SUICIDE IN MODERN IRELAND
NEW DIMENSIONS, NEW RESPONSES

Questions & Answers
SUICIDAL IRELAND: A FUTURE?
PANEL DISCUSSION

Sunday Morning 14 November 2004

In the Chair: **Olivia O'Leary /** Journalist, Author & Broadcaster

Panel Discussion: **John Mann MD /** Professor of Psychiatry at Columbia University
Prof Kevin Malone / SVUH, UCD & 3Ts
Prof Paul Soloff / Professor of Psychiatry Western Psychiatric Institute & Clinic University of Pittsburgh
Derek Chambers

Olivia O'Leary: You know who are two speakers this morning are but just to remind you who the other members of the panel are. On my left we have Professor John Mann, Professor of Psychiatry at Columbia University and Director of the Conti(??) Centre for Research and Suicidal behaviour at Columbia University and currently President of the American Foundation for suicide prevention. Also joining us is Doctor Paul Soloff who is Professor of Psychiatry at the Western Psychiatric Institute and Clinic University of Pittsburgh and with support from the National Institute of Mental Health USA, he has engaged in studies of the Psycho Social and Biological risk factors for suicidal behaviour in patients with borderline personality disorder.

So I am going to start to throw out a few ideas, first with our two Irishmen here and taking Derek's point that his research has shown poverty does not cause suicide. If prosperity does, Derek, why? Is it suddenly having all the choices. There was there was a time when we did not have all the choices?

Derek Chambers: It is a bit abstract but to talk about it overall and not maybe just in terms of individuals, but the influence of Irish Society, definitely our suicide rate increased in tandem with our economic growth. I think the idea is a kind of a sociological concept, this idea of anomy. When you have anomy in society and that means that your norms, your values have broken down. It happens had times of big social transition, big social change and we have had massive social change in a very short space of time in Irish Society. In those periods, people don't have the framework really to live their lives anymore. The traditional institutions like the church, family structures, working life, they have all changed, they have all broken down. New ways of life, post-modern ways of life, the way of life in the US, in big cities, takes longer to settle down and to come on stream. So you have this period of change in between traditional Irish society and settled post-modern Irish society. In that period of transition, you get huge symptoms of deviancy and not just suicide but increased rates of alcohol abuse, increased crime rates.

Olivia O'Leary: Tell me, is it to do with communities breaking down? We are in what they call the post-Fordist society in terms of not having big work forces anymore, so even somebody who is unemployed doesn't have perhaps the support of a big workplace with all the organisation structure that goes with that. We have maybe communities / parishes breaking down. We don't have the same sense of being part of something bigger that perhaps I would have grown up with.

Derek Chambers: Yes, that is the key thing. People are not integrated into society anymore. Society is much more individualistic, material, a greedy society in some ways and also the level of expectations that are propagated through the media.

Olivia O'Leary: Yes, there used to be a great thing in Ireland called the "Poor Whore" mentality, which I suppose is the compassionate pen. We are all familiar with that. In fact in Ireland we were always very vague on failures, as I remember it. We took them to our hearts, so I suppose that is gone.

Derek Chambers: Yes, Kevin mentioned the idea that you have to achieve and if you don't, you're a loser. We did some work with young men and one of the guys in one of small focus groups that we did said that nowadays if you do not have a job, you are the ultimate loser, because everybody else around you apparently is doing so well, has the car, has the house etc. If you are young man in your '20's and you don't have that, then you are the reject.

Olivia O'Leary: It is a phrase that young people. It upsets me with my daughter, she is constantly using that phrase "Mum, he was such a loser". Whereas, I would have said he was a pain in the ass or a nerd, but this is the phrase that she uses, Loser. And Kevin, just remembering Ireland as it used to be at a time when suicide was the sin of despair. I remember as a youngster that there was this thing that you didn't talk about it that it was a sin and yet it happened. In the part of the country that I am from, with its waterways, there were regularly people who would drown themselves in the local locks. It was never referred to as a suicide but we all knew that was what it was. So is there an element that we didn't report it because we never admitted either as suicide or indeed to psychiatric illness?

Kevin Malone: Yes. If I could just put on my psychiatrist's hat for a minute and something that I touched on yesterday and that was the whole notion of have we incubated suicide in this country and as a psychiatrist with a slightly cynical hat, you could say that we have just really let our patients with mental health illnesses down badly over the last 20 years. We put together a programme called Planning for the Future where we closed all of the psychiatric hospitals, which at the end of the day, even thought they were custodial, they were actually caring, they cared for people with enduring mental illness at a time when a lot of modern treatments weren't available. We talked about increased prosperity, increased suicide rates and I presented a slide which has increased suicide rates and I have a line going direct diametrically opposed the other direction and what is this variable? People come up with all sorts of social this, that and the other but the variable is reduction in in-patient beds. I am not saying that beds are the answer but I am saying that when we did close the beds, what we were meant to put in place was a comprehensive community psychiatric and mental health service and that has been appalling under funded when you compare what has been going on in other countries that are really serious about looking after patients with mental health problems. We have a skeleton service where people are expected to assume responsibility for severe, enduring mental illness in the community. They can be just about admitted to hospital in an absolute crisis and as a result of which I would hypothesise that you could argue that the suicide rates began increasing in the '80's when you started closing beds, because at the end of the day, most of the suicides have severe or significant mental illness. Now some of the young people now don't, but you could argue that the trend was set in the '80's and then it trickled back into more mainstream society in the '90's and that is what we are seeing now in terms of an incubation that is acceptable because it began being more apparent. I know that is a slightly radical statement, but I would like to hear the audience's view as to how far they think that is from the mark, because it is such a travesty how badly we are letting down our patients with mental health difficulties.

Olivia O'Leary: And what you are describing is a lack of safe places where people feel safe.

Kevin Malone: Well, I think you have got to triage it at different levels. If you are in a suicidal crisis with a severe mental illness, obviously you don't want everybody in a hospital bed, but sometimes it is enough to be able to reach out and communicate with those people. There is no 24/7 service that helps those particular people and that if you like keeps them out of hospital, if you want to be very economical about it, but that actually supports them. So it is a real hit or miss. So if you are in that crisis, you may reach out but if you have had a bad experience before, you are not going to reach out again. So actually, you do not get as John has talked about earlier and I will come back to, you don't get the Second Chance. And when you have got a severe mental illness, there is notion that you are all washed up, you are finished. This is not the case. People can have significant mental illness and get back to lead incredibly productive, fulfilling lives. We have got to be serious about that. Just like somebody with a significant childhood illness. You treat the illness, they get better, then they are able to resume their place in society. But we treat our patients with mental illness so poorly that by the time they get back into the mainstream, they are stigmatised, they won't be employed in jobs, so they are right down the social ladder already and surprise, surprise, things go from bad to worse.

Olivia O'Leary: Well, I'll go to the audience and ask for an immediate response to that point of Kevin's as to whether part of what we are suffering from now is a dereliction of duty really to our mentally ill, right from the closing down of the big mental hospitals. I remember there was a big one in Carlow, called St Vincent's, which was closed down. And whether we simply have not either put the resources into treatment for the mentally ill or indeed taken seriously community care. Is it too early in the morning to be asking people for a comment on this?

Q - Margaret Fitzgerald: I am a psychiatrist for the Eastern Health Board and coincidentally married to Kevin Malone so he will have heard my opinion before. I just want to reinforce the difficulties we have out in the community working as psychiatrists. We are completely under-resourced. Firstly, it is very hard to get people to come for treatment, especially young men, and the last person they probably want to meet is a psychiatrist, but we are who they meet. We are at the coalface. We don't have access to proper counselling or psychological services so we are given 10 or 15 minutes per outpatient. We have to try and fix everything in that short time. Much to other people's disappointment I guess, a lot of that is prescribing medication, which does solve some of the problems but it is very much hanging by a thread. In our particular area, we have at least a 6 month waiting list to refer somebody to a psychologist and it is just like a war zone. We know the young men don't necessarily want to interface with us.

Olivia O'Leary: And there may also be, perhaps the medical profession itself doesn't fight hard enough for resources for mental health. There is a hierarchy there as well I suppose. There was another hand?

Q – Ella Arensman: I am Ella Arensman from the National Suicide Research Foundation. We also have quite a lot of pieces of evidence underlining Kevin's hypothesis or Kevin's explanation. With regard to previous studies in the Netherlands and in England, I must say that still, although even we work intensively with psychiatrists and psychologists, people who are suicidal I would say are the people or sub-group that needs attention. They are the less popular group but also even people, researchers, psychologists, psychotherapist…

Olivia O'Leary: Why is that? Is there still the thing of "you brought it on yourself?"

Ella Arensman: Well, even in many western European countries, the taboo issue and the fear of working with people who are suicidal, especially among young psychiatrists, young psychologists is an issue that is not really properly dealt with. So I think also,

instead of the quantity of services, I think also the quality of services is an important aspect.

Olivia O'Leary: Why are they afraid? Are they afraid of taking responsibility, afraid of not being able to find an answer, of not being able to stop somebody from committing suicide?

Ella Arensman: Well, that is one particular aspect and I think in any team of psychotherapists or psychiatrists, I think there should be a specific protocol in place on how to deal and how to work with people who are suicidal or people who have repeatedly harmed themselves. Such a protocol is not always in place. One comment of another possible explanation - I think there is a lot of evidence for Kevin's explanation but it doesn't explain the fact that we saw this very strong increase in male suicides which we didn't observe in the females, so I think it is definitely not one hypothesis and the aspect of deviancy in males which is referring to Derek's model or evidence, I think that might be more strongly or a more important fact associated with the male suicides. We don't know yet everything about it but we see this strong discrepancy.

Olivia O'Leary: Can you put a name on deviancy?

Ella Arensman: Derek gave a few examples. Apparently, the Celtic Tiger arrived for the whole nation of the Republic of Ireland. But in practice it does not mean that everybody can profit from that in the same way. A few recent studies done by a psychiatrist who originally came from the Netherlands but worked in UK as well, Professor Nellemann, he did some studies in London and he found that whether people were deviant from an ethnic point of view or a socio-economic point of view, they still seemed to have the highest risk of being suicidal. So being unemployed itself was not a risk factor but if you were unemployed in an area where the majority is not unemployed, then you seem to be having a particular high risk. So there is not one answer but there is evidence for both.

Olivia O'Leary: I'll just take a comment from the woman behind you and then I want to come back to John Mann and Paul Soloff.

Q – Theresa Millea: I would like to comment on something Derek mentioned. It is about the counsellors for schools being funded by the health boards and the Department of Education. The suicide rate in Ireland now is a national tragedy as so many lives are lost at every age and a huge industry has built up around this. This industry is counselling and it is a very lucrative industry really. I talk to people and they say that they met with other people who had lost somebody and they called in a counsellor to talk to them and the first thing she said was it was going to cost x amount per hour, before any listening was done or anything. I think that really people need to just be prepared to listen and not to put a value on their listening because really the listening is priceless. There is a very good reason that when God created us, he gave us two ears and only one mouth because he wanted people to listen. I know counsellors pay a lot to be trained and they are entitled to make a living but it shouldn't be the be-all and end-all of everything. There should be something that is either low-cost or free and I am really more in favour of the low-cost because if there is a small fee paid, the person receiving that service will put more value on it than if it was free.

Olivia O'Leary: Yes, there should be free listening aid like free legal aid.

Theresa Millea: Yes, people should be prepared to listen and people with a qualification and training should really be prepared to put something forward and listen.

Olivia O'Leary: Yes I am sure there are lots of ways of handling that. Do you want to comment on that?

Derek Chambers: Yes, just very briefly Theresa, by and large I agree with you. I don't have a clinical background, but when you were speaking you reminded me of another important point. I think there is a notion out there that men do not talk and I think that from what we heard when we were around the mid-west, the guys were all around 20-25yrs and anecdotally as well, young guys do talk but they don't talk necessarily to authority figures or health services as Margaret was saying, but they do talk to each other. There is something there. I have heard of cases where somebody had taken their own life and in speaking to relatives afterwards, they would have said that the person who had died had told his friends in the weeks leading up that he was going to harm himself, that he was going to do something. The difficulty is for the friends and the other young people because they don't know what to do with that knowledge because there is something about choice of words and teaching people how to listen and how to respond.

Olivia O'Leary: Moving on from Kevin's point, to what extent and I am a total ignoramus in this area, to what extent should we assume that people who die by suicide have a psychological disorder? Is that always necessarily the case?

John Mann: I was impressed by the comment about the two ears and the one mouth and especially when you are coming from another country. It is very hard for us to see things differently from our own point of view. When somebody comes and tells you something that you don't agree with, especially when they come in as a so called expert from another country, you can always say especially in Ireland that you really don't understand what life is like in Ireland and the history and the culture and the society and the role of religion and what has happened over the years. So if I say something that you might not agree with, it is easily dismissed, especially when people start the question with the statement that they don't know a lot about it. That makes me very nervous. The fact of the matter is that I have now been to many countries around the world who have been concerned about the horrific loss of life due to suicide and the same question arises everywhere. In practically every country people have ascribed all sorts of explanations and causes for the suicides. The one they come to most reluctantly is the fact that psychiatric illness may be playing a critical role. I will give you an example; we went to Hungary to a very poor rural area in the southern part of Hungary. There were no tourists, in fact most Hungarians don't go and visit. It is an area with about 50,000 adults and older people, most came from rural areas and gone to the city and psychiatric services are miserable and they have the highest suicide rate in the elderly in the world. They had all kinds of explanations for the reasons for the suicide – poverty, isolation, people living on their farms, their kids have gone to the cities, they regard themselves as failures etc. In fact what we did was that we started what Kevin is proposing to do here in Ireland. We decided to ask the question, why are they really committing suicide? We set up a programme to interview the families of all the suicides. The interviewers by the way were people from Hungary who we trained in the interview techniques so we did not bring our own prejudices to the situation. One was a psychiatrist and one was a psychologist so it was not like only medical people going in looking for a single explanations or psychologists looking for psychological explanations. 96% of these people who killed themselves had a psychiatric illness at the time of their death and the commonest psychiatric illness was an untreated depression. By the way, they were almost all untreated. A very high percentage in this area which was a winegrowing area were also alcoholics. So we then went in and tried to educate the GPs who were providing most of the healthcare services, there were no counsellors around. There was not a single Alcoholics Anonymous group within the entire area. By the way, there still is not one even though we have been trying set up one for 4 years. We then asked the question, what can you do about this to these GPs. Some of these GPs had several suicides per year in their practice, which is just mind boggling. In the US, if a GP has a suicide every 4 or 5 years, that seems like a lot. Some of these GPs had four suicides and one had five suicides in a single year. There was an amazing amount of nihilism about this. They thought they were recognising all of the psychiatric illness; they thought they were treating all of the people who needed help and they just thought that suicide was an inevitable problem in their area, in their country. We talked about

alcoholism. When a couple of the GPs are going to have a drink at the bar at 10am in the morning, you begin to wonder what is their threshold for recognising alcoholism in the area and in fact they were not much good at picking it up. In fact all of the same type of things – the men didn't go for help; people drank; they had one ?? patient unit which was a room that was about 20% of the size of this main room here. That room had 8 guys in it and they were being treated for the DTs (delirium tremens). The admitted to their local hospital one guy a day for treatment of the DTs and they got an IV, some vitamins and a bit of sedation and then they went home after a few days. That was the entire areas treatment for alcoholism.

Olivia O'Leary: So, alcohol and depression?

John Mann: Yes, I am going on a bit long, got it!!!

Olivia O'Leary: Aah no!

John Mann: I think that if you don't go and ask and talk to the families and ask what is going on you are going to have a lot of myths. I am a little startled by the nation that prosperity is as big a threat in terms of suicide as poverty. Maybe the real issue is that when people have a psychiatric illness, they just have trouble coping with a lot of things. You will never ever be able to control the environmental factors and social stressors that are important. The only thing you really can get at is treating their psychiatric illness so they are more resilient and can cope with the demands of society.

Olivia O'Leary: Right, Paul. The questions that ignoramuses like me ask, does that mean that everybody who dies by suicide has a psychiatric disorder?

Paul Soloff: Going by the numbers, one would have to say not everyone but the vast majority, especially depression. I would like to address myself to the other side of the equation and that is what is being done. We have a great deal of knowledge of risk factors for suicide, of major depression, alcohol; John has just outlined conditions in a very poor part of Hungary, appalling conditions. The Republic of Ireland is enjoying a period of prosperity and is certainly a very advanced and sophisticated society at this point and yet there is a gross discrepancy between your ability to diagnose and the ability to treat and that discrepancy is caused here over and over by lack of funding. As an outsider, I was most impressed to meet your President on the very first day of this conference. President McAleese was very eloquent and she talked about the stresses in society and she used the word predators over and over again. Society has to protect its young from predators. I assume that was a catch phrase for the epidemics of drug abuse and drink that we have throughout all of the western cultures. So there are stresses that come with prosperity. But the President of the Republic was here in support of this organisation, in support of the effort to deal with suicide in Ireland and then to listen to one speaker after another describing very good science, very strong efforts to treat and yet each of them mentioning at some point in their presentation the lack of funding. Good projects going for lack of funding. There is a gross discrepancy. Your health budget, one of the speakers mentioned, was actually cut. A decrease in the health budget in Ireland. Prof Malone has mentioned the difficulties they have obtaining adequate funding. So perhaps some of the difficulty in the epidemic of suicide is that it is not being treated adequately. Maybe some of the other European countries, eg. Norway was mentioned, have been more effective in applying the funding to the male health issues and getting treatment where it is needed. Certainly treating major depression and treating it aggressively, treatment substance abuse and treating it aggressively would go a long way in removing some of the major risk factors that we know are responsible or at least involved in much of suicide. The knowledge is there but there seems to be a lack of political will that results in the funding of the programmes that would provide the treatment. As I say, I am outsider, I just note the inconsistency and wonder why there is a lack of political will. I just leave that as an open question.

Olivia O'Leary: And it may be that there is a particular lack of political will in relation to mental illness because there has been a silence generally in the country about mental illness so maybe we are just growing the lobby to demand better services in that area. Moving on to a phenomenon that was the contagious nature of suicide and one does hear about these clusters of suicide or that sometimes in a family there can be one suicide related to another, copycat suicide. Why does this happen?

Paul Soloff: Well, again, of the variety of reasons that have been offered, probably the simplest explanation and it may be the one that applies the least is that in some families there is a genetic pattern of depression. If you follow a family history that has multiple suicides over the years, you can sometimes find a pedigree of recurring depression throughout that family. As I say, that is the simplest explanation and may be the one that accounts for the least number of cases. Why suicide becomes, in some ways fashionable, as a solution for social problems and why, especially teens, impulsively follow each other's lead? I don't believe there is a good answer for that yet, at least none that I am aware of.

Olivia O'Leary: I remember doing a programme years ago with two people who had had relations who had died by suicide and it was an upsetting programme. In one case, a woman's mother had died by suicide and in the other a woman's older brother had died by suicide. But they both spoke of their sense of dread every year on the anniversary of what had happened and also they sensed that they were not safe until they had passed the age at which the other person had died by suicide almost as though they had taken on board this pattern and had thereby set almost an end to their own life at the same date as the age that this relation had died and did not feel safe until they had passed that point.

Paul Soloff: What I hear as a therapist is that suicide in a family sets an example. It gives permission for other people in the family who are facing extreme stress to follow that path. It takes away some of the burden, some of the stigma within that family. But again, being biologically oriented, I would prefer to look at these families and look for major depression, a genetic basis for the depression. But there are also the psycho-dynamic factors of making it the family way of resolving, making it acceptable in some ways to resolve the problem.

Kevin Malone: Can I make a contribution there briefly? This is in regard to a training of therapist. I think we have this sort of standard that anniversaries are a risk period. People say that Christmas, New Year, Easter and maybe the day that the person died, but actually everybody has specific anniversary events inside, so as a clinician you have got to be able to interact with the person and from an identification of risk point of view, you have got to identify with the patient their specific anniversary events. Whatever day, it is significant for them. Rather than just going with the generic, you have just got to watch out for everybody at Christmas time, in terms of individuals when you are training people with regard to risk for suicide, there are specific points that are significant for people and that is part and parcel of training and early identification.

Olivia O'Leary: Just to ask John about the whole business of the contagious nature of suicide and suicide clusters. What do we know about that?

John Mann: Well it is something that seems to mainly effect young people so you see it in schools; you see it when there is a highly publicised suicide of say a pop star such as Kurt Cobain or somebody like that. There was a famous incident in Germany where a movie was shown of a young man killing himself by throwing himself in front of a high speed train and they had an increase amongst young people throwing themselves in front of high speed trains. So the media have to be educated to either report constructively or don't say anything basically. To prevent these episodes of contagion and in the case of suicide occurring, the same thing applies to obviously television reporting. When they televise something live and in a very melodramatic fashion etc, what they are doing

essentially is dramatising suicide, romanticising suicide, presenting suicide as an acceptable solution instead of presenting the real message which is that suicide is a tragedy, a consequence of something which was potentially preventable and it needs expert help to evaluate the risk and the causes and to provide them with help.

Olivia O'Leary: Just quickly before we go to the audience, can we talk a little bit about that, the romanticising of suicide. Everything from the elaborate funeral, which perhaps may make some vulnerable young people feel oh gosh that's the way to gain attention, to validate my life, or even the whole thing in popular culture from Mayerling to Elvira Madigan to Billy Joe McAllister, this thing that somehow there is something romantic about the notion of death. The media obviously have a role to play but do churches have a role to play in the way that they handle the funerals of suicides?

John Mann: You have presented many very good ideas and it is all about getting the message across that there is something beyond the suicide itself and the funeral and the attention that the young person who commits suicide gets, that the real story behind the suicide is a lost life and a life that could have been very different and the life of the family could have been very different. To get it back you have to begin to de-stigmatise the real causes of suicide and to allow people to confront those causes. Part of that is de-stigmatising the fact that you may be suffering from a mood disorder or have alcoholism or substance abuse and that it is okay to get help. That is a very difficult task. The stigma of mental illness is so great that I am convinced that that is one of the reasons we get questioned the whole time, over and over again "aren't there a lot of suicides that are not due to mental illness?" Just the fact that that question keeps coming up when there are so many studies around the world that have found that over 90% of suicides are due to mental illness. Why would you want to keep on getting an answer? Well is it really 10% or 5% or 3%, there's got to be some? Well, when you start dealing with the problem that is causing the loss of so many young lives and you know the major cause of 90% of them, let us get to work on the 90%.

Kevin Malone: Then I suppose everyone says, well how come 20 years ago young men weren't depressed and now they are? I believe they were depressed 20 years ago, I just don't think that they had the option of killing themselves and they had sort of transient depression that they struggled through, went on the other side and then came out and lived on.

Olivia O'Leary: The glamorisation and romanticisation of suicide, Kevin, is there anything that we as a society can do, Kevin? Are there things unconsciously that we are doing that we need to stop doing?

Kevin Malone: Well I suppose I don't want to be repetitious and I certainly would like to hear from any clergy that are in the audience with regard to how they think that the whole glamorisation thing and I think that a funeral is a very difficult time because it is obviously such a tragedy for the family and you go one of two ways. You either are completely angry with the suicide victim or else you want to embrace them and you almost talk them up to sort of cover over the fact of the tragedy. I think it is a real dilemma for the clergy and whether or not there are training programmes that help them with regard that within their own spiritual guidance and leadership, I don't know. But I think, as John says, they are more likely to identify with the fact that the person died as opposed to the fact that the person was depressed and took their lives.

Olivia O'Leary: Well, I suppose their emphasis is on the next life very often, maybe too much so in this situation. Derek?

Derek Chambers: I would like to briefly comment on the imitation and copycat nature and glamorisation factor. I think that especially in a country like Ireland where there is that community still and people do know each other, I think the most important thing in the aftermath of a suicide is to ask the people who are left behind, are they okay, at least

to provide relevant support services. I think that imitation or clusters are happening in Irish society. It's social modelling and I think that there are direct factors involved. I think that is the most important thing to take from it, it is developing fair and decent support services.

Paul Soloff: Let me just address the issue of glamorising. I deal with suicidal patients who are para-suicides ie. they have survived. One of the things that we do in any kind of psycho-dynamic interview with such a patient is that we ask them to imagine what would happen had the suicide succeeded. Who comes to the funeral; what does the funeral look like; how do the people who were attending feel and think about them? That gets at the motivation of the psycho-dynamic motivation of why the suicidal act was committed. To be absolutely frank, I have never heard anyone talk about how glamorous it was. They talk about "now my mother will miss me; now my father will respect me; they'll all be sorry". Nobody talks about how glamorous it was. Maybe my patients don't do glamorous things. They take overdoses or they cut themselves but I think that the glamorisation issue may give permission to somebody, may tell them how to do it but I think the psycho-dynamics and depression, the biology of depression, the psycho-dynamic part of it are really what is behind the suicide. The glamorisation I think is a false issue.

Olivia O'Leary: It is interesting how in this area suddenly we are talking again in a country that regards itself as secular and having escaped from the maw of being otherwise and that suddenly again we are turning perhaps to clergy people as the gatekeepers in this area. But just before we move on to final points about things we can do, do we have any comments from people on this area?

Q: I think that we have to get into the mind of somebody… for the increased co-operation … look at more or less their life revolves around Friday, Saturday and Sunday, drinks, and alcohol and spend the rest of the week in depression and looking forward to the next time they can get drunk and I really really think that there's no awareness that that is what is going along. …..**[couldn't make out all of question as questioner elected to do without a microphone]**

Olivia O'Leary: You are absolutely right. Go into Dublin any weekend, go into any half decent size town at the weekend and look at the number of youngsters falling around drunk and then ask yourself why there has been an increase among young people in depression and suicide. We don't challenge it.

Q: I came on Friday and I wanted to ask a question about the comment that SSRI drugs in particular can cause suicide. We have eminent doctors in Ireland, Michael Corry and Terry Lynch and in North Wales, David Heany, the chairman of MIND in the UK, have all participated in programmes such as those. I am just a layman, confused and happy having listened to John Mann in particular, I am leaving with a different impression of SSRI medication. The whole issue of medication and medicalisation of depression is perhaps something that the 3Ts must engage with. Doctors differ and the public are confused, I am confused.

Olivia O'Leary: As to whether medication should be the main answer, is that what you are saying?

Q: Exactly, but also because of the pharmaceutical companies and the withholding of medical trials and unfavourable information and the fact that regulatory authorities are not perhaps always on the ball. It is a huge issue and nowadays we suspect and question everything about this.

Olivia O'Leary: It is. Just going back to the previous speaker about the things that we don't talk about. Young women often find when they go on the pill that there is a big depressive reaction. We don't hear about that. That's not spoken about. Maybe it is the

more political correct area of things we won't talk about. There was somebody behind you wanted to get in and I will put your point to the panel.

Q: Yesterday Prof Soloff made a point that religious background had no effect on a person's decision to commit suicide and yet later he did say, he enumerated clergy as one of the gatekeepers who would be in a position to influence a person's decision to commit suicide. I am wondering as there seems to be a paradox there.

Olivia O'Leary: I will let Paul answer that.

Paul Soloff: The finding that religion is not protective had to do with the attempted suicides within my sample of 136 patients that I presented. Religion was not or did not favour the prevention. It did not statistically favour attempters or non-attempters. It was not a protective factor in my study. Clergy, school authorities, physicians, family, friends etc are all part of social support so I was talking about the importance of increasing social supports which turned out to be protective. Clergy can be introduced in that area. When people are asked do you adhere to a defined religion and we look at whether they went on to attempt, then it makes no distinction as they adhere to a defined religion. But clergy from the point of view of a social support, contributing to social support, would add protection from that side. There are two different ways of looking at the same issue – whether you adhere to a defined religion or whether you are able to find support from a clergyman or from other sources of social support. They are two different issues.

Olivia O'Leary: Just quickly then to you, John, and to you Kevin, the question raised about medication. Do we too quickly look for the medication answer to depression or are there other areas we should explore.

John Mann: I just want to say a quick thing first about religion and that is that I think that I am a religious person so I sort of ponder about these matters. There are two things about religion, one is that for religious people this is a way of gaining extra strength which allows you to cope with adversity. So the fact that they may not commit suicide because they are religious and they are getting support from the church or whatever is good because it is keeping them alive. It is another way of getting a second chance. It is a particular way of getting a second chance if the clergy are trained in the recognition that sometimes people have a psychiatric illness and that is something to look for if they say that life is not worth living. Instead of being the therapist, the psychiatrist, the doctor or whatever, refer them to some place where they can get help. Speaking of help, then the question is what sort of help is useful and of course we are aware of the concerns that some psychiatrists have raised about the safety of the use of certain types of anti-depressants. The first rule of medicine is they do no harm. So we want to be sure that the treatment we are offering is more helpful than harmful. With a few notable exceptions I would say that the overwhelming body of medical opinion is that SSRIs and other anti-depressants are probably our main tool for reducing suicide rates worldwide. The question that arises, is that also true for young people because analyses of some of the clinical trials suggests that young people getting the anti-depressants will have more suicidal ideation or may have made more suicidal attempts than young people getting the placebo. The fortunate thing is that out of all of the thousands of kids who have been in clinical trials that we know of and I think that now we have analysed all of the data of all the regulatory agencies, there has not been a single young person on the active drug who has committed suicide. Not one. On the other hand, we have all the other data analysing, showing a relationship between more anti-depressant prescriptions given to young people with a lowering of the suicide rate in young people. So our assessment is, and if you look at who commits suicide, nearly all young people who commit suicide who have depression are untreated at the time of their death, so it is the lack of treatment that is the reason it is not the treatment.

Olivia O'Leary: Kevin, is it a matter of yes using the available medication but there are other therapies available as well.

Kevin Malone: I think it is a very important question but to be a little bit cynical about it again**.** We were pushed into that vacuum when there was a lack of complementary psychology services through the '80's and early '90's so if you were a doctor or a psychiatrist or clinician sitting in front of a patient, you had no alternative. All you could prescribe was medication. You could not recommend medication and psychological therapy because it was not and it still is not funded in this country. So of course, the drug companies are going to make.. you can see at all their conferences all over the country, (you will note the lack of drug company sponsorship for this meeting which I assure you was not coincidental), they are all over the country; they are very good at publicity. If you are a clinician and you have no supplementary or complementary therapy that you know is effective and available to the patients, then all you have to do is prescribe them the medication. The other point that Margaret Fitzgerald made is that the reality is that for most public psychiatrists or psychiatrists in public service or clinicians, you have a maximum of 15 minutes per patient and you just cannot deliver a quality service. When I started off with the health board, there were 40 patients in the Mater sitting outside my door and I had 2 hours to see them, so I ploughed through with one other doctor. I saw 25 patients and he saw 15. The same thing happened the next week and the next week. After 3 weeks, I wrote to the health board and I said they had appointed the wrong person. I am trained to deliver a quality service and not a quantity service which really got me off on the right foot.

Olivia O'Leary: I could point to Kevin and I am going to put it very quickly to everyone. We had a minister in this country at one stage who said that suicide was a deeply selfish act. Is that how you see it or is it a highly individualistic act of somebody for whatever reason has become alienated or removed from his / her community / family / society?

KM: My recollection is that that is a paraphrase, Olivia, a deeply selfish act, if I am thinking of the person you are speaking of. I drew attention to that minister's comments not because of what he said at that time but because of really the lack of reaction that there was to it, that there was not a greater outcry. I guess there is a subtle feeling across the country and again it has to do with stigma that while it is a selfish act, how dare they do that and there is an enormous amount of anger and unresolved grief, and that can transmit itself in all kinds of ways, so I suppose individualistic act is one way. Again, you asked earlier whether it is glorified or romanticised, I have seen it around funerals people saying "he always did his own thing". That ignores the fact that the poor fellow was in a deep crisis at the time and was not able to reach out and there was not the support or the service for him to reach out. I don't want to emphasise services as I think support has to come through the community and not just that it's the government's responsibility to give support. I think it is the community's responsibility to give support. I think that it is the community's now responsibility to get beyond this selfish act and to really start understanding some of the significant underlying problems that are there.

Olivia O'Leary: Okay, I am just going to go quickly around the panel because we are coming to the end. If you were to name three important measures that you could take or start to take in terms of preventing suicide or even beginning to understand suicide, Paul, what would they be?

Paul Soloff: I would start with lack of funding and I would say that is your biggest problem and that organisations like the 3Ts need to become, as they are, proactive, lobbying politicians, educating, swaying the electorate, bringing effective pressure on the purse holders in the Irish government such that funding can be made available to adequately supply what is already known and that is treatment for depression, substance abuse, and dealing with school drop-outs and adolescents. Some of the mechanisms are already known but they have to be funded, that would be the first priority. The second would be educating the general public much more aggressively in the medical aspects of

depression. There is a lot of resistance to that idea. In the US it is actually a matter of publicity campaigns, bringing essentially commercial people into the project and using their skills to educate the public on the medicalisation or medical causes of depression. The third thing would be the same sort of thing about substance abuse. Ireland is stereotyped in that way. I am a tourist. I have been told to go see the Guinness Brewery and the Jameson Distillery. In my own country, we make wonderful beer. I would never recommend that somebody go visit a brewery.

Olivia O'Leary: What about the California Wineries?

Paul Soloff: Touché.

Olivia O'Leary: Derek, if you were to mention three or even because we haven't got a lot of time, two important measures that we could take to start addressing this problem what would they be?

Derek Chambers: I suppose the most important thing for me is how we conceive of suicide prevention or what it is. I think it is really important, it all ties in, it is all part of the one loop. We can all speak of lack of funding for mental health funding, that is because (and it has been mentioned by Paul and John and Kevin) the stigma is still massively there and that is right to the top – the people with the monies, the ministers. So I think we have to see suicide prevention in terms of starting at the very beginning and educating people in mental health issues and emotional health issues that have that general population approach. Plus obviously we have to target the people that we know through the research who are at risk. So it is the general population approach plus focussing on those who we know to be high risk and who we know to be vulnerable.

Olivia O'Leary: Thank you. John, the main things we could do to address this problem?

John Mann: Well, I think you need to do the thing that Kevin Malone is proposing which is to find out why people commit suicide in Ireland. I think that that is what will allow you to identify the major causes as opposed to the minor causes. Then with the kind of effort that Paul Soloff suggests is to get money, use the money and spend it wisely. It is important to do things that really work rather than spend a lot of money doing things that feel good. You know, death due to suicide is not a selfish act. It is no more selfish than a person who has cancer and dies because of the cancer. This is the whole problem. People are devaluing the role of psychiatric illness, the role of the pain and the distress of the individual who kills themselves. I think it is terribly unfair to judge these people. I never judge them. I just feel distressed and unhappy that they have cut their lives off and we need to see this as a missed opportunity to have detected and treated another person and give them a chance to live a full life.

Olivia O'Leary: Kevin?

KM: Not to touch on the same points and I have lobbied for it at the University and I have drawn attention to the fact that we have a Dept of Women's Studies in our universities and they are flourishing and I have called for a Dept of Men's Studies and I think we need to shift the balance a little bit as I think we need to understand more about men in Irish society. I think if we hive off suicide as purely a mental health issue it is just going to get mental health money. Whereas if we say we need a major men's health initiative, there some significant men's health problems in Ireland that we need to address – prostate cancer, bowel cancer and suicide are the three biggest killers of our men and we should have a very very focussed and dedicated campaign. That way we are going to get money from outside mental health. They are going to have to enlarge the health budget. Just to correct Paul, the health budget has been increased, it's the mental health spend as part of that budget that has dropped from 12% to 7% over the last 5 years. People should be aware of that. I still reiterate John's point, the second chance.

We really owe it to the people who have problems to help them beyond the problem so that they can have a second chance. Thank.

Olivia O'Leary: Thank you Kevin. I would like to thank our panel, our distinguished visitors from abroad, John Mann and Paul Soloff and Derek Chambers and Kevin Malone. We'll return in a few moments for the closing remarks from the chairman of the 3Ts.