A Fianna Fáil Policy Document on Suicide Prevention
Foreword

The loss of life through suicide is annually responsible for the equivalent of the loss of the population of an entire village. In preparing this policy paper we identified the necessary measures that are required to place Ireland on the correct path to successfully deal with this issue.

In the preparation of this policy, our starting point was not one of blind political opportunism which proposes to design a solution to our nation’s silent crisis. Rather, it is an admission that the legislature is responsible for providing the correct structural environment and the necessary resources to those experts who are competent and qualified in the relevant areas to make a real difference.

Throughout the entire country there is no doubt that there are many professionals, volunteers, state agencies and non-governmental organisations specifically involved in doing very good work in fighting this battle. In isolation, this is fantastic and has helped.

However, the statistics sadly speak for themselves as we continue to lose the fight against loss of life through suicide.

There needs to be a coordinated, appropriately resourced structure and agreed multi-faceted strategy to unite those engaged in this effort so that we can achieve the necessary results.

*Actions Speak Louder Than Words: A Structural Approach to a Societal Issue* is Fianna Fail’s outline of how we must provide the correct structure and resources to the professionals and volunteers who are best placed to design a penetrative national strategy.

Only then will it be possible to begin to peel back the blindfold on the deadly phenomena of suicide. Ireland needs to take positive actions to decrease the scourge of suicide. Our research clearly shows that with the right approach success is certain as our Scottish cousins have shown in reducing suicide by 16.7% in eleven years. Fianna Fail’s *Actions Speak Louder Than Words* hopes to provide the experts with the structure and resources to ensure that Ireland can follow suit. There is light and hope ahead, so let’s make a start.

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Senator Marc Mac Sharry
SEANAD SPOKESPERSON ON HEALTH
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Acknowledgements

There are simply too many individuals who contributed to this policy to summarily name. The quality of response attained from our survey, coupled with the quantity of forthcoming individuals offering their advice, opinions, and support was overwhelming, and for that, we are sincerely thankful.

Additionally, to the individuals who bravely shared their personal experiences, the people went out of their way to accommodate us, and to those who graciously took time out of their working days to express their opinions in the interest of making a meaningful policy, we are equally indebted.

Specifically however, I would like to extend my deepest gratitude to the following: Bryan McCann, Brian Mooney of the Institute of Guidance Counsellors, Claire Hayes of Aware, Cora Garvey, Noel Smyth and Lisa Alford of 3TS, Paul Kelly of Console, Seamus Sheedy of the Irish Association of Counselling and Psychotherapy and finally, Suzanne Costello of Samaritans.

Additionally, I wish to extend a personal thanks to Cllr. Deirdre Heney B.L. and Tracey Flinter for their contributions made to all aspects of the policy's formulation.

To conclude, I would like to highlight the tireless contribution and initiative of Colin O'Donnell who was so dedicated with his time and energy in the preparation and formulation of this policy document. His fresh, energetic and youthful approach has proved invaluable in ensuring a well-researched, innovative, informed and credible position can now be put forward by Fianna Fail on this most sensitive and difficult issue. We believe our approach as outlined is correct and in practice will make a real difference.
Key Proposals

For a full list of proposals, and the rationale behind them, please see sections 1-8 of Part II. The following are some of the key proposals made in this policy:

- Reform and Restructure the National Office for Suicide Prevention (NOSP) as an independent Office with special status, a ring-fenced budget, performance targets and an independent employment system, with clear inter-departmental input at government and secretary general level.
- Enhance the size and role of the NOSP to undertake matters such as the development of a new national strategy and the creation of a national 24-hour helpline.
- Increase the number of Resource Officers for Suicide Prevention, enhance their role, and link them directly to the NOSP.
- Adequately Resource all GPs to provide comprehensive help to individuals at risk of dying by suicide;
- Implement a system of GP practice whereby the prescription of anti-depressant medication has to be reviewed on a monthly basis until the GP is satisfied that medication is the best course of action.
- Establish out-of-hours emergency social worker teams across all of Ireland.
- Reverse the Government’s decision to abolish dedicated Guidance Counsellor time allocations for Secondary Schools.
- Introduce SPHE into the Senior-Cycle in Secondary Schools.
- Introduce Guidance Counsellors for Primary Schools.
- Regulate the professions of Counsellors and Psychotherapists via mandatory registration to a statutory body for Psychological Therapy.
- Phase out advertising and sponsorship of events by alcohol brands that may be deemed to specifically target young audiences.
- Consider alcohol and substance abuse as a form of self-harm, and to be treated appropriately.
- Increase the funding dramatically to projects aimed at preventing the rates of suicide for all sections of society, especially the high-risk areas such as middle-aged men and young adults.
- Compel banks to provide for professional counselling to patrons in heavy mortgage arrears, business or personal debt at risk of foreclosure.
- Implore all forms of media to take a more responsible role in the coverage of suicide, adhering to media guidelines on the subject.
Introduction

The alarming rate of suicide in Ireland has been an incredibly serious issue that has robbed many parents of their children and children of their parents. Essentially, the population of entire villages are being wiped out annually, despite the best efforts of frontline staff, charitable organisations, psychological therapists, the HSE, its Resource Officers, and the National Office for Suicide Prevention (NOSP).

Over the course of 40 years, the prevalence of suicide has been rising steadily. By 2009, Ireland tragically saw a record high of 527. This unprecedented figure was to repeat itself in 2011, indicating that the current stance being taken to adequately address the crisis is simply inadequate to sufficiently address the task at hand. Approximately 80% of registered cases are male, which suggests that men in particular, are being failed by the system. It is estimated that 450,000 people are suffering from depression at any one time, while the use of sedatives and anti-depressants has increased by 40% in the last five years.¹

It is no coincidence that these striking figures coincide with the onset of the global economic crisis and the subsequent recession. For middle-aged males, unemployment, social change, severe financial strain and the threat of losing their homes has undoubtedly taken its toll. At the same time, young people are suffering from the aftermath of budgetary measures, such as the cuts to guidance counsellors, the reallocation of mental health funding for HSE deficits, and the insufficient resources being afforded to the National Office for Suicide Prevention.

While it is understandable that the state may be hesitant in committing resources to a sector with little short-term apparent gains, it is simply unacceptable how a nation of our GDP and economic standing continually scores amongst the highest in suicide rates. At present for example, Ireland currently has the fifth highest rate of male suicides aged between 15 and 29, while overall, Ireland has struggled to remain on par with the European average over the years. Remarkably, we fall short of the United Kingdom’s relatively low rates in every criteria.

Ideally there should be an all-party approach to tackling suicide. In 2012 for example, despite all the hopeful promises and budgetary resolution to increase both mental health and NOSP funding substantially, this failed to materialise as the ring-fenced money was reallocated into the HSE to reduce the budgetary deficits it had accrued elsewhere.

This is not to be overly critical of the current government. Indeed the apathy to this issue has been systemic of all governments, who have also diverted mental health funds for deficit purposes. Indeed the entire political system of Europe has failed in this area. As a European Commission report scathed:

“Despite the acknowledgement of prevention and promotion by politicians and policy makers, the priority of mental health promotion and mental disorder prevention seems to be lower when it comes to translation of words into action. Mental health experts across countries rated promotion and prevention as being a low priority and mostly rhetoric”.\(^2\)

It is time to abandon rhetoric and adopt a genuine and meaningful look at the present approach to suicide prevention.

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Methodology

This policy is the culmination of several months’ research, discussion and deliberation. Our initial stages involved exhaustive research on our part, drawing on pre-existing policies, reports and studies. We examined the structure of suicide prevention from every aspect, highlighting potential systematic problems, and outlining very preliminary suggestions as how to potentially rectify the situation.

Finally, we met with key personnel involved in suicide prevention, including heads of suicide prevention organisations, and individuals who had unsuccessfully acted on their suicidal ideation whose unique experiences proved invaluable.

Having ascertained both the qualified and experienced opinions of individuals specialised on the subject, we highlighted specific shortcomings within various industries and sectors, accountable for the present state of suicide prevention.

We then sought a comprehensive idea of how effective the provision of assistance in the avoidance of suicide is, as well as how help is dispersed based on locality and population. Thus we decided to conduct a sampled survey.

The survey was comprised of a range of questions aimed at ascertaining the perceived ability of specific individuals and organisations to adequately provide the best assistance to individuals at risk of dying by suicide.

Seeking a balanced sample of low to high populous regions, urban and rural settings, and equal representation of Irish regions location-wise, we decided to use a varied range of cities and entire counties of differing sizes and locations as our samples.

Accordingly, we sent tailored questionnaires to the sectors least accounted for in pre-existing research; that of Garda Stations, Secondary Schools, Community Centres, Youth Clubs, Suicide Prevention Organisations, Counsellors and Psychotherapists.

Given the trends that emerged from our questionnaire, we feel that our survey is a reliable representation of the opinions of the industries.

Much additional advice and follow-up details were voluntarily provided in the responses, leading to further communication with many principals, counsellors and psychotherapists. Their help and the responses of the survey in general, greatly informed our process.

In the final stage of our process, drawing on our pre-existing conceptions combined with the information attained from the survey and follow-up communications, we revised our initial list of problems and suggestions to formulate a supplementary policy. We then met and presented many of our findings to appropriate key individuals involved in the education, psychological therapy, and of course, suicide prevention sectors. With their input our policy was again revised to the final proposal presented here.
Suicide Prevention in Ireland
Suicide Prevention Organisations

Successive governments have placed an overwhelming reliance on Non-Governmental Organisations for the provision of suicide prevention services. Charitable organisations cover the country and provide an informal, non-institutionalised, friendly, and often lifesaving service to the public at an extent that psychiatric wards could never match. To assist them in this endeavour, the National Office for Suicide Prevention provides some organisations with funding to help them in their work.

Unfortunately, financial constraints result in relatively limited funding being afforded to these organisations. 85% of organisations that we surveyed reported that fundraising occupied a significant amount of their time, with all respondents claiming that they had a reliance on fundraising. The larger organisations are particularly reliant on fundraising. Both Samaritans and Console, for example, receive only a fraction of their annual budget from the NOSP. As a result, the key services that they provide, free of charge, are offered on the provision that they appeal to the public’s charitable tendencies. It is our opinion that leaving these organisations to struggle to provide a service in which the government has such a reliance, is unacceptable and needs to be changed.

FIGURE:3

A common thread amongst the discourse we found throughout our research, survey, and communications was the prevalence of smaller charities dedicated to the prevention of suicide. Many charities are established as a result of individuals losing an immediate family member to suicide, feeling that the services must have been lacking, and thus setting up their own service. While all of these organisations have the best intentions at heart, occasionally they may be providing superficial or unqualified support.

More frequently however, is that in establishing an organisation in an effort to help, independent of any national strategy, they provide services that may duplicate, or at least divide the provision of scarce resources, while other organisations offer the same services in the same area, where perhaps bereavement or other services are not provided.
Finally, up until very recently, it was much too easy for an organisation to attain charitable status. It is possible thus, that some agencies may have sadly formed to access the money ring-fenced for mental health charities and while well intentioned, are arguably doing little more than creating a job for themselves. Again, it must be stressed that these charities are in the extreme minority, and that the vast majority of volunteers and organisations within the service are incredibly hardworking, dedicated and critical to the success of suicide and self-harm prevention.

It will not be until the establishment of the Charities Regulatory Authority, as outlined in the Charities Act, 2009, that the state can begin to investigate the intentions and performance of existing charities, as well as seriously limit the registration of new charities without a defined need together with their undeniable capability.

Additionally, statutory regulation will also ensure that services are efficiently streamlined and the number of people and duplication in administrative function in these organisations is kept as low as feasibly possible. This would ensure that state and other resources have the maximum impact on the core mission being pursued.

The National Office for Suicide Prevention

The National Office for Suicide Prevention (NOSP) is the HSE body tasked with tackling suicide in Ireland. Established in 2005, it strives to carry out three main functions; overseeing the implementation of Reach Out: National Strategy for Action on Suicide Prevention, coordinating suicide prevention efforts around the country, and communicating regularly with agencies and individuals interested and active in suicide prevention. These tasks fall upon a five-person team; the Director, National Training and Development Officer, Senior Executive Officer, Assistant Research & Resource Officer and an Administrative Officer.

Arguably, the performance of the NOSP should be measurable on its impact on suicide rates in Ireland; however six years on, the number of people dying by suicide since 2006 has risen by 28%. Even before the onset of the recession, the NOSP failed to make an empirical impact in its first three years.

Of the respondents who replied that they had regular contact with the NOSP, praise for its hard work and determination is frequent and generous. This reference however is starkly overshadowed by the sheer volume of respondents (83.5%) who had never had any contact from the NOSP whatsoever. This is despite being amongst the most likely sectors to come into contact with individuals suffering from suicidal thoughts. Many of these respondents further explained that they did not even know that the NOSP existed.

This remarkably low-profile is more understandable when we consider the structure of the NOSP itself. The notion of a five-person team adequately dealing with suicide in Ireland is a somewhat difficult one to comprehend. According to former deputy head of the NOSP, Derek Chambers, the structure “is not something that is replicated in other countries”, whereby the “incredibly exposed office” leaves the implementation of a suicide prevention policy to only ”a handful of people”.

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3 www.NOSP.ie
4 Catherine Shanahan, “Strategy on Suicide left to ‘handful’ of people” in the Irish Examiner, (03/10/12).
Furthermore, as part of the Health Service Executive, the NOSP is dogged by lack of resources. For one, the HSE’s internal recruitment policy, combined with a failure of government to empower the NOSP had a considerably negative effect on the implementation of NOSP’s services in recent years. In December 2010, the Administrative Officer took a voluntary redundancy package. The moratorium on recruitment decreed that only a HSE employee could fill the position, whereby a lack of an administrative replacement resulted in the position being left unfilled for over eight months. In June 2011, then Director of the NOSP, Geoff Day, wrote to the HSE stating that having no administrative element to the entire office meant that the NOSP’s work “is now seriously impeded and this current situation cannot continue”. Day resigned in September, 2011 and a new Director, Ms Stephanie O’Keefe, was appointed. Within three months, Ms O’Keefe was seconded into the Department of Health, and the internal recruitment policy left the NOSP without a director and direction. Again due to the detrimental nature of HSE recruitment policy, the vital position of Director was left vacant for over a year, until Mr Gerry Raleigh’s appointment in November 2012. As a result of the NOSP’s subservience to the HSE, its lack of resources has ensured that its team has been constantly undermanned, hindering both its effectiveness and direction at a time where a sustained, strategic, well resourced and meaningful approach to suicide prevention is needed the most.

In addition to suffering major key staff shortages, as a part of the HSE the NOSP must also feel the ill effects of being part of an organisation with heavy financial impediments. Despite being highlighted as a priority for the current government, the €35m additional allocation to mental health services for 2012 was instead diverted to reducing the deficit accrued by the HSE in other services. Again, the 2013 Budget designated an additional €35m to mental health services, with the caveat of being “subject to affordability”. This year however, the NOSP was given a budgetary increase of only €1m. Providing meaningful assistance and funding to important organisations and schemes will be incredibly difficult to achieve under such tight financial constraints, let alone one which may never materialise due to “budgetary pressures”. Due to the intense financial pressures forced upon the NOSP by the HSE, an

Jennifer Hough, “Head of suicide office threatens to resign” in the Irish Examiner, (08/08/2011)
immediate limitation in the office’s ability to bring about real change can already be seen. One of the primary initiatives ran by NOSP, the ASIST course (Applied Suicide Intervention Skills Training) has been cancelled for the remainder of the year across many locations in Ireland as of September 2012. This is not the vision required to deal with this issue.

HSE Resource Officers for suicide prevention
There are ten HSE Resource Officers for Suicide Prevention in Ireland. They are distributed under the old regional Health Boards, and while also being employed by the HSE, operate ‘closely with’ but independently of the NOSP. The duties of the resource officers include:

- Coordinate action on suicide prevention within communities through providing leadership and advice
- Develop action plans
- Deliver community gatekeeper training eg: ASIST, safeTALK
- Promote public awareness of how suicidal behaviour can be prevented and of the availability of support services based within communities
- Highlight resources and supports available to people bereaved by a suicide death
- Provide support to people bereaved by suicide and promote healing and recovery
- Promote the mental health and wellbeing of all community members

Like the NOSP however, the book starts and stops with resources. The work of the resource officers suffers drastically as a result of their overburdened work load. Results mirrored those of the NOSP response that the vast majority of respondents rarely or never heard from their regions resource officer, but of those who did, many had glowing references to give of their hard work and effectiveness. This policy is of no doubt that the resource officers are in no way responsible for the inadequacies of the system, but the blame solely has to be placed on the structure. 97% of our respondents felt that there should be more officers in place than at present. It is simply too much to ask of these ten individuals to fulfil all the duties required over such broad areas. On top of this, what little they can do is impeded severely by their incredibly low profile. Many respondents outlined that they had never even heard of a Resource Officer for Suicide Prevention, while a continuous thread independently suggested by various communicants suggested that the profile was much too low for community members to avail of their support and expertise.

How many regional Suicide Resource Officers would be sufficient?

![Diagram showing the distribution of responses to the question about the number of regional Suicide Resource Officers that would be sufficient. The diagram indicates that 53% of respondents believe 1 to 10 officers would be sufficient, 28% believe 11 to 20 officers would be sufficient, 16% believe 21 to 30 officers would be sufficient, and 3% believe 31+ officers would be sufficient.]

FIGURE:5

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Reach Out

Reach Out: National Strategy for Action on Suicide Prevention is the current national strategy on Suicide Prevention. Written in 2005, it describes a ten year plan in order to tackle the prevalence of suicide in Ireland. It addresses suicide on four levels:

Level A- General Population Approach

➢ Promotion of positive mental health on a whole-population level, by working with families, schools, colleges, workplaces, voluntary and community groups, and through media outlets.

Level B: TARGETED APPROACH

➢ Targeted initiatives to reduce the risk of suicide among high-risk and vulnerable people, such as people who self-harm, mental health service users, marginalised groups (LGBT, asylum seekers, homeless people, the travelling community), young men, unemployed, indebted, and those in prison.

Level C: RESPONDING TO SUICIDE

➢ Support services to reduce the distress felt by families, friends and communities following death by suicide.

Level D: INFORMATION AND RESEARCH

➢ Ascertaining what works best in suicide prevention and mental health promotion and determining the prevalence of suicidal behaviour in Ireland.

Despite its tenure coming to an end naturally in 2014, this policy argues that Reach Out needs to be abandoned in place of a new national strategy as soon as is feasible, conscious of an era whereby suicide is occurring at an unprecedented level, capable of addressing the recent phenomenon of the huge rates of middle aged male suicides that we are witnessing today. Secondly, a national strategy needs to be specific as to identifying areas in which attention is most needed and how exactly to rectify this. Finally, the new strategy needs to contain a realistic yet challenging goal for the reduction of suicide rates, similar to international best practice.⁷

This national strategy must facilitate local strategies in agreement with Resource Officers and local authorities, with specific performance goals and strategic ring-fenced budgets.

⁷ Choose Life: A National Strategy and Action Plan to Prevent Suicide in Scotland sets out the clear goal of reducing suicide rates by 20% over the 10 year duration of the strategy.
The Cost of Mental Health & Suicide in Ireland

Calculating the economic cost of poor mental health and suicide in Ireland is a challenging task. Mental health is generally a much higher cost, given its higher prevalence within Ireland. The principle direct costs of mental health on the state are that of outpatient care, pharmaceuticals and hospitalisation, while a much higher indirect cost exists indirectly to the state, through elements such as work absenteeism and premature mortality.\(^8\) Using these factors, the estimated cost of poor mental health in Ireland was €3 billion for 2006, or 2\% of our GNP.\(^9\)

Equally, while suicide alone takes a lighter toll on the Irish economy, it does nonetheless comprise a very significant cost. Kennelly, Evans and O’Shea (2005), used a calculation method of accounting for direct, indirect and human costs. Further, they took into consideration that the loss of output from premature mortality would have been impaired somewhat by pre-existing mental illnesses. In all, they suggest, that in 2002, suicide cost the country €835 million.\(^10\)

For the same year, there were 451 registered cases of suicide. In 2011, there were 525 suicides. It is fair to suggest that this figure of €835 million therefore, has either sustained or increased on its cost to the state. In 2011 however, the National Office for Suicide Prevention was allocated a budget of just €4.1 million.

For 2013, the NOSP has been allocated just over €8.1 million to achieve its goals, while the entire mental health service budget will be €733 million, or 5.5\% of the overall health budget.\(^11\) The national policy on mental health since 2006, \textit{A Vision for Change} even advocated that a minimum 8.2\% of the health budget be spent on mental health, at a time when 20\% less suicides were occurring annually.

Both allocations (NOSP & Mental Health Service budgets) are entirely disproportionate to the overall costs that mental illness and suicide impose on the economy and thus a dramatic increase in resources in both fields makes economic sense. Essentially, the government can barely afford \textit{not} to increase spending on mental health.

\(^9\) Canadian Institute for Health Information, Cited in \textit{Well-Being: promoting mental health in schools}.
\(^11\) HSE, \textit{2013 National Service Plan}.
Suggestions
1- Reforming the National Office for Suicide Prevention

We have thus far established that the present endeavours made by the state to reduce the rates of suicide are structurally flawed. Therefore, we suggest that significant reforms of the NOSP be enacted.

The NOSP must become a body independent of the HSE, with special status, a ring fenced budget, performance targets and independent recruitment capabilities. It will report directly to the Minister of Health and will enjoy clearly defined access to intra-departmental input at secretary general level to ensure the necessary agility to adjust national policy in line with what is required to advance its mission.

Secondly, the Suicide Prevention Resource Officers for Suicide Prevention will become directly accountable to the NOSP.\textsuperscript{12}

Finally, the NOSP will be given the autonomous power to work cross-departmentally, with the ability to work closely with, lobby, and issue recommendations to the Departments of Health, Education, Finance, Social Welfare, Enterprise and Justice.

1.1- Structure

The new NOSP will be a much larger operation than the present 5-person office. Under the Director of Operations will be the Senior Executive Officer, a National Training and Development team, a Resource team, and an Administrative team. Strong leadership is required of the NOSP and therefore, the NOSP will be exempt from any form of internal HSE recruitment prerequisite or embargo so as to ensure the best possible individuals are sourced.

Equally, the number of Suicide Prevention Resource Officers needs to be dramatically increased. As mentioned, only 3\% of our respondents felt that at present, there are enough officers to sufficiently promote suicide prevention in Ireland. This policy submits that at least one officer and one assistant should be posted for each county, with the most populous counties of Dublin, Cork, Limerick and Galway receiving more. Officers can be located at hospital based offices, primary care centres, local authority buildings or elsewhere that would not incur additional expenses.

1.2- Functions

The overall system to be created is twofold. First, the NOSP will centrally develop research based strategies and campaigns on a national level, while the resource officers will coordinate delivery on a local level.

In addition to its current tasks, the NOSP will additionally be responsible for a number of key tasks:

\textsuperscript{12} As recommended in the Joint Committee Report on Health & Children, \textit{The High Level of Suicide in Ireland}, (2006).
• A new national policy on Suicide Prevention needs to be created with specific targets and deadlines, culminating in the inclusion of a realistic goal of reducing suicide by 30% within ten years.

• Defined Pathways and Direct liaison between the NOSP and regional officers must become an intrinsic function of both parties. For the NOSP’s part, it will be its duty to provide policies, funding, resources and general assistance to the officers, who will provide direct assistance to existing organisations in their region in interpreting the national policy and implementing and adjusting the application process where necessary on a practical level.

• Specific programmes for national implementation must be created and rolled out, such as mental health promotion programmes to schools, community-wide mental health awareness campaigns to the officers and national campaigns aimed at the delicate reduction of stigma of suicide and mental illnesses.

• The Research team will be tasked with investigating and examining internationally successful campaigns as well as locally successful programmes such as Jigsaw and Iorras Le Cheile Community Project with a view to assessing their feasibility to be augmented and expanded nationally.

• An NOSP 24 hour hotline needs to be established for dual purposes; the provision of counsel by trained professionals to individuals suffering from suicidal thoughts and ideation or struggling to deal with grief, as well as working as a personalised directory whereby one can immediately learn where and what services are available and identify an immediate pathway for clients to access them.

• The NOSP will also be charged with the task of examining existing suicide prevention/bereavement services in Ireland, either through using existing information or by jointly-sponsoring a review with 3TS who have generously made this offer. Should this be financially unfeasible, leading experts from existing suicide prevention organisations will be brought together to formulate a report based on their experience and knowledge. It will identify the exact areas in which there is an overlap in the provision of services, as well as the areas that are found wanting in specific services. Furthermore, it will highlight the work done by each individual body/organisation and recommend if, and to what extent, they should be provided with funding.

• On completion of its audit/report, the NOSP will issue a comprehensive strategy, outlining the areas, organisations, and services that need to be provided / alter their existing services in order to streamline delivery and adequately ensure that sufficient and universal provision of services is provided efficiently across Ireland.

• The NOSP will continue to be responsible for the distribution of funding to key organisations that provide important public services for the benefit of Irish peoples’ welfare and mental health. Having drawn up a comprehensive strategy, funding from the NOSP will be conditional on organisations’ adherence to the defined missions of the national strategy both what the strategy demands of them, as well as their adherence to the national policy.

• Furthermore, the NOSP will need to draw up a comprehensive national suicide prevention directory, drawing on the Irish Medical Directory but adding every registered Counsellor, Psychotherapist, social worker and local complimentary therapists such as reflexologists, yoga etc. to the original list of organisations by location, speciality and accessibility, and circulate it to every GP, Garda Station, Post Office, Youth Clubs, Community Centres, and other places of social interest, free of charge. This will also be available to access via the national helpline and the NOSP’s website and will be updated regularly.
The profile of both the NOSP resource officers has to be increased dramatically, so as to ensure that each organisation, school, community centre, GP, counsellor, clergy member etc. is aware, and in regular contact with them in relation to the implementation of policies and programmes.

Assist and SafeTalk need to be reviewed and sought to be improved in light of the growing recognition that needing to be able to communicate properly with bereaved families is of equal importance to being able to talk to suicidal individuals. Furthermore, it is apparent that confidence building is critically important aspect, as important as the training itself, and thus needs to be included appropriately.

STORM training must be provided by the NOSP to all frontline services, while Assist and SafeTalk training will be provided to teachers, pharmacists, community centre and youth club leaders, as well as be available on demand for anyone who contacts the resource officers wishing to receive the training.

Gardaí are in many cases the first port of call to scenes in which an individual has died by suicide or has attempted to do so. As a result, Gardaí should have specialist training designed to equip them with emergency risk assessment and the ability to offer immediate and professional consoling to family members.

Continual Professional Development is vital to the provision of any professional service, and as such training ‘top ups’ must be provided on set intervals.

Resource Officers will annually meet with their respective county councils and draw up an annual strategy for each area, including budgetary measures and specific reduction proposals to be met by the end of the year, in line with the national strategy objectives.

Coroners and Gardaí will be obliged to notify the NOSP in the event of a suspected or attempted death by suicide.

**Recommendations:**

- Reform and Restructure the National Office for Suicide Prevention into a body independent of the HSE, with a ring-fenced budget, performance targets and independent employment system.
- Grant the NOSP cross-departmental power so that it can interact directly with other departments.
- Enhance the size and role of the NOSP.
- Perform a comprehensive study / audit of the efficiency of existing suicide prevention organisations in Ireland.
- Draw up a new national strategy with set performance target of reducing suicide by 30% within 10 years.
- Create of a national 24hour helpline.
- Enhance the existing medical directory to a comprehensive directory for suicide prevention, distribute it widely and publish it online.
- Increase the number of Resource Officers for Suicide Prevention from 10 to 40, enhance their roles, and link them directly into the NOSP.
- Create a localised strategic system whereby Resource Officers work with local authorities to draw up annual strategies for each area with set performance targets in line with the national strategy.
2- General Practitioners (GPs)

A systematic review of suicide prevention strategies worldwide discovered that 75% of people who die by suicide have contact with their GP within the month before they die. GPs therefore, serve to play a central role in any holistic approach to suicide prevention. The suitability of GPs to provide the best possible aid to individuals, however, is worryingly questionable. Indeed a 2012 study found that 31% of GPs felt that they were inadequately trained and unprepared in the assessment of suicide. The same study also found that 58% of those studied felt that they were “not adequately informed as to the best available resources (HSE & Voluntary) in their area when dealing with a patient who is suicidal or deemed at risk of same”, while only 8% of respondents “felt that primary care was adequately resourced to deal with suicidal patients”. This inadequacy in provision of sufficient assistance by the state also emerged as a thread amongst our discussions with individuals, who suggested that anti-depressant medication was often the only solution offered by individual GPs that they had encountered.

This policy does not seek to express an inadequacy in practicing GP’s. It highlights the room to improve the standing of suicide prevention via the means of enhancing and augmenting the link between the Irish College of General Practitioners and the NOSP. The NOSP must therefore provide each GP, through their continual professional development, with specialised training to ensure that GPs become sufficiently familiar with suicide risk assessment and the various forms of treatment aside from anti-depressant medication. These could include methods such as cognitive behavioural therapy or complimentary medicine. GPs must also be provided with a localised directory for suicide prevention detailing all forms of therapy available within the local surroundings, by which they can refer an individual to, as previously mentioned.

Another major cause for concern is the current practice that exists by which an individual is prescribed medication on a three-month basis, and upon seeking renewal some individuals are issued another prescription without being reviewed by the GP themselves. Should they maintain, in their professional experience and opinion, that prescription medication is the best course of action, it must therefore become best practice for GPs to prescribe and review their patients on a monthly basis, with a view to establishing if medication is indeed the best course of action. At this point, the GP should consider the individual’s potential for complimentary therapy, or an altogether change of tact with the referral to a counsellor or psychotherapist. Only if a GP is satisfied that medication is both showing positive results and is the best course of action should they begin to prescribe medication on a three-monthly basis, again upon review.

Recommendations:
- GPs must be provided with the best possible training in suicide prevention.
- The Prescription of Anti-Depressant medication cannot be provided without monthly review of whether or not medication is the best course of action.

14 ICGP, Educational Needs Assessment on suicide and deliberate self harm to shape a course in Primary Care, (2012).
Social Workers typically work on a 9-5, Monday – Friday basis, whereas suicidal thoughts do not. If an individual finds themselves in a state of suicidal emergency and needs immediate help, but is unfortunately suffering outside of these specific hours, he/she must avail of the HSE ‘out of hours’ psychiatric assessment in Accident and Emergency wings of various hospitals in Dublin, the North East (Drogheda, Dundalk, Navan and Cavan) and the Midlands (Mullingar, Tullamore, Portlaoise and Naas) only. For those countless individuals who do not live near these very specific hospitals, or do not possess the means to make their way to one, could mean the difference between life and death. At the same time, while an individual may be willing to seek the help of a social worker, the psychiatric facilities in hospitals create a formal and institutionalised environment for the individual, dissuading incalculable individuals from seeking out of hours help.

It is thus time for Ireland to develop a widespread and readily available ‘out-of-hours’ social work services. This policy recommends that we establish a system similar to Britain’s Emergency Duty Services, whereby qualified social workers can be paid a higher rate to work shifts that can be after-hours, on weekends and bank holidays. In addition to the pay bonus of up to 20%, out of hours social workers do not have cases like day-workers, and generally work less days, which serve to make the post more appealing to applicants. Considering that this emergency team does not take on case studies, but rather writes up the cases it has worked on and presents it to the relevant day-worker, it is both feasible and beneficial to all parties that both social workers and emergency teams work in the same offices.

Establishing out-of-hours services is of benefit to all parties. It provides a much needed service to individuals at a time of crisis, and is one of the areas that can directly be seen as a fundamental flaw in suicide prevention. On the other hand, it also reduces the pressure on an already overburdened system of psychiatric units.

**Recommendations:**

- **Out-of-Hours Emergency Social Work Teams must be established across the country.**
4- Education

Education is the best avenue to inform the younger generations’ understanding of suicide. It is the only possible channel in which a systematic alteration would affect every child in Ireland under the age of 16. As of 2010, Ireland ranks the fifth worst in the EU for its rate of 22.46 deaths by suicide per 100,000, as opposed to the United Kingdom’s 8.91 per 100,000. This figure is completely out of kilter with our standard of living and GDP for the same year, suggesting that our suicide prevention services are a good distance behind where they should be in terms of an EU standard.

At present, schools are notably ill-equipped to prevent suicide. Guidance Counsellors, who would have traditionally provided one-to-one professional counselling at an extremely high standard due to the process of annual supervision, have been practically removed from the system due to cost-cutting budgetary measures from the Department of Education in Budget 2012. An estimated 700 counsellors have been lost as a result, leading to a system whereby 50% of one-to-one service has now been lost, while 37% of respondents to our survey now possess no staff with any training in suicide prevention.

In the place of a professional counselling service, many schools now provide their own version of help, on an ad hoc basis often consisting of pastoral care teams or concerned teachers. While their intentions are undeniably in the right place, leaving such a vital service in untrained and unqualified hands can and of ten does have a more adverse effect.

In addition, schools are also being forced to affectively ‘wing it’ on an ad hoc basis in terms of a suicide prevention policy. From the survey we conducted, we found that 53% of

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15 European Mortality Database.
16 Eurostat
17 Institute of Guidance Counsellors study, 2013.
respondent schools do not have a mental health or suicide prevention policy or programme. Of those who answered that they do, 77% of these were created without any input from their regions HSE Suicide Resource Officer or NOSP. A common thread found across all our deliberations with professional counsellors, psychotherapists, and guidance counsellors was of their certainty that unqualified help is more dangerous to the mental health and well-being of individuals than receiving no help at all. This is not to assume that each school-thought out policy is negatively affecting their students, but that the most beneficial results would come out of specific suicide prevention policies, strategies and guidelines informed and co-ordinated directly through the Resource Officers or the NOSP in line with the national strategy. 90% of schools agreed that a national policy ought to be drafted for their implementation.

The Fianna Fáil policy proposals on promoting mental health in education, Promoting Positive Youth Mental Health (2012), outlined the absolute necessity to enact significant changes in the education system. Using the alarming argument that almost 75% of all mental disorders first emerge in individuals when they are aged 15-25, it proposed a number of key recommendations to be made, including:

- A focus on positive mental health promotion at all levels of the education system, from pre-school to third level.
- All schools and colleges to have their own mental health promotion plans, with students, staff and parents being involved in the development and implementation of these plans;
- The Department of Education to provide schools with the supports they need to deliver mental health programmes, including information packs for teachers and teacher training.
- The implementation of effective strategies to tackle bullying in all its forms, including cyber bullying, with a major emphasis on peer support and students being encouraged to stand up for classmates who are being bullied.
- Each school to put in place a care team to oversee the implementation of its mental health initiatives, to be made up of staff, students, parents and appropriate external bodies such as professional mental health workers and local youth services
- A national ‘Positive Schools’ initiative, similar to the ‘Green Schools’ programme with schools being awarded ‘Positive Schools Flags’ for promoting mental health and having effective strategies to tackle bullying and support students experiencing mental health difficulties
- Headstrong to be funded to establish a Jigsaw centre in every county so that young people can get access to appropriate professional support in a welcoming environment
- A greater emphasis in schools on the importance of physical exercise and diet to students’ mental wellbeing and a focus on ensuring that all students, particularly those in exam years, get the recommended number of hours of PE classes
- A reversal of the Government’s decision to abolish dedicated guidance counsellor allocations for schools, which has dramatically reduced access for young people to counselling supports.
4.1- The Guidance Counsellor

It is undeniable that the Dept. of Education did save money by reducing counsellor hours, but at what cost to young people and their families? A 2012 Value for Money study ran in Kildare by the HSE, for example, found that community-based services cost the state approximately one-fifth less per capita than the traditional hospital-based alternative.¹⁸

On top of the economic aspect lies, of course, the practicality of young people suffering from suicidal thoughts being provided with as rapid a service as possible. While students in immediate danger of carrying out their suicidal ideation could seek professional counselling, in a familiar and warm environment, on any given weekday, they must now join the back of the overburdened queue for a HSE counsellor, who would ideally see them in a few months. That timeframe is vital in saving a young persons’ life, and while measuring the counter fallacy is impossible, it is suggestive that the prevalence of student suicides tragically occurring in Ireland may be considerably less if, amongst other reasons, the guidance counsellor was still in school on a full-time basis.

Finally, Young Men and Suicide Report identified that young men were unlikely to seek the help of an official service due to embarrassment, shame, stigma, confidentiality, and the fear of others finding out.¹⁹ One of the undeniable strengths of school guidance counselling is its dual role in both mental health counselling and career guidance; an individual can seek help on a personal issue whilst appearing to their peers to be receiving advice on their CAO. It is a vital frontline service for young people, and thus it is imperative that the government reverses its decision and reinstates the guidance counsellor as a full time occupation in schools. The services they provide lies at the very epicentre of a concerted effort to prevent students from opting to take their lives.

4.2- The Role of Teachers

“[Guidance Counsellors] are the specialists in schools. To suggest that ordinary teachers … have the skills and the clinical skills to be able to identify depression, to be able to deal with young peoples’ problems, to be able to make referrals, would be similar to suggest that we do away with ambulances and have passing motorists take people to hospitals.”²⁰

It is both unfair and irresponsible to expect teachers to deal with an issue that they are inadequately resourced for and unqualified to deal with. It is our belief that addressing suicidal ideation and crises within the schooling environment be left solely to the guidance counsellor. That said, this policy does envisage an instrumental role for teachers to adopt in order to maximise the welfare of the child. In this case, we recommend that all serving teachers registered on the Teaching Council be provided with both the ASIST and SafeTalk courses, as part of their Croke Park Agreement hours. Additionally, participation of these courses should henceforth become a necessary requirement for new entrants to register on the Teaching Council and practice as a teacher.

¹⁹ Men’s Health Forum in Ireland, Young Men and Suicide Report, (2013).
²⁰ Brian Mooney, Frontline, 28 Jan 2013, Rte1.
Having received both courses, the teacher will be in a much better position to accurately detect students suffering from suicidal thoughts or being of poor mental health, and will report any suspicions to the guidance counsellor as part of their duty of care to the student. The guidance counsellor can then act on the advice as they see fit, so long as it is done in a discreet manner and retaining the full confidentiality of the teacher.

Current duty of care stipulates that if a teacher fails to act upon a student issue it is tantamount to negligence, and the board is liable to lawsuit. Therefore it is of vital importance, in order to protect teachers that the teacher’s duty of care be altered in order to provide indemnity to the teacher who declared their suspicions, rightfully or wrongfully, to the guidance counsellor. Additionally, as even trained professionals can sometimes struggle to detect mental illness in individuals due to its very nature, teachers who technically fail in their duty of care by not picking up on an issue cannot be deemed negligent.

4.3- The Role of the Student

*Promoting Positive Youth Mental Health* makes a number of recommendations that considerably enhance the role of the student in promoting mental health, which we believe, have equal weighting in their potential to reduce and prevent suicide.

Firstly, the school and class mentality has to be dramatically altered to promote the notion of camaraderie and a “one for all”, or “Our Class” attitude. The Stand Up! campaign ran by BelongTo targeting homophobic bullying is one successful method which should be rolled out nationally. The paper explains how such a campaign is successful:

“They should be taught to look out for each other and value the experiences of everybody in the class. If someone in the class is isolated and left out then the rest of the class should feel that it is their responsibility to include them. They should be taught the language and tools required to stand up for victims of bullying and report bullying on behalf of their classmates.”

This ties in closely with the communications we made with guidance counsellors and principals on the nature of bullying. As they put it, the on-looking peers are often the oxygen that fuels the bullies’ fire, and thus bullying is done predominately in open public areas such as school halls and common rooms with a view to gaining a response from their peers. Should an Our Class mentality be successfully established, the bully will be stripped of his audience. Should this fail to deter the bully, the closeness of the group should ensure that teachers are promptly informed.

*Promoting Positive Youth Mental Health* goes on to suggest that Peer Mentoring by senior students to first year students, as well as Peer Teaching by senior students to junior ones about complex topics such as alcohol, drugs and cyber bullying both have the capability for promoting positive health in an informal manner that students are more likely to consider than from their superiors, as evidenced in the Men’s Health Forum in Ireland report. This policy suggests another utility of the student body in the prevention of suicide through the tasks of the student council. Schools can capitalise on their informal influence by giving them tasks within their capabilities, such as designing posters aimed at promoting mental health or tackling bullying etc. The council then formulate their own campaigns and are

thought to be much more thought-provoking and powerful than anything that the teachers could formulate, given the peer element of the council, as well as their intrinsic knowledge of what appeals to their age. It is in this light that this policy recommends that student councils be established as a regular institution within all schools, and that specific guidelines and recommendations be issued from the Suicide Prevention Authority to them for their design and implementation.

4.4- SPHE

A common concern amongst many principals, according to our research, was that having called for so long for the de-stigmatisation of the concept of suicide; the pendulum had swung full swing to a state whereby the media and public commentary had inadvertently made suicide seem appealing and a viable option to vulnerable teenagers. It is time that Irish education rid its taboo idea of teaching about suicide and its aftermath. Only through SPHE can we exert some form of influence in shaping students opinion on this delicate situation. SPHE teachers therefore need to be provided with specific training, as part of their Higher Diploma in Education, in teaching about mental health, suicide, the meaning, cause and effects of human emotion, and mental state of mind.

Physical Education is a core aspect of education to all years, using the logic that “a healthy body is a healthy mind”. Using this train of thought, if mental health became an intrinsic aspect of the SPHE course, a healthy mind is just as important, if not more so as physical health, in enhancing educational performance. In this light, this policy further underpins the fact that SPHE must be extended to the senior cycle and enhanced using the mental health recommendations suggested in the NCCA Senior Cycle SPHE draft curriculum (2005) and highlighted in Promoting Positive Youth Mental Health. One of the core modules in SPHE is learning how to cope with exam stress. With the government scrapping of the Junior Certificate, students will in 2016 take a state examination for the first time when it matters the most, the Leaving Certificate. As such, students may well feel unprepared to handle pressure and exam anxiety. As it is, education is completely results driven as a consequence of the imbalance between Leaving Cert. students and third level education places. As Brian Mooney forewarned in our discussions, the augmented birth rate coupled with the government’s economic inability to rapidly enhance third-level institutions’ capabilities, means an even worse disparity of applicants to availability. Short of a massive over-haul of the entire CAO system, students will only fall under even more intense pressure by the entire system. As a result of exam pressure, an estimated 30% of all second level US students suffer from sever anxiety, which in turn can cause under-performance in exams, low self-esteem, reduced effort and a loss of motivation for school tasks. If this is not already an undiagnosed case in Ireland, it is not implausible to foresee a similar problem arising should school pressure increase even more. Given this knowledge, it is now more important than ever to be adequately providing an updated SPHE course to all students.

Despite the significant resources spent by the Department of Education on enhancing the syllabus of SPHE, and our recommendations to the subject, concern has been raised by numerous guidance counsellors that the subject is not being taken seriously enough by schools given the ultimate importance of exam results and thus, exam based subjects.

Consequently, the most experienced and advanced teachers are often designated to the ‘important’ subjects, with the least experienced and newest teachers left with SPHE, without necessarily having done any relevant courses as part of their training. Furthermore, as these teachers gain more experience they are given the ‘important’ subjects while the new teachers replace them. Under this system, there is no provision for experienced SPHE teachers to emerge who would be most beneficial to suicide prevention. If we establish the aforementioned correlation between anxiety, exam related stress and poor exam performance in the dept. of education’s discourse, it should therefore become clear just how important SPHE could be in terms of student success. Finally, in the need to create established and experienced SPHE teachers, as well as the fact that the task of teaching about mental health, human emotions, anxiety, stress and suicide will no doubt be a tough ask, it must therefore become a specific requirement that only those who have taken relevant additional courses as part of their Professional Diploma in Education be permitted to teach the subject.

4.5- Primary School Counsellor

"It is only quite recently that we have come to realise that the foundations of learning – as well as the chief mainsprings of inequalities – lie buried in the pre-school phase of childhood and that schools are generally ill-equipped to remedy a bad start."\(^{23}\)

The National Guidance Forum’s Guidance for Life report affirms an EU-wide directive that every person in Ireland has the right to life-long guidance.\(^{24}\) For children aged 6-12 years old, a structured approach to guidance would provide children with necessary help in areas such as Emotional Development (e.g. developing coping skills, an awareness of own emotions, capacity for emotional self-regulation), Social Development (e.g. developing


positive relationships and interpersonal competences), Learning Development (e.g. developing learner skills and acquiring knowledge of post-primary schools and the transition) and finally, Career Development (e.g. increasing an awareness of gender and social stereotypes, developing a healthy lifestyle and developing skills to manage change, conflict and stress).  

Many negative concepts such as homophobia and masculinity, and predispositions against the expression of emotions and the seeking of help from others could therefore be adequately addressed before they manifest in post-primary education to the extent that currently exists whereby mental health problems are created, and left untreated due to the societal norms that form.

Furthermore, given the fact that the transition from primary to post-primary education can be a somewhat overwhelming for a child, and that children are often making blind decisions on subject choice that could shape their schooling, and even careers, it is therefore a recommendation of this policy that guidance counsellors be provided to primary schools. For economic and workload purposes, and the fact that the guidance will be predominantly provided to sixth class students, it is feasible to provide one guidance counsellor for numerous schools, depending on school size and location.

**Recommendations:**

- Guidance Counsellor allocated hours must be reinstated.
- Teachers must be provided with ASIST & SafeTalk
- Duty of Care be enhanced to allow teachers to refer students to Guidance Counsellors anonymously.
- Students must be utilised as a key component in the protecting each other's mental health.
- Schools must utilise the informal influence of Student Councils/Prefects to run campaigns.
- SPHE must be extended into the senior cycle, and acknowledged for its important dual role in promoting students’ mental health and attaining better exam results.
- SPHE Teachers must have undertaken relevant additional courses pertaining to Social, Political or Health Education as part of their Professional Diploma in Education.
- Guidance Counsellors must be placed in Primary Schools.

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5- Counsellors / Psychotherapists

In the discourse of any holistic approach, the role of the Counsellor and Psychotherapist are of invaluable importance for the mental health and welfare of both individuals suffering from suicidal thoughts and individuals stricken with grief following the death by suicide of a loved one. To a large extent, the state has a dependency on counsellors and psychotherapists to support and protect the mental health of society, much in the same way that there is a dependency on the frontline health service to support and ensure the welfare of individuals with physical illnesses.

Unlike GPs, nurses, dentists, pharmacists or opticians, Counsellors and Psychotherapists are left to their own devices, whereby at present in Ireland, there is no restriction on any individual offering counselling or psychotherapy services. In addition, present Counsellors and Psychotherapists that are members of strict Psychological Therapy councils suffer from a distinct discord from the HSE and NOSP, whereby they are effectively 'out of the loop' of the research done by both bodies in terms of best practice and strategy guidelines.

5.1- Regulation of Psychological Therapists

The greatest concern of this policy as regards Counselling and Psychotherapy is the quality of counsel being administered to those individuals, who must surely be considered amongst the most vulnerable in society. A common thread amongst many respondents to our survey was the voluntary suggestion that unqualified counselling was extremely dangerous and must be regulated immediately. The difference in treatment quality being offered by graduates of courses recognised by Irish, British and European counselling associations, as opposed to the ‘expert’ counsel offered by others who received sub-par training meant that in many cases, the outcome of a client’s mental welfare depended dramatically on the person they happened to see. While many bodies and associations for psychological therapists exist, with their own minimum requirements for entry and set codes of conduct, association to one of these is not a pre-requisite to practice in the industry. One respondent detailed the availability of a €150 online course that could prepare an individual to offer counsel to individuals with eating disorders. Online it is not difficult to find details of courses that claim they can grant students the sufficient skills, theoretical background and knowledge to enable them counsel individuals who are at risk of taking their own lives, over the course of just six weekends! Others disclosed the practice of unqualified psychological therapists developing their own strategies that could potentially be more harmful than good. In sum, it is simply unacceptable that we leave such a vital cog in suicide prevention unchecked, considering the immense potential to both Irish mental health and the development and the integrity of the profession.

For the purposes of suicide prevention, this means that any individual can offer counsel towards others suffering from suicidal thoughts, harbouring suicidal ideation, or attempting to overcome grief, without the proper training. Even practitioners who are registered to governing bodies with their own requirements are not necessarily mandated to have done specific training in suicide prevention. For example, we surveyed a number of counsellors and psychotherapists registered to specific boards across Ireland, and found that while 80.5% of Counsellors/Psychotherapists had received formal suicide prevention training, only 9% of these had to do so out of a mandatory requirement.
The call for the establishment of a statutory body for psychological therapists has been headed by the Psychological Therapies Forum, a forum consisting of various Counselling, Psychotherapists, Cognitive Therapists, Psychoanalyst and Psychiatrists amounting to over 5,000 qualified practitioners. They argue, and rightly so, that the practice of Psychosocial Therapy falls under the description of “any profession in which a person exercises skill or judgement relating to … the care of those in need of protection, guidance or support” in section 4 (3) (d) of The Health and Social Care Professionals Act (2005), and should thus follow the Acts requirements for said profession to be registered and regulated.26

Thus this policy strongly recommends that a statutory body for Psychological Therapists be established, including but not limited to the following:

**Recommendations:**

- That a mandatory statutory register be established for those wishing to practice Counselling and Psychotherapy;
- The professions of “Counselling” and “Psychotherapist” be withheld exclusively for those practitioners of psychological therapy that are registered on the statutory register;
- That a strict set of minimum requirements be set for entry, such as an accredited qualification from an institution recognised by the statutory body and minimum voluntary experience in a related organisation;
- That a code of conduct be drawn up by the statutory body which registrants must adhere to;
- That a range of sanctions be put in place ranging in severity for sanctioning unregistered individuals practicing as Counsellors and Psychotherapists or registered practitioners for breaching the code of conduct;
- That the statutory body create a board of enquiry to investigate both unregistered and/or malpractice.

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A number of factors must of course be taken into account when proposing this statutory body. Firstly, this policy is acutely aware of the Government’s current backlog of bodies being registered, such as CORU and Lobbyists. That said, this policy feels that the necessity to regulate Counsellors and Psychotherapists is of equal importance to the need for CORU to regulate dieters, occupational therapists, psychologists, social workers and social care workers, amongst others, who are being afforded the government’s full attention.

Secondly grandfathering, or the allowance of existing counsellors and psychotherapists who do not meet the initial requirements of the register a set time period to up skill will have to be given consideration based on factors to be determined by the body.

Finally in terms of finance, similar to most statutory bodies, an annual registration fee will naturally be necessary to cover operational costs.

5.2- Correspondence with the HSE/NOSP

A worrying trend emerged from the results of our survey to counsellors and psychotherapists is the lack of communication many experienced from either the Resource Officer or the NOSP. Indeed 68% and 76% of respondents claimed that they had never heard from the Resource Officer and/or the NOSP respectively.

Some added that they felt that as private practitioners, as opposed to being directly employed by the HSE, meant that they were specifically overlooked in terms of issued guidelines and strategy. Specifically, 76% of respondents felt that they had not been provided with adequate help in terms of policy and programme implementation.
The Government must acknowledge that the better all Counsellors and Psychotherapists are equipped to deal with suicide prevention, the less stress will be placed on public services. Having established a statutory body for Psychological Therapy therefore, the Suicide Prevention Authority will work closely with it to ensure that guidelines, programmes, and the most up-to-date research and best practices be provided to both public services and private therapies, with a view to safeguarding the best interests of the public, so that regardless of who the individual decides to see, they receive treatment consistent with the best practice informed by national strategy.

Do you (Counsellors/Psychotherapists) feel the HSE or NOSP provide you with enough help in terms of policy and programme implementation?

![Pie chart showing responses](chart.png)

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**Recommendations:**
- Counsellors and Psychotherapists must become regulated professions under a statutory body.
- Both must be kept informed by and in regular contact the the NOSP & HSE, and be advised on strategy and best practice.
6- Alcohol Abuse

There is an undeniable association between suicide and alcohol abuse. Individuals often turn to the use of substances (namely alcohol) as a method of coping with the stress of emotional and social problems, such as the deterioration of relationships or financial pressure, which can adversely affect one’s ability to deal, control, or even overcome these issues. Alternatively, individuals who engage in substance misuse are at an increased risk of developing health problems, namely depression, which in turn has a high correlation to suicidality.

In sum, a mutually harmful relationship exists whereby suicidality can lead to alcohol abuse, while the abuse of alcohol can impede our coping mechanisms and cause suicidal thoughts. A New Zealand study, for instance, found that 90% of youth who were suicidal were found to be both depressed and had a substance abuse disorder. Furthermore, alcohol can remove the inhibitions of an individual with suicidal ideation, resulting in them following through on thoughts when they may not have done so without the influence of alcohol. In Ireland, alcohol abuse has been found to have had a “significant influence” on suicide rates of men of all ages, and young women between the period 1968-2009.

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Fianna Fáil’s Senator Mary White published a special paper on this issue in 2008 offering a broad range of recommendations to lower the rate of suicide in Ireland. While many of her recommendations came to be, we wish to particularly stress her calls to phase out “the high profile sponsorship by alcoholic beverage companies of sporting events, usually shown on television, and of public events, such as music concerts, aimed at young people… over the next 5 years.”

Fianna Fáil is of the opinion that alcohol advertising specifically aimed at young people is immoral and unacceptable on a number of levels; young people are more impressionable to targeted marketing than their elders, they are significantly less likely to fully understand the toll, both physically and mentally, that alcohol can have over ones’ body, and are already extremely vulnerable to turn to alcohol as a social and coping mechanism.

Furthermore, considerable work needs to be done in the form of an awareness campaign over the correlation between alcohol and suicide. Should parents be fully aware of problem-intensification effect that alcohol can induce on their academically and socially pressured children, it is possible to speculate that they may become much stricter on the frequency and volume of alcohol that many young adults consume. What is imperative to understand is that it is not simply regular heavy drinkers that are at risk of dying by suicide. According to Alcohol Action Ireland; “just one occasion of heavy drinking can reduce inhibitions enough to self-harm or act on suicidal thoughts”.

In addition, we are calling for the key recommendations offered by the Steering Group Report on the National Substance Misuse Strategy should be further explored for feasibility, namely the changes to pricing, marketing and availability of alcohol. Finally, considering the damage that the misuse of alcohol can have on the physical and mental health of an individual, it is time that the health service adopted the concept that substance abuse is a form of self-harm, and thus individuals admitted to hospital as a result of the volume of substance they have consumed should be treated in the same means that an individual who physically self-harms, being entitled and encouraged to counsel and social work.

**Recommendations:**

- Phase out Alcoholic sponsorship and advertising specifically aimed at young people.
- Mass Awareness Campaigns need to be run outlining the correlation between alcohol abuse and suicide.
- Pricing and Availability of alcohol needs to be assessed for their role in alcohol abuse, suicide and self-harm.
- Substance Abuse must be treated in the eyes of healthcare professionally as a form of self-harm, and treated appropriately.
7- Middle-Aged Men

Over the past 40 years, the rates of deaths by suicide of men aged 30-59 has been steadily increasing and shows little signs of slowing pace. Using the most recent comparable results, it is evident that for both the male age groups of 30-44 and 45-59, we are narrowly above the EU average, yet significantly above the rates for the same aged males in the UK.

![Deaths by Suicide & Intentional Self-Harm, per 100,000. Males aged 30-44 & 45-59 (2010)](image)

There are a number of factors that can be attributed to this phenomenon. Men’s general personality traits including perceptions of masculinity and emotional illiteracy and the breakdown of a relationship can all be suggested. So too, can be the profound effect that the changing world is having on them. Men can find themselves in a ‘buffer’ generation, “caught between their older, more traditional, strong, silent, austere fathers and their younger, more progressive, individualistic sons.”31 Financially, these men have witnessed the dramatic economic changes that have occurred in Ireland over the past 30 years, and many may be faring poorly in the current recession. Other factors relate to the major social changes that men may be struggling to handle, including the systematic failure of the financial system, the inherent lack of trust in the perceived failure of our political system, and indeed the change in the relationship and public trust in the church and the state.

The current economic climate has undoubtedly put significant stress on individuals’ mental health, and recent studies suggest that individuals who struggle to pay their debts are more than twice as likely to suffer from serious mental health issues, namely depression and severe anxiety, than those who are financially comfortable.32 Currently, there are 180,000 residential mortgages in some sort of trouble, either in arrears or have been restructured. Statistically, this means a huge number of adults in Ireland are suffering from debt-incurred depression, with one survey suggesting that as many as one in three homeowners fear losing their homes due to financial strain.33 Another poll suggested that 77% of respondents

31 Samaritans, Men and Suicide: Why it’s a social issue, (2012).
33 Irish Charity Engagement Monitor study by nfpSynergy. Figures compare 1,000 respondents in November 2010 and 1,575 respondents in April 2012. All respondents are aged 16+ and based in the Republic of Ireland
who admitted to being under severe financial strain have experienced mental health issues.\textsuperscript{34} Unemployment too, has become a major problem for suicide prevention, with non-working people being 2-3 times more likely to die by suicide than their employed counterparts.\textsuperscript{35}

Considering that men are much less likely to share and seek help for the difficulties they undergo, as well as the inherent personality trait ingrained in many men to view themselves as the “bread-winner” charged with keeping their families fed and housed, many men simply cannot cope with the strain they are under and act on their suicidal thoughts. The concept of the “Men’s Sheds” ran by the Irish Mens Shed’s Association is taking the right direction in terms of it being impractical and unrealistic to expect men to gain benefit from the traditional model. As such, it aims to include men into community projects, reducing isolation, building camaraderie, a closer sense of community, and inadvertently encouraging the men to talk to one another. Similar campaigns ran by Samaritans to bring the service to the men rather than hoping the men will come to them are equally innovative and should both, as well as the Money Advice and Budgeting Service (MABS), and any new campaigns aimed at the age-group should be targeted by the NOSP and funded appropriately.

On the other hand, it is also reasonable to expect some assistance to derive from the source of many men’s mental health woes. As such, we recommend that banks be compelled to provide professional counselling service to the individuals who fall into arrears and debts with which they are struggling to cope.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{Deaths_by_Suicide_Self-Harm_Males_Aged_30-59_collated_per_100000_1980-2010.png}
\caption{Deaths by Suicide & Self-Harm, Males Aged 30-59 (collated) per 100,000, (1980-2010)}
\end{figure}

**Recommendations:**
- Highlight and increase funding to existing projects aimed at preventing the rates of suicide for middle-aged men.
- Banks must be compelled to provide for professional counselling service to patrons in heavy mortgage, business and other forms of debt.

\textsuperscript{34} SeeChange research, www.seechange.ie
\textsuperscript{35} Men and Suicide; Why it’s a social issue.
8- Media Coverage

Many of the recommendations made in this policy highlight the relatively untapped potential that the media possesses in terms of raising the status of official bodies, raising awareness over numerous issues, and reducing the stigma of suicide and poor mental health. Equally, the media also possesses the same potential to inadvertently raise, or prevent the reduction, of suicide rates in Ireland. For example, correct and delicate coverage of suicide, bereavement, or attempted suicides can encourage others to speak out and seek the proper assistance. On the extreme opposite end of the spectrum, incorrect portrayal can have devastating consequences. A German television series, “Death of a student” featured an explicit depiction of a railway suicide in its opening credits. Consequently, the prevalence of railway suicides rose 175% in young people aged 15-19 years throughout and after the series, and again when the series was repeated years later.36

Adding to this concern is the worry raised by many of the respondents to our survey. A number of principals indicated that while they had previously been calling for the de-stigmatisation of suicide, so as to encourage young people to speak up and seek help, the pendulum had swung full swing thanks to the media’s portrayal of suicide, reporting on wailing masses at the elaborate funerals of children who had died by suicide. The media, covering large numbers of people showing their regret at the deceased’s passing, as well as highlighting support for bereaved families, can mean something else to children suffering from depression, who may see this as a glorified end to their lives, sure to gain national attention, and thus can ignite fierce suicidal ideation.

Thus the media has to be extremely delicate in the coverage and portrayal of suicide. The joint Irish Association of Suicidology / Samaritans media guidelines offer professional and thorough advice on how to correctly portray cases of suicide in Ireland without having an unintended consequence.

Under Content Rule 3.8 (Imitative Behaviour) of the Broadcasting Commission of Ireland Code of Programme Standards: “Broadcasters shall avoid the inclusion of programme content which could encourage people to imitate acts which are dangerous or prejudicial to the environment and/or the health and safety of themselves or others”.37 Fianna Fáil views irresponsible media coverage of suicide as tantamount to being in breach of Content Rule 3.8. In advance of any legislative action or government policy, we invite the media to adhere to the IAS / Samaritans media guidelines on proper coverage in order to avoid endangering the lives of individuals and risk facing sanction from the Broadcasting Authority of Ireland.

Recommendations:

- Implore all forms of media to take a responsible role in the coverage of suicide, adhering to media guidelines set out by The Irish Association of Suicidology and Samaritans, in order to avoid breaching BAI codes and save lives.

37 Broadcasting Commission of Ireland, BCI Code of Programme Standards.
Part III

Finance
Financing

“Currently, the resources spent in mental health care, (which include prevention and promotion), are far from being proportional to the costs incurred by mental ill health.”

We have already established the case that the costs incurred to the state as a result of mental illnesses and suicide far outstrip the budgetary allocations by which the state attempts to deal with them.

Using this logic, we are of the position that the Government can ill afford not to invest more finance into both mental health and suicide prevention. It is clear that our economy will be in difficulty for some years to come. Introducing the measures outlined in this policy, while initially incurring relatively high costs to the state, the long-term benefits of improving the mental wellbeing of the public and reducing the rates of suicide will significantly cut into the annual substantial costs of mental illness and suicide. From a purely economic perspective, this policy proposes an investment that can reduce massive costs to the state at a time when financial difficulty is clearly an issue of seminal importance to the state.

The Roads Safety Authority

The RSA is a state body arguably somewhat comparable to NOSP in that its underlying goal is to reduce fatalities that occur annually. Over the years, the RSA has seen outstanding success in reducing the number of road related deaths, halving the rate from its inception in 2006 to the present day. While the functions and characteristics of both bodies are incomparable, one undeniable and inexcusable difference exists between the two: the ratio of funding allocated to the body compared to the number of fatalities which occur. The number of lives lost on the roads has always been reflected in the RSA’s budget. As it began to show positive results, the budget lessened. The overall budget however, always reflected a significant ratio of resources spent per life lost, ranging from €124,646 per fatality at its highest, to €74,650 at its lowest.

Unfortunately, the same ratio cannot be said to exist of the annual suicide rates to budgetary allocation. The most shocking disparity can be seen in the 2010 budget. Released at the end of 2009, 238 people had lost their lives on the roads, and the RSA was allocated €28.75m, or €120,781 per fatality to ensure that fewer fatalities would occur. The NOSP for the same year (that witnessed 527 individuals dying by suicide) were allocated €3.1m, or €5,882 per fatality. Conscious of economic pressures, using this weighting system the NOSP should have been allocate €39.2m in 2012 to balance the allocation of 13.9m given to the RSA.

Naturally this comparison could be seen as somewhat simplistic, in that other factors obviously also contribute to budgetary allocations, yet it does still highlight the sheer disparity between the two bodies, as well as outline the inadequacy of resources provided for the prevention of loss of life through suicide.

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We can no longer justify spending in certain areas in order to save lives, yet overlook suicide prevention. It is the view of Fianna Fáil that until every citizen is provided with sufficient services, and until every young adult is made aware that the suicidal ideation they are harbouring can be helped and treated, it is the responsibility of governments to do everything within their means to prevent suicide.
Suicide Prevention Budget

**NOSP Budget:**
- Funding of Organisations: €20m
- Continuous Mental Health Awareness Campaigns: €2.5m
- Training Resources:
  - €200k in research funding,
  - €900k in the employment of 30 training instructors at €30k each
- Salaries:
  - €570k on enlarged NOSP team,
  - €1.6m in the employment of 40 Resource officers at €40k each
- 24-hr Hotline: €2.5m
- Audit with 3TS: €0.3m

**Total** €28.57m

**Additional Cost to Department of Health:**
- Out-of-Hours Social Workers:
  - 20 teams of 2 Social Workers at €51k each

**Total** €2.04m

**Additional Cost to Department of Education:**
- Reversal of cuts to guidance counsellors in Secondary Schools: €32m
- Establishment of Primary School guidance counselling service:
  - 660 counsellors at €39k each

**Total** €57.74m

**Cost of Psychological Therapy Regulatory Body:** €0

Similar to recently proposed regulatory bodies, a mandatory annual fee of registrants will ensure that the regulatory body is self-sufficient.

**Estimated Total Expenses:** €85.58m

At times of such scarce resources it seems inconceivable that €85.58m could be found. **However the impact of this issue on society and the growing nature of the problem demand that we do.**

Given the contribution of alcohol abuse to this issue and the unprecedentedly low prices of alcohol in the off-sales sector, Fianna Fáil believe that a 7.5% “Mental Health Levy” be applied to all alcoholic off-sales.

If those purchasing alcohol at off-sales for home use or for a party were assured that 7.5% of their purchase had been added on, from what already such a low level, was for the specific purpose of reducing loss of life by suicide and the treatment of mental health, we envisage that there will be little complaint. Indeed, we would venture this would be a development to be welcomed by most.

The revenue generated for such a measure would generate an estimated €120 million, easily covering the cost of the implementation of the measures recommended within *Actions Speak Louder than Words*, leaving a substantial additional amount for the accelerated role out of *A Vision for Change* and improving psychiatric services.

**Estimated Total Income:** €120m

While initial costs of implementing the aforementioned recommendations in this policy may be higher than our estimations due to unforeseen circumstances such as office rental and increments, we envisage that equally, if not more so, the annual cost will decrease annually as the goal of training all existing frontline staff / GPs/ Gardai / Teachers etc. is gradually met, reducing the need to retain all training instructors. As for new entrants, a minimum requirement of suicide prevention training will become a necessary requirement for entry into their given field.
Appendix:
Policy Budget

<table>
<thead>
<tr>
<th>€m</th>
<th>Total €m</th>
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<tr>
<td>7.5% Tax on Alcohol Off-Sales</td>
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<td><strong>Total Income</strong></td>
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<tr>
<th>Expenditure</th>
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<tr>
<td>Funding of Organisations</td>
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<td>Awareness Campaigns</td>
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<td>Training Resources</td>
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<td>Research Funding</td>
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<td>30 Training Instructors</td>
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<td>Audit with 3TS</td>
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<td>24-Hour Hotline</td>
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<td>Salaries</td>
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<td>NOSP Teams</td>
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<td>40 Research Officers</td>
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<td><strong>Total NOSP Budget</strong></td>
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<tr>
<td>Dept. of Health</td>
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<td>20 Out-of-Hours Teams</td>
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<td><strong>Total Dept. of Health Cost</strong></td>
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<tr>
<td>Dept. of Education</td>
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<td>Guidance Counsellor Reversal</td>
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<td>660 Primary School Counsellors</td>
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<td><strong>Total Dept. of Education Cost</strong></td>
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<td>Others</td>
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<td>Psychological Therapy Body</td>
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<tr>
<td><strong>Total Expenditure</strong></td>
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Ratio of Funding to Fatalities for RSA & NOSP (2007-2012)

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<thead>
<tr>
<th>Year</th>
<th>RSA €m</th>
<th>Fatalities</th>
<th>NOSP €m</th>
<th>Fatalities</th>
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<tbody>
<tr>
<td>2006</td>
<td>31.1</td>
<td>365</td>
<td>4.5</td>
<td>409</td>
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<tr>
<td>2008</td>
<td>39.704</td>
<td>279</td>
<td>5.1</td>
<td>424</td>
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<td>2009</td>
<td>32.835</td>
<td>238</td>
<td>5.6</td>
<td>527</td>
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<td>2010</td>
<td>28.746</td>
<td>212</td>
<td>3.1</td>
<td>486</td>
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<tr>
<td>2011</td>
<td>22.185</td>
<td>186</td>
<td>4.1</td>
<td>525</td>
</tr>
<tr>
<td>2012</td>
<td>13.885</td>
<td>2012</td>
<td>7.1</td>
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<table>
<thead>
<tr>
<th>RSA €per fatality</th>
<th>NOSP €per fatality</th>
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<tbody>
<tr>
<td>2007</td>
<td>85,205</td>
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<td>2008</td>
<td>117,467</td>
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<tr>
<td>2009</td>
<td>117,688</td>
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<td>2010</td>
<td>120,781</td>
</tr>
<tr>
<td>2011</td>
<td>124,646</td>
</tr>
<tr>
<td>2012</td>
<td>74,650</td>
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