DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE AGUS LEANAÍ

JOINT COMMITTEE ON HEALTH AND CHILDREN

Déardaoin, 13 Márta 2014

Thursday, 13 March 2014

The Joint Committee met at 9.30 a.m.

MEMBERS PRESENT:

Deputy Catherine Byrne,	Senator Colm Burke,
Deputy Ciara Conway,	Senator John Gilroy,
Deputy Regina Doherty,	Senator Marc MacSharry.
Deputy Robert Dowds,	
Deputy Peter Fitzpatrick,	
Deputy Seamus Healy,	
Deputy Billy Kelleher,	
Deputy Sandra McLellan,	
Deputy Mary Mitchell O'Connor,	
Deputy Dan Neville,	
Deputy Caoimhghín Ó Caoláin,	
Deputy Robert Troy,	

DEPUTY JERRY BUTTIMER IN THE CHAIR.

The joint committee met in private session until 9.50 a.m.

Suicide in Ireland: Discussion

Chairman: We have received apologies from Deputy Ciara Conway, Deputy Eamonn Maloney, Senator MacSharry, Senator Imelda Henry and Senator Jillian van Turnhout.

Our topic this morning is the issue of suicide in Ireland. I thank Senator John Gilroy, who has been acting as the committee rapporteur for the past 18 months and has compiled and completed the report of the joint committee. He has put in a good deal of work and travelled thousands of kilometres throughout the country engaging with members of the public, those affected by suicide and those working with people, families and various organisations. As part of his work we are holding two sessions of further public engagement today on this topical, sensitive and important issue for many people, not only those in government and the Houses of the Oireachtas but those in many communities throughout the country.

I welcome Professor Ella Arensman from the National Suicide Research Foundation. I also welcome Dr. Myra Cullinane, vice president, Coroners Society of Ireland. I welcome Dr. Steve MacFeely, assistant director general from the Central Statistics Office in Cork as well as Mr. Paul Crowley, senior statistician. I also welcome viewers on UPC channel 207 who are watching the programme this morning.

Before we commence I wish to remind people of the position regarding privilege. Witnesses are protected by absolute privilege in respect of the evidence they are to give to the committee. However, if you are directed by the committee to cease giving evidence on a particular matter and you continue to so do, you are entitled thereafter only to a qualified privilege in respect of your evidence. You are directed that only evidence connected with the subject matter of these proceedings is to be given and you are asked to respect the parliamentary practice to the effect that, where possible, your should not comment on, criticise or make charges against a person or persons or an entity by name or in such a way as to make him or her identifiable. Members are reminded of the long-standing parliamentary practice or ruling of the Chair to the effect that they should not comment on, criticise or make charges against a person outside the House or an official either by name or in such a way as to make him or her identifiable.

I welcome again Professor Ella Arensman, who is director of research at the National Suicide Research Foundation. She is an adjunct professor in the department of epidemiology and public health at University College Cork and president of the International Association of Suicide Prevention.

Professor Ella Arensman: I thank the Chairman and all the members of the Joint Oireachtas Committee for addressing the important issue of suicide prevention and for inviting me to comment on the report prepared by the rapporteur, Senator John Gilroy.

The National Suicide Research Foundation, NSRF, in Ireland was-----

Chairman: My apologies, I should have called Senator John Gilroy first.

Professor Ella Arensman: My apologies.

Chairman: That was my fault.

Senator John Gilroy: Thank you, Chairman. I acknowledge the Chairman's ongoing support and the support of the committee for the public consultation process that we are undertaking with regard to suicide prevention. I also welcome the witnesses this morning. I do not intend to say a great deal about the paper being presented. I would prefer to listen to the comments and opinions of the witnesses. Some clarifications have been offered in the opening statements of some of the witnesses. These clarifications have been noted and will be incorporated into the report in due course.

The committee will note that I have circulated new hard copies of the paper. There have been one or two minor changes. It was pointed out to me that the intention of the paper may not be 100% clear. Therefore, I added one or two minor changes in the interests of achieving greater clarity. The document downloaded and circulated to members previously is almost identical, although not quite, to the hard copy before members this morning. For example, the signposts for conversations within the paper might best be approached as if they were a series of questions. Instead of being thought of as recommendations, it might be better to consider asking the question, "What if we were to..." followed by the signposts.

I will detail something of my background for information. I am the health spokesperson for the Labour Party in Seanad Éireann. Previously, I worked for 28 years as a psychiatric nurse in the Irish and United Kingdom mental health services, mainly in the area of acute mental health. I was appointed as committee rapporteur. I decided to approach the project in a manner that might not immediately suggest itself. Some might have thought that a good place to start would have been to hold discussions with the Department, the National Office for Suicide Prevention or the main agencies working in the area. However, I decided to pursue a different path. Instead, I sought the opinion of members of the public in the first instance, including people who have been affected by or who have an interest in the area. Having done that, I decided I would bring the concerns to the attention of the main stakeholding organisations. This is how we find ourselves at this meeting this morning.

I held public consultation meetings at nine locations through the country. They were attended by approximately 600 people. I also met many individuals, groups and organisations. During the past 12 months I have devoted virtually all my time to the process. During the course of the public consultation many concerns were raised about the issues of suicide and suicide prevention and I have incorporated those concerns into five main points in the paper. The first point relates to the effects of the recession. The point was one of the most frequently raised topics from the public. Points 2 to 5, inclusive, were raised frequently as well. I do not believe any member of the public used the actual words that I have used in the report. For example, no one said to me that we need to reconfigure the policy formulation and delivery apparatus. The point set out in conversation five uses my words but they contain the ideas of the members of the public with whom I consulted. In attempting to bring together the various points I formulated them in the manner apparent in the document. To expand on the points and create a conversation around them I laid them out in the manner apparent in the paper. While the writing is mine, the ideas are not. I could have laid out the five points for discussion as a series of questions from one through to five. However, to create a conversation around the points and achieve a level of engagement with stakeholders I decided to put forward some ideas about how they might be addressed.

I am pleased to note a divergence of opinion among the stakeholders with regard to the paper. That is the point of the exercise. I look forward to hearing the opinions of the committee.

I remind the witnesses that this is not a final report. These are the opinions and comments that I have gathered from members of the public and they have been formally brought before the committee and the witnesses. Following today's hearings, I intend to move onto the next phase of public consultation, which will involve engagement with the stakeholder organisations at former level.

Chairman: Thank you, Senator Gilroy. My apologies for omitting you at the beginning. We will go back to Professor Arensman.

Professor Ella Arensman: Thank you. I will start again. I thank Senator Gilroy for the excellent introduction. I thank all the members of this important committee for addressing this sensitive timely and important issue of suicide prevention and for giving me the opportunity to comment on the draft report prepared by the rapporteur, Senator John Gilroy.

The National Suicide Research Foundation in Ireland was founded in 20 years ago by the late Dr. Michael J Kelleher. Many of the committee members may have known the late Dr. Michael Kelleher. The NSRF is recognised as a major centre of expertise in research into suicide, self-harm and related mental health issues, nationally and, in particular, internationally. It co-ordinates 22 research projects in the area of suicide, self-harm and related mental health issues, including one on the evaluation of interventions and suicide prevention programmes. One of the major projects is the national registry of deliberate self-harm. It is unique for Ireland to manage such a national system. It is funded by the National Office for Suicide Prevention, NOSP. The NSRF works in partnership with the NOSP and other key stakeholders in implementing evidence-informed actions at regional and national levels, for example, the national implementation of dialectical behaviour therapy for people with frequent patterns of repeated self-harm, guidelines for assessment and management of self-harm in emergency departments, restricting access to lethal means and the implementation of guidelines on media reporting of suicide.

This draft report and the discussion I hope will follow are timely considering that we are this year reviewing the national strategy for action on suicide prevention, Reach Out. In parallel with this, we are working hard - the NOSP is taking the lead - on preparing the next phase of suicide prevention, that is, a new framework to be launched in autumn.

I will make a few comments on the section in the draft report on the accuracy of suicide statistics. It correctly addresses the concerns about the level of accuracy. Therefore, I support the proposal to conduct a nationally representative survey of coroners' records to establish which deaths might be attributable to suicide but do not meet the legal standard of proof required at inquest. It is exactly for this reason that, in recent years, the NSRF has piloted the suicide support and information system, SSIS, in Cork city and county, funded by the NOSP. In the national and international contexts, the SSIS can be considered innovative, as it combines a number of key objectives, for example, facilitation of support for people bereaved by suicide, access to real-time information on the incidence of suicide and associated risk factors and identification of emerging suicide clusters. One of the key outcomes of the SSIS revealed that the characteristics of people who died prematurely and were classified by a coroner as open verdicts were found to be more similar than dissimilar when compared with confirmed cases of suicide, in particular, their psychosocial and psychiatric characteristics.

In recent months, the NSRF has also started a review of all external cause of death verdicts in the Dublin region covering the 2011-12 period in close collaboration with Dr. Brian Farrell, the Dublin area coroner. We are using internationally validated screening criteria to detect probable

cases of suicide and are using the review to enhance these criteria further. This approach could be expanded to coroners' services in other regions in the country. In line with recommendations from the World Health Organization, WHO, improving national data systems for surveillance of suicide and access to real-time data is fundamental to national suicide prevention strategies.

I will comment on the report's section on suicide and the economic recession. It correctly describes the increasing trend of suicide and self-harm, particularly between 2007 and 2012, with as many as 560 extra cases of suicide and an increase in the number of cases of deliberate self-harm to 8,862. These numbers are based on analysis recently completed by the NSRF and reflect the worrying impact of the recession. We still do not have a clear indication as to whether the recession is over, if matters have stabilised or so on.

In addition to these statistical outcomes, the SSIS provides supporting evidence that reflects the impact of the recession. For example, of 307 suicide cases that we investigated in great depth, 35.8% were unemployed at the time of death and 41.6% had worked in the construction or production sector until they died. As we know, those work settings were particularly affected by the recession. We must take a balanced view, however, as the SSIS also found that, of the people who died and were unemployed at the time of death, nearly half had a history of alcohol and-or drug abuse and 42% had a history of self-harm. This reflects the importance of the interaction of individual risk factors and external contributing factors.

When we compared Irish trends in suicide with those of neighbouring countries, we found something remarkable. Most of the five nations in question has seen a strong increase in the rates of suicide and self-harm. The exception is Scotland, which has not seen a significant increase during the recession. In fact, it has actually seen a significant decrease in the past 12 years.

Taking this information into account, I propose that we undertake a comparative study involving experts in suicide research and prevention from the five nations to compare suicide trends, the characteristics of the recession and the austerity measures implemented by the different governments, for example, reduced access to mental health and community services, being unable to afford treatment, losing medical cards and having sickness and disability supports restricted.

I wish to comment on another important section in the report, that being, mapping and predicting suicide and self-harm using geospatial analysis, which is an innovative approach to this field. I am pleased to see that the report underlines the importance of using these techniques. A recommended form of analysis is something called SaTScan, which has been used for more than two decades to map infectious diseases but has never been applied to suicide. Last year, the NSRF applied this technique for the first time to suicide data obtained through the SSIS and we identified two significant clusters of suicide in the South. Applying this technique to real-time suicide mortality data from coroners and possibly An Garda Síochána would help us in identifying emerging suicide clusters much sooner than we have been able to do previously.

This approach has a number of important advantages. For example, it improves the early identification of clustering of suicide and self-harm and identifies areas with recurrent suicide and self-harm clustering, something that we have not been able to do so far. We hear about repeated clustering in certain areas through the public and the media, but we have been unable to verify them. The other advantage would be the ability to identify the area level and individual factors associated with clustering of suicide and self-harm, particularly in repeated patterns.

I strongly recommend the use of our national registry of self-harm and this technique, given their possible benefits. In light of the significant and consistent association between trends in non-fatal self-harm and trends in suicide among men in particular, I would also recommend applying the SaTScan to the registry nationally in order to enable the possible prediction of suicide clustering among men in specific areas.

I will make two brief comments on a pair of sections in the report, the first of which is on the establishment of a national registry of organisations that provide services relating to suicide. I agree with the rapporteur on the importance of enhancing co-ordination and collaboration among services working in the field of suicide prevention, ensuring best practice and enhancing quality wherever possible. In a highly positive development the National Office for Suicide Prevention is compiling a directory of quality assured services in suicide prevention and the Irish Association of Suicidology and representatives from the University of Ulster are developing guidelines for the accreditation of organisations working in suicide prevention. This work has been commissioned by the NOSP.

The final proposal for future action in the report refers to the repositioning and reconfiguring of the National Office for Suicide Prevention at the Department of the Taoiseach and the provision of a dedicated budget for the organisation. While this proposal requires in-depth and lengthy discussion, my current view is that, in light of the growing insight into suicide and the need for multisectoral partnership and collaboration in suicide prevention nationally, there may be benefits in repositioning the NOSP at the Department of the Taoiseach. The Department of Health is, without doubt, the key player and stakeholder and should retain its fundamental role in suicide prevention. Nevertheless, other Departments should take a more prominent role and should be the subject of greater collaboration. I refer specifically to the Departments of Education and Skills, Justice and Equality, Social Protection, Transport, Tourism and Sport and Agriculture, Food and the Marine. A move towards a multisectoral partnership approach would be in line with recommendations issued by the World Health Organisation in the public health area of suicide prevention. Other benefits of repositioning the National Office for Suicide Prevention at the Department of the Taoiseach include greater autonomy and enhanced political prioritisation of suicide prevention.

My written submission includes several practical notes providing clarification on certain matters.

Chairman: I thank Professor Arensman. I invite Dr. Myra Cullinane, Cork County Coroner and vice-president of the Coroners Society of Ireland to make her presentation.

Dr. Myra Cullinane: I thank the Chairman and members for inviting coroners to make a contribution to this discussion. In my short submission, I will confine my remarks to the coronial aspects of suicide deaths as they pertain to the subject matter of the draft report on suicide prevention produced by the committee rapporteur, Senator John Conroy, whom I compliment on his work.

To provide a little background on the role of the coroner, he or she is the death investigator tasked under statute with investigating all sudden, unexplained, violent and unnatural deaths. There are 43 coroners districts in the State and coroners currently divide almost equally between doctors and lawyers in respect of their profession. All unnatural deaths will be the subject of a coroner's investigation. Included in this group are deaths by suspected suicide.

The coronial process begins on the occurrence of a death in which suicide is suspected. The

death is reported to the coroner either by a member of An Garda Síochána, a hospital doctor or a director of premises in which the event may have occurred. At this point, which is early in the process, the coroner directs that an autopsy is carried out. A member of An Garda Síochána will carry out formal identification of the remains in the presence of the next of kin and subsequently attend the mortuary to identify the remains to the directed pathologist. This step also occurs early in the process. Ultimately, the coroner receives the autopsy report from the pathologist. If the unnatural cause of death, as suspected, is confirmed - I refer in this context to suspected suicide deaths - an inquest hearing must take place.

In preparation for the inquest the coroner gathers evidence to compile a comprehensive inquest file. Such files include, for example, eyewitness evidence of the events, medical and psychiatric evidence, documentary evidence such as notes that may have been left by the deceased and the report of the investigating gardaí. An Garda Síochána is involved initially in all deaths to exclude criminality and, having done so, gardaí assist the coroner in compiling the file and will act as coroners' officers in those circumstances. All gathered evidence is to assist the coroner in making the findings of fact we are obliged to make under statute at inquest and assist the coroner in returning a verdict in relation to the manner in which death occurred.

In terms of the subject matter of the report, coroners fully recognise the issues raised regarding suicide. However, I should clarify for members that coroners are bound by a legal standard of proof before we can record a verdict of suicide at inquest. This legal standard is "beyond reasonable doubt". Coroners will, therefore, record a suicide verdict in circumstances where the legal standard is reached. This standard is defined as being where the deceased killed himself or herself, that he or she intended to do so and the evidence before the coroner proves this beyond reasonable doubt. This is a high legal standard, which is not always reached, even in cases where the totality of the circumstances point to suicide on the balance of probabilities. In such cases, the appropriate verdict to be recorded by the coroner is the open verdict.

At the conclusion of the inquest, in addition to recording a verdict, the coroner will issue a coroner's certificate to the Registrar of Deaths. This certificate records the medical cause of death. I circulated a copy of a certificate. Members will note from its format that it does not include an entry for the coroner's verdict. As such, the coroner's verdict or the manner in which death occurred may not appear on the coroner's certificate, which is submitted to the Registrar of Deaths for subsequent transfer to the Central Statistics Office. In view of this, suicide statistics cannot be fully extracted by confining oneself to inquests recording the suicide verdict, nor can they always be extracted from the coroner's certificate.

Historically, there was some difficulty regarding the recording of the suicide verdict in that prior to the Criminal Law (Suicide) Act of 1993, suicide was deemed a criminal act and coroners either did not use the verdict or were reluctant to so do. This is no longer the case. After the enactment of the Coroners Act 1962, suicide statistics were gathered from coroners but it became apparent that they were so rare as to give a false impression of a low suicide rate in the country. To overcome this difficulty An Garda Síochána was enlisted to assist the Central Statistics Office. Form 104, to which the report refers, was developed for use by the Garda and remains in use, providing a significant amount of the information on which the Central Statistics Office bases its suicide statistics analysis.

Current national suicide statistics, as indicated in the report of the rapporteur, are drawn from a number of sources, including Form 104 and the Central Statistics Office. They are not, however, drawn from the coroner's inquest file as distinct from the coroner's verdict or certificate. Coroners concur with the concerns raised in the draft report in relation to the reliability of

national suicide statistics as currently compiled. I refer to signpost 1 of the draft report, which suggests "a national survey of Coroners records to establish which deaths might be attributable to suicide but do not meet the legal standard of proof required at inquest. We will call this 'the research standard'".

As previously indicated, all deaths by suicide are the subject of a coroner's inquest. At the conclusion of the inquest of a death by suicide, the coroner holds a file on his or her investigation which could provide detailed information for statistical analysis. Currently, the Health Research Board examines coroners inquest files in every district annually to compile drug and alcohol associated death statistics. I understand the board's statistics in this regard are regarded as among the most comprehensive in Europe.

Coroners support the suggestion at signpost 1. Such a survey should be carried out on an annual basis. We are strongly of the opinion that coroners hold the best primary source of statistical and other information from which could be compiled a comprehensive epidemiological database in relation to deaths by suicide, thus informing the national debate in a more authoritative manner in addition to assisting in identifying and prioritising areas for intervention and prevention and measuring the effects of such intervention.

Chairman: Next we have Dr. Steve MacFeely, assistant director general of the CSO.

Dr. Steve MacFeely: I thank the Chair for the invitation to appear before the joint committee in order to provide our reaction to the draft report on suicide prevention. I also thank Senator Gilroy for his opening remarks and clarifications.

The CSO is mandated, under the Statistics Act 1993, to collect, compile, extract and disseminate - for statistical purposes - information relating to economic, social and general activities and conditions in the State. The provision of reliable, independent and transparent statistics is our key objective. In compiling mortality statistics, the CSO works in close co-operation with the General Registration Office, GRO, coroners, medical practitioners and An Garda Síochána. On behalf of the CSO, I wish like to put on record our sincere thanks and appreciation to those entities for their continued co-operation with our inquiries.

I will begin by summarising the procedure for compiling mortality statistics. Under the Civil Registration Act 2004, it is the duty of a qualified relative or informant to register a death at a local registrar's office within three months. Details of all registered deaths are then forwarded by individual registrar's offices, located around the country, to the GRO in Roscommon which, in turn, forwards details to the CSO. Data sent to the CSO include information on causes of death as reported on medical certificates. Any deaths classified as sudden, unexplained, violent or unnatural must be reported and investigated by the coroner. A coroner's inquiry establishes whether the cause of death was natural or unnatural. All deaths determined by a coroner to be of unnatural causes must be followed by an inquest. These deaths are registered with the local registrar by means of a coroner's certificate when the inquest is concluded or, in some cases, adjourned. Underlying cause of death is coded by the CSO to the World Health Organisation's international cause of death classification system - version 10 - in accordance with medical evidence detailed on the medical practitioner or coroner's death certificate. A form 104 is issued to the Garda in respect of most inquest cases. This form includes additional information on the circumstances and location of the death in question. Gardaí completing it provide their opinion as to whether the death was an accident, homicide or suicide or whether the cause is undetermined. This additional information is taken into account by the CSO when coding cause of death.

In cases where a coroner's death certificate does not mention suicide but where, in the opinion of the responding garda, death was as a result of intentional self-harm, the coroner's opinion is overwritten for statistical purposes and cause of death is attributed to suicide. Conversely, if the coroner's certificate states that cause of death was suicide and if sufficient information is provided to attribute an accurate cause of death code, then form 104 is not issued. In cases where a completed form 104 is not returned by the Garda, the cause of death is coded based on information available from the coroner's certificate only.

I take this opportunity to congratulate Senator Gilroy on the production of a generally balanced and fair report. There are, however, a number of important points which, from a statistical perspective, need to be made. I am concerned with the stated assumption that events of undetermined intent can be taken as a proxy for suicide. This may be the practice from a research perspective but from the standpoint of official statistics, the CSO classifies deaths according to the evidence available. In the context of appendix 1 and recording procedures, it should be stated that the CSO generally receives mortality data from the GRO rather than the individual registrars throughout the country. While I appreciate that members of the public may perceive the incidence of suicide in Ireland to be increasing, the data do not support this perception. Consequently, in my view, the statement in the report to the effect that "it seems that the public perception that suicide is increasing in Ireland is not unfounded," is inaccurate. There is a danger that too much is being read into relatively small changes in suicide rates. The number of suicides in any given year is volatile and hence I suggest that making strong statements regarding short-term trends is unwise. In our written submissions I made a number of observations regarding language and the presentation on which we will be happy to work with the Senator.

In the context of form 104 and confidentiality, I wish to make two important points. Signpost 2 suggests that gardaí, as first responders, would furnish their opinion as to whether the death is a suicide to the office responsible for maintaining the proposed SaTScan programme in order that suicides can be mapped at electoral division, ED, level. We are not clear if the intention is to use form 104 for this purpose but this form, which is voluntary, is designed to be used purely to provide accurate statistical data under the terms of section 32 of the Statistics Act. Furthermore, under section 33 of that Act, no information collected for statistical purposes, and which could identify an individual, can be disseminated. As there are 3,440 legally defined EDs in the state - implying a low probability of several suicides per ED - this raises concerns regarding the protection of privacy and confidentiality. Any information collected from form 104 is protected by the guarantee of confidentiality, that is, that the return will be solely used for statistical purposes, specifically to better classify cause of death.

I again thank the committee for the opportunity to clarify these important points before the report is published.

Chairman: I thank all our witnesses for their contributions. Cork is strongly represented among them and I thank those who made the journey to Dublin this morning for being here.

Deputy Caoimhghín Ó Caoláin: I thank Senator Gilroy for all the work he has done. It is clear the Senator has invested a significant amount of time and effort in preparing the draft report. I am of the view that it will make a very useful contribution to the committee's overall contribution to addressing this most serious and distressing subject. I also thank our guests for their respective contributions.

I have a number of brief questions to ask in respect of what we have been told. There is much to be grappled with in the context of what has been said. I would like to ask the opinion

of Professor Arensman from the National Suicide Research Foundation on a particular matter. It is stated in the foundation's submission that a survey carried out in respect of the incidence of suicide in Cork city and county and the impact thereon of the recession shows that nearly half of those who were unemployed at time of death had a history of alcohol and/or drug abuse. Of 307 suicide cases that the foundation investigated in great depth, 35.8% of the individuals involved were unemployed at time of death. In addition, there were questions as to what might have been underlying contributory factors - in the context of a disposition towards alcohol and/or drug abuse - in 55% of those 307 cases. The foundation proposes to carry out a further comparative test in conjunction with the authorities on the neighbouring island and across this island. It has cast this matter in the context of the recession and there is no question that the latter and the difficulties to which it has given rise have been a factor in terms of the incidence of suicide. There is no question in my mind that the recession and the difficulties contingent on it have been a factor in suicide incidence. I am aware of that in my constituency.

Is it possible to do an assessment for the years prior to 2007 to ascertain whether the same statistics would hold if alcohol and drug abuse were as prevalent at all times as opposed to in the context of a recession only? Such an exercise would shine a useful light on that area. Death by suicide constitutes approximately one sixth of all deaths taken into account in the exercise. I ask the witnesses to comment. Could they undertake such an exercise? Dealing with the situation as we know it is by far the most informative approach. I am a little puzzled as to the reason our Scottish cousins have been able to make such significant progress in suicide prevention. Perhaps our guests would comment on that matter also.

It was very interesting to note the information shared with us on the role of coroners. This is an area of significant interest to people and not one where any of us would like to present as it generally indicates that a tragedy of close connection may have taken place. A point was made regarding the compilation of statistics and how we can obtain a more accurate picture. In previous exchanges in this committee members have all been of the view that the statistics understate the factual position and the position is graver than the statistics suggest. I do not recall any member taking a contrary view. Dr. Cullinane is strongly of the opinion that coroners hold the best primary source of statistical and other information in this regard. What specific steps must be taken to ensure this source is of an appropriate standard, exactitude and reliability?

On Dr. MacFeely's presentation on the figures from the Central Statistics Office, it is interesting that the CSO takes a more cautious approach to the general view that the number of suicides has increased. I do not use the word "cautious" in a disparaging manner. The CSO's figures do not blow the views of members out of the water. It was noted that coroners' opinions are overridden for statistical purposes in certain circumstances. I ask Dr. MacFeely to elaborate on that practice. Is it appropriate that it should take place? In respect of my earlier question to Dr. Cullinane, would this practice address the need to have a specific, focused and dependable source, rather than a number of possible sources? Ultimately, we want to get as close to exactitude as possible to better inform how prevention is addressed, as all of us would like.

Deputy Dan Neville: I welcome the delegation and congratulate Professor Arensman on securing the most prestigious position internationally in the area of suicide research and prevention. Before her election to the post of president of the International Association for Suicide Prevention, she held the position of vice-president for many years. All of those involved in suicide prevention are proud of this development. I thank Professor Arensman for her contribution and that of her association towards understanding suicide and suicide research. Is international evidence available on suicides that take place beyond the boundaries of our discussion, for ex-

ample, in single-vehicle road accidents and certain drownings? No such research has been carried out at national level. Is any information, even low level information, available in this area?

In Northern Ireland and Britain, the coroner can reach a verdict of suicide without an inquest or hearing in the coroner's court. We are all aware of the difficulties and trauma the bereaved endure in a coroner's court, as the process is currently structured. In certain countries, in circumstances where it is obvious that no verdict other than death by suicide can be reached, the coroner can reach a verdict without a hearing. Does Dr. Cullinane have any views on that practice?

A Coroners Bill introduced in 2007 has not yet been passed. I was recently informed that the Bill is to undergo a full review. Has the Coroners Society of Ireland been consulted as part of any such review? What are its views on the Bill?

I found the presentation from the Central Statistics Office very interesting, specifically with regard to Form 104. Some years ago, the National Suicide Research Foundation did good research on the number of these forms being returned. It found that the number of forms returned was much lower in certain areas, especially in Dublin where Garda stations are very busy and gardaí are under great pressure. Has the position changed in this regard? Are coroners concerned about variations in the number of forms being returned between districts and how this divergence may affect statistics? Undetermined deaths are included in suicide statistics in most other jurisdictions and Ireland is one of the few western states where this does not occur. Does Dr. Cullinane have any views on that matter?

Senator John Gilroy: I also congratulate Professor Arensman on her recent election to the post of president of the International Association for Suicide Prevention. I thank the witnesses for their very interesting contributions and look forward, if possible, to exploring at a deeper level some of the issues they raised. It is convenient that some of them are, like the Chairman and myself, based in Cork.

To elaborate a little on an issue raised by Deputy Ó Caoláin, it would be useful to establish in the first instance if suicide is being under-reported and, if so, where the under-reporting occurs in the mechanism for collecting data.

Deputy Billy Kelleher: I apologise for being unable to be present for the presentations. The most important thing about this document is that it can challenge assumptions and highlight the need for purposeful conversation, two things we decidedly need to do in this country. Reference was made to expressions we make in terms of describing suicide as an epidemic and a national crisis, as mentioned in the report. We must be brave. To a certain extent this document challenges traditional thinking in the area and that is positive in view of the fact that we are facing a serious situation with the escalating number of suicides in the country. We also need to consider the issue of mental health. Obviously, the HSE has a lead role in addressing this issue. We need to have a serious conversation as a nation and we need to do so quickly because while we prevaricate as a people there are vulnerable people in the country every day who are contemplating suicide. Although we talk about it, are we putting the structures in place? As a people, do we accept that the issue must be addressed? Are we aggressively and actively pursuing policies and implementing and resourcing those policies? One could argue that the HSE has been lethargic, to say the least, in addressing many of the issues. One could argue that the recruitment of people has not been aggressively approached. The National Office for Suicide Prevention was left without a lead person for a long period. There may be reasons for this but while all these reasons are being offered as excuses, many people are taking their lives and that

should be our priority.

This document pushes the boundaries to a certain extent in this regard. Senator Gilroy has brought forward this document. However, the key issue to flow from it is to identify where there is an alarming lack of resources and where to prioritise resources. That is where the real conversation will take place in terms of our priorities. This is not a political point against the Government. As a people, are we willing to make a larger contribution from the Exchequer to ensure that suicide prevention is at the highest level in every aspect? This is something we need to do.

We need to consider the practicality. Often, as Deputies, we hear of cases. We have raised issues in the areas of mental health and associated support services. Often people who are in a vulnerable position have to go to the emergency departments of hospitals out of hours. People may argue that this is the obvious place for a person to go if he is in a crisis. However, assuming that he has not ingested anything dangerous or self-harmed in any way, he may simply need talk therapy rapidly. Is an emergency department the right place for people to go in the first instance? Should we reconsider this? I am unsure whether there should be an isolation area or separate area but perhaps there should be an area where people can go and sit down with professionals in a more relaxed format to have a discussion, as opposed to being in the front line in an emergency department. This is something we should examine quickly.

I have no wish to delay the committee but I wish to make another point relating to under-reporting. I missed the last part of the presentation on that. Why is there under-reporting, if any? What is the motivation or the reasoning? Why does the system allow under-reporting? Is it because of the coroners' inquests? Is it because of family sensitivities? What exactly is the reason that there may be under-reporting of suicide? The deputations pointed to concerns about the alarming figures. If there is under-reporting then we should be more alarmed again but I am unsure whether that will spur us into swifter action.

Senator Gilroy's report referred to the downturn in the economy and financial pressures. The Chairman and I are aware of some tragic episodes in our city because of people who were under serious financial pressure. This was not necessarily the only reason but it could have been a contributory reason.

I have a question about another area although I am unsure whether we will have the answers in the committee today. I am keen for a more in-depth analysis carried out on the linkage between alcohol, drug addiction, relationship break-up and suicide, especially among young males. I have no evidence whatsoever other than my own instincts and what I have heard anecdotally. I attend funerals from time to time and I have met families who were bereaved. Perhaps the son was involved in drug addiction or was taking drugs for some time and then life escalated out of control to a certain extent and then ultimately it ended in suicide. Often families will explain that it started off and then gradually escalated to the point where the person saw no hope. Do we have enough analysis and detail in this area? The cohort of young males stands out obviously. What are the reasons young males aged 19, 20, 21 and 22 years of age believe that there is nothing left in life? I am keen to hear some observations on that. I congratulate the rapporteur on his work.

Senator Colm Burke: I thank all of the contributors for their contributions. I thank Senator Gilroy for bringing forward the report. Many of the issues I wanted to raise have been raised already. Deputy Kelleher referred to the problem in respect of males under 30 years of age. What changes have occurred in the past five or six years in this area? Has any analysis been

carried out? Has the substantial increase in suicides been in any particular age group? We have seen the figures in respect of unemployment but are there corresponding figures for the various age groups?

Another issue is the role of the coroner and coroners' inquests. I realise I am straying somewhat from the report. I raised the matter at a meeting less than two weeks ago of the period following which coroners hold inquests. I have come across cases in which there has been a substantial delay in the holding of an inquest although I know for a fact that in one case all the information was available. The case does not relate to Cork, in case the coroner thinks it does. All the information was available to the coroner but there was a substantial delay in holding of an inquest. Such was the delay that representatives of the hospital concerned contacted the State Claims Agency because they were concerned that the family might have come to the conclusion that something was being hidden. I understand there is no requirement for a given period under the Coroners Act, although I am open to correction.

Another issue relates to what is written on death certificates. I have come across situations in which the physical cause of death is written on the death certificate. One case arose in which a parent had to present the death certificate to the primary school of the child. The parent was concerned about what was written on the death certificate. What are the criteria for what should be written on death certificates? Is medical cause included? For example, what if there was a physical cause? Let us suppose a death was caused by suicide but the medical cause of death was not written; rather, the physical cause of death was put down. Do we need to tidy up this area? What are the views of the witnesses? The case in question caused major trauma for the spouse have to bring the death certificate to the primary school to show that the parent had full responsibility for the care of the child. Can the position be clarified? What is the view of the deputations on whether we should change the law on the issue?

Deputy Mary Mitchell O'Connor: I thank all those involved in the Gilroy report. It is most illuminating and very well put together. I am unsure whether I should direct my questions to Senator John Gilroy or the witnesses but perhaps they can offer some comments. One of my questions relates to suicide numbers. I realise we have discussed the recession and population growth. I wonder about cyberbullying and homophobic bullying. We had representatives of the transgender community before the committee and they talked about the rate of suicide being high among its members. I would welcome a comment in that regard.

I wish to ask about the coroner's report. I do not know much about it, but I did watch a programme last week which worried me. It featured two families, one of which stated it was not allowed to attend the coroner's inquest to give evidence. As a member of the public, will our guest tell me how one decides who is brought in to give evidence?

In the context of family sensitivities, I am also concerned about life insurance and mortgage repayments. Does this impact on what is written in a coroner's report?

Reference is made on page 16 of the Gilroy report to the organisations working in the area of suicide prevention. Are coroners happy with what is available? How many organisations are involved?

Reference was also made to the accreditation of suicide support services. I understand the need for suicide prevention measures, but I am also worried about what happens to families following a death by suicide. Are coroners happy with the counselling services provided for families and communities?

I note the recording of verdicts. Is counselling training provided for persons dealing with families who have been bereaved such as members of the Garda or those involved in the coroner's service? Are they trained to deal with individuals in huge emotional distress?

Chairman: This time we might work in reverse order and start with Dr. MacFeely from the CSO or Mr. Crowley, whoever wishes to speak first. Both of them can feel free to engage or interject.

Dr. Steve MacFeely: I will stick to the statistical questions as I am not qualified to discuss other issues.

Deputy Caoimhghín Ó Caoláin raised the issue of whether it was appropriate to supplement information and over-write a record. That is for statistical purposes. In some cases we do not have sufficient information to code a death to the exacting standards of the ICD 10. A death might generally be coded as a suicide, but as we do not know the type, we need to collect supplementary information.

A preliminary examination this week in preparation for today's meeting suggested that in 2010, for example, there were 1,864 cases that proceeded to an inquest.

Chairman: How many?

Dr. Steve MacFeely: There were 1,864 cases, in 1,570 of which we had insufficient information; therefore, we had to issue form 104. In only 21 of these did we recode a death to suicide. The examination was preliminary and undertaken fairly quickly last week. As 2010 was a fairly typical year, I would not imagine that it had a huge bearing on the numbers.

Deputy Dan Neville inquired about response rates. We typically have a response rate of in excess of 80% from form 104. We have not conducted a spatial analysis, but given the small number of areas in which the form 104 contributes to a new statistical verdict, taking 2010 as an example, if the pattern in responding to form 104 was similar to that for those which were not responding, it would have added either five or six suicides to the number. We do not think it would have a statistically significant impact on the rate.

On the question of under-reporting generally, from a statistical perspective, there is no evidence to suggest there is under-reporting, but that is not to say there is not as it is entirely possible that there is. There is no systematic evidence to suggest there is and one could think of many anecdotal reasons there might be under-reporting, but unless we have evidence it is very hard to know. I have nothing useful to say other than if one looks back over time, the numbers are generally quite stable and the patterns are not dissimilar to what we see in terms of a standardised rate across Europe and neighbouring countries.

One member discussed the escalating rate of suicide. I caution that there is no statistical evidence to suggest there is an escalating or an exponential rate of suicide. In fact, over a long time statistical evidence shows that the rate of suicide is volatile but relatively stable.

Chairman: When Dr. MacFeely says the rate is volatile but relatively stable, there seems to be a contraction.

Dr. Steve MacFeely: I am sorry. If one takes any one start year, because the data are volatile, one can reach a different conclusion. If one were to look at a time horizon of five or six years, one could decide that the rate of suicide was increasing dramatically, but if one were to

look over ten years, one would reach a completely different conclusion. Therefore, one must be cautious in carrying out an analysis. The CSO takes an agnostic view. We compile the data. One can make the results go up or down as one wishes, depending on the year one takes. People must be cautious about where they start or end their analysis.

A few members referred to causal effects. The CSO does not typically undertake a multi-variable analysis, but as a statistician – my colleagues will know more about this – I imagine that unless one has a long case history for the individuals who have unfortunately committed suicide, one might not have sufficient data to carry out a robust multi-variable analysis, especially of some of the issues highlighted such as cyberbullying and substance abuse. We do not have the data linked with the individual.

Chairman: Does the CSO seek that information as part of its compilation of information for analysis?

Dr. Steve MacFeely: No; what we are concerned with is the underlying cause of death. We are not interested from a statistical point of view in the case history and the factors that might have led to the death.

Deputy Dan Neville: What is the impact of the time period between the suicide and the coroner's inquest? It is a lengthy period. How does it overlap with the work of the CSO?

Mr. Paul M. Crowley: Given the nature of the coroner's inquest process, it can take a number of years for a verdict to be finally reached and the case to be closed. In our releases we have a separate table on late registrations where external causes of death may be registered many years afterwards. We publish data based on the current state, but they do not cover cases that will be closed three or more years after the incident occurred.

Many organisations, including the National Office for Suicide Prevention, come to the CSO to examine our records for inquests and data for vital statistics. There is much research in this area and we support the activities of all organisations which are interested in this issue. Even though, as Dr. MacFeely said, we do not perform this analysis, we do facilitate, as far as we can, the organisations which want to support it. It is active and many organisations avail of the data we have available.

Chairman: I thank Mr. Crowley.

Dr. Myra Cullinane: I will respond first to the question from Deputy Caoimhghín Ó Caoláin on the steps that need to be taken in the gathering of statistics. One aspect of the statistics gathering process that has become apparent in the course of the hearing is the interchangeability of the terms used such as report, verdict and death certificate, not all of which are used accurately. Coroners are strongly of the opinion that the gathering of information based on the coroner's certificate is inadequate because there is no entry on the certificate for a verdict. It simply requires an indication of the medical cause of death which may not be helpful in establishing whether it was a death by suicide. Coroners have no role in regard to form 104 which is a matter for An Garda Síochána.

The Health Research Board study that has been compiled in recent years of deaths associated with drugs and alcohol provides a useful model. An analogous study focusing on deaths by suicide could yield very comprehensive and accurate information by looking at the totality of the coroner's file, not just the coroner's certificate or record of the verdict. I have explained the issues around the latter in that it may not always reach a standard whereby one could record

a death by suicide. In looking at the totality of the file, one will identify factors such as whether there was, for instance, drug addiction, marital breakdown, homophobic bullying, cyberbullying and so on. All of this will be contained within the file. A formal analysis of coronial files every year, analogous to the HRB study, is something we would strongly support. There is a fund of information for analysis.

Deputy Dan Neville asked about the possibility of recording a verdict of suicide without the hearing of an inquest. My own experience is that a sensitively held inquest into a death that may have been caused by suicide can be a very cathartic experience for the family. It can serve to vindicate the life of the deceased, give an opportunity to acknowledge the efforts the family had made in life for the deceased and acknowledge the individual's pain. In addition, it provides an opportunity to answer some of the questions that may remain to be answered for the family. There is a great public utility in the holding of an inquest in such cases. I am aware that a Bill was published in 2007 which is being progressed through the Oireachtas. Coroners are engaging in that process.

Deputy Billy Kelleher asked why suicide deaths were under-reported. I agree with my colleague that we do not know whether they are, in fact, being under-reported. We need a proper analysis of the data in order to establish exactly what is the position on suicide deaths. I refer once again to the suggested HRB-type analysis which would capture all of the related factors the Deputy raised. These data will not be captured on the coroner's certificate or form 104 which, as I understand it, are the basis of all statistical analyses.

Senator Colm Burke asked about the time lag between the occurrence of a death and the hearing of an inquest. This can vary considerably, depending on the circumstances of the death and the complexity of the evidence required to be compiled by the coroner. One of the main causes of delay is where results of toxicology tests from the State laboratory are required, which can take between four and six months. Other issues which may delay the holding of an inquest include the making of arrangements for hearing rooms and court access, the notification of witnesses and general administrative issues. Coroners agree that once the information has been compiled and they are in a position to hold an inquest, it should not, for the sake of the family, be delayed unduly.

The Senator also referred to the death certificate. I assume he is referring to the coroner's certificate which is submitted to the registry of deaths and from which the information that will appear on the formal death certificate is extracted. Coroners have long been of the opinion that it would be of assistance to families if a short form was available, as is the case in the United Kingdom. The death would still be registered and include the full medical cause of death, the details of which we are obliged to set out fully. All of this information is essential for the statistical analysis and so on. However, there is nothing to preclude the introduction of a short form which would simply set out the fact of death, the name of the deceased and the date and place of death, without including the cause. We know it causes distress when people have to deal with a certificate which includes very personal information on a deceased parent or sibling, for example. We are very much in support of having a short form. This is not a matter for coroners or the Department of Justice and Equality but for the Department that governs civil registration.

Deputy Mary Mitchell O'Connor asked how coroners decided which witnesses would be heard at an inquest. Again, I preface my remarks by noting that I am not in a position to comment on the practice of any of my colleagues. In general terms, however, the inquest is an inquisitorial form and, therefore, different from other court proceedings. The coroner is the inquisitor carrying out the investigation and the witnesses are called at his or her discretion.

By contrast, in other court proceedings the parties will bring their own witnesses. Coroners, in calling witnesses and deciding who is to give evidence, do so to establish the facts they are obliged to establish under statute and assist them in recording a verdict. The coroner is governed in all of this by the principles of fair procedure. If a properly interested party presenting before the coroner expresses a desire to hear from a particular witness, the coroner will give due consideration to that request.

The Deputy also asked whether coroners and coroners' staff received any counselling or other training to deal with members of the public who were distressed and bereaved. I can only speak for my own jurisdiction, but I have arranged informal training for my staff in this regard, which was kindly delivered by Professor Arensman and her staff. It is an important issue because we need to be able to deal with distressed individuals in a professional manner.

Deputy Mary Mitchell O'Connor: Will Dr. Cullinane respond to my question about pressure being applied regarding life insurance and mortgage protection?

Dr. Myra Cullinane: Although I have not experienced this personally, I did previously inquire of insurance companies as to whether this was an issue for them and their policies. My understanding is that each insurance company has different policies around this issue, but it is not the case that where a death occurs by suicide, it automatically cancels a policy.

Chairman: I thank Dr. Cullinane. I now invite Professor Arensman to respond to members' questions.

Professor Ella Arensman: Before dealing with specific questions, I refer back to the discussion about whether we could conclude that there had been an increase in the number of suicides during the recession. I appreciate the correct approach that was presented by the Central Statistics Office. We also analysed so-called three year average rates of suicide over a ten year period. The period included the years of the recession. This model is usually recommended when one is dealing with a relatively small population - even 4 million is considered small - and a correspondingly small number of suicides. Even in the context of this analysis, we still discovered a significant - 4.5% - increase in the number of suicides from 2007 to 2011. I apologise for extrapolating, but we also have available to us the national registry of self-harm which allowed us to identify the fact that between 2007 and 2011 there was a 30% increase in the level of male self-harm in Ireland. In the 25 years I have been working in this area I have never come across such an increase in the level of male self-harm. There is sufficient international evidence available to allow us to stand over our approach and use changes in trends in male self-harm as a proxy for changes in trends in suicide. I very much appreciate, however, that we are not fully up to speed in knowing all of the details of people's histories and additional factors, particularly over a long period.

The first question to which I wish to respond came from Deputy Caoimhghín Ó Caoláin and relates to whether we might be able to consider baseline figures for the period prior to the recession. If they were available, we would have examined them already. The Deputy also inquired about what we had identified by means of the suicide support and information system. It is a new system that we can use to access full data from coroners' records, including post-mortem records. We also invite family members who have been bereaved as a result of suicide to participate in interviews with well-trained specialist psychologists. In addition to the interview, we also seek permission from the family member involved to contact a health care professional who was in contact with the deceased prior to death. These are three sources from which we have been able to collect very in-depth information. Given that we only began collecting the

information in question in 2008, it is very difficult to carry out a baseline study. If we consider the comprehensive psychological autopsy study compiled by Dr. Tom Foster in Northern Ireland some years ago, we find similar prevalence rates in respect of previous self-harm and mental health issues, particularly depression, but significantly lower levels of unemployment and much lower numbers of people working in the construction and production sectors. Even though they do not provide a direct baseline, the high levels of unemployment and the large numbers of people working in the construction and productions sectors which we identified give an indication of the contributing impact of the recession in Ireland.

I was also asked about the potential value of comparing the position here with that in neighbouring countries. I have just proposed this to a colleague in Scotland. It is certainly something we could consider, particularly in the context of potential differences. One of the differences I have already encountered relates to the fact that at the beginning of the recession the government in Scotland decided to increase alcohol prices and introduce even more stringent rules in the advertising of alcohol at sports and other events. During the same period alcohol prices in Ireland were reduced. Regardless of whether there is a recession, we know that alcohol has an important impact in the context of suicide and self-harm. I hope that by the time the committee moves forward with its report, we will have begun our comparison with neighbouring countries.

Deputy Dan Neville inquired about the international experience with regard to other external causes of death which might include or capture probable cases of suicide. In the United States, Australia and the United Kingdom comprehensive research has been conducted into possible other categories of external causes of death which may capture probable cases of suicide, including single vehicle road traffic accidents and accidental drownings and poisonings. Unfortunately, there has been an increase in the number of such poisonings in Ireland in recent times. Before the recession began, there were indications of a reducing trend in the number of suicides in the United Kingdom. At the same time, however, there had also been an increasing trend across that jurisdiction for so-called narrative verdicts. Such verdicts refer to descriptions of particular situations in the context of the methods used, the circumstances in which a person died and the sequence of events, but they do not involve specific findings on whether the death was intentional or accidental. On the basis of this work, the Centre for Disease Control and Prevention in the United States developed screening criteria. They were first introduced in the 1980s, but they have been updated in the interim and there is always scope to update them further. There is a tool available to facilitate screening for external causes of death in respect of the probability of whether they capture probable cases of suicide.

I was delighted when Deputy Billy Kelleher asked whether accident and emergency departments offered an appropriate setting for dealing with people - even if they have not engaged in self-harm - expressing suicidal ideation. On the basis of the current setting and also the capacity of staff in accident and emergency departments to deal with such individuals, I would be concerned. I am particularly concerned about whether staff are adequately equipped to deal with this very challenging group of individuals. One of my concerns is based on the outcomes of an evaluation of accident and emergency department staff, particularly nurses, in terms of the extent to which they had received training in the area of suicide and self-harm awareness. We recently finalised this evaluation in Cork and discovered that fewer than 10% of the relevant staff had received such training. I do not have a clear-cut alternative to offer, but we must give further consideration to this matter.

Chairman: What would be Professor Arensman's initial impression of how the individuals in question should be dealt with?

Professor Ella Arensman: If they arrive in accident and emergency departments, they should be approached in an empathic way. If they have not engaged in self-harm and they do not require medical treatment, at the very least a psychosocial assessment should be carried out immediately rather than after a period of three, four or more hours. As stated, we do not have a clear-cut alternative to offer. However, there should be collaboration with mental health services in a more comprehensive way in order to refer people at an early stage, not after they have been obliged to wait for assistance for three or more hours.

Deputy Ciara Conway: Is Professor Arensman aware that some facilities such as Waterford Regional Hospital have full-time psychiatric nurses in their accident and emergency departments? This has proved to be very effective in terms of engagement with people. It is a really good model of practice to have a specialised member of staff present. This service is now provided seven days a week. That needs to be said.

Professor Ella Arensman: It certainly needs to be said, but that was an incidental model up until January. It is only since the beginning of this year that 37 new specialised self-harm assessment nurses were appointed to work in various accident and emergency departments throughout the country. That is a very positive development. However, that national approach only came to be applied in January.

Chairman: It has been introduced, though.

Professor Ella Arensman: It has, and the nurses have been appointed.

Chairman: That is good.

Professor Ella Arensman: Senator Colm Burke inquired, in the context of suicide, about the position on specific age and gender groups and whether changes had occurred. At the start of the recession - in 2007 and 2008 - the peak rate of suicide was among young men in the 15 to 29 year age group. In recent years there has been a shift and an additional peak among middle-aged men. This does not mean, however, that there has been a significant reduction in the rate of suicide among younger men. We have been referring almost exclusively to men, but when we consider the position historically with regard to the opposite sex, we find that middle-aged women have consistently been the highest at risk group among females.

Chairman: Perhaps it is an obvious question but has the fact that death by suicide is four to five times more prevalent among men than women been examined and how does the incidence of suicide in Ireland compare internationally or on a European level?

Professor Ella Arensman: In terms of the gender comparison, Ireland is not unique. When one compares the figures worldwide on the profile of people who die by suicide it is around 70% to 80% men and 20% to 30% women. That ratio is almost an international given. There are factors that contribute to this gender difference with respect to the different use of methods in regard to self-harm and even self-harm may be founded on different motives. The lethality of self-harm methods among men is significantly higher. Even if we consider the category of less lethal methods, it is always the men who apparently select the more lethal methods of suicide.

We see differences between men and women in terms of access to services. In studies that have been done on mental health issues and access to mental health services among men and women and boys and girls, the uptake by women is significantly higher among women compared to men.

Another important aspect is the major issue of appropriate and early assessment. The time window between a man engaging in non-fatal self-harm and subsequently undertaking a fatal act of self-harm or suicide is significantly shorter than what we have seen among women. Among women we may see more patterns of repeated non-fatal self-harm, but that is not typical for men. In that regard, for the people in question who present to the emergency department or a GP practice, specialised assessment is key.

Moving on to the question posed by Deputy Mitchell O'Connor on cyberbullying and homophobic bullying, there is a certain lack of high quality research in Ireland and worldwide on this area but the research that can be considered of relatively good quality indicates that bullying, whether it is traditional bullying or cyberbullying, cannot be seen as a causal factor in most cases of self-harm and suicide. For a person who is perfectly healthy and fares well in life, if he or she was subject to bullying in a certain period in his or her life, such bullying would be a causal factor. The research points in the direction of a combination of individual vulnerability, and sometimes relatively severe mental health issues, and that bullying and cyberbullying can be triggering factors. In Ireland, we have a slightly different profile compared to other countries towards male self-harm; we have relatively high levels of self-cutting. We also identified particularly among adolescent males that bullying - traditional bullying and cyberbullying - was an important contributing factor to self-harm but it came very much on top of depression, low self-esteem and issues such as sexual and physical abuse.

On the number of organisations in the country, as I mentioned in my statement, last year the National Office for Suicide Prevention started a review to establish an inventory of all the organisations working in this area. That is an important approach but the issue of accreditation is crucial and that is taken on at the same time. People who are bereaved by suicide or people who have family members at risk of suicide need to know by one look at a website or by looking at one helpline whether they are on the right route and, unfortunately, that has not always been the case. I am confident the work that has been started by the National Office for Suicide Prevention will result in a more comprehensive approach and more cohesion among services.

Chairman: There are two further speakers - Deputy Catherine Byrne to be followed by Deputy Fitzpatrick. I am conscious that we must conclude by 11.30 a.m.

Deputy Catherine Byrne: I will be brief. I thank Senator Gilroy for the report he compiled which is very interesting. I am conscious there might be people watching these proceedings on television at home and I want to assure them that although we are talking about suicide and statistics we know we are talking about their loved ones and that they are not statistics. I want to make that point because it strikes me when we are discussing a subject such as this one and the proceedings are broadcast to the public that sometimes it might appear that we are insensitive to the subject we are discussing, but this is a very important issue. I want to assure people that we are all very conscious of that fact that somebody could be watching these proceedings who has lost somebody through suicide or as a result of a tragic death.

It is hard to single out one of the contributors as one could sit in awe of them all listening to what they had to say but I wish to refer to one of them, the coroner, Dr. Myra Cullinane. If is very difficult for any family to go to an inquest in the Coroner's Court. It takes a great deal of courage. Many people go because they want to find some answers and closure. Dr. Cullinane explained the process very well and the sincerity that is shown at the time of the inquest in having regard to people's feelings about their loved one who has passed away. I compliment Dr. Cullinane on that. When we think of coroners, we thinks of other things but we do not realise that coroners have a very a particular and sensitive job to do and they need to be able to deal

with people who are sitting in the room at the time. I attended an inquest and I felt that it was dealt with very well and I left with a sense of comfort that the person who was being spoken about was very important to them. When the inquest is over, unfortunately, sometimes there are no answers for the coroner or for the family. In a moment of darkness a person can take his or her life who, as a member of a family, would never have dreamt of doing so previously. That is an important point to make.

I note from the report, and also from Dr. Steve MacFeely's comments on statistics, that it deals with the last 12 years. Are there figures for the period prior to that covering the last 30 years?

I grew up in a society where religion was very important. We lived in a very religious society where people had deep religious beliefs. There was less money and probably less drink consumed, particularly at home. I do not remember there being alcohol in my home - only at Christmas, when a few bits and pieces were brought in for visitors. There were no drugs, in the sense of illicit drugs that are prevalent now, at that time. I know from having teenage children that drinking plays a big part in their social outlook when they go out. I am always conscious of guiding them when they go out to be careful of what they drink because it completely changes a person's mood. I am not a drinker but I know that is the case.

I have two questions. The contributors probably cannot answer this question but I would highlight the impact religion had on people's lives in the past. I am conscious of that in today's world where views around religion have changed. Do the contributors believe that enough is being done in our schools to identify young people with difficulties given that this report shows a major increase from the age 15 to 24 in the number of young males - and females presumably - taking their lives? Teachers do their best but I often think that we need to be more proactive in this respect, particularly during students' college years when they are thinking of many things and their lives are changing around them. Is enough being done in that respect? One of the contributors might provide some insight on this aspect.

Deputy Peter Fitzpatrick: I welcome all our guests to the meeting. I had no intention of speaking today as basically came here to look, listen and learn because I have no experience of dealing with suicide. There is not a family in the country who has not had some experience of dealing with suicide. The biggest issue for family members, friends and colleagues is that they would like to know if there is a pattern that could be identified indicating that something was wrong with the person concerned. If I were to go to a friend's funeral and talk to the family members, they would ask if there was any sign to point to what was about to happen because the person concerned always seems to have been in a very happy frame of mind, which might have been due to the fact that he or she knew that the end was close. It is a very delicate subject. Many families ask whether there is something they should have seen or some help they could have given. We can all talk about problems with finance or other problems but could the witnesses indicate whether there is something one can do if someone is behaving strangely or having mood swings? Families try to get closure over what happened to loved ones and they just cannot seem to achieve it.

I do not have experience in this area and I am sure the witnesses are very experienced. Could they indicate whether mood swings or other such behaviour would suggest that something is wrong with their loved ones? If they could interact perhaps it would help the person with the problem.

Chairman: I wish to ask a question about statistics on emigrants abroad. Do we have any

record of the number of Irish people abroad who have died as a consequence of self-harm or from suicide? Do we have figures for young people under the age of 18? I will start with Professor Arensman.

Professor Ella Arensman: Would you like me to comment first?

Chairman: Yes, please do.

Professor Ella Arensman: We have not yet conducted any systematic research in terms of self-harm and suicide among Irish people abroad but it would be relevant to look at that.

In terms of suicide and self-harm among people under the age of 18, at the start of the recession the increase we observed was among young men in particular aged 15 to 29 years. Interestingly, in terms of non-fatal self-harm, which we have observed over many years, the highest peak of self-harm among young men occurs in the 20 to 24 years age group. That is also the age group among which we see many cases of suicide, where possibly the link between non-fatal self-harm and suicide is strongly associated. Would you like me to comment on the other points, Chairman?

Chairman: Yes, please.

Professor Ella Arensman: I very much appreciate the comments of Deputy Byrne, particularly her emphasis on mental health promotion for young people in schools. Under the umbrella of ReachOut, a lot of initiatives have taken place in recent years. An important document was implemented and launched last year on guidelines for schools on how to take on issues around mental health and how to respond when a suicide occurs. It is great when those documents exist but the next step is appropriate implementation.

Even though I am very optimistic that it is feasible to implement the work, we are still dealing with very strong stigma around mental health. If I see that among health professionals then it is certainly still there in schools. I am a strong supporter of implementation in terms of not only explaining to school principals what the guidelines are about but offering them a training package as well or lunch time sessions where they can also talk about their experiences with young people who have engaged in self-harm or who have died by suicide.

My final comment is in response to the very good contribution of Deputy Fitzpatrick. That is an issue of great concern. Through the very in-depth approach we have established with the suicide support and information system we have seen a relatively large number of groups of teenage friends but also families with multiple cases of suicide or self-harm in a short space of time. It is one of the priorities that we have put in place – a lot of work has been done by Console and the National Office for Suicide Prevention, NOSP – but we still need to have a greater capacity of counsellors who can liaise with families after a suicide in particular where they can also address the needs of the people who are left behind. That is particularly a priority when one sees multiple cases of suicide and self-harm in one family.

In terms of risk factors it must be clear that there is a great variety of risk factors but reference has already been made to behaviour change and changes in mood. Increases in alcohol and substance abuse are often indicators of possible risk of self-harm and suicide. Interestingly, a pattern that we have seen through the suicide support and information system among men is that when men who may have been depressed or abusing alcohol or drugs over a long period come closer to a plan and have higher ideation of suicide their depression or substance abuse sometimes apparently improves. That is all information that is apparent in hindsight, unfor-

tunately, but it seems that up to two weeks prior to a suicide family members who otherwise might have been quite severely depressed or suffering from addictions suddenly seem to do better, but that pattern of improving may be part of their plan or decision or even a ritual such as organising events to get distance from family members. To refer to that in a more clinical way, people become more disconnected from their loved ones.

Chairman: I thank Professor Arensman and I call on Dr. Cullinane.

Dr. Myra Cullinane: I simply want to agree with Deputy Byrne and thank her for her comments on coroners at inquest. Professor Arensman has dealt comprehensively with Deputy Fitzpatrick's question and I will leave the question on emigrant statistics to my colleague.

Chairman: I thank Dr. Cullinane and I call on Dr. MacFeely.

Dr. Steve MacFeely: In response to Deputy Byrne, mortality statistics go back as far as 1864 but the Central Statistics Office has been involved since the 1950s. A review was carried out in the 1980s where suicide was again the topic and there were concerns about the level and recording of suicide. That is when the form 104 was introduced. There might be issues with comparability. I congratulate Deputy Gilmore on his table.

Chairman: It is Senator Gilroy. He might like to be Deputy Gilroy or perhaps he might not.

Dr. Steve MacFeely: I am sorry, Senator Gilroy.

Senator Marc MacSharry: Tánaiste Gilroy.

Dr. Steve MacFeely: He brings data back to the 1960s. It reinforces the point. Depending on what part of the graph one looks at as one's starting point one can reach a very different conclusion.

I have no information on the suicide rates of emigrants. What we can do is inquire of some of our colleagues in statistical offices to see if they code suicide by nationality.

Chairman: Do we do that here?

Dr. Steve MacFeely: We do not publish it, but we probably have data. However, it might not be consistent.

Chairman: That is all right.

Dr. Steve MacFeely: The one thing I would say is that given the volumes of emigration over time the numbers might be quite small for any individual country. We can make inquiries.

Chairman: I will give Senator Gilroy the final word. I thank all of the witnesses for their participation and for their very informative, challenging and provocative comments, which as Deputy Byrne correctly said are about people. All of us in this room are concerned about people, be they those suffering from mental health issues or the families of those who have died from suicide or self-harm. We are discussing people's lives, their families, people in the workforce, colleagues in work and in the community. We are very conscious that it is not about statistics. The work of the witnesses is very much focused on the person as well. We thank them for that.

I thank those who are watching at home on channel 207 and remind them that we do have a second hearing following this meeting, which will be equally as informative and challenging.

I thank members for their contribution this morning. I call on Senator Gilroy to say the final word.

Senator John Gilroy: I also thank the witnesses – Mr. Crowley, Dr. MacFeely, Dr. Cullinane and Professor Arensman. This morning's conversation has really added to the public good we are trying to achieve. In the next week or so, if it is okay with the witnesses, I will contact their offices with the intention of having an in-depth look at what we talked about this morning.

Sitting suspended at 11.39 a.m. and resumed at 11.52 a.m.

Chairman: The joint committee has now resumed in public session for the second part of this meeting. I thank everyone for their attendance and I thank the witnesses for their patience. As the last part of the meeting was extended and the joint committee also had some business in private session at the outset, I apologise for the delay. The joint committee has reconvened for the second part of its two-part meeting today on the issue of suicide as part of the report being compiled by the joint committee's rapporteur, Senator Gilroy, entitled, "Challenging Assumptions: A Powerful Conversation". At this point, I thank Senator Gilroy for his work. He will complete the aforementioned report, which then will be furnished to the joint committee for adoption after which it will be forwarded by the joint committee to the Minister as a committee report. I welcome Mr. Ciaran Austin, director of services, Console; Mr. Dominic Layden, chief executive officer, Aware; Ms Joan Freeman from Pieta House; Dr. Justin Brophy from the Irish Association of Suicidology; and Mr. Gerry Raleigh and Ms Susan Kenny from the National Office for Suicide Prevention. They are all welcome to this meeting and I thank them for their attendance. I also welcome viewers on UPC channel 207.

Before we commence, I remind people their mobile telephones should be in the off position or in aeroplane mode. In a similar manner to the previous part of the meeting, it is important to put this in context by noting we are talking about the lives of people, the families affected by this issue, as well as people's colleagues, friends and communities. I also wish to remind witnesses of the position regarding privilege. Witnesses are protected by absolute privilege in respect of the evidence they are to give to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against a person or persons or an entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing parliamentary practice or ruling of the Chair to the effect that they should not comment on, criticise or make charges against a person outside the House or an official either by name or in such a way as to make him or her identifiable.

Before calling on Mr. Ciaran Austin, I invite the joint committee's rapporteur, Senator Gilroy, to make a few brief opening remarks.

Senator John Gilroy: With the indulgence of the Chairman, I will repeat the remarks I made this morning at the outset of the earlier session in order to introduce a level of consistency between the respective groups of witnesses. I thank the Chairman for his ongoing support for this public consultation process. I also welcome the witnesses who are giving evidence this morning. I do not intend to say a great deal about the paper presented to the committee as I prefer simply to listen to the comments and the opinions of the witnesses. I acknowledge that

one or two clarifications have been offered in respect of the opening statements of some of the witnesses. These clarifications have been noted and will be incorporated into the report in due course.

The witnesses will note that I have circulated to them hard copies of the paper. There are one or two minor editorial changes. It was pointed out to me that the paper's intent might not be 100% clear and consequently, I added one or two minor changes in the interests of achieving greater clarity. For instance, the signposts for conversations within the paper might best be approached as if they were a series of questions. Instead of being thought of as recommendations, it might be better to consider them as asking the question "What if we were to do...(whatever is contained in the signpost in question)?".

As for my background, I am the health spokesperson for the Labour Party in Seanad Éireann. Previously, I worked for 28 years as a psychiatric nurse in the mental health services in Ireland and the United Kingdom, mainly in the area of acute mental health. I was appointed as the joint committee's rapporteur and decided to approach the project in a manner that might not immediately suggest itself. Some might have thought a good place to start such an exercise would have been to hold discussions with the Department, the National Office for Suicide Prevention or the main agencies working in the area. However, I decided to pursue a different path and instead sought the opinion of members of the public in the first instance, including those who have been affected by or who have an interest in the area. Having done that, I decided I would bring their concerns to the attention of the main stakeholding organisations. This is how we find ourselves at this meeting today.

I held public consultation meetings at nine locations through the country that were attended by approximately 600 people. I also met many individuals, groups and organisations and during the past 12 months, I have devoted virtually all my political time to this project. During the course of the public consultations, many issues were raised and I have incorporated those concerns into five main points in the paper. The first point relates to the effects of the recession, which was one of the most frequently raised questions from the public. Points 2 to 5, inclusive, also were raised constantly. While I do not believe any member of the public used terminology such as expressing to me the need to reconfigure the policy formulation and delivery apparatus, this was the theme of many conversations I had. Consequently, I have modelled the questions within the paper on that kind of thematic view. These are questions on how to deliver services or how such services have an impact on the lived experience of those affected by suicide as well. Therefore, I have attempted to bring together the various points by formulating the questions in the manner to be found in the paper. To expand on the points and create a conversation around them I laid them out in the manner the witnesses can see before them and while the writing is mine, the ideas are not. I could have laid out the five points for discussion as a series of five questions but to create a conversation around the points and achieve a level of engagement with stakeholders, I decided to put forward some ideas as to how they might be addressed.

I am pleased to note a divergence of opinion among stakeholders with regard to this paper, as its purpose is to create a conversation. Were one able to agree on everything, one could claim that everything was being done perfectly and this is not the case. I look forward to hearing witnesses' opinions of the paper and remind them that this is not the final report. These are the opinions and comments I have gathered from members of the public that have been formally brought before the committee and the witnesses. Following today's hearings, I intend to move onto the next phase of public consultation, which will involve engagement with the stakeholder organisations such as those represented here today.

Chairman: I now invite Mr. Ciaran Austin, director of services for Console, to make his opening statement. He is welcome.

Mr. Ciaran Austin: At the outset, I thank the Chairman for the invitation to the meeting today. I also wish to acknowledge publicly the work of Senator Gilroy in this area. We have no doubt that the public consultation process was difficult and probably involved many late nights, as well as many emotive and emotional stories and encounters nationwide. I acknowledge how helpful that process has been to giving communities throughout Ireland a voice and so, we broadly welcome that.

Chairman: I remind members that mobile telephones should be turned off or put in aeroplane mode, not silent mode, because the latter does not allow the telephone to be blocked and consequently causes interference. I ask anyone with a mobile telephone to turn it off or to put it into aeroplane mode. I apologise to Mr. Austin.

Mr. Ciaran Austin: I wish to spend a few minutes commenting on the five main areas as broken down in Senator Gilroy's report. However, by way of introduction, Console is an Irish suicide prevention and postvention charity founded in 2002. Initially, we were founded to provide professional help, support and information for those bereaved by suicide. Since then, we have developed into a national organisation providing a variety of suicide postvention and prevention services, supports and resources, most importantly, including professional counselling and psychotherapy provided by fully qualified and accredited therapists from our centres in Dublin, Cork, Limerick, Galway, Wexford, Tralee, Athlone and Mayo. We also operate Ireland's only 24-hour freephone suicide prevention and bereavement helpline, also manned by fully qualified and accredited therapists, supporting those in crisis, bereaved or supporting a loved one with suicidal ideation. In addition, in the past two years, we have taken ownership of the farm and rural stress helpline initiative which started in HSE South approximately two years ago. We also provide a wide range of information, training and education programmes and resources for communities, agencies, workplaces and professionals. Recent, we opened our first centre in the United Kingdom, in Westminster in London.

There are two points of note about the organisation relevant to Senator Gilroy's report. This year, we are introducing a new family Suicide bereavement liaison service, in counties Donegal, Galway, Sligo-Leitrim, Clare and Limerick-north Tipperary, in collaboration with HSE West. In 2012, Console published the National Quality Standards for the Provision of Suicide Bereavement Services, in collaboration with the HSE's National Office for Suicide Prevention, NOSP, in an effort to provide a robust framework and self-assessment tool for any organisation providing postvention support in Ireland, and that is available to download on the website for anyone who wants a copy.

I will touch on the five key areas in Senator Gilroy's report. Some of this may reiterate key messages that came out this morning.

On suicide and the recession, we are in broad agreement with the findings outlined in the report on the rise in suicide and self-harm rates during the time of economic recession. Increasingly, since 2008, our work has involved supporting individuals and families who are experiencing unemployment, financial pressure, reduced employment prospects and mortgage stress. These additional risk factors have greater potential for harm with those already vulnerable to mental ill-health.

Nonetheless, we are also of the view that, given the multifaceted nature of death by suicide

and its varied risk factors and complexity, directly relating suicide to economic stress is not always helpful. The oversimplification of reasons behind suicide, in particular, from a media perspective, may be harmful to those in similar situations and hurtful to those who have already been bereaved by a suicide loss. That is something that comes to mind on recent media coverage of the publication of this report, even prior to the weekend.

On how we gather information about suicide and self-harm, there is no doubt that the number of deaths recorded as suicide or intentional self-harm under-represent the true numbers of such deaths in Ireland. This morning the committee heard from witnesses who talked about the lack of analytical evidence to suggest this but, from our evidence in working with bereaved families, there is definitely an under-representation.

In addition, given the current system, the probable time lapse between the death and registration with the CSO means that annual or monthly patterns are difficult to ascertain and are often skewed. The process of recording and registering such deaths is outdated and the provision of much more timely and accurate statistics on suicide is crucial, if services are to respond effectively to emerging trends, clusters or community crises. Console is of the view that the research standard noted in Senator Gilroy's report would go some way in addressing these deficits.

The inquest and coroners' courts are often traumatic and upsetting experiences for bereaved families - that might contradict a little of what the committee heard this morning. In our experience, unfortunately, it is a negative experience for bereaved families. In working with bereaved families for over 12 years, we have noticed a distinct lack of consistency across coroners' courts in Ireland, with extremely varied types of systems in place or levels of care afforded to bereaved families at such a traumatic time in their lives. Bearing in mind that some suicides may have been preceded by fractious family difficulties, relationship break-ups, etc., the need of a bereaved family for support, privacy and sensitivity after such a devastating loss should remain paramount. In Scotland, if all concerned parties form a consensus about a suicide death, a public inquest is not held. There must be a more compassionate way forward with this process in Ireland.

On the mapping of suicide deaths, Console also endorses the suggested development of the SaTScan programme, as noted in the report, in particular, its linking with first responders such as gardaí. If front-line service providers, such as Console, are to effectively mobilise services, address educational and awareness deficits in communities and respond to suicide in the most helpful way possible, the provision of accurate real-time information is crucial.

In addition, community agencies, such those present here, and front-line service providers are ideally placed to participate in new systems for provision of more timely regional data. We collaborated with the National Suicide Research Foundation on its Suicide Support and Information Systems, SSIS, project, which the committee heard about this morning, and there were extremely productive and proactive community responses as a result.

During this year, as I mentioned, we are developing a family suicide bereavement liaison service in five counties across the western seaboard. This service will provide a proactive approach to families after a suicide loss, promoting access to services and practical support for the bereaved. The service will see the development of county-specific protocols on responding to suicide, outlining collaborative roles for the first responders, service providers, coroners and health services. If extended nationwide, such projects provide ample opportunity for the development of new systems for registering and mapping deaths by suicide.

The area of the community and voluntary sector is particularly relevant to ourselves. Here, too, we are in broad agreement with the issues raised in Senator Gilroy's report. Our considerations include the following. First, while there are numerous agencies working in the fields of suicide awareness, prevention or postvention, and, often, it is quoted that there are too many, careful consideration should be given to the extremely varied types of services or supports offered. For those in immediate crisis, bereaved or concerned about suicide, there is rarely a sense from them that there is a wide variety of options open to them. Second, given that suicide is such a complex and multifaceted issue, the number of initiatives, services or programmes required to tackle it effectively is large. Without significant investment and restructuring, the required targeted and general population approaches to prevent suicide could not be realistically achieved by one agency or merely a few. Third, the issue of standardisation of work is most important. Quality frameworks are essential, if we are to ensure the safety and standard of individuals, groups or agencies working to prevent suicide. The National Quality Standards for the Provision of Suicide Bereavement Services of 2012 attempts to do this with regard to postvention services. The document relies on self-assessment and to be effective, tools like this would require significant external input to assess and ensure compliance. Still, it allows agencies of all sizes to ascertain their level of contribution to a wider nationwide postvention strategy and benchmarks their work by providing specific standards and recommendations relevant to their particular service levels.

Lastly, on the reconfiguration of policy formation and delivery, I suppose our only comment as a front-line service provider is we acknowledge the significant good work of the National Office for Suicide Prevention, in particular, the considerable impetus it has got in the past few years under some new directorship, but also note the enormity of the tasks asked of it. If it is to carry out its work more effectively, the NOSP requires greater sustenance and significant financial investment. With a new national strategy on suicide prevention due for development this year, agencies and policy makers need to support the NOSP in its difficult work and to help improve its constructive engagement with community and agencies across Ireland.

Chairman: I welcome Mr. Dominic Layden, chief executive officer of Aware. I thank him for being here and ask that he make his presentation.

Mr. Dominic Layden: I thank the Chairman and the committee members for the invitation and opportunity to present here today on what is a key issue in Ireland.

Before I begin, I should point out that Aware is not a suicide prevention charity. Our vision and mission is to provide information, education and support for those individuals and their families who are experiencing stress, depression and other mood-related disorders.

Before I comment on the rapporteur's report, I will deal with some macro issues and provide the committee with data about Aware which I hope will give it a better appreciation on our response to Senator Gilroy's report.

As the committee will be aware, mental health services and supports are provided by the State and the HSE, and a vast range of organisations from within the community and voluntary sector. We conducted a survey last month among the general public, that is, all those 15 years of age, and we asked the question: "What organisations are available to those affected by depression and mental ill-health?" An omnibus survey was conducted by Amárach Research in February and it showed Aware is the organisation most widely spontaneously associated with depression and mental ill health in Ireland, at 31%, followed closely by the Samaritans, at 28%. A wide range of other organisations was recalled although these were listed as having signifi-

cantly lower levels, including the State and HSE, at 12%. This points to the fact that where mental health is concerned, people think of Aware and the Samaritans before they think of the public sector, the HSE and other organisations.

This prompts two questions. Why does the public think of Aware and the Samaritans before any other body? What are they looking for when they come to our organisation? Aware has longevity, trust and brand awareness. The organisation has been in existence for just over 29 years. All our services are independently evaluated. A clinical sub-committee of our board oversees all the services we provide. We appointed a clinical director and a full-time training and recruitment officer in recent years. The independent evaluation of services for any organisation is a major challenge. Within the voluntary sector, it poses even more challenges because, obviously, most of our services are provided by highly trained, active and committed volunteers.

We have a very strong and committed volunteer base nationwide. More than 345 active and highly-trained volunteers are involved in our service delivery and each receives a minimum ten hours' training. We have a wide range of volunteer policies and procedures, from confidentiality policies to procedures in dealing with individuals attending our support groups or helpline. We have a well-trained organisation.

The public, when it approaches Aware, comes for information in the first instance, then for support and education. The public is now coming to us for wellness training programmes at work. The primary source of information on depression stress and other mental health mood-related disorders is our website. We get approximately 260,000 unique hits on our website every day, which amounts to approximately two hits every two minutes. We hold a monthly lecture in St. Patrick's. We video them and have published them online in the past year and a half. Over 39,000 people have downloaded the monthly lectures. A range of experts in the field, namely, experts in depression, mood-related disorders and suicide, are invited to deliver the lectures.

We have three support mechanisms. We have a helpline and just over 50,000 calls have been answered in past three years. We have an encrypted e-mail service, which means a volunteer will not know whom an e-mail has been sent from. The transcript of the response is read by another volunteer before it is sent back to the person who sent the e-mail. Finally, we have support groups. We have 45 locations nationwide. Some groups meet weekly and sometimes bimonthly or monthly. In the past 29 years, many people have remained alive because of the services attendees at the support groups have been able to receive.

Beyond the provision of information and support, the third area is education. We have three educational programmes. The first, Beat the Blues, is delivered by professional trainers to students aged from 15 to 18 in all secondary schools. In the past two years, we have delivered the programme to over 60,000 students. Approximately half of all secondary schools have received our programme to date. This programme helps young people to learn coping skills for dealing with concerns, in addition to tips for looking after mental health and building resilience. It costs approximately €7 to deliver the programme to each child. This is excellent value for money.

Our second education programme is a lifeskills group programme, which is available for adults of 18 and over. It is delivered to groups of up to 25 people over six weekly 90-minute sessions and it is based on the principles of cognitive behavioural therapy. Launched in May 2012, the programme has now been delivered to 3,000 people across most counties, with several more phases planned between now and the end of the year. The programme is inde-

pendently evaluated. We have seen significant improvements in self-reported depression and anxiety, using standardised clinical measures. Crucially, these results are sustained at 12-month follow-up, as shown in evaluations by Dr. Katrina Collins. With private one-to-one cognitive behavioural therapy sessions costing approximately €100 each, the real value of Aware's free programmes could be estimated at just under €2 million.

The third education programme is Life Skills Online. It offers a unique option for service users to access a programme based on cognitive behavioural therapy from the comfort of their own home, with the added benefit of encouragement from a trained supporter, equivalent to a personal trainer in a gym. Launched in 2012, the eight-module programme has been completed by over 800 to date, and we are currently involved in a randomised controlled trial with Trinity College Dublin and SilverCloud technology company. All these services are free to the public. We recently launched wellness-at-work training programmes that provide talks for employees and half and full-day training programmes for managers in the workplace.

Aware welcomes the report on suicide by the rapporteur to this committee, Senator John Gilroy, and has a number of observations and comments. First, as referenced in the report, there are a large number of organisations working in the area of mental health, and their services are provided in addition to the services provided by the State. We welcome the suggestion that there should be a national registry of all organisations working in this area. We believe such a registry would be helpful for all stakeholders and that, in addition, the publishing of information on how and why organisations or projects are funded is important for transparency and accountability.

Second, Aware has significant concerns about the use of the word "suicide" and the focus, particularly in media circles, on the issue. Suicide has become an everyday word, and to a vulnerable person, particularly a younger person, the common, almost casual, manner of speaking about such a serious issue can mean suicide is in some way perceived as a real option in life.

Aware would like people to understand that just because someone has thoughts of taking his or her own life does not mean he or she has to do it; there are always alternative options. Just because someone has depression does not mean that he or she will inevitably take his or her own life as many people experience depression and make a full recovery.

Third, the recession over recent years has made many people feel more vulnerable. There have been continuing conversations about austerity and a sense that there will be many years of battle before things begin to show signs of recovery. There is a real need for people to understand what they can do to maintain their mental health in the face of such challenges, and how to build and develop resilience to lessen the impact on their mental well-being.

Fourth, alcohol is a significant factor in influencing mental health but there seems to be reluctance to acknowledge this. The rapporteur has included detail in his report about the link seen between the increase in the suicide rate in the late 1990s and the increase in the *per capita* alcohol consumption rate. Research commissioned by Aware in 2004, carried out by Dr. Conor Farren, noted that in Ireland, being unique among European countries, there was a 41% increase in alcohol consumption per head of population over the ten years to 2000, and this mirrored a parallel increase in the national suicide rate.

Fifth, in addition to the need to provide services that focus on helping people who are in acute suicidal crisis, there is a real need for everyone to understand suicide prevention is not just about acute crises. It begins at a much earlier point in the journey. If this were understood

and acted on, so many lives and so much distress could be prevented. If we look at how cancer is dealt with, people are encouraged to check themselves regularly for symptoms of some of the more common types of cancer, such as breast cancer or testicular cancer. There are also a number of screening options which people are actively encouraged to take advantage of such as cervical cancer screenings. These seem to be showing real results in terms of identifying people who are at risk at an earlier stage and improving outcomes.

Aware is trying to encourage people to take more responsibility for their mental health and monitor how they are doing through its positive mental health programmes. It is helping people to understand that mental health is something that we all have but there are ways that we can look after it to prevent issues from developing.

Aware believes education is the key to bringing about a fundamental shift in society's attitude to mental health and, ultimately, suicide. Aware has delivered its Beat the Blues positive mental health programme to 60,000 senior cycle students in over half of the secondary schools in the past two years. We recommend the State and Department of Education and Skills encourage all secondary schools to avail of this free programme, as there is nothing else there for young students at this pivotal stage in their lives.

We also recommend that mental health education and resilience development should be part of the curriculum, including at primary level. We should all aspire to create a well society with young men and women resilient and adaptable no matter what the challenges they face.

Chairman: I thank Mr. Layden for his presentation. The footnote on his submission on the organisation's board members' salaries is welcome and shows leadership.

I call on Ms Joan Freeman, Pieta House, to make her opening statement.

Ms Joan Freeman: I am sure many members have heard of Pieta House but probably do not know why we chose that name in the first place. It is taken from the name of the wonderful sculpture by Michelangelo of Mary holding the dead broken body of her son Jesus, the *Pietà*. The remarkable feature of that sculpture is that Michelangelo made it a symbolic piece with the mother larger than her son, which would have been the opposite of the case. Her shoulders are very broad, her lap is very deep. She is embracing not only his death but his broken body. It was one of those lightbulb moments when we decided that what we need in every single community is a living *Pietà*, a service that can hold the broken lives of people in our community.

Pieta House opened its doors in 2006 with two full-time and four part-time staff. Today, we have 170 staff in nine centres across the country. Last year alone, we saw 4,000 people ranging from six to 80 years of age. It has become a very much loved charity. In a way, the public has taken ownership of Pieta House as it is led by the community. We have opened centres through invitation and public support. If it were not for the public, Pieta House would not be in existence. One of the main reasons why we have grown in popularity and accessibility is because it is free of charge. Second, we have removed as many barriers as possible by removing the necessity for a GP letter or a psychiatric report to access our services. Anyone can pick up the telephone to make an appointment for a loved one who might be in distress.

Today, the committee heard much about statistics and numbers. If members think about 4,000 people who came to us last year, any of them could have been their brother, mother, daughter. As we all know, a colleague of members took his own life last year. Suicide can happen to anyone. We need to stop debating suicide prevention and do something instead. I com-

mend Senator Gilroy's report, most of which I agree with. However, there are several points that I do not agree with. While I liked his call for a purposeful conversation, it should be an honest one too.

I am not here to criticise the Government, the Health Service Executive, HSE, or the NOSP, National Office for Suicide Prevention. We are all trying to do a difficult job. Not only am I representing Pieta House, I am representing the possible ten people who may take their lives by next Thursday. We need to be clear about whom we are speaking about and representing. We cannot expect any government to do the job of Pieta House or to take over the Society of St. Vincent de Paul. However, we need to acknowledge organisations such as Pieta House and Console who are doing the Government's job in providing a service it cannot provide.

My challenge to Senator Gilroy is over the reconfiguration of the policy formation. I disagree with his suggestion that the NOSP remit should be broadened. It is not only underresourced but it is overwhelmed. It was initially given the remit of rolling out the Reach Out strategy which still has not happened nine years later. If its remit is further broadened, the office will be crippled. The Government should put up its hand and admit it cannot do this but it would like the collaboration of organisations such as Pieta House to work on this problem. While the NOSP brings us into meetings, that is all that is happening. We are having lots of dialogue. An organisation like Pieta House is standing on the cliff edge while someone is trying to let go. If the Government wants to know how to have a service, then it should talk to us. We should be in charge of the intervention piece. Console should be in charge of post-intervention while the NOSP helps us deliver these. What is happening now is like going to McDonald's and telling them how to cook a burger. The HSE and the NOSP are not on the ground. We are. We can tell the Government how to best run the service.

I know the NOSP is trying very hard. If the committee wants to see a reduction in suicide, then we have to stop sitting around and talking. I have heard many criticisms about using the word "suicide" and that we have nearly normalised it. We can never go back to putting it under the carpet. Last year 4,000 people came to us because they were unafraid to do so. I ask the Government to examine this issue in a way that we can tell the public that there will be a major reduction in suicide if they include us in that dialogue and in the implementation.

Dr. Justin Brophy: I thank the Chairman and the committee for this opportunity for the Irish Association of Suicidology, IAS, to give this presentation. IAS has been in existence for more than 20 years and has set the stage for much of what is happening today. It was one of the first organisations to raise a conversation and engage the public and the body politic on the subject of suicide. It would be unfair not to note the presence today of the founding members who are Members as well as other people present who remain committed to the issue of suicide.

Over the years the association has been of great assistance to the development of other agencies in addressing the problem of suicide. It has provided expertise and invited and brokered expertise to all those organisations so they can complete the missions they so admirably have achieved. IAS continues to exist in a knowledge transfer capacity. By that I mean it provides knowledge about research, policy and international developments in the arena of suicide prevention. IAS channels that knowledge into the policy arena, the public arena and communities, with a deep reach into the people who are working outside the professional domain in trying to prevent suicide.

The association has recently completed a piece of commissioned research which addresses some of the issues in Senator Gilroy's report regarding the accreditation of organisations pro-

viding counselling and support services to persons affected by suicide. I commend that report to the House and urge that steps be taken to action the recommendations in it. The organisation thanks Senator Gilroy for his report and we will speak to some of the issues raised therein. We will also make some other recommendations.

Regarding the current trends in suicide in Ireland, while rates have mysteriously fluctuated over the last number of years, this is not linked simply to economic and social trends. Ireland is paradoxical in several respects in that regard. We have a persistent problem with male suicide in two different age groups primarily, younger men and men in their 30s and 40s. We also have a less described problem of suicide among the elderly. As our population grows older we will have an increasing problem in that arena. That should not be forgotten. Marginalised people, particularly marginalised communities within Ireland, are at particular risk and that is very important to remember, particularly for this House. These include persons in the LGBT community, Travellers and people with drug misuse problems, particularly opiate or polydrug abuse. Unemployed and indebted persons are at particular risk. Inescapable debt is an extreme pressure on people. Migrants should not be forgotten. Many migrants have come here full of promise and hope but their lives have become incredibly difficult.

In addition to those general trends, the organisation's horizon scanning indicates that there are impending increasing pressures on the population. A faster rate of acceleration of home repossessions is something we should be aware of. Family breakdown has increased during the social difficulties of the last few years. Homelessness is a growing problem and lack of access to rented accommodation is putting extreme pressure on people who are now finding themselves with almost no access to basic housing. People who are trapped in the asylum-seeker system through delayed migration applications are in great despair and the system must be reformed in a way that allows people to clarify their status much more quickly and definitively.

There are also significant problems for persons with additional employability challenges, such as people recovering from mental ill-health, people with disabilities and people whose lives have become broken in some way. They are finding it very difficult to access informal or temporary employment. Schemes that existed in the past need to be revisited because work provides an enormous opportunity for people to rebuild their dignity and their lives. There is not enough of that. We must be aware, although not in dread, of the pressures around the pernicious comments that can circulate via the Internet and social media and its effect on suicide epidemiology in Ireland. There is an undeniable increased demand in the population for assisted suicide. This is full of hazard. A significant post-conflict rise in suicide deaths in Northern Ireland has been described and we should be acutely aware of that. There is a growing problem of importation and misuse of prescribed drugs in Ireland, which are significantly over-represented in suicide deaths.

I will present our recommendations, including the signpost to which Senator Gilroy referred. I will take them collectively. We urge the Government to take further steps to educate the population on the risks of binge-drinking for suicidal behaviour and take steps to promote sensible drinking limits and behaviours at second level. For example, bar extensions at festivals are obvious incentives for heavy binge drinking. Unfortunately, the consequences of those periods of State-sponsored excess needed to be curtailed. We encourage the Government to extend mental health services and best practices in prisons for at-risk individuals. Schemes in operation have shown positive impacts in prisons but they are not in all prisons.

The Northern Ireland Statistics and Research Agency has become a sort of one-stop shop for contemporary and all-encompassing research in suicide. The committee has heard evidence

of this already this morning. Notwithstanding the comments the committee has already heard today, we need a contemporary suicide investigation agency that can examine real life trends. It is no good responding to a trend that emerged two or three years previously. We recommend the Government support and continue active surveillance and take steps to facilitate press and broadcasting complaints around suicide reporting. It is not easy to make a complaint if one's suicide death has been misreported. The Press Council of Ireland and Broadcasting Authority of Ireland could make that easier.

We recommend the Government extend generic and self-harm specific counselling agencies, such as we have heard from already today, nationally and take steps towards accreditation and quality assurance of counselling and support services according to the framework the IAS research recommended. We recommend an acceleration of and investment in the promotion of quality in mental health services in Ireland, especially out-of-hours services and urgent crisis access services. It is still difficult to get help because the point of call is often an out-of-hours service in a general practice that would not necessarily know the person and may involve a lot of waiting or an emergency department that is often a fraught and difficult environment in which to conduct such assessments. There is a better way of doing it.

We also recommend greater investment in a comprehensive range of drug and alcohol services. We do not have services commensurate with the extent of the problem in this country. We recommend greater drug controls around benzodiazepines. There have been notable examples this week, including reports in today's newspapers, of banks taking measures to protect people who are about to lose their family home. They are taking commendable and honourable debt correction measures and if people lose their home, pathways are being provided to ensure they do not become homeless as a result of debt repayment measures.

We would like to recommend further investment in the NOSP. We believe it does great work and we believe, contrary to some of the evidence the committee has heard, that it is the best placed agency to commission and co-ordinate suicide prevention efforts. Stigma campaigns need to be balanced with campaigns that show the impact of suicide on communities and individuals. The normalisation of self-harm needs to be challenged. The more training, the better and suicide resource officers should be trained and given standard operational procedures in order that they can operate in a co-ordinated and targeted way. We also suggest that any relief measures in respect of assisted suicide that this or a subsequent Government may need to be assessed not only in terms of a civil rights, human rights and legal perspective but also in term of the impact on the population. If assisted suicide is to be supported by the Government, it needs to be done in a way that does not defeat the other purpose of the Government to prevent suicide.

We ask the Government to recognise the achievability and political value of suicide prevention because there is still a lot of defeatism and complacency in public and even in political circles that suicide can be prevented. We strongly commend to the Government the importance and achievability of suicide prevention and ask it to be unstinting in its efforts in that regard.

Mr. Gerry Raleigh: The HSE National Office for Suicide Prevention would like to thank the committee for the opportunity to provide a response to Senator Gilroy's draft report. The office is based in the HSE mental health division and it was established in 2005. Its purpose is to oversee the implementation, monitoring and evaluation of Reach Out, the current Government national strategy for action on suicide prevention. NOSP was originally formed to progress the 26 action areas and 96 recommendations in association with pre-existing and emerging partners. The office's staff complement has stabilised and has increased from 4.5 in 2012 to the current team of ten. This will increase to 13 in 2014. Our budget has increased to €8.8 million,

which represents a 283% increase since 2010, and we provide funding to 31 NGOs working in the sector, including Console and Pieta House.

We also have a strong working relationship with the ten resource officers for suicide prevention and that number will increase to 16 this year. They have an important role in translating national policy into local action. It is a big challenge for them but they embrace it with remarkable energy. I note Dr. Brophy's comment about the issue of consistency. We will examine that in terms of how these officers discharge their function.

The NOSP plays a pivotal role in leading, funding, co-ordinating and giving strategic direction to the work of the diverse agencies working in Ireland to promote positive mental health and reduce suicide and self-harm. The national office is required under Reach Out to publish an annual report, which is laid before the Houses of the Oireachtas. Behind all the words, we have one simple goal and everyone in the room shares it: to reduce the loss of life to suicide.

The NOSP recognises the significant work undertaken by the rapporteur and we thank him for that. We welcome any informed and balanced discussion on suicide prevention at national, regional and community level. We have not been part of the consultation in the development of the document. We had an opportunity to meet the Senator earlier this week, which we welcome, and we look forward to further discussion with him to bring the report to the next stage.

Within our communities, too many people die by suicide in Ireland each year. As Ms Freeman said, ten people will most likely end their lives this week and this should bring anyone to a halt. Suicide rates throughout the population are a concern but the rates among young and middle aged men are of particular concern. Each one of these deaths is an inexplicable loss for families, friends and communities.

Suicide prevention is complex and there is no simple explanation for someone choosing to end their life and it is rarely due to one factor. Pervasive mental health issues, substance misuse, bereavement, physical or sexual abuse and feelings of despair, helplessness or hopelessness are significant risk factors for suicide. In publishing a report for public discourse, it is important, therefore, that the causes of suicide are not overly simplistic. For example, it is necessary to avoid the suggestion that a single incident such as job loss, relationship breakdown or bereavement was the cause. With regard to the recommendations or signposts in the draft report, the NOSP would like it to be noted that in the discussion on suicide mortality and morbidity and the consideration of the impact of the recession on same, care needs to be taken in presenting statistics on suicide. Statistics should be reported in line with international best practice in public health.

This year, the NOSP has been requested to lead on the development of a new national strategic framework for suicide prevention, which will need to be supported by strong governance structures. Ongoing evaluation and robust monitoring of outcomes for the new strategic framework will be necessary. The framework will require bilateral and multilateral engagement, ownership and oversight. In this context, the NOSP puts forward considerations in respect of the recommendations in the draft report.

With regard to signpost 1, the recording and the analysis of suicide statistics is complex and the NOSP welcomes any opportunity within the context of a new national framework for this recording to be improved, if deemed necessary. The Department of Justice and Equality, the Coroner's Association and relevant statutory agencies need to be involved in the discussion and undertaking of the proposed research. The mapping of suicide rates can be undertaken using

geospatial techniques. We have consulted with our colleagues in the NSRF and understand that it is contrary to good practice to report suicide rates on the basis of population cohorts of 10,000. Furthermore, when the numbers of deaths by suicide are small within a geographical area it is necessary to report changes in rates over a three-year rolling average.

On signpost 2, consultation with the Department of Justice and Equality, and the HSE should be undertaken as to whether such a scheme is feasible within current legislation and the remit of the organisations I mentioned.

On signpost 3, the SSIS study was a pilot study funded by the National Office for Suicide Prevention. The establishment of any new data-recording systems on suicide mortality should be done as part of the development of a new strategic framework for suicide prevention. Consideration needs to be given to the cost effectiveness of any new data-recording system having regard to the current investment in the national self-harm registry funded by the NOSP and delivered by the NSRF; integration with existing suicide bereavement support services; and the learning from existing national and international data-collection systems for suicide and other public health concerns, for example substance misuse.

On signpost 4, as part of the HSE's new national mental health awareness campaign, which will be launched in 2014, a national mapping exercise of support services that have a relationship with the NOSP and partner organisations will be made available to the community in an effort to provide very simple and clear signposting to services, with an emphasis on services that are accredited.

On signposts 5 and 6, the NOSP recognises the need for the establishment of national standards for agencies working in the area of suicide prevention, which would apply equally to all community groups working at a community and national level. The development of standards will form part of the new national strategic framework. Consideration needs to be given to the accreditation process to support this and the appropriate agency to oversee these standards.

On signpost 7, the NOSP has its own budget of €8.8 million for 2014. The reconfiguration of the NOSP to a new location is a policy decision for Government. It is our view that at present the NOSP should remain within the HSE mental health division, because that is where we can exercise most influence in delivering help to people who seek it. As part of a new strategic framework on suicide prevention, consideration needs to be given to the governance structures both within the HSE and at government level. In addition, any new governance system will need to be integrated and linked to the Cabinet committee on social policy governance structure for the Healthy Ireland framework. In terms of signpost 8, this is a policy decision for Government and the Department of Health.

In 2014, the NOSP has been mandated by the Department of Health to take the lead on the development of a new Government strategic framework for suicide prevention. This is an exciting but challenging task for the organisation. The process for the development of the framework has commenced and the NOSP will commit to using the signposts and the discussion that has commenced today in terms of developing this framework. We see the outcome as one which is action based, reflecting the input of all our partners and will allow us to give very clear direction and confidence to the community that we can reduce the loss of life by suicide. We would also welcome any additional recommendations that the committee may feel are helpful for the new framework.

Senator Marc MacSharry: I thank the witnesses for attending. I wish to pay tribute to

Senator Gilroy, our colleague, for his work so far. I know he has a very special interest and has done considerable work in this area. The Fianna Fáil members of the committee, Deputies Troy and Kelleher, and I, will give our own policy, entitled Actions Speak Louder than Words, to Senator Gilroy as our submission to the committee. Some of those present may be aware of that policy which was prepared about a year ago.

I fully agree with Ms Freeman of Pieta House. Governments and politicians do not have the solutions and will never have the solutions. We are all tired of what happens following a high-profile incident. There is shock and horror, and shouting from the rooftops about what has to be done and the reports that are needed. It goes on for about a week and then if falls away.

While I agree with everything the witnesses said, I am not sure we agree on how to achieve it. The Government of the day is responsible for the structure and resourcing to allow the organisations represented here to excel at what they do. They are the super heroes in this regard. They peel back the blindfold on the phenomenon of loss of life through suicide. There is nothing we can say here to teach them how to cook the burgers in McDonalds, so we will not try to do that.

However, the correct structure needs to be in place and we need the appropriate resourcing for that structure to excel. I certainly do not believe that is the case at the moment. I fully agree that the National Office for Suicide Prevention is overwhelmed, overworked and under-resourced. While I do not expect people from the office to agree with me, their efforts are hampered by being subservient to an organisation that has financial challenges on a daily basis. The Minister of State, Deputy Kathleen Lynch, would agree with me that when the chips are down the first money to be cut is from the mental health area. That is why I believe responsibility for this area must be removed from the HSE - it needs to be an organisation in itself.

As the organisation knows the area best, it should define the national policy. The old policy has not really worked although it has some great aspects. We need to draw up a new policy quickly and get on with it. There has been enough talk and as the witnesses have rightly said, action is what is required. The Scottish model has shown us what can be done, with a 16.7% reduction in eleven years; this is a battle we can win. We know two planes are going to crash next year and we know where, but what are we doing about it? The witnesses are doing the best they can with almost no resources.

Our estimate - it is available online for those who want to see it - is that the National Office for Suicide Prevention is under-resourced by €80 million based on what is needed. We will submit our proposals to Senator Gilroy, who can factor them into his work.

I believe that as a nation we are emotionally illiterate and are doing nothing to teach people how to be angry and what anger is, how to be sad and what sadness is, and how to cope with the various emotions in life. There is no teaching in that regard of which I am aware. Among other items, we proposed that guidance counsellors be restored to schools, including primary schools. We proposed that SPHE should include that kind of emotional training and for it to be extended into the senior cycle to prepare students for the difficult challenges of life. While the issue might be repossession for one person, it could be depression for another person and relationship break-up for someone else. There is no exact science to this.

While all the witnesses are doing a great a job, the one thing the Government should do is to put the correct structure in place and begin to resource that structure. At that point the work of the Legislature will be done and the organisations represented here can do the rest. Apart

from those organisations, which are the high-profile ones, there is a plethora of organisations throughout the country that are engaged in superficiality. Following an incident in a community, money is raised and goes somewhere. However, are we having the kind of penetrative impact that such a level of effort should have? The answer is "No" because we pay lip service to putting the correct structure in place and resourcing it. That is what needs to change.

I am aware of all the organisations represented here today and have read a considerable amount about them. My only question is on the emotional literacy.

Deputy Sandra McLellan: I apologise on behalf of Deputy Caoimhghín Ó Caoláin, who could not be present for this session. I thank Senator Gilroy for the very important body of work he undertook. I thank the witnesses for their presentations and I commend each of them for the very important work they do. Everyone has been affected in some way by death by suicide. The work done on this is very important to the committee. All of us are on a continuous learning curve.

A point was made on comparing trends in suicide in Ireland to those in neighbouring countries. Suicide rates in Scotland decreased by 18% between 2002 and 2012. Why did the suicide rates there decrease? Does it have better resources than here or is it how suicides are reported? A proposal was made to undertake a comparative study of suicide trends involving experts on suicide research and prevention from the five nations. Do witnesses agree with this?

Alcohol is a significant factor in mental health but there seems to be a reluctance to acknowledge this. During one of the presentations it was stated there was a 41% increase in alcohol consumption per head of population over the ten years to 2000. I presume all of the witnesses agree a decrease in alcohol consumption would lead to a decrease in suicide. Our relationship with alcohol in this country leaves much to be desired. As a nation we are completely in denial about the effects of alcohol.

It should be mandatory for all schools to take part in an education programme. Considering some of the programmes outlined this morning I am absolutely astonished, and it is hard to believe, that some schools do not partake in them. It is essential they are all encouraged to do so.

There is no doubt the number of deaths recorded as suicide or intentional self-harm underrepresent the true numbers. Suicides are under-reported. What do witnesses believe are the real figures? Do they have a percentage of by how much they feel the figures are under-reported?

It was stated the National Office for Suicide Prevention requires greater resources and significant financial investment if it is to carry out its work more effectively. This was also mentioned with regard to mental health issues and people's medical cards being discontinued. Many people who may have mental health issues present to our constituency offices. They are often the most vulnerable and have difficulties with getting on housing lists, getting their entitlements and having their medical cards discontinued. The very people who need less stress than others are often those stressed out more. I have had instances of people not taking medication because they cannot afford it although they really need it. Recently I spoke to a lady whose medical card was taken off her and whose husband was working. He did not understand her depression and need for medication and told her she did not need the tablets and to get on with it. Many issues arise which we do not accept and do not really understand.

There is a lack of consistency in how families are dealt with in the Coroner's Court. I presume this is a resource issue. How can it be improved? I thank the witnesses for their positive

recommendations. I am sure they will be very useful to the committee.

Deputy Dan Neville: I have declared, under the declaration of interests of the Ethics in Public Office Act, that I am a company director and president of the Irish Association of Suicidology but I wish to put it on the record for those reading this report.

I am very interested to hear how Mr. Austen would propose to have earlier statistics from the Central Statistics Office, because to decide on a suicide is complex. It would be admirable to have earlier statistics and confidence in their accuracy. There is quite a complicated approach in operation at present, between form 104 and the coroner's report.

I wish to discuss the effect of stigma. All of the organisations are working on reducing stigma, and this is done through their discussing it, speaking about it and providing services to people in crisis. Amnesty International and St. Patrick's Hospital have conducted surveys on the level of stigma which still exists with regard to those with mental illness. St. Patrick's Hospital examined the general population and Amnesty examined those who suffer or have suffered from a mental illness. It is quite frightening. It is accepted it is under-reported because people want to be positive rather than negative. This is a very big challenge faced by everybody involved in mental health services, NGOs and suicide prevention.

The former Minister of State, John Moloney, did excellent work. I cannot overstate how interested he was in working on mental health and suicide. He launched the See Change programme. Has any evaluation been done on how effective State organisations are in reducing the stigma of mental illness and suicide?

Deputy Mary Mitchell O'Connor: I thank the witnesses for the very good work they do. If somebody comes to my constituency office seeking advice on where to go, where do I send the person? This has happened in the past. I accompanied someone to a mental health hospital and I was very disappointed and concerned because on every evening I went to see the person different personnel were working there. There were also different members of staff at family meetings and one had to start at the beginning and explain the whole case again. I do not have much confidence in sending people to mental health hospitals, one in particular. Where do the witnesses suggest we send people when they come to our offices?

My background is in education. When the witnesses spoke about education in the classroom for children and teenagers do they believe it should be delivered by guidance counsellors? I believe it must come from the home. One must learn one's resilience in the home and bring it with one to the classroom. My experience is that if they do not get learn that at home, it is very difficult to develop it in the school.

Mr. Austin's report alludes to the fact that there may be too many agencies. I asked the previous group the number of agencies providing support to people who have difficulties in mental health and suicidal ideation.

The representative of the Irish Association of Suicidology mentioned quality assurance of counselling. Can he assure us that there is quality assurance in respect of the people delivering it on the ground, be it to people with suicidal ideation or to family members after a suicide who are very vulnerable? I want to make sure there is quality assurance in that regard. Can Mr. Austin tell me if that is the case? I am sure that is the case in respect of some of his organisation's groups but I have attended meetings where people have outlined their experiences and I would be concerned about them giving advice. We must have sound advice from experts. Is

that happening on the ground or is the service so diluted and fractured that some of the expert organisations are not getting the resources that should be ploughed into them? Is it being diluted across the sector?

Deputy Ciara Conway: I thank everybody for their contributions and for the work they do in communities across the country. I have identified some common themes from the witnesses' submissions. Would I be right in saying they believe there is a lack of a united approach and, if so, will they expand on that? We frequently read about the tragedies that befall people's families and communities and I am exasperated that we still do not have a united approach when we are all trying to get to the end result of keeping people alive and well in their communities. Why do we not have a united approach on the fundamental issue of keeping people safe and well?

My background prior to becoming involved in politics was as a social worker working with very young children, and often with families who had significant difficulties. To pick up on a question Senator MacSharry posed about emotional literacy, I believe we can and should be teaching children as young as two and a half and three years of age about emotional literacy, and there are programmes that do that. Barnardos has a programme called Tús Maith where the language is explained and the emotional support given by their preschool teachers. That message and exposure to education trickles home, and it is reinforced with the parents with support from people like those in Barnardos. However, Barnardos is not an organisation that springs to mind in terms of promotion of mental health and emotional literacy, and that highlights the lack of a united approach. The work Barnardos is doing with children aged three, four and five in very disadvantaged communities across this country is as important as the work being done by Aware, Pieta House and the Office of Suicide Prevention. We must not forget that we are all stakeholders in positive mental health and looking after ourselves.

Another important consideration, and Mr. Layden from Aware spoke about it also, is screening. We have very effective cancer screening and have seen great results but we rarely screen ourselves in regard to how we are feeling. People often ask us how we are doing and the response is "I am grand", but we do not look at that in a significant way. That is important for all of us, regardless of whether we are on top of the world or at the bottom of the heap in terms of how we feel. There should be some way of being able to monitor that.

I would like to know from the witnesses the reason for the lack of a united approach because that greatly concerns me.

Senator Colm Burke: I thank everyone for their contributions. I apologise for missing some of the contributions but I have read them.

I raise the issue of suicide among males between the age of 15 and 30. Is there one area the witnesses believe we should prioritise in terms of trying to reduce suicide in that age group? There is a range of actions we should be taking, some of which, in fairness, are being done, but is there any one area we should priorities to try to make an impact on reducing the suicide rate in that age category? Between 2005 and 2010, the population in the 20 to 24 age group was 28.5% per 100,000. The highest number of suicides is in that age group. How can we bring about a change to reduce the number of suicides in that group?

Deputy Ciara Conway took the Chair.

Senator John Gilroy: To give context to what we are trying to achieve with this report,

doing a public consultation throughout the country with members of the public who are not experts in this area but are interested in it is a starting point. Since I wrote the paper in draft form I have had the opportunity to meet some of the chief executive officers and leading people in some of our voluntary organisations. I met with Mr. Austin, Mr. Layden and Ms Freeman, and I met Ms Kenny this week. Unfortunately, I did not get a chance to meet Dr. Brophy. I was very impressed by the quality of thinking taking place at the top levels of our organisations.

We have heard the contributions from the witnesses and how some of them have approached the problem of suicide from their own perspective. We have heard a divergence of opinions, which is welcome. The Central Statistics Office will take the statistical approach, as one would expect. The coroner and even ourselves as politicians have a different perspective on how we might approach this area but juxtaposing those perspectives creates an energy with which we might be able to gain further insights. It is important that when we leave here today we do not forget about it. This process should be seen as a starting point.

I wish to clarify one or two issues that may not be clear from the report, one of which was raised by two witnesses earlier. It relates to the application of the geospatial analysis to the electoral division. There was no suggestion that we would use 10,000 of a population to change the rates of suicide; it was merely used for illustrative purposes. We could have used any other cohort of the population including small areas or even constituencies. The point is that there is data available within which cohorts can be measured and to which geospatial tools can be applied. That is not to suggest that we intend to change the way we map the rates of suicide.

I address this question to Mr. Raleigh. I congratulate him on his appointment. The new energy he has brought to the national office is obvious, even in the course of my travels in the past 18 months, and I commend him on that. When I mentioned the National Office for Suicide Prevention at a meeting there was no recognition of its value. Senator MacSharry's research from the year before last would verify that but that has changed since Mr. Raleigh took over the office, and we congratulate him on that.

We welcome that the national strategic framework is making good progress. When are we likely to see that? What agencies are involved in compilation of the policy? The reason I refer to the National Office for Suicide Prevention and express the rather radical view that it should be removed from the area of mental health services, serves several purposes. One reason is that we are not very good at policy-making in this country and I mean generally, not just in the area of health or mental health. We have seen the results over the years, much to our dismay. Our policy-makers may be of the view that it is sufficient to decide policy at the top and expect it to be fully implemented at the bottom without being mediated through each stage of its implementation.

I commend the Reach Out document but it suffers from some of the flaws I have outlined. It is vague in many areas and its language is woolly, which is very difficult to understand. The document presents no measurable outcomes. There is no built-in formal annual review as opposed to an *ad hoc* review even though it is a ten-year policy across both sides of the recession. There is a great lack of resource planning. Some media reports last year - before Mr. Raleigh's time - may have suggested that the National Office for Suicide Prevention had underspent its budget in 2012.

Vice Chairman: Has the Senator a question?

Senator John Gilroy: Certainly. The Reach Out document does not contain a list of named

agencies with responsibility for implementation or outcomes nor does it contain any timeframe for completion of the outcomes. That is not a criticism of the National Office for Suicide Prevention but rather of us as politicians.

The Health Research Board published a document entitled Document No. 7 which included a rather depressing and dispiriting statement. It stated that when it comes to basing our policies on empirical evidence or basing it on political expediency, political expediency always wins out.

I hope all these issues will be addressed in the national framework. I acknowledge that my view that suicide prevention should be moved away from its connection with mental health services may seem counter-intuitive but hopefully it will create a debate.

I will speak again to the stakeholders and include more national organisations. I will amend this paper accordingly to include some of the suggestions made at this meeting. I will attach the deliberations of this committee and the evidence of the witnesses to an amended document which will be circulated for further public consultation. I hope the committee will oblige me in a few months' time by giving time to discuss the final report. I thank the witnesses for their attendance. I am very impressed with the level of thinking, which is excellent and very hopeful for the future.

Vice Chairman: I invite Mr. Raleigh to respond to some of the points raised.

Mr. Gerry Raleigh: I will do my best. I will deal with the points in sequence and my colleague, Ms Susan Kenny, will help me.

I refer to the issue of emotional literacy raised by Senator MacSharry and Deputy Conway. As a parent of teenage children it is one of my concerns. I worry about how well they are being prepared for life and whether they have the skills to go beyond school and step out into the world. We agreed the framework guidelines for schools with the Department of Education and Skills. I agree with Deputy Mary Mitchell O'Connor about the home being the primary nurturing base and the space where people learn most of their life skills. After that, in the case of young people, school is the most engaging environment and it is where young people spend their lives. We need to exploit school as a place where people attain more than just academic capacity. Equally important is their emotional development and second-level schools have a framework for this to happen. I refer to exciting developments in curricular approaches at primary level with programmes like Zippy and Zippy's Friends and two or three other teaching methodologies used at that level. It becomes trickier in second-level schools because of the dramatic increase in the challenges, demands and pressures on young people. We envisage a triangular approach including the use of programmes like Beat the Blues and other programmes in schools in order to equip everyone in the school with a range of skills and capacities.

The second layer is called, Something for Some, which is for young people who are beginning to experience difficulties and who need extra support. Usually the best guides in this respect are the teachers but also classmates or the people in the school community who may spot someone who used to be very keen on football or dancing or music but has dropped those interests or perhaps there is a deterioration in his or her homework. Sometimes the relationship between school and parents is not as open and robust as parents might wish. This is often more down to the parents than to the school. It is a question of how to bridge that gap. At the top of the pyramid is crisis support for children in distress. Most usually we defer to CAMS, child and adolescent mental health service, for that level of input. This service has made progress.

Its recent report indicated that the staffing of CAMS teams, while still only 50% of optimum, is going in the right direction but there is more work to be done.

At the middle level we have been working with partner agencies such as Jigsaw. These agencies open their doors to schoolchildren and are very supportive and nurturing. I have seen some excellent examples such as Jigsaw groups in Galway, Navan and I helped to establish a Jigsaw group in Tullamore. The numbers of young people walking through the doors are good. We are building a support system. That is a long way of answering the question that I agree absolutely that the issue of emotional literacy for young people has to be a priority and we need to address it in very concrete steps in the new national framework.

I was asked how has Scotland achieved progress compared to our apparent lack of progress. We have been to Scotland and to the UK and we have set up a forum with our colleagues from the UK. Professor Steve Platt from Scotland visited us a fortnight ago to advise us on how best we should approach the development of a new framework and to tell us what Scotland has learned. Two aspects stand out in my view and this is without prejudging the strategy. The first is local implementation and how national policy is translated into local action. There are a couple of examples in Ireland modelled on the Scottish approach through local implementation plans. For example, in Waterford, Donegal, Kerry, Carlow and Kilkenny, there are slightly different approaches to local implementation planning and we are attempting to standardise the mechanism for delivery of service. This is following the example of Scotland. The second aspect from Scotland is the approach to alcohol which would appear to be the elephant in the room over all our discourse.

Deputy McLellan asked if there is sufficient resourcing. There are never enough resources. We have a budget of almost €9 million this year. I might bite my lip saying this but I believe we have sufficient resources for this year to do what we need to do.

In terms of the future, the platform is around the new national framework, which I believe should set out clear targets and points of delivery in terms of what we will do so that we can say to the man and woman in the street that, in terms of suicide prevention, these are the services we will deliver in their community, this is how we will resource them etc.? We have learned from Reach Out, which was mentioned. That was an excellent document of its day and we would embrace and bring forward many of the principles that underlie Reach Out but we must be much sharper in terms of what we intend to do, who will do it, who will resource it, what it will cost and how we will monitor its effectiveness. We see the timeframe for a new framework as being four to five years. Our expectation is that we will deliver it in November, although there is a lot of road to be travelled between now and November. We will have a much surer point of view in mid-summer on delivering it but that is our objective, and we are confident we will achieve it.

In terms of how we will arrive at that point, today is an important part of our discussion. We want to open the discussion as widely as possible without having the capacity - we are not sure of the value - of travelling across the country with a blank sheet, so to speak. We know enough in terms of where the priorities lie and how we approach that but we are trying to design an engagement process, which will involve the community and the sector, in terms of agreeing a new framework.

The issue of stigma was mentioned. On a personal level, I have read the See Change evaluation, which shows that we are making progress in terms of stigma but as a slightly beyond middle aged man, I know the challenges in terms of the discussion about mental health with my

peers and while there has been some improvement in that regard, there is still an issue of stigma, particularly for men in terms of opening up about their emotional literacy and welfare. We have a further journey to go in that regard.

On whether there are too many agencies, I genuinely believe that the response to dealing with suicide requires everybody putting their shoulder to the wheel. Everybody in every community has a role to play. There are probably too many agencies. Agencies often arise locally in response to local tragedies but often have a very beneficial impact on the community in that they provide a forum for people to come together and support one another at a time when they are in distress. From a community point of view, therefore, they have their purpose.

Sometimes we see agencies drifting into areas of therapy provision, which would worry me. I heard Deputy Neville speaking on a radio programme last Sunday about the issue of regularising, overseeing and quality assuring counselling services. I strongly endorse that view, and we need to examine a platform for doing that, be it legislative or whatever is the best approach.

On whether there is an issue for men in the 15 to 21 age group raised by Senator Burke, I will defer to Dr. Justin Brophy to give a clinical perspective. Every death by suicide shakes us but most particularly the death of young people who have their lives in front of them. What brings a young person to that space? It is difficult to understand and very difficult to rationalise. As we mentioned earlier, generally, there are multiple issues involved. It is very seldom one causative factor and therefore we need to look behind that.

Deputy Jerry Buttimer resumed the Chair.

Dr. Justin Brophy: I thank the members for the opportunity to address some of the points raised.

In terms of the emotional literacy question, that is an important issue, particularly among Irish boys. The University of Limerick has done some work on single sex schools being an influence on whether boys develop emotional literacy contemporary with girls or whether mixed schools do better in some cases. There is some evidence on that. On its own, emotional literacy is not sufficient. There is emotional competency and emotional mastery also. There is a lot to be said for experiences in childhood that give children the capacity and the experience of dealing with difficult emotions. A little hardship and a little positivity combine to make resilience, and we have to factor that in somehow. Areas such as mindfulness increase our capacity to be emotionally in control, and we could do much more in terms of investing in and developing that.

On the Scottish programme, Mr. Raleigh has spoken to that already but the point is that it is programmatic in that it has defined, unambiguous objectives, ambitions and actions. That is the problem, but the next iteration of Reach Out will be much more like that. The Scottish do their health programmes very well but they do it in a very systematic way. It is not a figment of under-reporting or misreporting. They get it, and they do it. Alcohol misuse is central to that, and I will mention that later in regard to those aged 16 to 18.

In terms of the availability of services and medical cards, much more could be done about the availability of personal medical cards for people with mental health difficulties. There were such schemes in the past but the member is right that it is an issue.

Regarding eligibility for services, the squeezed middle are the people most in difficulty in that they do not have eligibility and they do not have the finance to seek and avail of services.

That local flexibility around schemes has reduced. There is a much greater and more tightly controlled environment around that. That could be relaxed. As the economy improves, I hope we will see that it might.

I cannot speak to the experience in terms of the coroners. In terms of earlier determination, and this speaks to Senator Gilroy's question, the Suicide Support and Information System, SSIS, and so on, determining suicide for research or a health policy is an important and different purpose from a legal point of view in terms of cause of death. We can be more proactive in earlier determination of likely suicides but it is a question of language also. It may be that we do not have to determine them as suicides in the legal sense but we could be creative in our language around that.

In terms of stigma, I cannot comment on the benefit of the See Change programme. In terms of the experience of use of services, unfortunately, that is a commonly echoed experience of people approaching mental health services. With the national clinical programme in self-harm, which has yet to be launched but is imminent and is a collaboration between the Health Service Executive and the College of Psychiatrists and the accident and emergency departments across the country, we will see a much more consistent, proactive and perhaps post-crisis approach being taken to people presenting with self-harm crisis. That programme will make a big difference but we still have very scarce resources in front-line mental health service. In terms of the physical quality of the buildings and the personal quality of the experience, much needs to improve but that should not discourage people from availing of service, which is often compassionate, helpful and effective. We should not lose that message in the criticisms.

I do not have a comment on the number of agencies. In terms of the quality assurance of counselling, it is clear that much of the counselling provided by some of the agencies is of a very high quality but the consistency is a problem. There is not a standard. While the Irish Association of Suicidology, IAS, document speaks to accreditation, there is no assurance of quality in counselling services at present. It pertains to the licensing and regulation of counsellors as well but in the next iteration, I expect that issue to be raised and perhaps addressed. As for a singular approach to suicide, that speaks around the notion of a single agency. We only have had a single agency with responsibility for suicide in recent years. Its singular authority and mandate to deliver in this area will increase as it is expected to deliver not merely on aspirations but on actual results. I have confidence in the agency's ability to deliver in that way, given an opportunity to develop a singular programme in the context of a wider policy development.

As for measures to reduce the incidence in respect of 16 to 18-year-olds, binge drinking in that age group probably is the single most important risk behaviour for self-harm and other forms of accidental death. I believe we still have not merely an ambiguous attitude but an extremely wanton approach to the State-sponsored encouragement of drinking sprees through extensions and State-sponsored festivals at which 18 to 30-year-----

Chairman: How can Dr. Brophy suggest it is State-sponsored when it is-----

Dr. Justin Brophy: Every extension requires a court judgment.

Chairman: That not the State but is a separate arm.

Dr. Justin Brophy: Even in the very idea that the licensing laws can be used in that way, the State does not appear to perceive there is a necessity-----

Chairman: Does Dr. Brophy suggest we should have no festivals with extensions?

Dr. Justin Brophy: No, my point is the conditions under which extensions are granted must be policed and the consequences of the excesses such extensions create must be considered in making those extensions. While I do not wish to be the party pooper here-----

Chairman: Is Dr. Brophy suggesting the judge or Garda superintendent who signs off on such matters does not consider all the criteria?

Dr. Justin Brophy: The evidence indicates that is the case, yes. Not in every case, as there are many responsible judges and many responsible superintendents, but there also are examples of pretty excessive dispensation being afforded in this arena.

To return to the growth in alcohol from 1960 up to the present in Ireland, we went from the lowest consumption per head of population in Europe to the highest. This largely was contrived through licensing extensions, which create the circumstances of excessive drinking in respect of young people and in women, who prior to that point did not drink. This has been how licensing has been exploited and used to extend the availability of alcohol into sectors of the population that did not previously drink.

Chairman: What does Dr. Brophy have in mind in respect of licensing extensions?

Dr. Justin Brophy: Extensions must be-----

Chairman: Can Dr. Brophy be definitive in respect of what he means and can he be descriptive?

Dr. Justin Brophy: What I mean by that is where one officially sanctions drinking in a pretty untrammelled way until 3 a.m. or 4 a.m. by an entire community and its attendant visitors. I mean where one sanctions this for between two and seven nights in a row without imposing conditions in respect of policing, the serving of intoxicated persons or other limits. This must be policed very closely.

Senator Colm Burke: Dr. Brophy has referred to binge drinking and one of the worst days for this activity that I have witnessed is Arthur's day.

Dr. Justin Brophy: Absolutely, yes.

Senator Colm Burke: Is there evidence that there is an increase?

Dr. Justin Brophy: That is an interesting question. I have not heard that question raised previously as to whether there is an immediate post-binge increase but every mental hospital, police cell and community knows what are the actual social consequences in the week after a drinking spree.

Senator Colm Burke: It would be an interesting piece of research.

Dr. Justin Brophy: Yes, it would.

Deputy Mary Mitchell O'Connor: Dr. Brophy mentioned women and I ask him to clarify that point.

Dr. Justin Brophy: Effectively, women were non-drinkers in Ireland in 1960 in respect of any significant population consumption. Consequently, the drinks industry was obliged to create a market of drinking among women to increase sales, which is what drinks companies do. I drink myself and am not anti-alcohol but by promoting the consumption of alcohol in women to

the extent it has by changing the social circumstances, the drinks industry increased the amount of alcohol consumption among women exponentially. The consequences of this are measurable in respect of the death rates by cirrhosis and cancer in women as a result. The link with suicide is less clear, as it is clearer in men.

Deputy Mary Mitchell O'Connor: Members heard earlier that older and middle-aged woman were taking their lives to a greater extent. I do not know whether they are drinking in the clubs.

Dr. Justin Brophy: This is an issue for older persons in general.

Deputy Mary Mitchell O'Connor: This morning, the point was specifically made in respect of women.

Ms Susan Kenny: In response to Senator Burke's question, the National Office for Suicide Prevention carried out some research last year in conjunction with the National Suicide Research Foundation and Professor Ella Arensman. She found that the level of presentations related to self-harm in emergency departments in which people present with alcohol in their system is highest after the bank holiday weekends.

Chairman: That is not necessarily linked to the licensing law.

Ms Susan Kenny: No, but she has been able to demonstrate this, particularly among a younger cohort.

Deputy Ciara Conway: Bar extensions are often granted at bank holiday weekends.

Chairman: Given everything that has been heard at this meeting, it is important that the joint committee should send a message expressing the hope that the use of alcohol over the weekend marking the St Patrick's Day festival will be moderate. Moreover, it is to be hoped the exploitation that has happened in the past in respect of Arthur's day and other events will not take place and the image of Ireland abroad and at home will not be one including a pint or a bottle of beer but should be about culture and music. I urge people to watch the video produced by the Department of Foreign Affairs and Trade on what it means to be Irish. It provides a very good image of how we should be projected.

Senator John Gilroy: On that point, it might be worthwhile for the message to go out that providers of alcohol might take a particularly responsible attitude towards the serving thereof this weekend.

Chairman: We have been digressing. I am conscious that Dr. Brophy has been on his feet for 12 minutes.

Dr. Justin Brophy: The primary instrument of State regulation in this regard is the number and extent of extensions granted. Aspirations are not sufficient if the quantum of extensions is not addressed.

The last point in respect of 18 to 30-year-olds is that the health seeking behaviour of 18 to 30-year-old men must be changed in a way that makes them seek services. This perhaps is best achieved through peer networks and the Mind Ur Buddy programme sponsored by Pieta House is a very good example of where peer networks in people's existing communities are the primary access and route into support. It is a highly commendable example of a perfect way to try to improve this.

Chairman: I thank Dr. Brophy and invite Ms Freeman to respond.

Ms Joan Freeman: I wish to comment on three statements. First, I wish to address Deputy Conway's question on the reason there is not a united approach. One must imagine that all the agencies dealing with suicide, whether it be prevention, intervention or postvention, are all scrambling for the one pot. There is no cohesion whatsoever and one agency battles against the other. If one thinks about the sum of €8 million, I note it will cost more than €4 million to run Pieta House this year. We get 10% from the National Office for Suicide Prevention, that is, between €300,000 and €400,000, and the rest is given by the public.

Chairman: Why is that battle taking place? As Deputy Conway and others have rightly noted, the bottom line is to reduce death and self-harm. Consequently, why is this intense battling taking place?

Ms Joan Freeman: It is because they are trying to save lives but cannot so do without resources. In fairness, each agency truly believes what it is doing will make an impact.

On the question of there being too many agencies, I do not believe this is the case. There are between 350 to 500 agencies nationwide, ranging from someone who is trying to befriend a person who is in distress to organisations such as Pieta House. As Mr. Raleigh pointed out, the reason they are there usually is as a response to people's own personal events. They believe they can make an impact. In addition, they also are all that is available in many country areas and consequently are very valuable. However, they are being completely ignored and their energy is not being drawn on. There is no directory of these agencies either.

Chairman: Why is that? Surely in a modern, sophisticated world with IT, that could be done relatively easily.

Ms Joan Freeman: I would like to finish my answer first before responding to that. Senator Gilroy pointed out that there is no directory of agencies. This has been requested by the NOSP for several years. I know that-----

Chairman: I will just bring in Susan Kenny on that point.

Ms Susan Kenny: As part of the new national mental health awareness campaign under the programme for Government, the office has been given a resource to develop an online, one-stop shop for services. The previous criticism was that when awareness campaigns were run on television, radio and in cinemas, there was not one website with a directory of services for people to go to. In November the office commissioned a national mapping of all suicide prevention services, which is being carried out on a county by county basis. We have completed the first part of that project and have identified 1,200 agencies. Those agencies, it must be noted, include statutory services such as the MABS and every Console office is an individual contact point within that directory. We hope to sort the services based on what they do. Some services, as Joan says, provide intervention while others provide befriending and so forth. Once we actually categorise the agencies in terms of services they offer, we will be able to develop an online system which will allow people to search for the service they need in their local area. The fundamental point is that people need to have choice. At present, the database does not include the statutory services. We still have to map our own mental health and psychology services. That work-----

Chairman: When will that work be completed?

Ms Susan Kenny: A new campaign will be launched in September. The website will have a soft launch in June and will be available to the public by September.

Chairman: Thank you. Apologies to Ms Freeman for interrupting.

Ms Joan Freeman: The caveat is that such a directory will only be available to those who can go online. We have just sent a booklet out to 90,000 farming families because only 20,000 of them can go online for information.

Chairman: Which families received the booklet?

Ms Joan Freeman: Farming families, approximately 70,000 of whom do not access information online.

To return to the issue of male suicide, we were not consulted in this. Last year more than 4,000 people came to us and we were able to ask them why they attempted suicide. We discovered, although we should have known already, that most men will not ask for help. We have got to accept that fact. Regardless of what type of campaign is run urging people to let someone know about their difficulties, most men will not ask for help. We devised a campaign called "Mind Our Men". While alcohol is most definitely a risk factor, we have found that there are two main tipping points for men which may cause them to attempt suicide. The first is employment issues, including retirement, unemployment, business failure and so forth because for many men, their job is closely tied up with their identity. The second tipping point is the loss of a significant relationship. As men get older, they rely on women more and more for emotional support and when that is lost, they find it extremely difficult.

We are talking here about reducing male suicide. As I have said earlier, by this time next week, ten more people will have died by suicide, eight of whom will be men. If we want to reduce male suicide, which is what we should be concentrating on, we must promote the mind your body message, the Mind Our Men message and make everyone aware of the signs of distress and potential suicide. I am thinking here about that wonderful campaign about stroke. Everyone knows the signs of stroke now and we are trying to ensure that everybody knows the signs of suicide. The stroke awareness campaign is not aimed at the person who is having a stroke but at the people around him or her. We must try to teach everybody the signs of suicide so that they can spot the person who is in distress.

Deputy Mitchell O'Connor asked where she should go if one of her constituents is suicidal. She now knows that she should direct her constituent to Pieta House. We are in Dublin and are open seven days a week, including bank holidays. We specialise in suicide and crisis intervention. Deputy Conway made reference to the need for a united approach. It is terrible to see an office like the NSOP having to try to juggle. It is supporting 31 agencies with a budget of €8 million and only ten staff. The Road Safety Authority, on the other hand, has more than 300 staff.

Deputy Ciara Conway: It also has a budget of €41 million.

Ms Joan Freeman: Yes. The RSA has a budget of € 41 million. We are talking about lives here. This Government created the new Department of Children and Youth Affairs, with Deputy Frances Fitzgerald as Minister. She is the Minister with responsibility for children but we need a Minister for life. That should be a priority. The acting Minister for life or Deputy for life is Deputy Dan Neville. Thanks to him, we have had our laws changed and suicide is no longer illegal.

Chairman: I now call Mr. Dominic Layden.

Mr. Dominic Layden: I will try to deal with the questions from Senator MacSharry and Deputies McLellan, Mitchell O'Connor and Neville. Several references were made to emotional intelligence and questions were asked about our education system in the context of suicide prevention. I believe that the goal of our education system should be to equip our children for life. When they come out of the formal education system at 18, the issue should not be whether they got 600 points in their leaving certificate but whether they are able to deal with the challenges that life brings. Those challenges will include relationship breakdown and changes, multiple career choices, financial insecurity and so forth. It is a bit late to be learning the skills to deal with such challenges in mid or later life or, as with many people, when a crisis emerges. Our education system should not be just about points. Our education system, from primary level and through secondary level, should be based on the principle of giving kids life skills that will last them for life.

On the issue of emotional intelligence, the programme we run is based on a cognitive behaviour therapy, CBT, model. We talk to kids about their thoughts, feelings and the actions they must take. We do not talk about suicide or the negative side of things. We try to help them to develop coping skills that are relevant to what is going on in their lives. A 15 year old who did not make the first team in rugby is asked how he felt when he was not selected. The child who does not know who to invite to the debs dance is asked how she feels today. These are the issues that young people are dealing with and we want to them to understand how their thoughts are connected to their feelings and to know what actions they can take to deal with problems that arise. That programme is going on in our schools today but the problem is that it is only reaching about 50% of all secondary schools. Interestingly, a very important organisation that is not represented at today's meeting is Tesco. The programme I have just described is actually funded by the private sector. We have received over €2 million in the last two years from a private company. It is funding an education programme for secondary school students. We are reaching approximately 50% of secondary schools but if we had more money, we would be able to reach the other 50%. I am not saying that a training programme over a double-period class explaining the coping triangle, the symptoms of depression and the differences between anxiety, stress and depression is going to solve every child's problems. I agree with Deputy Mitchell O'Connor that it starts with the home, but we also have a responsibility. The Department of Education and Skills has a responsibility. This is not merely a health issue; this is an education issue. The Department of Education and Skills has a responsibility to ensure that our children have those skills. At present, the SPHE programme finishes when students reach 15 years of age. The reason we are going into the schools is because the schools are asking us to come in.

When we go into the schools, we have professional trainers who go in to deliver. We used to have volunteers who might have come in and given their own personal experience. We stopped all of that. We ensure that it is a standardised programme that they are delivering and we independently evaluate those. There is an inspection that goes on with all of those trainers to ensure that they are delivering the content that we have asked them to deliver.

If one sits in the classroom, it is interesting to hear the children and the questions that they ask. They ask relevant questions. One might be surprised to hear them. In many cases, they are actually quite well informed about depression and mental health. More often, we hear they are aware of it because of what is going on in their families. One will hear a question asked about what is going on in the pupil's family or an example of something. They are quite well aware that if there is a relationship breakdown, financial pressures or the loss of a job in a family, it

has an impact. That is what we are here to do in our education programmes.

The second question related to stigma. Many come to organisations, such as Aware, Console and Pieta House, in times of crisis and we deal with the individual at that point in time. Since Aware was founded 29 years ago, and the other organisations that are here were founded, there have been massive changes in perceptions of mental health in Ireland. It has changed significantly. Earlier mention was made of the change in the law, but a variety of changes have taken place. However, there is one area that has probably been neglected, that is, the workplace. It is important to recognise there is a growing trend. If one watches companies, particularly the foreign multinationals coming into Ireland, they will have wellness programmes, and these are connecting diet, mind and body. One will find there are a number of organisations that have wellness managers operating. They are coming to us asking what training we can give their managers and HR staff, and what we can provide to their employees, because there are plenty of staff in their work environment who are experiencing severe stress from career change and additional work pressures. We are responding by trying to deliver programmes to the workplace. I believe that as we do that, as we engage in the workplace environment, it is another way of trying to reduce the issue of stigma.

The final point I would make is this. I believe there are too many agencies. I fully respect how in agencies and among individuals, when a tragedy occurs in a local community, there is a natural response. I fully accept that. However, there is an issue. The State has limited resources. There is austerity. Obviously, the Government is working in a challenging environment for the next few years. The private sector is funding a lot of this stuff. I mentioned at the beginning of the presentation that when one asks what organisations the public thinks about first in mental health, the public thinks of organisations such as Aware, The Samaritans, Pieta House and Console. That is where the people come to first. That is not in any way to speak ill of the State or to cherry-pick. That is where the people go when they have an issue. That is where we are called in. However, as for where we fund it, 92% of our funding comes from the private sector, which I am sure is like a lot of other organisations.

Mr. Ciaran Austin: Given the nature of the complex topic, I am sure many committee members will probably go away with more questions than answers.

I will not reiterate what has been said already and will focus on two of the questions that came up. The first was on the number of agencies and the united approach. I suppose we would have a similar view to that expressed here. In principle, there probably are not too many agencies because each of these has been born out of a need for something specific. From the outside, the members of the public, until suicide visits their door or until the crisis occurs, do not know the intricacies of what is provided by the little community agency on the street corner as opposed to Aware, Pieta House, Console and The Samaritans because they just know that something bad has happened and they need to reach out for help. That is when the panic comes in and the crisis occurs, and who can one blame them? As for whether it is realistic to ask of we need to educate the public as to the range of supports and services available, there is probably some need for that but until it comes on the doorstep, one is not likely to go and investigate it. The registry proposed with the national office will be a considerable help.

One area where we need to adopt a more united approach is in the public messages about suicide. The difficulty with charitable organisations, such as ourselves, is that we are continually balancing the demand to provide and extend a service to meet demands with the other demand to get resources in and to fund-raise. That is a most difficult balancing act. We must be cognisant that there needs to be a united voice on suicide because the noise around suicide

can be quite unhelpful at times as well. Perhaps that is where we would see the national office taking on a strong leadership role as well.

Deputies Neville and McLellan both asked about the Coroner's Court and about the lack of consistency there, and asked is there a way to provide earlier statistics taking away those forms. I do not have a simple answer as to an alternative method. I am aware that there is a severe lack of consistence in the coroners' courts across the country. In many cases, coroners seem to do what they like. Some coroners are sensitive and take parts of inquest hearings in private. Others make them public and encourage them to be public. Some invite members of the media in to inquest hearings. I would even go so far as to raise the question - do we really need an inquest in the case of suicide? Obviously, there is a legal obligation and the investigating authorities need some kind of certainty as to the cause of death, but, in my view, the inquest procedure for suicide is a bit of a hangover from the days when suicide was a criminal act and it still has that feel about it. Nowhere are the needs of the bereaved family central to the process. There must be a better way. All we are doing through these difficult processes is re-stigmatising the family who have experienced this loss and, often, re-traumatising them as well.

Chairman: I thank everybody, in particular, Mr. Austin, Mr. Layden, Ms Freeman, Dr. Brophy and Mr. Raleigh, for being here this afternoon. Before I finish up, I call on Senator Gilroy to make brief final remarks.

Senator John Gilroy: I thank the Chairman for facilitating these two sessions today. It was tremendously useful in what I am proposing to do. I thank the witnesses for coming in. Their comments, constructive and otherwise, are more than welcome. As I stated earlier, the milieu in which good ideas arise is when there are conflicting views being thrown forward. If we all agreed on everything, we would have a perfect service, and we are very far from that. I thank them very much.

Chairman: I thank all of our viewers who have been watching on UPC on Channel 207. The most important message that we leave today for them is that our public messaging must be positive, we must be united in our response, there is a need for all of us to engage and to talk, and there are organisations available to help. After the meeting, we will put up on the Joint Committee on Health and Children's website the organisations which were here today, plus The Samaritans, and their contact details. It is important that we are united in our messaging and that we engage properly on this. Beannachtaí na Féile Pádraig oraibh go léir.

The committee next meeting, our quarterly meeting with the Minister for Children and Youth Affairs, is at 9.30 a.m. on 27 March.

The joint committee adjourned at 2.10 p.m. until 9.30 a.m. on Thursday, 27 March 2014.