

SUICIDE IN IRELAND

a national study



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A National Study

2001

Published by the Departments of Public
Health on Behalf of the Chief Executive
Officers of the Health Boards

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Preface

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 In 1998, suicide ranked as the fourth highest cause of years of potential life lost for males in Ireland, superseded only by deaths from circulatory diseases, cancers and respiratory diseases.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. A steering committee was established to undertake the research and to oversee the process in each health board. 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 *Report of 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 co-operation 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, North Eastern Health Board and Ms Margaret Hegarty, Research Fellow, North Eastern Health Board/Trinity College, Dublin, for their major contributions in collating and analysing the information.



Dr Rosaleen Corcoran

Co-ordinator & Chair of National Steering Committee

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executive summary



Executive Summary

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 growing concerns about the rising trend 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 total number of suicides identified in this study was 807, broadly similar to official figures released by the Central Statistics Office (CSO). The study involved a wide range of professionals and was co-ordinated in the North Eastern Health Board.

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

The study has confirmed the high rate of suicides in young males, with 40% of the deaths occurring in males aged 30 years and under. Almost five times more men died from suicide than women. The most common method used by males was hanging, with drowning the most common for females. The majority of those who died lived at home with others. The strong protective effect of marriage, as 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. Two-thirds of these had been unemployed for more than one year (at the time of this study the national unemployment rate was 10% or less). Medical cardholders were also over-represented in this study.

The importance of general practice as a point of contact for those at risk of suicide was confirmed in this study, as 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 most common 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 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 to have attended than older counterparts.

Of those patients referred to consultant psychiatrists, two-thirds were treated as in-patients. The majority of patients attending the mental health services were in established treatment, with only 5.4%

Executive Summary

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, with almost a quarter of the study population having a known history of this behaviour. In addition, a quarter of those who died were known to have expressed suicidal intent at some time.

Details of prescribed medication at the time of death are outlined in this report. The majority of both males and females on prescribed medication were taking nervous system drugs, with females more likely than males to be taking such 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 most common 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 the event. 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 include the need to improve the skills of young people, particularly males, in dealing with emotional and other problems in life. Other areas identified are; the high prevalence of depression, the need for easy access to health and social services, the role 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 who 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



Recommendations

1. The recommendations of the *Report of the National Suicide Task Force on Suicide* 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 quality at all levels of the service and reflect evidence-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.
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 settings 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 co-ordinator 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 men's health strategies. Men, 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.

Recommendations

14. Training on suicide and related issues should be an integral part of the training of GPs. 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 ongoing 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 flexibility, accessibility, and a low threshold for referral.
19. Lifeskills 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.
22. The use of guns should be reviewed and a new policy developed which should include increasing awareness by gun holders on firearm control, access and safe-keeping of arms.

introduction



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.^{1,2} In Europe it is amongst the top 10 leading causes of death,³ where a similar picture of a high suicide rate among young males is also seen. Figure 1 illustrates 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).³

FIGURE 1. STANDARDISED MORTALITY RATES FOR MALES, FOR SUICIDE AND SELF-INFLICTED INJURY, FOR IRELAND AND EUROPEAN UNION (EU) 1970 - 1996

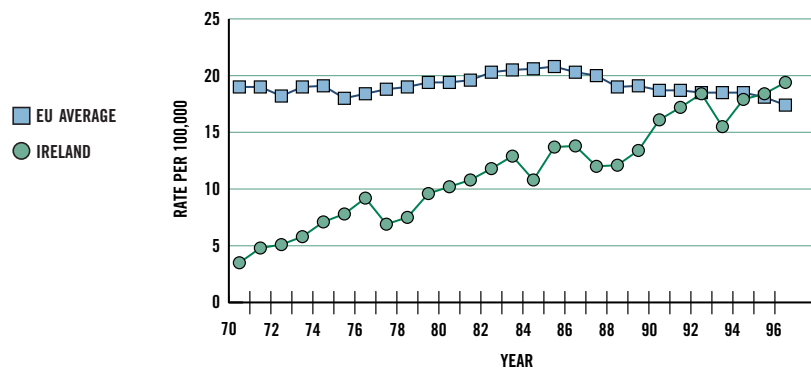
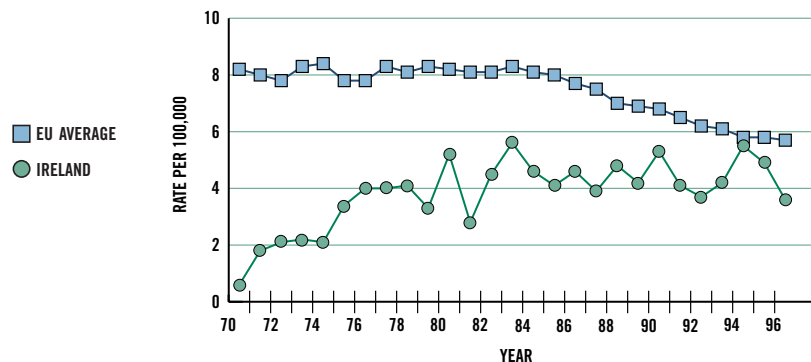


Figure 2 shows the female rate for suicide in Ireland and the EU for the same time-period. The female rates are much lower than the male rates and whilst the female rate in Ireland has risen over the time period, the rise has been less dramatic, with the Irish rate for females still being less than the 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

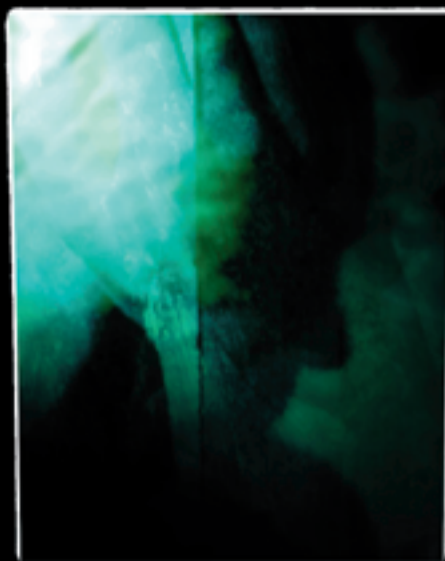


The reason for increases in Irish rates is unclear. There is a need for additional information on factors and circumstances relating to each case of suicide that would facilitate a better understanding of cause and allow for more appropriate prevention programmes to be developed for each region. As a 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 risk factors of suicide nationally, and on a health board basis, so as to inform the present knowledge base on suicide.
2. To facilitate the future planning of a suicide prevention programme.

methods



Methods

A steering committee was established to oversee the project. The study was co-ordinated, in each health board area, 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 sought only for 1997. Due to organisational restructuring the EHB no longer exists and has 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 for deaths which require 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 coroners’ 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 possessed a medical card or other records that would enable identification of a GP. If no GP was identified from the records, 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 coroner’s 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

Methods

deceased had attended, that psychiatrist was also sent a confidential questionnaire and asked to return the completed document, again, without the name of the patient. 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 steering 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 statistical software 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 God's Hospital, Dublin.

The social class classification used is that used by the CSO⁴ in Census 96. For the purpose of this study, however, farmers were assigned to a separate category, as the size of farms was not available.

The Anatomical Therapeutic Chemical Classification (ATC classification)⁵ was used to classify medications. The International Classification of Diseases-10 (ICD-10),⁶ was used to classify the diagnoses of patients as given by the consultant psychiatrists. The International Classification for Primary Care-2 (ICPC-2)⁷ was used to classify the presenting complaints and diagnoses of patients when attending their GP.

profile of the deceased
section 1.



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, with the exception of 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 details the age group by sex of those who died.

- * Males accounted for 668(82.8%) of the suicides and females for 139(17.2%).
- * 40.2% of the deaths in males were in those aged less than 30 years.
- * 26.6% of the deaths in females were in those aged less than 30 years.

TABLE 2. AGE GROUP BY SEX

AGE GROUP	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

section 1.

Profile of the Deceased

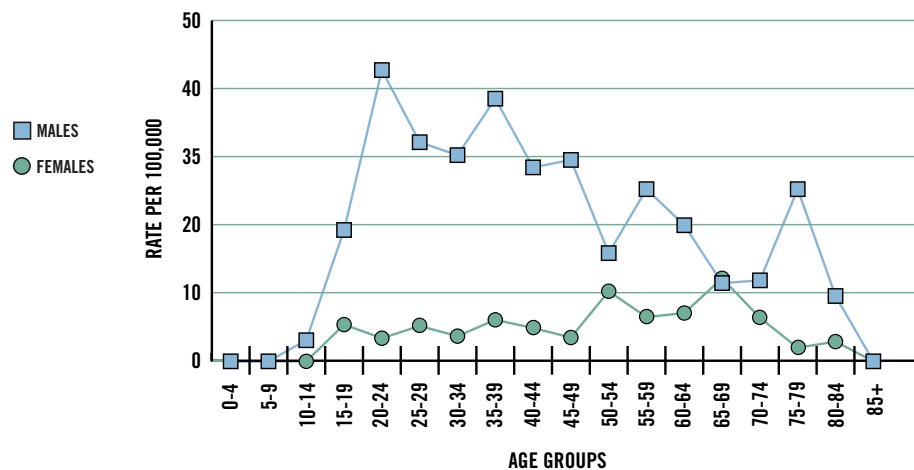
Females were significantly older than males when they committed suicide ($p < 0.0001$). The mean (average) age of females who committed suicide was 44.1 years (Standard deviation (SD) = 17.8), while the mean age of males was 37.4 years (SD = 16.2).

Section 1.2 Standardised Mortality Ratios and Mortality Rates

Standardised mortality ratios (SMRs) and age-specific mortality rates are methods of standardising mortality data so that comparisons can be made. An 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 illustrates the age-specific mortality rates 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.

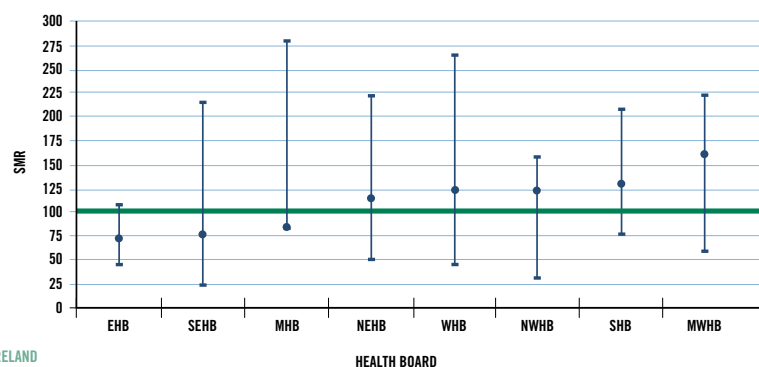
FIGURE 3. AGE-SPECIFIC MORTALITY RATES PER 100,000 POPULATION FOR SUICIDE IN 1997



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 WITH CONFIDENCE INTERVALS FOR FEMALE SUICIDES IN 1997



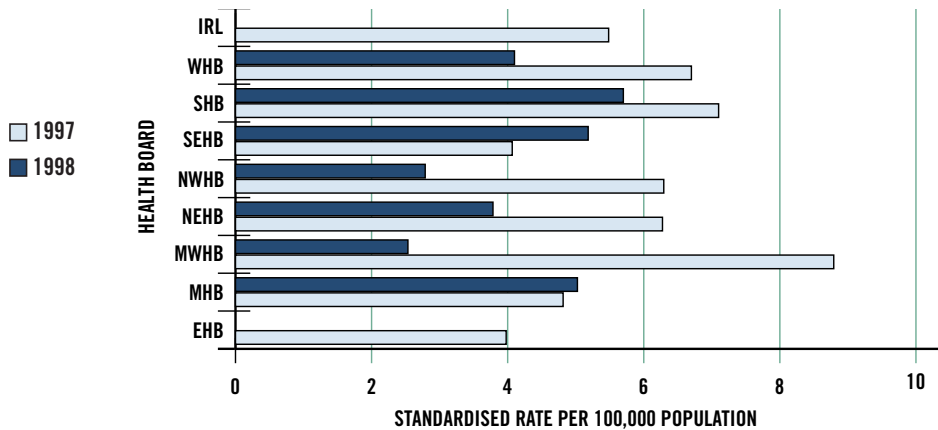
* GREEN LINE AT 100 IS IRELAND

section 1.

Profile of the Deceased

Figure 5 shows 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 to be expected.

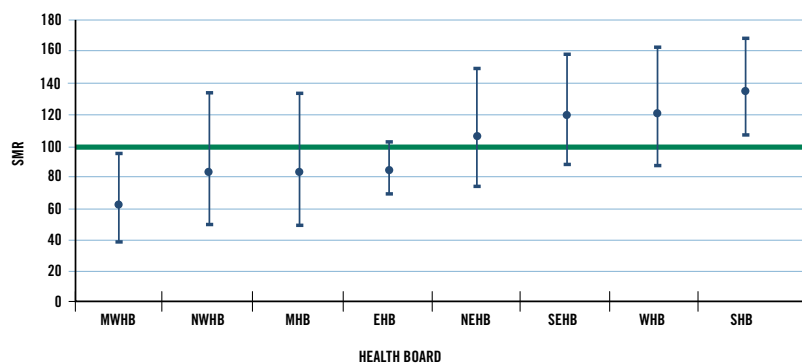
FIGURE 5. FEMALE STANDARDISED MORTALITY RATES FOR SUICIDE PER 100,000 POPULATION FOR 1997 AND 1998 (IRELAND AND EHB FOR 1997 ONLY)



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



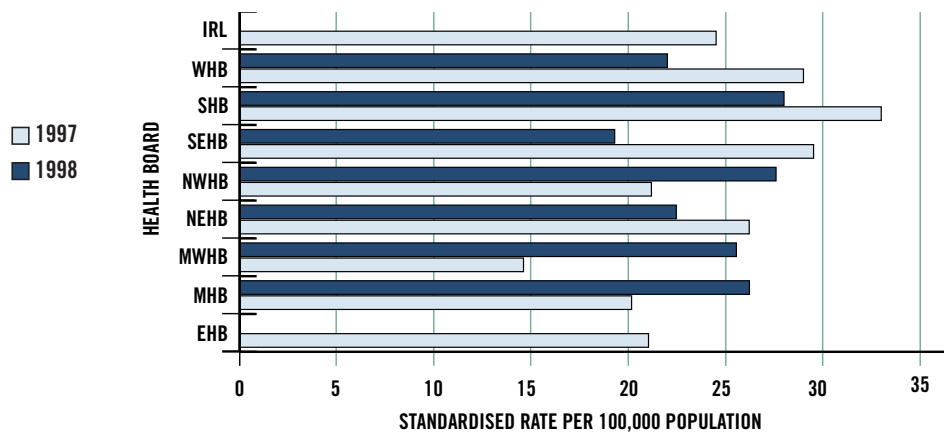
* GREEN LINE AT 100 IS IRELAND

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

section 1.

Profile of the Deceased

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 details 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 POPULATION 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.

Profile of the Deceased

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 describes 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 BY SEX

MARITAL 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
COHABITING	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
TOTAL	139	100.0	668	100.0	807	100.0

Section 1.5 Sexual Orientation

Table 5 outlines the sexual orientation of the deceased, based on information from their GPs and consultant psychiatrists. As set out on the table, the sexual orientation for over a third was unknown. Where sexual orientation was recorded ($n=502$), 96.8% were stated to be heterosexual.

TABLE 5. SEXUAL ORIENTATION OF THE DECEASED BY SEX

SEXUAL ORIENTATION	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
HETEROSEXUAL	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

section 1.

Profile of the Deceased

Section 1.6 Religion

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

TABLE 6. RELIGION OF THE DECEASED BY SEX

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
TOTAL	139	100.0	668	100.0	807	100.0

Section 1.7 Employment Status

Table 7 details 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 ($p < 0.01$).
- * 16(25.8%) of those classified as students had not completed second level education.

TABLE 7. EMPLOYMENT STATUS OF THE DECEASED BY SEX

EMPLOYMENT 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

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.

section 1.

Profile of the Deceased

TABLE 8. DURATION OF UNEMPLOYMENT BY SEX (FOR THOSE UNEMPLOYED)

DURATION OF UNEMPLOYMENT	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

Section 1.8 Social Class

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 the occupation was unknown for a large number of persons (43.6%), social class 7 contains the largest numbers. This is particularly noticeable in respect of females.

TABLE 9. SOCIAL CLASS OF THE DECEASED BY SEX

SOCIAL CLASS	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
1. PROFESSIONAL WORKERS	0	0.0	14	2.1	14	1.7
2. MANAGERIAL & 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 indicates 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 BY THE DECEASED BY SEX

HIGHEST LEVEL OF 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.

Profile of the Deceased

Section 1.9 Accommodation Prior to Suicide

Table 11 sets out the living arrangements of the deceased prior to suicide.

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

TABLE 11. ACCOMMODATION PRIOR TO SUICIDE BY SEX

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**



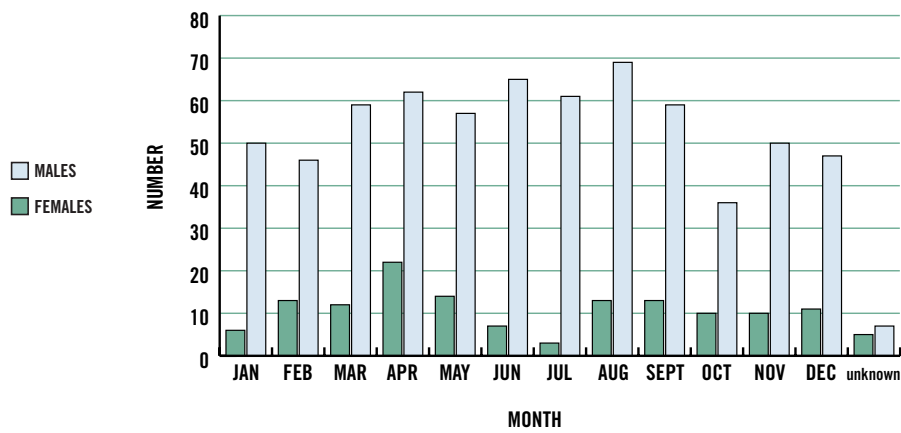
section 2.

Details of Suicide

Section 2.1 Month of Suicide

Figure 8 illustrates the month of occurrence of the suicides, with the months of April and May being the most common for females and August and June for males.

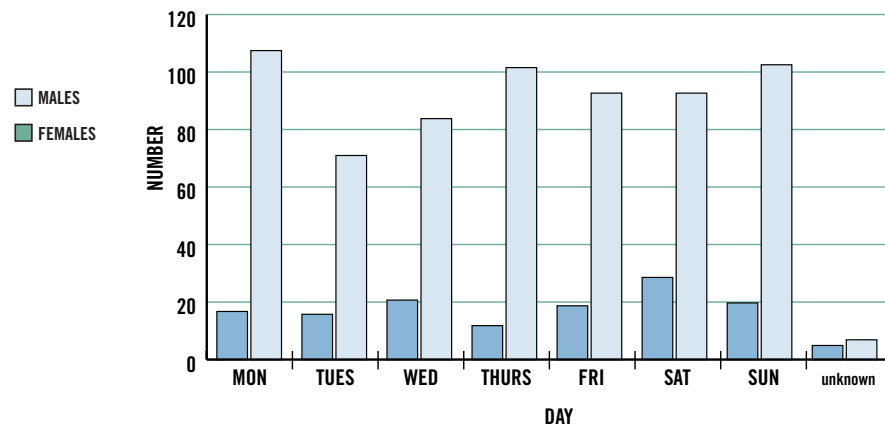
FIGURE 8. MONTH OF OCCURRENCE OF SUICIDES FOR MALES AND FEMALES



Section 2.2 Day of Suicide

Figure 9 illustrates the day of occurrence of suicides for males and females. Monday was the most common day of occurrence followed by Sunday and Saturday, for males while Saturday and Wednesday were most common for females.

FIGURE 9. THE DAY OF OCCURRENCE OF SUICIDE FOR MALES AND FEMALES



section 2.

Details of Suicide**Section 2.3 Method of Suicide**

Table 12 details the method of suicide for males and females. Drowning was the most common method of suicide for females while hanging was the most common method for males.

- * Males were significantly more likely than females to have used either hanging or shooting as a method of suicide ($p < 0.001$).
- * Females were significantly more likely than males to have used either drowning, overdose or poisoning ($p < 0.001$).

TABLE 12. METHOD OF SUICIDE BY SEX

METHOD OF SUICIDE	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.

attendance patterns with
section 3. **general practice**



section 3.

Attendance Patterns with General Practice

Section 3.1 Introduction

Questionnaires were returned by GPs and made available for analysis in respect of 562(69.6%) patients. Of these, 105(18.7%) were female and 457(81.3%) were male. 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, and 54(9.6%) for those aged 65 and over. Age was not stated for 2(0.4%) cases.

Section 3.2 Final Visit to GP

Table 13 sets out the timescale within which 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 death.

- * Females were more likely than males to have been seen by their GP in the four weeks prior to their death ($p < 0.002$).
- * 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 BY SEX

LENGTH OF TIME PRIOR TO DEATH	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 (n=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 details the presenting complaints made by the deceased at the last visit to their GP. Complaints were classified using the ICPC-2. This was amended for the purpose of the study to include a category "miscellaneous", which incorporated visits to the GP for a variety of reasons not readily classified by ICPC-2.

section 3.

Attendance Patterns with General Practice

The most common presenting complaint for both males and females was 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 BY SEX

PRESENTING 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(75.4%), 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 the table, “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 BY SEX

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.

Attendance Patterns with General Practice

Section 3.4 Diagnosis at Last Visit to GP

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

- * Psychological illnesses were most common 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 WITH GP, CLASSIFIED BY ICPC-2 BY SEX

COMPLAINT	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
RELATED TO PSYCHOLOGICAL ILLNESS (P)	63	60.0	181	39.6	244	43.4
RELATED TO RESPIRATORY SYSTEM (R)	6	5.7	60	13.1	66	11.7
RELATED TO MUSCULO-SKELETAL SYSTEM (L)	1	1.0	28	6.1	29	5.2
RELATED TO DIGESTIVE SYSTEM (D)	2	1.9	16	3.5	18	3.2
RELATED TO CIRCULATION (K)	3	2.9	12	2.6	15	2.7
RELATED 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
RELATED TO URINARY SYSTEM (U)	3	2.9	4	0.9	7	1.3
RELATED TO NEUROLOGICAL DISEASE (N)	1	1.0	5	1.1	6	1.1
RELATED TO EYES (F)	0	0.0	2	0.4	2	0.4
RELATED TO EARS (H)	0	0.0	1	0.2	1	0.2
RELATED 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. 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.

section 3.

Attendance Patterns with General Practice

TABLE 17. CLASSIFICATION DIAGNOSES OF PSYCHOLOGICAL ILLNESSES AT LAST VISIT TO GP, AS CLASSIFIED BY ICPC-2 BY SEX

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 3.5 Psychiatric Diagnosis by GP

Table 18 describes the psychiatric diagnosis, as described by the GP, of the 265 patients referred by the GP to the mental health 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 BY SEX

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 3.6 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.

Attendance Patterns with General Practice

Section 3.6.1 Attendees following Referral

Table 19 outlines the age distribution of the 240 patients who attended the mental health 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 female suicides in this study and 54.3% of all females for whom a GP questionnaire was returned). Females were more likely to have attended than males ($p < 0.02$).
- * 183 males attended (27.4% of all 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 years were also less likely to have attended than older females ($p < 0.004$).

TABLE 19. AGE GROUP OF THOSE WHO ATTENDED PSYCHIATRIC CARE BY SEX

AGE GROUP	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 3.6.2 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 patients discharged from psychiatric care, 21(40.4%) had problems (known to their GP) afterwards. 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 in 2(9.5%),
- * Marital/domestic problems in 2(9.5%),
- * Drug related problems in 1(4.8%)
- * Other problems in 7(33.33%).

*section 3.***Attendance Patterns with General Practice****(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 3.7 GP Description of Patient Circumstances

- * 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 ($p<0.001$).
- * 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 ($p<0.008$).
- * 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 ($p<0.0001$).
- * 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, and there was likely to have been a history of alcohol abuse ($p<0.001$).

attendance with
section 4. **mental health services**



section 4.

Attendance with Mental Health Services

Section 4.1 Introduction

Questionnaires were returned by consultant psychiatrists in respect of 148 patients. This represents 61.7% of those who attended these services following referral by their GP, and 18.3% of all patients in the study. Table 20 sets out the age and sex breakdown of those for whom questionnaires were returned.

TABLE 20. AGE GROUP OF PATIENTS FOR WHOM A QUESTIONNAIRE WAS RETURNED BY CONSULTANT PSYCHIATRISTS, BY SEX

AGE GROUP	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
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

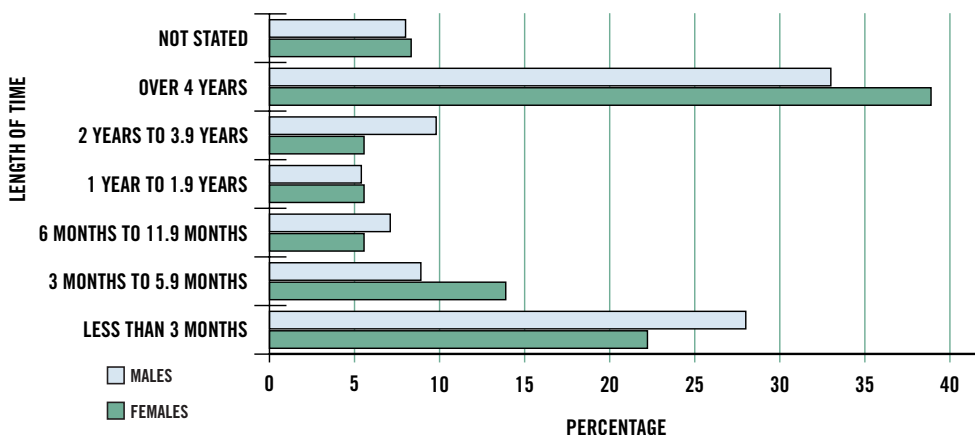
Figure 10 outlines the length of time patients had been attending.

- * 38.9% of females and 33.0% of males had been attending mental health services for 4 years or more.
- * 27.7% of males and 22.2% of females had been attending for less than 3 months.

section 4.

Attendance with Mental Health Services

FIGURE 10. LENGTH OF TIME ATTENDING MENTAL HEALTH SERVICES FOR MALES AND FEMALES



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 these services at time of death. Sixty-two (41.9%) were not attending at time of death. 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.
- * 65(43%) 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 BY SEX

LAST SEEN	FEMALES		MALES		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 not to be 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.

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Attendance with Mental Health Services

Section 4.3.3 Those Treated as In-patients

A total of 102(68.9%) of the deceased had been treated as in-patients.

(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.

- * 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 In-Patient Discharge to Time of Death:

For those treated as in-patients, Table 23 indicates when, prior to death, they were last discharged from in-patient 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 IN-PATIENT 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.

Attendance with Mental Health Services

Section 4.4 Stage of Treatment at Time of Death

Table 24 indicates the stage of treatment at the time of death, with a minority 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 & 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 details the psychiatric diagnosis made by the consultant psychiatrist.

TABLE 25. PSYCHIATRIC DIAGNOSIS BY ICD-10 CLASSIFICATION BY SEX

ICD-10 CODE	FEMALES		MALES	TOTAL
	No (%)	No (%)	No (%)	No (%)
MOOD (AFFECTIVE) DISORDERS (F30-F39)	20(55.6)	35(31.3)	55(37.1)	
SCHIZOPHRENIA, SCHIZOTYPAL & DELUSIONAL DISORDERS (F20-F29)	7(19.4)	29(25.9)	36(24.3)	
MENTAL & BEHAVIOURAL DISORDERS DUE TO PSYCHOACTIVE SUBSTANCE MISUSE (F10-F19)	1(2.8)	14(12.5)	15(10.1)	
NEUROTIC, STRESS-RELATED & SOMATOFORM DISORDERS (F40-F48)	3(8.3)	8(7.1)	11(7.4)	
DISORDERS OF ADULT PERSONALITY & 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(16.2)	
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 a diagnosis of a bipolar affective disorder (F31).

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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 a diagnosis of a bipolar affective disorder (F31).
- * 1(2.9%) had a diagnosis of a 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) of which 15 (51.7%) males received a diagnosis.

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

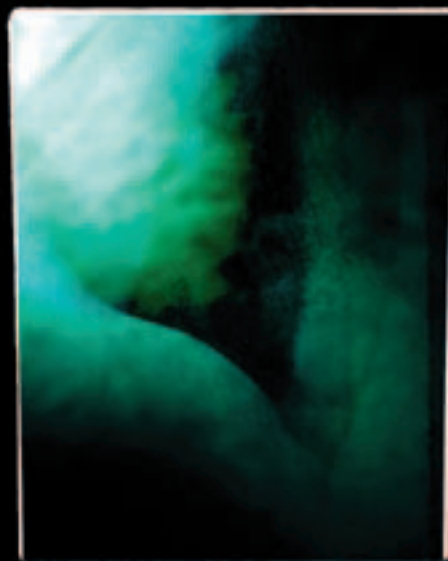
- * 99(66.9%) were referred by their GP.
- * 17(11.5%) were referred by a hospital.
- * 7(4.7%) were referred by family / friend.
- * 5(3.4%) were self-referrals.
- * 6(4.1%) were referred by other means.
- * The source of referral was not stated in respect of 14(9.5%).

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

Section 4.7 Consultant Psychiatrist Description of Patient Circumstances

- * 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' descriptions, but was related to marital status. This description was more likely in those who were single ($p < 0.03$).
- * 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' descriptions.
- * Consultant psychiatrists described 7(4.7%) of their patients as having been in, or having conflict with, the law. All 7 were male.
- * 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
medication**



section 5.

Prescribed Medication

Section 5.1 Number on Medication

Based on the information obtained from GP and consultant psychiatrist questionnaires, the following details were obtained:

(a) Total:

- * 286 of the deceased 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.

Prescribed Medication

Section 5.2 ATC Classification of Medication

(a) All Medications:

Table 26 indicates the medications taken by 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 under 30 years of age were less likely to be taking prescribed medications than females aged 30 and over ($p < 0.002$)
- * Males under 30 years of age were less likely to be taking prescribed medications than females aged less than 30 ($p < 0.03$)
- * Males under 30 years of age 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 medications.

(b) Nervous System Medications:

Table 27 details the nervous system medications by type for males and females.

- * Antidepressants were the most commonly prescribed medications for males and females.
- * 18(21.1%) of the females taking nervous system medications were on 1 nervous system medication, 32(50.0%) were on 2 and 14(21.9%) were taking 3 or more.
- * 76(44.7%) of the males taking nervous system medications were taking 1 nervous system medication, 67(39.4%) were on 2 and 27(15.9%) were on 3 or more.

section 5.

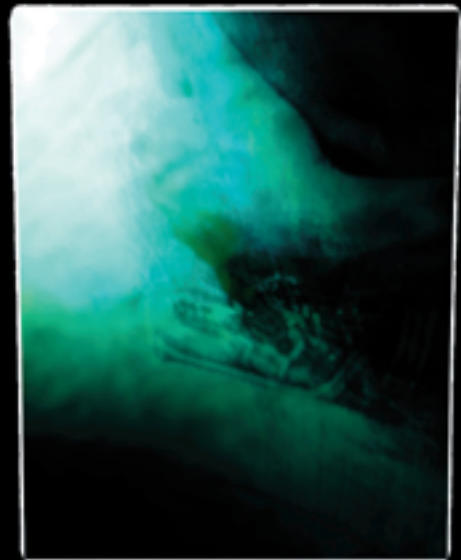
Prescribed Medication

TABLE 27. TYPE OF NERVOUS SYSTEM MEDICATION 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 & 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 medication ($p < 0.0001$).

section 6. **reported patient
behaviour**



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 engaged in 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 who attended psychiatrists were more likely than those who had not, to have a report of deliberate self-harm ($p < 0.0001$). Table 28 describes the age group by sex 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 GROUP OF THOSE WITH A HISTORY OF DELIBERATE SELF-HARM BY SEX

AGE GROUP	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 suicidal intent at some time. Table 29 describes the age group by sex 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.

section 6.

Reported Patient Behaviour

TABLE 29. THE AGE GROUP OF THOSE WHO EXPRESSED SUICIDAL INTENT BY SEX

AGE GROUP	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
85+	0	0	0	0	0	0
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 GPs 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 consultant psychiatrists' 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.***Reported Patient 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 a 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 gender, 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.
- * 32 patients (59.3%) with a history of drug or solvent abuse 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 under 25 years of age 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 death 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.

section 6.

Reported Patient Behaviour

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 347(61.7%) patients had experienced a recent significant event.
- * From the 148 questionnaires from the psychiatrists 78(52.7%) patients had experienced a recent significant event.

Table 30 describes the age group by sex of those with a recent significant event known to their GP or consultant psychiatrist.

TABLE 30. AGE GROUP OF THOSE WITH A RECENT SIGNIFICANT EVENT BY SEX

AGE GROUP	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
85+	0	0	0	0	0	0
NOT KNOWN	0	0.0	2	0.6	2	0.5
TOTAL	69	100.0	310	100.0	379	100.0

section 6.

Reported Patient Behaviour

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

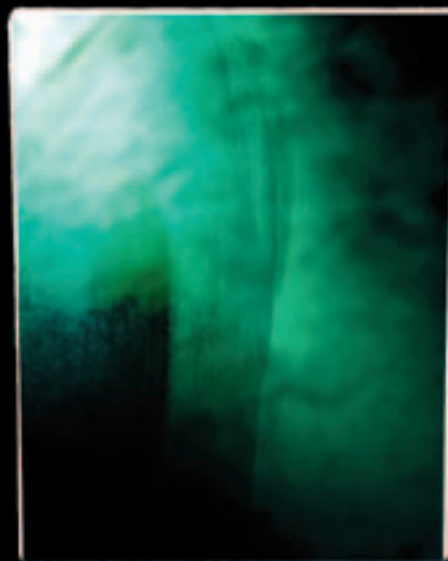
TABLE 31. THE 15 MOST COMMONLY REPORTED RECENT SIGNIFICANT EVENTS BY SEX

EVENT	FEMALES		MALES		TOTAL	
	No	%*	No	%*	No	%*
BREAK UP OF 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
PERSONAL 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

* THE PERCENTAGES IN THE TABLE REFER TO THE PERCENTAGE OF THE TOTAL MALE AND FEMALE STUDY POPULATIONS, THAT IS, 668 AND 139

- * Break up of relationship/marriage was the most common single recent event recorded. Those whose marital status was described as separated or single, were more likely than those who were described as married, cohabiting, divorced or widowed to have experienced a recent break up in a relationship ($p < 0.0001$). The mean age of females who experienced a break up was 40.8 years (SD: 16.0, range 15-71), while for males it was 34.4 years (SD: 12.4, range 16-75).
- * 39(34.2%) of the 114 males with a history of a relationship break up, were known by their GP or psychiatrist to have a history of alcohol abuse, 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 break up, were known by their GP or psychiatrist to have a history of alcohol abuse, 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 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 was fear of, or failure in exams, had a mean age of 17 years (SD: 2.2, range 16-18). Males had a median age of 19 years (mean = 23 years, SD: 10.0, range 16-47).

discussion



Discussion

Suicide is recognised as a major public health problem in Ireland. *The Report of the National Task Force on Suicide*, following a detailed analysis and consideration of the factors involved, formulated a prevention/reduction strategy to reduce the number of suicides⁸. The findings in this study confirm many of the factors discussed in that report, and in the Interim Report of the Task Force,¹ and provide information on many aspects of suicide in Ireland that can be used in 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 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 EHB region) 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* to provide more detailed information on the deceased.

The methods used to identify suicides in this study included a combination of using C71 forms, attendance at Coroners' 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 not included in the study. Regardless of which methods are used, however, some suicides will be difficult to identify, for example, single vehicle road accidents with single occupant only, drug overdoses and 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.⁹ 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. The lack of integration and fundamental changes in Irish society, including changes in spiritual values and rising rates of births outside of marriage, have been suggested as being associated with an increased rate of suicide.¹⁰ Such societal changes in other countries have seen increases in the suicide rates, particularly in young men. The excellent literature review produced by Aware,¹¹ 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,

Discussion

increases in the alcohol consumption of the population and a reduction in church membership, were associated with an increased rate of suicide in those aged 15-24.

Unemployment is considered to be an important risk factor for suicide.^{12, 13} 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 rate was 10.4% and 6.4% for the fourth quarters of 1997 and 1998, respectively.¹⁴ 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.¹³ The increased rate of suicide in Ireland has also been linked to unemployment. It is therefore more difficult to understand the continuing rise in suicide rates whilst the Irish economy is booming, with falling unemployment rates. Unemployment is, of course, 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.¹³

Marital status has a strong protective effect on mortality from suicide, with single, separated, divorced and widowed persons have higher rates.¹⁵ There is some evidence to suggest, however, that the protective effect of marriage only applies to males.¹⁶ 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.¹⁷ 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 assist in doing so in time. Medical cardholders were over-represented in this study, with 41.8% having medical cards, compared to 32% of the Irish population in 1998.¹⁸ 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 over-representation of "unskilled workers", with 13.6% in this study categorised as "unskilled", compared to 7.5% in the 96 Census. This may indicate 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 in this study who died as a result of suicide, 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 whose sexual orientation is other than heterosexual is unknown. They should not, however, 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,¹⁹ and that homosexual/bisexual males are four times more likely to report suicidal intent.²⁰ In

Discussion

addition, young males who are homosexual may have a difficulty in “coming out”, with one of the consequences of the confusion over their identity being an increased risk of suicide.²¹

Mental health disorders are known to increase the risk of suicide,²² 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.²³ 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 help²⁴ 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*⁵ 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.²⁵ This may be due to a reduced level of care and support. In this study, almost a third (31.4%) of those treated as in-patients died within three months of discharge from hospital. This is slightly higher than the 24% reported in the United Kingdom.²⁶ This figure 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 individuals 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.¹¹

Significant events in life have been associated with suicide,²⁷ 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.²⁸ 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*,¹¹ 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.^{29, 30} Several suggestions have been

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put forward to help explain the relationship between alcohol and suicide. These include the perception of alcohol as a self-destructive behaviour, the frequent incidence of depression among alcoholics, and the increased risk of fatal outcome in suicide attempts following consumption of large quantities of alcohol.³¹ 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*⁸ recommended the full implementation of the *National Alcohol Policy*.³⁰

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.³²

Given that the overall level of drinking in a population is significantly related to alcohol related problems that the population will experience,³³ 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.^{34,35} 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, young males in particular, are less likely to attend their GP and are, therefore, less amenable to help. Depression is an important psychiatric disorder in adolescence 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.³⁶ 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.³⁷

Discussion

Adolescents themselves very rarely seek professional help in relation to how they are feeling - rather, the consultation is usually made by a parent.³⁸ 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.³⁹ Nervous system drugs, as classified by the ATC classification, accounted for 19% of the total drugs, medicines and appliances budget in the GMS in 1998.¹⁸ This is second only to drugs for the cardiovascular system. Looking specifically at psycholeptics (N05) and psychoanaleptics (N06, 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.^{18,40} The increased use of such drugs may suggest that GPs are more aware of the need to identify and 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 such management should be retained within general practice, with more specialist advice being made available to them.⁴¹ There are many specific recommendations on the care of those who deliberately self-harm in the *Report of the National Task Force on Suicide*.⁸ 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.⁴² 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,⁴³ the findings in this study, as in others in Ireland,⁴⁴ 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. With 10% of suicides in this study occurring, however, as a result of the use of firearms, a decrease in the availability of guns may prevent some suicides, as has been demonstrated elsewhere.⁴⁵

conclusions



Conclusions

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. 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. 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 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. Almost a third of those who were treated as in-patients died within three months of discharge from hospital.
9. Recent significant events prior to death were an important factor. For almost half, such an event was known to their GP or psychiatrist. Relationship problems were the most common 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 subsequently die as a result of suicide. 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



Appendix

Summary Tables for Each Health Board Region

Eastern Health Board Region

TABLE 1. EASTERN HEALTH BOARD REGION, AGE GROUP BY SEX

AGE GROUP	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
10-14	0	0.0	1	0.8	1	0.7
15-19	2	8.7	16	13.6	18	12.8
20-24	1	4.3	19	16.1	20	14.2
25-29	0	0.0	14	11.9	14	9.9
30-34	1	4.3	16	13.6	17	12.1
35-39	4	17.4	14	11.9	18	12.8
40-44	1	4.3	7	5.9	8	5.7
45-49	1	4.3	5	4.2	6	4.3
50-54	4	17.4	9	7.6	13	9.2
55-59	3	13.0	6	5.1	9	6.4
60-64	3	13.0	5	4.2	8	5.7
65-69	2	8.7	2	1.7	4	2.8
70-74	0	0.0	0	0.0	0	0
75-79	0	0.0	3	2.5	3	2.1
80-84	0	0.0	0	0.0	0	0
85+	1	4.3	0	0.0	1	0.7
NOT STATED	0	0.0	1	0.8	1	0.7
TOTAL	23	100.0	118	100.0	141	100.0

TABLE 2. EASTERN HEALTH BOARD REGION, MARITAL STATUS BY SEX

MARITAL 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
COHABITING	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 BY SEX

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
TOTAL	23	100.0	118	100.0	141	100.0

Appendix

Summary Tables for Each Health Board Region

TABLE 4. EASTERN HEALTH BOARD REGION, EMPLOYMENT STATUS BY SEX

EMPLOYMENT 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 BY SEX (FOR THOSE UNEMPLOYED)

UNEMPLOYMENT 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 BY SEX

SOCIAL CLASS	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
1. PROFESSIONAL WORKERS	0	0.0	4	3.42	4	2.8
2. MANAGERIAL & TECHNICAL	6	25.0	11	9.40	17	12.1
3. NON-MANUAL	3	12.5	7	6.0	10	7.1
4. SKILLED MANUAL	0	0.0	12	10.3	12	8.5
5. SEMI-SKILLED	1	4.2	10	8.5	11	7.8
6. UNSKILLED	0	0.0	16	13.7	16	11.3
7. UNKNOWN	14	58.3	54	46.2	68	48.2
8. FARMERS	0	0.0	3	2.6	3	2.1
TOTAL	24	100.0	117	100.0	141	100.0

TABLE 7. EASTERN HEALTH BOARD REGION, HIGHEST LEVEL OF EDUCATION COMPLETED BY SEX

HIGHEST LEVEL OF EDUCATION COMPLETED	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 LEVEL	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

Appendix

Summary Tables for Each Health Board Region

TABLE 8. EASTERN HEALTH BOARD REGION, ACCOMMODATION BY SEX

ACCOMMODATION	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
HOME WITH 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 BY SEX

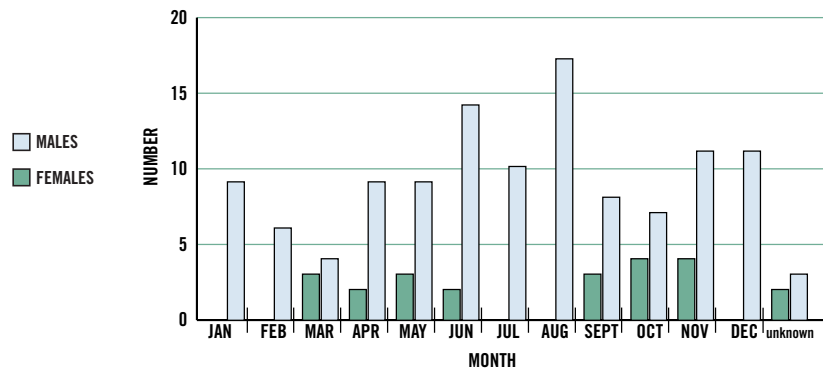
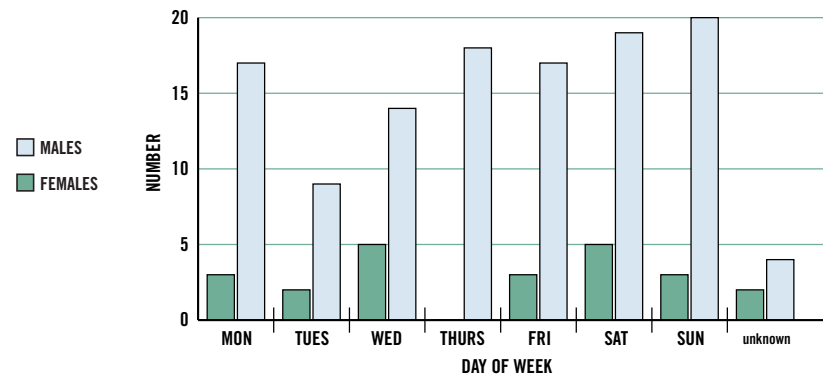


FIGURE 2. EASTERN HEALTH BOARD REGION, DAY OF OCCURRENCE BY SEX



Appendix

Summary Tables for Each Health Board Region

TABLE 9. EASTERN HEALTH BOARD REGION, METHOD OF SUICIDE BY SEX

METHOD OF SUICIDE	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 FROM 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 GROUP BY SEX

AGE GROUP	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
TOTAL	9	100.0	45	100.0	54	100.0

Appendix

Summary Tables for Each Health Board Region

TABLE 11. MIDLAND HEALTH BOARD REGION, MARITAL STATUS BY SEX

MARITAL 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
COHABITING	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 12. MIDLAND HEALTH BOARD REGION, RELIGION BY SEX

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 13. MIDLAND HEALTH BOARD REGION, EMPLOYMENT STATUS BY SEX

EMPLOYMENT 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
RETIRED	0	0.0	11	24.4	11	20.4
S-EMPLOYED	4	44.4	0	0.0	4	7.4
STUDENT	0	0.0	4	8.9	4	7.4
HOUSEWIFE/HUSBAND	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 14. MIDLAND HEALTH BOARD REGION, DURATION OF UNEMPLOYMENT BY SEX (FOR THOSE UNEMPLOYED)

DURATION OF UNEMPLOYMENT	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

Appendix

Summary Tables for Each Health Board Region

TABLE 15. MIDLAND HEALTH BOARD REGION, SOCIAL CLASS BY SEX

SOCIAL CLASS	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
1. PROFESSIONAL WORKERS	0	0.0	1	2.2	1	1.9
2. MANAGERIAL & 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

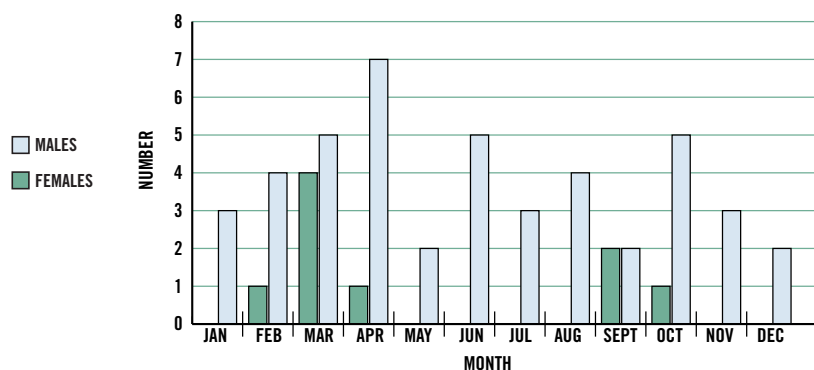
TABLE 16. MIDLAND HEALTH BOARD REGION, HIGHEST LEVEL OF EDUCATION COMPLETED BY SEX

HIGHEST LEVEL OF EDUCATION COMPLETED	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
THIRD LEVEL	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 BY SEX

ACCOMMODATION	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
HOME WITH OTHERS	4	44.4	33	73.3	37	68.5
HOME ALONE	1	11.1	3	6.7	4	7.4
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 BY SEX



Appendix

Summary Tables for Each Health Board Region

FIGURE 4. MIDLAND HEALTH BOARD REGION, DAY OF OCCURRENCE BY SEX

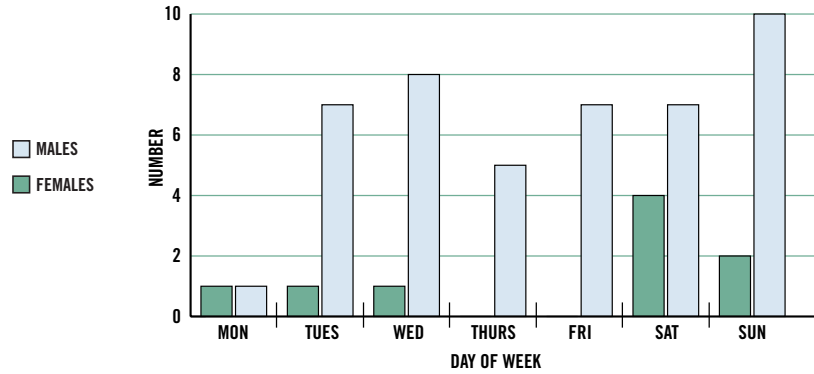


TABLE 18. MIDLAND HEALTH BOARD, METHOD OF SUICIDE BY SEX

METHOD OF SUICIDE	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
DROWNING	4	44.4	13	28.9	17	31.5
HANGING	2	22.2	15	33.3	17	31.5
SHOOTING	0	0	10	22.2	10	18.5
OVERDOSE	3	33.3	1	2.2	4	7.4
CAR EXHAUST	0	0	2	4.4	2	3.7
JUMP 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 GROUP BY SEX

AGE GROUP	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

Appendix

Summary Tables for Each Health Board Region

TABLE 20. MID-WESTERN HEALTH BOARD REGION, MARITAL STATUS BY SEX

MARITAL 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
COHABITING	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 BY SEX

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 BY SEX

EMPLOYMENT 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 BY SEX (FOR THOSE UNEMPLOYED)

DURATION OF UNEMPLOYMENT	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

Appendix

Summary Tables for Each Health Board Region

TABLE 24. MID-WESTERN HEALTH BOARD REGION, SOCIAL CLASS BY SEX

SOCIAL CLASS	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
1. PROFESSIONAL WORKERS	0	0.0	0	0.0	0	0.0
2. MANAGERIAL & 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

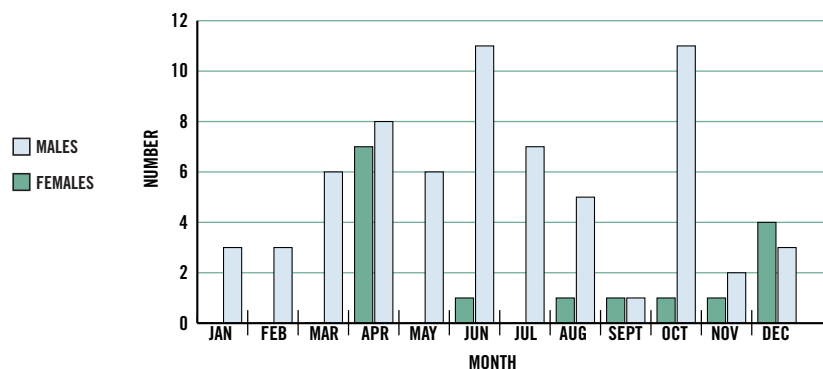
TABLE 25. MID-WESTERN HEALTH BOARD REGION, HIGHEST LEVEL OF EDUCATION COMPLETED BY SEX

HIGHEST LEVEL OF EDUCATION COMPLETED	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 LEVEL	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 BY SEX

ACCOMMODATION	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
HOME WITH 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 BY SEX



Appendix

Summary Tables for Each Health Board Region

FIGURE 6. MID-WESTERN HEALTH BOARD REGION, DAY OF OCCURRENCE BY SEX

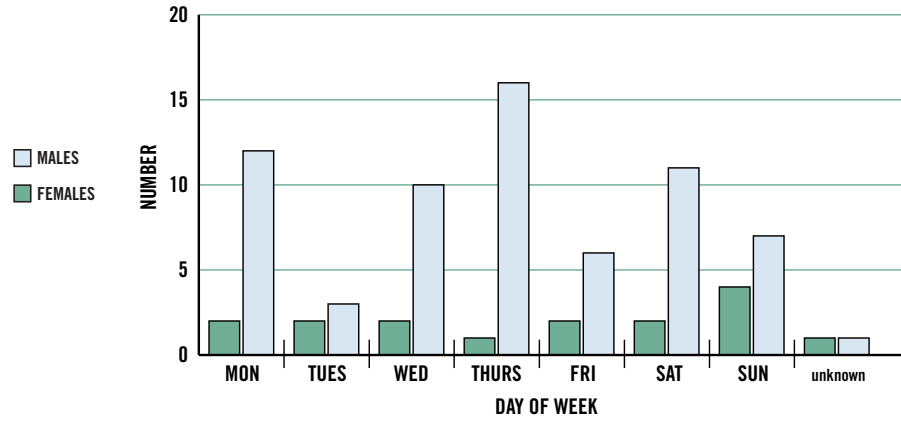


TABLE 27. MID-WESTERN HEALTH BOARD REGION, METHOD OF SUICIDE BY SEX

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
TOTAL	16	100.0	66	100.0	82	100.0

Appendix

Summary Tables for Each Health Board Region

North Eastern Health Board

TABLE 28. NORTH EASTERN HEALTH BOARD REGION, AGE GROUP BY SEX

AGE GROUP	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 REGION, MARITAL STATUS BY SEX

MARITAL 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
COHABITING	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 BY SEX

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

Appendix

Summary Tables for Each Health Board Region

TABLE 31. NORTH EASTERN HEALTH BOARD REGION, EMPLOYMENT STATUS BY SEX

EMPLOYMENT 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 BY SEX (FOR THOSE UNEMPLOYED)

DURATION OF UNEMPLOYMENT	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 BY SEX

SOCIAL CLASS	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
1. PROFESSIONAL WORKERS	0	0.0	0	0.0	0	0.0
2. MANAGERIAL & 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 REGION, HIGHEST LEVEL OF EDUCATION COMPLETED BY SEX

HIGHEST LEVEL OF EDUCATION COMPLETED	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 LEVEL	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

Appendix

Summary Tables for Each Health Board Region

TABLE 35. NORTH EASTERN HEALTH BOARD REGION, ACCOMMODATION BY SEX

ACCOMMODATION	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
HOME WITH 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 BY SEX

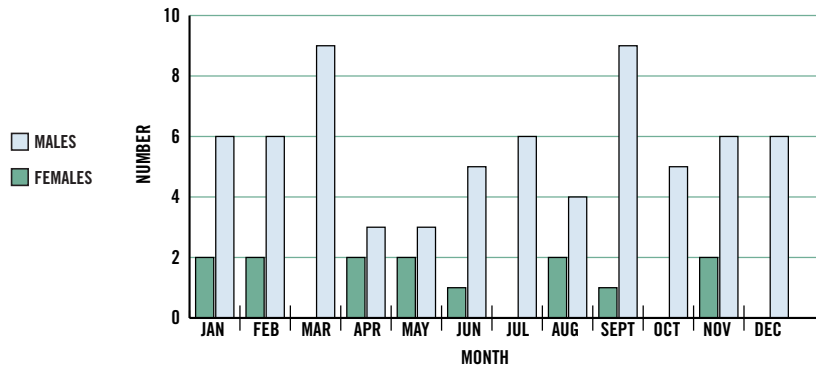
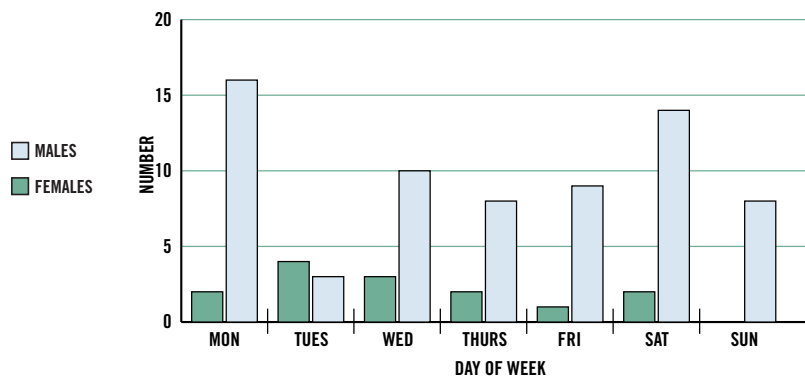


FIGURE 8. NORTH EASTERN HEALTH BOARD REGION, DAY OF OCCURRENCE BY SEX



Appendix

Summary Tables for Each Health Board Region

TABLE 36. NORTH EASTERN HEALTH BOARD REGION, METHOD OF SUICIDE BY SEX

METHOD OF SUICIDE	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	1	1.5	2	2.4
TOTAL	14	100.0	68	100.0	82	100.0

North Western Health Board

TABLE 37. NORTH WESTERN HEALTH BOARD REGION, AGE GROUP BY SEX

AGE GROUP	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 BY SEX

MARITAL 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

Appendix

Summary Tables for Each Health Board Region

TABLE 39. NORTH WESTERN HEALTH BOARD REGION, RELIGION BY SEX

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 BY SEX

EMPLOYMENT 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 BY SEX (FOR THOSE UNEMPLOYED)

DURATION OF UNEMPLOYMENT	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
1 TO 5.9 MONTHS	0	0.0	0	0.0	0	0.0
6 TO 11.9 MONTHS	1	33.3	0	7.7	1	7.1
OVER A YEAR	0	0	10	90.9	10	71.4
NOT KNOWN	2	66.7	1	9.1	3	21.4
TOTAL	3	100.0	11	100.0	14	100.0

TABLE 42. NORTH WESTERN HEALTH BOARD REGION, SOCIAL CLASS BY SEX

SOCIAL CLASS	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
1. PROFESSIONAL WORKERS	0	0.0	1	2.1	1	1.8
2. MANAGERIAL & TECHNICAL	2	22.2	0	0.0	2	3.6
3. NON-MANUAL	1	11.1	3	6.4	4	7.1
4. SKILLED MANUAL	0	0.0	11	23.4	11	19.6
5. SEMI-SKILLED	0	0.0	2	4.3	2	3.6
6. UNSKILLED	0	0.0	11	23.4	11	19.6
7. UNKNOWN	6	66.7	15	31.9	21	37.5
8. FARMERS	0	0.0	4	8.5	4	7.1
TOTAL	9	100.0	47	100.0	56	100.0

Appendix

Summary Tables for Each Health Board Region

TABLE 43. NORTH WESTERN HEALTH BOARD, HIGHEST LEVEL OF EDUCATION COMPLETED BY SEX

HIGHEST LEVEL OF EDUCATION COMPLETED	FEMALES		MALES		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 LEVEL	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 BY SEX

ACCOMMODATION	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
HOME WITH 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 BY SEX

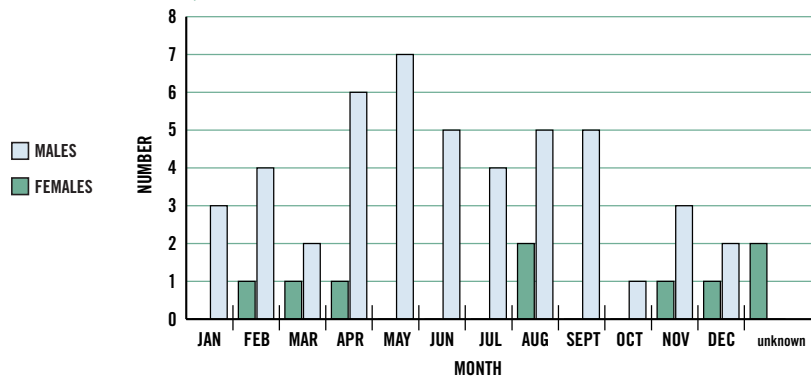
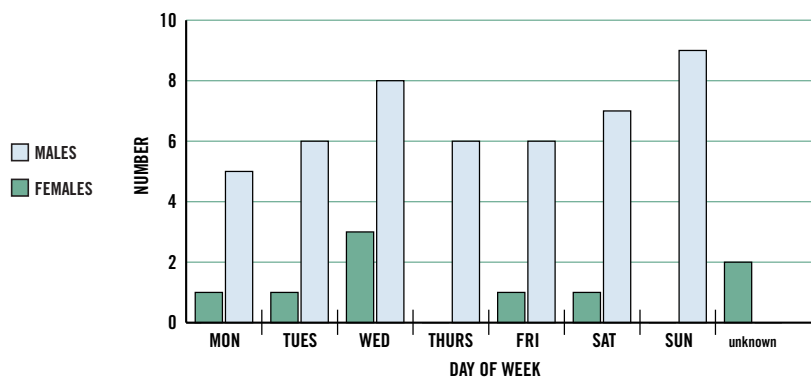


FIGURE 10. NORTH WESTERN HEALTH BOARD REGION, DAY OF OCCURRENCE BY SEX



Appendix

Summary Tables for Each Health Board Region

TABLE 45. NORTH WESTERN HEALTH BOARD REGION, METHOD OF SUICIDE BY SEX

METHOD OF SUICIDE	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
HANGING	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	0.0	3	6.3	3	5.4
TOTAL	9	100.0	47	100.0	56	100.0

South Eastern Health Board Region

TABLE 46. SOUTH EASTERN HEALTH BOARD REGION, AGE GROUP BY SEX

AGE GROUP	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
TOTAL	17	100.0	88	100.0	105	100.0

TABLE 47. SOUTH EASTERN HEALTH BOARD REGION, MARITAL STATUS BY SEX

MARITAL 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
COHABITING	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

Appendix

Summary Tables for Each Health Board Region

TABLE 48. SOUTH EASTERN HEALTH BOARD REGION, RELIGION BY SEX

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 BY SEX

EMPLOYMENT 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 BY SEX (FOR THOSE UNEMPLOYED)

DURATION OF UNEMPLOYMENT	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 BY SEX

SOCIAL CLASS	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
1. PROFESSIONAL WORKERS	0	0.0	2	2.3	2	1.9
2. MANAGERIAL & 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

Appendix

Summary Tables for Each Health Board Region

TABLE 52. SOUTH EASTERN HEALTH BOARD REGION, HIGHEST LEVEL OF EDUCATION COMPLETED BY SEX

HIGHEST LEVEL OF EDUCATION COMPLETED	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 LEVEL	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 BY SEX

ACCOMMODATION	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
HOME WITH 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 BY SEX

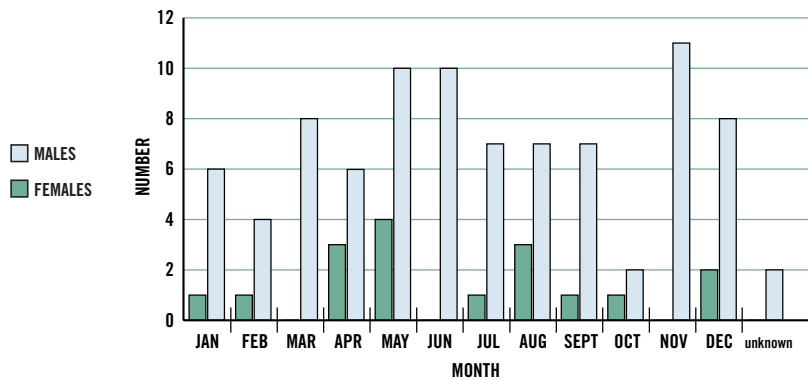
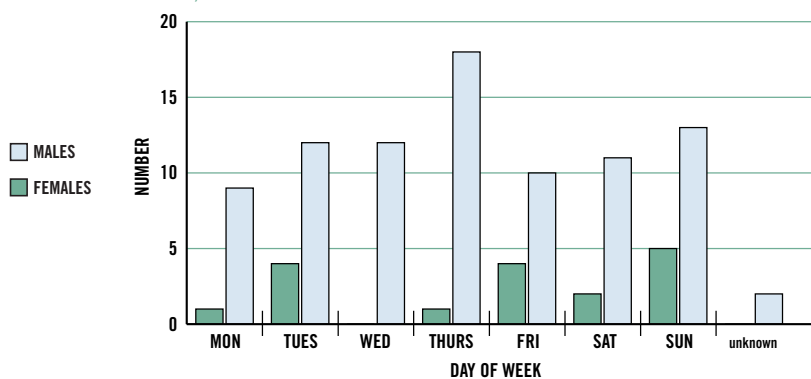


FIGURE 12. SOUTH EASTERN HEALTH BOARD REGION, DAY OF OCCURRENCE BY SEX



Appendix

Summary Tables for Each Health Board Region

TABLE 54. SOUTH EASTERN HEALTH BOARD REGION, METHOD OF SUICIDE BY SEX

METHOD OF SUICIDE	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 GROUP BY SEX

AGE GROUP	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 BY SEX

MARITAL 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
COHABITING	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

Appendix

Summary Tables for Each Health Board Region

TABLE 57. SOUTHERN HEALTH BOARD REGION, RELIGION BY SEX

RELIGION	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
CATHOLIC	31	91.2	140	91.5	171	91.4
CHURCH OF IRELAND	1	2.9	4	2.6	5	2.7
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 BY SEX

EMPLOYMENT 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 BY SEX (FOR THOSE UNEMPLOYED)

DURATION OF UNEMPLOYMENT	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 BY SEX

SOCIAL CLASS	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
1. PROFESSIONAL WORKERS	0	0.0	3	2.0	3	1.6
2. MANAGERIAL AND TECHNICAL	5	14.7	5	3.3	10	5.3
3. NON-MANUAL	2	5.9	5	3.3	7	3.7
4. SKILLED MANUAL	0	0	19	12.4	19	10.1
5. SEMI-SKILLED	2	5.9	12	7.8	14	7.5
6. UNSKILLED	1	3.0	30	19.6	31	16.6
7. UNKNOWN	22	64.7	69	45.1	91	48.6
8. FARMERS	2	5.9	10	6.5	12	6.4
TOTAL	34	100.0	153	100.0	187	100.0

Appendix

Summary Tables for Each Health Board Region

TABLE 61. SOUTHERN HEALTH BOARD REGION, HIGHEST LEVEL OF EDUCATION COMPLETED BY SEX

HIGHEST LEVEL OF EDUCATION COMPLETED	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 LEVEL	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 BY SEX

ACCOMMODATION	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
HOME WITH 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 BY SEX

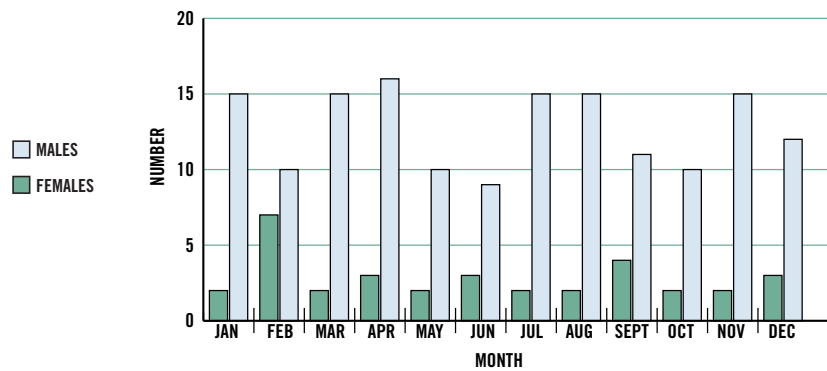
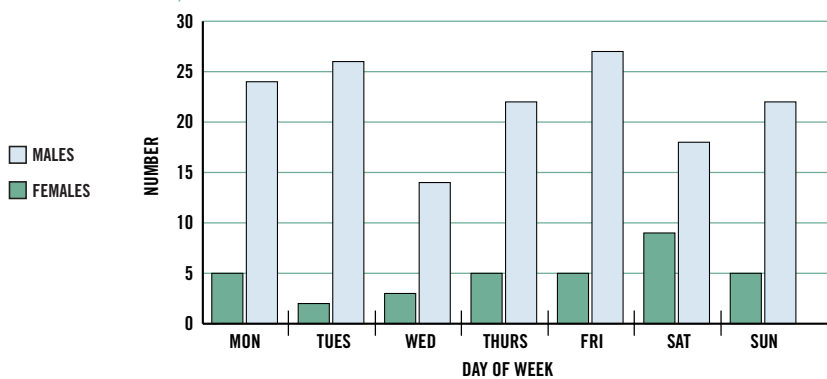


FIGURE 14. SOUTHERN HEALTH BOARD REGION, DAY OF OCCURRENCE BY SEX



Appendix

Summary Tables for Each Health Board Region

TABLE 63. SOUTHERN HEALTH BOARD REGION, METHOD OF SUICIDE BY SEX

METHOD OF SUICIDE	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 FROM 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 GROUP BY SEX

AGE GROUP	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
TOTAL	17	100.0	83	100.0	100	100.0

TABLE 65. WESTERN HEALTH BOARD REGION, MARITAL STATUS BY SEX

MARITAL 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
COHABITING	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

Appendix

Summary Tables for Each Health Board Region

TABLE 66. WESTERN HEALTH BOARD REGION, RELIGION BY SEX

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	4.8	5	5.0
TOTAL	17	100.0	83	100.0	100	100.0

TABLE 67. WESTERN HEALTH BOARD REGION, EMPLOYMENT STATUS BY SEX

EMPLOYMENT 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 BY SEX (FOR THOSE UNEMPLOYED)

DURATION OF UNEMPLOYMENT	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 BY SEX

SOCIAL CLASS	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
1. PROFESSIONAL WORKERS	0	0.0	3	3.6	3	3.0
2. MANAGERIAL & 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

Appendix

Summary Tables for Each Health Board Region

TABLE 70. WESTERN HEALTH BOARD REGION, HIGHEST LEVEL OF EDUCATION COMPLETED BY SEX

HIGHEST LEVEL OF EDUCATION COMPLETED	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 LEVEL	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 BY SEX

ACCOMMODATION	FEMALES		MALES		TOTAL	
	No	%	No	%	No	%
HOME WITH 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 BY SEX

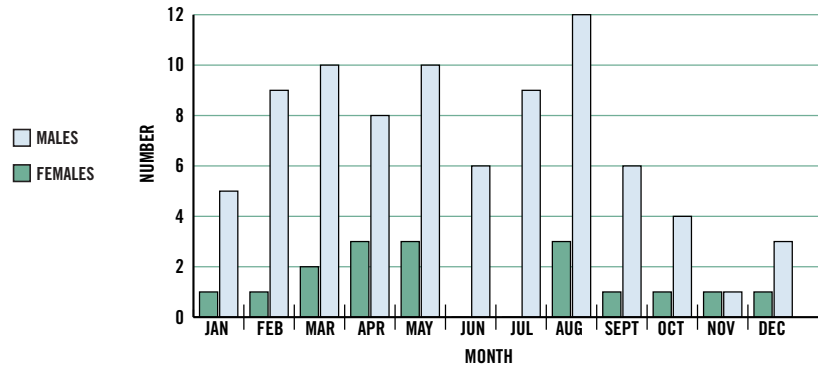
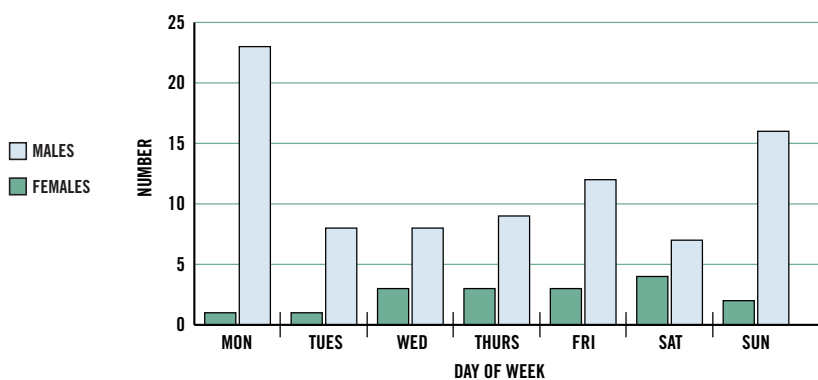


FIGURE 16. WESTERN HEALTH BOARD REGION, DAY OF OCCURRENCE BY SEX



Appendix

Summary Tables for Each Health Board Region

TABLE 72. WESTERN HEALTH BOARD REGION, METHOD OF SUICIDE BY SEX

METHOD OF SUICIDE	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	0.0	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	100.0	83	100.0	100	100.0