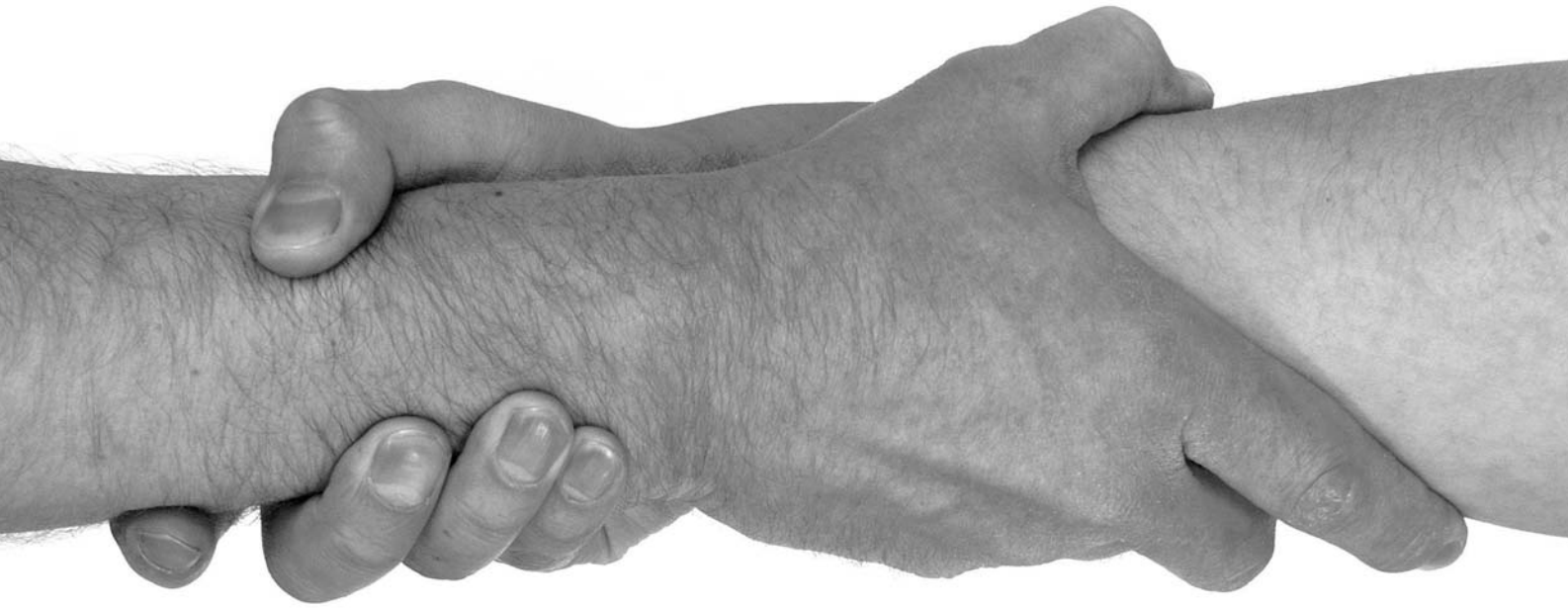
Reach Out



Irish National Strategy for
Action on Suicide Prevention

2005-2014

Reach Out

National Strategy for
Action on Suicide Prevention

2005-2014

Produced by the Health Service Executive, the National Suicide Review Group and Department of Health and Children.

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

DEPARTMENT
OF HEALTH & CHILDREN
AN ROINN SLÁINTE
AGUS LEANAÍ

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Foreword

Suicidal behaviour represents a global public health problem and its prevention continues to provide a major challenge to health and social services at all levels of Irish society. More people die by suicide in Ireland each year than in road traffic accidents. Currently, youth suicide rates in Ireland are fifth highest in the European Union (World Health Organisation, 2005). Older people, especially older men, may also be vulnerable and suicide is affecting increasing numbers of Irish people across the lifespan.

Deliberate self-harm is also a significant problem. According to the National Parasuicide Registry, over 11,000 cases of deliberate self-harm are seen in the accident and emergency departments of our hospitals annually and many more cases of deliberate self-harm never come to the attention of the health services.

The causes of suicide are complex and are likely to involve an inter-play of psychological, biological, social and environmental factors in the context of a person's negative experiences over a lifetime, sometimes aggravated by a recent personal difficulty. Premature death from suicide has many adverse consequences, not only for the family and friends of those who die but for all of those in the wider community who have to cope with the impact of the tragedy.

There is no single intervention or approach that will, in itself, adequately challenge the problem of suicide in Ireland. A strategic framework is required to assist all of us in identifying actions we can undertake in a coordinated way, through partnership working between statutory, voluntary and community groups and individuals, supported by Government. Everyone has a role to play in suicide prevention – from the health sector to our schools, community groups and those in private enterprise.

This strategy builds on the work of the National Task Force on Suicide (1998) and takes account of the important strategic and operational initiatives developed by the former health boards in recent years. During the two years developing this strategy, wide ranging consultation took place throughout the country to draw on the experience, perspectives and ideas of the key stakeholders and interested parties. This consultation process, combined with continuous monitoring of evidence and best practice, allowed the project team to take both an evidence-based and pragmatic approach in prioritising actions to be undertaken by the various agencies and groups in order to effect real change over the next 5 to 10 years.

The recently established Health Service Executive (HSE) will take a lead role in overseeing the implementation of the strategy in partnership with those statutory and voluntary organisations that have a key role to play in making the actions happen. At government level, a Task Force will be established with representatives of relevant government departments to advise on and provide support in overcoming any barriers encountered in implementing the strategy. Additional funding allocations will be made available over the coming years to support the strategy and to complement local and national efforts.

The action plan is practical, achievable, based on evidence and international best practice. It will be subject to ongoing, regular evaluation to determine whether the expected outcomes have been achieved. Experience in other countries has shown us that reductions in the suicide rate do not necessarily follow the publication of a national suicide prevention strategy in the short term. However, if the comprehensive and sustained action recommended in this document takes place over the coming years, then we have cause to be optimistic that the best possible response to the problem of suicide in Ireland will be developed.

We would like to thank the authors for their foresight in identifying the need for this comprehensive strategic approach to the problem of suicidal behaviour in Ireland.

As we move towards the implementation of the actions outlined in this strategy, coordinated partnership working across all sectors and communities in Irish society will best reflect the reality that the problem of suicide is everyone's business.

Bertie Ahern T.D.
Taoiseach

Acknowledgements

The proposal to develop a national strategy for action on suicide prevention was approved by the Health Boards Executive (HeBE) at their board meeting of February 26th 2003. We wish to acknowledge the support of HeBE and its Director, Denis Doherty. We are particularly grateful to Paul Robinson, lead Chief Executive Officer overseeing this project, for his personal interest and his readily accessible advice in developing the strategy.

The strategy was developed in partnership with the National Suicide Review Group, under the Chairmanship of Geoff Day, and the Department of Health and Children under the guidance of Bairbre Nic Aongusa, Principal, Mental Health Division and we wish to acknowledge their support.

Key to the development of the strategy was the guidance provided by a Steering Group, the membership of which is listed below. Particular thanks are due to Ann Marie Sheehan (National Educational Psychological Service) and to Emer Shelley (Department of Health and Children) for their respective contributions to the work of the Writing Group. Brendan Kennelly, Eamon O'Shea and Jane Ennis, Department of Economics, NUI Galway, prepared the section on the economic cost of suicidal behaviour. Elaine Maye, Business Manager, and Edel Fitzpatrick, Staff Officer, HSE Project Management Unit assisted in the final design and production of the document.

Quality assurance was provided by an external Reference Group, comprised of national and international experts in the areas of suicide prevention, mental health promotion and related policy.

The work of the HSE Resource Officers for Suicide Prevention, especially during the regional consultation meetings, is gratefully acknowledged.

The input of the many individuals and agencies with personal and professional experience of suicidal behaviour has been of vital importance in shaping this document. It is our hope that the widespread and open consultation will mean that the actions called for will resonate with the people who can help make them happen.

The development of this national strategy has been a challenging but positive experience. We are very grateful for the support, assistance and encouragement we received from the many people who made the work possible. It is our hope and intention that this strategy will shape the work of the Health Service Executive and other relevant agencies in developing suicide prevention and mental health promotion in the coming years.

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Ms. Bernie Carroll, HSE Mid Western Area
Ms. Brenda Crowley, HSE Southern Area
Mr. Martin Kane, HSE East Coast Area
Ms. Rita Kelly, HSE Midland Area
Ms. Teresa Mason, HSE Northern Area (replaced by Ms. Caroline Lennon-Nally from March 2005)
Mr. Seán McCarthy, HSE South Eastern Area
Mr. John McGuire, HSE North Eastern Area
Ms. Mary O'Sullivan, HSE Western Area
Ms. Anne Sheridan, HSE North Western Area

Administrative Support

Rachel Farrow and **Carolyn Sullivan**.

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Vision and Guiding Principles

Vision

The vision of this strategy is of a society where life is valued across all age groups, where the young learn from and are strengthened by the experiences of others and where the needs of those who are going through a hard time are met in a caring way so that:

- the mental health and well-being of the whole population is valued
- mental illness is more widely recognised and understood and those experiencing difficulties are offered the most effective and timely support possible
- the abuse of alcohol and other drugs is reduced considerably
- everyone who has engaged in deliberate self-harm is offered the most effective and timely support possible
- those affected by a suicide death or deliberate self-harm receive the most caring and helpful response possible

Guiding Principles

Action - The strategy is action focused.

Shared Responsibility - No single organisation, group or sector can be solely responsible for suicide prevention.

Practical, Achievable and Subject to Regular Evaluation - The strategy will identify expected deliverables which can be measured, monitored and revised.

Evidence Based - The strategy draws, where possible, on published scientific research and on the experience of those working in suicide prevention.

Broad Based - A fundamental aim of the strategy is to prevent suicide and deliberate self-harm, and to reduce levels of suicidal ideation in the general population by tackling contributing factors.

Information and Communications Technology - In developing services and supports, the potential to exploit Information and Communications Technology (ICT) will be given full consideration, for example using the Internet or SMS text messaging through mobile phones to reach out and provide support.

Research and Development - Ongoing, quality, multi-disciplinary research will be an essential strand of the strategy and findings will be of greatest value where they can inform and stimulate action and service development.

Continuous Quality Improvement - Continuous quality control and ongoing modification and improvement of the strategy will be central to its implementation.

Consultation and Partnership - Actions, projects and services will be developed following consultation with those targeted, in partnership with the voluntary and community sector.

Resources - Where possible, existing human and other resources will be used to implement the strategy, but where these are not available new resources will be required. The potential to work in partnership with private sector businesses will also be explored.

Definition of Key Terms

Deliberate Self-Harm* (DSH)

The various methods by which people deliberately harm themselves, including self-cutting and taking overdoses. Varying degrees of suicide intent can be present and sometimes there may not be any suicidal intent, although an increased risk of further suicidal behaviour is associated with all DSH.

Mental Health Promotion

Mental health promotion is an approach characterized by a positive view of mental health, rather than emphasizing mental illness or deficits, which aims to engage with people and empower them to improve population health (WHO, 2004).

Parasuicide

A non-habitual act with a non-fatal outcome that is deliberately initiated and performed and is likely to cause self-harm.

Suicidal Behaviour

The spectrum of activities related to suicide including suicidal thinking, self-harming behaviours not aimed at causing death and suicide attempts (Commonwealth Department of Health and Aged Care, Australia, 1999).

Suicide

A conscious or deliberate act that ends ones life when an individual is attempting to solve a problem that is perceived as unsolvable by any other means (Commonwealth Department of Health and Aged Care, LIFE Strategy, Australia, 1999).

Suicide Prevention

The science and practice of identifying and reducing the impact of risk factors associated with suicidal behaviour and of identifying and promoting factors that protect against engaging in suicidal behaviour.

* There is some debate about the definition and use of the terms attempted suicide, parasuicide, deliberate self-harm and non-fatal suicidal behaviour. These terms are sometimes used inter-changeably but deliberate self-harm is the preferred term in the present report.

Introduction

There has been a ground swell of public concern about the problem of suicide in Ireland since it was finally de-criminalised in 1993. Since then, many efforts to develop a coordinated response to suicide have been undertaken, most notably in the setting up of the National Task Force on Suicide which published its final report in 1998.

However, a recent review of the implementation of the National Task Force recommendations by the National Suicide Review Group (NSRG) identified significant gaps and limitations in their implementation (NSRG, 2005). Added to this, the ongoing concern about reported rates of suicidal behaviour has underlined the need to develop a national strategy for action on suicide prevention - building on earlier efforts and learning from national and international experiences. In the section on the economic context of suicidal behaviour below, the overall direct, indirect and human costs of suicidal behaviour are highlighted to further reinforce the importance of action to prevent suicide.

As well as reviewing the implementation of the Task Force recommendations, a number of international strategy documents were also reviewed. This international review suggested that a broad-based approach to suicide prevention is the approach currently adopted in most countries. This is also the approach advocated by the International Association for Suicide Prevention (IASP) and is in keeping with the *European Action Plan for Mental Health* (WHO website) which was signed and endorsed on behalf the 52 member states of the European Region of the World Health Organization at the Ministerial Conference on Mental Health in Helsinki, Finland in January 2005.

Data Collection and Reliability

Mortality data in Ireland is compiled largely on the basis of information recorded by An Garda Síochána (police) on the confidential Form 104 which is sent to the Central Statistics Office (CSO) after a coroner's inquest has taken place. The National Task Force on Suicide, in consultation with the CSO, estimated a margin of error in the region of just less than 5% in relation to the accuracy of data on suicide deaths in Ireland. This estimation was based on the number of deaths coded as 'undetermined' expressed as a percentage of suicide deaths. Since 1998, there has been an increase in the number of deaths coded as 'undetermined', which, as a percentage of suicide deaths, had risen to 18% by 2002. It therefore seems likely that data on suicide mortality is less reliable than has been supposed in recent years, although this requires further investigation (see Area 25 below). For this reason, extra care is necessary in interpreting data on suicide deaths to avoid under-estimating the extent of the problem.

Setting Targets

Much consideration was given to the setting of an overall target for the reduction of our national suicide rate as an outcome measure of this strategy. At this stage, it has been decided that a specific target will not be set for the following two reasons:

- The priority is to establish the accuracy of suicide mortality in Ireland
- Due to the range and inter-play of factors that influence the suicide rate, a direct cause and effect relationship between prevention programmes and a change in the overall population rates is virtually impossible to establish

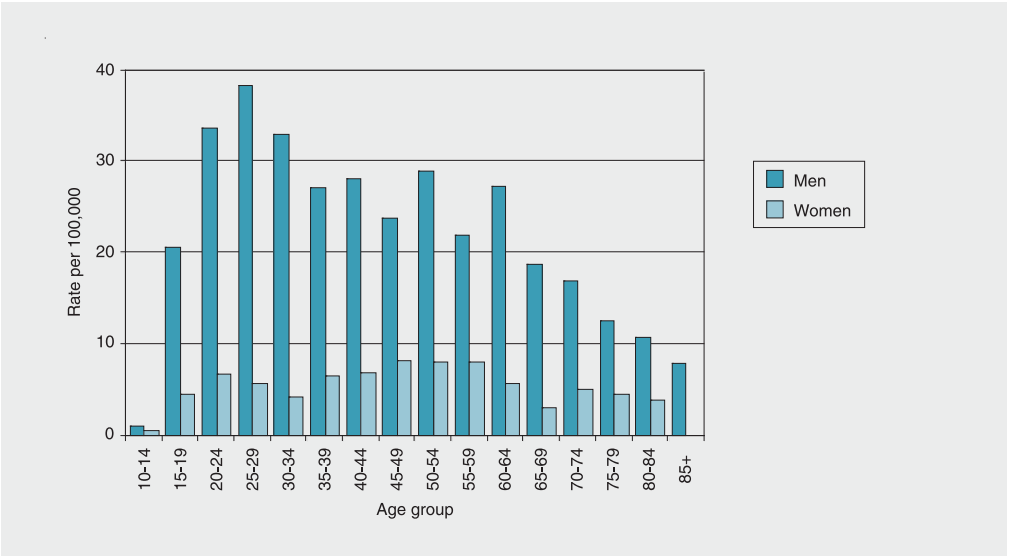
Nevertheless, there are undoubted advantages to setting targets for an overall reduction, not least the fact that it focuses the attention of those working in mental health promotion and in the health services more generally. It is recommended that an overall target for the reduction of suicide rates should be set by the Government, on the advice of the Minister for Health and Children, when the Minister is satisfied that suicide rates have been accurately determined.

Suicide Mortality

Based on official suicide mortality data from the CSO, between 2000 and 2002 there were, on average, 494 deaths by suicide in Ireland annually, peaking at 519 in 2001. This number of deaths represents a rate of approximately 12.9 per 100,000 of our population and is average when compared to other countries in the European Union (EU). Of particular concern is the rate of youth suicide in Ireland, currently the fifth highest in the European Union at 15.7 per 100,000 for 15-24 year olds (an age group typically used for international comparison). The rate is even higher in Ireland among those in their 20s and early 30s, with men under 35 years accounting for approximately 40% of all Irish suicides.

The increase in rates of youth suicide in Ireland in recent years should not deflect attention also from the problem of suicide among older people. It is important to note that when older people engage in non-fatal suicidal behaviour it tends, in general, to be more serious and is associated with a higher risk of eventual completed suicide. Figure 1 below shows the current rate of suicide in Ireland by age and gender.

Figure 1 - Annual Male and Female Suicide Rate, by age, per 100,000 population (2000-2002 average)



Figures represented are based on a 3-year average from the most recent years that data by 'year of occurrence' (rather than provisional data) are available (2000 - 2002).

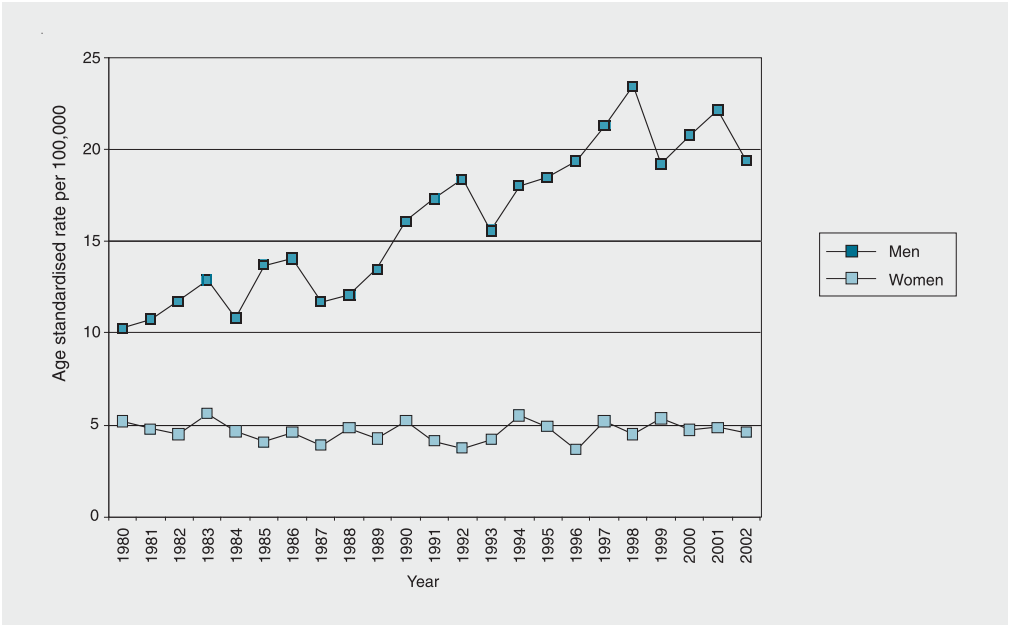
As in all other European countries, suicide in Ireland is more common in men than in women. The male to female ratio in Ireland is approximately 4.5:1. Currently, the highest rate of suicide is found among young men in the age group 20-29 years (35 per 100,000). This contrasts with traditional patterns and with most other countries, where suicide is more frequently observed in older men (Corcoran et al., 2004).

In recent years, hanging has been the method of suicide most frequently used by males (60%) followed by drowning (16%). In females who die by suicide, hanging (31%), poisoning (31%) and drowning (24%) are the most common methods. Detailed information on the specific medication taken in fatal overdose in Ireland is not available at present, representing a gap in our knowledge that should be addressed in the coming years.

Trends in Suicide

Ireland experienced one of the fastest rising suicide rates in the world during the 1980s and 1990s, the overall suicide rate having doubled over that period. The rise was largely confined to men (see Figure 2) and has been most striking in young men. While the overall female suicide rate has not increased since 1980, the rate of suicide in young women (15 to 24 years) more than doubled in the 1990s, albeit from a low base rate. Furthermore, recent provisional data from the CSO is suggesting that the female rate overall may be increasing and this possible trend should be monitored closely in the coming years.

Figure 2 – Trends in the Population-Based Suicide Rate by Gender, 1980-2002

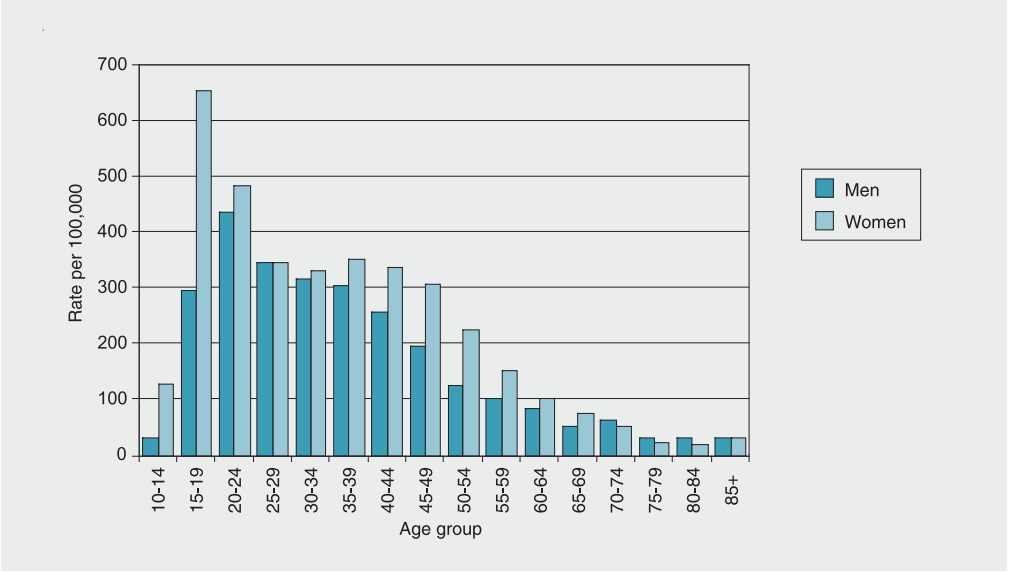


The most recent year for which suicide mortality data by 'year of occurrence' are available is 2002.

Deliberate Self-Harm (DSH)

According to the National Parasuicide Registry (NPR), over 11,000 cases of deliberate self-harm (DSH), some of which are the result of serious suicide attempts, present to Irish hospitals each year for assessment and treatment. In 2003, based on hospital treated cases, the rate of DSH for women was 241 per 100,000 and for men was 177 per 100,000 (NSRF, 2004). Deliberate self-harm rates are highest among the younger age groups, peaking for girls aged between 15 and 19 years and for young men aged between 20 and 24 years (Figure 3). Presentations to hospital due to repeated DSH are a serious problem. In 2003, 21% of all self-harm presentations to hospital in Ireland were due to repeat acts.

Figure 3: Deliberate Self-Harm Rate, by age and gender, 2003



Drug overdose is more commonly used as a method of DSH by women (80%) than by men (64%), while self-cutting is significantly more often used as a method by men (23%) than by women (14%). This is in contrast with findings in most other countries, where self-cutting appears to be more typically used by women. In 2003, alcohol was involved in nearly half of the male DSH episodes (47%) and in 39% of the female DSH episodes (NSRF, 2004).

A substantial number of people are thought to harm themselves without coming to the attention of hospital services – perhaps in some cases being treated by a GP, or not receiving any medical attention. Indeed, in a recent Irish survey of almost 4,000 young people aged 15-17 years, 12% of the study population (n = 458) reported having engaged in DSH yet only 11% of those young people attended hospital as a result of their DSH (Sullivan et al, 2004). Of those who had harmed themselves, nearly half of them had done so more than once.

The Wider Impact

Each year more and more Irish people are affected by the problem of suicide in some way. When a community sample of young men (aged 18-34 years) was asked about whether or not they knew someone who had died by suicide, 78% said 'yes', 42% knew 'more than one person', while 17% knew 'a close friend' who died by suicide (Begley et al, 2004). Furthermore, many Irish people are affected by DSH every year. While it is difficult to measure the full impact of each suicidal act, the devastation caused by such acts has, unfortunately, become well known across all Irish communities in recent years.

Social Change and Suicide

Suicide rates in Ireland doubled during the 1980s and 1990s at a time when Irish society experienced considerable transition. Traditional forms of social institutions such as the church, the family and the agricultural economy were undermined and challenged by values reflective of a more economically developed, secular and individualised society. This transition occurred at a time of unprecedented economic growth, earning the Irish economy comparisons with the tiger economies of Asia. It was also marked by significant legislative changes reflecting changing values such as the decriminalisation of suicide in 1993 and the introduction of divorce in 1997.

In a short space of time, Ireland moved from being a highly integrated society with shared values which regulated the way of life to a more consumer orientated society where communities have become less integrated and traditional values to regulate individual life are no longer deeply held or widely shared. This reduced integration has coincided with increased urbanisation as reflected in the 2002 census figures which report that 60% of the total population is now living in urban areas, representing an urban population increase of 10% since 1996 (CSO, 2002).

As social changes have impacted on the nature and extent of suicidal behaviour in Ireland, efforts to address this serious public health issue must be located in the area of social policy as well as within the health sector. By appropriately influencing social policy, support will be improved for those people who may have lost their way during the transition of Irish society. Examples include young men in rural areas who no longer have a clear pathway into farming as a way of life due to the modernisation of agriculture, fathers who are isolated from the increasing number of single-parent families, teenage girls who struggle with the burden of unrealistic expectations about physical appearance and achievement propagated by popular culture and the media, or older people who no longer have the support of an integrated and extended family and community network to turn to.

Finally, existing health inequalities in Irish society and the evidence of a link between socio-economic status and suicidal behaviour further underlines the need for social policy measures to address the wider determinants of mental health and well-being. As part of the General Population Approach to suicide prevention and in the Targeted Approach, every effort has been made to address these broad social determinants of mental health and well-being by identifying them as areas for action.

The Response to Date

Following the passing of the Criminal Law (Suicide) Act 1993, the issue of suicide prevention firmly entered the public discourse. In 1995, the Minister for Health and Children established a National Task Force on Suicide. The National Suicide Research Foundation was established in the same year with the aim of clearly determining the nature and extent of the suicide problem in Ireland. The Irish Association of Suicidology was established in the following year with the aim of promoting public and professional awareness of suicide and suicide prevention.

The National Task Force published its final report in 1998 making a range of recommendations covering service provision, primary prevention, crisis intervention and research. In the same year, and following a recommendation of the Task Force, the National Suicide Review Group (NSRG) was set up by the Chief Executive Officers of the former health boards to coordinate suicide prevention activities in Ireland and regional Resource Officers for Suicide Prevention were appointed. This National Strategy for Action on Suicide Prevention builds on the experience of the Task Force and on the work of the National Suicide Review Group and regional Resource Officers for Suicide Prevention.

Making it Happen

Developing the Strategy

Consultation was central to developing this strategy. Five regional consultation meetings and one national consultation meeting were held with interested representatives from the statutory and voluntary sectors. Key messages from this consultation process are outlined in Appendix 2. The importance of the national and regional consultation meetings was in bringing together a diverse range of organisations and individuals that not only contributed to the development of the strategy but will also support its implementation over the coming years (proceedings reports from all consultation meetings are available at www.nsrg.ie). Many of these stakeholders were subsequently invited to a forum hosted by President Mary McAleese in March 2005 to encourage increased coordination in the area of suicide prevention.

In addition to the consultation meetings, an advertisement was placed in the national press calling for submissions from members of the public and from private, public and voluntary organisations. Local media also covered the call for submissions ensuring that a wide section of the population would become aware of the strategy and its development.

The Approach

The approach to the strategy is a straightforward one. Four levels of action comprise the main body of the strategy. These are categorised as:

- General population approach
- Targeted approach
- Responding to suicide
- Information and research

Rationale

Improving access to quality mental health services is an essential part of any suicide prevention strategy. In addition, it is essential to develop other interventions to tackle risk conditions and factors which contribute to poor mental health, negative thinking and existential crises which make people vulnerable to engaging in suicidal behaviour.

Many of those who take their own life do not come into regular contact with the health services. A recent study undertaken by the Departments of Public Health (DPH) found that the length of time before a suicide death that a patient had seen a GP was either over one year or reported as 'unknown' for 30% of the sample for whom a GP questionnaire was returned (Departments of Public Health, 2001). This underlines the need to focus prevention efforts beyond traditional health service settings.

It is important to stress that the general population approach to suicide prevention and targeting those who are known to be at increased risk should be complementary approaches. By effectively developing an anti-stigma campaign (general population) and by promoting awareness of positive mental health, the likelihood of vulnerable individuals with signs of mental health problems (more

high risk) seeking help through the health services will increase. In turn, services must be resourced and focussed to provide effective treatment and support to the people who contact them.

As referred to above, this broad-based approach to suicide prevention is the approach advocated by the World Health Organisation (WHO) and the International Association for Suicide Prevention (IASP). In particular, the WHO recommends that member states should develop national prevention strategies that are linked, where possible, to other public health policies. The role of governments in developing general population strategies has been further endorsed by the United Nations. In Ireland, the National Health Strategy *Quality and Fairness – a Health System for You* (Department of Health and Children 2001a) commits to the principles of promoting, protecting and improving health, reducing premature mortality and intensifying suicide prevention programmes.

Implementation and Evaluation

With the development of the Health Service Executive (HSE) comes a unique opportunity to determine the location and structure of suicide prevention and mental health promotion services into the future. Throughout the strategy consultation process, and at the 2005 Presidential Forum on Suicide Prevention, the need for leadership in the development of suicide prevention and research was highlighted. For the implementation of this strategy, formal partnership links between suicide prevention services and a range of voluntary and statutory agencies, including those outside the health sector, will be important.

In order to develop this leadership and to promote coordination, it is recommended that the HSE establish a National Office for Suicide Prevention* within the National Population Health Directorate. This Office would be the main driver of strategy implementation. The first task of the National Office would be to initiate work on the following key priorities:

- Stigma reduction and mental health promotion
- The development of a national training programme
- The development of 'fast-track' priority referral systems from primary care to community-based mental health services
- The development of an effective service response for people who have engaged in deliberate self-harm or who are acutely suicidal
- The development of bereavement support services
- The improvement of data collection and data use in relation to suicidal behaviour and suicide prevention

The work of the HSE Resource Officers for Suicide Prevention, which will be key to local and regional implementation of this strategy, would be guided by the National Office.

Efforts in relation to strategy implementation will be further supported and strengthened by the anticipated appointment of an Assistant Director of Population Health with responsibility for Health Promotion. Successful implementation will also depend on strong links with the National Primary, Community and Continuing Care Services (PCCC) of the HSE.

* *National Office for Suicide Prevention is used only as a working title for this office.*

A steering group comprised of key individuals who can offer their expertise to guide the work of the National Office should also be appointed. This steering group would replace the National Suicide Review Group. In turn, a representative national forum (building on the network developed at the Presidential Forum on Suicide Prevention 2005 mentioned above) would be briefed by the National Office on the achievements overall in suicide prevention and, in particular, in relation to strategy implementation. This forum would also provide an opportunity for the exchange of views on developments in suicide research and prevention.

An annual report will be produced by the National Office detailing progress in relation to the implementation of strategy actions in the previous calendar year, beginning with a report in 2006. It is proposed that the annual report will meet the requirement of the Health (Miscellaneous Provisions) Act 2001 which requires a report on activities in the area of suicide prevention to be presented to the houses of the Oireachtas each year (this report has been a function of the NSRG). In addition, an annual service plan will be prepared, which will propose service developments for suicide prevention and mental health promotion. The HSE Resource Officers for Suicide Prevention would provide information to the proposed National Office in relation to both the annual report and the annual service plan.

Action Areas

Level A - General Population Approach

Level B - Targeted Approach

Level C - Responding to Suicide

Level D - Information and Research

Level A - General Population Approach

Goal

To promote positive mental health and well-being and bring about positive attitude change towards mental health, problem solving and coping in the general population.

Action Areas

1	The Family	
	Objective:	To Improve support for all families in Irish society, especially those socially excluded and those in crisis.

The changing nature of the family unit is something that was repeatedly highlighted during the strategy consultation process. As the move away from traditional extended family structures continues, towards tighter nuclear and single-parent families, there is increased pressure on parents and consequent strain on relationships. This change in family structures is related to, and compounded by, changing work practices, living arrangements and locations, all of which challenge family cohesion.

In *Suicide in Ireland: a national study* (Departments of Public Health, 2001), it was reported that two thirds of those who died by suicide lived 'at home with others'. This reinforces the idea that the home is an important setting in which to build awareness of suicide prevention and also indicates the importance of supporting families in the aftermath of a suicide death.

The family and the home are important for the promotion of positive mental health and awareness of suicide prevention. The benefits of close caring attachment between parents and infants will have a positive effect in later life. Also central to this promotion of positive mental health, is the development of safe and supportive ways of talking to children about mental health and suicide bereavement. Voluntary organisations such as Barnardos and Schizophrenia Ireland are already working on this issue.

It is at times of crisis or potential crisis that support for families must be especially strong such as when families are in the process of breaking up. It is important that the Family Court Service is sensitive to the dangers associated with isolating any family member as a consequence of court proceedings and rulings.

All action and policy aimed at improving support for families must take into account the diversity of family types now existing in Irish society and aim to tailor supports and services accordingly.

Action to Take	
1.1	Determine the range, extent, nature and quality of support services for families available through the statutory and voluntary sectors, especially for families in crisis
1.2	Review existing practice and information resources in relation to family support, parenting, home-based mental health promotion and crisis resolution
1.3	Guided by the review in 1.2, disseminate information to the agencies identified in 1.1 and to other relevant agencies such as the Family Court Service and ensure quality information is routinely and easily available (see also 25.4)
1.4	Put in place a requirement to conduct Health Impact Assessments (incorporating mental health) on all new housing developments, in addition to the current requirement for Environmental Impact Assessment

For actions on supporting families affected by a death by suicide see Areas 23 and 24 below.

2 Schools

Objective:	To promote positive mental health, develop counselling services and put standard crisis response protocols in place in all primary and secondary schools.

Schools can play an important role in the promotion of positive mental health, building up resilience and in identifying and supporting students who may be vulnerable or at risk, including students who are bullied or who are suffering from low self-esteem. Students who are perceived as being different, for example on the grounds of sexual orientation or race, may be particularly vulnerable in this regard. The school response in the aftermath of a student or staff suicide is also extremely important in order to minimise the negative and distressing impact on the school and the wider community.

While the treatment of child and adolescent psychiatric problems is the responsibility of the health services, mental health promotion and the provision of supports for vulnerable students depend on cooperation between government departments, particularly the Department of Education and Science (DES) and the Department of Health and Children (DoHC).

Education about mental well-being and mental health problems should become an integral part of the school curriculum, starting in primary school. It is especially important to address the myths and stigma surrounding mental health which, for many young people, are barriers to seeking help for emotional and mental health problems. Finally, the support needs of staff in developing mental and emotional health promotion must be acknowledged and met.

The ongoing development of the Social, Personal and Health Education (SPHE) module, which is now compulsory in all second level schools at Junior Cycle, offers an important vehicle for the delivery of mental health promotion efforts. This development will build on the experience of all

primary school children as SPHE is a core part of the primary curriculum. The importance of SPHE in promoting positive mental health is further underlined by the strong working partnerships it has fostered and encouraged between the education sector and the HSE, especially with Health Promotion Officers across the regions. Links between the education and health sectors have been further strengthened through the development of the Health Promoting Schools Network.

Note: *youth organisations and services for early school leavers such as YouthReach are addressed in Area 3 below.*

Action to Take	
2.1	Establish an inter-departmental working group between the Department of Education and Science (DES) and the Department of Health and Children (DoHC) to develop, implement, monitor and coordinate protocols and policy for mental health promotion and critical incident response in schools
2.2	At an operational level, appoint a national coordinator in the education sector to work in partnership with appropriate HSE staff to oversee the implementation of mental health promotion activities and critical incident response in schools
2.3	Conduct a formal review, making recommendations for service development, of school guidance and counselling services to establish staffing levels, training and accreditation standards and the extent and nature of counselling provided
2.4	Survey primary and secondary schools to establish base line information in relation to mental health promotion programmes, critical incident response protocols and the Social, Personal and Health Education (SPHE) module
2.5	Review and rate the usefulness and effectiveness of all of the available mental and emotional health promotion materials and programmes, including peer support programmes, and the relevant guidelines documents for primary and secondary schools and for students, including help websites
2.6	Compile a database of statutory and voluntary mental health and social support services that schools can access for information and referral, making the database available on appropriate websites (see also 25.4)
2.7	Building on existing programmes (such as the HSE South Eastern Area schools training programme which has been independently evaluated), develop and implement a training programme for teachers at all levels and for trainee teachers on mental health promotion and crisis response
2.8	Expand SPHE in primary and secondary schools, with a focus on age-appropriate mental and emotional health issues such as self-esteem, bullying, discrimination and alcohol, requiring all schools to implement SPHE at senior cycle post-primary, informed by the review in 2.4 above
2.9	Guided by the review in 2.3, develop an independent counselling service that can be accessed through schools or in the community by school students and by early school leavers

3 Youth Organisations and Services

Objective:	To equip the youth sector with the resources needed to provide support to all young people, especially those who may be disadvantaged or at increased risk and to reflect the voice of young people in the planning and development of services.

Youth organisations and services refer to statutory and voluntary agencies and organisations that either directly provide social and educational services for young people or which represent the interests of young people. These agencies include the Child Care Services and agencies that cater for early school leavers, a group who may be at increased risk of engaging in self-harming behaviour. Many of these agencies operate under the umbrella of the National Youth Council of Ireland (NYCI).

In many cases, youth organisations may not have identified for themselves a role in suicide prevention, especially in terms of their capacity for mental health promotion. Creation of awareness among youth organisations of this role will be important for the successful implementation of this strategy.

Action to Take	
3.1	Identify and list all of the relevant national youth organisations outlining the role and nature of the service provided and make this information widely and easily available
3.2	Organise a consultation with a broad and widely representative sample of young people to ask them about existing services and about the type of services they would prefer to use if they were distressed or suicidal and develop services on that basis as pilot projects to be evaluated for efficacy
3.3	Establish the percentage of early school leavers nationally who go on to attend YouthReach and similar services and establish targets to increase attendance and resource these services on the basis of the findings so that less young people fall through the protective net of continued education and training

4	Third Level Eductaion Settings	
	Objective:	To promote positive mental health, develop counselling and support services and put standard crisis response protocols in place in all third level education settings, and to establish mental health issues as part of the appropriate third level curricula.

Note: *When discussing 'Third Level Education Settings' we include all colleges and universities and all vocational and professional training institutions such as the Garda Training College, Defence Forces training colleges and FÁS Training Centres.*

According to *The Mental Health Initiative* (TCD and NAHB, 2003), "the progress regarding mental health promotion and suicide awareness varies greatly among individual Irish third level institutions". Entry into college marks a time of great transition for all students. For many young people this can lead to increased stress and vulnerability to mental health difficulties. When suicidal behaviour occurs in a third level setting, the response of the college can be important in supporting vulnerable students who may be affected by the incident.

Third level institutions have the opportunity to influence attitudes to mental health and help-seeking among all students. Furthermore, there is an opportunity to influence the attitudes to mental health and suicide prevention of students who will later work professionally in health and education. By acknowledging mental and emotional health issues within a college's ethos, in formal and informal aspects of college life, a greater number of students will move on to working life with a positive and open attitude to mental health problems.

Action to Take	
4.1	Review, adapt if appropriate, and disseminate mental health promotion, suicide prevention and critical incident management materials and resources for third level colleges (such as *The Mental Health Initiative*, 2003, Trinity College Dublin and the Northern Area Health Board)
4.2	Review and develop as appropriate peer support services and systems, especially in light of the strong peer group influence at the traditional student/apprentice ages of late teens and early 20s and review and develop the existing counselling and other formal support services
4.3	Review recent Irish research into the psychological well-being of students to inform future planning of student support services (e.g. CLAN survey – Hope et al, 2005)
4.4	Develop a mental health / suicide prevention module to be formally incorporated into training for all undergraduate medical, paramedical and nursing students, undergraduate education sector students, media/journalism students and other appropriate occupations such as Gardaí and the Defence Forces and for appropriate postgraduate courses

5 Workplaces

Objective:	To promote positive mental health, employee supports and crisis readiness in all places of work.

The workplace can act as a setting for suicide prevention in three basic ways, first by supporting positive mental health promotion, second by responding in a supportive way when employees are under stress or strain for whatever reason (such as having an alcohol problem, an experience of bullying or having family problems) and third, by developing protocols of response when suicidal behaviour occurs aimed at helping to minimise the negative impact.

In addition, it is important that we reach out to people who are self-employed or those who work in places and settings that can be isolated, such as farmers.

It should be acknowledged by employers' representative bodies that the 'General Duties of Employers' as set out in the Safety, Health and Welfare at Work Act, 2004 apply in relation to mental and emotional as well as physical health. Chapter 1, section 8.1 states that "every employer shall ensure, as far as is reasonably practicable, the safety, health and welfare at work of his or her employees".

The statutory role of the Health and Safety Authority (HSA) will be important in supporting workplace mental health promotion and suicide prevention initiatives.

Action to Take	
5.1	Review existing resources and establish best practice in the provision of health information, psychological support services and critical incident response in the workplace and among those who may work in isolation such as farmers and disseminate this information to all employers, employer bodies or relevant representative organisations including, for example, the Irish Farmer's Association
5.2	In the delivery of community education on suicide prevention and mental health promotion (including public lecture series and awareness talks) invite participation from specific occupations who are often well placed as 'gatekeepers' within the community, such as taxi drivers, post office workers, pharmacists and shopkeepers (see also 7.4)

6 Sports Clubs and Organisations

Objective:	To develop the potential of sports clubs as settings for positive mental health promotion.

There is a strong sporting tradition in Irish society which can be used to promote positive mental health, especially among young men. The use of role models in sport to promote mental or emotional health issues is an approach that has been recommended throughout the consultation process for this strategy. It may be the case that those who are most vulnerable to suicidal thoughts or behaviour are less likely to be involved in sports clubs. However, the promotion of positive mental health through these clubs will have a positive add-on effect in the wider community by encouraging people to listen better and be more supportive of those who are more vulnerable.

Action to Take	
6.1	Review and, where appropriate, develop the current guidelines/codes of conduct of the major national sporting organisations as they pertain to mental health issues, risk situations and critical incidents
6.2	Provide for increased community, sports and leisure facilities in county development plans
6.3	Review the impact of alcohol sponsorship of sports clubs and events, with a view to breaking the commercially reinforced links between alcohol and sport
6.4	Recruit the major national sporting organisations as partners in the development of a national positive mental health promotion campaign (see also 10.1)

7 Voluntary and Community Organisations

Objective:	To develop formal and structured partnerships between voluntary and community organisations and the statutory sector in order to support and strengthen community based suicide prevention, mental health promotion and bereavement support initiatives.

Voluntary sector and community groups have an important role to play across all aspects of suicide prevention, from mental health promotion to crisis intervention and bereavement support.

In January 2005, the Oireachtas Joint Committee on Arts, Sport, Tourism, Community, Rural and Gaeltacht Affairs published its report *Volunteers and Volunteering in Ireland* to highlight the importance of voluntary and community work, the value of volunteers and the need to support genuine partnerships. Work in the area of mental health promotion and suicide prevention will benefit from the further development of the voluntary and community sector and of partnership work to respond to service deficits in a coordinated way.

When a particular community has been affected by suicide in the locality, the immediate supportive responses are often strongest from within the community itself. In order to ensure that the most comprehensive supports are in place and that all available resources can be identified at the time when a community most needs them, it is essential that the voluntary/community and statutory sectors can work closely together as partners. There is an onus on the statutory sector to give support to all local voluntary and community efforts in suicide prevention, mental health promotion and bereavement support. The provision of this support will take learning from, and build on the work of, the Regional Resource Officers for Suicide Prevention of the HSE as we move towards the standardisation of service provision in suicide prevention.

Action to Take	
7.1	Identify and list all of the relevant national organisations in the voluntary and community sector that have a focus on suicide prevention and mental health promotion as a national directory of services to be made widely and easily available, making use of Information and Communications Technology (ICT – see also 25.4)
7.2	Promote and facilitate the formal networking of voluntary groups that operate at a national level, building on the efforts of the Alliance for Mental Health which is coordinated by Mental Health Ireland
7.3	Agree and deliver, on a partnership basis, a national training programme for volunteers and staff of voluntary and community groups involved in mental health promotion and suicide prevention, building on the work in the area of training developed by the National Youth Federation
7.4	Support a systematic programme of community education (including public lecture series and information materials) on mental health promotion and suicide prevention issues

8 Church and Religious Groups

Objective:	To support the role of churches and religious groups in providing pastoral care to the community and in promoting positive mental health, especially after a death by suicide.

Ireland remains a predominantly Catholic country (88% according to Census 2002) although it is becoming increasingly multi-denominational and increasingly secular. Through the ages, suicide came to be condemned as sinful and as an act against God by the main monotheistic religions (Christianity, Islam and Judaism). However, the religious sanctions imposed following a death by suicide have long ceased in Ireland and elsewhere. Today, churches and church organisations have a more open, caring, pastoral attitude towards mental health issues, suicide and suicide bereavement.

All churches have a supportive role to play in the aftermath of death by suicide and also have the potential to promote positive mental well-being. As Ireland is rapidly becoming a multi-ethnic society, the views of all denominations must be taken into consideration and respected.

Action to Take	
8.1	Offer training in mental health promotion, suicide prevention, bereavement support and communicating sensitively about suicide to all religious groups in Ireland

9 Media

Objective:	To develop alliances with the media so that potentially harmful media portrayal of suicidal behaviour is avoided and that helpful portrayal of the issues is encouraged.

It is more likely that someone who is distressed or vulnerable will be negatively affected by media coverage of mental health or suicide related issues. At the same time, the media is a potential ally in the promotion of positive mental health and help seeking behaviour among the general public. The media can also help in tackling the stigma associated with mental health and suicidal behaviour - which is one of the greatest barriers to suicide prevention (see Area 10 below).

In the preparation of media coverage of suicide or mental health, the most important issue to consider is whether a distressed listener, viewer or reader would be more encouraged to engage in self-harm by the piece or more encouraged to seek help (Irish Association of Suicidology and Samaritans, 2000).

Action to Take	
9.1	Revise the publication *Media Guidelines for the Responsible Portrayal of Suicide* (IAS and Samaritans, 2000), in partnership with media representatives including owners, editors, senior producers and the National Union of Journalists
9.2	Develop a system of media monitoring and response for mental health and suicide related issues with the aim of encouraging and maintaining responsible, safe and helpful standards (learning from the Media StopWatch campaign in Scotland and Schizophrenia Ireland's Media Watch campaign)
9.3	Appoint and train a panel of media spokespersons within the HSE and the voluntary sector to respond to the media in relation to the statutory and voluntary work in suicide prevention, mental health promotion and bereavement support
9.4	Recruit and train a network of volunteers who have been affected by suicidal behaviour and / or mental health problems and who are willing to engage with the media to discuss these issues in a way that is responsible, safe and likely to encourage help-seeking and reduce stigma
9.5	Promote an annual award for a journalist who has excelled in reporting responsibly and positively on mental health and suicide prevention issues in Ireland

10 Reducing Stigma and Promoting Mental Health

Objective:	To reduce the stigma associated with suicidal behaviour and emotional distress that exists in every sector of society, from public office to health professionals and among the general public, and promote positive mental health

It is becoming increasingly recognised that the stigma attached to mental ill health and suicidal behaviour is proving one of the biggest challenges to prevention. Stigma encourages intolerance and prejudice against those seen as different, which can lead to social exclusion and isolation.

Professionals working in suicide prevention and dealing with those who have engaged in suicidal behaviour must be made aware that stigma relating to suicide and mental health are serious barriers to help seeking. In addition, health and education professionals must become aware of, and deal with, any prejudices they may have which could potentially have adverse effects on the way they work.

In order to improve the priority afforded to suicide prevention, more targeted education and awareness around suicide prevention is required for front line staff in the public service and community sectors, including elected public representatives.

In attempting to challenge the stigma associated with suicide and with mental health issues the language used by the media, and by those working in health, social and education services is of great importance. Efforts called for in relation to the media and in relation to training and education throughout this strategy will complement and facilitate a targeted anti-stigma campaign.

High visibility media campaigns in relation to other issues (such as smoking cessation) appear to have had a significant impact in recent years and the same resource intensive approach is now required in the area of stigma reduction and positive mental health promotion.

It is important to establish baseline attitudes and opinions in relation to mental health and suicidal behaviour and some work has already been conducted in this area (for example, by Mental Health Ireland). Certain efforts have also been developed to tackle stigma in the general population (for example by the NSRF as part of the European Alliance Against Depression and Suicidal Behaviour) and it is important that these efforts are built upon.

Action to Take	
10.1	Tender for the development and production of a sustainable anti-stigma and positive mental health promotion campaign

11 Primary Care and General Practice

Objective:	To support the development of mental health care within primary care services and to develop suicide prevention awareness and skills training for primary health care workers.

Many GPs will rarely, and sometimes never, have a patient who dies by suicide and the opportunity for GPs to intervene directly in this area may be limited. However, General Practice settings are usually the first point of contact with the health and social support services, providing a unique opportunity for early diagnosis, intervention and treatment initiatives. The importance of the GP as the first point of contact in relation to mental health is highlighted in international and national studies (Rutz et al, 1995; and Departments of Public Health, 2001).

To date, efforts at developing suicide prevention and mental health promotion in primary care have concentrated on the development of training for practising GPs and for GP trainees. While this training has been valuable in terms of education and awareness, the need to develop new approaches to service provision has become apparent.

Primary care infrastructure is poorly developed at present and the services are fragmented with limited team involvement. However, while the *Primary Care Strategy* (Department of Health and Children, 2001b) has not yet been fully implemented, a number of pilot practice areas have been established to develop and evaluate some of the initiatives outlined in the strategy.

Information management issues in primary care are also diverse, ranging from the need for improved information transfer within health services to the dissemination of information about services and how they are delivered. It is important that an information system be developed for primary care which would facilitate accurate and timely feedback to GPs and their team on the status of their patients and indicate how health and social care needs are being met. This is especially important following discharge from mental health in-patient services and following treatment for deliberate self-harm (DSH).

Awareness building in primary care relating to suicide prevention and mental health promotion should be extended to pharmacists, given the level of contact between pharmacists and service users. Furthermore, pharmacists have an important role to play in monitoring any harmful use of medications and in supporting the use of systems for disposing of unused medication safely.

Action to Take	
11.1	Agree, plan and deliver a programme of education and training on suicide prevention for all relevant members of primary care teams including GP trainees and community pharmacists in conjunction with the ICGP
11.2	Determine and report on, with recommendations, the extent and nature of GPs' experience of treating mental health problems, suicidal ideation and DSH
11.3	Develop accessible community-based mental health support services by increasing the level of multi-disciplinary input, establishing innovative services and increasing the number of community mental health workers and by supporting the training, information and resource needs of GPs in responding to mental health problems and DSH
11.4	Determine and standardise the provision of support and information provided by primary care services to clients who are bereaved following a suicide death
11.5	Develop a 'fast-track' priority referral system from primary care to community-based mental health services for individuals experiencing a suicidal crisis who contact primary care services

Level B - Targeted Approach

Goal

To reduce the risk of suicidal behaviour among high risk groups and vulnerable people.

Action Areas

12	Deliberate Self-Harm (DSH)	
	Objective:	To develop and resource an effective response in the health services for people who present to services having engaged in deliberate self-harm and design ways to reach out to those who self-harm but are reluctant to access traditional services and supports.

A history of one or more acts of deliberate self-harm is the strongest predictor of repeated suicidal behaviour, both fatal and non-fatal. Therefore, the assessment of future suicide risk and adequate treatment referral are crucial in preventing further suicidal behaviour. The National Parasuicide Registry reports that among deliberate self-harm patients presenting to accident and emergency departments, there is considerable diversity with regard to assessment procedures and treatment referral.

Of concern following DSH is the need to develop support services in the hospital setting and also to develop active outreach for those who do not currently access services. The sub-group of teenage girls who consistently show the highest rates of hospital treated DSH, which appear to be increasing (NSRF, 2004), is of particular concern. As psycho-social supports and services are developed, it will also be important to maintain and seek to improve the medical management of DSH.

Action to Take	
12.1	Review the nature and extent of assessment, treatment and aftercare for people who have engaged in deliberate self-harm or who are acutely suicidal presenting to accident and emergency departments
12.2	Develop, pilot and introduce guidelines for responding to people presenting to hospitals following DSH to be used in the context of new services, learning from existing guidelines such as those developed by the National Institute for Health and Clinical Excellence in the UK (NICE, 2004)
12.3	Informed by the review report produced following 12.1 above, plan, develop and implement an effective service response appropriate to the need in each area, such as liaison psychiatric nurse services, in all accident and emergency departments for responding to those who present following DSH or who are acutely suicidal
12.4	Plan and deliver basic awareness training for all levels of hospital staff on suicidal behaviour and develop and deliver specialist intervention, skills-based training for the appropriate staff as part of a national training programme

12.5	Highlight the issue of deliberate self-harm that is 'hidden' or that does not come to the attention of the health services in the delivery of the awareness training and the skills-based intervention training delivered in the context of this strategy

13 Mental Health Services

Objective:	To improve mental health service provision, especially in the areas of community mental health, pre-discharge assessment from in-patient services and follow up support.

Suicidal behaviour, especially completed suicide, is strongly associated with mental health problems (diagnosed and undiagnosed). A recent review paper reports that 87.3% of those who died by suicide had a diagnosable mental illness (Arsenault-Lapierre et al, 2004), although caution should be exercised in interpreting such results as many of the studies included in the review did not use a control sample. In *Suicide in Ireland: a national study* nearly half (47%) of those for whom a GP could be identified had been referred to the mental health services. According to GPs, 43% of those who died by suicide were suffering from a diagnosable mental health problem at the time of their last visit to the GP (Departments of Public Health, 2001).

The most common diagnoses in those who die by suicide is an affective disorder (including major depression) followed by a substance abuse disorder, personality disorders and psychotic disorders (including schizophrenia) (Arsenault-Lapierre et al, 2004). Co-morbidity of a psychiatric disorder and alcohol or substance abuse greatly increases the risk of suicide.

While mental health service provision goes beyond the area of suicide prevention there have been initiatives developed by suicide prevention services in recent years which can inform the development and nature of mental health services. A recent example of such an initiative is the Wexford Self-Harm Intervention Project (WSHIP) which is a pilot counselling project aimed at providing low threshold access to counselling for people aged 16 and over who are experiencing a suicidal crisis or who are at risk of self-harm. It is proposed that the evaluation of this service is reviewed when planning additional community based services (see 13.5 below).

The Department of Health and Children appointed an Expert Group on Mental Health Policy in 2003 to develop new policy in this area and the Strategy Writing Team have worked closely with members of the Expert Group on Mental Health Policy in order to share information and ideas on the future of both suicide prevention and of mental health policy. It is expected that the report of the Expert Group will significantly develop many of the actions listed below in this area. Furthermore, the Expert Group is likely to address issues such as health inequalities in terms of the location and provision of mental heath services and issues around the various possible approaches to mental health service provision.

Action to Take	
13.1	Review, improve and standardise pre-discharge and transfer planning from or between mental health service settings, guided by the availability of appropriate supports in the given community - taking account of issues such as appropriate housing and involving family and significant others
13.2	Plan and deliver a basic suicide awareness training programme for mental health services staff and develop and deliver a specialist skills-based training programme for the appropriate clinical staff as part of a national training programme
13.3	Review current practice and resources in relation to psychological support for staff and ensure that all staff working with mental health service users have adequate psychological supports, especially in the aftermath of critical incidents
13.4	Further develop and implement standardised systems of audit, investigation and routine reporting (including to the bereaved family) following in-patient deaths in conjunction with the Mental Health Commission
13.5	Further resource and appoint multi-disciplinary, community-based mental health teams and develop and evaluate pilot service initiatives which aim to improve the early detection and improved treatment of psychological distress and mental health problems through community services
13.6	Develop Child and Adolescent Psychiatric Services, by increasing the level of in-patient resources and improving service provision in the community

14 Alcohol and Substance Abuse

Objective:	To challenge permissive, harmful attitudes to alcohol abuse, help to reduce overall consumption rates and raise awareness of the association between alcohol and/or substance abuse and suicidal behaviour.

Alcohol and substance abuse are strongly related to suicide and DSH. In a psychological autopsy study in Northern Ireland, it was found that the estimated risk of suicide in the presence of current alcohol abuse was eight times greater than in its absence (Foster et al., 1999). In a recent study in the HSE North Eastern Area, alcohol was detected in more than half of a sample of consecutive suicide deaths in three counties in the area which occurred in 2001 and 2002 (Bedford et al, 2004).

Recent findings from the National Parasuicide Registry indicate that nearly half (47.4%) of the male episodes and 39.1% of the female episodes of deliberate self-harm involved alcohol (NSRF, 2004). Alcohol can be used to provide false courage before a suicidal act and can lead to increased impulsiveness while prolonged abuse of alcohol is in itself a major contributory factor in depression and suicidal behaviour.

Action to Take	
14.1	Implement the recommendations of the *Interim Report* (Department of Health and Children, 2002) and the *Second Report of the Strategic Task Force on Alcohol* (Department of Health and Children, 2004) on a planned, phased basis, beginning with a multi-disciplinary analysis to agree priority recommendations
14.2	Review the current provision of alcohol and addiction treatment services, making recommendations for future service development, especially in the context of people experiencing both alcohol/addiction problems and mental health problems together (co-morbidity)

For actions in relation to alcohol and sport, see Area 6 above.

15 Marginalised Groups

Objective:	To determine the particular vulnerability of socially excluded, marginalised groups in society to suicidal behaviour and develop supports to counteract that vulnerability.

Marginalised groups often experience discrimination and can be vulnerable to self-harming behaviour. Such groups include lesbians, gays, bisexual and transgender people, asylum seekers, homeless people and the traveller community.

According to the BeLonG to Youth organisation lesbians, gays, bisexual and transgender people are more likely to be medicated for depression and are more likely to engage in alcohol misuse, drug abuse and deliberate self-harm.

At present, there is a lack of research on mental health and suicide among the traveller community but anecdotally, service providers are expressing concern about an apparent increase in suicide risk and suicidal ideation among this group, especially among young traveller men.

In homeless people, a recent study has shown a prevalence rate of 33% for depression and 28% for anxiety (Holohan, 2000), which is significantly higher than rates reported for the general population.

Refugees and asylum seekers often arrive from countries that are war torn, impoverished or both. Due to the experience of these adverse events, refugees and asylum seekers can be at increased risk of mental health problems and of deliberate self-harm and other suicidal behaviour.

Action to Take	
15.1	Determine the risk of engaging in suicidal behaviour associated with belonging to a marginalised group, and review the available services and support agencies for marginalised groups
15.2	Develop services, supports and information / education resources to improve mental health and well-being and reduce any increased risk of suicidal behaviour among marginalised people, learning from the review in 15.1, in consultation with members of marginalised groups

16 Prisons

Objective:	To reduce the level of suicidal behaviour in prisons as recorded by the Irish Prison Service and the National Parasuicide Registry.

Unfortunately, the Irish Prison Service (IPS) like many other services, encounters the problem of suicide and DSH among the 11,000 or so people who are committed to its care each year. On any given day, the prison population in Ireland is around 3,200. This represents an average daily increase of about 50% since the mid-1980s.

Prisoners are internationally recognised as particularly vulnerable in relation to suicidal behaviour and mental health difficulties, due in part to the increased risks associated with incarceration.

Optimum suicide prevention efforts in prisons should focus on screening for risk upon entering prison, the provision of support services for prisoners in distress and the appropriate management of deliberate self-harm behaviour when such behaviour occurs.

In recognition of the seriousness of the problem, a National Steering Group on Deaths in Prison was established by the Irish Prison Service in 1996 with a remit of reviewing deaths in custody since 1991 and also of implementing, as appropriate, recommendations contained in the *Report of the Advisory Group on Prison Deaths* (Department of Justice, Equality and Law Reform, 1991).

Under the aegis of the National Steering Group, the initiatives taken over the period from 1996 onwards have included: the implementation of many of the recommendations of the 1991 Advisory Group, including the setting up of multi-disciplinary suicide awareness groups in each prison and place of detention; the introduction of twenty-four hour medical cover; training for staff working in prisons on suicide awareness and prevention; and increased participation by Samaritans in prison work. Mental health services for the prisoner population, funded by the Department of Health and Children, have also been significantly improved in the same period.

Action in relation to suicide prevention has been further advanced by the IPS following its establishment as a stand alone agency of the Department of Justice, Equality and Law Reform in November 2001.

Action to Take	
16.1	Establish a formal partnership between prison health services and the HSE in order to support mental health promotion and suicide prevention in prison settings
16.2	Determine the range, extent, nature and quality of psychological support services for prisoners, those on remand and those recently released from prison, including those supports provided by voluntary organisations such as Samaritans

16.3	Review existing best practice guidelines, information resources and staff training in relation to prisoner support, conflict resolution and critical incident response in prisons
16.4	Based on the outcomes of 16.2 and 16.3, develop and implement support services, information resources and staff training to support suicide prevention and mental health promotion in prison settings, for those on remand and for those recently released from prison

17 An Garda Síochána

Objective:	To support the Gardaí in all aspects of their work related to suicidal behaviour.

Gardaí are often the first to be called to the scene of a suspected suicide death and are likely to be involved in breaking the tragic news to the family of the deceased person. At the time of inquest, the investigating Garda is also likely to be in contact with the relatives and friends of the person who has taken his or her life.

On another level, Gardaí will often be called when a relative or friend is concerned about the safety of someone who is threatening self-harm or suicide. The Gardaí can be well placed to identify adults in the local community who may be vulnerable or at risk while vulnerable young people might be identified through the work of Garda Juvenile Liaison Officers.

The coding of cause of death for unexpected, unnatural or sudden deaths is based to some extent on a confidential Garda return to the Central Statistics Office.

Therefore, Gardaí play a role in suicide prevention issues on a number of levels and should be supported in these aspects of their work.

Action to Take	
17.1	Prioritise the delivery of a structured, coordinated, national training and support programme, drawing on existing training resources, on suicide related issues for established members of the Garda Force and for trainee Gardaí
17.2	Pending a report on the impact of the 1998 revisions to the confidential Garda return to the CSO, Form 104, re-examine the role of the Gardaí in relation to the coding of deaths
17.3	Initiate formal discussions between the HSE and An Garda Síochána on the possibility of Gardaí notifying local health services in a discreet and confidential manner when a suspected suicide death has occurred
17.4	Provide bereavement support information to Gardaí so that they can provide this to the relatives they are informing about a sudden death and agree a protocol for the routine dissemination of this information

18 Unemployed People

Objective:	To support the development of services and programmes for unemployed people to help increase resilience and reduce the risk of engaging in suicidal behaviour.

Unemployed people are at an increased risk of engaging in suicidal behaviour when compared with the general population. *Suicide in Ireland: a national study* (Departments of Public Health, 2001) reports that almost one in three of those who died by suicide were unemployed - this was at a time when the unemployment rate in the general population had fallen to less than 10% (9.8% and 7.1% as of December 1997 and 1998 respectively).

Deliberate self-harm is also significantly associated with unemployment and socio-economic deprivation. Unemployment by its very nature can be an isolating experience and the relative risk associated with unemployment is likely to increase at times when the overall economy is performing well.

Action to Take	
18.1	Review and evaluate existing mental health promotion programmes for early school leavers and unemployed people
18.2	Informed by the review in 18.1, building on existing initiatives and working directly with local and national groups representing unemployed people, pilot and evaluate mental health promotion programmes for early school leavers and the unemployed

19 People who have experienced Abuse

Objective:	To develop awareness of the increased risk of suicidal behaviour among victims of abuse and develop support services building on the services provided currently by the National Counselling Service.

People who experience traumatic life events, in particular sexual and/or physical abuse in childhood, have a high risk of engaging in DSH and suicide (Santa Mina and Gallop, 1998). In most cases these characteristics alone are not associated with a high risk of suicidal behaviour, but in combination with other risk factors such as depression, the risk increases. Considering the relatively high prevalence of sexual abuse in Ireland - the SAVI study (McGee et al 2002) identified that 16% of men and 20% of women had experienced sexual abuse as children - survivors of sexual and/or physical abuse including those who have suffered abuse in state institutions, are an important group for suicide prevention and mental health promotion efforts. The risk associated with abuse is further compounded by the problem of non-disclosure, especially in the case of men who have been abused.

Given the learning gained within the National Counselling Service (NCS) in providing low threshold, easy access counselling services to adults who have experienced childhood abuse, it will be important to fully determine the value of this kind of counselling service provision for people at risk of suicidal behaviour.

The training and education of relevant professionals will be central to addressing this issue. Furthermore, it will be important to increase the awareness of the effects of abuse as part of the training and awareness initiatives planned throughout this strategy.

Action to Take	
19.1	Further research and provide information and training on the risk of suicidal behaviour associated with sexual and/or physical abuse, including information on self-care, to the relevant health sector employees, voluntary organisations, support groups and relevant professionals such as special Garda detectives and investigators
19.2	Evaluate the NCS model of counselling service provision making recommendations for further service development as appropriate

20 Young Men

Objective:	To develop services and initiatives that will help young men to cope with changing roles in society and involve them in the development of policy and services that affect them.

Developing suicide prevention strategies for young men is particularly challenging given the recent finding that less than half (41%) of young male suicides (under 35 years) who take their own life have been in contact with a GP in the year before death (unpublished study data from Departments of Public Health, 2001).

On an encouraging note however, a recent population based study reported that 96% of young men (sample aged between 18 and 34 years) believe that suicide is, 'at least sometimes', preventable (Begley et al, 2004). The same study also reported that young men are willing to talk about their problems, a fact which was confirmed during a series of focus group discussions with groups of young men during the same study. The main challenge in suicide prevention may actually be in encouraging more confiding relationships and in teaching listening skills, as well as talking skills.

In the context of the present strategy it may be fair to say that there is a certain increased vulnerability associated with being young and male in Ireland today compared with the past, sometimes manifest in unhealthy and anti-social behaviours. Sometimes these behaviours are extremely self-destructive.

Action to Take	
20.1	Review all of the recent research and various service initiatives for men's health in Ireland (such as the appointment of a number of Men's Health Officers in the HSE) and internationally (such as the CALM project in England)
20.2	Based on the review in 20.1 above, prepare a detailed service plan, setting out the evaluation criteria, for the development of pilot mental health promotion and support initiatives for young men
20.3	Meet with voluntary organisations (see 7.2) to discuss ways of developing partnership approaches to providing support for young men through the voluntary sector and in community settings

21 Older People

Objective:	To promote positive mental health among older people, raise awareness of the vulnerabilities of older people and develop support services for isolated older people.

In Ireland, the population profile is currently changing, albeit at a relatively slow pace, from a young, low dependency population to an ageing one.

In older people, particularly among older men, psychiatric illness (most notably depression), certain personality traits and physical illnesses are associated with an increased risk of suicide. Social isolation, loneliness and being divorced, widowed or single also increase the risk of suicide for older men. In Ireland, 45.3% of people over 65 years live in rural areas and approximately 27% of people aged 65 years and older live alone. Reduced help seeking and remoteness from services can put older people further at risk, although it must be noted that isolation is not simply just a matter of distance and can occur in the context of many living arrangements.

Action to Take	
21.1	Improve and further resource community care services for dependent older people (including home-help and day care services) as planned for in *Quality and Fairness*, 2001
21.2	Review current practice and develop as appropriate the assessment and clinical management of depression, other mood disorders and alcohol abuse, addiction or problems relating to the misuse of prescribed medication in older people at primary care level and in the nursing home setting
21.3	As part of a national training programme, promote knowledge, awareness and self-advocacy in mental health issues among older people and make provision for awareness training of key community gatekeepers who are in regular contact with isolated older people

22 Restricting and Reducing Access to Means

Objective:	To limit access to the means and methods of self-harm and suicide.

Action to reduce access to methods of self-harm, while being a general population measure, is aimed at reducing risk among vulnerable and distressed people or people at a high risk of engaging in self-harm.

The relative value of efforts to restrict access to the means of self-harm and suicide depend on how difficult such means are to restrict and on how frequently such means are used. In Ireland, hanging accounts for an average of 50% and drowning of 20% of suicide deaths each year. Restricting access to these methods of suicide is extremely difficult. Recent research suggests that in England only a small minority (around 10%) of suicides by hanging take place in controlled environments such as prisons and hospitals (Gunnell et al, 2005). Nevertheless, there is work to be done to find out more about why these methods of suicide are chosen.

The next most common method of suicide in Ireland is poisoning / overdose accounting for an average of 17% of all suicides annually. This is also the most common method of DSH, accounting for 73% of all hospital-treated cases of DSH each year (NSRF, 2004). Unfortunately, detailed data on the type of medication or drugs taken in fatal overdoses is not routinely available in Ireland at present.

On average, less than 10% of suicides are due to firearms. However, this method is more common in certain sub-groups (especially those with easy access such as farmers and soldiers) and it varies on a regional basis as well. Restriction of access to firearms and safer gun storage practice has been found to be effective in reducing suicide by firearms elsewhere (e.g. Grossman et al, 2005).

Action to Take	
22.1	Determine the risk of suicidal behaviour associated with prescription and over-the-counter medication, with a view to developing, implementing and evaluating recommendations on the availability, marketing and prescribing of these medications
22.2	Provide facilities and promote the safe disposal of unused and unwanted medicines, building on the work in relation to the DUMP project in the HSE South Western Area, Eastern Region (Dispose of Unwanted Medicines Properly)
22.3	Facilitate and encourage discussions between the NARGC (National Association of Regional Game Councils) and the Gardaí in relation to developing safer ways of licensing and storing firearms and ammunition and of disposing safely of unused or unwanted firearms
22.4	Establish whether there are specific places and types of place that are associated with suicidal acts and, where feasible, implement ways of restricting access, improving safety and promoting help-seeking
22.5	Formalise links between Irish Water Safety and the Suicide Prevention and Mental Health Promotion services of the HSE to advance work in meeting shared objectives

Level C - Responding to Suicide

Goal

To minimise the distress felt among families, friends and in a community following a death by suicide and ensure that individuals are not isolated or left vulnerable so that the risk of any related suicidal behaviour is reduced.

Action Areas

23	**Support following Suicide**
Objective:	To ensure that an effective and standardised service and supportive response is provided by relevant professionals and voluntary agencies across a range of settings when a death by suicide occurs.

It is difficult to ascertain the true number of people affected by each suicide death (one estimate from Schneidman in 1969 was that on average 6 people suffer intense grief). Also difficult to ascertain is the increased risk or likelihood of further suicidal behaviour following a suicide death in a given community. The aftermath of a suicide death is an extraordinarily difficult time for the bereaved and for the wider community. Whether related to genetic factors, social modelling or other reasons, an increased risk of further suicidal behaviour in the aftermath of a suicide death is always a possibility. For these reasons, and because of the need to support those bereaved following a suicide death, it is important that as a society we respond in the right, supportive and helpful way when a suicide death has occurred. The role of voluntary support groups and organisations at national and local levels are crucial in this regard. The media can play an important role in how we shape that response over the coming years (see Area 9 above).

Action to Take	
23.1	Audit and review the range and quality of general bereavement support services and specific services available to support those bereaved following suicide
23.2	Following the review in 23.1 above, develop standardised bereavement support services ensuring the registration, training, supervision and support of bereavement counsellors providing such services
23.3	Determine the support and information needs of people who have been bereaved following suicide, including, for example, practical information in relation to the Coroners court and information on life insurance policies
23.4	Develop and implement protocols for the health service and voluntary sector response if a community is affected by suicide, learning from the experience of previous crises and building on existing critical incident response protocols
23.5	Facilitate and support the proposed coordination of national organisations working in the area of suicide bereavement support including the National Suicide Bereavement Support Network, Living Links and Console

24 Coroner Service

Objective:	To develop the Coroner Service as a service for the living, especially those bereaved by suicide, and support coroners themselves as their role develops.

While the Coroner Service is one of the oldest public services in Ireland, the modern coroner seeks to provide a professional medico-legal investigation system for sudden, unexplained, violent and unnatural deaths. The coroner acts in the wider public interest but it is important to note that it is a service for the living and therefore the needs of the bereaved must be placed at the centre of service delivery. The recent review of the coroner service was comprehensive and legislation relating to the *Report of the Working Group on the Coroner Service* (Department of Justice, Equality and Law Reform, 2000) and the *Report of the Coroners Rules Committee* (Department of Justice, Equality and Law Reform, 2003) is expected to be published in 2005.

Although an inquest into a suspected death by suicide may be held some months after death, the bereaved relatives and friends may continue to experience distressing grief responses at that time. Therefore, the inquest procedure should not be unduly intrusive on the family but rather should be a positive and helpful part of the grieving process.

Overall, there remains an important need to develop services in a consistent way in order to ensure that the experience of the suicide bereaved is as manageable as possible, minimising the level of distress or upset that may be felt during what can be an extremely difficult time. In order to meet these needs, the issue of public information with regard to the inquest procedure needs to be addressed (see 23.3 above) as well as the issue of training and improved resources for coroners.

Action to Take	
24.1	Appoint Coroner's Officers (at present Gardaí act as such) to act as the link person between the public and the Coroner Service as recommended in the *Report of the Working Group on the Coroner Service* (Department of Justice, Equality and Law Reform, 2000)
24.2	Review existing information resources and if necessary produce and disseminate revised materials on the Coroner Service that would be helpful to the bereaved and to people working in relevant professions (see 23.3)
24.3	In discussion with the Coroners Society of Ireland, review existing guidelines on conducting the inquest procedure in a sensitive and supportive manner and agree a revised national set of guidelines for the inquest procedure, especially in relation to cases of possible suicide

24.4	Organise and deliver training for coroners with regard to the psychological management of sensitive cases and other matters that arise in the course of coroners' work
24.5	Develop the role of the coroner in providing information on suicide and other deaths from external causes

Level D - Information and Research

Goal

To improve access to information relating to suicidal behaviour and on where and how to get help, and to encourage suicide research and improve access to research findings.

Action Areas

25	Information	
	Objective:	To establish effective and integrated national information systems relating to suicidal behaviour in order to inform service development and to improve the availability and accessibility of information on where and how to get help.

Information relating to the circumstances of suicide deaths is routinely collected by a range of statutory agencies and professional groups. These include the Central Statistics Office (CSO), Gardaí, coroners and pathologists. Depending on the history of health service contact, data are also collected by GPs, the National Parasuicide Registry, the Hospital In-Patient Enquiry (HIPE) system, the National Psychiatric Inpatient Reporting System (NPIRS) and the National Drug Treatment Reporting System (NDTRS).

The potential of this information to answer fundamental questions about suicide has yet to be realised. For example, there is no central location for the records of the 48 coroner jurisdictions in Ireland. Therefore, there are 48 locations around the country where detailed data on suicide and other deaths which lead to an inquest are stored but not used to guide and inform prevention efforts.

At present, much of our knowledge on the patterns of death by suicide is based on CSO data which is informed by the confidential Garda Form 104. This form was expanded in 1998 and an analysis of the additional information has been conducted by the NSRG Officer of Statistics. A report on this work will be published in 2005.

The National Parasuicide Registry has established the extent of hospital-treated DSH in Ireland, identifying the groups and areas with the highest rates and describing the methods of self-harm involved in the acts. However, there is limited information in relation to what happens to DSH patients following presentation to an accident and emergency department.

Currently, the relevant Health Services National Performance Indicators focus not only on the incidence and repetition of DSH presentations to accident and emergency departments (data supplied by the National Parasuicide Registry) but also on the assessment and referral of patients (data supplied by the relevant hospitals, liaison psychiatry teams or mental health services). There is no linkage or information exchange at the level of the individual between the NPR and the services responsible for assessing and referring patients. Therefore, the extent to which patients are assessed is not known.

Information on suicidal behaviour is vital in order to guide the planning of effective services and supports. However, of more fundamental importance perhaps, is the need to make information on such services and supports available and accessible to as many people as possible. In recent years regional directories of support services have been published throughout Ireland by regional Resource Officers for Suicide Prevention. The information contained in these directories was detailed and comprehensive, however, such printed resources can become dated. Rather than constantly re-produce print materials, it may be more effective to develop alternative approaches to information provision. Possible approaches include SMS text messaging services, telephone information helplines and Internet directories, i.e. by using Information and Communications Technology (ICT).

Action to Take	
25.1	Link and exchange data between relevant national information systems, including the National Parasuicide Registry, the Hospital In-Patient Enquiry system, the National Psychiatric Inpatient Reporting System and the National Drug Treatment Reporting System
25.2	Informed by a commissioned scoping paper, establish a comprehensive, routine, national, confidential inquiry into deaths from unnatural causes including suicide, collating data from all of the relevant agencies
25.3	Review all available guidelines relevant to suicide prevention (ranging from guidelines for the management of deliberate self-harm, to guidelines on media portrayal of suicide and guidelines for supporting those bereaved) with a view to agreeing a set of guidelines for use in Irish settings
25.4	Review existing sources of information on where and how to get help and design, pilot and evaluate new information services using Information and Communications Technology (ICT)

26 Research

Objective:	To systematically plan research into suicidal behaviour to address deficits in our knowledge, ensure that the development of services is evidence-based and bridge the gap between research and practice.

While many of the actions called for in this strategy require an element of research, audit or review in order to establish baseline information, there is also a need to develop a coordinated plan for research into suicidal behaviour and suicide prevention efforts in Ireland. The development of a coordinated plan will allow for the best use of available resources and will also facilitate the development of information systems along the lines outlined in Area 25 above. A national research plan, to be monitored by the proposed National Office for Suicide Prevention, should be developed in cooperation with all of the relevant stakeholders. It is essential that systems are put in place to ensure that ongoing research in the area of suicide should be fully coordinated and planned on a partnership basis between the various research agencies.

In line with the overall aims of the strategy, the priority areas for research will include (but are not exclusive to) approaches to the assessment, treatment and care of people who have engaged in deliberate self-harm, the development of sustainable information systems in relation to completed suicide (along the lines of a national confidential inquiry) and the value and benefit of approaches to mental health promotion, particularly efforts aimed at younger people and delivered through schools and other settings. Developments in other areas such as pharmacological treatments of mental illness and research into possible biological or genetic vulnerability to suicidal behaviour will be monitored on an ongoing basis.

Action to Take	
26.1	Agree a national programme and plan of research into deliberate self-harm, suicide and suicide prevention, detailing the means of using research findings to inform service provision and health and social policy
26.2	Develop and maintain international suicide prevention and research links through membership of the International Association for Suicide Prevention and other relevant networks so that Ireland can learn from, and contribute to, international best practice

Action Table

- Phase 1 Actions (Short-term priorities for immediate start-up)
- Phase 2 Actions (Start-up pending partnership commitment)
- Phase 3 Actions (Follow-on actions linked to Phase 1 and Phase 2)

Note 1: Some actions have been summarised for the purposes of clearer presentation (see the document above for the full text of each action).

Note 2: HSE National Office for Suicide Prevention (NOSP) is a *working title only* for the proposed office.

Implementation Phase Code: ■ □ □ - Phase 1 Actions ■ ■ □ - Phase 2 Actions ■ ■ ■ - Phase 3 Actions

Level A - General Population Approach

Implementation Phase	Action to Take		Lead / Identified Agencies	Deliverables
	Area 1 - The Family			
■ ■ □	1.1	Determine the range, extent, nature and quality of support services for families	HSE National Office for Suicide Prevention (NOSP), HSE Health Promotion and family support services	Report to inform services directory in 1.3
■ ■ □	1.2	Review practice and information resources in relation to family support, parenting, home-based mental health promotion and crisis resolution	HSE NOSP, HSE Health Promotion and family support services	Report to inform services directory in 1.3
■ ■ ■	1.3	Guided by the review in 1.2, disseminate information to the agencies identified in 1.1	HSE NOSP, HSE Health Promotion and family support services	A widely disseminated and easily available directory (see also 25.4)
■ ■ □	1.4	Conduct a Health Impact Assessment (including mental health) on all new housing developments, in addition to the Environmental Impact Assessment	HSE Population Health Directorate, HSE NOSP, Department of the Environment and Local Government and Department of Health and Children (DoHC)	A Health Impact Assessment tool
	Area 2 - Schools			
■ ■ □	2.1	Establish an inter-departmental working group between the Department of Education and Science (DES) and the Department of Health and Children (DoHC) to develop, implement, monitor and coordinate protocols and policy for mental health promotion and critical incident response in schools	Department of Education and Science (DES) and DoHC	Shared protocol and policy in the promotion of positive mental health and crisis management

Implementation Phase	Action to Take		Lead / Identified Agencies	Deliverables
	Area 2 - Schools (continued)			
■ ■ □	2.2	At an operational level, appoint a national coordinator in the education sector to work in partnership with appropriate HSE staff to oversee the implementation of mental health promotion activities and critical incident response in schools	DES	Appointment of national coordinator
■ ■ □	2.3	Conduct a formal review, making recommendations for service development, of school guidance and counselling services to establish staffing levels, training standards and the extent and nature of counselling provided	DES and HSE to commission	Review report to inform service planning
■ ■ □	2.4	Survey primary and secondary schools to establish base line information in relation to mental health promotion programmes, critical incident response protocols and the Social, Personal and Health Education (SPHE) module	HSE NOSP, DES, and SPHE Support Service	Report with recommendations to inform the development of SPHE and health promotion and crisis response more generally
■ ■ □	2.5	Review and rate the usefulness and effectiveness of the available mental and emotional health promotion materials and programmes and the relevant guidelines documents for primary and secondary schools and for students, including help web sites	HSE NOSP	National guidelines on quality of materials and programmes for schools
■ ■ □	2.6	Compile a database of statutory and voluntary mental health and social support services that schools can access for information and referral, making the database available on appropriate websites (see also 25.4)	HSE NOSP	Database for schools

Implementation Phase	Action to Take		Lead / Identified Agencies	Deliverables
	Area 2 - Schools (continued)			
■ ■ □	2.7	Building on existing programmes (such as the HSE South Eastern Area schools training programme), develop and implement a training programme for teachers at all levels and for trainee teachers on mental health promotion and crisis response	HSE NOSP and DES	National teacher training programme
■ ■ □	2.8	Expand SPHE in primary and secondary schools, with a focus on age appropriate mental health issues, requiring all schools to implement SPHE at senior cycle (see 2.4 also)	DES and SPHE Support Service	Expanded SPHE delivery and compulsory SPHE at senior cycle
■ ■ ■	2.9	Guided by the review in 2.3, develop and instigate a service plan for an independent counselling service that can be accessed through schools or in the community by school students and by early school leavers	DES and National Council for Guidance in Education	Independent counselling service for students and early school leavers
	Area 3 - Youth Organisations and Services			
■ ■ □	3.1	Identify and list all of the relevant national youth organisations	HSE NOSP, HSE Health Promotion and national youth organisations	Internet accessible, fully explained directory of youth services and organisations
■ ■ □	3.2	Organise a consultation with young people to ask them about services and service development	HSE NOSP, HSE Health Promotion and national youth organisations	Report on young people's views on service development
■ ■ □	3.3	Establish the percentage of early school leavers nationally who go on to attend YouthReach and similar services and establish targets to increase attendance and resources	DES, YouthReach and HSE NOSP	Development of services for early school leavers

Implementation Phase	Action to Take		Lead / Identified Agencies	Deliverables
	Area 4 - Third Level Education Settings			
■ ■ □	4.1	Review, adapt if appropriate, and disseminate mental health promotion, suicide prevention and critical incident management materials and resources for third level colleges and vocational training centres	Third level colleges and vocational training centres and HSE NOSP	Standard, evidence-based mental health promotion, and critical incident management protocols in place
■ ■ □	4.2	Review and develop as appropriate peer support services and systems and develop the current counselling and formal support services	Third level colleges and vocational training centres and HSE NOSP	Standardised and innovative support services
■ ■ □	4.3	Review recent Irish research into the psychological well-being of students to inform future planning of student support services (e.g. CLAN survey – Hope et al, 2005)	Third level colleges and vocational training centres and HSE NOSP	Review report informing 4.1 and 4.2
■ ■ □	4.4	Develop a mental health / suicide prevention module to be formally incorporated into the training of relevant occupations and professions	Vocational training bodies (including those in health, education and the emergency services) and HSE NOSP	Routine, standard structured training for all relevant future professionals
	Area 5 - Workplaces			
■ ■ □	5.1	Review existing resources and establish best practice in the provision of health information, psychological support services and critical incident response in the workplace (including those who may work in isolation such as farmers) and disseminate this information to all employers and relevant representative organisations	HSE NOSP, Health and Safety Authority and the relevant representative bodies (including employer groups, and groups such the Irish Farmer's Association and the Vintner's Federation)	Best practice guidelines to support health promotion and crisis response in all work settings
■ ■ □	5.2	In the delivery of community training and education invite participation from specific occupations who are often well placed as 'gatekeepers' within the community (see also 7.4 below)	HSE NOSP	Gatekeeper participation in HSE and community sector training

Implementation Phase	Action to Take		Lead / Identified Agencies	Deliverables
	Area 6 - Sports Clubs and Organisations			
■ ■ □	6.1	Review and develop the current guidelines/codes of conduct of the major national sporting organisations as they pertain to mental health issues, risk situations and critical incidents, promote awareness of the existence of these documents and encourage their increased use	Irish Sports Council, IRFU, FAI, GAA, other national sports organisations, HSE NOSP and HSE Health Promotion	Widely available best practice guidelines in all major sporting organisations
■ ■ □	6.2	Provide for increased community, sports and leisure facilities in county development plans	County development boards	Increased community and leisure facilities
■ ■ □	6.3	Review the impact of alcohol sponsorship of sports clubs and events, with a view to breaking the commercially reinforced links between alcohol and sport	Department of Justice, Equality and Law Reform, DoHC and major sporting organisations	Clear statement on the impact of alcohol sponsorship in sport with recommendations
■ ■ □	6.4	Recruit the major national sporting organisations as partners in the development of a national anti-stigma campaign (see also 10.1)	HSE and major national sporting organisations	Sporting organisations partnership in anti-stigma campaigning
	Area 7 - Voluntary and Community Organisations			
■ ■ □	7.1	Identify and list all relevant national organisations in the voluntary and community sector as an easily and widely available national information directory (see also 25.4)	HSE NOSP, HSE Health Promotion and voluntary and community groups	Easily and widely available information directory
■ □ □	7.2	Promote and facilitate the Alliance for Mental Health	Mental Health Ireland and other voluntary and community organisations and HSE NOSP	Resourced and operational National Alliance for Mental Health
■ □ □	7.3	Agree and deliver, on a partnership basis, a national training programme for volunteers and staff of voluntary and community groups involved in mental health promotion and suicide prevention	Voluntary and community groups and HSE NOSP	Agreed national training programme for the voluntary and community sector

Implementation Phase	Action to Take		Lead / Identified Agencies	Deliverables
	Area 7 - Voluntary and Community Organisations (continued)			
■ □ □	7.4	Support a systematic programme of community education (including public lecture series and information materials) on mental health promotion and suicide prevention issues	Voluntary and community groups, HSE NOSP and county development boards	Agreed community education programme
	Area 8 - Church and Religious Groups			
■ □ □	8.1	Offer training in mental health promotion, suicide prevention, bereavement support and communicating sensitively about suicide to all religious groups	Religious groups and HSE NOSP	Agreed training programme for religious groups
	Area 9 - Media			
■ □ □	9.1	Revise the publication *Media Guidelines for the Responsible Portrayal of Suicide* (IAS and Samaritans, 2000)	IAS, Samaritans, HSE NOSP, NUJ and the Irish Film Board	Revised Media Guidelines
■ □ □	9.2	Develop a system of media monitoring and response for mental health and suicide related issues (learning from the Media StopWatch campaign in Scotland and Schizophrenia Ireland's Media Watch campaign)	Schizophrenia Ireland, HSE NOSP and other voluntary/community organisations	Media monitoring and response system
■ □ □	9.3	Appoint and train a panel of media spokespersons within the HSE and voluntary sector to respond to the media in relation to the statutory and voluntary work in suicide prevention, mental health promotion and bereavement support	HSE NOSP and voluntary/community organisations	A panel of media spokespersons
■ □ □	9.4	Recruit and train a network of volunteers who have been affected by suicidal behaviour and / or mental health problems and who are willing to engage with the media in a way that is responsible, safe and likely to encourage help-seeking and reduce stigma	Alliance for Mental Health and HSE NOSP	A panel of trained and supported volunteers
■ □ □	9.5	Promote an annual award for a journalist covering mental health and suicide prevention issues	IAS, NUJ and Alliance for Mental Health	Annual journalists award

Implementation Phase	Action to Take		Lead / Identified Agencies	Deliverables
	Area 10 - Reducing Stigma and Promoting Mental Health			
■ □ □	10.1	Tender for the development and production of a sustainable anti-stigma and positive mental health promotion campaign in the media	HSE NOSP, HSE Health Promotion, DoHC Health Promotion Unit, Alliance for Mental Health, and successful tendering PR / Media company	Sustainable anti-stigma and positive mental health promotion campaign
	Area 11 - Primary Care and General Practice			
■ □ □	11.1	Agree, plan and deliver a programme of education and training on suicide prevention for all relevant members of the Primary Care Team including GP trainees and community pharmacists	HSE NOSP and ICGP	National training programme for primary care
■ ■ □	11.2	Determine and report on, with recommendations, the extent and nature of GPs' experience of treating mental health problems, suicidal ideation and DSH	HSE NOSP and ICGP	Report on GPs attitudes towards and experience of mental health and self harm behaviour to informing service planning
■ ■ □	11.3	Develop accessible, community-based, mental health services	HSE NOSP, DoHC, ICGP and GP out-of-hours service	Accessible, community-based mental heath support services and relevant information
■ □ □	11.4	Determine and standardise the provision of support and information provided by primary care services to clients who are bereaved by suicide (See 23.1 and 23.2 below)	HSE NOSP, ICGP, bereavement support groups and Gardaí	Agreed guidelines for the role of GPs in supporting clients bereaved by suicide

Implementation Phase	Action to Take		Lead / Identified Agencies	Deliverables
	Area 11 - Primary Care and General Practice (continued)			
■ □ □	11.5	Develop a 'fast-track' priority referral system from primary care to community-based mental health services for individuals experiencing a suicidal crisis who contact primary care services	HSE NOSP, HSE PCCC, DoHC, ICGP, and GP out-of-hours services	Reduced waiting times for community-based mental health services and increased referral rates from primary care / early intervention services

Implementation Phase Code: ■ □ □ - Phase 1 Actions ■ ■ □ - Phase 2 Actions ■ ■ ■ - Phase 3 Actions

Level B - Targeted Approach

Implementation Phase	Action to Take		Lead / Identified Agencies	Deliverables
	Area 12 - Deliberate Self-Harm			
■ □ □	12.1	Review the nature and extent of assessment, treatment and aftercare for people who have engaged in deliberate self-harm or who are acutely suicidal presenting to A&E departments	HSE NOSP and National Suicide Research Foundation	Report with service planning recommendations on the treatment and aftercare of people attending general hospitals following DSH
■ □ □	12.2	Develop, pilot and introduce, pending positive evaluation, guidelines for responding to people presenting to hospitals following DSH	HSE NOSP to commission	Guidelines / standard instrument for use in the assessment of DSH
■ □ □	12.3	Plan, develop and implement services, such as liaison psychiatric nurse services, in all A&E Departments for responding to those who present following DSH or who are acutely suicidal	HSE NOSP, HSE National Hospitals Office and HSE PCCC	Effective service provision in every A&E Department for people who have engaged in DSH
■ □ □	12.4	As part of a comprehensive national training programme, plan and deliver basic awareness training for all levels of hospital staff on suicidal behaviour and develop and deliver specialist intervention, skills-based training for the appropriate staff	HSE NOSP, HSE National Hospitals Office and HSE PCCC	Training programme for A&E staff
■ □ □	12.5	Highlight the issue of DSH that is ‘hidden’ or that doesn’t come to the attention of the health services in the delivery of awareness training and skills-based intervention training	HSE NOSP	Inclusion of information on ‘hidden’ DSH in training

Implementation Phase	Action to Take		Lead / Identified Agencies	Deliverables
	Area 13 - Mental Health Services			
■ ■ □	13.1	Review, improve and standardise pre-discharge and transfer planning from or between mental health service settings, guided by the availability of appropriate supports in the given community	HSE NOSP, HSE PCCC, Mental Health Commission and advocates	Standardised pre-discharge and transfer of patient protocols
■ □ □	13.2	As part of a comprehensive national training programme, plan and deliver a basic awareness training programme for mental health services staff on suicidal behaviour and develop and deliver a specialist skills-based training programme for the appropriate clinical staff	HSE NOSP	Training programme for mental health services staff
■ ■ □	13.3	Review current practice and resources in relation to psychological support and ensure that all staff working with mental health service users have adequate psychological supports	HSE NOSP and HSE PCCC	Referral system in place for staff to access psychological support
■ ■ □	13.4	Further develop and implement standardised systems of audit, investigation and routine reporting (including to the bereaved family) following in-patient deaths	HSE NOSP, HSE PCCC, Mental Health Commission and DoHC	Routine, standardised systems in place following in-patient suicide death
■ ■ □	13.5	Further resource and appoint multi-disciplinary, community-based mental health teams and develop and evaluate pilot service initiatives which aim to improve the early detection of psychological distress and mental health problems through community outreach work	HSE PCCC, HSE NOSP, DoHC and Mental Health Commission (see also, work of Expert Group on Mental Health Policy)	Increase in multi-disciplinary community-based mental health services and improved early detection
■ ■ □	13.6	Develop Child and Adolescent Psychiatric Services, by increasing the level of in-patient resources and improving service provision in the community	HSE PCCC and DoHC	Improved and new Child and Adolescent Services in community and in-patient settings

Implementation Phase	Action to Take		Lead / Identified Agencies	Deliverables
	Area 14 - Alcohol and Substance Abuse			
■ ■ □	14.1	Implement recommendations of the *Interim Report* (DoHC, 2002) and *Second Report of the Strategic Task Force on Alcohol* (DoHC, 2004) on a planned, phased basis, beginning with a multi-disciplinary analysis to agree priority recommendations	Department of Justice, Equality and Law Reform and DoHC	Implementation of priority actions based on the recommendations of the Strategic Task Force on Alcohol
■ ■ □	14.2	Review the current provision of alcohol and addiction treatment services, making recommendations for future service development, especially in the context of people experiencing both alcohol/addiction problems and mental health problems together (co-morbidity)	HSE NOSP, HSE PCCC and DoHC	Recommendations for HSE National Service Plan
	Area 15 - Marginalised Groups			
■ ■ □	15.1	Determine the risk of engaging in suicidal behaviour associated with belonging to a marginalised group, and review the available services and support agencies for marginalised groups	HSE NOSP (to commission) and agencies representing marginalised groups	Recommendations for HSE National Service Plan
■ ■ ■	15.2	Develop services, supports and information / education resources to improve mental health and well-being and reduce any increased risk of suicidal behaviour among marginalised people, learning from the review in 15.1	HSE NOSP and the representative bodies identified in 15.1 such as ARASI (Association of Refugees and Asylum Seekers in Ireland), Gay/HIV Strategies and Pavee Point	Services, supports and information relevant to marginalised groups in relation to mental health promotion and suicide prevention
	Area 16 - Prisons			
■ ■ □	16.1	Establish a formal partnership between prison healthcare services and the HSE in order to support mental health promotion and suicide prevention in prison settings	Irish Prison Service (IPS) and HSE NOSP	Establishment of shared protocols and service plans

Implementation Phase	Action to Take		Lead / Identified Agencies	Deliverables
	Area 16 - Prisons (continued)			
■ ■ □	16.2	Determine the range, extent, nature and quality of psychological support services for prisoners, those on remand and those recently discharged from prison	IPS, Probation and Welfare Service and HSE NOSP	Report with recommendations for service planning with prisoner population and recently discharged people
■ ■ □	16.3	Review existing best practice guidelines, information resources and staff training in relation to prisoner support, conflict resolution and critical incident response in prisons	IPS and HSE NOSP	Report with recommendations on information resources, training and protocols of response in relation to prisons
■ ■ ■	16.4	Based on the outcomes of 16.2 and 16.3, develop and implement support services, information resources and staff training to support suicide prevention and mental health promotion in prison settings, for those on remand and for those recently released from prison	IPS, Probation and Welfare Service and HSE	Report on services for those on remand and those recently released from prison
	Area 17 - An Garda Síochána			
■ □ □	17.1	Prioritise the delivery of a structured, coordinated, national training and support programme, drawing on existing training resources, on suicide related issues for established members of the Garda Force and for trainee Gardaí	An Garda Síochána and HSE NOSP	National training and support programme
■ ■ ■	17.2	Pending a report on the impact of the 1998 revisions to the confidential Garda return to the CSO, Form 104, re-examine the role of the Gardaí in relation to the coding of deaths	CSO, HSE NOSP, NSRF and Gardaí	Report on Form 104 and report on role of Gardaí with recommendations
■ ■ □	17.3	Initiate formal discussions between the HSE and An Garda Síochána on the possibility of Gardaí notifying local health services in a discreet and confidential manner when a suspected suicide death has occurred	HSE NOSP and Gardaí	System of discreet and confidential notification of local health services of a suicide death

Implementation Phase	Action to Take		Lead / Identified Agencies	Deliverables
	Area 17 - An Garda Síochána (continued)			
■ ■ ■	17.4	Provide bereavement support information to Gardaí so that they can provide this to the relatives they are informing about a suicide death and agree a protocol for the routine dissemination of this information	HSE NOSP and Gardaí	Bereavement support materials and a protocol for distribution of the materials by Gardaí (dependent on review of bereavement support services and resources – see 23.1 and 23.2)
	Area 18 - Unemployed People			
■ ■ □	18.1	Review and assess existing mental health promotion programmes for early school leavers and unemployed people	HSE NOSP, Department of Social and Family Affairs and voluntary/community organisations	Report with recommendations for service planning to go to service providers on improving programmes for positive mental health promotion for unemployed people
■ ■ ■	18.2	Informed by the review in 18.1, building on existing initiatives and working directly with local and national groups representing unemployed people, pilot and evaluate mental health promotion programmes for early school leavers and the unemployed	HSE NOSP, Department of Social and Family Affairs, voluntary and community organisations, county development boards and ADM Ltd (Dormant Accounts Fund)	Quality assured, effective positive mental health promotion programmes for unemployed people
	Area 19 - People who have experienced Abuse			
■ ■ □	19.1	Develop research and provide information and training on the risk of suicidal behaviour associated with sexual and/or physical abuse, including information on self-care, to the relevant health sector employees, voluntary organisations and support groups and other relevant professionals	HSE NOSP, National Counselling Service, Residential Institutions Redress Board of Ireland and the National Organisation for Victims of Abuse	Information on the risk of suicidal behaviour and self harm associated with abuse and a protocol for its distribution
■ ■ □	19.2	Evaluate the National Counselling Service model of counselling service provision with recommendations for further service development as appropriate	HSE NOSP and National Counselling Service to commission	Evaluation of the efficacy of easy access, low threshold counselling services with recommendations for service developments

Implementation Phase	Action to Take		Lead / Identified Agencies	Deliverables
	Area 20 - Young Men			
■ ■ □	20.1	Review all of the recent research and various service initiatives for men's health in Ireland (such as the appointment of a number of Men's Health Officers in the HSE), and internationally	HSE NOSP, DoHC and HSE Health Promotion	Review report on all available information and services relevant to men and mental health issues
■ ■ ■	20.2	Based on the review in 20.1 above, prepare a service plan for the development of pilot mental health promotion and support initiatives for young men	HSE NOSP, DoHC and HSE Health Promotion	Evidence based service plan for men's health
■ ■ □	20.3	Meet with voluntary organisations (see 7.2) to discuss ways of developing approaches to providing support for young men through the voluntary sector	HSE NOSP, HSE Health Promotion and Alliance for Mental Health	Formal agreement to work in partnership on developing initiatives to promote young men's mental health, well-being and help-seeking
	Area 21 - Older People			
■ ■ □	21.1	Improve and further resource community care services for dependent older people (including home helps and day care services) as planned for in *Quality and Fairness*, 2001	DoHC and HSE NOSP	Improved community services for dependent older people
■ ■ □	21.2	Review current practice and develop the assessment and clinical management of depression, other mood disorders and alcohol, addiction or medication misuse problems in older people at primary care level and in nursing home services	Mental Health Commission and HSE NOSP (to be commissioned)	Report outlining service development proposals and guidelines for improved management of mental health problems in older people
■ □ □	21.3	As part of a national training programme, promote knowledge, awareness and self-advocacy in mental health issues among older people and make provision for awareness training of key community gatekeepers who come into regular contact with isolated older people	National Council for Ageing and Older People, HSE and voluntary and community organisations	National training programme relevant to older people

Implementation Phase	Action to Take		Lead / Identified Agencies	Deliverables
	Area 22 - Restriction and Reducing Access To Means			
■ ■ □	22.1	Determine the risk of suicidal behaviour associated with prescription and over-the-counter medication, with a view to developing, implementing and evaluating recommendations on the availability, marketing and prescribing of these medications	HSE NOSP to commission	Independent review report with recommendations on the relationship between prescription and over-the-counter medication and suicidal or self-harming behaviour
■ ■ □	22.2	Provide facilities and promote the safe disposal of unused and unwanted medicines, building on the work in relation to the DUMP project in the HSE South Western Area, Eastern Region (Dispose of Unwanted Medicines Properly)	HSE NOSP, Irish Medicines Board, Department of the Environment and Local Government and Pharmaceutical Society of Ireland	Nationwide facilities and procedures for the safe and efficient disposal of unwanted medicines
■ ■ □	22.3	Facilitate and encourage discussions between the NARGC (National Association of Regional Game Councils) and the Gardaí in relation to developing safer ways of licensing and storing firearms and ammunition and of disposing safely of unused or unwanted firearms	HSE NOSP, NARGC and Gardaí	Safer storage and licensing in relation to firearms agreed on a partnership basis
■ ■ ■	22.4	Establish whether there are specific places and types of place that are associated with suicidal acts (in the context of 25.2) and, where feasible, implement ways of restricting access, improving safety and promoting help-seeking	HSE NOSP, Gardaí, Coroners, Irish Water Safety and emergency services	Report on places / types of place associated with suicidal behaviour, with recommendations on restricting access, improving safety and promoting help-seeking
■ ■ □	22.5	Formalise links between Irish Water Safety and the Suicide Prevention and Mental Health Promotion services of the HSE to advance work in meeting shared objectives	Irish Water Safety, HSE NOSP and HSE Health Promotion services	Shared protocols and strategy / pooled resources in relation to water safety / reducing suicide by drowning

Implementation Phase Code: ■ □ □ - Phase 1 Actions ■ ■ □ - Phase 2 Actions ■ ■ ■ - Phase 3 Actions

Level C - Responding to Suicide

Implementation Phase	Action to Take		Lead / Identified Agencies	Deliverables
	Area 23 - Support following Suicide			
■ □ □	23.1	Audit and review the range and quality of general bereavement support services and specific services to support those bereaved following suicide	HSE NOSP and voluntary and community support groups (to be commissioned)	Service plan for bereavement support services nationally
■ ■ ■	23.2	Following the review in 23.1 above, develop services for those bereaved ensuring the registration, training, supervision and support of bereavement counsellors	HSE NOSP and HSE PCCC	Standardised, quality assured bereavement counselling services
■ □ □	23.3	Review existing information resources and determine the future information needs of people who have been bereaved following suicide	HSE NOSP and voluntary and community groups (to be commissioned)	Information resources on bereavement support issues developed following consultation with bereaved people
■ □ □	23.4	Develop and implement protocols for the health service response if a community is affected by suicide, learning from the experience of previous crises and building on existing critical incident response protocols	HSE NOSP	Agreed and planned protocols of health service response to support communities affected by suicide
■ □ □	23.5	Facilitate and support the proposed formal coordination of the national organisations working in the area of suicide bereavement support including the National Suicide Bereavement Support Network (NSBSN), Living Links and Console	HSE NOSP, NSBSN, Living Links and Console	Coordinated voluntary and community suicide bereavement support
	Area 24 - Coroner Service			
■ ■ □	24.1	Appoint Coroner's Officers (at present Gardaí act as such) to act as the link person between the public and the Coroner Service as recommended in Report of the Working Group on the Coroner Service (2000)	Department of Justice, Equality and Law Reform	Regional Coroner's Officers

Implementation Phase	Action to Take		Lead / Identified Agencies	Deliverables
	Area 24 - Coroner Service (continued)			
■ □ □	24.2	Review existing information resources and if necessary produce and disseminate revised materials on the coroner service that would be helpful to the bereaved and to people working in relevant professions (see 23.3)	HSE NOSP, Coroner Service and bereavement support groups	Information resources on the coroner service and guidelines for Inquest
■ □ □	24.3	Review existing guidelines on conducting the inquest procedure in a sensitive and supportive manner and agree a revised national set of guidelines for the inquest procedure	HSE NOSP, voluntary and community groups and the Coroner's Society of Ireland (to be commissioned)	Revised guidelines for conducting inquests
■ □ □	24.4	Organise and deliver training (as part of a national training programme) for coroners with regard to the psychological management of sensitive cases and other matters that arise in the course of coroners' work	HSE NOSP and Coroner Service	National training programme to support coroners in their role
■ ■ □	24.5	Develop the role of the coroner in providing information on suicide and other deaths from external causes	Coroner Service, HSE NOSP, Gardaí and NSRF	Earlier access to accurate mortality data

Level D - Information and Research

Implementation Phase	Action to Take		Lead / Identified Agencies	Deliverables
	Area 25 - Information			
■ □ □	25.1	Link and exchange data between relevant national information systems, including the National Parasuicide Registry, the Hospital In-Patient Enquiry system, the National Psychiatric Inpatient Reporting System and the National Drug Treatment Reporting System	HSE, DoHC, relevant national information systems and the Data Protection Commissioner	Accurate seamless data systems to inform service provision
■ □ □	25.2	Establish a national confidential inquiry into deaths from unnatural causes, including suicide	HSE NOSP to commission	Accurate, in-depth, routinely available data on suicide from the relevant information sources to inform suicide prevention and the planning of services
■ ■ □	25.3	Review all available guidelines relevant to suicide prevention (ranging from guidelines for the management of deliberate self-harm, to guidelines on media portrayal of suicide and guidelines for supporting those bereaved) with a view to agreeing a set of guidelines for use in Irish settings	HSE NOSP to commission	Rating and listing of quality assured guidelines relevant to suicide prevention and mental health promotion
■ ■ □	25.4	Review existing sources of information on where and how to get help and design, pilot and evaluate new information provision services using Information and Communications Technology (ICT)	HSE NOSP to commission	Pilot mental health information services using ICT

Implementation Phase	Action to Take		Lead / Identified Agencies	Deliverables
	Area 26 - Research			
■ ■ □	26.1	Agree a national programme and plan of research into deliberate self-harm, suicide and suicide prevention	HSE NOSP and DoHC (to agree with interested stakeholders from statutory and voluntary sectors)	National programme and plan to guide research into DSH, suicide and suicide prevention
■ ■ □	26.2	Develop and maintain international suicide prevention and research links through membership of the International Association for Suicide Prevention and other relevant networks	HSE NOSP, NSRF, IAS, 3Ts and all other interested researchers and planners	Meaningful contribution to, and support from, international experience and best practice

Economic Cost of Suicide & Deliberate Self-Harm

Economic Cost of Suicide & Deliberate Self-Harm

(Brendan Kennelly, Jane Ennis and Eamon O'Shea, Dept of Economics, NUI Galway)

In the context of the human tragedy of suicidal behaviour, it may seem insensitive or inappropriate to attempt to place a monetary value on the costs of suicide mortality and deliberate self-harm (DSH). However, international evidence suggests that suicide and DSH carry high economic costs (e.g. Clayton and Barceló, 1999; Kashner et al, 2000). This implies that a successful suicide prevention strategy may generate significant economic returns in addition to bringing obvious benefits in the form of lives saved and emotional trauma avoided. The economic benefits of a successful suicide prevention strategy are the gains to society as measured by the economic value of the lives saved.

The methodology for this economic examination of suicide is incidence-based, examining all identified suicide deaths (in 2001 and 2002) and projecting the economic costs arising from these over subsequent years. The economic costs associated with episodes of hospital-treated deliberate self-harm (DSH) are calculated for 2002 only.

Suicide

There are three kinds of potential economic costs associated with suicide: direct, indirect and human. Direct costs are explicit monetary outlays associated with suicide and its aftermath. They include medical costs, funeral expenses, administrative costs and the cost of emergency services. It is reasonable to assume that these are likely to be low relative to indirect costs. Canadian research indicates that such costs amount to 0.67 of a per cent of the indirect costs of suicide (Clayton and Barceló,1999). This ratio has been applied to estimate direct costs in Ireland.

Indirect costs refer to the value of lost output or production arising from suicide and incorporate the value of both paid and unpaid productive work that can no longer be performed because of premature mortality. The method used to estimate the value of indirect output is outlined in detail in a Technical Appendix to this section which is available on request as a separate document through the HSE NOSP. It was decided not to subtract lost consumption from the value of lost output, in line with most current practice in this regard (e.g. Miller, 1995). For lost output in the unpaid sector of the economy, data collected in the UK on the amount of time spent on these activities is used to develop a very rough estimate of this cost for suicide in Ireland (Short, 2001). The indirect cost estimates do not include the impact of suicide on the output of family, friends and colleagues.

Human costs refer to the value that individuals place on their lives beyond their capacity to work. This value is supposed to capture all the various dimensions of human existence that affect an individual's quality of life. It is clearly very difficult to put a monetary value on dimensions such as self-awareness, emotional experiences and spiritual matters. Economists have used evidence from studies on people's willingness to pay for reductions in the risk of death to calculate the human cost of premature mortality. Such studies have not been conducted in Ireland so estimates carried out by the Department for Transport in the UK were adapted to estimate the human cost of suicide in Ireland.

The total cost of suicide in Ireland is estimated at around 900 million in 2001 and 835 million in 2002 (Tables 2 and 3). This is equivalent to a little under 1 per cent of Gross National Product in Ireland for those years. The obvious explanation for the drop in total costs between 2001 and 2002 is the lower number of suicides in the latter year. The most significant costs associated with suicide are those that we term human costs, making up more than 70% of the total costs. Lost output associated with suicide amounted to approximately 28% of the total costs in both years (with lost market output accounting for the bulk of this, at 23% of total costs). The total costs for males are much higher than for females reflecting the higher number of male suicides in the country. The high incidence of suicide in young males is reflected in the fact that half of the total

loss of market output for males is accounted for by males up to age 29. The increase in the value of both market and non-market lost output for females between 2001 and 2002 (despite very little change in the number of suicides) can be explained by the fact that the median age of suicide for females was significantly lower in the latter year. Further details about the costs are contained in the Technical Appendix.

Table 2: Total Cost of Suicides in 2001 (in €)

	Males (n = 429)	Females (n = 90)	Total (n = 519)
Lost market output	192,502,644	13,411,353	205,913,997
Lost non-market output	32,118,952	13,500,259	45,619,211
Human costs	540,130,305	113,314,050	653,444,355
Direct costs	1,504,965	180,308	1,685,273
Total	766,256,866	140,405,970	906,662,836

Table 3: Total Cost of Suicides in 2002 (in €)

	Males (n = 387)	Females (n = 91)	Total (n = 478)
Lost market output	177,186,406	15,618,513	192,804,919
Lost non-market output	30,374,299	15,323,068	45,697,367
Human costs	482,181,489	113,381,177	595,562,666
Direct costs	1,390,657	207,309	1,597,966
Total	691,132,851	144,530,067	835,662,918

Deliberate Self-Harm

In addition to suicide deaths, every year there are thousands of incidents of deliberate self-harm (DSH) in Ireland. Looking only at hospital-treated episodes of DSH in 2002, we estimated the cost of DSH to be around 29.4 million (Table 4). In attempting to approximate an economic value for the costs of DSH, the same categories of costs as in the analysis of suicide mortality above are included, with the exception of human costs. Lost market output resulting from DSH was an estimated 4 million for males and 2.5 million for females in 2002. The corresponding figures for lost non-market output were estimated as 0.6 million for males and 1.9 million for females. Lost market output is higher for males, despite fewer episodes of DSH, because participation rates and wage rates are higher for men than for women. The direct costs of parasuicide refer mainly to the costs of hospital and other medical services. Based on average costs for psychiatric and general hospital inpatient stays, the estimated direct costs of DSH were around 20 million in 2002. We were unable to calculate separate direct costs for males and females and only report the total direct costs in the following table.

Table 4: Total Cost of Deliberate Self-Harm (DSH) in 2002 (in €)

	Males	Females	Total
Lost market output	4,004,392	2,531,422	6,535,814
Lost non-market output	627,070	1,948,943	2,576,013
Direct costs	-	-	20,265,068
Total	-	-	29,376,895

Conclusion

The estimates for suicide and DSH contained in this report should be treated with caution given the problems with the data which are common to cost of suicide studies in every country. These problems are discussed in the Technical Appendix.

Notwithstanding this caveat, the economic analysis shows that investment in suicide prevention and mental health promotion could yield significant returns in terms of offsetting and reducing lost market output and lost non-market output associated with suicide and DSH in Ireland. The potential economic gains to society are, therefore, significant. The considerable human cost of suffering associated with suicide can also be reduced through appropriate intervention to prevent suicidal behaviour occurring.

Appendices and References

Appendix 1

Glossary of Abbreviations

3Ts	Turning the Tide of Suicide
A&E	Accident and Emergency
ARASI	Association of Refugees and Asylum Seekers in Ireland
CSO	Central Statistics Office
DES	Department of Education and Science
DoHC	Department of Health and Children
DPH	Departments of Public Health
DSH	Deliberate Self-Harm
DUMP	Dispose of Unwanted Medicines Properly
EU	European Union
FAI	Football Association of Ireland
GAA	Gaelic Athletic Association
GP	General Practitioner
HeBE	Health Boards Executive
HIPE	Hospital In-patient Enquiry
HSE	Health Service Executive
IAS	Irish Association of Suicidology
IASP	International Association for Suicide Prevention
ICGP	Irish College of General Practitioners
ICT	Information and Communications Technology
IPS	Irish Prison Service
IRFU	Irish Rugby Football Union
NAHB	Northern Area Health Board
NARGC	National Association of Regional Game Councils
NDTRS	National Drug Treatment Reporting System
NOSP	National Office for Suicide Prevention
NPIRS	National Psychiatric Inpatient Reporting System
NPR	National Parasuicide Registry
NSBSN	National Suicide Bereavement Support Network
NSRF	National Suicide Research Foundation
NSRG	National Suicide Review Group
NUI	National University of Ireland
NUJ	National Union of Journalists
NYCI	National Youth Council of Ireland
PCCC	Primary, Community and Continuing Care
SMS	Short Messaging Service
SPHE	Social, Personal and Health Education
SWAHB	South Western Area Health Board
TCD	Trinity College Dublin
WHO	World Health Organisation

Appendix 2

Key Messages from the Consultation Process

- Develop holistic prevention strategies based on interagency collaboration.
- Implement a national public health campaign to raise awareness about mental health.
- Increase access to existing research and implement further research into groups at risk.
- Improve training for those in the front line e.g. ambulance service, fire brigade service and GPs.
- Consult young people to help create confidential services within the school and surrounding community that are youth friendly.
- Support and reach out to young men at risk.
- Focus efforts on early school leavers and on male members of the traveller community.
- Ensure access to treatment programmes is available to everyone.
- Improve services for those presenting to hospital with deliberate self-harm.
- Increase awareness and recognition of depression.
- Change negative attitudes towards older people.
- Co-ordinate the community response by including Gardaí, schools, GPs, clergy and undertakers.
- Increase public knowledge of services available to those who are bereaved.
- Revise the inquest process.

Appendix 3

List of Contributors

Those listed below made a submission to the Writing Group following a call for submissions in the national press.

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Consultation Meetings Participants

A list of the participants is available on the website www.nsrg.ie

Appendix 4

Concerned about Suicide

(This appendix is based on information contained in the leaflet 'Concerned about Suicide' which was produced by the Resource Officers for Suicide Prevention of the former health boards and the Suicide Awareness Coordinators for Northern Ireland).

Some Warning Signs:

Most people who feel suicidal don't really want to die, they just want to end their pain. These are some of the signs which may indicate that someone is having thoughts of suicide:

- Engaging in deliberate self-harm
- Talking about suicide
- Becoming isolated
- Drug and alcohol abuse
- Sudden changes in mood and behaviour
- Making 'final' arrangements

Some Associated Risk Factors:

- Access to a method of suicide such as harmful medication or a firearm
- Loss of someone close such as a family member
- Impulsiveness and risk-taking behaviour
- Relationship or family break-up

How to Respond:

- Show you care by offering support, for example say something like: "I'm worried about you and I want to help"
- Don't shy away from the subject, if you are concerned that someone is acutely suicidal find out by asking them if they have plans to harm themselves
- Get help or encourage them to get help, for example by saying "I will stay with you until you can get help"

There are a wide range of supports and services that can help in a crisis, including:

- The local GP or family doctor
- GP out-of-hours co-operative services
- Accident and emergency departments of general hospitals

The voluntary sector also provides services to help people in crisis.
Samaritans can be contacted 24 hours a day by phoning:
1850 609090 (Republic of Ireland)
08457 909090 (Northern Ireland)
Or by e-mailing: jo@samaritans.org

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