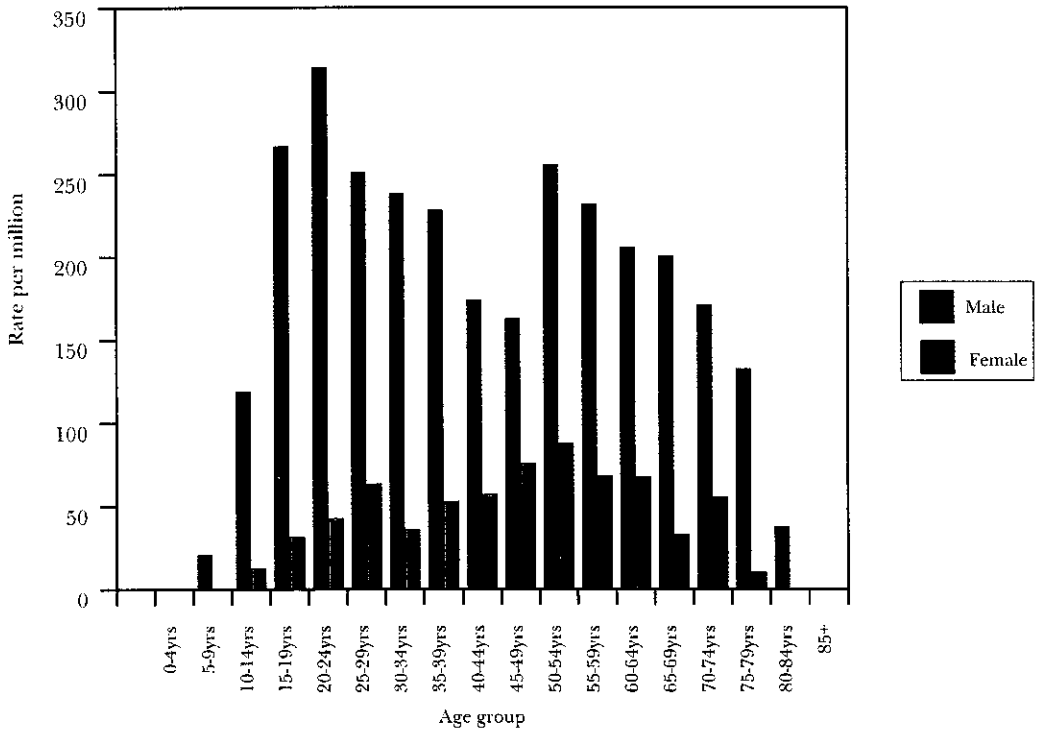
The earlier research work on suicide and attempted suicide in Ireland focused on the low rates by international standards (see paragraph 2.7) and emphasised the level of under-recording of suicide in the official statistics. Current reporting and recording mechanisms for suicide are described in Chapter 1 and the Task Force is satisfied that the current understatement of the number of suicides probably amounts to no more than 5%.

2.2 DEMOGRAPHIC FACTORS AND SUICIDE

The Task Force examined the average male and female suicide rates, classified by gender, in Ireland at five year age group intervals for the years 1991 to 1993.

FIGURE 2.3

Male and Female Suicide Rate in 5 Year Age Groups, 1991-1993



Source: Suicide Research Foundation, Cork.

2.2.1 Age

Suicide is virtually unknown in childhood. There have been few self-inflicted deaths in children under the age of ten. The level of intention in this age group is very uncertain. Also death, its meaning, and its finality, may not be understood.

From the early teens, suicide, starting from a very low base, begins to increase in frequency and accelerates during the late teenage years. This age-determined rise is common in other cultures. Psychological illnesses and access to alcohol and drugs become increasingly important factors in late teenage suicides and thereafter.

2.2.1.1 Suicide in Particular Risk Groups

(i) Young Men

Suicide is the second most common cause of death among young men in Ireland (Figure 2.4). It must be appreciated that throughout the western world, there has been an increase in suicide among young males.

Among young Irish women, only one in thirteen deaths are due to suicide (Figure 2.5).

FIGURE 2.4
Cause of Death for 15-24 Year-Old Males, 1991-1993
(836 Deaths)

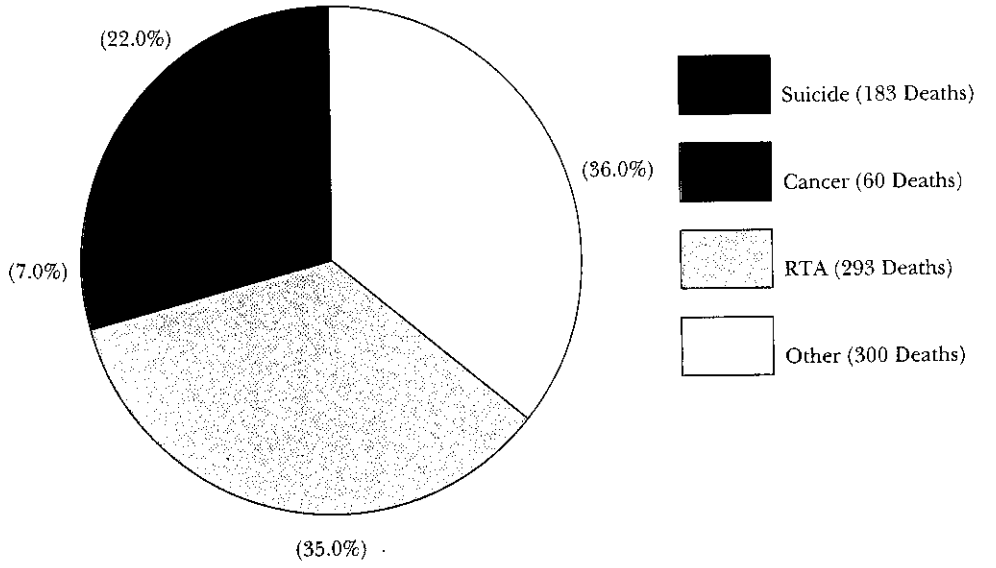
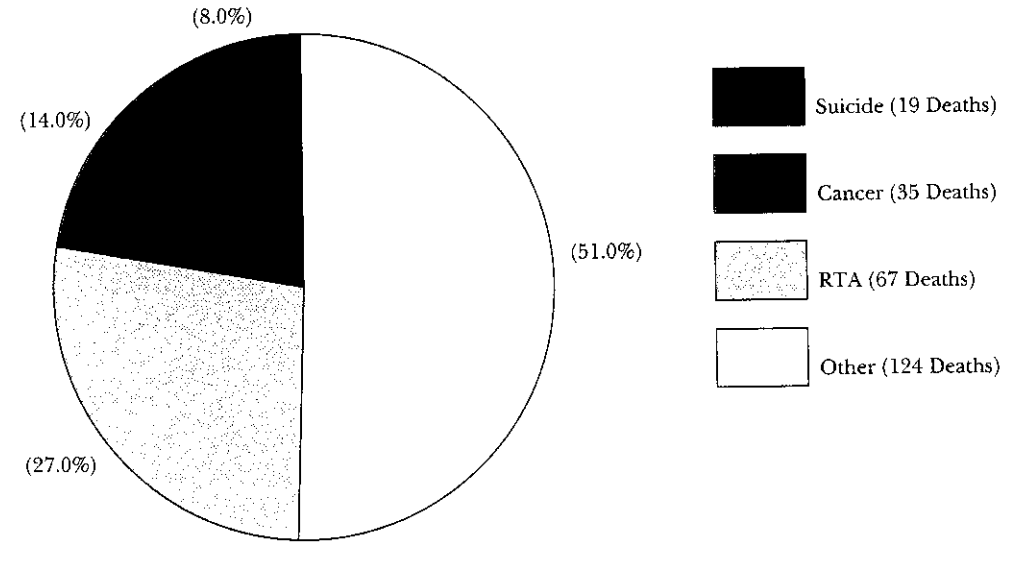


FIGURE 2.5
Cause of Death for 15-24 Year-Old Females, 1991-1993
(245 Deaths)

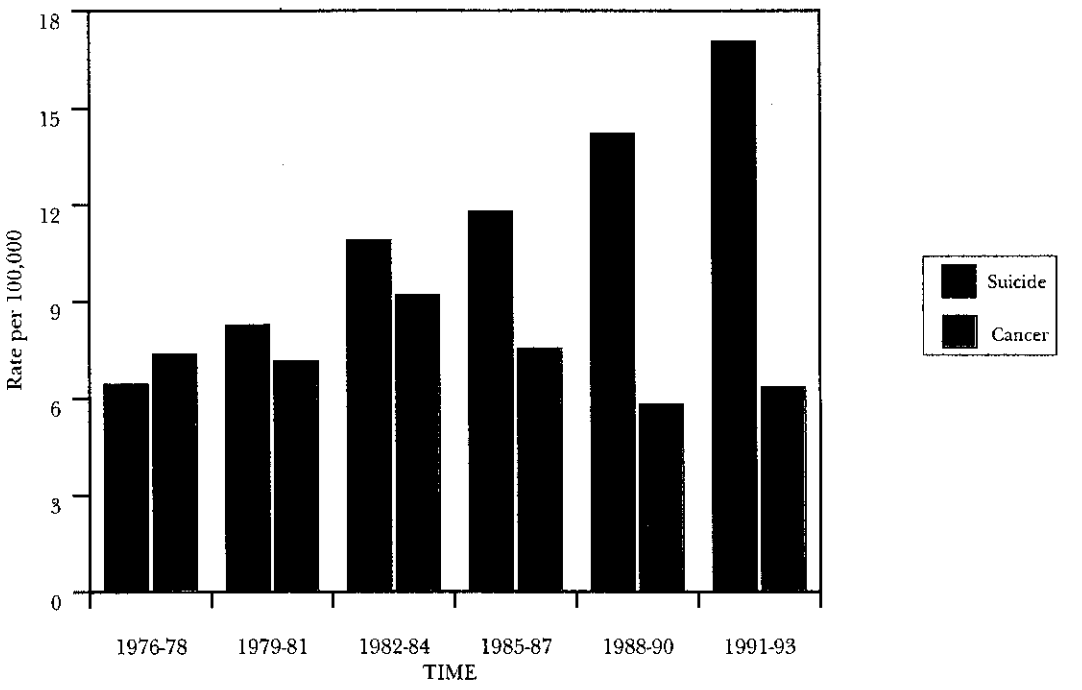


Sources: Suicide Research Foundation, Cork & the Central Statistics Office.

While the overall mortality rate for cancer increased in the years 1976 to 1993 the mortality rate among those under 65 years of age fell. This was partly due to better prevention, earlier recognition and to better treatment, particularly in the case of leukaemia. During the same period youth suicide deaths increased from a position where they were as frequent as cancer deaths in 1976 to greatly exceeding cancer deaths by 1993 (Figure 2.6). The contrast with road traffic accidents is even more striking. These were eight times more common than suicide deaths in 1976. By 1993, they were only twice as common (Figure 2.7).

FIGURE 2.6

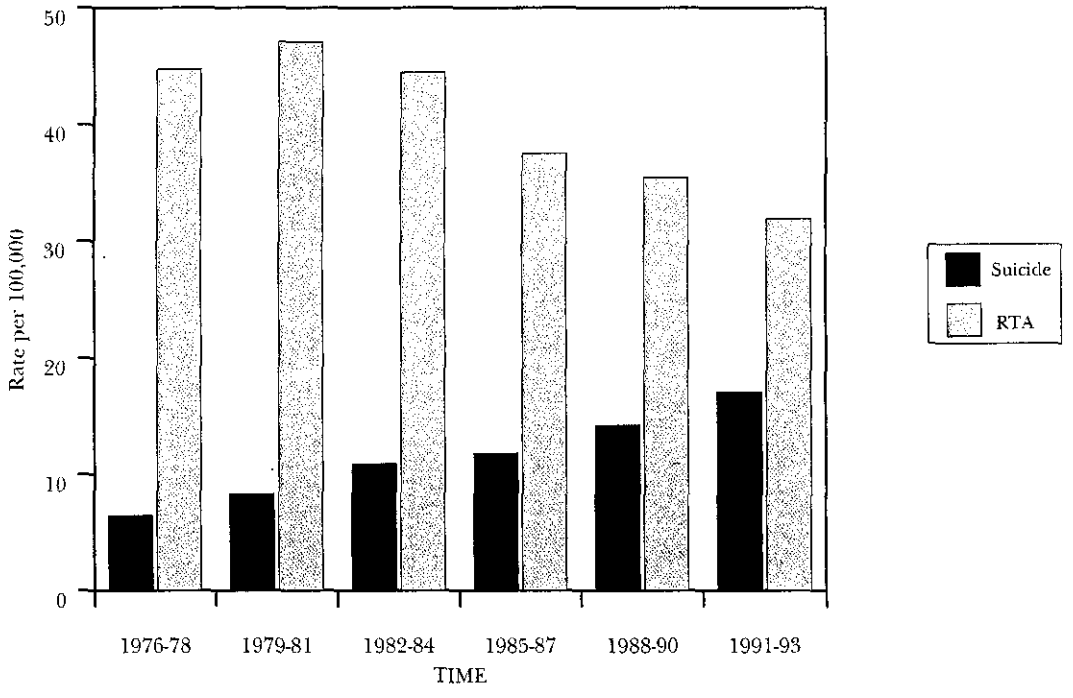
Suicide Rate Versus Rate of Cancer Deaths for 15-24 Year-Old Irish Males



Source: Suicide Research Foundation, Cork.

FIGURE 2.7

Suicide Rate Versus Rate of Road Traffic Accident Deaths for 15-24 Year-Old Irish Males



Source: Suicide Research Foundation, Cork.

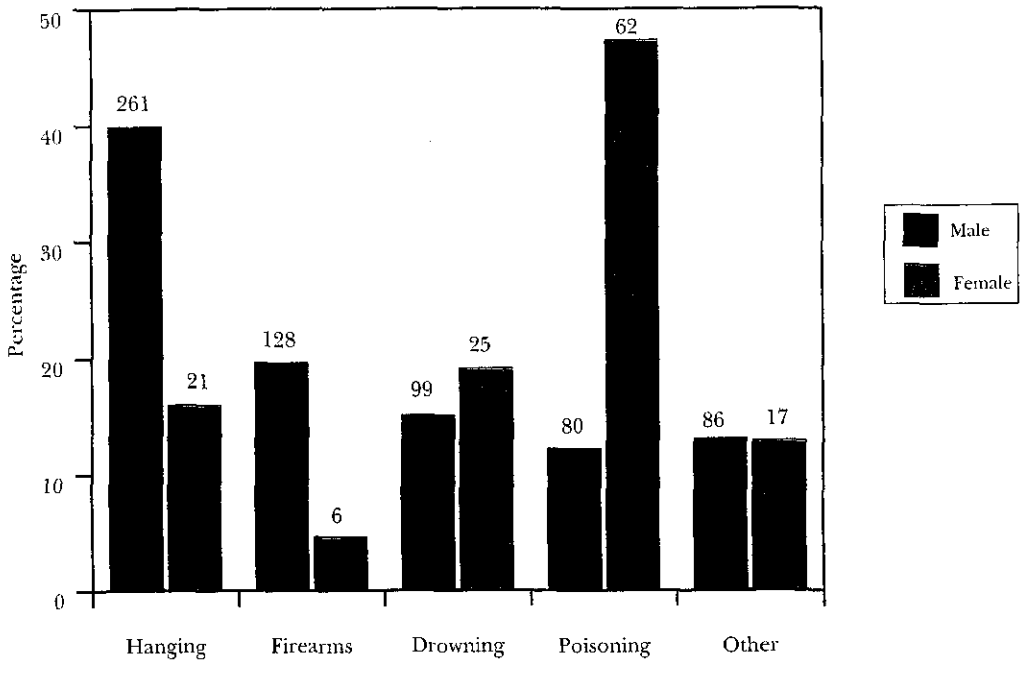
While it may be argued that suicide is a matter of choice, health promotion strategies may play a part in reducing the number of suicides, as has happened in the case of road traffic accidents and cancer deaths.

Early intervention may also be important. The psychological autopsy of suicides in Cork (see paragraph 2.8) found that only 18% of youths aged 15 to 24 years who had committed suicide had received psychological treatment in the year before their death even though almost three quarters of this group were regarded as being mentally ill. While it would appear that perhaps some young people kill themselves on impulse in the absence of psychological illness, it may be that some youth suicides could be prevented if the sufferer were recognised as being ill, either by himself/herself or by others, and given appropriate treatment.

For young men the most common methods of suicide used were hanging (40%) and firearms (20%), whilst young women used poisoning (47%) and drowning (19%).

FIGURE 2.8

Method of Suicide by Irish Male and Female 15-24 Year-Olds, 1976-1993



Source: Suicide Research Foundation, Cork.

(ii) The Elderly

As well as young males, elderly men aged 65 years and over have shown a significant increase in their rate of suicide. There has been no increase in female suicide in any age group including the over 65 age group (See Figure 2.12).

In the age group 65 to 74 years, there is a far greater incidence of suicide, for both men and women, than in the 75+ age group. Above the age of 75 years, the Irish male suicide rate falls steeply (Figures 2.9 & 2.10).

FIGURE 2.9

Irish Male 'Young' Old and 'Old' Old Suicide Rate

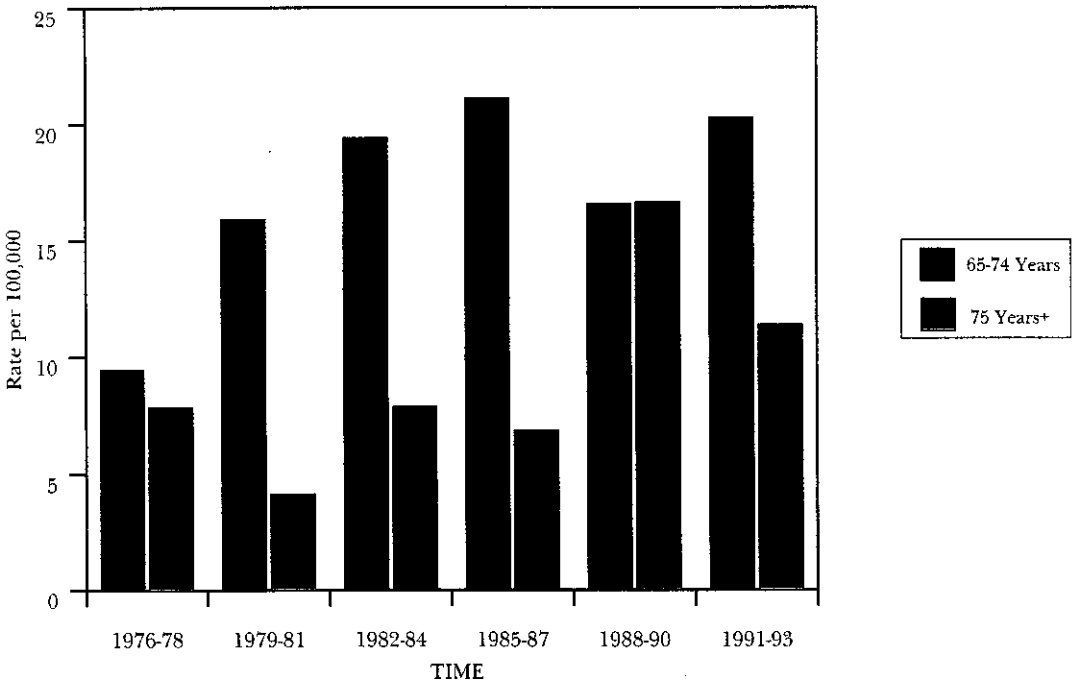
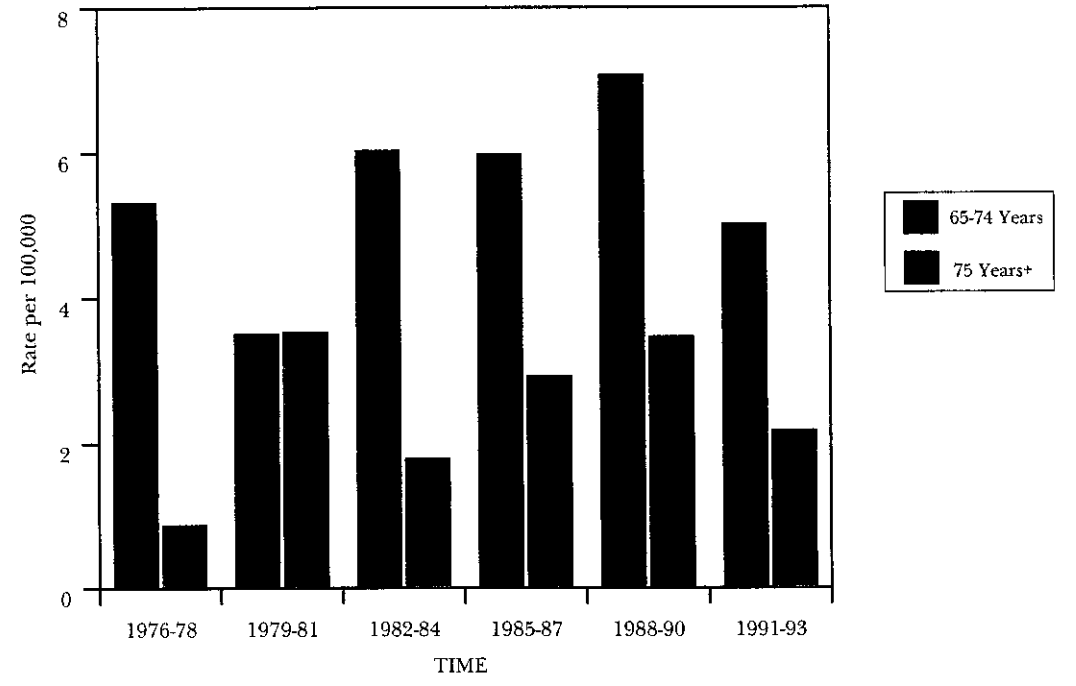


FIGURE 2.10

Irish Female 'Young' Old and 'Old' Old Suicide Rate

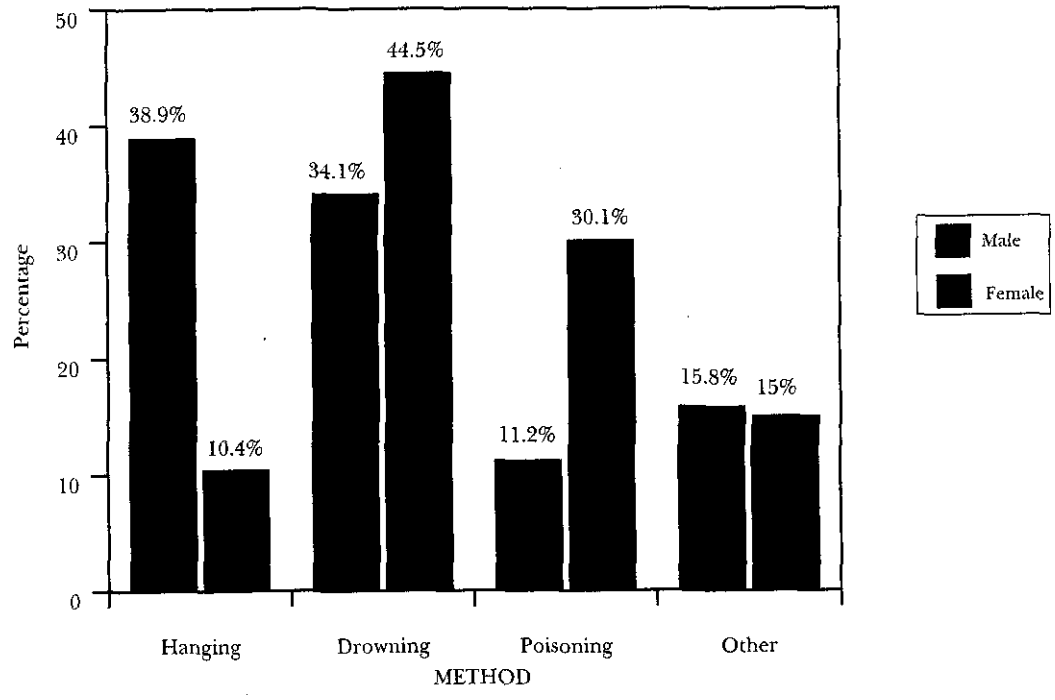


Source: Suicide Research Foundation, Cork.

Most elderly suicides use distressing methods of dying. Hanging and drowning are the most common (Figure 2.11). However, 30% of women and 11% of men poisoned themselves with medicinal substances.

FIGURE 2.11

Method of Suicide of Elderly Irish Males and Females 1976-1993



Source: *Suicide Research Foundation, Cork.*

The psychological autopsy in Cork (see paragraph 2.8) showed that, of the 12 elderly suicides examined, five of the six men were unmarried. All of the six females were married but three had recently been bereaved. It may be that marriage is a protective factor against elderly male suicide. Bereavement, however, would appear to be a common precipitant of elderly female suicide. All of the elderly Cork women who committed suicide were known to be suffering from depression and all had received treatment prior to their death. Only two of the six men who committed suicide were known to have received treatment even though five of them were known to have been mentally ill.

2.2.2 Gender

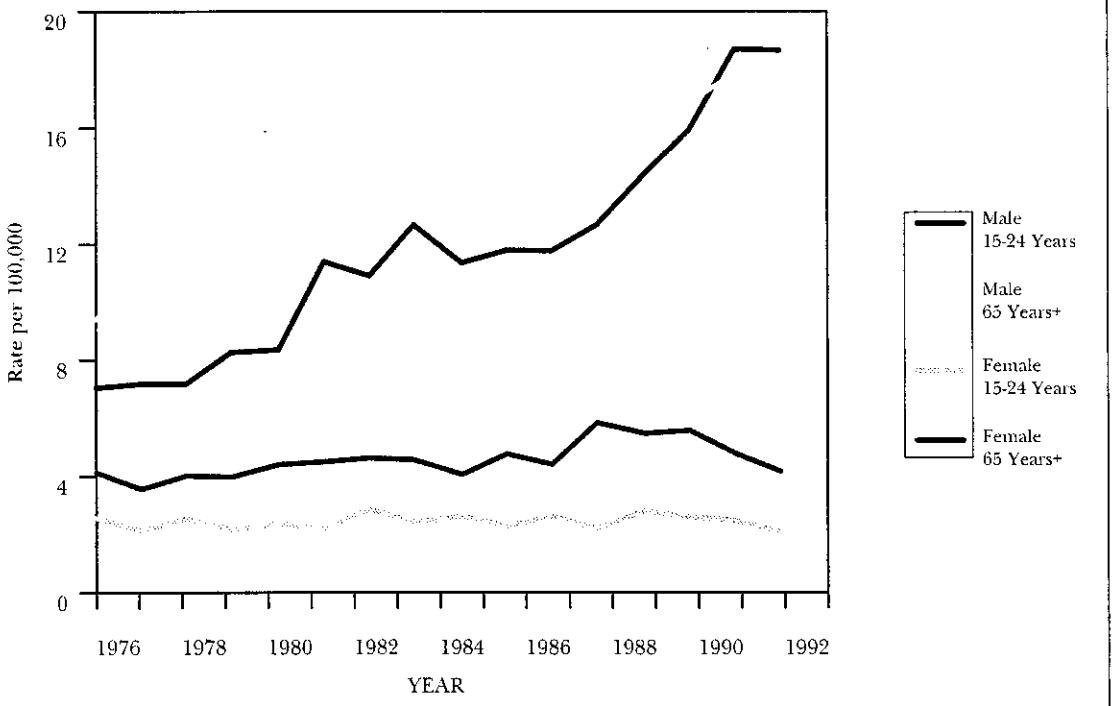
The increase in suicide in recent decades has been primarily a male phenomenon. The overall rate of suicide among men in 1995 was 17.17 compared with a rate of 4.32 among women per 100,000 population.

The relationship between age and suicide is different for men and women. For men, the vulnerable age groups are young to middle age and young elderly. Late middle age is associated with higher risk among women (See Figure 2.3).

In 1995, there were 142 deaths attributed to suicide among 15-34 year old males, while there were 35 such deaths among males over 65 years. Between 1976 and 1992 there was a significant increase in the rate of suicide in both these age groups (Figure 2.12).

FIGURE 2.12

Suicide Rate of Young and Old Irish Males and Females



Note: Three-year moving averages of the rates are plotted.

Source: Suicide Research Foundation, Cork.

Given the large number of young men who commit suicide, the rise in the suicide rate in this age group is a particular cause for concern because of the number of life years lost.

2.3 REGIONAL VARIATIONS IN SUICIDE

In general, Munster and Connaught return slightly higher rates of suicide than Leinster (Table 2.1). Some Irish counties have higher rates than their neighbours. However, the causes and associated factors need to be identified.

Table 2.1

Average annual suicide rate per 100,000 population for 1991 to 1995.

Province	Suicide Rate
Leinster	9.18
Munster	11.37
Connaught	11.54
Ulster (part of)	11.89

Source: Central Statistics Office.

2.4 SOCIAL FACTORS AND SUICIDE

There have been significant changes within Irish society over the past thirty years. A number of social factors, such as those detailed below, have been identified which appear to be correlated with changes in the suicide rate, but further research is required before a cause and effect relationship could be definitively established.

2.4.1 Occupations and Suicide

Some occupations in Ireland may have higher rates of suicide than others. Farmers, veterinary practitioners and members of the caring professions, in particular doctors and nurses, have been considered as being amongst these. The same has been found in Britain and elsewhere. The initial response is to assume that there are some specific stressors or lack of support structures that generate these fatal outcomes. Other possibilities should also be considered, for instance, access to fatal methods of deliberate self-harm are not equally distributed across society.

2.4.2 Unemployment

Unemployment and the threat of unemployment is frequently blamed for the rise in suicide. Research has disclosed a complicated relationship between unemployment and suicide among young people. Young male suicides and unemployment rates for young people appear to be positively correlated unlike the situation with young females. When individual suicides are examined, as has been done in a psychological autopsy on suicides in Cork (see paragraph 2.8), a disproportionate number are unemployed. However, there is evidence from 1995 that the unemployment figures for young people are beginning to fall whereas the suicide figures continue on a gradual upward trend.

2.4.3 Alcohol and Drug Dependency

(i) Suicide and Alcohol Misuse

Alcohol may play a role in some Irish suicides. Some individuals, who may not necessarily have alcohol-related disorders, consume alcohol prior to killing themselves.

Persons with alcohol-related disorders who have been treated in hospitals had been commonly reported as having a lifetime death rate by suicide of 15%. Some recent work, however, has suggested that previous estimates of lifetime suicide risk among persons with alcohol-related disorders may have been too high.

(ii) Suicide and Drug Dependency
Dependency on and misuse of 'street' drugs may be associated with some young male suicides, particularly in urban areas.

Dependency on medically prescribed drugs is more common in the older age groups, both male and female, and may also be important in some suicides.

2.4.4 Changes in Family Life

Family life has undergone great change in Ireland over the past twenty five years and its impact on the suicide rate warrants further investigation. The marriage rate has fallen and the age of marriage has increased. The incidence of marital breakdowns and separations have greatly increased.

2.5 SUICIDE AND ILLNESS

Suicide is associated with particular groups and an awareness of such is important in planning a strategy of suicide reduction. Professional carers should be aware of the possibility of suicide, skilled in its assessment and knowledgeable of what is to be done.

2.5.1 Persons with Mental Illness

Suicide has a highly consistent association with mental illness in every country where research has been carefully carried out. Of those who deliberately end their lives, over 90% are mentally ill, of which the commonest illness is depression. This was clearly shown in Britain thirty years ago and more recently a psychological autopsy study, carried out on a hundred cases of suicide in Ireland, demonstrated that 93% were mentally ill in the time before their deaths (Suicide Research Foundation).

Most persons who are mentally ill, however, do not kill themselves. It is thought that about 15% of those who suffer from major mood disorder end their lives. Other illnesses associated with suicide include schizophrenia, where the figure given is usually 10%, and personality disorder (either psychopathic or anti-social) where a similar figure is given.

2.5.2 Persons with Physical Illness

Major physical illness has a lower but definite association with suicide. The illnesses include chronic painful conditions, heart disease and neurological illnesses including Huntington's Chorea, early Alzheimer's Disease and more recently HIV/AIDS.

2.6 SUICIDE IN PRISON

The report of the Advisory Group on Prison Deaths, published in August 1991, included an examination of suicide in prison. In the years 1975 to 1990 the number of deaths per annum attributed to suicide in prison in Ireland ranged from zero to five. Of the total of 23 suicides during that period only one was female. In 1990 there were three suicides in prison representing a rate of 143 per 100,000 of the prison population. This compares with a rate of 64 per 100,000 prison population in the same year in Scotland and a rate of 105 for the same year in England. The group noted that almost all the suicides in Irish prisons were by individuals in the 17-35 age group.

Among the Advisory Group's recommendations was that a Suicide Awareness Group be established within each prison under the Chairmanship of the Governor of each prison. This recommendation has been fully implemented. In fact, fifty two of the fifty seven recommendations contained in the Report have either been implemented or are currently in the course of being implemented. The remaining recommendations were more long term in nature, a fact that was acknowledged by the Advisory Group, and will be implemented in the context of the overall development of the Prison System. The Minister for Justice has also established a National Steering Group overseeing the local Suicide Awareness Groups in the institutions under the Chairmanship of a Senior Prison Governor.

2.7 COMPARISONS WITH SOME OTHER COUNTRIES

In 1976 young males (15-24 years) in Ireland, as in England and Wales, had a very low rate of suicide in comparison to Japan, the US and to Finland, which was at the top of the range. Since then Ireland has left the lower grouping and joined the US in the median range. By contrast, Japan has returned a falling rate of suicide so that, officially, it is now in the lower range (Figure 2.13).

The rate of suicide among young Irish females (15-24 years) began, in 1976, in the lower range and has retained this position through to 1992. Young Japanese females were in the highest range in 1976 but their rate has fallen to the median range by 1992 (Figure 2.14).

The Japanese data does not make clear whether the fall in its official rates is due to a genuine fall or whether it is a consequence of a change in the administrative practice of recording suicides and the Task Force is awaiting further information on this issue.

FIGURE 2.13

International Suicide Rates for 15-24 Year-Old Males, 1976-1992

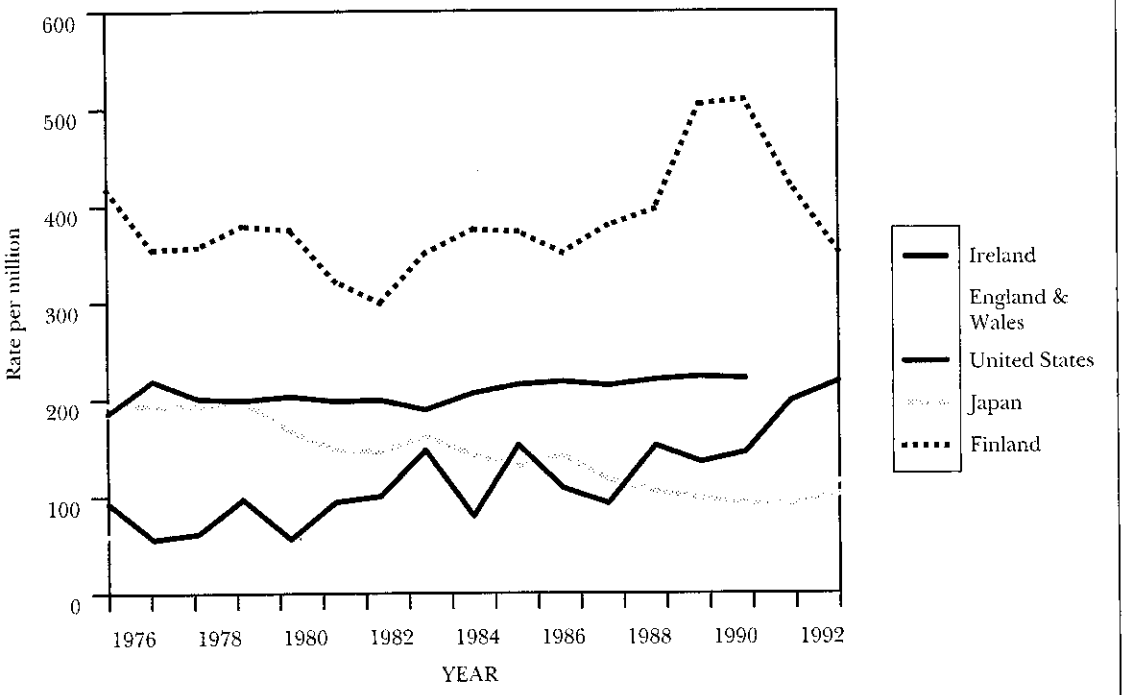
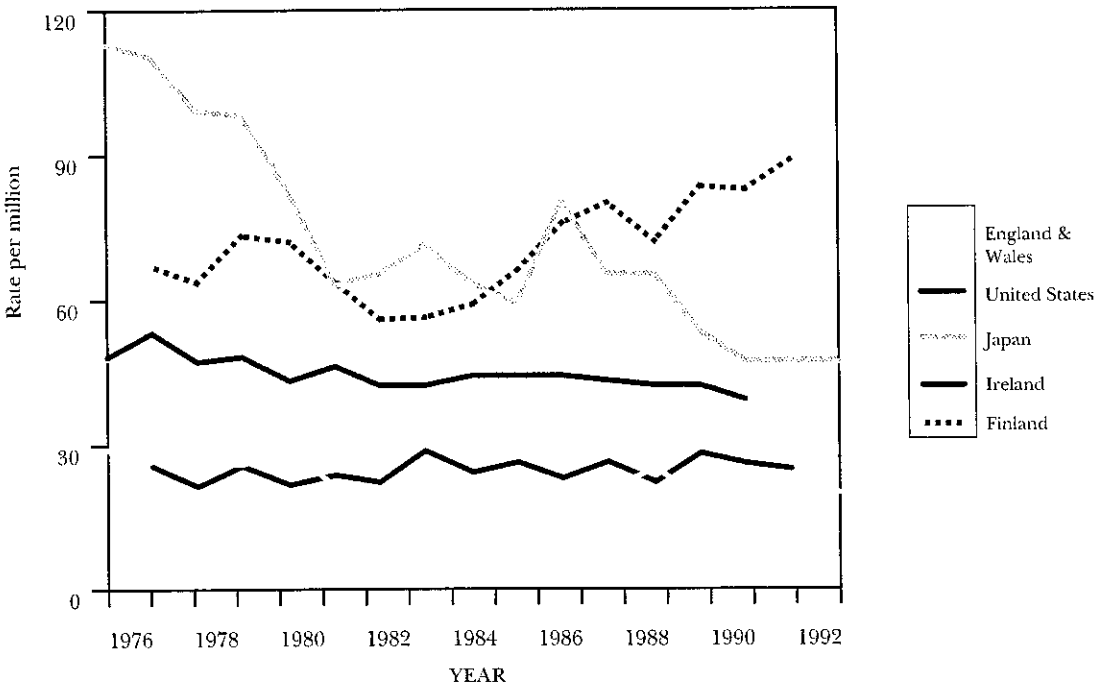


FIGURE 2.14

International Suicide Rates for 15-24 Year-Old Females, 1976-1992



Due to the volatility of the Finnish and Irish rates, 3 year moving averages were used.

Source: Suicide Research Foundation, Cork.

2.8 PSYCHOLOGICAL AUTOPSY ON A SAMPLE OF SUICIDES

A hundred consecutive suicides in Cork were the subject of a psychological enquiry (autopsy) by attendance at the two Coroners' Courts in Cork, and by speaking to relatives, Gardaí, and care-givers as well as by examining hospital notes.

Most of the suicides examined were male and most were young (Figure 2.15). Most of the men were single or separated, less than one in five being married (Figure 2.16). Over half of the women were married although a significant proportion (18%) were bereaved. Just over half of the men were unemployed and over a third of the women worked in the home (Figure 2.17). Most used violent methods of suicide (Figure 2.18); 40% of male suicides were by hanging while 32% of female suicides used medicinal drugs.

Three quarters of the women had received treatment for psychological illness in the year before their deaths as opposed to only 40% of the men.

FIGURE 2.15

Age/Sex Distribution of 100 Cork Suicides

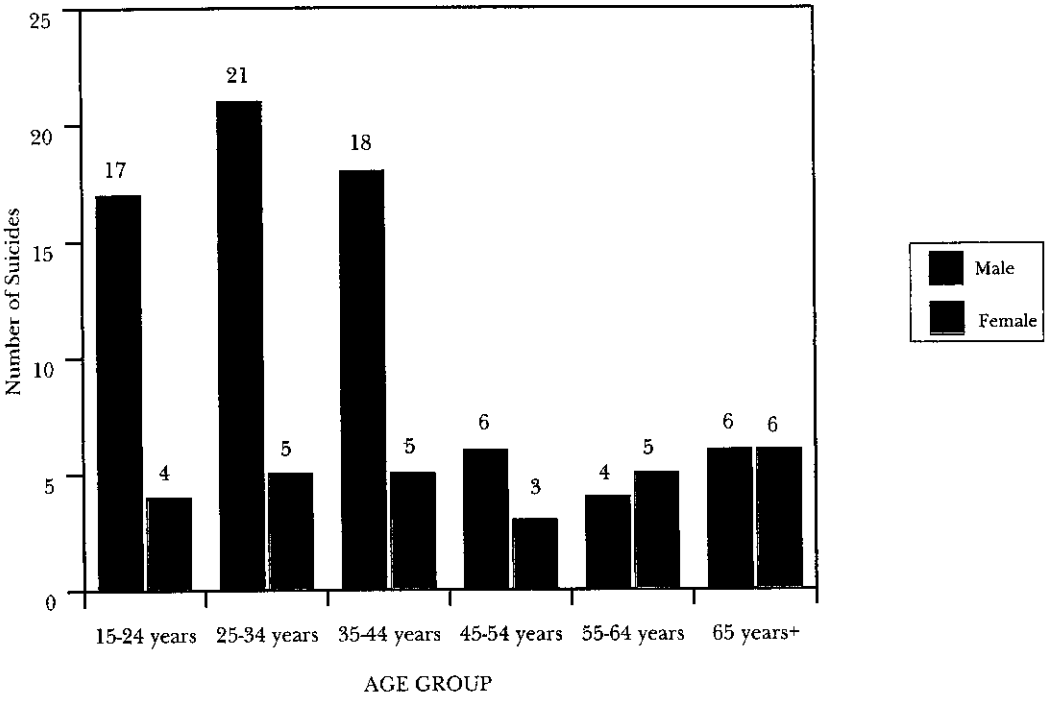
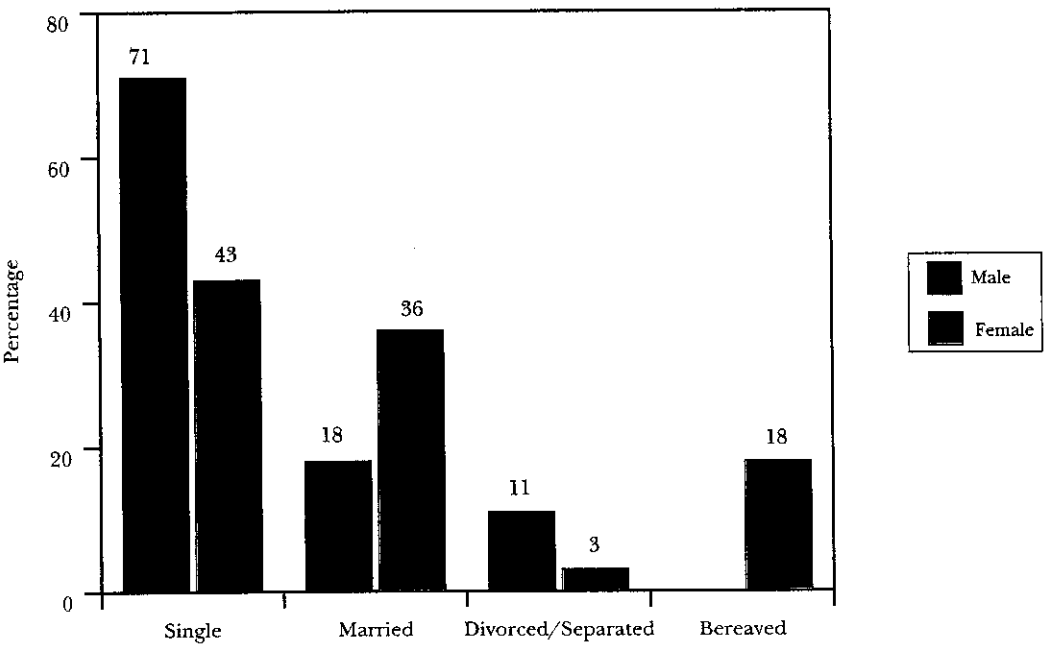


FIGURE 2.16

Marital Status of 100 Cork Suicides



Source: Suicide Research Foundation, Cork.

FIGURE 2.17

Employment Status of 100 Cork Suicides

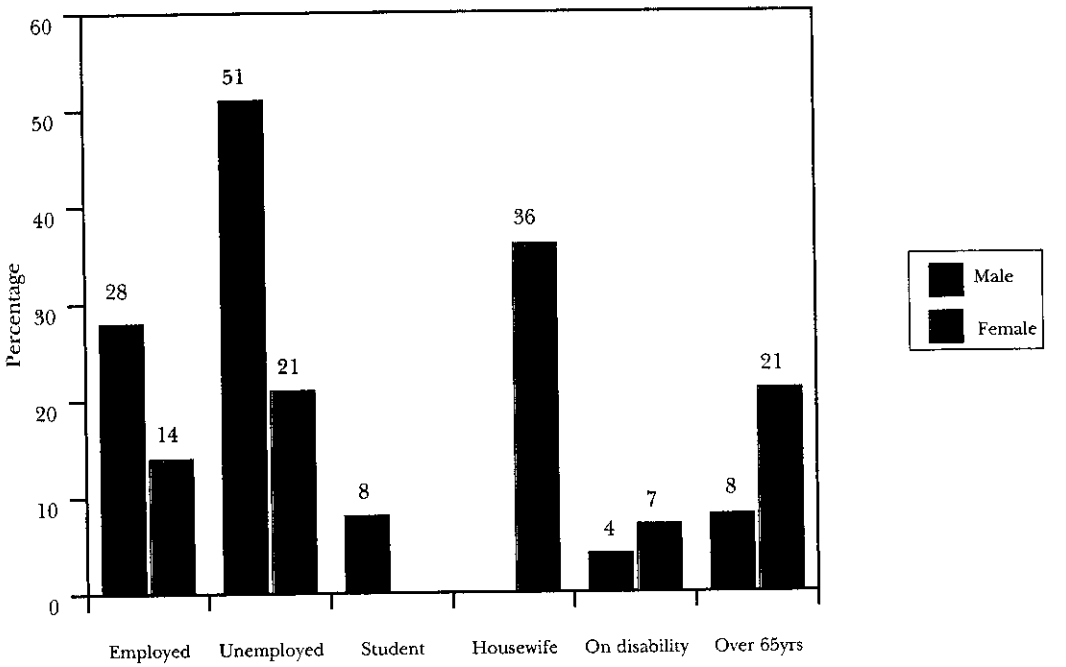
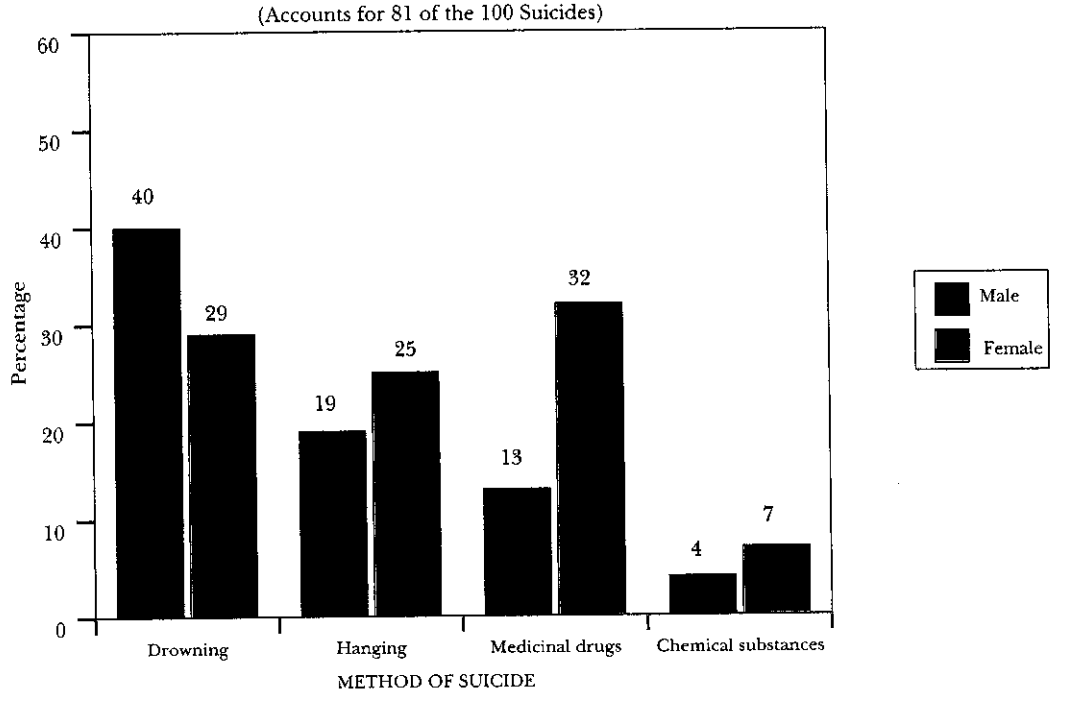


FIGURE 2.18

Main Methods of Suicide Used

(Accounts for 81 of the 100 Suicides)



Source: Suicide Research Foundation, Cork.

2.9 THE COST OF SUICIDE

About eight years ago, it was calculated that each youth suicide (age group 15-24 years) in the United States resulted in an average loss of 53 years of human life, at a cost in US dollars of $432,000 (IR£270,000) in lost economic productivity (Weinstein & Saturno (1989)[1]. In Ireland, between 1991 and 1994, there were 280 suicides in this age group (28 females and 252 males). If the US calculations are used for those years, the cost of young adult suicide amounts to approximately $120,960,000 (IR£75,600,000) – or approximately $12,096,000 (IR£7,560,000) for females and $108,864,000 (IR£68,040,000) for males. If suicides among those in older age groups are added, the cost would be considerably more.

The real burden and cost of suicide, however, is immeasurable. The stress and morbidity caused to the bereaved is enormous and this may continue in succeeding generations.

[1]Weinstein M & Saturno P. Economic impact of youth suicides and attempted suicides. Rockville, USA Department of Health and Human Services Publications No (ADM) 89-1264 (p4) 1989.

CHAPTER 3

Attempted Suicide in Ireland

CHAPTER 3

Attempted Suicide in Ireland

3.1 INTRODUCTION

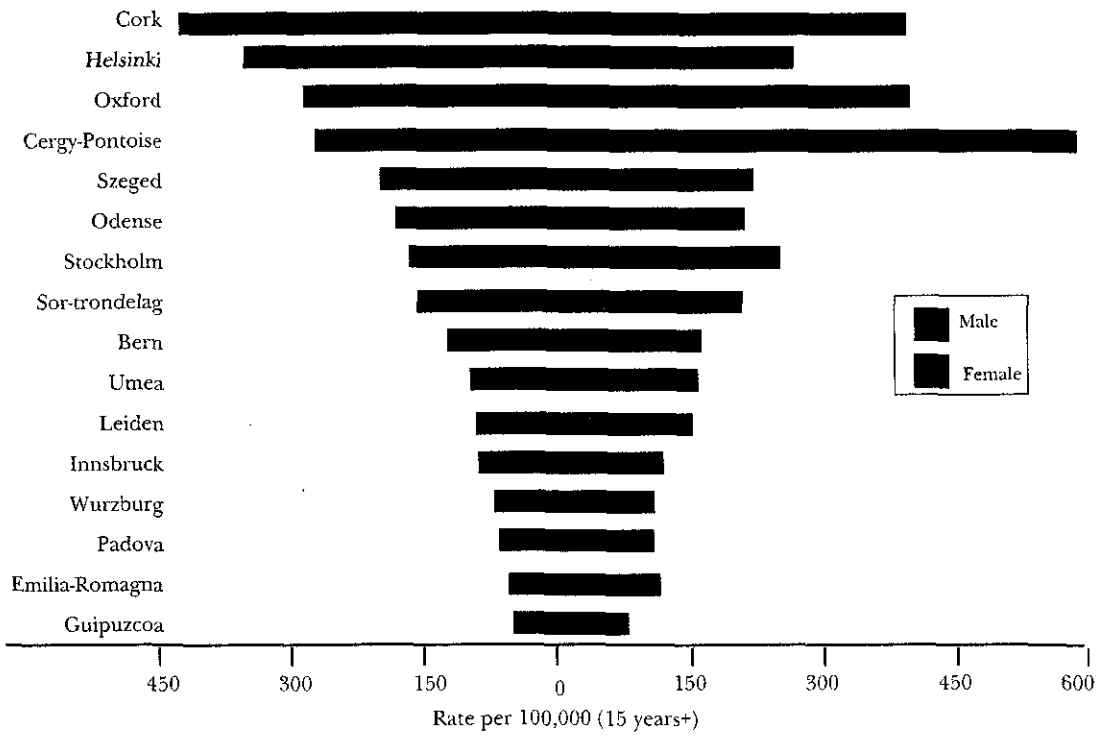
Because many of those who engage in acts of deliberate self-poisoning and deliberate self-harm are not intent on ending their lives, but rather in drawing attention to their circumstances, the term 'parasuicide' is now increasingly used instead of the older term 'attempted suicide'. However, there is not a universal acceptance of the difference between those terms and throughout this Report, they have been used interchangeably.

The difficulties of ascertaining and defining the true rate of attempted suicide in Ireland were referred to in Chapter 1. Much of the information which is available has been gathered by the Suicide Research Foundation, which has done extensive work in the area of parasuicide in Cork.

3.2 WHO EUROPEAN PARASUICIDE STUDY

The Suicide Research Foundation is participating in the International Studies of Parasuicide organised under the auspices of the WHO. These studies use the same methodology and instruments of enquiry. The Irish population base includes the Southern Health Board and Mid-Western Health Board areas, made up of the counties Cork, Kerry, Limerick, Clare and Tipperary North Riding. The data from Cork City only is used in the comparison with the other fifteen centres. As can be readily seen from Figure 3.1, Cork is highest among the sixteen centres in the rate of male parasuicide and third highest among the females. Many factors may contribute to these differences. The fact that the work in Cork was done assiduously so that under-estimation is minimal or virtually non-existent should be taken into consideration.

FIGURE 3.1
Person-Based Parasuicide Rates for Cork, 1995 and European Centres, 1989-1992



Source of European centres' rates: Attempted suicide in Europe. Kerkhof AJFM et al (Eds.). Leiden, The Netherlands: *DSWO Press*, 1994.

Source: Suicide Research Foundation, Cork.

3.3 SURVEYS ON DELIBERATE SELF-POISONING AND SELF-HARM IN CORK

Over the years, three major surveys of deliberate self-poisoning, referred to casualty department's in Cork City were carried out. The years studied were 1982, 1988 and 1992. These results will now be compared with the preliminary results for 1995.

Table 3.1 gives the number of episodes of self-poisoning referred to casualty, and the number of individuals involved, for the four years under study. An upward trend, both in terms of individuals and episodes, is evident with a peak in 1992.

Table 3.1
Number of episodes of self-poisoning and number of individuals involved, in Cork City, 1982, 1988, 1992 and 1995.

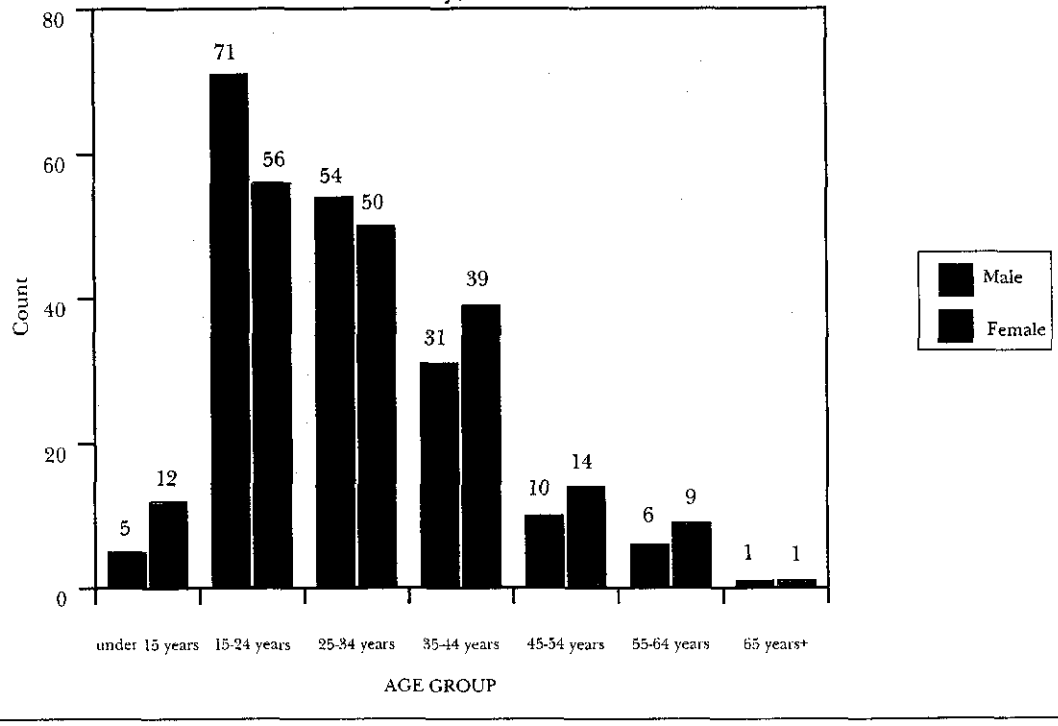
Year	Number of Individuals	Number of Episodes
1982	245	308
1988	285	316
1992	336	383
1995	256*	337*

*These are preliminary figures.
Source: Suicide Research Foundation, Cork.

Parasuicide also includes acts other than deliberate self-poisoning such as cutting, attempted drowning, attempted hanging and others. However, deliberate self-poisoning accounts for some 75% of all acts of parasuicide. In 1995, every act of parasuicide occurring within the Southern Health Board area and referred to casualty, was monitored. Since 1 July, 1995 every such act occurring in the Mid-Western Health Board has been the subject of inquiry. At this moment in time, only figures for Cork City are available.

The number of individuals, in each age group and sex, who exhibited parasuicidal behaviour in Cork City is shown in Figure 3.2.

FIGURE 3.2
Age/Sex Distribution of Parasuicidal Individuals
Cork City, 1995

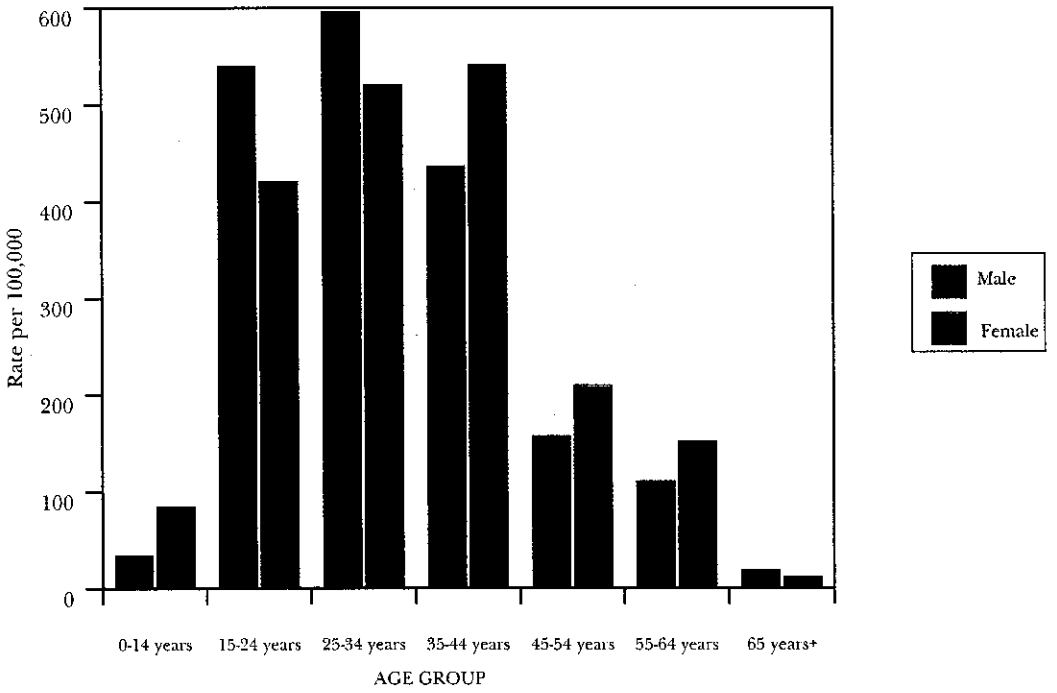


Source: Suicide Research Foundation, Cork.

It would appear that parasuicide is most common in the late teens and early adulthood. However, when the rates of parasuicide are calculated, it can be seen that parasuicide is a major problem right into middle age for Cork City residents, showing a fall-off after the age of 45 years (Figure 3.3).

FIGURE 3.3

Person-Based Rate of Parasuicide, Cork City, 1995



Source: Suicide Research Foundation, Cork.

3.4 THE DISTRIBUTION OF PARASUICIDE ACROSS CORK CITY

Some areas of the city have much higher parasuicide rates than others. Many factors may contribute to these differences. However, areas with high parasuicide rates are characterised by the following social factors:

- Domestic units mainly rented from local authority
- High density of people per room and per hectare
- Majority have minimum education
- Most are unemployed

3.5 A TEN YEAR FOLLOW-UP STUDY OF SELF-POISONERS

Previously, it was thought that acts of deliberate self-poisoning were usually trivial, mainly affecting young women who, once chastened by the events, disengaged in such futile behaviour in the future. The Cork study shows differently. Acts of deliberate self-poisoning usually betoken gross personal and social distress which, for most, carries an abysmal prognosis or outcome over time.

In 1982, there were 245 self-poisoners seen at casualty departments in Cork City. Of these, 195 were available for follow-up ten years later. In 99 cases the study team interviewed a subject and a relative and had access to available hospital notes. In 57, they were only able to speak to a relative as well as getting the hospital notes and in the remaining 39, they had access to the notes only. There were 111 women and 84 men in the follow-up investigation.

3.5.1 Disadvantages in Childhood

Most of the women had multiple disadvantages in childhood. Over 40% described their childhood as unhappy and almost 50% had significant disadvantages. In almost a half, there was a family history of mental illness and in a third, a family history of alcoholism. Six per cent had suicidal parents and 15% had suicidal siblings. Ten per cent had been sexually abused and 14% had been physically abused with almost 10% spending time in care.

The situation with the boys was not dissimilar. However, 85% of the boys left school at the minimum age whereas only 5% of the girls did so. Similar proportions of the boys had experienced mental illness and alcoholism within the family, but over a quarter had been subjected to physical abuse and 9% were the subject of sexual abuse.

3.5.2 Stresses at time of Overdose

Over 60% of the women had a current mental illness and over 40% had major personality difficulties. Over half also were in marital discord. Alcoholism was a factor in over a quarter and addiction to sedatives in over 14%. One in six was the subject of domestic violence and 6% to 8% were either personally, or through their spouses, in conflict with the law (Figure 3.4).

For the men, alcoholism and personality difficulties, as well as current psychiatric illness, were factors in over half the cases. Almost a third were in poor physical health and just over a third were in conflict with the law. The vast majority were unemployed and half had marital difficulties. A greater proportion of the men, as compared with the women, were addicted to sedatives, particularly benzodiazepines (Figure 3.5).

FIGURE 3.4

Social and Personal Deficit at Time of Overdose, 111 Females

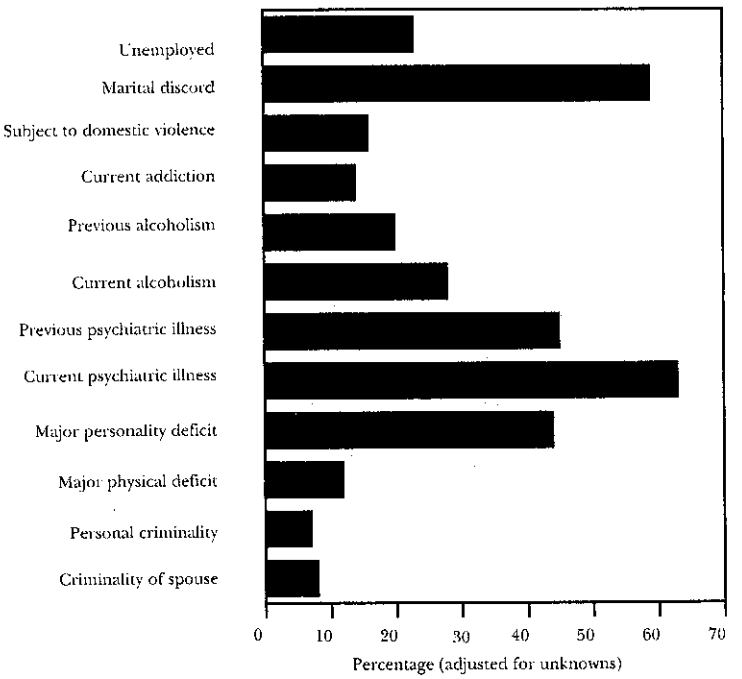
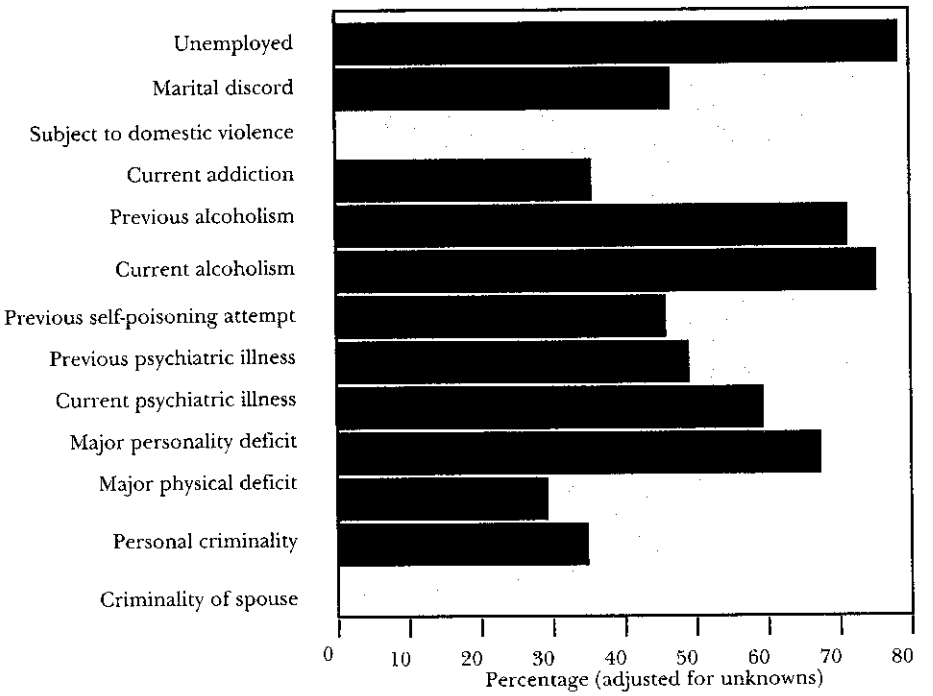


FIGURE 3.5

Social and Personal Deficit at Time of Overdose, 84 Males



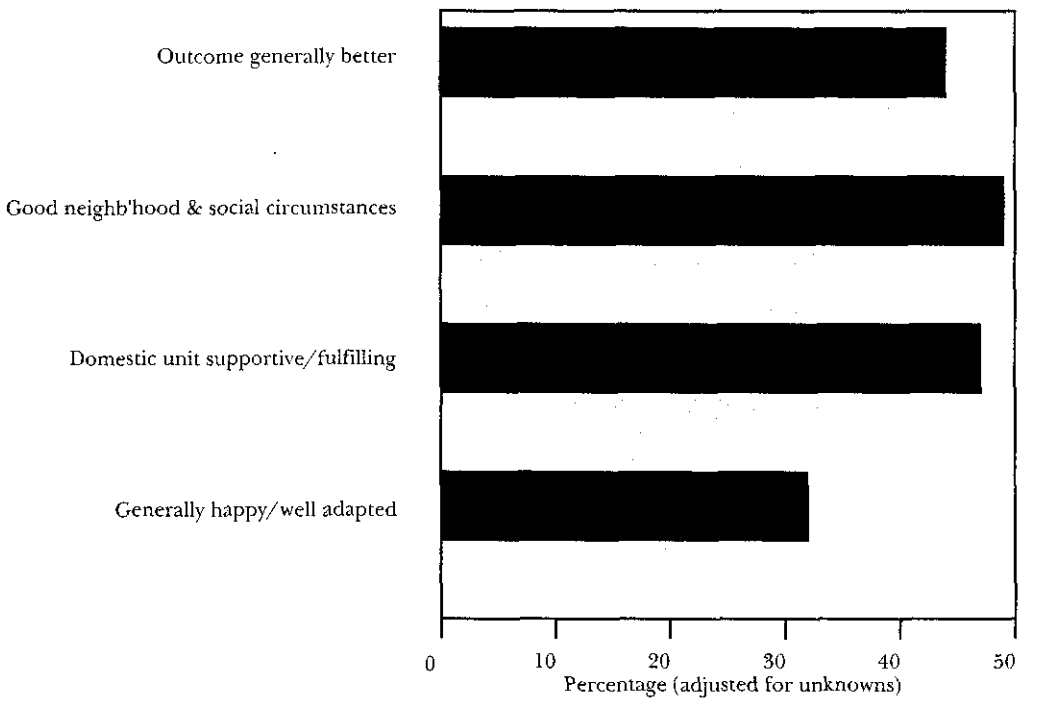
Source: Suicide Research Foundation, Cork.

3.5.3 Favourable Aspects of Outcome

In spite of the above difficulties, many of the subjects were pleased with the outcome of their situation over the intervening ten years. Over 60% of the women and about 44% of the men said that things were generally better. Similar proportions were happy with the general neighbourhood and their social circumstances, and roughly over half found their current domestic situation supportive. In psychological and some social terms, however, the outcome for both sexes was poor (Figure 3.6 and Figure 3.7).

FIGURE 3.6

Positive Development over 10 Year Follow-Up, 84 Males



Source: Suicide Research Foundation, Cork.

FIGURE 3.7

Positive Development over 10 Year Follow-Up, 111 Females

Source: Suicide Research Foundation, Cork.

3.5.4 Unfavourable Aspects of Outcome

Over 40% of the women had engaged in subsequent acts of deliberate self-poisoning and a further 12% had engaged in other acts of self-harm with 6% dead at time of follow-up. Approximately one third of the women were treated for either psychiatric illness, alcoholism, or both, and over 70% were unemployed. It was estimated that a third were in danger of exhibiting further parasuicidal behaviour (Figure 3.8).

For the men, if anything, the situation was worse. Almost two thirds had repeated the act of deliberate self-poisoning and almost a third had deliberately injured themselves in other ways. About 13% were dead. Over 60% had been treated for alcoholism and over 40% for addiction to sedatives. Two thirds were unemployed and half were estimated to be at risk of repetition of parasuicide (Figure 3.9).

A substantial proportion of the men and women who died during the ten year follow-up period, did so by suicide. It is estimated generally, that 10% to 15% of those who engage in acts of parasuicide, die by suicide in the succeeding ten to fifteen years – on average about 1% per annum.

FIGURE 3.8

Negative Aspects of Outcome, 111 Females

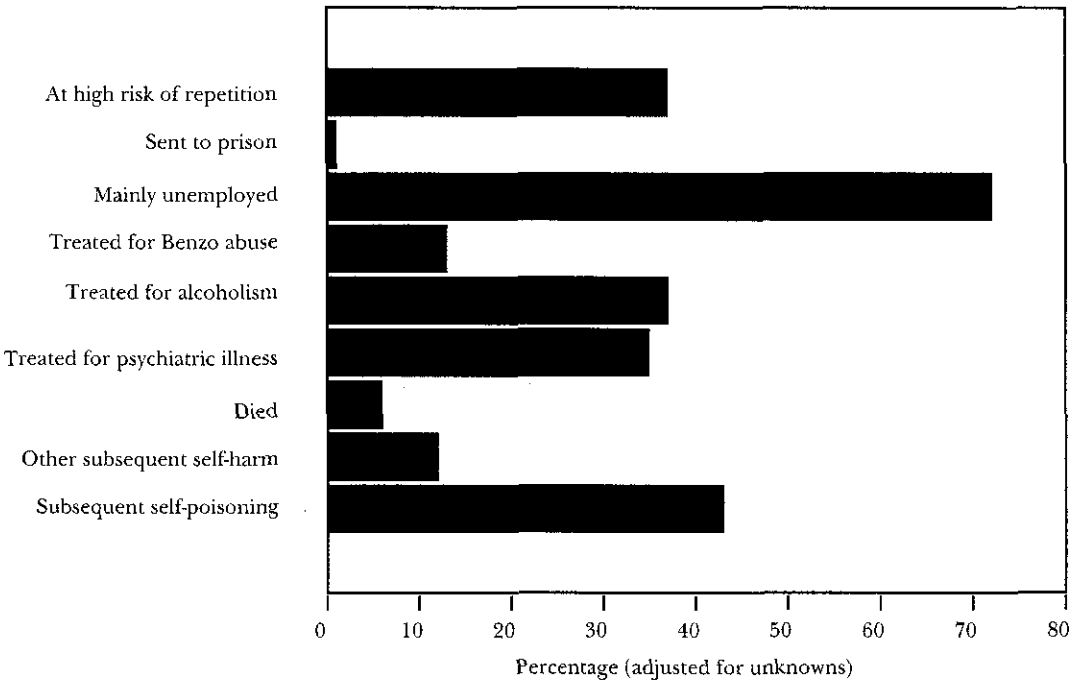
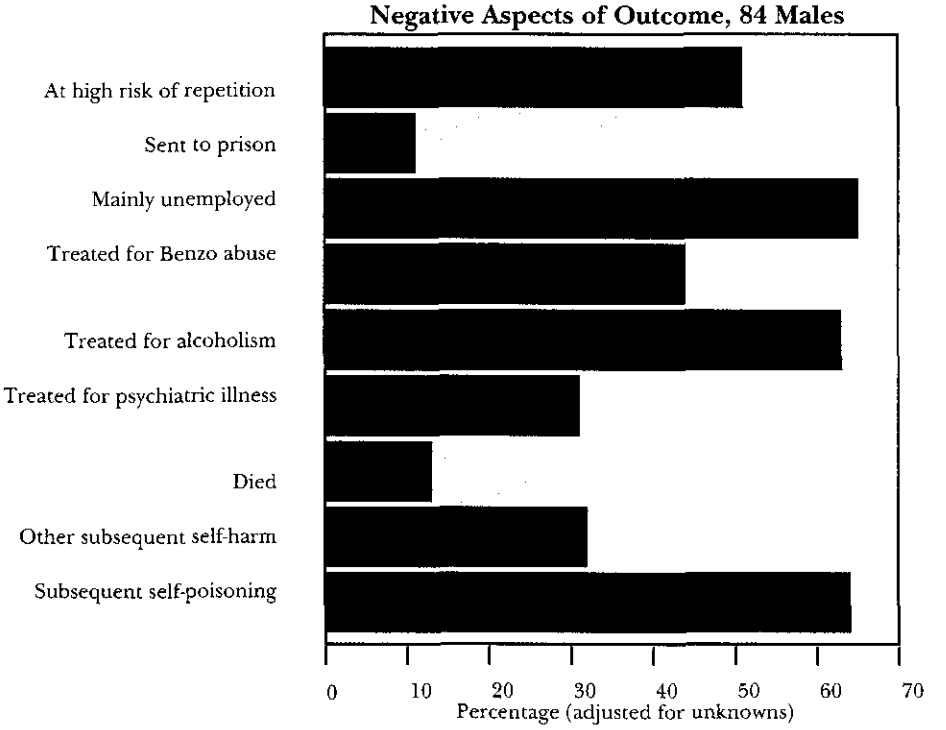


FIGURE 3.9

Negative Aspects of Outcome, 84 Males



Source: Suicide Research Foundation, Cork.

3.6 PARASUICIDE AND THE GENERAL PRACTITIONER

During 1995, with the full co-operation of the Cork City Faculty of General Practitioners, every listed family doctor within the City, its suburbs and satellite towns, was contacted to estimate the number of acts of parasuicide that the practice had to deal with in the previous twelve months. The Faculty and the individual doctors were most co-operative. The results are currently being analysed, but initial results indicate that up to 10% of parasuicidal behaviour may not be referred to casualty. It is either retained within the general practice itself, or referred directly to psychiatric in-patients, psychiatric out-patients or psychological services. There is a further, much smaller proportion of parasuicidal behaviour that never comes to medical attention.

3.7 THE COST OF PARASUICIDE

No country in Europe knows the true cost of parasuicide to its services. Cork has been asked by the World Health Organisation to clarify what the real costs are, and towards this end, a special cost questionnaire has been constructed and is at present being used and piloted. If, however, it is assumed that each casualty-referred act of parasuicide, on average, costs the services £300 – based on the concept of bed occupancy, nursing time, casualty officer time, laboratory investigation costs and psychiatric consultation costs – then the amount of money being spent is sizeable.

In 1995, 256 Cork City residents (population 127,000) were referred to casualty with 337 acts of parasuicide (some repeating within the year). This suggests an estimated cost in excess of £100,000 per annum for the immediate response to the act of parasuicide for Cork City residents. The final and long-term costs would be considerably in excess of this.

The equation is not as simple as this, however. Some individuals need continued treatment, either within the general hospital or within the psychiatric service. Some also cause considerable distress to friends and relatives, and there is also the loss of their economic productivity. As against this, however, it might be argued that many of those who engage in acts of parasuicide are socially disabled people, who would be likely in any case to seek the support of professional services.

Bearing these reservations and qualifications in mind, it is still reasonable to say that parasuicide is a major cost to services within the Southern Health Board and Mid-Western Health Board areas. Once all these data have been analysed, it will be possible to say what the likely cost is to the country as a whole, bearing in mind the differences between rural and urban areas, big towns and small.

As against these 'costs' associated with parasuicide it should be noted that quite often an act of parasuicide is a 'cry for help' and to that extent can be useful in solving problems for some individuals and in having an array of social and medical services directed at those individuals to help them deal with what might otherwise be an intolerable situation.

APPENDIX 1

APPENDIX 1

Form 104

CONFIDENTIAL STATISTICAL RETURN IN RESPECT OF INQUEST

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

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

3. Date on which death occurred

4. Place at which death occurred (full address)

5. Name, surname and home address of deceased

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

9. Occupation of deceased

10. Medical evidence as to cause of death

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

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

13. Was deceased at work at time of accident.

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

Signature of Sergeant in Charge _____

Sub District _____

Date _____