

# **National Study on Suicide**

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## Preface

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The increase in the number of people, particularly males, taking their own lives in Ireland in recent years, is a major cause for concern. In 1998, suicide ranked as the fourth highest cause of years of potential life lost for males in Ireland, superseded only by deaths from circulatory diseases, cancers and respiratory diseases. In order to address this important Public Health problem, the Chief Executive Officers of the Health Boards commissioned a study from the Departments of Public Health, on the epidemiological factors associated with suicide. The findings of this study will inform a national suicide prevention/reduction strategy and will also provide a baseline against which future trends can be measured. In addition, the findings of this study will strengthen those contained in the National Task Force on Suicide, which was published early in 1998. This study was made possible by the contribution and collaboration of a number of people whom I would like to thank.

- The members of the Steering Committee for undertaking this research.
- The Garda Síochána for their cooperation and willingness in helping to identify possible suicides.
- Coroners, who made their records and offices available and in many instances their own time and experience to discuss cases.
- All General Practitioners and Consultant Psychiatrists, who kindly returned questionnaires.
- The Ethics Committees of St. Patrick's Hospital, Dublin and St. John of God's Hospital, Dublin for approving the study.

A special thanks to Dr Declan Bedford, Specialist in Public Health Medicine and Ms Margaret Hegarty, Research Fellow, North Eastern Health Board/Trinity College, Dublin, for their major contributions in collating and analysing the information.



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## Executive Summary

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The Directors of Public Health were commissioned by the Chief Executive Officers of the Health Boards to undertake a national study on suicide. This was in response to the growing concerns about the rising trends in people taking their own lives, particularly young men.

Information was sought on all suicides that occurred nationally in 1997. The study was extended for a further year in seven of the Health Boards in 1998. The study involved a wide range of professionals and was co-ordinated in the North Eastern Health Board.

The findings of this study confirm many of those discussed in *The Report of the National Task Force on Suicide (1998)* and provide additional information on many aspects of suicide in Ireland that can be used in efforts to reduce the number of deaths and give a clear indication of where the resources of the boards should be targeted in order to bring about a reduction in suicide.

The total number of suicides identified in this study was 807, broadly similar to official figures released by the Central Statistics Office (CSO).

The study has confirmed the high rate of suicides in young males, with 40% of the deaths in males in those aged less than 30 years of age. Almost five times more men died from suicide than women. The most common method used by males was hanging, with drowning the commonest for females.

The majority of those who died, lived at home with others. The strong protective effect of marriage, found in other studies, was confirmed in this research, with

single, separated, divorced and widowed persons having higher rates of suicide. Females were more likely than males to be married or widowed.

Unemployment remains an important risk factor for suicide. There was an over-representation of the unemployed in the study, with almost a third of men unemployed, and two thirds of these had been unemployed for more than one year (at the time of this study the national unemployment rates were 10% or less). Medical cardholders were also over represented in this study.

The importance of general practice as an important point of contact for people who commit suicide, was confirmed in this study. There was a high rate of contact with general practitioners (GPs) by patients prior to the suicide act. Females were more likely than males to have been seen by their GP in the four weeks prior to their deaths.

The commonest presenting complaint for both males and females was classified as “complaints relating to psychological symptoms”. This category includes mental health related complaints. A diagnosis of a depressive episode accounted for over a quarter of all the diagnoses.

Almost half of the study group were referred by their GP to a consultant psychiatrist at some time and there was a high attendance rate by those who were referred. Males and females aged less than 30 years were less likely than older males and older females to have attended.

Of those patients referred to consultant psychiatrists, two-thirds were treated as inpatients. The majority of patients attending the mental health services were in



established treatment with only 5.4% still at the stage of assessment. Again, the most common diagnosis was depression. Studies in other countries have shown that patients are at increased risk of suicide in the period after discharge from psychiatric care. In this study almost a third of those who were treated as in-patients, died within three months of discharge from hospital.

Mental health disorders, especially depression, remain the highest risk factor for suicide. A history of deliberate self-harm is also a significant risk factor for suicide. In this study, almost a quarter of the study population had a known history of deliberate self-harm. A quarter of those who died were known to have expressed suicidal intent at some time.

Details of prescribing medication at the time of death are outlined in this study. The majority of both males and females on prescribed medication were taking nervous system drugs and females were more likely than males to be taking prescribed medications. Antidepressants were the most commonly prescribed drugs for males and females.

Recent significant events prior to death were also an important factor. Almost half of the study group had such an event known to their GP or psychiatrist. Relationship problems were the commonest recent significant event, prior to suicide, identified in this study. These difficulties were often compounded by the use of alcohol.

Misuse of alcohol is a significant risk factor for suicide, including its use immediately prior to suicide. Males were more likely than females to have used alcohol immediately prior to their deaths.

In conclusion, this study has provided additional information on many of the factors pertinent to suicide prevention strategies. Suicide is a societal problem and a comprehensive approach involving many agencies is required to reduce the number of deaths. Important areas identified in this study include the need to improve the skills of young people, particularly males, in dealing with emotional and other problems in life. Other important areas are: the high prevalence of depression; the need for easy access to health and social services; the important roles played by GPs and the mental health services and the need to develop seamless care plans, based on agreed shared care protocols. Specific attention should be paid to those who deliberately self-harm and those that declare their intent to commit suicide. The important role that alcohol plays in suicide needs to be recognised and addressed at both local and national level.

## **Recommendations**

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1. The recommendations of the National Suicide Task Force Report should be implemented.
2. Each health board should review the findings of this study when planning and reviewing their services.
3. Access to mental health services should be improved by the development of a community-wide, flexible range of mental health services. Given the high level of mental illness, barriers to referral or access to mental health services should be eliminated.
4. There should be a seamless transfer of care from hospital services and mental health services to primary care for all patients.
5. Support structures for primary care need to be developed.
6. Each local mental health service should develop multidisciplinary guidelines for the recognition, treatment and follow up of patients at risk. These guidelines should aim for the pursuit of quality at all levels of the service and reflect evidenced based health care.
7. Prior suicide intent and deliberate self-harm should be taken as serious risk factors and support services and care plans should be put in place. These services should be accessible and user friendly especially for young people.
8. Written protocols should be developed on a shared care basis for the assessment, treatment and follow-up of patients presenting with deliberate self-harm. These should be used in Accident and Emergency Departments, primary care and in the mental health services.
9. The National Parasuicide Registry should be supported and facilitated in all health board areas and hospitals.

10. People undergoing life crises should get appropriate social support through the availability of counselling and psychological services in health boards and voluntary organisations.
11. Each health board should appoint a coordinator to implement a strategy to improve men's health.
12. Improving access to health services, particularly primary care should be a key target area of all such strategies. Men and especially young men should be encouraged to access health services and other support services.
13. Men should be encouraged to discuss problems more readily and the media should be used to promote this.
14. Training on suicide and related issues should be an integral part of the training of GPs and the continuing education of GPs in this regard should be facilitated and funded.
15. Training in suicidal behaviour recognition and management should be available to: community groups, parent associations, youth groups, health care staff, schools, relevant voluntary agencies and professional groups. This training should be adequately resourced and be made available in a systematic and on-going manner.
16. A new National Alcohol Policy should be developed and implemented as a matter of priority.
17. Health care professionals should be given training on the recognition of alcohol related problems and encouraged to ask clients about their drinking habits where appropriate.
18. Support services for those with alcohol related problems should be developed to ensure a low threshold for referral, flexibility and accessibility.
19. Life- skills education programmes, which would include coping skills in an emotional context, negotiating skills, assertiveness, resilience building and

self-esteem programmes, should be further developed as part of the curriculum in all schools.

20. The trauma of relationship difficulties needs to be addressed in the broader context of developing more effective coping mechanisms and development of self-esteem.

21. Health promotion campaigns should be further developed to encourage people of all ages to develop interests and healthy lifestyles. The use of guns should be reviewed and a new policy developed which should include increasing awareness of gun holders on firearm control, access and safekeeping of arms.

## Introduction

In recent years in Ireland, suicide has become the principal cause of death in men aged 15 to 34 years, surpassing the number of deaths from road traffic accidents. Suicide is also a major problem worldwide<sup>2</sup>. In Europe it is amongst the top 10 leading causes of death<sup>3</sup>, where a similar picture of a high suicide rate among young males is also seen. Figure 1 outlines the increasing rate of male suicides in Ireland from 1970 to 1996. The Irish male rate, relatively low in the early seventies, is now similar to the average rate for males in the European Union (EU)<sup>3</sup>.

**Figure 1. Standardised mortality rates for males for suicide and self inflicted injury for Ireland and European Union (EU) 1970 - 1996**

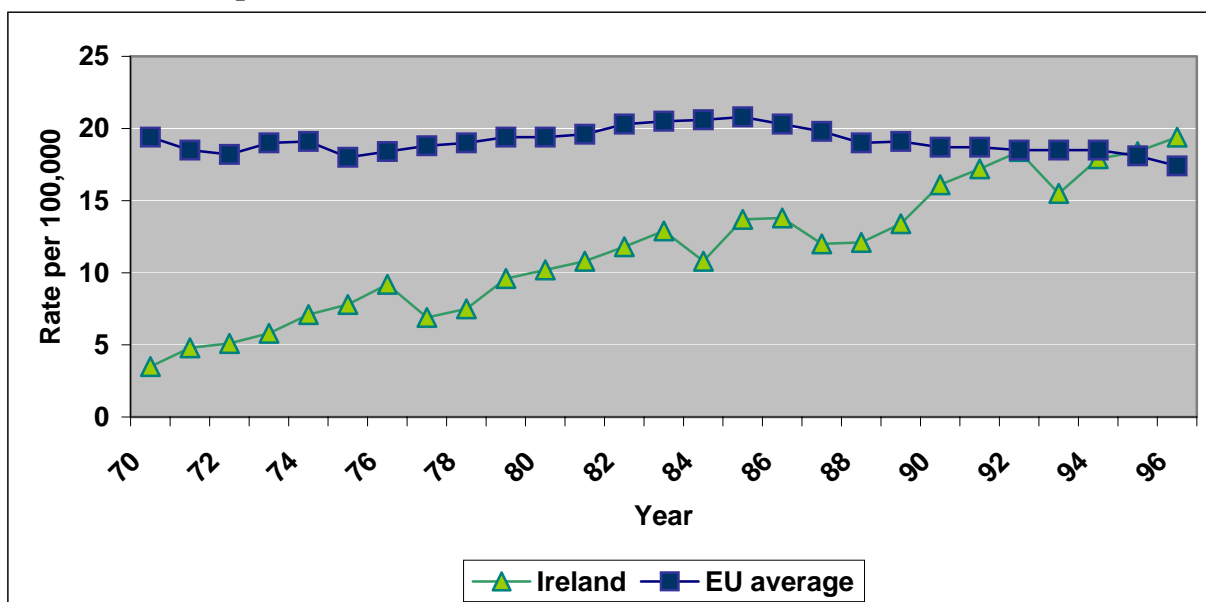
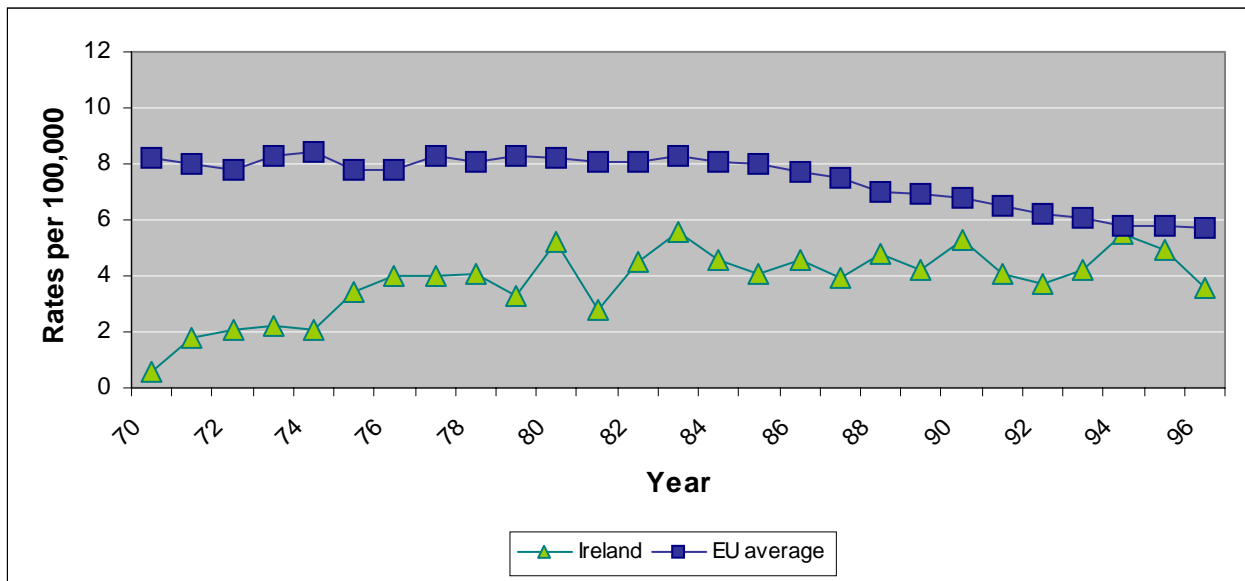


Figure 2 outlines the female rate for suicide in Ireland and the EU for the same time period. The female rates are much lower than the male rates and whilst the female rate in Ireland has risen over the time period, the rise has been less

dramatic and the Irish rate for females is still less than the EU average. The EU average rate has fallen slightly since the mid-eighties.

**Figure 2. Standardised mortality rates for females for suicide and self inflicted injury for Ireland and European Union (EU) 1970 - 1996**



The reasons for the increase in the Irish rates are unclear. There is a need for additional information on factors and circumstances relating to each case of suicide that would facilitate a better understanding of cause and allow for more appropriate prevention programmes to be developed for each region. As a response to this need, and to the increase in suicides nationally, the Chief Executive Officers of the health boards requested the Directors of Public Health to undertake research in this area.

The objectives of the research were:

1. To establish the incidence and associated factors of suicide nationally and on a health board basis, to inform the present knowledge base on suicide.
2. To facilitate the future planning of a suicide prevention programme.

## Methods

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A co-ordinating committee, to oversee the project was established. The study in each health board area was co-ordinated by a Specialist in Public Health Medicine.

Information was sought on all suicides that occurred in all health board areas in 1997 and 1998 except in the Eastern Health Board (EHB) where information on suicides was only sought for 1997. The EHB no longer exists, due to organisational restructuring and has now been replaced by the Eastern Regional Health Authority (ERHA). As the study was carried out when the EHB was in existence, the title EHB shall be used in this report. Possible suicides were identified in the following ways: -

1. In all health board areas, except the EHB area, the local Garda Síochána forwarded copies of the C71 forms to the Department of Public Health in each health board area. C71 forms are filled by the Garda Síochána and sent to the coroners in deaths requiring inquests. Coroners are obliged to hold inquests in cases of death that occurred in a “violent or unnatural manner” or “suddenly from unknown causes”.
2. Coroners were contacted and their records examined, where appropriate, or the coroners’ courts were attended to ascertain any possible suicides.
3. In the EHB region, it was agreed following discussions with a coroner, that copies of the C71 would not be used in that health board region. Instead, all records of coroner’s cases, where suicide was a possibility, were



examined in the coroner's office. As a result of this and due to the length of time taken for some cases to come before the coroner's court, it was decided to gather data in respect of suicides occurring in all Health Boards during 1997 only, and not to gather data on those that occurred in 1998 in the EHB region. Waiting for all 1998 deaths to go before the coroners' courts in the EHB region would have significantly lengthened the duration of the study.

Following identification of a possible suicide, the Health Board's records were checked to ascertain if the deceased had had a medical card or other records to try to identify the name of a GP. If no GP was identified from the record then phone calls were made to local GPs to see if it was possible to identify a GP.

If a GP was not identified, basic data, if available from the coroners' records and the C71 form, were recorded by the study co-ordinator for the area. These data included biographical details, date and method of suicide.

If a GP was identified, a confidential pre-piloted questionnaire was sent by post to the GP. In the majority of cases, the GP was contacted by phone prior to the questionnaire being sent. The GP was asked to return the completed questionnaire to the local co-ordinator without the patient's name on the completed questionnaire. Two reminders were sent to those GPs who had not returned completed questionnaires.

In the event that a completed questionnaire from a GP identified a consultant psychiatrist, whom the deceased had attended, that psychiatrist was also sent a confidential questionnaire and asked to return the completed questionnaire, again,

without the name of the patient on the completed questionnaire. Two reminders were also sent to those psychiatrists who did not return completed questionnaires.

The definition of suicide used in this study was that death was self-inflicted and intended. This was based on the judgement of the Specialist in Public Health Medicine, incorporating such criteria as mode of death, and whether or not the deceased had expressed an intent of suicide.

Where a doubt existed as to whether or not a case was a suicide, the co-ordinating committee discussed the case in an anonymous manner, and a decision on whether to include the case in the study was made, based on the judgement of the committee members. There were 20 cases where the evidence was considered by the committee to be insufficient to state with certainty, that the death was either a probable or definite case of suicide. These 20 possible cases were not included in the study.

A pilot for this study was carried out during 1996 in the North Eastern Health Board region. The total number of suicides identified during that time period was 26.

The Department of Community Health and General Practice in Trinity College, Dublin, carried out statistical analysis under the direction of Dr. Alan Kelly. The data were analysed using JMP, a software statistical package. Statistical analysis included chi-square and logistic regression where appropriate.

Ethical approval for the study was sought and obtained from the Ethics Committees of St. Patrick's Hospital, Dublin and St. John of Gods Hospital, Dublin.

The social class classification used is that used by the CSO<sup>4</sup> in Census 96. However, for the purpose of this study, farmers were given a separate category, as the size of farms was not available.

The Anatomical Therapeutic Chemical Classification (ATC classification)<sup>5</sup> was used to classify medications. The International Classification of Diseases–10 (ICD 10), (Classification of mental and behavioural disorders –clinical descriptions and diagnostic guidelines)<sup>6</sup> was used to classify the diagnoses of patients as given by the consultant psychiatrists. The International Classification for Primary Care (ICPC-2)<sup>7</sup> was used to classify the presenting complaints and diagnoses of patients when attending their GP.

## Results

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### Section 1. Profile of the Deceased

#### *Section 1.1 Numbers and Rates of Suicide*

The number of suicides identified was 807. Table 1 outlines the number of cases identified by health board area. The numbers are for 1997 and 1998 in respect of all health boards other than the EHB where the number refers only to suicides in 1997. Four hundred and sixty-seven of the suicides occurred in 1997(57.9%) and 340(42.1%) in 1998.

**Table 1. The number of suicides identified in each health board region**

	1997	1998	Total
Eastern Health Board	141	NA	141
Midland Health Board	22	32	54
Mid Western Health Board	33	49	82
North Eastern Health Board	42	40	82
North Western Health Board	24	32	56
South Eastern Health Board	56	49	105
Southern Health Board	95	92	187
Western Health Board	54	46	100
Total	467	340	807

#### *Section 1.1.1 Age and sex*

Table 2 outlines the age and gender of those who died.

- Males accounted for 668(82.8%) of the suicides and females 139(17.2%).
- 40.1% of the deaths in males were in those aged less than 30 years of age.
- 26.6% of the deaths in females were in those aged less than 30 years of age.

**Table 2. Age distribution by sex**

Age	Females		Males		Total	
	No	%	No	%	No	%
10-14	1	0.7	4	0.6	5	0.6
15-19	14	10.1	59	8.8	73	9.0
20-24	12	8.6	119	17.8	131	16.2
25-29	10	7.2	87	13.0	97	12.0
30-34	8	5.8	72	10.8	80	9.9
35-39	12	8.6	65	9.7	77	9.5
40-44	10	7.2	59	8.8	69	8.6
45-49	16	11.5	53	7.9	69	8.6
50-54	15	10.8	36	5.4	51	6.3
55-59	8	5.8	36	5.4	44	5.5
60-64	13	9.4	22	3.3	35	4.3
65-69	11	7.9	17	2.5	28	3.5
70-74	4	2.9	14	2.1	18	2.2
75-79	2	1.4	16	2.4	18	2.2
80-84	2	1.4	3	0.4	5	0.6
85+	1	0.7	1	0.1	2	0.2
Not stated	0	0.0	5	0.7	5	0.6
Total	139	100.0	668	100.0	807	100.0

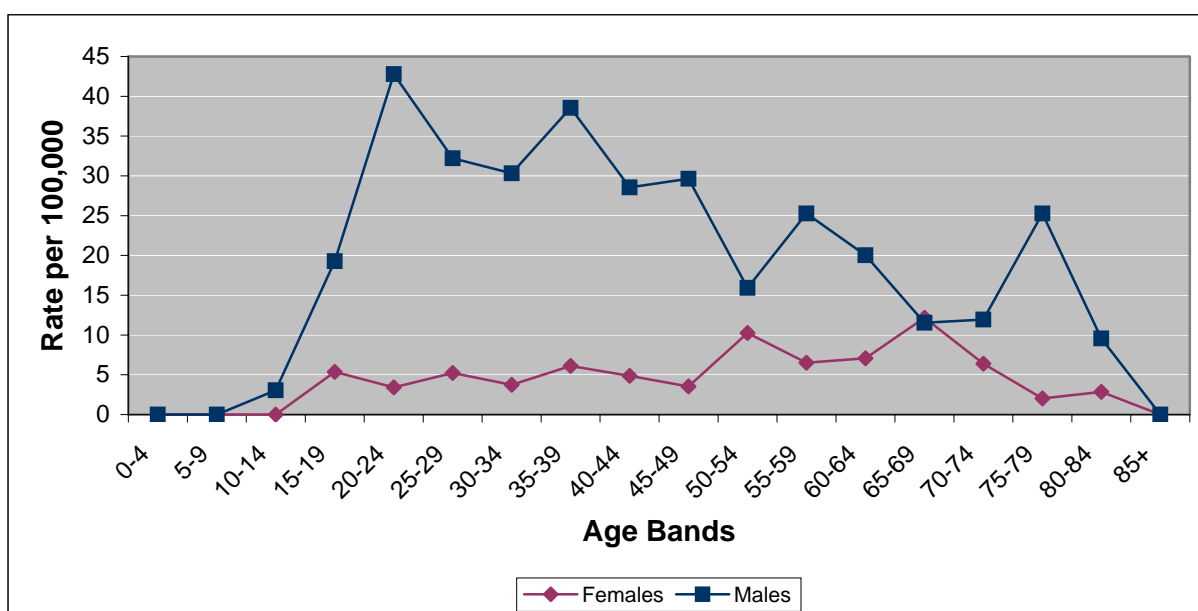
Women were significantly older than the males when they committed suicide ( $p < 0.0001$ ). The mean (average) age of females who committed suicide was 44.1 years (Standard deviation (SD) = 17.8). The mean age of males was 37.4 years (SD = 16.2).

### ***Section 1.2 Standardised Mortality Ratios and Mortality Rates***

Standardised mortality ratios (SMRs) and standardised mortality rates are methods of standardising mortality data so that comparisons can be made. A SMR is the ratio of observed to expected deaths multiplied by 100. SMRs in this study are available for 1997 only, as data were not collected for the EHB region in 1998. Standardised mortality rates are outlined for 1997 and 1998.

Figure 3 outlines the standardised mortality rate per 100,000 for suicide in 5-year age groups for both males and females in Ireland for 1997. As can be seen from the figure, the male rates are higher than the female rates, with the highest rates in young males.

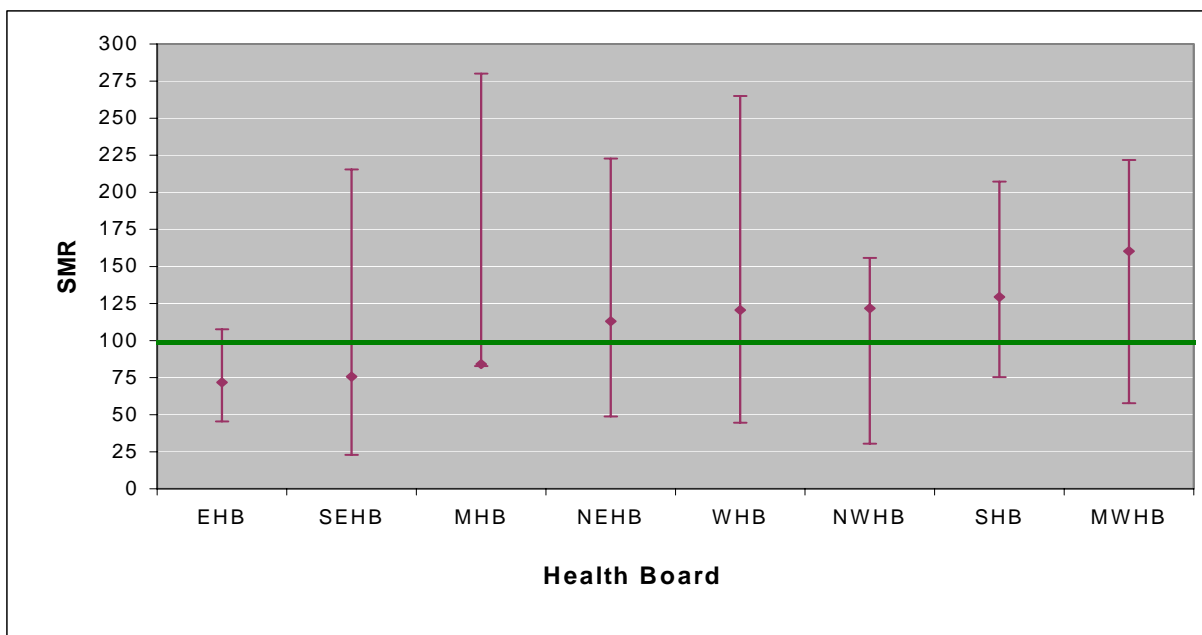
**Figure 3. Standardised mortality rates per 100,000 population for suicide in 1997**



### *Section 1.2.1 Female Rates and Ratios per Health Board*

Figure 4 displays SMRs with confidence intervals for females in 1997. While the SMRs were different for each health board region, the differences were not statistically significant.

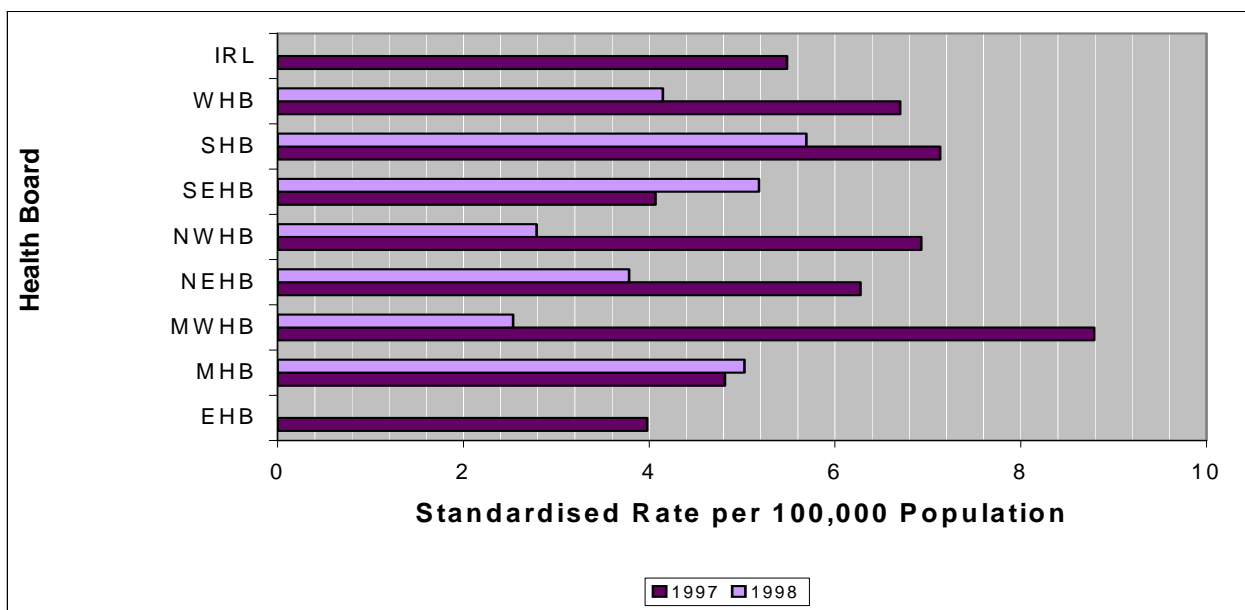
**Figure 4. SMRs for female suicides in 1997**



\* Green line at 100 is Ireland

Figure 5 outlines the standardised mortality rates for female suicides for 1997 and 1998 by health board region. There is no statistically significant difference between the rates. The rates seem to differ considerably in some health board areas from 1997 to 1998. However, this is a result of the relatively small numbers (from a statistical point of view), where variations from year to year are expected.

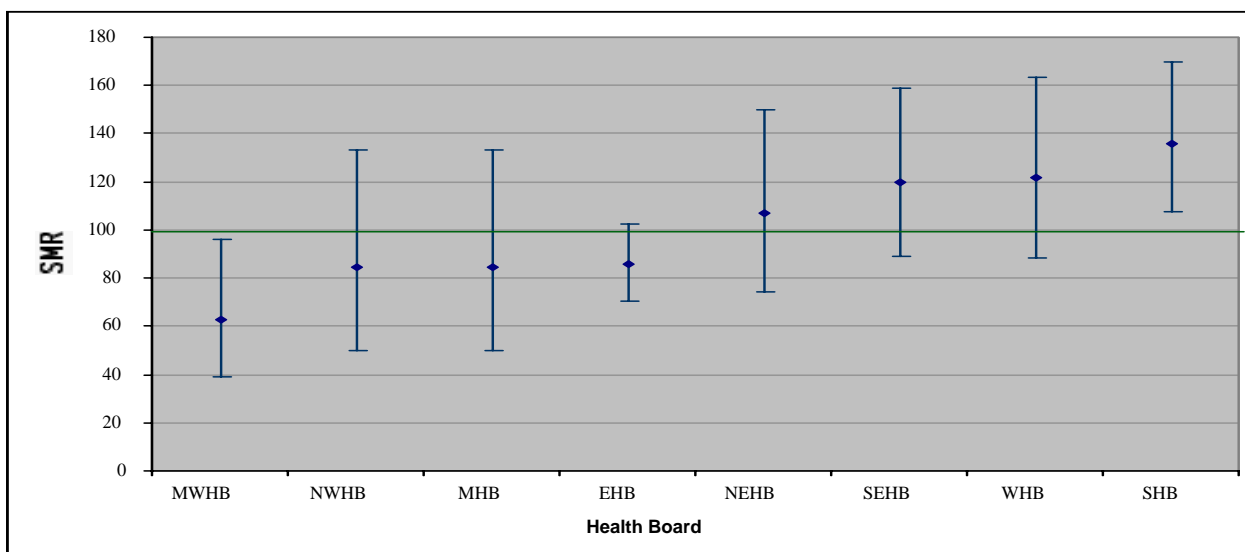
**Figure 5. Female standardised mortality rates for suicide per 100,000 for 1997 and 1998(Ireland and EHB for 1997 only)**



### *Section 1.2.2 Male Rates and Ratios per Health Board*

Figure 6 displays the male SMRs for suicide for 1997. The Southern Health Board (SHB) region had a significantly raised SMR in 1997, whilst the SMR in the Mid-Western Health Board (MWHB) region was significantly lower.

**Figure 6. SMRs for male suicides for 1997**

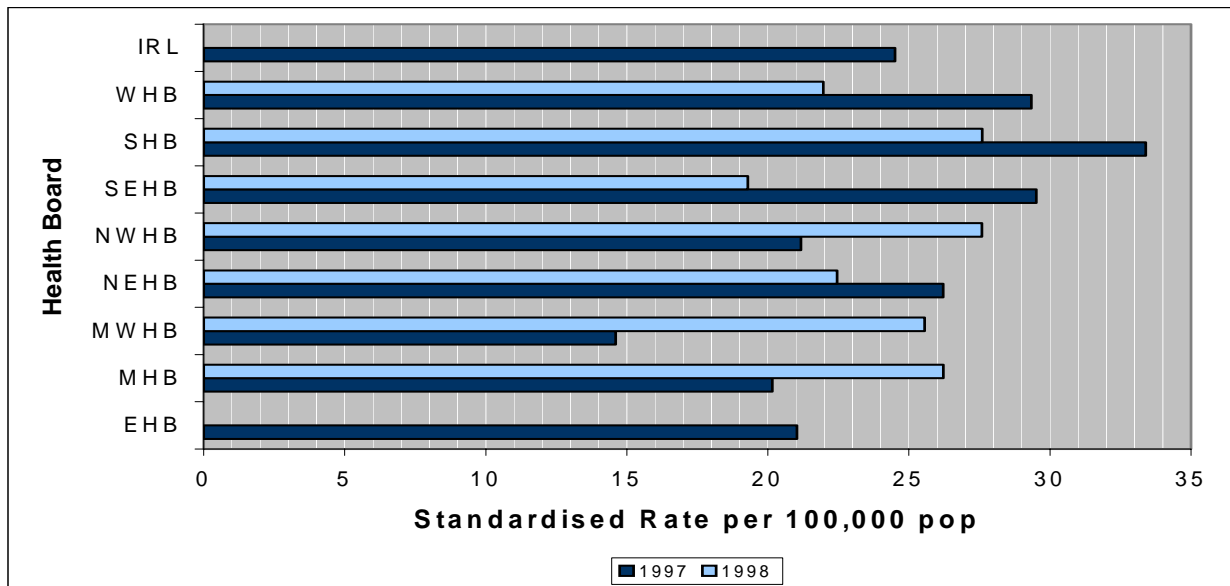


\* Green line at 100 is Ireland



Figure 7 outlines the standardised mortality rates for male suicides for 1997 and 1998 by health board region. There is no statistically significant difference between the rates.

**Figure 7. Male standardised mortality rates for suicide per 100,000 Population for 1997 and 1998 (Ireland and EHB for 1997 only)**



### *Section 1.2.3 Male and Female Standardised Mortality Rates per County*

Table 3 outlines the number of suicides identified for both males and females by county of residence, with rates per 100,000 for 1997 and 1998.

**Table 3. The number of suicides identified for both males and females by county of residence with standardised mortality rates per 100,000 for 1997 and 1998**

County	Females				Males			
	1997		1998		1997		1998	
	No	Rate	No	Rate	No	Rate	No	Rate
Dublin	19	4.0	NA	NA	92	20.1	NA	NA
Wicklow	1	2.1	NA	NA	10	23.0	NA	NA
Kildare	3	6.9	NA	NA	16	29.5	NA	NA
Carlow	0	0.0	0	0.0	10	56.3	2	9.2
Wexford	3	6.7	3	5.7	9	20.2	10	18.5
Kilkenny	0	0.0	2	5.2	5	15.3	9	23.8
Tipperary	1	1.8	3	4.8	14	25.1	19	27.8
Waterford	3	6.9	2	4.3	15	37.9	9	18.4
Cork	18	9.8	9	4.1	60	34.9	60	27.6
Kerry	1	1.8	6	9.2	16	30.5	16	26.2
Limerick	5	7.2	4	4.4	10	14.0	27	31.1
Clare	7	17.6	0	0.0	7	17.4	9	19.0
Galway	7	8.2	5	4.6	23	28.6	23	23.6
Roscommon	0	0.0	0	0.0	9	45.9	7	28.9
Mayo	3	7.2	2	3.6	12	24.9	9	16.2
Longford	0	0.0	0	0.0	5	39.2	2	12.8
Westmeath	0	0.0	3	9.2	5	18.5	10	31.2
Offaly	3	12.3	1	3.3	3	11.3	5	16.8
Laois	1	5.0	1	3.7	4	17.3	7	25.0
Leitrim	1	14.5	1	8.1	4	37.1	4	26.6
Sligo	1	3.9	1	3.4	2	7.9	10	35.8
Donegal	4	7.8	1	1.5	11	21.3	15	23.1
Cavan	0	0.0	0	0.0	8	37.9	5	19.2
Monaghan	1	4.3	1	4.0	6	26.3	7	26.7
Louth	5	12.4	3	6.2	8	20.8	15	32.6
Meath	2	4.4	2	4.1	11	23.9	8	14.9
Other/unknown	0	0	0	0	3	0	2	0
Ireland	89	5.6	50	NA	378	24.4	290	NA

\* NA = Not applicable.

### ***Section 1.3 Medical Cards***

- A total of 338(41.9%) of the deceased had medical cards.
- Females (49.6%) were more likely to have medical cards than males (40.1%).

### ***Section 1.4 Marital Status***

Table 4 outlines the marital status of the deceased.

- Females were more likely than males to be married or widowed ( $p<0.01$ ).

**Table 4. Marital status of the deceased**

Status	Females		Males		Total	
	No	%	No	%	No	%
Single	56	40.3	384	57.5	440	54.5
Married	43	30.9	142	21.3	185	22.9
Separated	12	8.6	56	8.4	68	8.4
Co-habiting	7	5.0	27	4.0	34	4.2
Widowed	14	10.1	19	2.8	33	4.1
Divorced	3	2.2	8	1.2	11	1.4
Not known	4	2.9	32	4.8	36	4.5
	139	100.0	668	100.0	807	100.0

Table 5 outlines the sexual orientation of the deceased, based on information from their GPs and consultant psychiatrists. As seen from the table the sexual orientation for over a third was unknown. Where sexual orientation was recorded, 97% were stated to be heterosexual.

**Table 5. Sexual orientation**

Orientation	Females		Males		Total	
	No	%	No	%	No	%
Hetero-sexual	101	72.7	385	57.6	486	60.2
Bisexual	1	0.7	9	1.3	10	1.2
Homosexual	0	0.0	6	0.9	6	0.7
Not known	37	26.6	268	40.1	305	37.8
Total	139	100.0	668	100.0	807	100.0

Table 6 outlines the religion of the deceased. If the “not knowns” are excluded from the table, 96.4% were Catholic.

**Table 6. Religion**

Religion	Females		Males		Total	
	No	%	No	%	No	%
Catholic	116	83.5	559	83.7	675	83.6
Church of Ireland	1	0.7	15	2.2	16	2.0
Other	2	1.4	8	1.2	10	1.2
Not known	20	14.4	86	12.9	106	13.1
	139	100.0	668	100.0	807	100.0

### ***Section 1.5 Employment Status***

Table 7 outlines the employment status of the deceased.

- Over a quarter were unemployed.
- Those aged 20 to 24 years were significantly more likely to be employed than those of other ages and males were significantly more likely than females to be described as employed ( $p<0.01$ )

**Table 7. Employment status**

Status	Females		Males		Total	
	No	%	No	%	No	%
Employed	25	18.0	212	31.7	237	29.4
Unemployed	25	18.0	202	30.2	227	28.1
Self-employed	8	5.8	92	13.8	100	12.4
Retired	16	11.5	56	8.4	72	8.9
Student	16	11.5	46	6.9	62	7.7
Housewife/husband	39	28.1	0	0.0	39	4.8
Not known	10	7.2	60	9.0	70	8.7
total	139	100.0	668	100.0	807	100.0

- 16 (25.8%) of those classified as students had not completed second level education.

***Duration of Unemployment:*** Table 8 outlines the duration of unemployment for those out of work. The duration of unemployment was unknown in 25.1% of cases.

- Over half were out of work for over 1 year.

**Table 8. Duration of unemployment for those unemployed**

Duration	Females		Males		Total	
	No	%	No	%	No	%
Less than 1 month	0	0.0	6	3.0	6	2.6
1 month to 5.9 months	1	4.0	15	7.4	16	7.0
6 months to 11.9 months	5	20.0	9	4.5	14	6.2
Over 1 year	9	36.0	125	61.9	134	59.0
Not known	10	40.0	47	23.3	57	25.1
Total	25	100.0	202	100.0	227	100.0

As outlined in the methods section, the social class classification used is that used in Census 96 with the exception, that farmers, for the purposes of this study, are classified separately as in table 9. As the occupation was unknown in

a large number of persons (43.6%), social class 7 has the largest number in it. This is particularly noticeable in respect of females.

**Table 9. Social class**

Social Class	Females		Males		Total	
	No	%	No	%	No	%
1. Professional workers	0	0.0	14	2.1	14	1.7
2. Managerial and technical	22	15.8	31	4.6	53	6.6
3. Non-manual	9	6.5	32	4.8	41	5.1
4. Skilled manual	7	5.0	97	14.5	104	13.0
5. Semi-skilled	10	7.2	49	7.3	59	7.3
6. Unskilled	1	0.7	110	16.5	111	13.6
7. Unknown	86	61.9	266	39.8	352	43.6
8. Farmers	4	2.9	69	10.3	73	9.0
Total	139	100.0	668	100.0	807	100.0

Table 10 outlines the highest level of education completed according to information from GPs and consultant psychiatrists. The level was unknown in 44.5% of cases.

**Table 10. Highest level of education completed**

Education	Females		Males		Total	
	No	%	No	%	No	%
Primary	18	12.9	119	17.8	137	17.0
Secondary	46	33.1	207	31.0	253	31.4
Third level	13	9.4	45	6.7	58	7.2
Not known	62	44.6	297	44.5	359	44.5
Total	139	100.0	668	100.0	807	100.0

### ***Section 1.6 Accommodation Prior to Suicide***

Table 11 outlines the living arrangements of the deceased.

- Two-thirds lived at home with others
- Less than half a percent were described as “homeless”.

**Table 11. Accommodation prior to suicide**

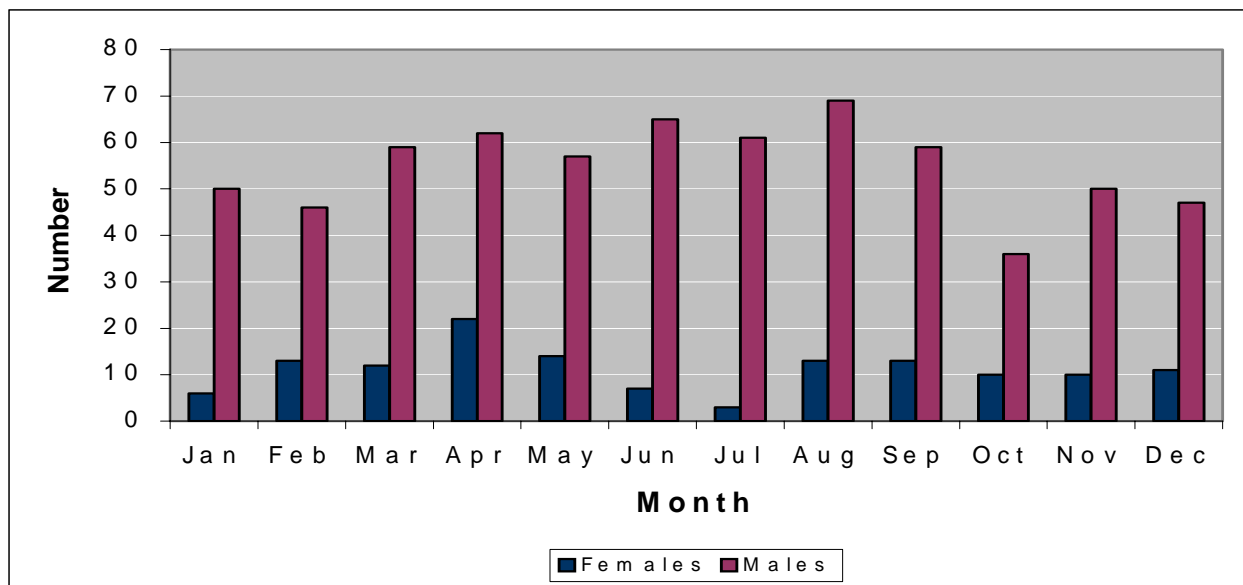
Accommodation	Females		Males		Total	
	No	%	No	%	No	%
Home with others	85	61.2	447	66.9	532	65.9
Home alone	23	16.5	89	13.3	112	13.9
Lodgings	12	8.6	30	4.5	42	5.2
Hostel	2	1.4	10	1.5	12	1.5
Prison	0	0.0	5	0.7	5	0.6
Homeless	0	0.0	3	0.4	3	0.4
Not known	17	12.2	84	12.6	101	12.5
Total	139	100.0	668	100.0	807	100.0

## Section 2. Details of Suicide

### *Section 2.1 Month of Suicide*

Figure 8 outlines the month of occurrence of the suicides. The months of April and May were the commonest for females and August and June for males.

**Figure 8. Month of occurrence of suicides for males and females**

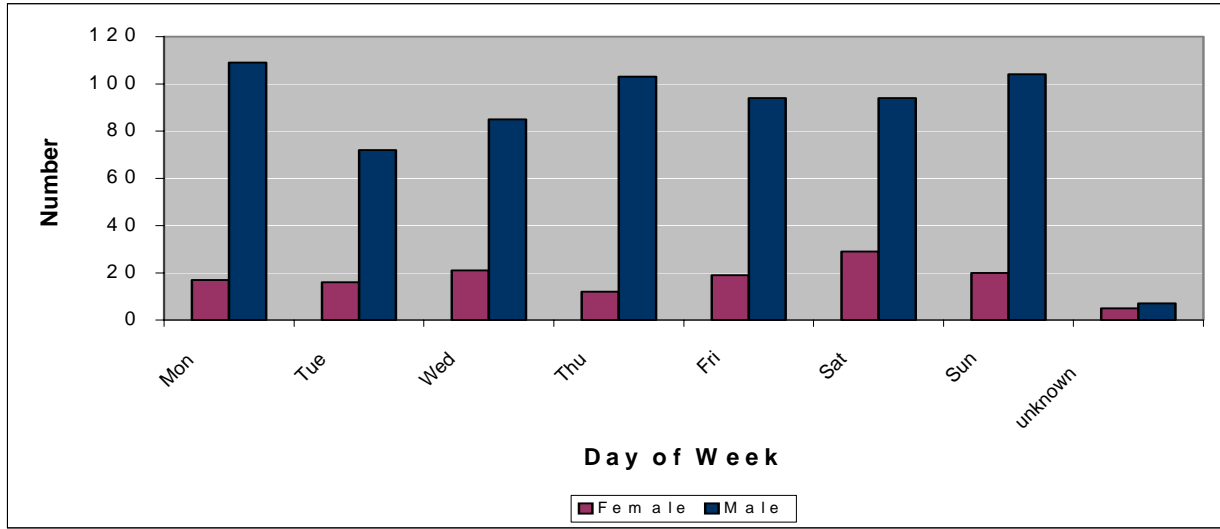


### *Section 2.2 Day of suicide*

Figure 9 outlines the day of occurrence of the suicides. Monday was the commonest day of occurrence followed by Sunday and Saturday.



**Figure 9. The Day of Occurrence**



### *Section 2.3 Method of suicide*

Table 12 outlines how males and females died. Hanging is the most common method used by males with drowning the commonest for females.

- Males are significantly more likely than females to use either hanging or shooting as a method of suicide ( $p < 0.001$ ).
- Females are significantly more likely than males to use either drowning or overdose/poisoning ( $p < 0.001$ ).

**Table 12. Method of suicide**

Method	Females		Males		Total	
	No	%	No	%	No	%
Hanging	33	23.7	318	47.6	351	43.5
Drowning	45	32.4	132	19.8	177	21.9
Shooting	8	5.8	75	11.2	83	10.3
Overdose	26	18.7	34	5.1	60	7.4
Car Exhaust	2	1.4	45	6.7	47	5.8
Poisoning	15	10.8	22	3.3	37	4.6
Jumped from Height	3	2.2	15	2.2	18	2.2
Jumped under Train	3	2.2	8	1.2	11	1.4
Laceration	1	0.7	5	0.7	6	0.7
Suffocation	1	0.7	4	0.6	5	0.6
Other	1	0.7	9	1.3	10	1.2
Not stated	1	0.7	1	0.1	2	0.2
Total	139	100.0	668	100.0	807	100.0

### *Section 2.4 County in Which Death Occurred*

The vast majority of suicides, 764(94.7%), occurred in the county in which the person resided. Forty males (6.0%) died in a county in which they did not reside compared to 3 females (2.2%). The difference was not statistically significant.

## Section 3. Attendance Patterns with General Practice

### Section 3.1 Introduction

Questionnaires were returned by GPs and available for analysis in respect of 562(69.6%) patients. Of these, 105(18.7%) were in respect of females and 457(81.3%) in respect of males. One hundred and forty one questionnaires were returned for those aged less than 25(25.1%), 365(64.9%) for those aged 25 to 64, 54(9.6%) for those aged 65 and over. Age was not stated in 2(0.4%) cases.

### Section 3.2 Final Visit to GP

Table 13 outlines when the deceased last attended their GP. Fifteen percent of those who had attended were seen by their GP in the week prior to their death with a third (32.8%) attending in the four weeks prior to their deaths.

- Females were more likely than males to have been seen by their GP in the four weeks prior to their deaths ( $p < 0.002$ ).
- Males were more likely than females to have had their last attendance with their GP over 1 year prior to their death ( $p < 0.006$ ).

**Table 13. When patients were last seen by GP prior to death**

Length	Females		Males		Total	
	No	%	No	%	No	%
Less than 24 hours	3	2.9	16	3.5	19	3.4
1 to 6.9 days	20	19.1	45	9.9	65	11.6
1 to 3.9 weeks	27	25.7	73	15.9	100	17.8
1 to 2.9 months	22	20.9	85	18.6	107	19.0
3 to 5.9 months	9	8.6	46	10.1	55	9.8
6 to 11.9 months	6	5.7	41	9.0	47	8.4
Over a year	12	11.4	109	23.9	121	21.5
Not known	6	5.7	42	9.2	48	8.5
Total	105	100.0	457	100.0	562	100.0

### *Section 3.3 Age and Attendance Pattern*

For the total study population (807), in the week prior to death 5.5% of those aged less than 35 years were seen by their GP as were 14.5% of those aged 35-64 and 20.0% of those aged 65 and over.

Of the total study population, in the month prior to death 14.1% of those aged less than 35 years were seen by their GP as were 28.8% of those aged 35-64 and 47.7% of those aged 65 and over.

Males under 35 were less likely than males aged 35 and over to be seen in the week prior to their death ( $p < 0.0001$ ) and also less likely to be seen in the month prior to death ( $p < 0.0001$ ).

Table 14 outlines the presenting complaints made by the deceased at their last visit to their GP. Complaints were classified using the International Classification of Primary Care (ICPC-2). This was amended for the purposes of this study to include a category “miscellaneous”. This included visits to the GP for a variety of reasons not readily classified by ICPC-2.

The commonest presenting complaint for both males and females were classified as “complaints relating to psychological symptoms”. This category includes mental health related complaints and substance abuse.

**Table 14. Presenting complaints at last visit to GP, as classified by ICPC-2**

Complaint	Females		Males		Total	
	no	%	no	%	no	%
Related to Psychological symptoms (P)	55	52.4	143	31.3	198	35.2
Related to Respiratory system (R)	6	5.7	62	13.6	68	12.1
Related to “Miscellaneous” issues	11	10.5	50	10.9	61	10.9
General and Unspecified (A)	3	2.9	43	9.4	46	8.2
Related to Musculo-Skeletal system (L)	1	1.0	25	5.5	26	4.6
Related to Digestive system (D)	4	3.8	20	4.4	24	4.3
Related to Skin (S)	2	1.9	20	4.4	22	3.9
Related to Urinary system (U)	5	4.8	10	2.2	15	2.7
Related to Neurological symptoms (N)	2	1.9	10	2.2	12	2.1
Related to Circulation (K)	2	1.9	9	2.0	11	2.0
Related to Eyes (F)	1	1.0	2	0.4	3	0.5
Related to Ears (H)	0	0.0	3	0.7	3	0.5
Related to Pregnancy, Child bearing, Family Planning (W)	2	1.9	0	0.0	2	0.4
Other	2	1.9	12	2.6	14	2.5
Not stated	9	8.6	48	10.5	57	10.1
Total	105	100.0	457	100.0	562	100.0

- Females were more likely than males to attend with complaints relating to psychological symptoms ( $p < 0.009$ ).
- Patients who last attended in the four weeks prior to their death were significantly more likely than those who presented earlier to present with complaints relating to psychological symptoms ( $p < 0.00001$ ).

There were 61 presenting complaints in the category “miscellaneous”. The majority of these, 46(75%), were in relation to patients seeking repeat prescriptions. Table 15 gives a more detailed breakdown of the presenting complaints of those classified as “complaints relating to psychological symptoms”. As can be seen from Table 15, “feeling depressed” accounted for over half of these presenting complaints.

**Table 15. Classification of “complaints relating to psychological symptoms” at last visit to GP, as classified by ICPC-2**

Complaint	Females		Males		Total	
	No	%	No	%	No	%
Feeling Depressed (P03)	32	58.2	71	49.7	103	52.0
Feeling Anxious /Nervous/ Tense (P01)	12	21.8	32	22.4	44	22.2
Acute Stress Reaction (P02)	5	9.1	6	4.2	11	5.6
Sleep Disturbance (P06)	2	3.6	9	6.3	11	5.6
Chronic Alcohol Abuse (P15)	2	3.6	9	6.3	11	5.6
Schizophrenia (P72)	1	1.8	8	6.0	9	4.6
Drug Abuse (P19)	0	0.0	5	3.5	5	2.5
Feeling Irritable/ Angry (P04)	0	0.0	1	0.7	1	0.5
Other (P29)	1	1.8	2	1.4	3	1.5
Total	55	100.0	143	100.0	198	100.0

### ***Section 3.5 Diagnosis at Last Visit to GP***

Table 16 outlines the GPs’ principal diagnoses of the patients’ conditions at their last attendance.

- “Psychological illnesses” were commonest at 60.0% for females and 39.6% for males.
- Females were significantly more likely than males to have been diagnosed with a “psychological illness” ( $p=0.007$ ).
- In the month prior to death, females were over twice as likely as males to have a diagnosis of “psychological illness” ( $p< 0.0001$ ).

**Table 16. Principal diagnosis at last attendance at GP, classified by ICPC-2**

Diagnosis	Females		Males		Total	
	No	%	No	%	No	%
Relating to Psychological illness (P)	63	60.0	181	39.6	244	43.4
Relating to Respiratory system (R)	6	5.7	60	13.1	66	11.7
Relating to Musculo-Skeletal system (L)	1	1.0	28	6.1	29	5.2
Relating to Digestive system (D)	2	1.9	16	3.5	18	3.2
Relating to Circulation (K)	3	2.9	12	2.6	15	2.7
Relating to Skin (S)	1	1.0	14	3.1	15	2.7
General and Unspecified (A)	1	1.0	13	2.8	14	2.5
Relating to Urinary system (U)	3	2.9	4	0.9	7	1.3
Relating to Neurological disease (N)	1	1.0	5	1.1	6	1.1
Relating to Eyes (F)	0	0.0	2	0.4	2	0.4
Relating to Ears (H)	0	0.0	1	0.2	1	0.2
Relating to Pregnancy, Child bearing, Family Planning (W)	1	1.0	0	0.0	1	0.2
Other	7	6.7	39	8.5	46	8.2
Not stated	16	15.2	82	17.9	98	17.4
Total	105	100.0	457	100.0	562	100.0

Table 17 further classifies those with a diagnosis of “psychological” illness. As can be seen from the table, in 71.4 % of females and 56.4% of males the diagnosis was a depressive episode.

- As a proportion of all diagnoses at the last visit to the GP, a diagnosis of a depressive episode accounts for 26.2%.
- Chronic alcohol abuse accounts for 3.2% of all diagnoses.

A total of 254(45.2%) of the patients were due to re-attend their GP.

**Table 17. Classification diagnoses of “psychological” illnesses at last visit to GP, as classified by ICPC-2**

Diagnosis	Females		Males		Total	
	No	%	No	%	No	%
Depressive Episode (P76)	45	71.4	102	56.4	147	60.2
Schizophrenia (P72)	6	9.5	24	13.3	30	12.3
Anxiety Disorder / State (P74)	4	6.4	19	10.5	23	9.4
Chronic Alcohol Abuse (P15)	2	3.2	16	8.8	18	7.4
Drug Abuse (P19)	0	0.0	8	4.4	8	3.3
Acute Stress Reaction (P02)	1	1.6	4	2.2	5	2.0
Affective Psychosis (P73)	2	3.2	2	1.1	4	1.6
Personality Disorder (P80)	0	0.0	3	1.7	3	1.2
Feeling Depressed (P03)	0	0.0	2	1.1	2	0.8
Suicide Attempt (P77)	0	0.0	1	0.6	1	0.4
Anorexia Nervosa / Bulimia (P86)	1	1.6	0	0.0	1	0.4
Other (P99)	2	3.2	0	0.0	2	0.8
Total	63	100.0	181	100.0	244	100.0

### *Section 3.6 Psychiatric Diagnosis by GP*

Table 18 outlines the psychiatric diagnosis, as described by the GP, of the 265 patients referred by the GP to the psychiatric services. Depression was the most common diagnosis.

**Table 18. Psychiatric diagnosis, as described by the GP, of those referred to consultant psychiatrists classified by ICPC-2.**

Diagnosis	Females		Males		Total	
	No	%	No	%	No	%
Depressive Episode (P76)	31	49.2	89	44.1	120	45.3
Schizophrenia (P72)	5	7.9	14	6.9	19	7.2
Psychosis NOS, other (P98)	4	6.4	10	5.0	14	5.3
Chronic Alcohol Abuse (P15)	3	4.8	10	5.0	13	4.9
Drug Abuse (P19)	0	0.0	10	5.0	10	3.8
Adjustment Disorder (P82)	2	3.2	8	4.0	10	3.8
Affective Psychosis (P73)	5	7.9	4	2.0	9	3.4
Anxiety Disorder / State (P74)	1	1.6	6	3.0	7	2.6
Personality Disorder (P80)	1	1.6	6	3.0	7	2.6
Feeling Behaving Irritable/ Angry (P04)	0	0.0	1	0.5	1	0.4
Suicide Attempt (P77)	0	0.0	1	0.5	1	0.4
Not known	11	17.5	43	21.3	54	20.4
Total	63	100.0	202	100.0	265	100.0



### ***Section 3.7 Referral to mental health services by GP***

Two hundred and sixty five patients (47.2% of those for whom questionnaires were returned by GPs)) were referred to a consultant psychiatrist by their GP at some time, 274(48.8%) were not and no information was available on 23(4.1%). Of those referred 240(90.6%) attended.

- Those who last attended their GP over one year prior to their death were less likely to have been referred to the mental health services ( $p<0.001$ ).

#### ***Section 3.7.1 Attendees Following Referral***

Table 19 outlines the age distribution of the 240 patients who attended the psychiatric services following referral by their GP.

- Of those who attended, 155(64.6%) were treated as in-patients
- 57 females attended (41.0% of all the female suicides in this study and 54.3% of all females for whom a GP questionnaire was returned). Females are more likely to have attended than males ( $p<0.02$ ).
- 183 males attended (27.4% of all the male suicides in this study and 40.0% of all males for whom a GP questionnaire was returned).
- Males aged less than 30 years were less likely than older men to have attended ( $p<0.0002$ ).
- Females aged less than 30 were also less likely to have attended than older females ( $p<0.004$ ).

**Table 19. Age and sex of those who attended psychiatric care**

Age Band	Females		Males		Total	
	No	%	No	%	No	%
10-14	0	0	0	0	0	0
15-19	2	3.5	6	3.3	8	3.3
20-24	3	5.3	23	12.6	26	10.8
25-29	3	5.3	22	12.0	25	10.4
30-34	3	5.3	17	9.3	20	8.3
35-39	8	14.0	20	10.9	28	11.7
40-44	5	8.8	25	13.7	30	12.5
45-49	9	15.8	22	12.0	31	12.9
50-54	5	8.8	12	6.6	17	7.1
55-59	2	3.5	14	7.7	16	6.7
60-64	7	12.3	7	3.8	14	5.8
65-69	5	8.8	6	3.3	11	4.6
70-74	3	5.3	4	2.2	7	2.9
75-79	1	1.8	4	2.2	5	2.1
80-84	1	1.8	1	0.6	2	0.8
85+	0	0.0	0	0.0	0	0.0
Total	57	100.0	183	100.0	240	100.0

### ***Section 3.7.2 Discharge from psychiatric care***

Reports from the psychiatrists were received by GPs in respect of their patients in 180(75.0%) cases. Fifty-two (21.7%) patients had been discharged from psychiatric care.

**(a) Problems After Discharge from Psychiatric Care:** Of the 52 discharged from psychiatric care, 21(40.4%) had problems (known to their GP) after discharge. Twenty (95.2%) of these were male and 1(4.8%) female. The problems after discharge were:

- Depression in 9(42.9%) patients,
- Alcohol related problems 2(9.5%),
- Marital/domestic problems 2(9.5%),
- Drug related problems 1(4.8%)
- Other problems 7 (33.33%).

**(b) Suicidal Intent:** In the case of 7(13.5%) patients, GPs were aware that the patients had expressed suicidal intentions after discharge from psychiatric care. Four (57.1%) of these patients died over a year after discharge and the remaining 3(42.9%) died between 1 and 6 months after discharge. Six (85.7%) were male.

### *Section 3.8 GP Description of Patient's Circumstances*

1. GPs described 195(34.7%) of their patients as having a difficulty in relating to others. There was no evidence that this was related to age, sex or marital status, but it was related to being unemployed ( $p<0.001$ ) or having been referred to psychiatric care ( $p<0.001$ ).
2. GPs described 156(27.7%) of their patients as unsettled (job changes, residence changes). There was no evidence that this was related to age or sex, but was related to being separated ( $p<0.008$ ).
3. GPs described 46(8.2%) of their patients as having abused drugs or solvents. There was no evidence that this was related to age or sex, but was related to a history of alcohol abuse ( $p<0.0001$ ).
4. GPs described 36(6.4%) of their patients as being in, or having been in conflict with the law. All but one of these were male, where there was likely to be a history of alcohol abuse ( $p<0.001$ ).

## Section 4. Attendance with Mental Health Services

### Section 4.1 Introduction

Questionnaires were returned by consultant psychiatrists in respect of 148 patients. This represents 65.5% of those who attended following referral by their GP and 18.3% of all patients in the study. Table 20 outlines the age and sex breakdown of those for whom questionnaires were returned.

**Table 20. Age and sex distribution of patients for whom a questionnaire was returned by consultant psychiatrists**

Age	Females		Males		Total	
	No	%	No	%	No	%
10-14	0	0	0	0	0	0
15-19	2	5.6	5	4.5	7	4.7
20-24	2	5.6	12	10.7	14	9.5
25-29	1	2.8	13	11.6	14	9.5
30-34	1	2.8	16	14.3	17	11.5
35-39	5	13.9	15	13.4	20	13.5
40-44	4	11.1	17	15.2	21	14.2
45-49	5	13.9	10	8.9	15	10.1
50-54	3	8.3	6	5.4	9	6.1
55-59	2	5.6	7	6.3	9	6.1
60-64	4	11.1	6	5.4	10	6.8
65-69	1	2.8	1	0.9	2	1.4
70-74	3	8.3	2	1.8	5	3.4
75-79	2	5.6	1	0.9	3	2.0
80-84	1	2.8	1	0.9	2	1.4
85+	0	0	0	0	0	0
Not stated	0	0	0	0	0	0
Total	36	100	112	100	148	100

### Section 4.2 Previous Psychiatric Care

Prior to coming under the care of the consultant psychiatrists who completed the questionnaires, 85 males (75.9% of all males for whom questionnaires were returned by psychiatrists) and 26 females (72.2 % of all females for whom

questionnaires were returned by psychiatrists) had attended the psychiatric services previously.

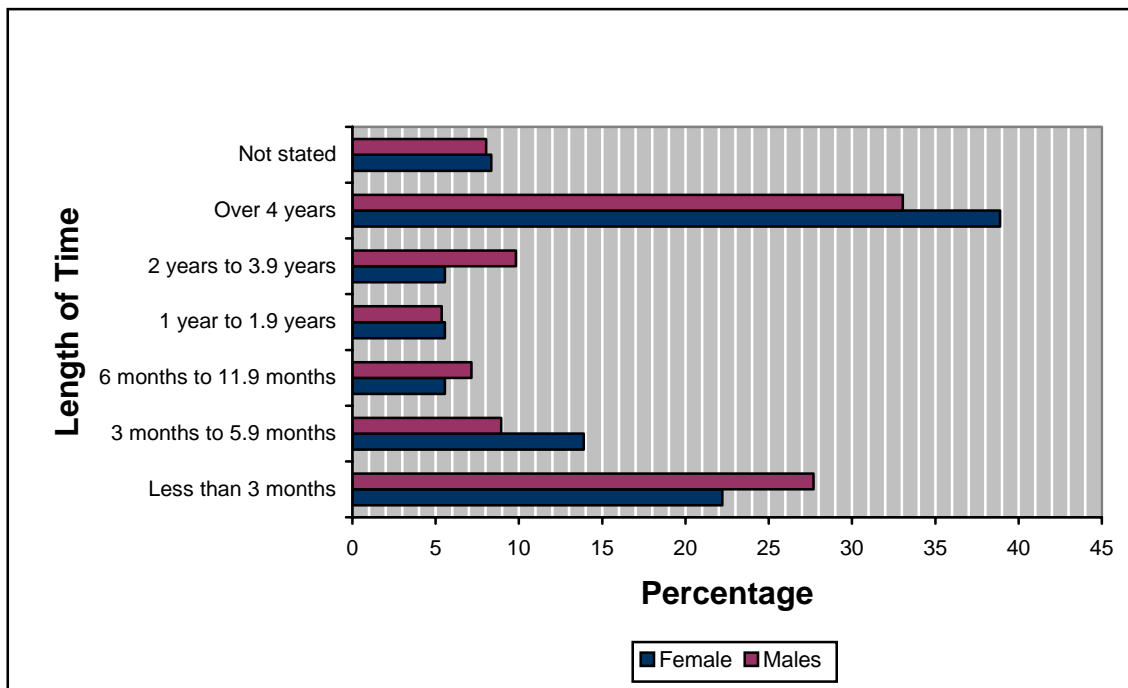
### ***Section 4.3 Pattern of Attendance***

#### ***Section 4.3.1 Duration of attendance***

Figure 10 outlines the length of time patients had been attending.

- 38.9% of females and 33.0% of males had been attending for over 4 years
- 27.7% of males and 22.2% of females had been attending for less than 3 months.

**Figure 10. Length of time attending mental health services**



### *Section 4.3.2 Attendance status at time of death*

Fifty-six males (50.0% of those for whom a questionnaire was returned by a consultant psychiatrist and 8.4% of all males) and 18 females (50.0% of those for whom a questionnaire was returned by a consultant psychiatrist and 12.9% of all females) were still attending at time of death. Sixty- two (41.9%) were not attending at time of death, while this information was not available for 12(8.1%).

**(a) Those Attending At Time Of Death:** Table 21 outlines when the patients were last seen.

- 31(21.0%) were seen in the week prior to death. This represents 3.8% of all the deceased.
- 55(44%) were seen in the month prior to death. This represents 6.8% of all the deceased.

**Table 21. When last seen by psychiatric service prior to death**

Last Seen	Females		Male		Total	
	no	%	no	%	no	%
Less than 24 hrs	3	8.3	7	6.3	10	6.8
1 day to 6.9 days	6	16.7	15	13.4	21	14.2
1 week to 3.9 weeks	9	25.0	25	22.3	34	23.0
1 month to 2.9 months	1	2.8	12	10.7	13	8.9
3 months to 5.9 months	1	2.8	3	2.7	4	2.7
6 months to 11.9 months	0	0	5	4.5	5	3.4
Over 1 year	4	11.1	11	9.8	15	10.1
Not stated	12	33.3	34	30.4	46	31.1
Total	36	100	112	100	148	100

**(b) Those Not Attending At Time Of Death:** Of the 62 known to be not attending at time of death:

- 29(46.8%) did not wish to attend.
- 12(19.4%) were discharged.
- 6(9.7%) had lost contact with the service.
- 4(6.5%) were attending another service in the community or hospital.
- 11(17.8%) were not attending for other reasons.

#### *Section 4.3.3 Those treated as inpatients*

A total of 102(68.9%) had been treated as inpatients.

**(a) Number of admissions:** Table 22 outlines the number of admissions for those patients who had been treated as inpatients. There was no significant difference across age groups in relation to the number of admissions.

- Only a quarter were admitted on one occasion only.
- Females had significantly more admissions than males ( $p=0.01$ ).
- Females had on average 6.1 admissions.
- Males had on average 3.4 admissions.

**Table 22. Number of admissions for inpatient care**

No of admissions	No	%
1	25	24.5
2	17	16.7
3	11	10.8
4	14	13.7
5-9	15	14.7
10-19	6	5.9
Over 20	2	2.0
Not stated	12	11.8
Total	102	100

**(b) Length of time from last inpatient discharge to time of death:** For those treated as inpatients, Table 23 outlines when prior to death, they were last discharged from inpatient care. For 30.4% their last discharge was over a year prior to their deaths, whilst for 15.7% the last discharge was less than a month prior to their deaths. The time from last discharge to death was not related to age or sex.

**Table 23. Length of time from last inpatient discharge to time of death**

	No	%
Less than 24 hrs	1	1.0
1 day to 6.9 days	3	2.9
1 week to 3.9 weeks	12	11.8
1 month to 2.9 months	16	15.7
3 months to 5.9 months	14	13.7
6 months to 11.9 months	10	9.8
Over 1 year	31	30.4
Not stated	15	14.7
Total	102	100



#### *Section 4.4 Stage of Treatment at Time of Death*

Table 24 outlines at which stage the treatment process was at, at the time of death. Only a minority were still at the stage of assessment or in the early stages of treatment. There was no evidence that the stage of treatment was related to age or sex.

**Table 24. Stage of treatment of those attending psychiatric service**

	No	%
Treatment well established	36	24.3
On-going long term treatment and supervision	36	24.3
Treatment recently commenced	11	7.4
Stage of rehabilitation reached	9	6.1
Still at assessment	8	5.4
Other	26	17.6
Not stated	22	14.9
Total	148	100

#### *Section 4.5 Psychiatric Diagnosis*

Table 25 outlines the psychiatric diagnosis according to the consultant psychiatrist.

**Table 25. Psychiatric diagnosis by ICD-10 classification**

ICD-10 code	Females	Males	Total
	No (%)	No(%)	No(%)
Mood {affective} Disorders (F30-F39)	20(55.6)	35(31.3)	55 (37.1)
Schizophrenia, Schizotypal and Delusional Disorders (F20-F29)	7(19.4)	29(25.9)	36 (24.3)
Mental and Behavioural Disorders due to Psychoactive Substance Misuse (F10-F19)	1(2.8)	14(12.5)	15 (10.1)
Neurotic, Stress-related and Somatoform Disorders (F40-F48)	3(8.3)	8(7.1%)	11 (7.4)
Disorders of Adult Personality and Behaviour (F60-F69)	0	6(5.4)	6 (4.1)
Unspecified Mental Disorder (F99)	0	1(0.9)	1 (0.6)
Not stated	5(13.9)	19(17.0)	24 (16.20)
Total	36(100)	112(100)	148 (100)

- Females were more likely to have a diagnosis of mood disorder than males ( $p < 0.01$ ).

Of the 20 females with a diagnosis of a mood disorder (F30-F39):

- 10(50%) had a diagnosis of a depressive episode (F32).
- 6(30%) had a diagnosis of recurrent depressive disorder (F33).
- 4(20%) had diagnosis of a bipolar affective disorder (F31).

Of the 35 males with a diagnosis of a mood disorder (F30-F39):

- 19(54.3%) had a diagnosis of a depressive episode (F32).
- 11(31.4%) had a diagnosis of recurrent depressive disorder (F33).
- 4(11.4%) had diagnosis of a bipolar affective disorder (F31).
- 1(2.9%) had a diagnosis of manic episode (F30).

Of the 29 males with a diagnosis of schizophrenia, schizotypal and delusional disorders (F20-F29);

- The single most common specific diagnosis was paranoid schizophrenia (F20.0), which 15(51.7%) males had.

Of the 14 males with a diagnosis of mental and behavioural disorders due to psychoactive substance misuse (F10-F19):

- 10(71.4%) had a specific diagnosis of mental and behavioural disorder due to the use of alcohol (F10).

#### ***Section 4.6 Source of referral To Psychiatric Services***

- 99 (66.9%) were referred by their GP.
- 17(11.5%) were referred by a hospital.
- 7(4.7%) were referred by family / friend.
- 5(3.4%) were self-referrals
- 6(4.1%) by referred other means
- The source of referral was not stated in respect of 14(9.5%).

Eighty-nine (60.1%) of the patients were admitted as voluntary patients, 11(7.4%) as temporary patients with 2(1.4%) others. The type of admission was not stated in respect of 46(31.1%).

#### ***Section 4.7 Consultant Psychiatrists Description of Patients' Circumstances***

1. Consultant psychiatrists described 61(41.2%) of their patients as having difficulty in relating to others. There was no evidence that this was related to unemployment as was the case with the GPs description but was related to marital status where this description was more likely in those who were single ( $p < 0.03$ ).
2. Consultant psychiatrists described 42(28.4%) of their patients as unsettled (job changes, residence changes). There was no evidence that this was related to age, sex or marital status, as was the case with the GPs' description.
3. Consultant psychiatrists described 7(4.7%) of their patients as having been in, or having conflict with the law. All 7 were male.
4. Consultant psychiatrists described 12(8.1%) of their patients as having a history of abusing drugs or solvents. All, but one, were male.

## Section 5. Prescribed Medications

### *Section 5.1 Numbers on Medications*

Based on the information from the GP and consultant psychiatrist questionnaires:

#### **(a) Total:**

- A total of 286 were on prescribed medications at the time of their deaths.
- This represents 35.4% of all the deceased and 48.6% of all those for whom a questionnaire was returned by a GP or consultant psychiatrist.

#### **(b) Female:**

- A total of 75 females (53.9% of the total female study population and 67.6% of those for whom a questionnaire was returned by a GP or consultant psychiatrist) were on prescribed medications.

Of the 75 females on prescribed medications:

- 21(28.0%) were known to be taking only 1 medication.
- 22(29.3%) were known to be taking 2 medications.
- 26(34.7%) were known to be taking 3 or more medications.
- Medications were not stated for 6(8.0%).

**(c) Male:**

- A total of 211 males (31.6%) of the total male study population and 44.1% of those for whom a questionnaire was returned by a GP or consultant psychiatrist) were on prescribed medications.

Of the 211 males on prescribed medications:

- 108(51.2%)were known to be taking 1 medication only.
- 63(29.9%) were known to be taking 2 medications.
- 40(18.9 %) were taking 3 or more.

***Section 5.2 ATC Classification of Medication***

**(a) All Medications:** Table 26 outlines the medications for both males and females using the ATC classification.

**Table 26. The number of males and females taking medications as classified by ATC classification at the time of their deaths**

Drug Classification	Females		Males	
	No	%	No	%
Nervous	64	81.3	170	80.6
Cardiovascular	0	0.0	11	5.2
Respiratory	0	0.0	7	3.3
Alimentary	4	5.3	3	1.4
Anti infective	0	0.0	2	0.9
Digestive	1	1.3	1	0.5
Musculo-skeletal	0	0.0	1	0.5
Allergen	1	1.3	0	0.0
Sensory organs	0	0.0	0	0.0
Genito-urinary	3	4.0	1	0.5
Not stated	3	6.7	15	7.1
Total	75	100.0	211	100.0

- Females were more likely than males to be taking prescribed medications (p< 0.0001).

- Females aged less than 30 were less likely to be taking prescribed medications than females aged 30 and over ( $p < 0.002$ )
- Males aged less than 30 were less likely to be taking prescribed medications than females aged less than 30 ( $p < 0.03$ )
- Males aged less than 30 were less likely to be taking prescribed medications than males 30 and over ( $p < 0.001$ )
- Females were more likely than males to be taking nervous system medications ( $p > 0.0001$ ).
- At least 80% of both males and females on prescribed medications were taking nervous system drugs.

**(b) Nervous System Drugs:** Table 27 outlines the nervous system drugs by type for males and females respectively.

- Antidepressants were the most commonly prescribed drugs for males and females.
- 18(21.1%) of the females taking nervous system drugs were on one nervous system drug, 32(50.0%) were on two and 14(21.9%) were taking 3 or more.
- 76 (44.7%) of the males taking nervous system drugs were taking one nervous system drug, 67(39.4%) were on two and 27(15.9%) were on 3 or more.

**Table 27. The type of Nervous System Drugs being taken by males and females at the time of their deaths by ATC classification**

Classification	Females		Males	
	No	%	No	%
N06A (Antidepressants)	32	50.0	75	44.1
N05A (Antipsychotics)	11	17.2	42	24.7
N05B (Anxiolytics)	11	17.2	27	15.9
N05C (Hypnotics and Sedatives)	5	7.8	12	7.1
N02 (Analgesics)	2	3.1	6	3.5
N03 (Antiepileptics)	0	0.0	4	2.4
N04(Antiparkinson Drugs)	1	1.6	2	1.2
N02A (Opioids)	0	0.0	1	0.6
N03A (Antiepileptics)	0	0.0	1	0.6
N04A(Anticholinergic Drugs)	1	1.6	0	0
N04B(Dopaminergic Drugs)	1	1.6	0	0
Total	64	100	170	100.0

Based on the questionnaires returned by the GPs, patients who did not attend a consultant psychiatrist were less likely than those who did attend to be on any medication ( $p < 0.0001$ ) and less likely to be on a nervous system medications ( $p < 0.0001$ ).

## Section 6. Reported Patient Behaviour

### *Section 6.1 Deliberate self-harm*

A total of 134 (22.8%) patients were known by their GP or consultant psychiatrist to have inflicted deliberate self-harm in the past. From the 562 GP questionnaires returned, 112(19.9%) reported deliberate self-harm. From the 148 questionnaires returned by the consultant psychiatrists, 55(37.2%) reported deliberate self-harm. Those attending psychiatrists were more likely than those who had not to have deliberate self-harm reported ( $p < 0.0001$ ). Table 28 outlines the age and sex distribution of those who were known to have deliberately self-harmed.

- Of those known to have inflicted deliberate self-harm, 33 were female (22.3% of all females in the study) and 101 were male (15.1% of all males in the study).

**Table 28. The age and sex of those with a history of deliberate self-harm**

Age Band	Females		Males		Total	
	No	%	No	%	No	%
10-14	0	0.0	0	0.0	0	0.0
15-19	3	9.1	3	3.0	6	4.5
20-24	4	12.1	24	23.8	28	20.9
25-29	3	9.1	14	13.9	17	12.7
30-34	3	9.1	13	12.9	16	11.9
35-39	2	6.1	13	12.9	15	11.2
40-44	4	12.1	14	13.9	18	13.4
45-49	5	15.2	7	6.9	12	9.0
50-54	1	3.0	4	4.0	5	3.7
55-59	1	3.0	3	3.0	4	3.0
60-64	4	12.1	2	2.0	6	4.5
65-69	0	0.0	2	2.0	2	1.5
70-74	2	6.1	1	1.0	3	2.2
75-79	1	3.0	0	0.0	1	0.7
80-84	0	0.0	1	1.0	1	0.7
85+	0	0.0	0	0.0	0	0.0
Total	33	100.0	101	100.0	134	100.0



## Section 6.2 Suicidal Intent

A total of 182(30.9%) patients were known by their GP or psychiatrist to have expressed at some time suicidal intention. Table 29 outlines the age and sex distribution of those known to have expressed suicidal intention at some time.

- 145 were male (30.3% of those for whom a GP or consultant psychiatrist returned a questionnaire and 21.7% of all males in the study)
- 37 were female (33.3% of those for whom a GP or consultant psychiatrist returned a questionnaire and 26.6% of all females in the study).

From the 562 GP questionnaires returned, 154(27.4%) patients were known to have expressed suicidal intentions at some time. From the 148 questionnaires returned by the consultant psychiatrists, 28(18.9%) were known to have expressed suicidal intentions at some time.

**Table 29. The age distribution of those who expressed suicidal intent**

Age Bands	Females		Males		Total	
	No	%	No	%	No	%
10-14	1	2.7	0	0.0	1	0.5
15-19	3	8.1	5	3.4	8	4.4
20-24	3	8.1	26	17.9	29	15.9
25-29	2	5.4	16	11.0	18	9.9
30-34	4	10.8	17	11.7	21	11.5
35-39	6	16.2	19	13.1	25	13.7
40-44	4	10.8	16	11.0	20	11.0
45-49	6	16.2	19	13.1	25	13.7
50-54	1	2.7	7	4.8	8	4.4
55-59	1	2.7	5	3.4	6	3.3
60-64	4	10.8	6	4.1	10	5.5
65-69	0	0.0	1	0.7	1	0.5
70-74	1	2.7	4	2.8	5	2.7
75-79	1	2.7	3	2.1	4	2.2
80-84	0	0.0	1	0.7	1	0.5
Total	37	100.0	145	100.0	182	100.0

### ***Section 6.3 Family history of suicide / deliberate self harm***

- A family history of suicide or deliberate self-harm was known by GP or psychiatrists in 110 cases (13.6% of the study population or 18.8% of all those for whom a questionnaire was returned by a GP or consultant psychiatrist).
- From the 562 GP questionnaires returned, 92(16.4%) reported a family history of suicide or deliberate self-harm.
- 23(15.5%) of the psychiatric questionnaires reported a family history of suicide or deliberate self-harm.

### ***Section 6.4 Episodes of Violence or Aggressive Behaviour***

A total of 132(22.4%) patients were known by their GP or psychiatrist to have had episodes of violent or aggressive behaviour. Of these:

- 25 were female (22.5% of those for whom a GP or consultant psychiatrist returned a questionnaire and 18.0% of all females in the study)
- 107 were male (22.4% of those for whom a GP or consultant psychiatrist returned a questionnaire and 16.0% of all males in the study).

From the 562 GP questionnaires returned, 117 (20.8%) patients were known by their GP to have had episodes of violent or aggressive behaviour. From the 148 questionnaires returned by the consultant psychiatrists, 26(17.7%) were known by their psychiatrist to have had episodes of violent or aggressive behaviour.

### *Section 6.5 Abuse of alcohol*

- A total of 132 of the deceased (16.4% of the total population and 22.4% of those for whom a questionnaire was returned by GP or psychiatrist) were known to have a history of alcohol abuse.
- Of the 562 questionnaires returned by GPs, 112(19.9%) reported a history of alcohol abuse.
- Of the 148 questionnaires returned by the consultant psychiatrists 40(27.0%) reported a history of alcohol abuse.
- There was no evidence that the prevalence of alcohol abuse was related to sex, but it was related to age, with those aged between 35 and 69 more likely to have a history of alcohol abuse ( $p < 0.001$ ).
- Those who were separated were over four times more likely than those who were not separated to have a history of alcohol abuse ( $p < 0.0001$ ).
- Almost half, 60(45.5%), were known by their GP or psychiatrist to have attended for alcohol counselling.

### *Section 6.6 Misuse of Drugs*

Fifty-four patients (6.7% of the total population, 9.2% of those for whom a questionnaire was returned by GP or psychiatrist) were known by their GP or consultant psychiatrist to have a history of drug or solvent abuse.

- Of these, 47(87.0%) were male.
- A history of drug or solvent abuse was not related to age.
- Thirty-two (59.3%) also had a history of alcohol abuse.

### *Section 6.7 Alcohol and drugs prior to death*

- 122(15.1% of total population and 20.7% of those who had a questionnaire returned by GP or psychiatrist) were known to have used alcohol immediately prior to their suicide.
- From the 562 questionnaires returned by GPs, 117(20.8%) patients were known to have taken alcohol immediately preceding the suicide event.
- From the 148 questionnaires returned by the consultant psychiatrists, 13(7.6%) patients were known to have taken alcohol immediately preceding the suicide event.
- Males were more likely than females to have used alcohol immediately prior to their deaths ( $p<0.02$ ).
- The number of males known to have used alcohol immediately prior to their deaths was 110 (16.5% of all males).
- Males aged less than 25 were more likely than those aged over 25 to have used alcohol immediately prior to death ( $p<0.001$ ).
- The number of females known to have used alcohol immediately prior to their deaths was 12(8.6% of all females).
- There was no significant difference in the method of suicide between those who used alcohol immediately prior to death and those who did not.
- There was no evidence that the use of alcohol was related to the day of the suicide.

From the 562 questionnaires returned by GPs, 27(4.8%) patients were known to have taken drugs immediately preceding the event. No questionnaires from the consultant psychiatrists reported any drug use immediately preceding the suicide event.

- GPs were more likely to be aware of drug use preceding the suicide event in females than in males ( $p < 0.05$ ).

### *Section 6.8 Recent Significant Events*

- 379 (47.0% of the total study population or 64.3% of all those for whom a questionnaire was returned by a GP or consultant psychiatrist) had a recent significant event prior to their death known either to their GP or consultant psychiatrist.
- 310 were male (46.4% of all males or 64.9% of males for whom a questionnaire was returned by a GP or psychiatrist).
- 69 were female (49.6% of all females or 62.2% of all females for whom a questionnaire was returned by a GP or psychiatrist).
- From the 562 questionnaires returned from GPs there were 347 (61.7%) patients with a history of a recent significant event.
- From the 148 questionnaires from the psychiatrists there were 78(52.7%) with a history of such an event.

Table 30 outlines the age distribution of those with a recent significant event known to their GP or consultant psychiatrist.

**Table 30. The age distribution of those with a recent significant event**

Age Band	Females		Males		Total	
	No	%	No	%	No	%
10-14	0	0.0	3	1.0	3	0.8
15-19	7	10.1	27	8.7	34	9.0
20-24	8	11.6	45	14.5	53	14.0
25-29	4	5.8	43	13.9	47	12.4
30-34	5	7.2	31	10.0	36	9.5
35-39	9	13.0	36	11.6	45	11.9
40-44	5	7.2	26	8.4	31	8.2
45-49	7	10.1	28	9.0	35	9.2
50-54	8	11.6	14	4.5	22	5.8
55-59	1	1.4	19	6.1	20	5.3
60-64	5	7.2	13	4.2	18	4.7
65-69	5	7.2	9	2.9	14	3.7
70-74	4	5.8	6	1.9	10	2.6
75-79	1	1.4	5	1.6	6	1.6
80-84	0	0.0	3	1.0	3	0.8
Not Known	0	0.0	2	0.6	2	0.5
Total	69	100.0	310	100.0	379	100.0

Table 31 outlines the 15 most commonly reported events. More than one significant event was recorded for a number of the patients and the total number is therefore greater than 379.

**Table 31. The 15 most commonly reported recent significant events. (The percentages in the table refer to the percentage of the total male and female study populations, i.e. 668 and 139)**

Event	Females		Males		Total	
	No	%	No	%	No	%
Breakup relationship/marriage	21	15.2	114	17.0	135	16.7
Substance/alcohol abuse	7	5.1	68	10.2	75	9.3
Death/ suicide family member/friend	15	10.9	57	8.5	72	8.9
Financial difficulties	6	4.3	40	6.0	46	5.7
Family strife	9	6.5	18	2.7	27	3.3
Family violence	3	2.2	20	3.0	23	2.9
Redundancy	2	1.4	15	2.2	17	2.1
Illness	0	0.0	16	2.4	16	2.0
Family illness	1	0.7	14	2.1	15	1.9
New job	1	0.7	12	1.8	13	1.6
Fear of or failure in exams	2	1.4	10	1.5	12	1.5
Conflict with the law	0	0.0	10	1.5	10	1.2
Child sex abuse	0	0.0	9	1.3	9	1.1
New home	1	0.7	8	1.2	9	1.1
Child birth	5	3.6	3	0.5	8	1.0

- Breakup of relationships/marriage was the commonest single recent event recorded. Those, whose marital status was described as separated or single, were more likely than those who were described as married, co-habiting, divorced or widowed to have a recent breakup in a relationship recorded ( $p < 0.0001$ ). The mean age of females was 40.8 years (SD: 16.0, range 15-71). Males had a mean age of 34.4 years (SD: 12.4, range 16-75).
- 39(34.2%) of the 114 males (with a history of a relationship breakup) were known to have a history of alcohol abuse by their GP or psychiatrist and 44 (38.6%) were known to have used alcohol immediately prior to their suicide.
- 5(23.8%) of the 21 females (with a history of a relationship breakup) were known to have a history of alcohol abuse by their GP or psychiatrist

and 3(14.3%) were known to have used alcohol immediately prior to their suicide.

- Females whose recent significant event was the death of a family member or friend had a mean age of females was 53.6 years (SD: 17.0, range 19-77). Males had a mean age of 39.1 years (SD: 18.1, range 17-83).
- Females whose recent significant event was substance abuse had a mean age of 39.9 years (SD: 11.3, range 22-56). Males had a mean age of 36.1 years (SD: 12.9, range 17-64).
- Females whose recent significant event fear of or failure in exams had a mean age of 17 years (SD: 2.2, range 16-18). Males had a mean age of 23 years (SD: 10.0, range 16-47), median age 19 years.



## Discussion

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Suicide is recognised as a major public health problem in Ireland. The Report of the National Task Force on Suicide (1998), following a detailed analysis and consideration of the factors involved in suicide, formulated a prevention / reduction strategy to reduce the number of suicides<sup>8</sup>. The findings in this study confirm many of the factors discussed in that report and in the Interim Report of the Task Force<sup>1</sup> and provide information on many aspects of suicide in Ireland that can be used in the efforts to reduce the number of deaths.

The number of suicides in this study, and in those published for the same time period by the Central Statistics Office (CSO), are broadly similar. The number of suicides identified in this study was 807. This compares to 843 as registered by the CSO as occurring for the whole country in 1997 and for all but the EHB region in 1998 (provisional data, personal communication). This is a difference of 4.3%. In 1997 this study identified 467 suicides compared to 478 as registered by the CSO. In 1998 this study identified 340 suicides in Health Boards (other than the Eastern Health Board area) compared to 365 as registered provisionally by the CSO. The differences are probably explained by the different methods used to identify suicides in this study and by the CSO.

The CSO gathers information using Form 104. This form is used solely for the purpose of supplementing the information on the Coroner's Certificate for the better classification of cause of death. It is completed by a member of the Garda Síochána attending the Coroner's Court and returned to the CSO. Form 104 has been redrafted since the publication of The Report of the National Task Force on

Suicide (1998) to provide more detailed and background information on the deceased.

The methods used to identify suicides in this study included a combination of using C71 forms, attendance at Coroner's Courts and examination of Coroner files. Using two different methodologies is likely to give different results. The fact that this study and the CSO figures are broadly similar would suggest that there is no major underestimation of the number of suicides, as often suggested in the past. As mentioned in the methods section, there were 20 other "possible" cases that were not included. However, regardless of which methods are used, there will always be some suicides that are difficult to identify (e.g. single vehicle road accidents with single occupant only, drug overdoses, drowning).

The total number of suicides registered by the CSO in 1998 was 504. It is worth noting that the number of suicides registered in 1999 was 439 and the number in 2000 was 413, a drop of 91 on the 1998 figure<sup>9</sup>. Whilst this drop is welcomed, we will have to await the figures for a number of years to see if the rising trend of suicide is reversing.

There is no doubt that Ireland has been going through a period of significant social change in recent years. In Ireland, lack of integration and fundamental changes in Irish society, including changes in spiritual values and rising rates of illegitimacy, have been suggested as being associated with increased an rate of suicide in Ireland<sup>10</sup>. Such societal changes in other countries have seen increases in the suicide rates, particularly in young men. The excellent literature review produced by Aware<sup>11</sup>, highlighted how high divorce rates, high unemployment, reductions in the population under 15 years of age, increases in population aged

over 65, more women in the workforce and in tertiary education, increases in the alcohol consumption of the population and a reduction in church membership were associated with an increased rate of suicide in those age 15-24.

Unemployment is considered to be an important risk factor for suicide<sup>12, 13</sup>. It is not surprising therefore to see an over representation of the unemployed in suicides in Ireland with 28.1% unemployed. At the time of this study, the national unemployment rates were 10.4% and 6.4% for the fourth quarters of 1997 and 1998 respectively<sup>14</sup>. The number of persons unemployed has been falling for a number of years with the rate in 1988 at 16.3%. Periods of economic crisis with growing unemployment can be associated with a rise in suicides, with higher rates amongst the unemployed<sup>13</sup>. The increased rate of suicide in Ireland has also been linked to unemployment. It is therefore more difficult to understand the continuing rise in the suicide rates whilst the Irish economy is booming with falling unemployment rates. Unemployment of course is only one factor and it may not always be clear whether it is unemployment which is influencing the suicide rates or that some other factors are influencing the suicide and unemployment rates. Unemployment should always be considered a risk factor because of the impact on self-esteem and on the ability to use supportive networks in an efficient way<sup>13</sup>.

Marital status has a strong protective effect on mortality from suicide. Single, separated, divorced and widowed persons have higher rates<sup>15</sup>. There is some evidence to suggest that the protective effect of marriage only applies to males<sup>16</sup>. The results in this study are in keeping with these findings particularly in respect of males, where only 21.3% of the males in this study were married compared to 38% in the 1996 Census<sup>17</sup>. It remains to be seen what effect, the increased level of

marriage breakdown, the availability of divorce and the older age at marriage, will have on suicide rates in the coming years. Of particular note, in respect of marital status, is that separated persons were more likely to have had alcohol problems. Whether this was a factor in the break-up of the relationship or otherwise is unknown.

Social class and various occupations have been associated with increased risk of suicide. Due to the large number for whom no occupation was known, it was not possible to demonstrate in this study any such association. The new revised Form 104, previously referred to, may be able to do so in time, as it is planned to collect this information in the future. Medical cardholders were over represented in this study with 41.8% having medical cards. This compares to 32% of the Irish population in 1998<sup>18</sup>. Medical card status is often used as a proxy for social class, as eligibility for medical cards is based on income. In addition, there was an overrepresentation of “unskilled workers”. In this study 13.6% were “unskilled” compared to 7.5% in the 96 Census, perhaps indicating that those left behind by the “Celtic Tiger” have been less able to cope than those who have gained materially from the improved economic situation in Ireland.

Only 1.8% of those who died as a result of suicide in this study were known to their GP or psychiatrist to be homosexual or bisexual. Not surprisingly, in just over a third of cases, sexual orientation was unknown. The number of persons in Ireland who are other than heterosexual is unknown. However, they should not be neglected, particularly from a mental health perspective, as there is evidence to suggest that there is an increased risk of suicide symptoms and recurrent depression amongst homosexual men<sup>19</sup> and that homosexual/ bisexual males are four times more likely to report suicidal intent<sup>20</sup>. Young males who are

homosexual may have a difficulty in “coming out”. One of the consequences of the confusion over their identity may be an increased risk of suicide<sup>21</sup>.

Mental health disorders are known to increase the risk of suicide<sup>22</sup> and the importance of these disorders is reflected in this study, with 47.2% of those seen by their GP having been referred to a consultant psychiatrist at some time with depression as the main illness. The importance of the training of GPs in recognising and diagnosing depression was highlighted in the Gotland study, as was the need for such programmes to be ongoing<sup>23</sup>. Otherwise the effectiveness will be short term. In this study females were more likely than males to have attended the mental health services. Irish males have been shown to be slow to seek help<sup>24</sup> and this is an area that needs to be addressed, perhaps in the broader context of the overall men’s health debate. Mental illness, particularly depression, has long been recognised as a major contributing factor in suicide. Depression may, as has been suggested, become the single biggest medical disorder in this millennium. The large number attending GPs with mental illness and depression underpins the recommendations in the Report of The National Task Force on Suicide<sup>8</sup> for undergraduate, postgraduate and continuing education for health care personnel in matters relating to suicide.

The large number of patients taking nervous system drugs, particularly antidepressants, again demonstrates the high level of morbidity in these patients as a result of mental illness.

Patients are at an increased risk of suicide in the period immediately after discharge from psychiatric care<sup>25</sup>. This may be due to a reduced level of care and support. In this study almost a third (31.4%) of those treated as inpatients died

within three months of discharge from hospital. This is slightly higher than the 24% reported in the United Kingdom<sup>26</sup>. This highlights the need for a systematic and seamless care plan for all patients after discharge from hospital. This follow-up cannot just be targeted at those patients considered to be “high risk”, as most people who commit suicide were thought to be at “low” or “medium” risk at final contact. Further research is required to assist in identifying those at risk. Fewer had been in contact with the mental health services (21%) in the week prior to death than in the UK (50%). However, loss of patients attending the mental health services to follow-up was not as high as described elsewhere<sup>26</sup>.

Significant events in life have been associated with suicide<sup>27</sup>, with relationship problems suggested as a precipitating factor in 26% of suicides and financial difficulties in 17%. Wenz found that a third of young people who had a broken relationship thought seriously about suicide<sup>28</sup>. Relationship problems (16.6%) were the commonest recent significant event identified in this study, followed by alcohol and/or substance abuse (9.1%). Financial difficulties were only cited in 5.7% of cases. The emotional trauma associated with the ending of relationships needs to be addressed in the broader context of developing more effective coping mechanisms, resilience building and development of self-esteem. These could be developed, as suggested by Suicide in Ireland, A Global Perspective and a National Strategy<sup>11</sup>, through educational programmes in the schools.

The apparent inability of males in particular, to cope with the breakdown of relationships, is compounded by the high level of alcohol problems in this cohort, with a third of these males having a known history of alcohol abuse. The role alcohol plays in suicide is well documented<sup>29, 30</sup>. Several reasons have been proposed to explain the link between alcohol and suicide, including that alcohol

abuse may be seen as self-destructive behaviour, depression is commoner in alcoholics and that large quantities of alcohol increase the risk of fatal outcome in suicide attempts<sup>31</sup>. The figures from this study in relation to alcohol are such that there is an urgent need to address the use of alcohol in our society. The Report of the National Task Force on Suicide<sup>8</sup> recommended the full implementation of the National Alcohol Policy<sup>30</sup>.

The National Alcohol Policy was developed to promote moderation in the consumption of alcohol and reduce the risks to physical, mental and family health that can arise from alcohol misuse. The policy recognised that alcohol consumption was likely to rise over the next number of years and that no single strategy will be effective if taken in isolation. More people are drinking, many are drinking too much. Twenty-seven percent of males and 21% of females consume more than the recommended weekly limits for alcohol. Young people are starting to drink, becoming regular drinkers and experiencing drunkenness at an earlier age than previously<sup>32</sup>.

Given that the overall level of drinking in a population is significantly related to alcohol related problems that the population will experience<sup>33</sup>, alcohol must be having a deleterious effect on mental health and on the overall level of suicide in Ireland. The two most effective measures outlined in the National Alcohol Policy are limiting availability and high prices. Both of these issues need to be addressed, regardless of how unpopular they may be to certain sections of the community. The availability of accessible alcohol counselling services needs to be addressed, given that less than half of those who were known to have an alcohol problem had attended counselling.

GPs play a pivotal and essential role in all aspects of health, from prevention to treatment and aftercare. Previous studies have shown that up to 25% of those who commit suicide have contact with health professionals in the week prior to suicide and 40% in the month prior to suicide <sup>34,35</sup>. Most of the contact is with GPs. This study has shown that 16.5% of females and 9.1% of males saw their GP in the week prior to their death, whilst over a third (36.0%) of females and a fifth of males, saw their GP within a month of their death. General practice therefore, offers an opportunity for patients to disclose their problems and offers the GP an opportunity to avert possible suicide attempts. This may be particularly so in respect of those aged 65 and over, where over a fifth were seen in the week prior to death and almost a half in the month prior to death. Patients attend their GP for a wide range of issues, from applications for driving licenses, to serious medical conditions. Patients, of course, present with mental health problems and it is interesting to note how those presenting nearer the time of their suicide were more likely to attend with mental health problems.

Unfortunately, young people, in particular young males, are less likely to attend their GP and are therefore less amenable to help. Depression is an important psychiatric disorder in adolescents that increases in frequency with age, often coexists with anxiety disorders and behaviour disorders, and is associated with long-term morbidity and risk of suicide<sup>36</sup>. A study of secondary school children in Northern Ireland found that 12% scored positive for depression, with 4% reporting that they wanted to kill themselves<sup>37</sup>.

Adolescents very rarely seek professional help in relation to how they are feeling, on their own behalf; rather, the consultation is usually made by a parent<sup>38</sup>. Given the high level of suicide and deliberate self-harm in young people in Ireland and the reluctance of young people to access primary care and other services, it is



essential that efforts are made to make the services friendly and accessible to them. Awareness programmes aimed at school children and also their parents are required.

Depression needs to be recognised and treated. In one study, less than 20% of elderly people with mild to moderate depression were treated with antidepressants<sup>39</sup>. Nervous system drugs, as classified by the ATC classification, accounted for 19% of the total drugs, medicines and appliances budget in the GMS in 1998<sup>18</sup>. This is second only to drugs for the cardiovascular system. Looking specifically at psycholeptics (NO5) and psychoanaleptics (NO6, which includes antidepressants), there were increases in the prescribing frequency to medical card patients nationwide of 13% and 47 % respectively over the five-year period 1993 – 1998<sup>18,40</sup>. The increased use of such drugs may suggest that GPs are more aware of the need to be aware of and the need to treat mental illness, in particular depression. It may also suggest that there is an increased expectation from patients for prescriptions for mental health problems.

Almost a quarter of those in this study, based on the replies from GPs and psychiatrists, had a known history of deliberate self-harm. It is essential that such persons, when they attend either the hospital services or their GPs, be provided with appropriate services and follow-up. GPs have been shown to be willing to become more involved in the management of deliberate self-harm. A significant proportion of GPs feel that the management should be retained within general practice, with more specialist advice being made available to them<sup>41</sup>. There are many specific recommendations on the care of those who deliberately self-harm in the Report of the National Task Force on Suicide<sup>8</sup>. The implementation of these recommendations might be more feasible if all hospitals were to develop protocols incorporating these recommendations. A significant correlation

between unemployment and the self-poisoning rate has been demonstrated in Ireland and suggests that deliberate self-harm is an issue that requires a public health approach for its resolution<sup>42</sup>. The advent of, and the further development of the National Parasuicide Registry by the National Suicide Research Foundation is a welcome initiative and will help to develop policies and implement measures to meet the needs of those at risk.

While the literature may suggest that limiting access to various methods can reduce suicide rates<sup>43</sup>, the findings in this study, as in others in Ireland<sup>44</sup>, suggest that achieving a significant reduction in this way may be difficult as most people either hang or drown themselves and it is difficult to make these methods unavailable. However, with 10% of suicides in this study occurring as a result of the use of firearms, a decrease in the availability of guns may prevent some suicides, as has been demonstrated elsewhere<sup>45</sup>.

## Conclusions

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1. Suicide continues to be a major cause of mortality in Ireland.
2. Almost five times more men died from suicide than women. Suicide is the principal cause of death for men aged 15-35 years
3. Based on this study, the incidence of suicide in Ireland is not significantly underestimated as suggested in the past.
4. Mental health disorders, especially depression, remain the highest risk factor for suicide.
5. Deliberate self-harm is a significant risk factor for suicide. In this study almost a quarter had a known history of deliberate self-harm.
6. A quarter of those who died were known to have expressed suicidal intent at some time.
7. Males who had a mental health disorder were less likely than females to have attended the mental health services.
8. Patients are at increased risk of suicide in the period after discharge from psychiatric care. In this study almost a third of those who were treated as inpatients died within three months of discharge from hospital.
9. Recent significant events prior to death were an important factor. Almost half had such an event known to their GP or psychiatrist. Relationship problems were the commonest recent significant event
10. Alcohol related problems were significant risk factors for suicide. Alcohol abuse compounds many of the risk factors for suicide.
11. General practice is an important point of contact for people who die as a result of suicide. In this study over a third of females and a fifth of males saw a GP less than one month before their death.
12. Young people, particularly males, are less likely to attend their GP.
13. Unemployment remains an important risk factor for suicide. Almost a third of men were unemployed, and two thirds of these had been unemployed for more than one year.

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## Appendix

### Summary tables for each health board region

#### *Eastern Health Board Region*

**Table 1. Eastern Health Board region, age distribution by sex.**

Age	Females		Males		Total	
	No	%	No	%	No	%
10-14	0	0.0	1	0.8	1	0.6
15-19	2	8.7	16	13.6	18	9.6
20-24	1	4.3	19	16.1	20	11.4
25-29	0	0.0	14	11.9	14	8.4
30-34	1	4.3	16	13.6	17	9.6
35-39	4	17.4	14	11.9	18	8.4
40-44	1	4.3	7	5.9	8	4.2
45-49	1	4.3	5	4.2	6	3.0
50-54	4	17.4	9	7.6	13	5.4
55-59	3	13.0	6	5.1	9	3.6
60-64	3	13.0	5	4.2	8	3.0
65-69	2	8.7	2	1.7	4	1.2
70-74	0	0.0	0	0.0	0	0.0
75-79	0	0.0	3	2.5	3	1.8
80-84	0	0.0	0	0.0	0	0.0
85+	1	4.3	0	0.0	1	0.0
Not stated	0	0.0	1	0.8	1	0.6
Total	23	100.0	118	100.0	141	70.9

**Table 2. Eastern Health Board region, marital status**

Status	Females		Males		Total	
	No	%	No	%	No	%
Single	7	30.4	64	54.2	71	50.4
Married	8	34.8	28	23.7	36	25.5
Co-habiting	2	8.7	8	6.8	10	7.1
Separated	3	13.0	8	6.8	11	7.8
Widow	3	13.0	5	4.2	8	5.7
Not Known	0	0.0	5	4.2	5	3.5
Total	23	100.0	118	100.0	141	100.0

**Table 3. Eastern Health Board region, religion**

Religion	Females		Males		Total	
	No	%	No	%	No	%
Catholic	20	87.0	84	71.2	104	73.8
Church of Ireland	0	0.0	6	5.1	6	4.3
Other	0	0.0	0	0.0	0	0.0
Not Known	3	13.0	28	23.7	31	22.0
	23	100.0	118	100.0	141	100.0

**Table 4. Eastern Health Board region, employment status**

Status	Females		Males		Total	
	No	%	No	%	No	%
Employed	7	30.4	44	37.3	51	36.2
Unemployed	6	26.1	39	33.1	45	31.9
Retired	3	13.0	7	5.9	10	7.1
S-employed	1	4.3	8	6.8	9	6.4
Student	0	0.0	8	6.8	8	5.7
Housewife/husband	6	26.1	0	0.0	6	4.3
Not Known	0	0.0	12	10.2	12	8.5
Total	23	100.0	118	100.0	141	100.0

**Table 5. Eastern Health Board region, duration of unemployment for those unemployed**

Duration	Females		Males		Total	
	No	%	No	%	No	%
Less than a month	0	0.0	3	7.7	3	6.7
1 to 5.9 months	0	0.0	3	7.7	3	6.7
6 to 11.9 months	2	33.3	0	0.0	2	4.4
Over a year	1	16.7	12	30.8	13	28.9
Not Known	3	50.0	21	53.8	24	53.3
Total	6	100.0	39	100.0	45	100.0

**Table 6. Eastern Health Board region, social class**

Social Class	Females		Males		Total	
	No	%	No	%	No	%
1. Professional workers	0	0.0	4	3.5	4	2.8
2. Managerial and technical	6	26.1	11	9.6	17	12.1
3. Non-manual	3	13.0	7	6.1	10	7.1
4. Skilled manual	0	0.0	12	10.5	12	8.5
5. Semi-skilled	1	4.3	10	8.8	11	7.8
6. Unskilled	0	0.0	16	14.0	16	11.3
7. Unknown	14	60.9	58	50.9	68	48.2
8. Farmers	0	0.0	3	2.6	3	2.1
Total	23	100.0	114	100.0	141	100.0

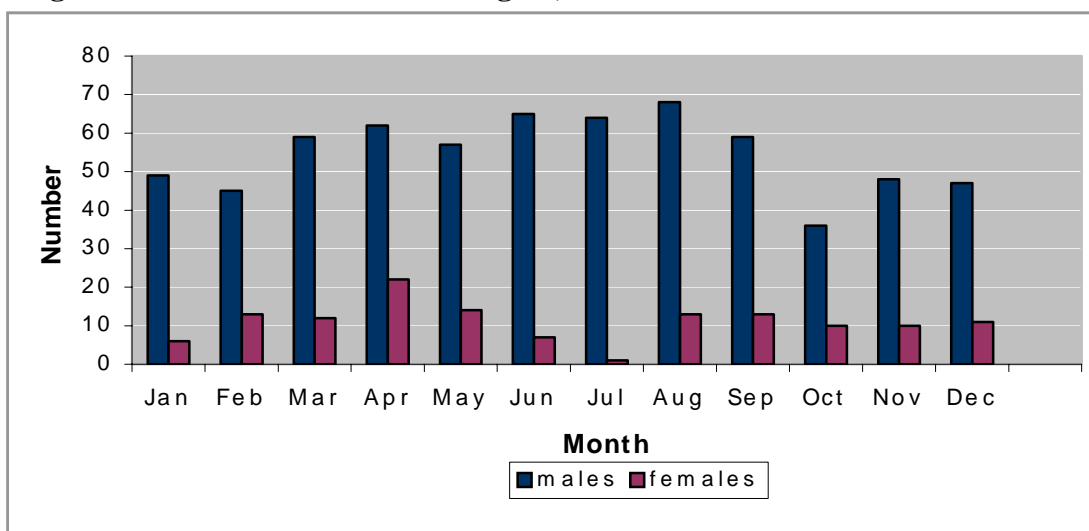
**Table 7. Eastern Health Board region, highest level of education completed.**

Education	Females		Males		Total	
	No	%	No	%	No	%
Secondary	8	34.8	30	25.4	38	27.0
Primary	1	4.3	12	10.2	13	9.2
Third	2	8.7	9	7.6	11	7.8
Not Known	12	52.2	67	56.8	79	56.0
Total	23	100.0	118	100.0	141	100.0

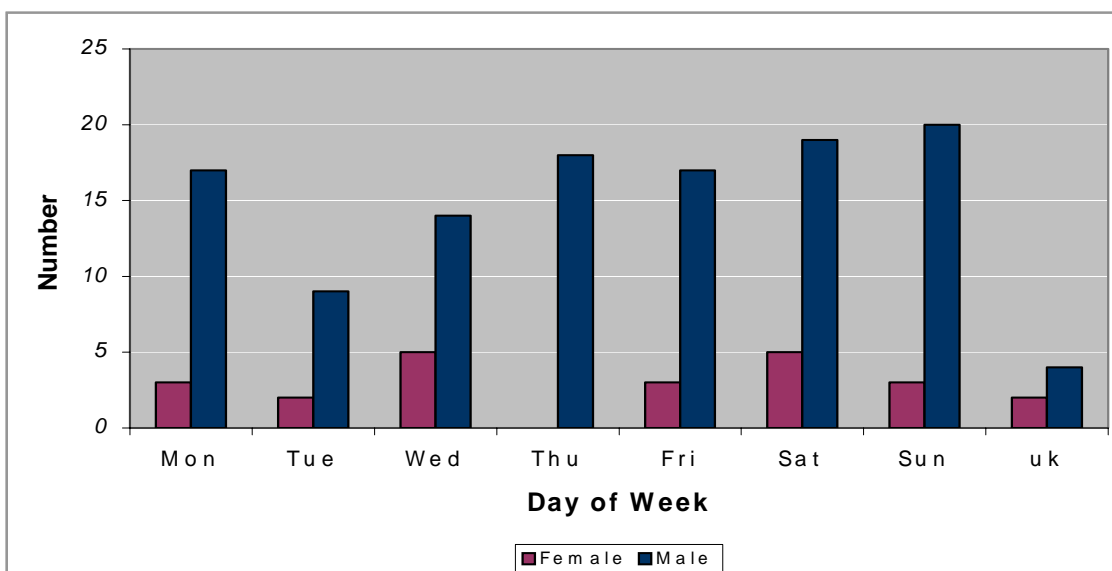
**Table 8. Eastern Health Board region, accommodation**

Accommodation	Females		Males		Total	
	No	%	No	%	No	%
Home others	12	52.2	74	62.7	86	61.0
Home alone	5	21.7	14	11.9	19	13.5
Lodgings	2	8.7	1	0.8	3	2.1
Homeless	0	0.0	2	1.7	2	1.4
Hostel	0	0.0	2	1.7	2	1.4
Prison	0	0.0	2	1.7	2	1.4
Not Known	4	17.4	23	19.5	27	19.1
Total	23	100.0	118	100.0	141	100.0

**Figure 1. Eastern Health Board region, month of occurrence**



**Figure 2. Eastern Health Board region, day of occurrence**



**Table 9. Eastern Health Board region, method of suicide**

Method	Females		Males		Total	
	No	%	No	%	No	%
Hanging	7	30.4	62	52.5	69	48.9
Overdose	6	26.1	8	6.8	14	9.9
Drowning	4	17.4	8	6.8	12	8.5
Shooting	0	0.0	9	7.6	9	6.4
Car Exhaust	0	0.0	8	6.8	8	5.7
Poison	3	13.0	3	2.5	6	4.3
Jumped height	0	0.0	5	4.2	5	3.5
Jump under train	1	4.3	3	2.5	4	2.8
Laceration	0	0.0	4	3.4	4	2.8
Other	1	4.3	7	5.9	8	5.7
Not known	1	4.3	1	0.8	2	1.4
Total	23	100.0	118	100.0	141	100.0

## Midland Health Board region

**Table 10. Midland Health Board region, age Distribution by Sex**

Age	Females		Males		Total	
	No	%	No	%	No	%
10-14	0	0.0	0	0.0	0	0.0
15-19	0	0.0	4	8.9	4	7.4
20-24	1	11.1	7	15.6	8	14.8
25-29	2	22.2	4	8.9	6	11.1
30-34	0	0.0	6	13.3	6	11.1
35-39	0	0.0	6	13.3	6	11.1
40-44	2	22.2	7	15.6	9	16.7
45-49	1	11.1	0	0.0	1	1.9
50-54	0	0.0	3	6.7	3	5.6
55-59	1	11.1	1	2.2	2	3.7
60-64	1	11.1	3	6.7	4	7.4
65-69	0	0.0	0	0.0	0	0.0
70-74	1	11.1	2	4.4	3	5.6
75-79	0	0.0	2	4.4	2	3.7
80-84	0	0.0	0	0.0	0	0.0
85+	0	0.0	0	0.0	0	0.0
Not stated	0	0.0	0	0.0	0	0.0
Total	9	100.0	45	100.0	54	100.0

**Table 12. Midland Health Board region, marital status**

Status	Females		Males		Total	
	No	%	No	%	No	%
Single	2	22.2	25	55.6	27	50.0
Married	5	55.6	10	22.2	15	27.8
Separated	0	0.0	5	11.1	5	9.3
Widowed	1	11.1	2	4.4	3	5.6
Co-habiting	0	0.0	2	4.4	2	3.7
Divorced	1	11.1	1	2.2	2	3.7
Total	9	100.0	45	100.0	54	100.0

**Table 13. Midland Health Board region, religion**

Religion	Females		Males		Total	
	No	%	No	%	No	%
Catholic	6	66.7	35	77.8	41	75.9
Not Known	3	33.3	10	22.2	13	24.1
Total	9	100.0	45	100.0	54	100.0

**Table 14. Midland Health Board region, employment status**

Status	Females		Males		Total	
	No	%	No	%	No	%
Employed	4	44.4	13	28.9	17	31.5
Unemployed	1	11.1	12	26.7	13	24.1
Self employed	0	0.0	11	24.4	11	20.4
Housewife/Husband	4	44.4	0	0.0	4	7.4
Retired	0	0.0	4	8.9	4	7.4
Student	0	0.0	3	6.7	3	5.6
Not known	0	0.0	2	4.4	2	3.7
Total	9	100.0	45	100.0	54	100.0

**Table 15. Midland Health Board region, duration of unemployment for those unemployed**

Duration	Females		Males		Total	
	No	%	No	%	No	%
1 to 5.9 months	0	0.0	1	8.3	1	7.7
Over a year	0	0.0	8	66.7	8	61.5
Not Known	1	100.0	3	25.0	4	30.8
Total	1	100.0	12	100.0	13	100.0

**Table 16. Midland Health Board region, social class**

Social Class	Females		Males		Total	
	No	%	No	%	No	%
1. Professional workers	0	0.0	1	2.2	1	1.9
2. Managerial and technical	2	22.2	5	11.1	7	13.0
3. Non-manual	1	11.1	2	4.4	3	5.6
4. Skilled manual	3	33.3	11	24.4	14	25.9
5. Semi-skilled	1	11.1	1	2.2	2	3.7
6. Unskilled	0	0.0	2	4.4	2	3.7
7. Unknown	2	22.2	17	37.8	19	35.2
8. Farmers	0	0.0	6	13.3	6	11.1
Total	9	100.0	45	100.0	54	100.0

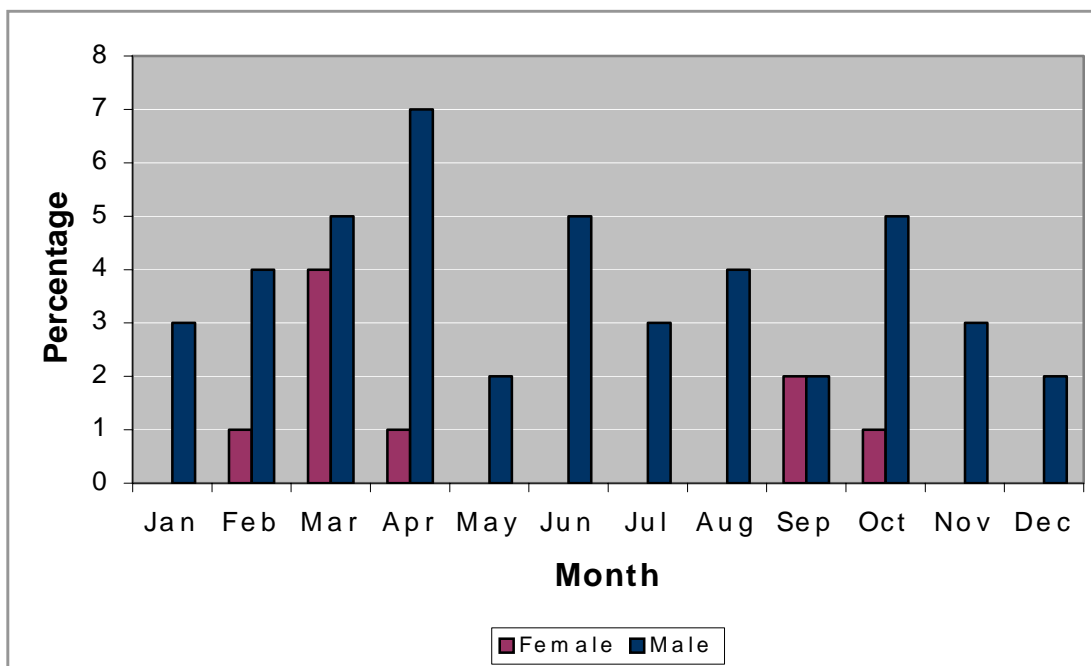
**Table 16. Midland Health Board region, highest level of education completed**

Education	Females		Males		Total	
	No	%	No	%	No	%
Primary	1	11.1	7	15.6	8	14.8
Secondary	2	22.2	13	28.9	15	27.8
3rd	0	0.0	5	11.1	5	9.3
Not known	6	66.7	20	44.4	26	48.1
Total	9	100.0	45	100.0	54	100.0

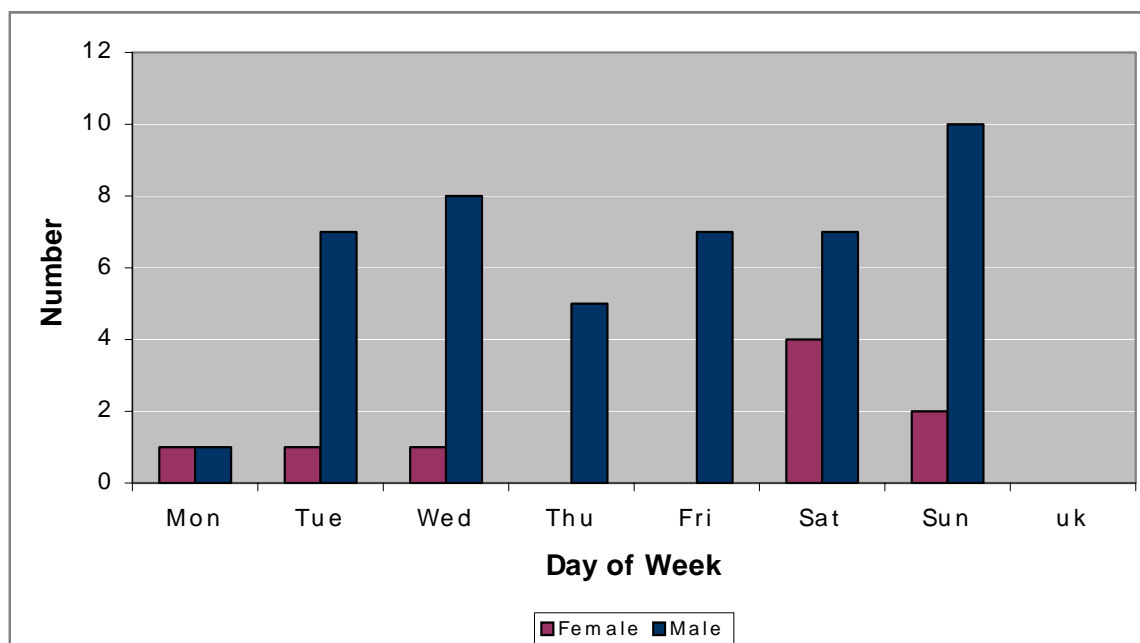
**Table 17. Midland Health Board region, accommodation**

Accommodation	Females		Males		Total	
	No	%	No	%	No	%
Home alone	1	11.1	3	6.7	4	7.4
Home others	4	44.4	33	73.3	37	68.5
Lodgings	1	11.1	5	11.1	6	11.1
Not known	3	33.3	4	8.9	7	13.0
Total	9	100.0	45	100.0	54	100.0

**Figure 3. Midland Health Board region, month of occurrence**



**Figure 4. Midland Health Board region, day of occurrence**



**Table 18. Midland Health Board, method of suicide**

Method	Females		Males		Total	
	No	%	No	%	No	%
Drowning	4	44	13	28.9	17	31.5
Hanging	2	22	15	33.3	17	31.5
Shooting	0	0	10	22.2	10	18.5
Overdose	3	33	1	2.2	4	7.4
Car Exhaust	0	0	2	4.4	2	3.7
Jumped under train	0	0	2	4.4	2	3.7
Other	0	0	2	4.4	2	3.8
Total	9	100	45	100.0	54	100.0



## Mid-Western Health Board

**Table 19. Mid Western Health Board region, age Distribution by Sex.**

Age	Females		Males		Total	
	No	%	No	%	No	%
10-14	0	0.0	1	1.5	1	1.2
15-19	0	0.0	4	6.1	4	4.9
20-24	1	6.3	10	15.2	11	13.4
25-29	1	6.3	13	19.7	14	17.1
30-34	1	6.3	5	7.6	6	7.3
35-39	2	12.5	6	9.1	8	9.8
40-44	1	6.3	3	4.5	4	4.9
45-49	1	6.3	2	3.0	3	3.7
50-54	3	18.8	6	9.1	9	11.0
55-59	0	0.0	3	4.5	3	3.7
60-64	3	18.8	2	3.0	5	6.1
65-69	1	6.3	5	7.6	6	7.3
70-74	1	6.3	2	3.0	3	3.7
75-79	0	0.0	0	0.0	0	0.0
80-84	1	6.3	0	0.0	1	1.2
85+	0	0.0	0	0.0	0	0.0
Not stated	0	0.0	4	6.1	4	4.9
Total	16	100.0	66	100.0	82	100.0

**Table 20. Mid Western Health Board region, marital status**

Status	Females		Males		Total	
	No	%	No	%	No	%
Single	4	25.0	29	43.9	33	40.2
Married	4	25.0	14	21.2	18	22.0
Separated	2	12.5	4	6.1	6	7.3
Co-habiting	1	6.3	3	4.5	4	4.9
Widowed	3	18.8	0	0.0	3	3.7
Divorced	0	0.0	2	3.0	2	2.4
Not known	2	12.5	14	21.2	16	19.5
Total	16	100.0	66	100.0	82	100.0

**Table 21. Mid Western Health Board region, religion**

Religion	Females		Males		Total	
	No	%	No	%	No	%
Catholic	13	81.3	47	71.2	60	73.2
Not Known	3	18.8	19	28.8	22	26.8
Total	16	100.0	66	100.0	82	100.0

**Table 22. Mid Western Health Board region, employment status**

Status	Females		Males		Total	
	No	%	No	%	No	%
Unemployed	1	6.3	12	18.2	13	15.9
Retired	3	18.8	8	12.1	11	13.4
Employed	1	6.3	9	13.6	10	12.2
Self-employed	1	6.3	9	13.6	10	12.2
Student	2	12.5	5	7.6	7	8.5
Housewife/husband	5	31.3	0	0.0	5	6.1
Not known	3	18.8	23	34.8	26	31.7
Total	16	100.0	66	100.0	82	100.0

**Table 23. Mid Western Health Board region, duration of unemployment for those unemployed**

Duration	Females		Males		Total	
	No	%	No	%	No	%
1 to 5.9 months	0	0.0	1	8.3	1	7.7
6 to 11.9 months	0	0.0	3	25.0	3	23.1
Over a year	0	0.0	4	33.3	4	30.8
Not Known	1	100.0	4	33.3	5	38.5
Total	1	100.0	12	100.0	13	100.0

**Table 24. Mid Western Health Board region, social class**

Social Class	Females		Males		Total	
	No	%	No	%	No	%
1. Professional workers	0	0.0	0	0.0	0	0.0
2. Managerial and Technical	0	0.0	2	3.0	2	2.4
3. Non-manual	1	6.3	1	1.5	2	2.4
4. Skilled manual	2	12.5	9	13.6	11	13.4
5. Semi-skilled	1	6.3	7	10.6	8	9.8
6. Unskilled	0	0.0	4	6.1	4	4.9
7. Unknown	11	68.8	34	51.5	45	54.9
8. Farmers	1	6.3	9	13.6	10	12.2
Total	16	100.0	66	100.0	82	100.0

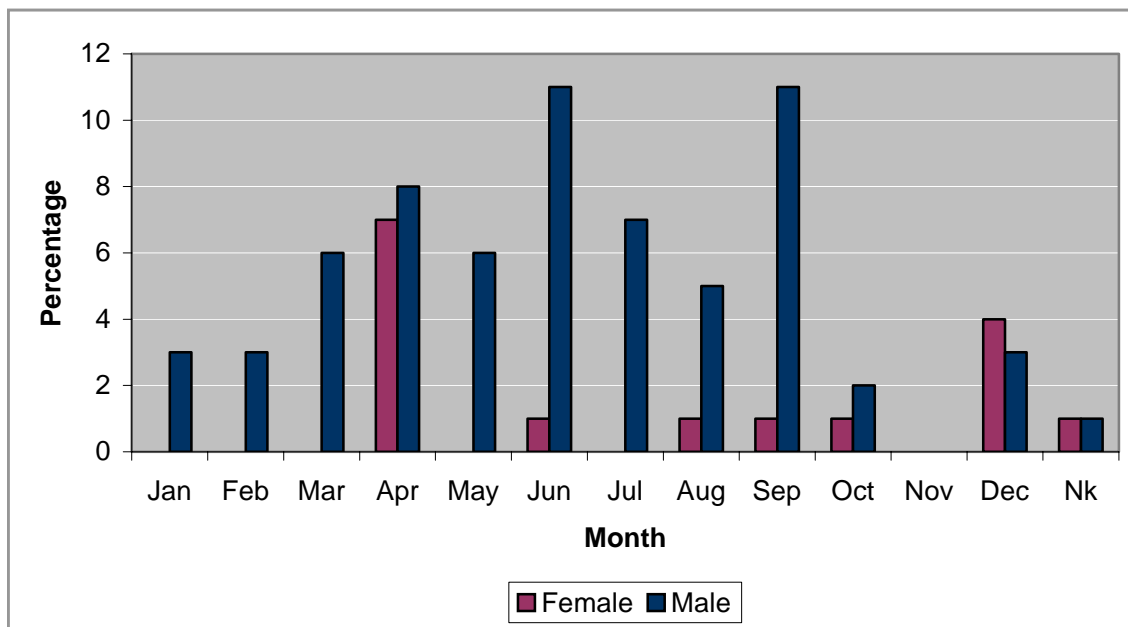
**Table 25. Mid Western Health Board region, highest level of education completed**

Education	Females		Males		Total	
	No	%	No	%	No	%
Primary	1	6.3	9	13.6	10	12.2
Secondary	3	18.8	13	19.7	16	19.5
Third	0	0.0	1	1.5	1	1.2
Not Known	12	75.0	43	65.2	55	67.1
Total	16	100.0	66	100.0	82	100.0

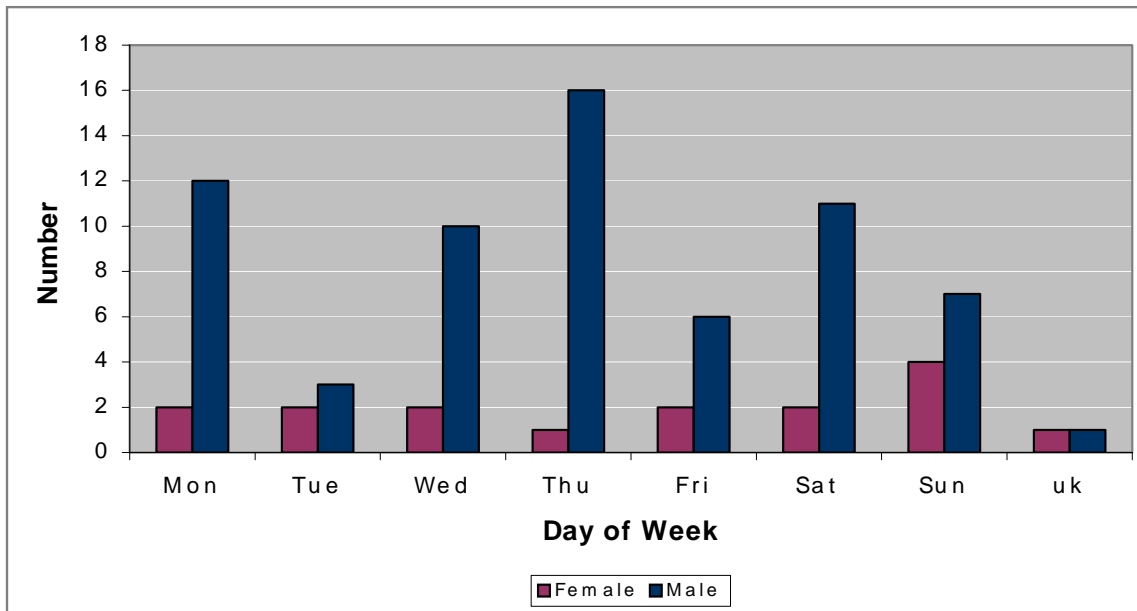
**Table 26. Mid Western Health Board region, accommodation**

Accommodation	Females		Males		Total	
	No	%	No	%	No	%
Home others	6	37.5	32	48.5	38	46.3
Home alone	2	12.5	4	6.1	6	7.3
Lodgings	0	0.0	2	3.0	2	2.4
Not Known	8	50.0	28	42.4	36	43.9
Total	16	100.0	66	100.0	82	100.0

**Figure 5. Mid Western Health Board region, month of occurrence**



**Figure 6. Mid Western Health Board region, day of occurrence**



**Table 27. Mid Western Health Board region, method of suicide**

Method	Females		Males		Total	
	No	%	No	%	No	%
Hanging	5	31.3	28	42.4	33	40.2
Drowning	4	25.0	12	18.2	16	19.5
Shooting	1	6.3	12	18.2	13	15.9
Overdose	5	31.3	5	7.6	10	12.2
Car Exhaust	0	0	3	4.5	3	3.7
Jumped from height	0	0	3	4.5	3	3.7
Poison	0	0	2	3.0	2	2.4
Other	1	6.3	1	1.5	2	2.4
Not known	0	0	0	0	1	0
Total	16	100	66	100.0	82	100.0

## North Eastern Health Board

**Table 28. North Eastern Health Board region, age distribution by sex**

Age	Females		Males		Total	
	No	%	No	%	No	%
10-14	0	0.0	0	0.0	0	0.0
15-19	2	14.3	7	10.3	9	11.0
20-24	0	0.0	10	14.7	10	12.2
25-29	3	21.4	12	17.6	15	18.3
30-34	0	0.0	8	11.8	8	9.8
35-39	1	7.1	4	5.9	5	6.1
40-44	0	0.0	5	7.4	5	6.1
45-49	4	28.6	7	10.3	11	13.4
50-54	1	7.1	2	2.9	3	3.7
55-59	0	0.0	2	2.9	2	2.4
60-64	0	0.0	3	4.4	3	3.7
65-69	1	7.1	5	7.4	6	7.3
70-74	0	0.0	2	2.9	2	2.4
75-79	2	14.3	1	1.5	3	3.7
80-84	0	0.0	0	0.0	0	0.0
85+	0	0.0	0	0.0	0	0.0
Not stated	0	0.0	0	0.0	0	0.0
Total	14	100.0	68	100.0	82	100.0

**Table 29. North Eastern Health Board, marital status**

Status	Females		Males		Total	
	No	%	No	%	No	%
Single	5	35.7	41	60.3	46	56.1
Married	3	21.4	11	16.2	14	17.1
Separated	0	0.0	6	8.8	6	7.3
Widowed	3	21.4	3	4.4	6	7.3
Co-habiting	1	7.1	0	0.0	1	1.2
Not known	2	14.3	7	10.3	9	11.0
Total	14	100.0	68	100.0	82	100.0

**Table 30. North Eastern Health Board region, religion**

Religion	Females		Males		Total	
	No	%	No	%	No	%
Catholic	6	42.9	55	80.9	61	74.4
Other	0	0	1	1.5	1	1.2
Not Known	8	57.1	12	17.6	20	24.4
Total	14	100.0	68	100.0	82	100.0

**Table 31. North Eastern Health Board region, employment status**

Status	Females		Males		Total	
	No	%	No	%	No	%
Unemployed	1	7.1	22	32.4	23	28.0
Employed	1	7.1	17	25.0	18	22.0
Retired	3	21.4	6	8.8	9	11.0
Self-employed	1	7.1	7	10.3	8	9.8
Student	2	14.3	4	5.9	6	7.3
Housewife/husband	3	21.4	0	0.0	3	3.7
Not known	3	21.4	12	17.6	15	18.3
Total	14	100.0	68	100.0	82	100.0

**Table 32. North Eastern Health Board region, duration of unemployment for those unemployed**

Duration	Females		Males		Total	
	No	%	No	%	No	%
Less than a month	0	0.0	2	9.1	2	8.7
1 to 5.9 months	0	0.0	2	9.1	2	8.7
6 to 11.9 months	0	0.0	1	4.5	1	4.3
Over a year	1	100.0	13	59.1	14	60.9
Not Known	0	0.0	4	18.2	4	17.4
Total	1	100.0	22	100.0	23	100.0

**Table 33. North Eastern Health Board region, social class.**

Social Class	Females		Males		Total	
	No	%	No	%	No	%
1. Professional workers	0	0.0	0	0.0	0	0.0
2. Managerial and technical	3	21.4	2	2.9	5	6.1
3. Non-manual	0	0.0	4	5.9	4	4.9
4. Skilled manual	1	7.1	7	10.3	8	9.8
5. Semi-skilled	0	0.0	4	5.9	4	4.9
6. Unskilled	0	0.0	11	16.2	11	13.4
7. Unknown	10	71.4	32	47.1	42	51.2
8. Farmers	0	0.0	8	11.8	8	9.8
Total	14	100.0	68	100.0	82	100.0

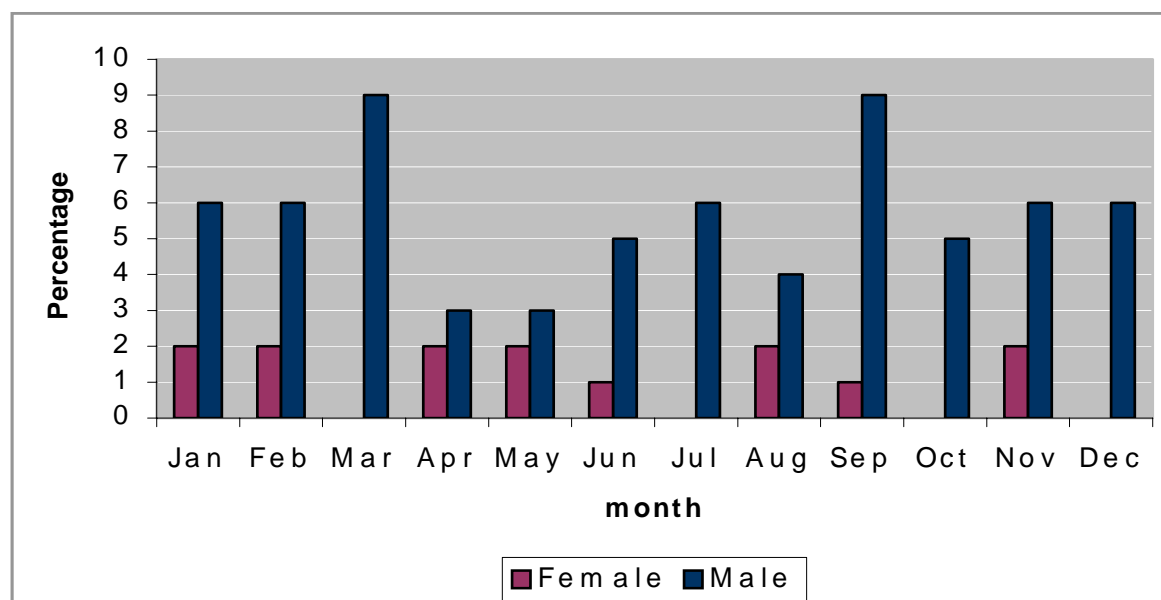
**Table 34. North Eastern Health Board, highest level of education completed**

Education	Females		Males		Total	
	No	%	No	%	No	%
Primary	2	14.3	5	7.4	7	8.5
Secondary	3	21.4	25	36.8	28	34.1
Third	0	0.0	3	4.4	3	3.7
Not Known	9	64.3	35	51.5	44	53.7
Total	14	100.0	68	100.0	82	100.0

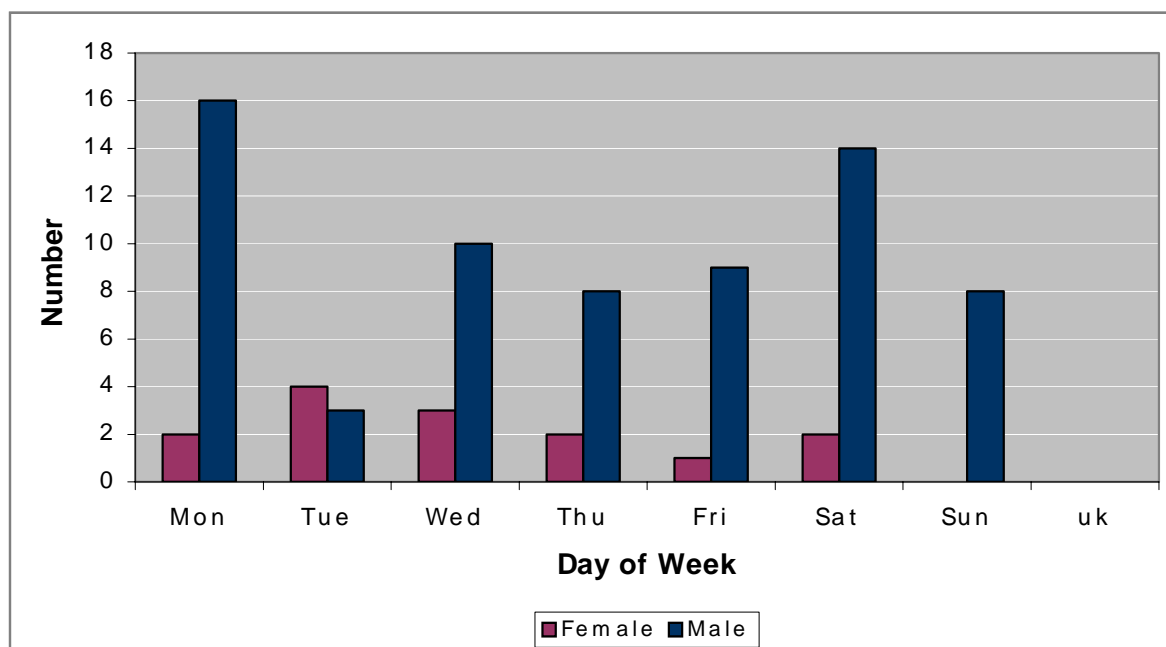
**Table 35. North Eastern Health Board region, accommodation**

Accommodation	Female		Male		Total	
	No	%	No	%	No	%
Home others	9	64.3	43	63.2	52	63.4
Home alone	1	7.1	9	13.2	10	12.2
Lodgings	2	14.3	4	5.9	6	7.3
Hostel	0	0.0	1	1.5	1	1.2
Not known	2	14.3	11	16.2	13	15.9
Total	14	100.0	68	100.0	82	100.0

**Figure 7. North Eastern Health Board region, month of occurrence**



**Figure 8. North Eastern Health Board region, day of occurrence**



**Table 36. North Eastern Health Board region, method of suicide**

Method	Females		Males		Total	
	No	%	No	%	No	%
Hanging	2	14.3	30	44.1	32	39.0
Drowning	3	21.4	17	25.0	20	24.4
Shooting	3	21.4	7	10.3	10	12.2
Car Exhaust	0	0	6	8.8	6	7.3
Overdose	1	7.1	3	4.4	4	4.9
Jumped from height	1	7.1	2	2.9	3	3.7
Poison	2	14.3	1	1.5	3	3.7
Laceration	1	7.1	1	1.5	2	2.4
Other	1	7.1	10	1.5	2	2.4
Total	14	100	68	100.0	82	100.0



## North Western Health Board

**Table 37. North Western Health Board region, age distribution by sex**

Age	Females		Males		Total	
	No	%	No	%	No	%
10-14	0	0.0	0	0.0	0	0.0
15-19	0	0.0	6	12.8	6	10.7
20-24	1	11.1	10	21.3	11	19.6
25-29	1	11.1	4	8.5	5	8.9
30-34	0	0.0	1	2.1	1	1.8
35-39	0	0.0	4	8.5	4	7.1
40-44	0	0.0	6	12.8	6	10.7
45-49	3	33.3	5	10.6	8	14.3
50-54	2	22.2	4	8.5	6	10.7
55-59	0	0.0	4	8.5	4	7.1
60-64	0	0.0	2	4.3	2	3.6
65-69	2	22.2	0	0.0	2	3.6
70-74	0	0.0	0	0.0	0	0.0
75-79	0	0.0	0	0.0	0	0.0
80-84	0	0.0	1	2.1	1	1.8
85+	0	0.0	0	0.0	0	0.0
Not stated	0	0.0	0	0.0	0	0.0
Total	9	100.0	47	100.0	56	100.0

**Table 38. North Western Health Board region, marital status**

Status	Females		Males		Total	
	No	%	No	%	No	%
Single	2	22.2	30	63.8	32	57.1
Married	2	22.2	10	21.3	12	21.4
Separated	3	33.3	4	8.5	7	12.5
Divorced	1	11.1	1	2.1	2	3.6
Widowed	1	11.1	1	2.1	2	3.6
Not known	0	0.0	1	2.1	1	1.8
Total	9	100.0	47	100.0	56	100.0

**Table 39. North Western Health Board region, religion**

Religion	Females		Males		Total	
	No	%	No	%	No	%
Catholic	8	88.9	44	93.6	52	92.9
Church of Ireland	0	0.0	2	4.3	2	3.6
Other	1	11.1	0	0.0	1	1.8
Not Known	0	0	1	2.1	1	1.8
Total	9	100.0	47	100.0	56	100.0

**Table 40. North Western Health Board region, employment status**

Status	Females		Males		Total	
	No	%	No	%	No	%
Employed	0	0.0	17	36.2	17	30.4
Unemployed	3	33.3	11	23.4	14	25.0
Self employed	1	11.1	8	17.0	9	16.1
Student	1	11.1	7	14.9	8	14.3
Housewife/husband	3	33.3	0	0.0	3	5.4
Retired	1	11.1	2	4.3	3	5.4
Not Known	0	0.0	2	4.3	2	3.6
Total	9	100.0	47	100.0	56	100.0

**Table 41. North Western Health Board region, duration of unemployment for those unemployed**

Duration	Females		Males		Total	
	No	%	No	%	No	%
1 to 5.9 months	0	0.0	3	7.7	3	6.7
6 to 11.9 months	2	33.3	0	0.0	2	4.4
Over a year	1	16.7	12	30.8	13	28.9
Not Known	3	50.0	21	53.8	24	53.3
Total	6	100.0	39	100.0	45	100.0

**Table 42. North Western Health Board region, social class**

Social Class	Females		Males		Total	
	No	%	No	%	No	%
1. Professional workers	0	0.0	1	2.2	1	1.8
2. Managerial and technical	2	22.2	0	0.0	2	3.6
3. Non-manual	1	11.1	3	6.5	4	7.1
4. Skilled manual	0	0.0	11	23.9	11	19.6
5. Semi-skilled	0	0.0	2	4.3	2	3.6
6. Unskilled	0	0.0	11	23.9	11	19.6
7. Unknown	6	66.7	15	32.6	21	37.5
8. Farmers	0	0.0	4	8.7	4	7.1
Total	9	100.0	46	100.0	56	100.0

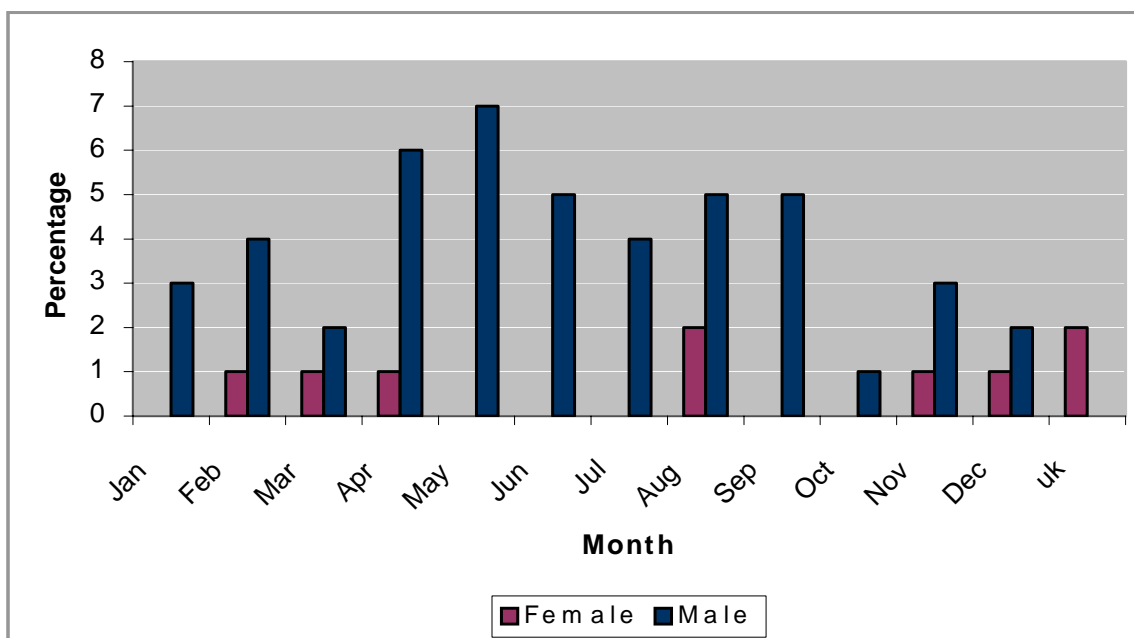
**Table 43. North Western Health Board, highest level of education completed**

Education	Female		Male		Total	
	No	%	No	%	No	%
Secondary	1	11.1	16	34.0	17	30.4
Primary	3	33.3	18	38.3	21	37.5
Third	0	0.0	1	2.1	1	1.8
Not Known	5	55.6	12	25.5	17	30.4
Total	9	100.0	47	100.0	56	100.0

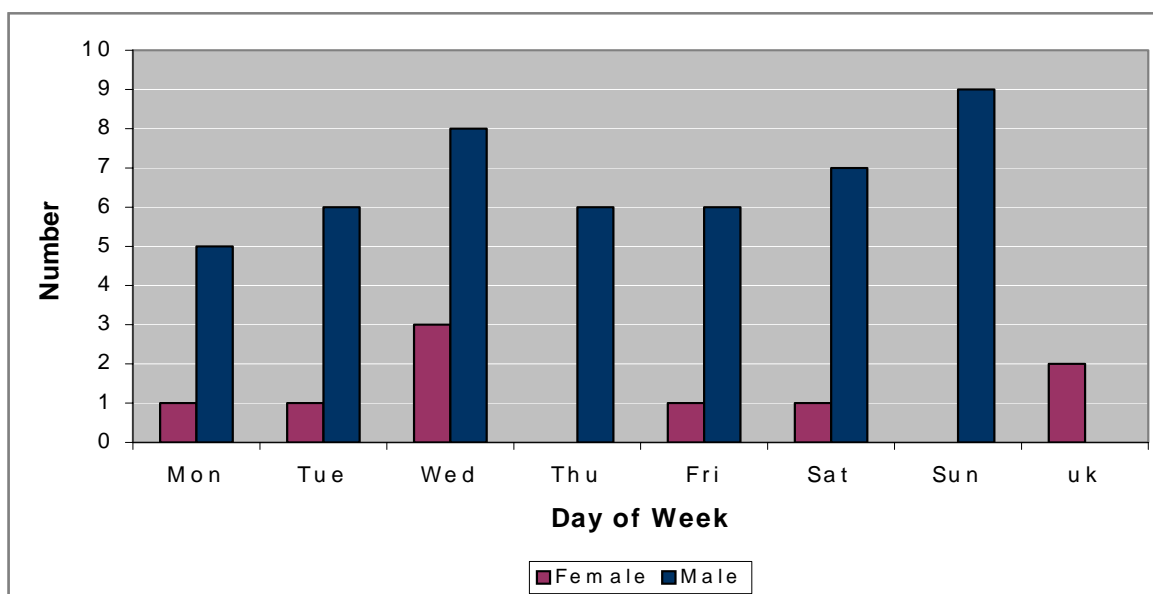
**Table 44. North Western Health Board region, accommodation**

Accommodation	Females		Males		Total	
	No	%	No	%	No	%
Home others	6	66.7	31	66.0	37	66.1
Home alone	2	22.2	11	23.4	13	23.2
Lodgings	1	11.1	1	2.1	2	3.6
Homeless	0	0.0	1	2.1	1	1.8
Prison	0	0.0	1	2.1	1	1.8
Not Known	0	0.0	2	4.3	2	3.6
Total	9	100.0	47	100.0	56	100.0

**Figure 9. North Western Health Board region, month of occurrence**



**Figure 10. North Western Health Board region, day of occurrence**



**Table 45. North Western Health Board region, method of suicide**

Method	Females		Males		Total	
	No	%	No	%	No	%
Hang	1	11.1	25	53.2	26	46.4
Drowning	5	55.5	12	25.5	17	30.4
Shooting	1	11.1	5	10.6	6	10.7
Car Exhaust	2	22.2	2	4.3	4	7.1
Other	0	0	3	6.3	3	5.4
Total	9	100	47	100.0	56	100.0

## South Eastern Health Board Region

**Table 46. South Eastern Health Board region, age distribution by sex**

Age	Females		Males		Total	
	No	%	No	%	No	%
10-14	0	0.0	1	1.1	1	1.0
15-19	2	11.8	6	6.8	8	7.6
20-24	2	11.8	14	15.9	16	15.2
25-29	0	0.0	13	14.8	13	12.4
30-34	1	5.9	9	10.2	10	9.5
35-39	2	11.8	11	12.5	13	12.4
40-44	2	11.8	11	12.5	13	12.4
45-49	1	5.9	7	8.0	8	7.6
50-54	0	0.0	2	2.3	2	1.9
55-59	1	5.9	8	9.1	9	8.6
60-64	2	11.8	1	1.1	3	2.9
65-69	2	11.8	1	1.1	3	2.9
70-74	1	5.9	1	1.1	2	1.9
75-79	0	0.0	2	2.3	2	1.9
80-84	1	5.9	0	0.0	1	1.0
85+	0	0.0	1	1.1	1	1.0
Not stated	0	0.0	0	0.0	0	0.0
Total	17	100.0	88	100.0	105	100.0

**Table 47. South Eastern Health Board region, marital status**

Status	Females		Males		Total	
	No	%	No	%	No	%
Single	7	41.2	54	61.4	61	58.1
Married	6	35.3	19	21.6	25	23.8
Separated	1	5.9	6	6.8	7	6.7
Widowed	2	11.8	3	3.4	5	4.8
Co-habiting	1	5.9	3	3.4	4	3.8
Divorced	0	0.0	2	2.3	2	1.9
Not known	0	0.0	1	1.1	1	1.0
Total	17	100.0	88	100.0	105	100.0

**Table 48. South Eastern Health Board region, religion**

Religion	Females		Males		Total	
	No	%	No	%	No	%
Catholic	16	94.1	76	86.4	92	87.6
Church of Ireland	0	0.0	3	3.4	3	2.9
Not Known	1	5.9	9	10.2	10	9.5
Total	17	100.0	88	100.0	105	100.0

**Table 49. South Eastern Health Board region, employment status**

Status	Females		Males		Total	
	No	%	No	%	No	%
Employed	1	5.9	33	37.5	34	32.4
Unemployed	2	11.8	25	28.4	27	25.7
Self employed	0	0.0	16	18.2	16	15.2
Retired	3	17.6	7	8.0	10	9.5
Student	3	17.6	3	3.4	6	5.7
Housewife/husband	5	29.4	0	0.0	5	4.8
Not known	3	17.6	4	4.5	7	6.7
Total	17	100.0	88	100.0	105	100.0

**Table 50. South Eastern Health Board region, duration of unemployment for those unemployed**

Duration	Females		Males		Total	
	No	%	No	%	No	%
1 to 5.9 months	0	0.0	3	12.0	3	11.1
6 to 11.9 months	0	0.0	1	4.0	1	3.7
Over a year	2	100.0	21	84.0	23	85.2
Total	2	100.0	25	100.0	27	100.0

**Table 51. South Eastern Health Board region, social class**

Social Class	Females		Males		Total	
	No	%	No	%	No	%
1. Professional workers	0	0.0	2	2.3	2	1.9
2. Managerial and technical	2	11.8	4	4.5	6	5.7
3. Non-manual	0	0.0	5	5.7	5	4.8
4. Skilled manual	0	0.0	16	18.2	16	15.2
5. Semi-skilled	1	5.9	6	6.8	7	6.7
6. Unskilled	0	0.0	20	22.7	20	19.0
7. Unknown	13	76.5	21	23.9	34	32.4
8. Farmers	1	5.9	14	15.9	15	14.3
Total	17	100.0	88	100.0	105	100.0

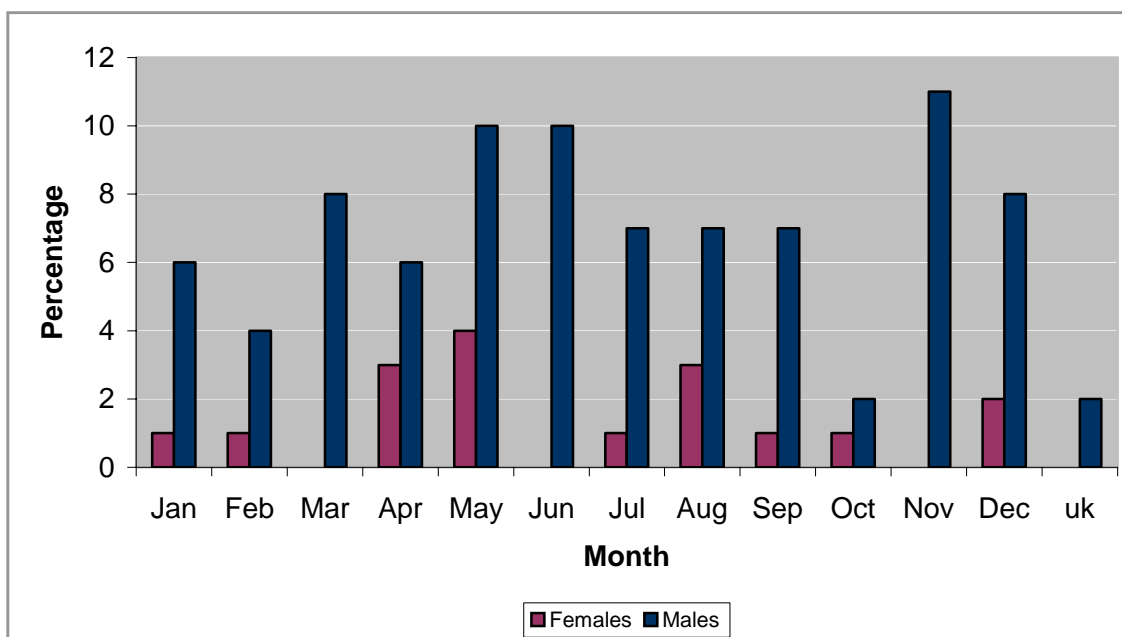
**Table 52. South Eastern Health Board , highest level of education completed**

Education	Females		Males		Total	
	No	%	No	%	No	%
Primary	4	23.5	23	26.1	27	25.7
Secondary	5	29.4	24	27.3	29	27.6
Third	2	11.8	7	8.0	9	8.6
Not Known	6	35.3	34	38.6	40	38.1
Total	17	100.0	88	100.0	105	100.0

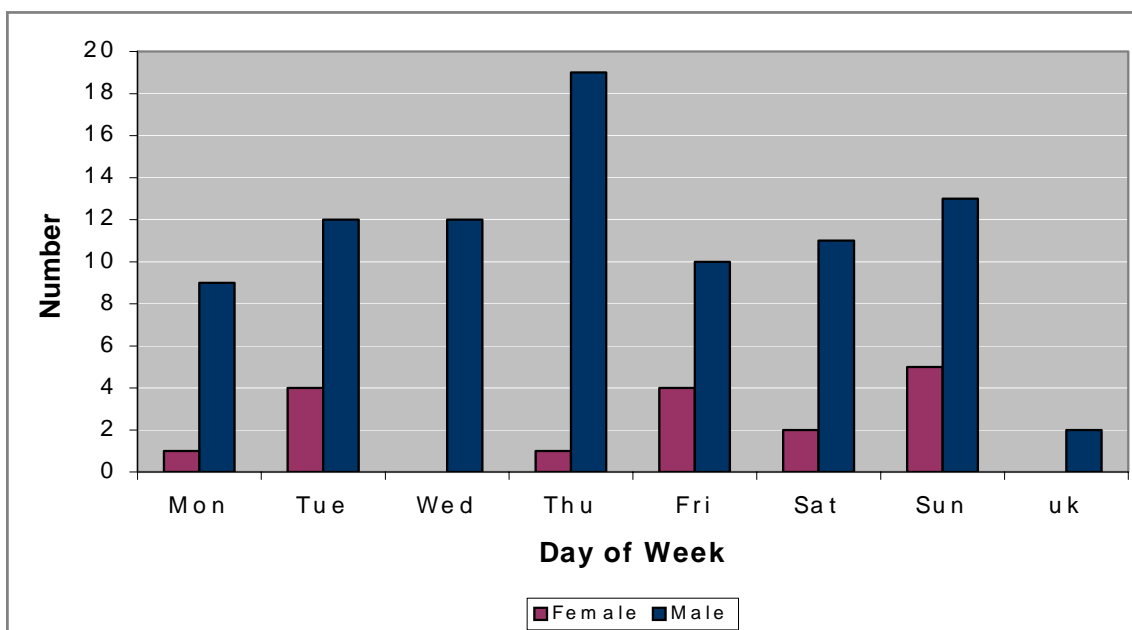
**Table 53. South Eastern Health Board region, accommodation**

Accommodation	Females		Males		Total	
	No	%	No	%	No	%
Home others	13	76.5	73	83.0	86	81.9
Home alone	3	17.6	9	10.2	12	11.4
Lodgings	1	5.9	2	2.3	3	2.9
Hostel	0	0.0	1	1.1	1	1.0
Prison	0	0.0	1	1.1	1	1.0
Not known	0	0.0	2	2.3	2	1.9
Total	17	100.0	88	100.0	105	100.0

**Figure 11. South Eastern Health Board region, month of occurrence for males and females**



**Figure 12. South Eastern Health Board region, day of occurrence**



**Table 54. South Eastern Health Board region, method of suicide**

Method	Females		Males		Total	
	No	%	No	%	No	%
Hanging	3	17.6	43	48.9	46	43.8
Shooting	2	11.8	16	18.2	18	17.1
Drowning	8	47.1	9	10.2	17	16.2
Car Exhaust	1	5.9	13	14.8	14	13.3
Overdose	2	11.8	5	5.7	7	6.7
Poison	1	5.9	2	2.3	3	2.9
Total	17	100.0	88	100.0	105	100.0



## Southern Health Board

**Table 55. Southern Health Board region, age distribution by sex**

Age	Females		Males		Total	
	No	%	No	%	No	%
10-14	1	2.9	1	0.7	2	1.1
15-19	3	8.8	9	5.9	12	6.4
20-24	1	2.9	31	20.3	32	17.1
25-29	2	5.9	19	12.4	21	11.2
30-34	4	11.8	23	15.0	27	14.4
35-39	3	8.8	16	10.5	19	10.2
40-44	3	8.8	10	6.5	13	7.0
45-49	5	14.7	15	9.8	20	10.7
50-54	3	8.8	7	4.6	10	5.3
55-59	3	8.8	7	4.6	10	5.3
60-64	3	8.8	4	2.6	7	3.7
65-69	2	5.9	2	1.3	4	2.1
70-74	1	2.9	3	2.0	4	2.1
75-79	0	0.0	5	3.3	5	2.7
80-84	0	0.0	1	0.7	1	0.5
85+	0	0.0	0	0.0	0	0.0
Total	34	100.0	153	100.0	187	100.0

**Table 56. Southern Health Board region, marital status**

Status	Females		Males		Total	
	No	%	No	%	No	%
Single	14	41.2	91	59.5	105	56.1
Married	13	38.2	34	22.2	47	25.1
Separated	3	8.8	15	9.8	18	9.6
Co-habiting	2	5.9	6	3.9	8	4.3
Widowed	1	2.9	3	2.0	4	2.1
Divorced	1	2.9	2	1.3	3	1.6
Not known	0	0.0	2	1.3	2	1.1
Total	34	100.0	153	100.0	187	100.0

**Table 57. Southern Health Board region, religion**

Religion	Females		Males		Total	
	No	%	No	%	No	%
Catholic	1	2.9	4	2.6	5	2.7
Church of Ireland	31	91.2	140	91.5	171	91.4
Not Known	2	5.9	9	5.9	11	5.9
Total	34	100.0	153	100.0	187	100.0

**Table 58. Southern Health Board region, employment status**

Status	Females		Males		Total	
	No	%	No	%	No	%
Unemployed	8	23.5	58	37.9	66	35.3
Employed	4	11.8	49	32.0	53	28.3
Self-employed	4	11.8	21	13.7	25	13.4
Retired	2	5.9	12	7.8	14	7.5
Student	3	8.8	10	6.5	13	7.0
Housewife/husband	12	35.3	0	0.0	12	6.4
Not known	1	2.9	3	2.0	4	2.1
Total	34	100.0	153	100.0	187	100.0

**Table 59. Southern Health Board region, duration of unemployment for those unemployed**

Duration	Females		Males		Total	
	No	%	No	%	No	%
Less than a month	0	0.0	1	1.7	1	1.5
1 to 5.9 months	1	12.5	3	5.2	4	6.1
6 to 11.9 months	2	25.0	3	5.2	5	7.6
Over a year	3	37.5	40	69.0	43	65.2
Not Known	2	25.0	11	19.0	13	19.7
Total	8	100.0	58	100.0	66	100.0

**Table 60. Southern Health Board region, social class**

Social Class	Females		Males		Total	
	No	%	No	%	No	%
1. Professional workers	0	0.0	3	5.2	3	4.5
2. Managerial and technical	5	62.5	5	8.6	10	15.2
3. Non-manual	2	25.0	5	8.6	7	10.6
4. Skilled manual	0	0.0	19	32.8	19	28.8
5. Semi-skilled	2	25.0	12	20.7	14	21.2
6. Unskilled	1	12.5	30	51.7	31	47.0
7. Unknown	22	64.7	69	45.1	91	48.7
8. Farmers	2	5.9	10	6.5	12	6.4
Total	34	100.0	153	100.0	187	100.0

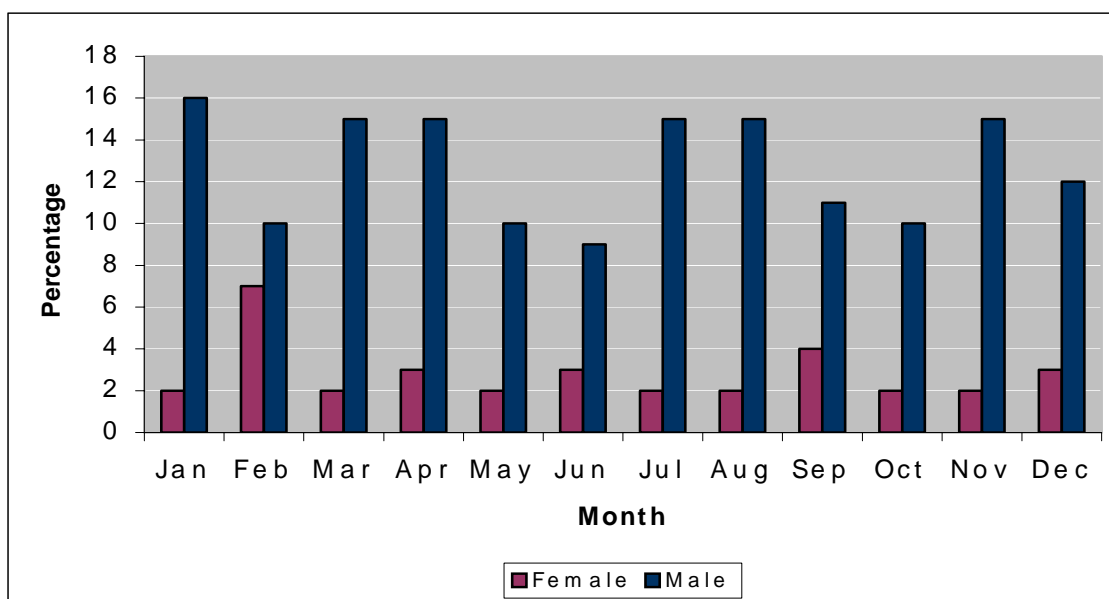
**Table 61. Southern Health Board region, highest level of education completed**

Education	Females		Males		Total	
	No	%	No	%	No	%
Primary	6	17.6	22	14.4	28	15.0
Secondary	12	35.3	51	33.3	63	33.7
Third	6	17.6	10	6.5	16	8.6
Not Known	10	29.4	70	45.8	80	42.8
Total	34	100.0	153	100.0	187	100.0

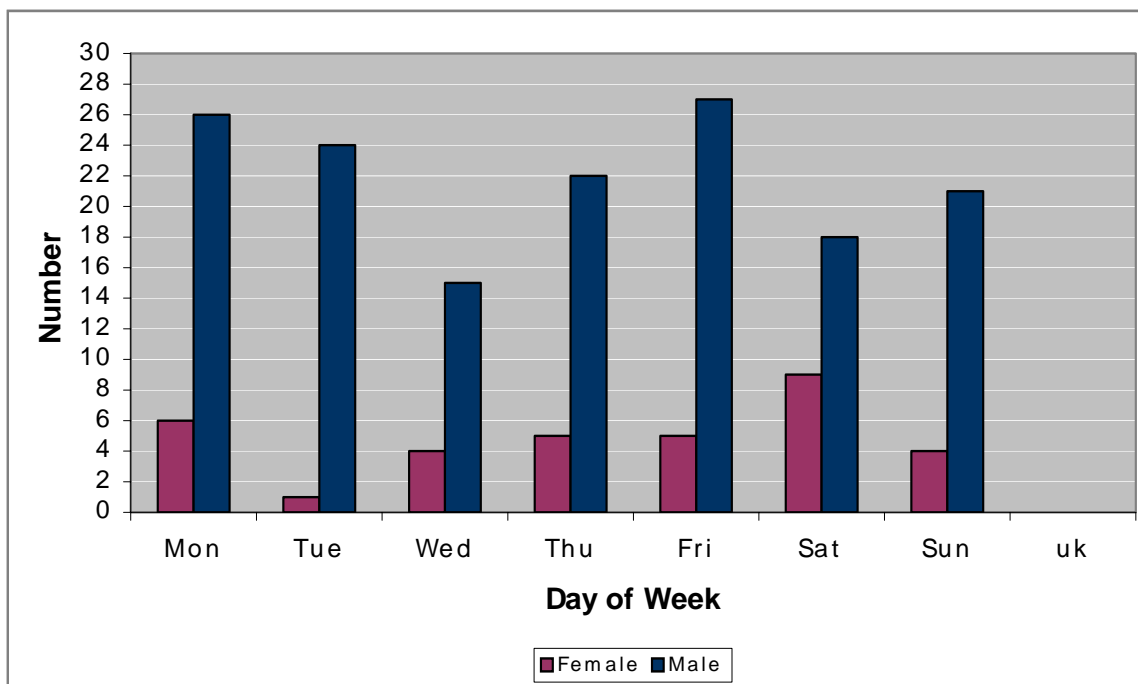
**Table 62. Southern Health Board region, accommodation**

Accommodation	Females		Males		Total	
	No	%	No	%	No	%
Home others	22	64.7	106	69.3	128	68.4
Home alone	8	23.5	24	15.7	32	17.1
Lodgings	2	5.9	11	7.2	13	7.0
Hostel	2	5.9	3	2.0	5	2.7
Not known	0	0.0	9	5.9	9	4.8
Total	34	100.0	153	100.0	187	100.0

**Figure 13. Southern Health Board region, month of occurrence for males and females**



**Figure 14. Southern Health Board region, day of occurrence**



**Table 63. Southern Health Board region, method of suicide**

Method	Females		Males		Total	
	No	%	No	%	No	%
Hanging	10	29.4	82	53.6	92	49.2
Drowning	12	35.3	36	23.5	48	25.7
Overdose	5	14.7	7	4.6	12	6.4
Poisoning	4	11.8	6	3.9	10	5.3
Car Exhaust	0	0.0	9	5.9	9	4.8
Shooting	1	2.9	8	5.2	9	4.8
Jumped Height	1	2.9	2	1.3	3	1.6
Jumped Train	1	2.9	2	1.3	3	1.6
Suffocation	0	0.0	1	0.7	1	0.5
Total	34	100.0	153	100.0	187	100.0

## Western Health Board

**Table 64. Western Health Board region, Age Distribution by Sex**

Age	Females		Males		Total	
	No	%	No	%	No	%
10-14	0	0.0	0	0.0	0	0.0
15-19	5	29.4	7	8.4	12	12.0
20-24	5	29.4	18	21.7	23	23.0
25-29	1	5.9	8	9.6	9	9.0
30-34	1	5.9	4	4.8	5	5.0
35-39	0	0.0	4	4.8	4	4.0
40-44	1	5.9	10	12.0	11	11.0
45-49	0	0.0	12	14.5	12	12.0
50-54	2	11.8	3	3.6	5	5.0
55-59	0	0.0	5	6.0	5	5.0
60-64	1	5.9	2	2.4	3	3.0
65-69	1	5.9	2	2.4	3	3.0
70-74	0	0.0	4	4.8	4	4.0
75-79	0	0.0	3	3.6	3	3.0
80-84	0	0.0	1	1.2	1	1.0
85+	0	0.0	0	0.0	0	0.0
Not stated	0	0.0	0	0.0	0	0.0
Total	17	100.0	83	100.0	100	100.0

**Table 65. Western Health Board region, marital status**

Status	Females		Males		Total	
	No	%	No	%	No	%
Single	15	88.2	50	60.2	65	65.0
Married	2	11.8	16	19.3	18	18.0
Separated	0	0.0	8	9.6	8	8.0
Co-habiting	0	0.0	5	6.0	5	5.0
Widowed	0	0.0	2	2.4	2	2.0
Not known	0	0.0	2	2.4	2	2.0
Total	17	100.0	83	100.0	100	100.0

**Table 66. Western Health Board region, religion**

Religion	Females		Males		Total	
	No	%	No	%	No	%
Catholic	16	94.1	78	94.0	94	94.0
Other	0	0.0	1	1.2	1	1.0
Not Known	1	5.9	4	6.0	5	5.0
Total	17	100.0	83	100.0	100	100.0

**Table 67. Western Health Board region, employment status**

Status	Females		Males		Total	
	No	%	No	%	No	%
Employed	7	41.2	30	36.1	37	37.0
Unemployed	3	17.6	23	27.7	26	26.0
Self employed	0	0.0	12	14.5	12	12.0
Retired	1	5.9	10	12.0	11	11.0
Student	5	29.4	6	7.2	11	11.0
Housewife/husband	1	5.9	0	0.0	1	1.0
Not known	0	0.0	2	2.4	2	2.0
Total	17	100.0	83	100.0	100	100.0

**Table 68. Western Health Board region, duration of unemployment for those unemployed**

Duration	Females		Males		Total	
	No	%	No	%	No	%
1 to 5.9 months	0	0.0	2	8.7	2	7.7
6 to 11.9 months	0	0.0	1	4.3	1	3.8
Over a year	2	66.7	17	73.9	19	73.1
Not Known	1	33.3	3	13.0	4	15.4
Total	3	100.0	23	100.0	26	100.0

**Table 69. Western Health Board region, social class**

Social Class	Females		Males		Total	
	No	%	No	%	No	%
1. Professional workers	0	0.0	3	3.6	3	3.0
2. Managerial and technical	2	11.8	2	2.4	4	4.0
3. Non-manual	1	5.9	5	6.0	6	6.0
4. Skilled manual	1	5.9	12	14.5	13	13.0
5. Semi-skilled	4	23.5	7	8.4	11	11.0
6. Unskilled	0	0.0	16	19.3	16	16.0
7. Unknown	9	52.9	23	27.7	32	32.0
8. Farmers	0	0.0	15	18.1	15	15.0
Total	17	100.0	83	100.0	100	100.0

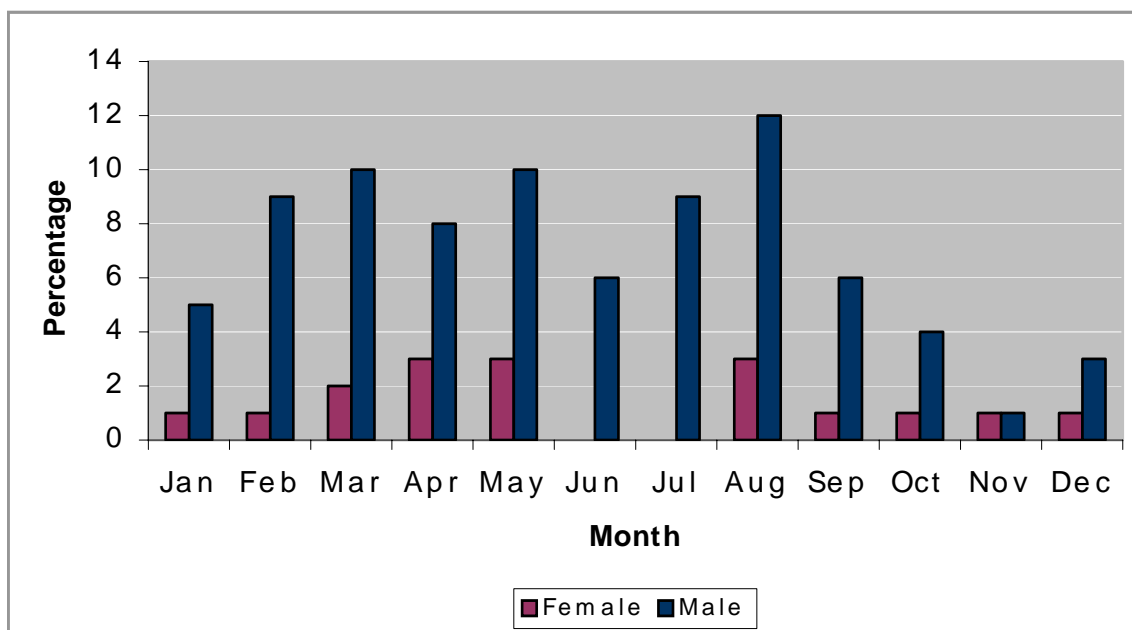
**Table 70. Western Health Board region, highest level of education completed**

Education	Females		Males		Total	
	No	%	No	%	No	%
Primary	3	17.6	9	10.8	12	12.0
Secondary	2	11.8	25	30.1	27	27.0
Third	10	58.8	33	39.8	43	43.0
Not Known	2	11.8	16	19.3	18	18.0
Total	17	100.0	83	100.0	100	100.0

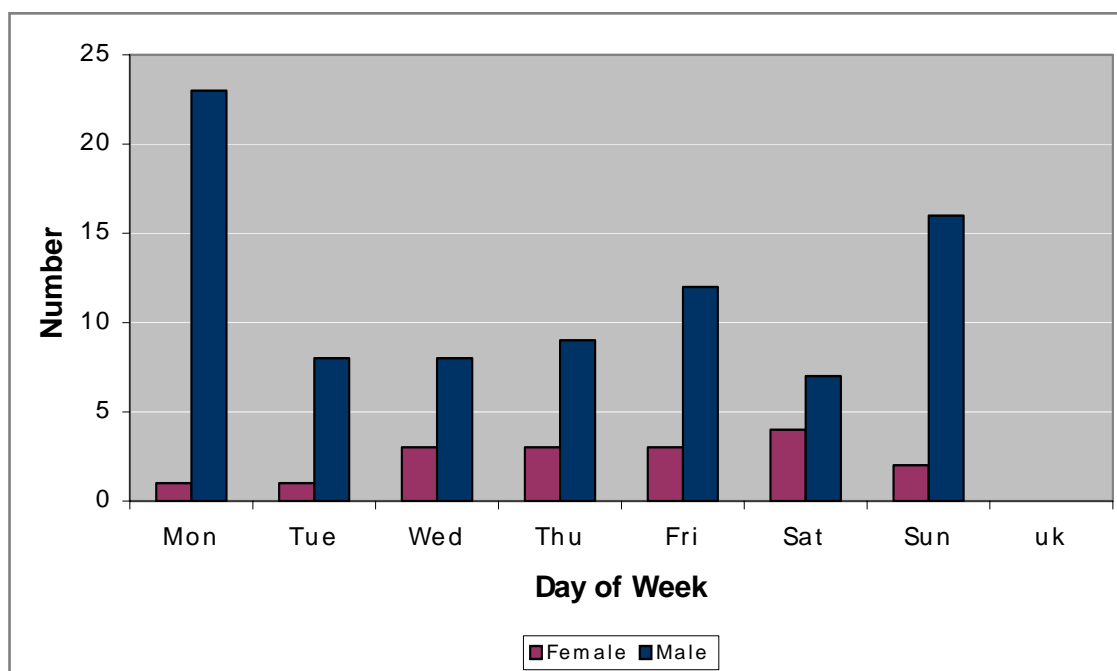
**Table 71. Western Health Board region, accommodation**

Accommodation	Females		Males		Total	
	No	%	No	%	No	%
Home others	13	76.5	55	66.3	68	68.0
Home alone	1	5.9	15	18.1	16	16.0
Lodgings	3	17.6	4	4.8	7	7.0
Hostel	0	0.0	3	3.6	3	3.0
Prison	0	0.0	1	1.2	1	1.0
Not known	0	0.0	5	6.0	5	5.0
Total	17	100.0	83	100.0	100	100.0

**Figure 15. Western Health Board region, month of occurrence for Males and Females**



**Figure 16. Western Health Board region, day of occurrence**



**Table 72. Western Health Board region, method of suicide**

Method	Females		Males		Total	
	No	%	No	%	No	%
Hanging	3	17.6	33	39.8	36	36.0
Drowning	5	29.4	25	30.1	30	30.0
Overdose	4	23.5	5	6.0	9	9.0
Poison	3	17.6	5	6.0	8	8.0
Shooting	0	0	8	9.6	8	8.0
Car Exhaust	1	5.9	3	3.6	4	4.0
Other	1	5.9	4	4.8	5	5.0
Total	17	100	83	100.0	100	100.0