

The Trouble with Suicide

*Mental Health, Suicide and the Northern Ireland Conflict:
A Review of the Evidence*



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The cover shows two of the wall murals in West Belfast on the theme of suicide. The centre picture is of a mural at the top of Whiterock Road on the edge of Ballymurphy. The 'suicide awareness' mural is off the Falls Road in the Beechmount area. Photographs by kind permission of P. Hillyard.

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Introduction

The Trouble with Suicide

In 2006, almost three hundred people in Northern Ireland took their own lives. The number of suicides registered that year – 291 – was the highest ever recorded in Northern Ireland’s history and a marked increase on 2005. These suicides were among more than 6,000 across these islands, including 840 in Scotland and 500 in the Republic of Ireland. Very probably, the numbers were even higher because, as will be seen, some suicides are hidden. Whatever the figures, the totality of suicide represents a huge impact on families and communities, emotionally, socially, and financially. It also confronts public policy with major challenges, which is why many countries have developed dedicated suicide prevention strategies, and why much of the social science research reviewed in this report is carried out.

The specific task of this review is to assess the evidence of the effects of the Northern Ireland conflict on mental health and well-being, with special reference to suicide. It is being carried out as part of the Suicide Prevention Strategy which recommends initial research on the topic, including finding out what if any relationship exists between the legacies of ‘the troubles’ and current suicide trends (Department of Health, Social Services and Public Safety, 2006). The Strategy also recommends research on the psychological profiling of deaths by suicide and an investigation into self-harm, some comments on which appear in this report. None of this is easy, as pointed out in the only attempt to cover this ground to date: ‘Such research in a sensitive political climate is fraught with ethical, methodological and interpretational problems’ (McWhirter, 2004: 37).

Private pain, public problem

No death is ordinary to those immediately affected, but suicide is especially shocking. When someone takes their own life it is usually sudden and unexpected. Even with warning signs, no-one can anticipate the moment, as part of the determination to die is to ensure that the suicide is not thwarted. But often there is no warning and those left behind struggle to understand what happened. Could they have done something to pick up on the clues and to prevent the death? Did the person really mean to do it: a cry for help that went wrong? Was it designed to get back at people, an act of revenge that was meant to inflict pain on family, a lover or friends? Even suicide notes, if one is left, may raise more questions than answers. Why didn't they ask for help and why was the help given not good enough? And why does suicide cause so much guilt, anger, shame, hurt, and – as in the case of 'suicide bombers' – either sympathy or utter hatred? Why people kill themselves is harder to explain, and to come to terms with at a personal level, than death through ageing or illness. Even 'accidental deaths' and murders do not attract the level of unresolved questions as raised by suicide, or leave quite the same legacy.¹

The big 'why?' questions are not at the centre of this report and it may be the case, as some survivors of suicide attempts have argued, that the only thing worth knowing is the depth of despair that drives a person to the closed, almost impregnable, depressive state of mind within which suicide becomes the only logical course of action. Certainly, the mass of academic research on suicide does not make the act any easier to bear at the personal level and this author would be the first to acknowledge that the Samaritans do more immediate good than any social science research project might achieve in the short-term.

¹ This is not to minimise the legacies of the Northern Ireland conflict-related deaths of recent decades. The £34m funding from 2005 to 2011 for the Historical Enquires Team to review thousands of killings, and the many campaigns for the truth around specific killings, together indicate the public and private legacies surrounding these deaths.

On the other hand, it is important to take the complexities of the social problem of suicide seriously, otherwise we are effectively colluding with the despair of the suicidal. While talk and support are the essential immediate responses to people at risk of suicide, more widely shared knowledge of the social and psychological background to suicide helps to relieve the sense of personal responsibility that surrounds it. If what defines suicide in a legalistic sense is the *intent* to kill oneself, then what fuels that intent is the central question. Only a part of this is in the control of individuals so there is a need to explore these influences systematically. This point is well understood by practitioners working in mental health and other public services, by policy makers and, of course, by researchers. But it is not a perspective that is universally shared, nor the main influence on public understanding and debate around suicide.

The first problem is with the concept of intent. As Durkheim argued, 'intent is too intimate a thing to be more than approximately interpreted by another' (2002: xli). Some of those with serious intent to kill themselves, fail in the attempt, like the literary critic Al Alvarez. Conversely, some people who kill themselves may not have intended to do so – this has been argued in relation to the poet Sylvia Plath, as there is evidence that her suicide was carried out in such a manner that her intention was to be discovered and rescued. Others who lack intent and are often explicit about this, nevertheless engage in highly self-destructive behaviour, slowly killing themselves with alcohol and/or drugs – so-called 'chronic suicides', whose deaths would invariably not be officially registered as suicide. Still others, often preoccupied with depressive thoughts or stress, subconsciously kill themselves through momentary lapses of reason, concentration or willpower (Alvarez, 1974: 152-156). Most of these will be recorded as 'accidental deaths'. Our ideas of what lies behind intent are further complicated by euthanasia, 'advanced directives', 'living wills' and the concept and practice of 'assisted suicide'. There is a fine line between allowing and helping people to die and whether 'suicide' is the appropriate term in either case.

Durkheim's definition of suicide avoids referring to intent and motive, and focuses instead on the idea that 'the determining act is performed advisedly; that at the moment of acting the victim knows the certain result of his conduct'. So:

the term suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result. (Durkheim, 2002: xlii)

But why be concerned about such distinctions and definitions or even about suicide at all? Contrary to mainstream opinion, the libertarian Thomas Szasz (1999) argues that the idea of suicide prevention within social policy rests of the false idea that suicide is a sickness. The 'fatal freedom' – the right of the individual to control their own death through suicide should not, he argues, be interfered with by doctors or psychiatrists. He labels suicide prevention services as 'coercive' because they deny the individual the choice of taking their own lives and he objects to 'physician assisted suicide' on similar grounds.

Armed conflict and suicide

A more recognisable form of coercion arises in the case of those who are 'driven' to suicide through the physical or mental bullying, violence and intimidation of others – perhaps manslaughter or murder are more appropriate descriptions. For instance, one of the public debates in Northern Ireland around suicide concerns the role of paramilitary groups. The argument is that the growth of suicide among young men in North Belfast can be attributed directly to 'punishment beatings' (*Sunday Life*, 28 November 2004). During a debate on the Northern Ireland (Emergency Provisions) Bill in 1996, the Secretary of State for Northern Ireland referred to 167 punishment beatings taking place in 1995 and went on to name two suicides that followed such beatings (Mo Mowlam, Hansard, 9 January 1996, col. 46). In 2004, there is another reference in House of Commons debates in which suicide is framed in terms of paramilitary violence, this time by a Conservative MP:

The sad situation in Northern Ireland is that the punishment beatings, the racketeering, the exclusions and even the pressure towards suicide among young people have all got worse since the joint agreement. (Geoffrey Clifton-Brown, Hansard, 10 March 2004, col. 1608)

Evidence on paramilitary beatings presented to the Northern Ireland Affairs Committee in 2001, however, made no mention of a link to suicide (Northern Ireland Affairs Committee, 2001).

The oppressive conditions associated with conflict and war alter the way suicide intention is understood and sharpen public arguments about responsibility and motive. This is especially the case when suicide itself becomes an intrinsic part of warfare as in the case of the 'Kamikaze' missions of Japanese fighter pilots towards the end of World War II, or the 'suicide bombers' associated with more contemporary conflicts. As Gambetta (2005: 265) shows, it is not easy to make sense of suicide missions given the variety of organisations, groups, targets and purposes involved. What is clear, however, is that suicide missions are easily condemned and this creates a climate in which it becomes more difficult to understand suicides that are not weapons of war but nonetheless arise from the conditions that wars bring about. For instance when three of those held in the Guantanamo Bay prison camps killed themselves in June 2006, the reaction of one US official was to describe the suicides as 'a good PR move', while the camp commander said, 'this was not an act of desperation, but an act of asymmetric warfare committed against us'.² Relatives and human rights lawyers have questioned whether the three deaths were in fact suicides. Such controversies are now a common part of the international politics of political violence and armed conflicts.

While 'suicide missions' were never a part of the tactics of the armed groups in the Northern Ireland conflict, the above debates have direct parallels. The most politicised public debate around the nature of suicide in Northern Ireland took place during the hunger strikes of 1981. On the one hand, the prisoners'

² The first remark is attributed to Colleen Graffy, Deputy Assistant Secretary of State for Public Diplomacy (BBC News, 11th June 2006). There have been hundreds of self-harming incidents and over 40 suicide attempts at the camps, including the simultaneous attempted suicide by 23 detainees in 2003.

protest was dismissed as 'self-inflicted': 'If the hunger strikers die as a result of their own action then it is through exercising their own free choice.' (Robinson, 1981: 7) On the other hand, the government's position of no concessions was attacked as tantamount to 'murder'. Arguably, had the prisoners intended to kill themselves as a form of protest they would not have engaged in prolonged hunger strikes.³ Their deaths were not solely the result of the determination to stick to the protest as they could have been averted through concessions (Biggs, 2005: 174). Nor could the Catholic church go along with the idea that the protest was 'suicide', as Mitchell points out: 'while the church tried to convince the prisoners to end the strike, it stopped short of labelling the strikes as suicide (an excommunicable sin)' (2004: 249).

Already we can see how the conflict has shaped public debate about suicide. When greater awareness of suicide emerged in the post-1998 Agreement period, the first response was to understand the problem through the traditional political dimensions of 'the troubles' rather than as a social problem in its own right. While 'altruistic suicide' is a common form of political protest throughout the world, political protests *about* suicide are unusual. But in the spring of 2005, community groups from North and West Belfast, fearing what was being described as an 'epidemic' of suicides among younger people in their neighbourhoods, began public protests to put pressure on service providers (*Irish News*, 27 April 2005), expressing frustration with the sluggish response of government to the problem. There were other actions, such as petitioning Belfast Council, designed to raise awareness and change the political debate on suicide (*Daily Ireland*, 18 February 2006). At one stage, the Health Minister Shaun Woodward, with an apparent reluctance to commit resources to the issue, stated:

This is a special flavour to Northern Ireland. You take out a young man. You shoot him in the kneecaps or the ankles. He'll never play sport again. His manhood feels destroyed. His self esteem - like his bones - is shattered. So when it comes to dealing with this problem [suicide] remember that with not a penny more if we could end the paramilitary-style attacks on these young men, we'd start saving many of these lives

³ For an account of Bobby Sands' approach to the issues see O'Hearn (2006).

from tomorrow. If we could solve the problem with a cheque book it would have been done. (*News Letter*, 29 June 2005)

The Minister had met with community groups and politicians a few days earlier and his remarks were widely seen as attributing the suicide problem to paramilitarism, in effect suggesting that the solution to the problem lay within the grasp of local communities and political leaders. As will be seen, this contrasts with an argument found in the research literature that ‘the troubles’ have had the effect of *reducing* suicide because local communities became more cohesive.

The number of suicides resulting directly from the interrogation and punishment practices of loyalist and republican armed groups is not established. But the argument as stated is somewhat one-sided because it makes no reference to the mental health impacts of the conflict-related practices and regimes of the ‘law and order’ agencies for which governments are responsible – impacts on those working for such agencies, as well as on those they sought to control.

The legacy of conflict

At the outset, there are two principal arguments to consider about the relationship of ‘the troubles’ to mental health. The first is that the conflict has had only marginal effects on individuals and communities. While there were particular periods of intensity, notably the early 1970s, and while specific traumatic incidents and atrocities stand out, normality prevailed on the whole and most people – including children – were psychologically untroubled by events going on around them. This idea was at times reinforced by government campaigns emphasizing that the only pathological feature of Northern Ireland society was a relatively small number of individuals committed to terrorism.

The second argument is that the conflict has had, and continues to have, deep and widespread effects because it has been the context of daily life and

experience for decades. Violent conflict has dominated politics, employment, residential space, and social and cultural activities to such an extent that there has been a profound psychological impact in at least two ways, argues Hamber (2004). One is what he calls the 'politicisation of everyday life' which means that no matter which side people are on, all sides of the political divide end up sanctioning violence. A culture of violence 'seeps into everyday life'. The other is 'a legacy of authoritarianism' which, Hamber argues, is detectable at the level of the state, within communities and within individuals. The period of transition out of conflict therefore presents many psychological challenges as institutions and people come to terms with the legacies of the past, and develop new directions and frameworks for the future. The fatalism and restricted horizons associated with conditions of stalemated conflict give way to optimism and raised expectations, particularly in the aftermath of a peace agreement. These expectations may not be fulfilled, however, either at a social or individual level.

The purpose of this review is to get behind the above headline debate on the degree to which the conflict has permeated Northern Irish society and affected mental well-being. While the debate cannot be settled as such, it can be informed by examining the evidence in relation to three main questions:

1. To what extent has the Northern Ireland conflict contributed to, and exacerbated, the social factors and circumstances known to be associated with poor mental health?
2. What research is there that identifies particular neighbourhoods and communities as high risk in terms of poor mental health and suicide?
3. What is known about the prevalence of suicide risk factors among those individuals who were in the frontline of violence?

The first task is to place suicide in the broad context of mental health and emotional well-being. Social scientists have become increasingly interested in understanding 'positive' as well as 'negative' mental health. This is reflected in the growth of research on 'happiness' which is discussed in the first part of Section 1. The somewhat undeveloped nature of this research means that little analysis of the links between violent conflict or political instability and mental well-being has been carried out.

In the second part of Section 1, studies that focus on the social factors affecting mental health are reviewed. The World Health Organisation's survey of how class and gender shape mental health outcomes across many countries is a useful summary of the evidence. This provides a guide as to what might be expected in countries at various levels of development, especially regarding gender, depression and anxiety, the principal backdrop to suicide.

Section 2 takes up the next question as to how these global patterns of mental health are further influenced by war, conflict and disasters, given the extreme situations that they bring about. Suicide comes into some of this research. Forced migration is the major theme because of its significance, often under-rated, to the Northern Ireland situation.

This section of the report introduces the concept of trauma, giving some background to its development, measurement and application. The literature reveals two broad schools of thought on the recognition and management of trauma. The review highlights some of the difficulties of distinguishing between the effects of different dimensions of trauma, such as the experience of violence, economic insecurity, and homelessness. The brutalisation of women and children often arises out of the refugee experience, rather than war itself.

The specific research evidence on the Northern Ireland conflict and mental health is covered in Section 3. Again, there are different arguments emerging from the research. One group of studies suggests widespread impacts on individuals and the society as a whole, while another sees the conflict as relatively insignificant: Northern Ireland itself is more normal than pathological, and traumatised individuals are few and far between. The discussion of this work is then followed by a presentation of the results from recent survey research on mental health and the conflict.

Section 4 turns to suicide specifically, beginning with the evidence on the relationship between suicide and mental health states, especially depression. It then tackles the problem of suicide statistics. There is a huge number of studies that look for statistical associations between suicide statistics and other data, whether psychologically or sociologically oriented. Most of these studies take the data for granted in the sense that national suicide statistics are a reliable record, both cross-sectionally and over time. The second part of Section 4 covers the analytical work challenging this assumption, and some of the empirical work that has shed light on the processes involved in creating suicide statistics.

A brief review of data on self-harming follows. Measures of self-harm are not well-developed but the available surveys and trends are described.

Suicide patterns and trends are examined in Section 5. Using World Health Organisation data, the international patterns of suicide are discussed in some detail, drawing out distinctive age profiles, gender ratios and fluctuations in trends. This provides clues on how the marked differences between countries should be understood, as well as allowing the Northern Ireland position to be put into perspective.

The emphasis then shifts towards Britain and Ireland. A number of charts are presented to assist the discussion of trends. Some of these go beyond the literature in the sense that they are compiled from data presented in the research as well as from the raw data published in annual reports of the Registrar General.

Detailed analysis of suicides in Northern Ireland is presented in Section 6. This discusses age and gender, as well as the available evidence on mental health backgrounds, treatment status, employment, class and social isolation. The section ends with a brief look at the data on method of suicide.

Section 7 draws together the principal explanations for Northern Ireland's suicide trends. It starts with the evidence on suicide and the equality

dimensions covered under Section 75 of the 1998 Northern Ireland Act and explores recent sociological studies of suicide and social isolation.

One of the most important and relevant generalisations about suicide for this review is the notion that war helps to hold suicide rates down and when peace is established, rates of suicide rise. This proposition is closely scrutinised in Section 7, both theoretically and in terms of available evidence for Northern Ireland and elsewhere. Registrar General data is used to raise questions about the assumed association between conflict-related deaths and deaths from suicide.

Finally, Section 8 covers suicide and the transition to peace. The arguments around social and political integration are considered before discussing the research evidence for relationships between suicide, experience of the conflict, neighbourhoods and specific groups who were in the frontline of 'the troubles'. Consumption of alcohol and drugs is discussed. The patchy evidence on the mental health of those in the frontline of conflict is examined, followed by a brief discussion of mental health services.

The main conclusions of the review and some recommendations for how knowledge gaps might be remedied are presented in Section 9. The method for carrying out the review is described in the Appendix.

Section 1

The Social Basis of Mental Well-being

Well-being and happiness

It is now widely accepted that mental health and well-being cannot simply be defined in terms of the absence of mental illnesses and disorders. There may be low levels of depression or suicide recorded for a country but this may not equate with high levels of subjective well-being or 'happiness'. Conversely, the 'happiest country on earth' (Denmark) (BBC News 28th July 2006) has a relatively high rate of recorded suicide and high levels of consumption of mood stabilising drugs such as lithium (Kessing *et al*, 2005).

Measures of well-being and happiness are a relatively recent addition to the discussion of mental health and vary considerably in approach. Most happiness indexes rely on survey evidence and popular responses to one or two key questions. Since 1946, for example, the North American General Social Survey, has asked '[...] would you say that you are very happy, pretty happy, or not too happy?'. The Eurobarometer Survey, from the early 1970s, poses the issue in terms of 'satisfaction': 'on the whole, are you very satisfied, fairly satisfied, not very satisfied, or not at all satisfied with the life you lead?' (Blanchflower and Oswald, 2004). The World Values Survey, which began in 1981 and for which four waves have now been carried out, asks 'Taking all things together, would you say you are very happy, quite happy, not very happy or not at all happy?'. The survey, which has included Northern Ireland as a separate entity in three of the waves, also asks about general satisfaction with life, a range of mood and motivation-type questions, and about how much autonomy and control people feel they have, providing a rich source of data relating perception of life to people's material position, work, family life and social networks (World Values Survey).

Happiness data have been of particular interest to economists because of the observation that in rich countries, as standards of living continue to increase, people seem to be no happier (Layard, 2005: 29-34). The World Values Survey data do show, however, that richer countries are generally happier than poorer ones and that 'the effect of income on happiness is greatest in the poorest countries, where people are nearest the breadline' (Layard, 2005: 33). Within richer countries, there are significant differences in happiness levels according to income and status.

Blanchflower and Oswald explored well-being over time in Britain and the USA and concluded that, overall, reported levels of well-being had declined in the USA and remained flat in Britain. But this was an average result. Particular groups, 'such as American men and blacks', have become happier over the last three decades, narrowing white/black differences. Nevertheless, black people in the USA remain much less happy than whites. Women, married people, the highly educated and those whose parents did not divorce report the highest well-being, although 'it is women rather than men who are experiencing the decline in well-being' (2004: 1366). The authors conclude by suggesting that their method of analysis may provide 'a new way to document the existence of discrimination' (2004: 1381).

Using data for 65 societies and a pooled sample of 146,000 respondents, Inglehart (2002) shows that the gender effect is age-related. Younger women are happier than younger men but the reverse is true for older women. The push for gender equality does not appear to have compensated for the 'systematic tendency to devalue older women'.

Borooah (2006) plotted results for some 80 countries, including scores for Northern Ireland and the Republic of Ireland, using the World Values Survey data (from the 1999 to 2002 wave). Of the 19 countries with the lowest mean happiness score, all bar two (Iran and Zimbabwe) were from the former countries of the Soviet Union and the Eastern European bloc. Lithuania, the country with one of the highest rates of recorded suicide in the world, had the fifteenth lowest mean happiness score but a moderately low 'unhappiness

rate' (based on the proportion who reported being 'not at all happy'). The result for Northern Ireland appears to be polarized between happiness and unhappiness. Northern Ireland's mean happiness (12th happiest out of 80 with a score of 8.48) was sandwiched between Denmark (with a score of 8.49) and Ireland (at 8.45). In terms of *unhappiness* Northern Ireland's rating is the same as that for Bangladesh, Croatia, Bosnia and Herzegovina, Argentina, Sweden and Germany.⁴ Romania and Bulgaria have the highest rate of unhappiness with a score of 12.

Borooah's main interest was to adjust the mean happiness scores to take account of the degree of inequality in a country. This had some effect on the rankings, for instance pushing Turkey down ten places and New Zealand up four places – Northern Ireland moved up slightly to tenth equal with Vietnam.

The World Database of Happiness shows that Northern Ireland became slightly unhappier during the 1980s and early 1990s (Veenhoven, n.d.). Using a ten-item balanced scale, Northern Ireland's mean score went down from 1.86 to 1.69 (out of a possible +5). This contrasts with the Irish Republic where the score rose from 1.63 to 2.0 between 1981 and 1990. Great Britain began the period with a much lower score (1.4) but improved this to 1.7 by 1991. On the single happiness question, however, Great Britain was slightly less happy in 2005 than in 1981. The same is true for the Irish Republic. Northern Ireland's happiness went down during the 1980s but rose against the trend between 1991 and 1999 (from 3.28 to 3.42 on a four point scale).

The country-wide finding on the coexistence of unhappiness and happiness is noted in the recent survey of mental health across the European Union (European Commission, 2004: 20-22). The report shows that positive mental health scores are found alongside low psychological distress levels in some countries (e.g. the Netherlands) while the opposite is the case for others. Italy, Portugal and France have low levels of positive mental health and high levels of psychological distress. But Spain and Belgium are high for positive mental

⁴ On a 12-point scale, Northern Ireland's unhappiness value was 2 compared to Ireland's 1 and Denmark's 0. Lithuania scored 3, as did Greece, South Africa, Pakistan and China.

health and relatively high for psychological distress.

Conflict and happiness

It would be reasonable to argue that Northern Ireland's happiness trends were related in some way to the conflict, the assumption being that less conflict from the mid-1990s onwards, coupled with the 1998 political agreement, are responsible for the observed improvement in overall happiness. To a degree the subjective measure of happiness fits with changes in levels of violence. Conflict-related killings declined sharply after the ceasefires of 1994 with the exception of the period leading up to and around the 1998 Agreement itself. Other types of violence – punishment attacks, shootings, bombings, and housing intimidation – increased post-Agreement, however (Shirlow and Murtagh, 2006: 51-56). This suggests a more complex relationship between violent conflict and impacts on mental well-being, and the need for a model that can take account of the juxtaposition of relatively high levels of happiness and unhappiness.

Conflicts may impact more heavily on some geographical areas than others within a national or regional entity. Similarly, specific groups within a population are likely to be more affected than others. This literature review has not been able to find research that relates happiness measures specifically to levels of violent conflict within (or between) countries. Friends of the Earth's *Happy Planet Index* (HPI), which combines life expectancy scores with 'life satisfaction' and 'environmental footprint', shows that life satisfaction does relate to general political conditions in a country but this is a relatively loose measure of prevailing democratic freedoms rather than political instability and conflict as such.

The HPI also discusses the negative impacts of war and conflict in specific regions and countries. Central America, for example, is the best region in the Index. While it has had 'a notorious history of conflict and political instability', for the past fifteen years there has been greater stability which, combined with

a high level of community engagement, results in high scores for life satisfaction for countries across the region (New Economics Foundation 2006: 4). Central America combines high life expectancy with high life satisfaction and a relatively low ecological footprint. Hence Colombia, Costa Rica, Guatemala, El Salvador and Cuba are all in the top ten whereas the UK and Ireland rank 108th and 113th respectively. Denmark sits at 99, while Zimbabwe lies at 178, the unhappiest part of the planet.

Political instability and conflict will lead to a fall in average happiness insofar as they can be shown, in any specific instance, to contribute to instability in employment, higher rates of unemployment, and marriage breakdown. Such causation is credible given that conflict on any serious scale typically involves damage and distortion to the economy, population movements, whether of 'refugees' or 'internally displaced persons', and disruptions to the fabric of family and community life occasioned by the recruitment of civilians into military forces.

The social basis of mental health

If happiness research has not as yet focused on political instability and conflict as explanatory variables,⁵ it has at least shown that variations in happiness are strongly associated with unemployment, job insecurity and breakdown of family and community relationships through separation and divorce (Layard, 2005: 62-70). In order of importance, according to data from the USA, family relationships come first followed by 'financial situation' and work. If a person is separated or divorced they are likely to be scoring around ten per cent lower on happiness measures than people who are married.

The new work on happiness adds to the substantial body of evidence that mental health and emotional well-being are shaped by social factors and the stresses associated with economic and social insecurities of all kinds. Social

⁵ There are at least two 'political stability' indexes that might be used for such an analysis: Kaufmann *et al* (2003) and Annett (2001).

and economic contexts are also key to the prospects for recovery from mental illness (Webber, 2005). Wallcraft (2005) found that, in addition to gaining access to appropriate treatments and therapies, the most important factors helping recovery were good relationships, financial security and satisfying work (or education and training opportunities), and 'self-management of problems', or autonomy. Although family relationships were important, it was the quality of personal relationships in providing closeness, emotional support, companionship and practical support that really counted and often such supports were supplied outside the family.

While it is not straightforward to demonstrate direct causal links between social and psychological factors, there is increasing evidence of the importance of 'psychosocial pathways' in linking social circumstances, notably income inequalities, to a wide range of physical and mental health problems and premature death (Wilkinson, 1996). The World Health Organisation reviewed evidence on the prevalence of mental illnesses by socio-economic position and showed that in many countries, the poorest groups have twice the risk of high income groups. For depression alone, the low versus high income group ratio was 1.6:1 for Ethiopia, the Netherlands and USA, and 1.9:1 for Finland and Germany. The same report noted that 'the overall prevalence of mental and behavioural disorders does not seem to be different between men and women' (World Health Organisation, 2001: 40-1).

For anxiety and depression, however, there are significant differences by gender. The women-to-men prevalence ratio is typically between 1.5:1 and 2:1 across developed and developing countries. Men have a higher prevalence of substance use and antisocial personality disorders. Gender differences in depression are found to be strongly age-related: 'the greatest differences occur in adult life, with no reported differences in childhood and few in the elderly' (WHO, 2001: 41).

One important factor behind women's higher risk of anxiety and depression is intimate partner violence (domestic violence), the main burden of which falls on women. Lifetime prevalence of intimate partner violence ranges between

16 and 50 per cent according to the available global evidence. In a survey across 35 developed countries, between 10 and 30 per cent of women reported they had experienced sexual violence by an intimate partner. Between 10 and 27 per cent of women and girls reported having been sexually abused, either as children or adults (cited in World Health Organization, 2005: 1). A more recent study collected data from over 24,000 women from ten countries representing a range of cultural settings, including Bangladesh, Brazil, Ethiopia and Thailand. The proportion of women who had ever experienced physical or sexual violence ranged from 15 per cent in Japan (one city) to 71 per cent in Ethiopia (one province). It was found that almost one third of the Ethiopian women in the sample had been physically forced to have sex within the last year, a finding which is 'particularly alarming in the light of the AIDS epidemic' (WHO, 2005: 7). Of the reported sexual violence, about half was based on degrading or humiliating sexual behaviours, and fear of what a partner might do if sex was refused, rather than physical force as such. Furthermore, there is a clear relationship between physical and sexual violence, and controlling behaviours and emotional abuse.⁶

As indicated, intimate partner violence is associated with emotional distress including chronic levels of fatigue, overwork, inability to enjoy life, anxiety and depression. As a result, women are more likely than men to be prescribed, and using, psychotropic drugs. In the UK, Italy, Germany, Canada and the USA, the ratio is over 2:1; in France it is close to 4:1 (WHO, 2001: 15)⁷ These dimensions of poor mental health also feed into suicidal thoughts and behaviour. Although in most countries men are much more likely than women to take their own lives, women who have experienced intimate partner violence are much more likely to report that they have contemplated suicide than those who have not experienced such violence.⁸

⁶ Such controlling behaviours include keeping the partner from seeing friends, restricting contact with family, frequently accusing a partner of being unfaithful and insisting on knowing where a partner is all the time.

⁷ High and low estimates are given for different countries and the higher estimates are quoted here.

⁸ Figures vary rather widely. Of women reporting that they had thought of suicide, the ratio of those who had experienced intimate partner violence to those who had not, was 11:1 for Indonesia, 8.7:1 for Egypt, 3.5:1 for Chile, 4.3:1 for India, and 3:1 for Japan (one city) WHO (2001: 42) and WHO (2005: 16).

Section 2

Mental Illness, Conflicts and Disasters

There is growing interest in the mental health impacts of violent conflicts and disasters. According to the World Health Organization, conflicts and disasters have similar effects in that large numbers of people are displaced from their homes, communities and livelihoods. Around 50 million people globally are refugees or have been 'internally displaced' as a result of war. Many more millions are coping with the effects of earthquakes, floods and hurricanes, and 'such situations take a heavy toll on the mental health of the people involved, most of whom live in developing countries, where capacity to take care of these problems is extremely limited. Between a third and half of all the affected persons suffer from mental distress.' WHO (2001: 43) Even in wealthy countries, disasters have major affects on mental stress and illness. Hurricane Katrina, which struck New Orleans in August 2005, led to a doubling of both 'mild-moderate' and serious mental illness. (Kessler, 2006) Suicide ideation fell to very low levels, however, a result that the researchers compare to Beirut during the first Lebanon–Israel war where high prevalence of depression was observed alongside low suicide ideation. They suggest that negative mental health effects of disasters and wars may be offset with respect to suicide by a growth in personal resilience, social support and other protective factors.

The literature on the relationship between wars, conflicts and mental ill-health focuses on two main themes. The first concerns the population displacement effects of conflicts and disasters, including problems of adjusting to, and getting established in, new locations. The second theme focuses on the direct effects on combatants and civilians of violence and human rights abuses, such as torture.

Displacement and mental health

De Jong's comprehensive survey of the literature, which refers to 'approximately 175 epidemiological studies on the mental health consequences of wars and conflicts', begins by charting the scale of global population movements up to 1999. By that year there were around 13.5 million refugees and a further 20 million internally displaced persons (IDPs) because of armed conflicts (De Jong, 2002: 2-5). The World Refugee Survey for 2006 shows that a further 1.04 million refugees and asylum seekers were created in 2005, as well as 2.1 million new IDPs, bringing the current total to 21 million (U.S. Committee for Refugees and Immigrants, 2006). The highest numbers of refugees are in the Middle East where close to 5 million people are displaced. More than 800,000 refugees from Iraq are living in Jordan and Syria. Iran and Pakistan have taken in more than two million refugees from Afghanistan. There are well over three million refugees in Africa. Europe, in contrast, had an estimated 530,000 refugees in 2005. Around three-quarters of refugees and displaced persons are women and children. Up to five per cent are orphaned children.

Clearly, children are the most exposed to harm and exploitation in conflict and disaster situations: 'armed conflict alters their lives in direct and indirect ways, and in addition to the risk of being killed or injured, they can be orphaned, abducted, subjected to sexual violence or left with deep emotional scars and psychosocial trauma from direct exposure to violence, dislocation, poverty and the loss of loved ones' (Baingana *et al*, 2005: 12). In some conflicts, children have been forced into military service and to kill a parent or community member (Mozambique and Uganda). Anne Kielland's taxonomy of OVC – Orphaned and Vulnerable Children – identifies an estimated 30 million OVC in sub-Saharan Africa as a result of HIV/AIDS and a further 7 million children affected by armed conflict.⁹ HIV/AIDS is an established risk factor for suicide (Starace, 1995).

⁹ See Anne Kielland's presentation available from the World Bank at info.worldbank.org/etools/docs/library/164047/pdf/ovc.pps

Recent refugees and displaced persons face particular stresses and adjustments as they seek to survive and then establish themselves in new situations, often in refugee camps. Conflict and relocation,

can have a profound effect on the mental health of affected populations, whether they are refugees, IDPs, asylum seekers or others trying to rebuild their lives and communities. The transition entails coming to grips with what has occurred and adjusting to life in new environments that may feel foreign and inhospitable. It may also mean impoverishment due to loss of assets and livelihoods, uncertainty regarding the status of loved ones, unemployment and a lack of skills suitable for the new location and circumstances. (Baingana *et al*, 2005: 6)

Unsurprisingly, there is evidence of displaced adults feeling useless and hopeless. Studies of refugee populations that have applied tests for 'post-traumatic stress disorder' (PTSD) show that rates of depression and trauma are much higher than would be expected in the general population across a range of contexts, such as in Mollica *et al*'s findings for Cambodia and Bosnia (1998; 2001).

Since the 1950s, the main tool for assessing mental ill-health has been the Diagnostic and Statistical Manual of Mental Disorders (DSM), developed by the American Psychiatric Association. Version III of DSM was published in 1980 and included for the first time a definition of PTSD. In DSM IV, PTSD is defined as an anxiety disorder of at least one month duration. The recent prominence of PTSD in psychiatric discourse comes in part from its acceptance in military and government circles: US war veterans may receive compensation on the basis of a PTSD diagnosis. Fifteen per cent of all male Vietnam veterans were diagnosed with PTSD in the mid-1980s and one half of these had been in trouble with the law. About one third of the veterans diagnosed with PTSD (over 160,000) were in receipt of disability compensation. Of those in the US military serving in Afghanistan and Iraq, slightly higher proportions have been diagnosed with PTSD (Epstein and Miller, 2005; Baingana *et al*, 2005: 7-8).

De Jong argues that 'the long-term sequelae of war traumas have been

underestimated. Thirty to 45 years after a war, a large proportion of veterans were still suffering from PTSD and were at an increased mortality risk from tuberculosis, accidents, or coronary heart disease... Time *per se* does not necessarily heal wounds for a considerable amount of people.' (De Jong, 2002: 42) The nightmares, anxiety, depression, anger, sleeplessness and aggression associated with highly stressful situations and experiences may, therefore, continue for many years, depending on the new situation, supports and opportunities. A study of refugees who lived through the Pol Pot regime in Cambodia and who settled in the USA prior to 1993, found that 90 per cent had experienced near death due to starvation and the same proportion had lost a friend or relative in the 'killing fields'. The refugees were surveyed between 2003 and 2005, and almost two-thirds were scoring highly for PTSD and a half for 'major depression'. Although revealing a strong *prima facie* need for mental health services, the study did not collect information on the prevalence of mental health treatment within the sample. (Marshall, 2005) There is also evidence of persistent adverse mental health symptoms among Mandaean refugees (from Iraqi and Iran) three years after being released from detention in Australia, although the uncertainties and conditions of the detention regime itself were shown to be the cause of ill-health, rather than the experience of pre-migration trauma as such. (Steel *et al*, 2006)

Refugees may anticipate returning to their place of origin but often they remain in camps for years. The U.S. Committee for Refugees and Immigrants publishes details of populations of 10,000 or more where people are restricted to camps or segregated in settlements, or otherwise deprived of basic rights, in situations lasting five years or more. At the end of 2005, almost eight million people were recorded as being in this position and for seven million of these, the situation had lasted ten years or more (U.S. Committee for Refugees and Immigrants, 2006: 10). The regimes of refugee camps, whether controlled initially by international relief agencies or by the host country, often amount to prison-like warehousing. Rather than assisting independence and autonomy, and respecting cultural practices and assets, camps and reception centres induce helplessness, 'especially in those camps that reproduce the authoritarian regimes from which the refugees escaped,

possibly reproduced by the militaristic approach of some relief agencies or peacekeepers.’ (De Jong, 2002: 76). A study of Sudanese refugees in northern Uganda found that stress factors accumulated well beyond the first few years following flight from war. The poverty and dependency associated with camp life caused many to lose hope. Some refugee settlements were plagued by rebel attacks and new traumatic experiences. By the time the Uganda Government and UNHCR adopted a plan to move refugees from camps to settlement sites, suicide and alcohol overuse had become significant problems (Baron, 2002).

Conflict and trauma

The second theme in the literature focuses on the conflict, violence and human rights abuses, such as torture, experienced by civilians and combatants. A review carried out for the World Bank found considerable evidence of post-traumatic stress disorder (PTSD), anxiety and depression arising directly from violent experiences which, typically, impact widely. A survey of 750,000 people in East Timor found that 22 per cent had witnessed the killing of a family member or friend, one quarter had been hit on the head, a third reported being beaten and 40 per cent had been psychologically tortured (Baingana *et al*, 2005: 5). Violence is often gender-based, involving the rape and mutilation of women, with ‘scars of brutality so extreme that survival seemed for some a worse fate than death’ (Rehn and Sirleaf, 2002: 9). Harassment, intimidation, forced displacement and fear associated with unexploded land mines, cluster bombs and other ordnance, all contribute to psychological insecurity and, overall, ‘the psychiatric literature shows that conflict situations increase disorder prevalence’ (Baingana *et al*, 2005: 5).

Unlike refugees, internally displaced persons do not have a defined status under international law although the Secretary General of the United Nations appointed a Representative on IDPs in 1992 in recognition of the growing scale of the problem. As was shown above, IDPs now outnumber refugees and such is the scale of human rights violations that in 2004 the UN appointed

a Representative on the Human Rights of IDPs. There were two major policy developments at the international level with respect to IDPs in 1998. First, the Commission on Human Rights adopted the Guiding Principles on Internal Displacement which refer to the right to 'mental and moral integrity'. There is explicit recognition of the need for 'psychological and social services' and the special health needs of women 'including access to female health care providers and services, such as reproductive health care, as well as appropriate counselling for victims of sexual and other abuses'.¹⁰ The second development was that the Norwegian Refugee Council established the Internal Displacement Monitoring Centre (IDMC). This works closely with the UN and provides regularly updated country and regional reports and statistics. The number of IDPs in Iraq, for example, was estimated to be 1.6 million in October 2006. India has approximately 600,000 IDPs while Sri Lanka has half a million. But Africa is worst affected: half of the world's IDPs are in Africa, with over five million in Sudan alone, a further two million in Uganda, a million in Algeria and 1.5 million in the Democratic Republic of the Congo.

In some conflicts it is not easy to separate the effects of traumatic experiences of violence from the context of displacement, economic insecurity and social fragmentation. Furthermore, some countries experience extreme cocktails of violent conflict *and* 'natural' disasters. Sri Lanka has lost approximately 65,000 people to the civil war that has ebbed and flowed since the early 1980s, with 3,300 killed during the first nine months of 2006 – almost as many as were killed in Northern Ireland's conflict over thirty years. A quarter of a million IDPs have been added to the total during 2006. The country was also badly affected by the December 2004 tsunami which made over half a million homeless. The latest country report from the Internal Displacement Monitoring Centre states that the degree of overlap between conflict and disaster-related IDPs is unknown. Whatever the scale and nature of displacement, however, 'the psycho-social effects of the conflict are

¹⁰ Principles 11 and 19 of *Guiding Principles on Internal Displacement*, Office of the United Nations High Commissioner for Human Rights.
<http://www.ohchr.org/english/issues/idp/standards.htm>

serious, leading to increased levels of suicide' (Internal Displacement Monitoring Centre, 2005: 125). By 2000, Sri Lanka was thought to have one of the highest suicide rates in the world. But in the 'welfare centres' where some of the IDPs have resided for long periods, the suicide rate is three times the country average (2005: 98)

Inevitably, systematic evidence of the psychological impacts of civil war and communal conflict in extreme circumstances such as those pertaining in Sri Lanka is patchy or based on small samples from local communities (Somasundaram and Jamunanantha, 2002: 231). But the real difficulty is the use of culturally specific concepts and diagnostic tools, with particular debate surrounding post-traumatic stress disorder (De Jong, 2002: 40-1). A study carried out in Cambodia as part of a community mental health programme found that all respondents had experienced several traumatic events. However, reactions were varied: 'some showed symptoms, such as recurrent nightmares, consistent with the PTSD criteria. Many more, however, showed crippling complaints such as "heat in the head", "stabbing in the abdomen", "thinking too much" ... Cases could be divided into three categories... Roughly 20 per cent had a physical illness, 35 per cent had a psychiatric problem, and 45 per cent can be described as having psychosocial problems' (Van de Put and Eisenbruch, 2002: 102). As Summerfield argues,

although post-traumatic stress disorder is reported to be prevalent worldwide in populations affected by war, the assumption that a Western diagnostic entity captures the essence of human response to such events anywhere, regardless of personal, social and cultural variables, is problematic. Features of post-traumatic stress disorder are often epiphenomenal and not what survivors are attending to or consider important: most of them remain active and effective in the face of continuing hardship and threat. Thus uncritical application of diagnostic checklists for post-traumatic stress disorder may generate large overestimates of the numbers needing treatment. (Summerfield, 2000: 231)

Critique of 'Trauma'

In a forceful critique of the 'globalisation of trauma' and the 'medicalisation of distress' Summerfield argues that PTSD checklists potentially turn functioning,

coping and resilient individuals into medical 'cases'. His own experience of examining over 800 asylum seekers and refugees while working for the Medical Foundation¹¹ led him to conclude that the vast majority were upset but not ill (Summerfield, 2004). The clinical evidence does not deny that war-related trauma has serious psychological effects for some individuals who would benefit from professional medical intervention. But he argues that 'survivor populations' will be able to manage suffering and recovery most successfully through a focus on rehabilitation: 'this means an overall approach which locates the quest of victims for rights and justice as a central and not peripheral issue' (Summerfield, 1996: 4; Summerfield, 2005: 50). A focus on individual models of treatment based on early intervention and re-visiting traumatic events, may do more harm than good, he argues.

Similar critical arguments have been developed in the Northern Ireland context by Gilligan (2006) using a sociological framework. Gilligan identifies and critiques core assumptions about peace, trauma and conflict. He concludes:

Therapists cannot adequately answer the question 'what was it all for?' because it requires a political or moral answer...The introspective, individualised and depoliticised approach to dealing with political violence is inherently self-limiting and may even serve to undermine peace-building efforts by promoting a view of the human subject as inherently vulnerable and in need of professional support. (2006: 339)

There is some recognition of these criticisms in the Swiss Agency for Development and Co-operation's recently published toolkit on gender and conflict transformation (2006). This is committed to addressing trauma and the psychosocial legacies of conflict but in the context of UN resolution 1325 on women, peace and security, and an overall emphasis on empowerment. The toolkit explicitly criticises the PTSD approach:

any approach that reduces trauma to a mental or physical pathology must be strictly avoided... Its [PTSD's] main drawback is that it reduces trauma to a disease of the individual, like any other. PTSD thus ignores and dislocates the relationship between individual suffering and the

¹¹ The London-based Medical Foundation for the Care of Victims was founded in 1985 and provides care and rehabilitation to survivors of torture and other forms of organised violence.

political context, thereby adding to the marginalization and victimisation'. (2006: 16)

The toolkit provides many examples of how, through directly involving those caught up in disasters and conflict in practical actions to rebuild economic and social activity, appropriate opportunities will arise to address the trauma, to prevent opportunities for the exploitation of women and children, and to generate the collective self-confidence needed to secure peace and reconstruction. In short, 'empowerment is not limited to developing more positive feelings about oneself and gaining insight into one's situation. It also means doing something about it.' (2006: 18)

Section 3

Northern Ireland, Conflict and Mental Health

While the scale of conflicts and disasters referred to above far outstrips the Northern Ireland experience, there remain important parallels. In societies characterised by military conflict of whatever scale, the sources of everyday stress and uncertainty are considerably magnified, for example, through unexpected disruptions of daily routines, forced migrations, loss of jobs and the shocks of death and injury. Violent conflicts, particularly civil wars, have well-documented impacts on economic activity, causing 'development in reverse', capital flight and high levels of military expenditure (Collier *et al*, 2003). Unemployment and poverty typically increase and fewer resources are devoted to health services, trends that sometimes continue long after the cessation of hostilities. The available evidence on the impact of the conflict on economic development, physical infrastructure public expenditure programmes, policing and punishment, forced migration, segregation of housing and schools, labour market participation, health and well-being, was reviewed as part of a study of the relationship between poverty and conflict (Hillyard, *et al*, 2005: 109-120). Not only have there been surprisingly few attempts to assess the overall economic and social costs of the conflict, but also there has been little analysis of how those costs are borne as between private individuals and households, the voluntary sector, business and commerce, and the public sector.

Mental ill-health is interesting in this respect as it is a private hurt that impacts on immediate relationships but also on wider roles. Poor mental health is costly for employers and state services. It also acts as a barrier to post-conflict reconstruction, especially when, as some have argued, the whole society has been traumatized by violence. In this view, the 'troubled mind' of Northern Ireland is dominated by an emotional intensity that resonates from the interpersonal to the political (Kapur and Campbell, 2004). Northern Irish society, so the argument runs, is pathological; it has become 'dehumanized'

and 'day-to-day societal relations are infected by destructive processes' (2004: xiii). This somewhat speculative application of psycho-analytical concepts leads the authors to suggest that 'the poor state of [physical] health in Northern Ireland represents a somatization of years of exposure to the intense emotional effects of the Troubles' (2004: 94).

Earlier, it was established that population displacement is one of the most important consequences of conflicts. Enforced population movements in the context of Ireland's recent experience are of course on a smaller scale than most of the examples given above, but no less significant in terms of the human impact. But they are poorly researched. One recent assessment states: 'intimidation, displacement and migration have occurred on a massive scale, leading to increased social segregation' (Hillyard *et al*, 2005: 113). In the 1969-72 period, an estimated 60,000 people were forced out of their homes, some crowding into West Belfast and other areas, and some leaving Northern Ireland altogether (Darby and Morris, 1974). Hundreds crossed the border in 1969 and became the responsibility of the Department of Defence and the Irish Army. In August 1971, over 2,800 refugees from the North were received into an Army camp in Co. Meath. A similar number were being looked after in police premises, schools, community centres and hospitals, mainly in border areas but also in Cork and Dublin. In 1972, 9,800 refugees were received (Rahaleen, 2005: 24-32). Then, after the initial crisis the refugee issue disappeared from public policy discussion, until resurfacing with the peace process and the EU Peace Programmes. The most recent estimate of the prevalence of displacement *within* Northern Ireland found that 54,000 households have been forced to move because of attack, intimidation or harassment (Hillyard, *et al*, 2003: 62).

Recent qualitative research with displaced people in the Southern border counties found that, while people had eventually become well-established in terms of work and housing, they were still haunted by the original refugee experience, including the way they were resented as outsiders and 'northerners'. In particular, 'the hurt at separation has not reduced over time and interviewees continue to this day to feel a void, or absence, or regret at

being away from their extended family' (Rahaleen, 2005: 97).

Other aspects of the international debate about conflict and trauma are better reflected in the literature on Northern Ireland. On the one hand, some of the earliest assessments carried out during the worst years of the conflict suggested strong affects on anxiety and depression (Lyons, 1971; Fraser, 1971). But these studies were based on small numbers and selected groups. As Gallagher points out, some of the early psychological work – again based on limited samples of specific groups including internees and children involved in riots – argued that people's mental health was being deliberately undermined 'as part of a campaign of psychological genocide on the part of the British state' (Gallagher, 2004: 632). This seemed to produce a reaction in the form of studies that appeared to demonstrate just how 'normal' a society Northern Ireland was and that young people were, on the whole, coping well. Thereafter, 'the stream of research and publications on the issue steadily dwindled... [and] a significant level of complacency developed as, for many, the abnormal was normalized and life continued' (2004: 633). The conflict itself became increasingly contained so that specific localities bore the brunt of the killings and other violence. Renewed interest in the psychological impact of the conflict emerged with the transition to peace and the 1998 Agreement. This was reflected both in research and in the state support given towards 'victims of the Troubles' and associated discussions of appropriate forms of remembrance, acknowledgement of the past and 'truth' commissions (Gilligan, 2006; Rolston, 2002).

Muldoon *et al* cite two studies from the 1980s which used the General Health Questionnaire to assess levels of possible psychopathology in Northern Ireland (Muldoon *et al*, 2005). One was based on a random sample of 547 people across Northern Ireland and the other focused on two towns (Barker *et al*, 1988; Cairns and Wilson, 1984). Both studies found that less than a quarter of the population was in the risk area for psychopathology as defined by the GHQ. This was slightly lower than the risk rates reported for Britain for the 1980s. These findings fit with another observation, namely that the conflict did not lead to an increase in referrals for mental health services (Loughrey,

1997). But did those services adapt to the needs of those traumatized by ‘the troubles’? From one in-depth account based on interviews with relatives 30 years after Bloody Sunday, it appears that, until recently, many services were neither equipped nor resourced to respond to the complex needs generated by such events and their aftermath (Hayes and Campbell, 2005: 118-128).

The Health and Wellbeing Surveys

In 1997 and 2001, population based surveys of Health and Social Wellbeing were carried out in Northern Ireland. The 2001 survey included three questions relating to the conflict.¹² First, respondents were asked ‘how much violence would you say there has been in this area because of the Troubles?’ and were given a four point scale from ‘a lot’ to ‘not very much at all’ to choose from. Second, (and somewhat confusingly), people were asked ‘how much have the Troubles affected your own life and the lives of your immediate family?’, answering again on a four point scale. The third question was ‘which of the following statements best describes the way you feel about the political situation in Northern Ireland at present?’ The four possible answers were based on the extent to which people worry about the situation.

Overall mental health was rated according to the GHQ (12 questions) which allows a threshold to be established above which a person may have a mental health problem – typically a score of four or more. As Miller *et al*’s (2003) secondary analysis shows, ‘the proportion of respondents in Northern Ireland over the GHQ12 threshold is one third higher than in both England and Scotland’ – the percentages were 21.1 for NI, 15.5 for Scotland and 14.5 for England. No English region matches Northern Ireland’s GHQ12 scores, although the North West came close for men, but not women, according to the Health Survey for England of 1998 (See Table 6.29, *Health Survey for England*, 1999). Rates of psychological morbidity in the Republic of Ireland are half UK levels (O’Reilly and Stevenson, 2003: 491). So Northern Ireland’s

¹² See the questionnaire at Central Survey Unit, Northern Ireland Statistics and Research Agency, <http://www.csu.nisra.gov.uk/surveys>

poor mental health was significantly different from the UK and Ireland around the turn of the century.

Gender differences, however, are very much in line with findings elsewhere. For both the 1997 and 2001 surveys women in Northern Ireland were 1.5 times more likely to score highly on GHQ12 as men. This gender gap was widest for the 16-24yrs age group, where the ratio was 1.7:1 (Miller *et al*, 2003: 80).

While there was a gradient of GHQ12 high scores by socio-economic group, with the highest scores recorded for the partly skilled and unskilled groups, non-manual status 'had no important impact on the GHQ12 score'. But the relatively affluent do have significantly better mental health than others, though this gap appeared to narrow between the two surveys.

High GHQ12 scores varied significantly by age. In the 2001 survey, 21 per cent of the youngest age group (16-24) scored four or above, compared to 24.8 per cent in the 45-54 age group and an overall figure of 20.9. The older groups showed significantly lower proportions with high GHQ12 scores.

Contrary to what might be expected, social isolation – as measured by 'living alone' and an index of social contacts – was not significantly related to poor mental health. Nor were 'religion' or 'education' (as measured by A Level attainment). The most important predictors of poor mental health are stressful family events, lack of social support and being married (Miller *et al*, 2003: 29). However there is a clear difference in the 2001 survey between depression rates for those married and living with a spouse (19 per cent) and those married but separated (35 per cent). With an overall depression rate of 21 per cent, the rates for the single (never married) and widowed were 20 and 23 per cent respectively, while one third of divorced respondents were recorded as depressed (Northern Ireland Health and Wellbeing Survey 2001).

In the 2001 survey, 9 per cent of respondents said that the conflict had affected their lives (and those of their families) 'a lot', and a further 17 per

cent, 'quite a bit'. These were higher rates than for 1997. Those reporting negative effects of the conflict on their neighbourhoods also rose between 1997 and 2001, (McWhirter, 2004: 52) reflecting observations above about increases in some forms of violence post-Agreement. Of those classed as depressed, 15 per cent thought that the conflict had affected them a lot (compared to 9 per cent overall). Looked at the other way round, those who said they were affected by the conflict 'a lot' were much more likely to be depressed – 34 per cent compared to 21 per cent overall. Of those who said that the conflict had affected their neighbourhood a lot, 44 per cent were depressed (as defined by a high GHQ score) according to the 1997 survey. The figure comes down to 29 per cent in 2001. The relationship between conflict experience and poor mental health, and between lack of conflict experience and good mental health, were statistically significant to a high level for both survey years (Miller *et al*, 2003: 62-72).

O'Reilly and Stevenson carried out secondary analysis of the 1997 survey data with the specific purpose of establishing what if any relationship exists between Northern Ireland's poor mental health and the conflict of past decades. Using regression analysis they established that 'the greater the extent to which the respondent's area or life was affected by the Troubles, the greater the likelihood that the respondent had poorer mental health. Neither demographic nor socioeconomic factors significantly diminished this relation although it was attenuated after adjusting for health related factors.' (O'Reilly and Stevenson, 2003: 490) Their conclusion, however, remained guarded as it is theoretically possible that the observed effects and relationships are in fact due to poverty and poor physical health. They did not attempt to explore the possible relationship between physical and mental ill-health. But it is 'probable' that the mental health of the population has been significantly affected by the conflict.

Such a finding has to be squared with the apparent lack of impact on demand for mental health services. The authors make a number of suggestions. The first is that doctors lack experience in recognizing PTSD. The second is that 'most people in Northern Ireland deal with the stress generated by the political

violence by denying the existence of the violence around them' (O'Reilly and Stevenson, 2003: 491), a point emphasized by Hayes and Campbell (2005: 44). A third is that the GHQ12 scores found in the 1997 and 2001 surveys represent relatively mild psychological responses that people are dealing with in a variety of ways, including GP prescribed medications, alcohol and illicit drugs consumption, or through community organization, religious practice and family support.

A study with the specific aim of assessing the impact of the conflict on mental health was carried out between 2003 and 2005 and covered the border counties of the Republic of Ireland as well as Northern Ireland (Muldoon *et al*, 2005). Based on telephone interviews with a random sample of the population, the researchers gathered data from a total of 3,000 respondents, 2,000 of whom were living in Northern Ireland. The achieved sample was quota controlled by area to reflect adult population statistics from the latest Censuses, North and South, and the overall response rate was 46 per cent.

The first aim of the study was to measure direct experience of the conflict. Nine dimensions of experience were surveyed using 28 questions covering, for example, violent events such as shootings and bombings, threats and intimidation, bereavement, forced movement, family separation, alteration of financial circumstances and impoverishment, injury and disability, and detention. They were also asked 'were you ever a member of a paramilitary group', and 'were you ever a member of the security forces'.¹³ The second aim was to find out about trauma by asking if people had experienced any event that was particularly distressing, how this was affecting them (seventeen questions covering 'flashbacks', avoidance, distressing dreams, irritability and so on) and whether they used alcohol, prescribed medication or other drugs to cope with their experience of the conflict. This was followed by the standard questions that test for psychological morbidity in GHQ12. The study also looked at religious and national identity, and social and political attitudes.

¹³ Given this survey was carried out by telephone, the reliability of the answers to such sensitive questions is doubtful.

Half of all respondents across Northern Ireland and the border counties had no direct or indirect experience of the conflict. Regarding direct experience, men (26%) were twice as likely as women to report experience of a riot, to have been caught up in a shooting (14%), and to have witnessed violent acts against others (25%). A quarter of men reported experience of intimidation (women, 15%). Eight per cent reported being a member of the security forces (four times the rate for women) and 1.8 per cent of men said they had been a member of a paramilitary organization (women, 0.5%). Men were seven times more likely to have been detained.

To an extent the inclusion of the Southern border counties dilutes the Northern Ireland experience. Taking the North alone, a quarter of respondents had experienced a bombing, 24 per cent a riot and 13 per cent a shooting. These results show a lower experience of conflict than recorded in the Poverty and Social Exclusion survey (PSE), carried out in 2002/03 (Hillyard *et al*, 2003). In the PSE survey 34 per cent had witnessed a bombing, 38 per cent rioting and 26 per cent a shooting. But some results were higher. In the *Legacy* study 23 per cent of the Northern Ireland respondents had witnessed a violent act against others; in the PSE survey, though not strictly comparable, 21 per cent had seen someone being assaulted (Hillyard *et al*, 2005: 135).

This experience of violence resulted in ten per cent of all respondents reporting symptoms severe enough to be classed as PTSD. For the Northern sample, the figure was 12 per cent. People in the PTSD category were six times more likely than average to be using alcohol to cope with their experience of violence, ten times more likely to be taking prescribed medication and six times more likely to be taking other drugs. Scores for PTSD and GHQ12 indicated that poorer mental health was associated with greater experience of violence. For PTSD the relationship was particularly strong, with direct experience of the conflict accounting for a quarter of the variation in PTSD scores.

Hayes and Campbell (2005) use the distinction between Type I and Type 2

trauma. The latter is complex, chronic and enduring. The original trauma of the loss of a relative on Bloody Sunday was further compounded by 'the treatment of family members by the military and police, the flawed Widgery investigation, and the persistent civil unrest and violence' (2005: 43). Thirty five years after the event, the Saville Inquiry is still deliberating on the events of that day. Many of the family members, they argue, display the features of a complex Type 2 PTSD reaction. While Bloody Sunday was a unique turning point in the conflict, Hayes and Campbell state that many others had similar experiences to those of the Bloody Sunday families (Reilly, 2002).

Section 4

Mental Health and Suicide

In much of the literature on suicide there is an implied, and sometimes explicit, causal chain between the risk factors for depression, mental disorders and both attempted and actual suicide. For example, the World Bank's website states:

Suicide is the worst case scenario for many mental health disorders. Lack of diagnosis and proper treatment as well as a range of social, political and economic risk factors compounds the risk of a mental disorder leading to suicide. People suffering from mental disorders are more likely to be poor, to be substance abusers, live on the street and be socially excluded.¹⁴

Suicide rates are often taken as indicators of the state of mental health within a country or locality, as well as being seen as a product of poor mental health. The relationship between suicide and mental ill-health is far from straightforward, however.

A review of studies of suicide and schizophrenia, itself a contested diagnosis, established that ten per cent of patients kill themselves and that their risk of suicide is 40 times that of the general population (De Hert and Peuskens, 2002). Similarly, a review of psychological autopsy studies carried out over the past 40 years found that about half of the suicide victims suffered from depressive disorder, and half had a major depressive episode (Lönngqvist, 2002: 111). It is also observed that over half of clinically depressed persons have suicidal thoughts which are more likely if the depression is severe (2002: 108). One study from Northern Ireland is cited in which a psychological autopsy was carried out on all suicides for a twelve month period in 1992/3. A strong gender effect was observed with 'major unipolar depression' as the principal diagnosis for 52 per cent of the women but only 26 per cent of the men. Age was also significant with depression as the principal factor in three-quarters of the suicides of those over 65yrs and 27 per cent for those under

¹⁴ See under 'mental health' at <http://web.worldbank.org/>

65. The findings are based on low numbers (especially of women), however (reported in Foster *et al*, 1997). While psychological morbidity is clearly associated with suicide to a degree, the association varies considerably from place to place and by significant social variables such as gender.

Depression, anxiety, and other mental disorders do not, however, provide anything like a complete picture of attempted and actual suicide.

Psychological factors themselves may be shaped by either biology (including genetic susceptibility) (Träskman-Bendz, 2002) or social processes and structures, or both. When suicide trends change over time and where suicide patterns differ significantly from place to place, biological explanations are of limited use.

Suicide statistics

Most discussions of suicide rates refer to the issue of the reliability of official data. The classic sociological text, Durkheim's *Suicide* – first published in 1897 (but not available in an English translation until 1951) – remains at the heart of core debates within sociology, not because of what it says about suicide as such but because of its treatment of official statistics as 'social facts' and debates around 'scientific' approaches to understanding social phenomena. As Atkinson points out, the attention paid to Durkheim's book does not reflect an intrinsic concern with the phenomenon of suicide as such but with the issues raised by his approach to the topic:

Paradoxically, the extensiveness of that interest is of little help to the would-be researcher into suicide. For from whatever stance one approaches the research, one is faced with fundamental and unsolved methodological problems which appear so obvious...[W]hether one's interest is in the relationship between sociological and psychological modes of explanation... important decisions have to be made about the status and adequacy of the data chosen for analysis. (Atkinson, 1978: 31-2)

Almost 50 years ago, the World Health Organisation began to investigate ways of improving the reliability and comparability of national suicide data, for

the simple reason that ‘many have suggested that suicide is generally under-reported and that the international suicide rates are so inaccurate that no useful conclusions can be drawn from them’ (Brooke, 1974: 15). At the time this study was carried out, the Republic of Ireland had the lowest recorded suicide rate of all the countries examined – 1.8 per 100,000 (for 1970). Scotland’s rate was 7.6 which exceeded Northern Ireland’s rate for men alone (7.3 in 1969). In contrast, the recorded rate for Czechoslovakia (1968) was 24.5, and for Sri Lanka, 17.2.

One issue in the accuracy debate concerns the classification of deaths. Since 1893 there has been an international system for classifying deaths and diseases, known as the International Classification of Diseases, now in its tenth revision (ICD 10).¹⁵ Chapter XX covers external causes of morbidity and mortality, including intentional self-harm for which there are 25 different codes covering everything from poisoning from antidepressants (X61) through to intentional self-harm by jumping or lying before a moving object (X81). Clearly, the key judgement required by legal and medical authorities with the responsibility to determine and record cause of death is whether there is sufficient evidence of ‘intent’. When that is deemed to be lacking, the death is likely to be recorded under ‘undetermined intent’ or even as an accidental death, and classified under one of 25 similar causes, including ‘contact with explosive material’ (Y25) and ‘crashing of motor vehicle’ (Y32). Hence, some research has focused on the role of coroners and registrars, looking into decision-making around imputing intent (see in the Belfast context Prior, 1989; also Atkinson, 1978).

In terms of the social processes involved in a death (or injury) becoming a suicide (or attempted suicide) statistic, sociologists have made much of ‘concealment’ – the capacity of families and others to hide evidence around cause of death (or injury). There may be social and material reasons for covering up suicide and these change over time and between social groups.

¹⁵ The ICD started life as the Bertillon Classification of Causes of Death, named after the Chief of Statistical Services of the City of Paris, Jacques Bertillon. See *History of the development of the ICD*, at <http://www.who.int/classifications/icd/en/>

The role of religion in society – one of Durkheim's main explanations for differences in suicide rates between 'Catholic' and 'Protestant' countries – may be important, depending of levels of religiosity in a community or family, and the extent to which suicide is frowned upon by religious leaders.

Suicide has been both sin and crime. Traditionally, suicides were denied a sacred burial and had to forfeit all property, though the pace and extent of the 'secularization' and medicalisation of suicide is a matter of considerable debate among historians (Healy, 2006). Prussia decriminalized as early as 1751 followed by revolutionary France in 1790. While 'laws on suicide are not a good index of actual practice', it is nevertheless interesting that decriminalization was much more protracted in Britain and Ireland. Bodily desecration came to an end in Britain in 1823, the confiscation of property in 1870 and the removal of remaining penalties in 1961. In the Irish Republic there was a prosecution for attempted suicide as late as 1967 and suicide remained a crime until 1993. In terms of social practices, what counts is the force of attitudes towards suicide, not the letter of the law. According to one authority, the Victorian middle classes in England went to great lengths to hide an act of suicide as not only was it illegal and immoral, but the only way of holding on to property in a known case of suicide was to plead insanity (Gates, 1988). Even if this had its own stigmatizing drawbacks, at least a Christian burial was possible for an 'insane' suicide. While the medicalization of suicide may not have suited the respectable classes it certainly suited the growing numbers of medical superintendents of asylums who were able to show that in-house suicide rates were kept low, without the use of restraints, compared to those outside of the asylum (MacDonald and Murphy, 1990; see also Anderson, 1987; Shepherd and Wright, 2002).

As indicated above, decriminalization came very late in Ireland and the Dáil debates at the time give a flavour of the prevailing attitudes. It is only in very recent years that Catholic Bishops have formally encouraged a sympathetic attitude towards suicide (Irish Bishops' Conference, 2004). So the incentive to conceal has been strong:

Bereavement for accidental or natural death rarely necessitates counselling because there is an obvious reason for the loss, however tragic, of a loved one. Loss of a loved one by suicide is different. The family are inevitably subjected to investigation by police, coroners and insurance agents. Because there is still a stigma attached to suicide, there is often less support for the survivors in a situation where more support is needed. The first and most notable reaction of the bereaved is that of guilt. There is a tendency to blame oneself. This is compounded by denial, shame, an avoidance of communication and a withdrawal from normal social relationships. Concealment of the fact seems more preferable than the awkwardness that the discussion of the suicide may bring. (Seanad Éireann, Volume 130, 4 December 1991, col. 1356.)

The power and desire to conceal a suicide has been linked to the degree of social integration. Forty years ago in his critique of Durkheim, Douglas argued that biases in official statistics reflect class, occupation and other aspects of social structure. In situations where suicide is stigmatized,

there will be both differential tendencies on the parts of members of different (official) categories to have any “suspicious” deaths within their families categorized as something other than “suicide” and differential degrees of success in these attempts. Moreover, it seems reasonable to expect that the attempts and the frequencies of success will be greatest precisely in those groups which are most “integrated” in the society... [T]he greater the degree of social “integration” of a group, the lower will be its official suicide rate *as a result of the nature of the official categorization process itself*. (Douglas, 1971: 129)

There remains a material element that provides an added incentive to concealment. It is still common to find suicide clauses in insurance contracts that invalidate claims on policies. Such clauses vary from outright exclusion to time-limited exclusion, typically one or two years in the case of life insurance.¹⁶ There is some evidence that such time limits influence suicide rates, or, possibly, disclosure of suicide. Tseng examined mortality data from the Society of Actuaries in the US covering a five year period in the early 1990s. These were records of those holding life insurance policies and who took their own lives – over 7,000 individuals or just under two per cent of all

¹⁶ For example, the company that specialises in services for the over-50s – Saga – offers a personal accident policy covering death benefits that states: ‘We will not pay any claim arising directly or indirectly from the following. Suicide or intentional self-inflicted injury’, in addition to all the other typical exclusions – war, terrorism, service in the armed forces, ‘civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power’.

insured deaths during the period in question (Tseng, 2004).¹⁷

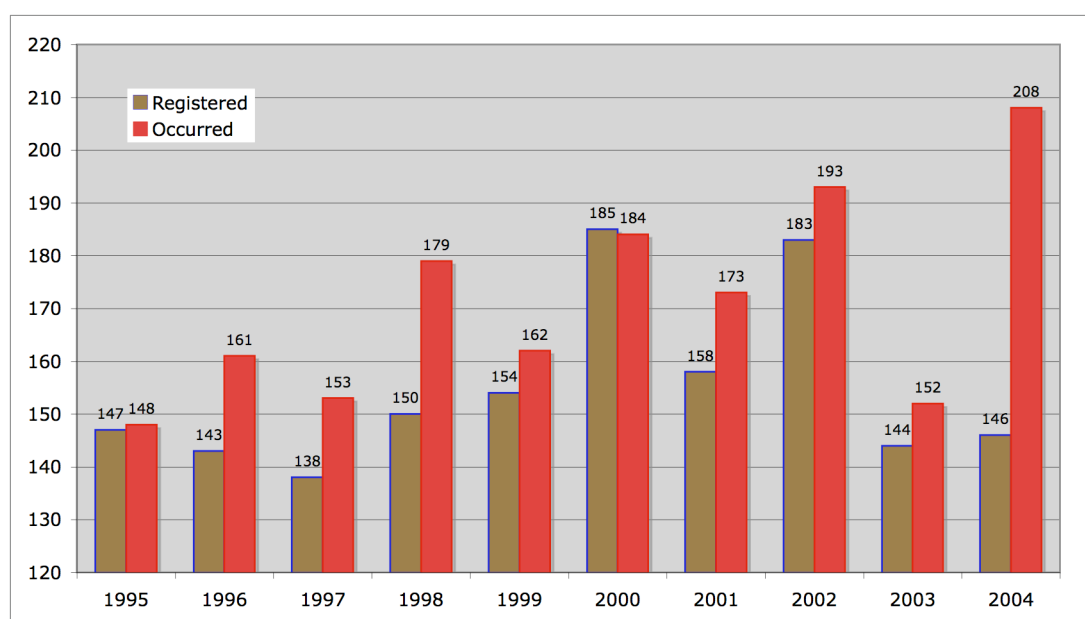
It was found that the suicide rate of the insured was only about a third of the overall rate in the population, probably because the insured earn more and because of insurance screening which results in the insured having better mental health than the population at large. Another finding was that insured males aged 15-24 had 2.3 times the suicide rate of insured males aged 25-34. In the population as a whole, however, the suicide rate for 15-24 yr olds was 89 per cent of the 25-34 yr old group. In terms of economic incentives, it is suggested that, 'people who purchase life insurance for their own lives are more cautious about the consequences of their deaths and therefore are less likely to commit suicide. Most young adults purchase life insurance for their own lives, while policies written on the life of youths are usually purchased by their parents or grandparents.' (Tseng, 2004: 6-7) The central finding, consistent across age and gender, was that the suicide rate of the insured quadruples after the two year exclusion period. Further, it is argued that many of the deaths recorded as 'accidental' during the first two years of the insurance policy (the period covered by the suicide exclusion clause) are in fact disguised suicides. In the absence of data showing the age and gender profile of all life insurance policy holders, it is not possible to estimate just how these findings might affect national suicide recording but given the relatively small numbers involved, the affect is unlikely to be significant.

Practices in relation to the recording of death continue to evolve. The Luce Report investigated death certification in Britain and Northern Ireland in 2003 and listed thirteen 'critical weaknesses' in a system that is fragmented, lacks consistency and is insensitive to the needs of the bereaved. (Luce Report, 2003) Prior to the Luce Report suspected suicides in Northern Ireland were referred to a coroner who held an inquest. Post-Luce, the practice is to hold an inquest only when the family requests this. The coroner's findings are passed to the General Register Office which will consult with the coroner if there are doubts about the appropriate ICD coding. This process involves delays between the occurrence of death and its actual registration – a delay of

¹⁷ The data are biased towards larger companies that tend to have lower mortality rates.

two years or more in 3 per cent of cases. A quarter of suicides are registered within six months of the death and 70 per cent within a year (Information Analysis Directorate, n.d.). This means that a substantial number of suicides are not recorded for the year in which they actually took place and the effect of this is that the official figures mask changes in suicide trends as illustrated in Figure 1: occurrences were 19 per cent above registrations in 1998.¹⁸ The lag is just as evident when the same data are presented as three year rolling averages (Figure 2) and the discrepancy between registration and occurrence is inconsistent from year to year. 'Events of undetermined intent' are not included in these figures.

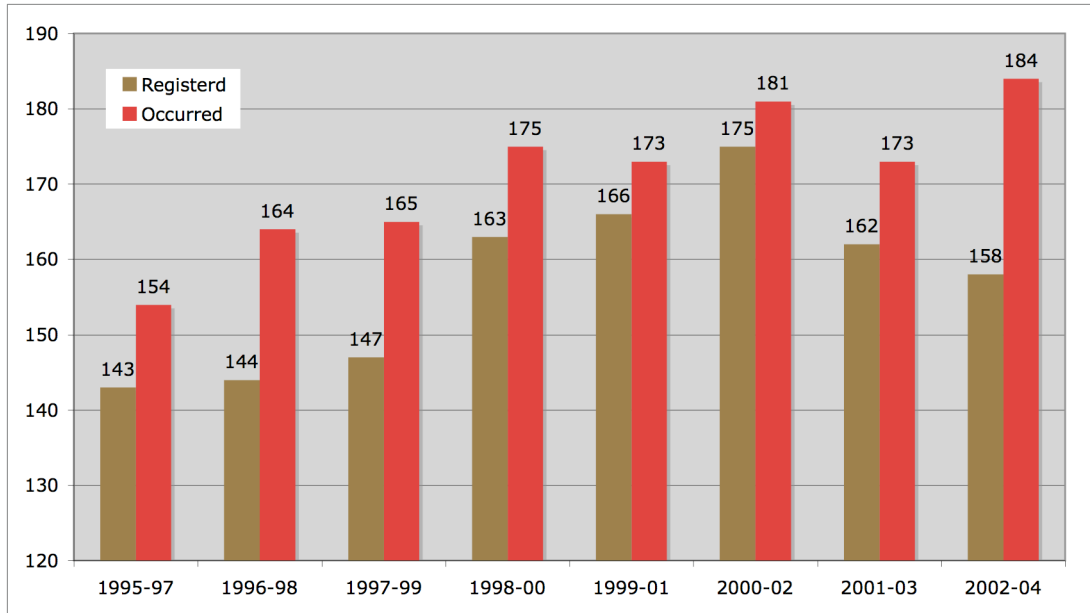
Figure 1: Comparison of suicide registration and occurrence



Source: Registrar General Northern Ireland, Annual Report 2005, Belfast: Northern Ireland Statistics and Research Agency, 2006, p. 19; Mortality Statistics for 2006, NISRA 22 March 2007.

¹⁸ Only 72 of the 291 suicides registered in 2006 occurred in that year.

Figure 2: Comparison of suicide registration and occurrence (three year rolling averages)



Source: Compiled from data in Registrar General Northern Ireland, Annual Report 2005, Belfast: Northern Ireland Statistics and Research Agency, 2006, p. 19.

A study in the Irish Republic looking at the registration/occurrence discrepancy between 1987 and 2003, found that the numbers of occurrences were always above registrations apart from the years 1987 and 1993. The last date was the year of decriminalisation although in the following year occurrences were about 12 per cent above registrations and were well above the 1992 figures (Corcoran *et al*, 2006: 131). In addition, the discrepancy has increased over the period and climbed as high as 18 per cent in 2000. Where there is a delay in registration it is possible that a suicide is omitted from the registration record altogether, as the authors explain:

While the CSO [Central Statistics Office] may have been notified that a death has taken place, it will not be recorded in their registration figures until sufficient data have been gathered to fully classify the cause of death. If this does not happen before the deadline for the annual registered deaths report, then such pending cases will not be included in the report nor will they be included in the subsequent year's annual registered deaths report. However, all such deaths will be included in the annual report based on year of occurrence. (Corcoran *et al*, 2006: 133)

The Luce Report points out that, compared to most other jurisdictions, many more deaths in the UK are referred to coroners and the autopsy rate is two to three times that found elsewhere. Regarding suicide and in conformity with international standards, Luce recommends that an inquest should not be automatic, but would be necessary only in those cases in which there was some third party involvement, or the death had taken place in prison or under mental health legislation. Deaths from suicide should not automatically qualify for a public inquest. The Report also recommends dropping the verdict of 'suicide', which still retains criminal connotations, and using the expression: "death from a deliberate act of self-harm or injury". (2003: 6)

A draft Coroner's Bill was published in June 2006 which rejects key recommendations of the Luce Report and does not tackle death certification. The Constitutional Affairs Select Committee (2006) is critical of the Bill for failing to address reform of the death certification process as proposed not only by the Luce Report, but also by the Shipman Inquiry (2003). Instead of a national Coroner's service, the Bill recommends a new office of Chief Coroner supported by an advisory council to improve liaison with registrars and medical practitioners. In its response to the Constitutional Affairs Committee report, the Government makes clear that it does not intend to reform the death certification process at present.¹⁹

All of these points mean that suicide statistics need to be treated with considerable caution and should not be used uncritically. Studies that are simply based on exploring statistical relationships between recorded suicides and any available variables rarely question the data. While the numbers of suicides and the rate of suicide are very often taken as plain facts in public as well as academic discussion, the data need to be treated with caution in the light of knowledge about what produces a suicide statistic and where this leads in terms of understanding the social context of suicide and the development of policy responses to it. Both international comparisons and changes in trends may have as much to do with differences in the way suicide

¹⁹ See Reform of the Coroners' System and Death Certification Government Response to the Constitutional Affairs Select Committee's Report, November 2006, Command Paper Cm 6943.

comes to be defined and registered, as with 'real' differences and changes in suicide *per se*.

Self-harm

Before exploring suicide statistics further, it is important to mention self-harming. It is only quite recently that attempts have been made to estimate the prevalence of self-harming, with the focus on younger people. One approach is to monitor relevant hospital attendances, about 8 per cent of which result in death that is registered as a suicide. But the difficulty with this is that most self-harming does not end up in a hospital casualty department or as a hospital admission. As Brophy (2006: 20) observes, many young people who self-harm do not come to the attention of services or professionals and statistics are further confused by survey evidence adopting different definitions.

According to a large-scale survey of 15 and 16 year olds in Birmingham, Northampton and Oxfordshire, 11 per cent of girls and 3 per cent of boys reported self-harming in the previous twelve months. Only 12.6 per cent of these reported incidents resulted in a visit to hospital (Samaritans 2002). In this survey, self-cutting was involved in almost two-thirds (64%) of the incidents of self-harming, but there is very little research on the subject. A study of hospital treated self-cutting carried out in Scotland indicates that 'the annual incidence of *hospital treated* self-cutting is about 31 per 100,000 population aged 15 to 19 years, with a somewhat higher rate among females than males' (Brophy, 2006: 21).

Hospital *admissions* as a consequence of self-harm in Northern Ireland are analysed in the DHSSPS Draft Suicide Prevention Strategy (2006: paras. 2.14-2.17). Two-thirds of the self-harming that requires hospital admission is accounted for by 25-54 years olds and a further quarter in the 16-24 age group. For most age groups more women than men are admitted as a result of self-harming with the widest difference in the youngest age groups. Those

admitted to hospital who die will be registered as suicides but such deaths account for only 8 per cent of all suicides (Information Analysis Directorate, n.d.). Clearly, much more work could be done to monitor parasuicide, following the example of the National Parasuicide Registry developed by the National Suicide Research Foundation based in Cork.

The traditional view of self-harming is that it is a step towards suicide, if not a suicide attempt itself. But Fox and Hawton (cited in Brophy, 2006) estimate that there are between 40 and 100 times more young people who self-harm than suicides. As Brophy puts it, 'Self-harm is usually intended to *harm*: not to kill, or even to inflict serious and/or permanent damage. It is a strategy which (however maladaptive and damaging) makes it possible for the young person to continue with life, not to end it. Some people who self-harm do also try to kill themselves at some point but these are a very small minority' (2006: 28)

Section 5

Suicide: Patterns and Trends

The World Health Organisation maintains a global suicide data set where the variable quality and availability of national suicide statistics is evident. There is very little information available for Africa: Zimbabwe, one of four countries represented in the dataset, has figures for 1990 only. For most of the Americas, the data are ten years out of date, possibly reflecting the lack of priority given to suicide in countries that appear to have low rates.²⁰ For example Argentina's rate fell from 9.9 to 6.4 per 100,000 persons between 1970 and 1996. Chile's rate was 4.2 in 1950, 7.5 in 1960 and has been more or less flat since the 1970s, with the latest recorded rate of 5.7 for 1994. Likewise, Venezuela and Brazil have stable rates of between 4 and 5. Mexico's rate is even lower at less than 2 for the period since 1960, although beginning to show an increase in the 1990s: a rate of 3.1 by 1995. The latest available figure for Guatemala is for 1984 with a recorded rate of 0.5 – the same as Peru. The Latin American exception is Cuba which has had a long history of high suicide rates, dipping down in the years following the revolution but from 1970 rising to 21.3 in 1992. The fall in the rate to 18.3 by 1996 suggests that public health initiatives launched in 1989 have made an impact.²¹ Cuban men aged 65-74 have a rate of 62.6 and the 75+ age group, 113.2. These high rates have been explained in terms of the social acceptability of suicide down the centuries, notwithstanding the Castro doctrine that life belongs to the revolution rather than the individual.

The other exceptions in the Americas are Canada and the US. Canadian rates rose from the 1950s, doubling between 1955 and 1980. By 2002 the rate stood at 11.6. Canada stands out for another reason – its age profile for suicide declines for people over 45. The reverse is true for most other

²⁰ All the rates that follow are based on suicides per 100,000 of the population and are taken from the World Health Organisation website at http://www.who.int/mental_health/prevention/suicide/country_reports/en/index.html

²¹ In 1989, the National Programme for the Prevention and Control of Suicidal Conduct was introduced. See Pérez (2005).

countries. The US rate was 7.6 in 1950 climbing steadily to 12.4 by 1990 and falling back to 11.0 by 2002. Unlike Canada, US rates climb with age after 65, but modestly as compared with most countries.

The wealthy countries in the pacific region have had relatively high suicide rates in recent decades. Japan in particular has rates twice those of the US and Canada. In 1955 Japan's suicide rate was 25.1. It was 25.5 in 2003 but varied in the interim reaching a low of 14.7 at one stage in the 1960s. In terms of age, the highest rates are for those in their mid-40s to their mid-60s, a bulge which reflects what is happening to men rather than women. Australia and New Zealand have quite flat profiles over time with Australia reaching a high point of 14.9 in the 1960s while New Zealand's peak came in the mid-1990s. Both countries have similar rates now: Australia, 11.8 for 2002 and New Zealand, 11.5 for 2003 (New Zealand Ministry of Health, 2006).

Before coming on to Europe, it is worth mentioning some other highs and lows. Iran, Jordan, Egypt, Kuwait and Syria have suicide rates that are negligible. Religion is thought to be a protective factor in Muslim countries as the Islamic religion 'poses strong sanctions against suicide as it is viewed as a form of homicide, forbids alcohol consumption, and teaches a problem-solving method for times of acute stress by the recitation of sayings from the *Koran*, thus reducing compulsive acts of suicide.' (Cheng and Lee, 2002: 39) This point was noted by Durkheim over a century ago when he wrote that 'nothing, in fact, is more contrary to the general spirit of Mahometan civilization than suicide' (Durkheim, 2002: 294). Or as Dabbagh puts it in her study of suicide in Palestine, 'it is popularly thought in the Arab world that suicide is a "Western thing"' (2005: 231) and indeed she found low rates of suicide even after unrecorded and undocumented cases were taken into account. The Islamic tradition defines suicide as a 'grave sin' while martyrdom is 'rewarded'. Dabbagh discusses how the 'cultural categories of suicide and martyrdom are not static' (2005: 232) so that in exceptionally desperate times, socially, economically and politically, 'martyrdom' expands to cover a broader range of deaths and intentions, even though religious conservatism still acts to keep 'suicide' at low levels.

However, religion does not appear to act as a protective factor for people in Sri Lanka where a rate of 35.8 was recorded for 1985 falling to 21.6 by 1996, though it is unclear how the civil war has affected the recording of suicide. About three-quarters of the Sri Lankan population are Sinhala, most of whom are Buddhist. This section of the population is slightly overrepresented in the suicide statistics compared to Tamils and those with the Muslim faith. Other largely Buddhist countries do not have high suicide rates (Cheng and Lee, 2002: 40).

China also stands out for having high rates of suicide, notably in rural areas. Unusually, rates for women either match or exceed those for men. For 1999 the 'selected urban areas' suicide rate was 6.7 overall and 6.6 for women. At the beginning of the decade it was 8.6 overall and 9.1 for women. For 'selected rural areas', the rates were as high as 32.3 for women, 23.2 for men and 27.6 overall in 1987. A rate of 24.7 was recorded for women in 1999. The male rate was 20.4 that year but for the over 75s it was 139.7.

As more in-depth research is carried out in developing countries there will be more challenges to what are understood as prevailing trends and patterns. Work carried out in the Tamil Nadu region of Southern India, for example, discovered very high rates of suicide among young women in the 15-19 age bracket (Aaron *et al*, 2004). Although dealing with relatively low numbers, the pattern over ten years was such that the average suicide rate for this group was 152. For young men it was 69. The rate for the women was 70 times the rate for the equivalent group in the UK. The researchers suggest that rates of suicide reported in other parts of India are low 'because identification of suicides is difficult owing to inefficient civil registration systems, non-reporting of deaths, variable standards in certifying death, and the legal and social consequences of suicide. We do not believe that our findings are a local aberration.' (Aaron *et al*, 2004: 1118)

The picture in Europe is also one of marked contrasts. The highest suicide rates are found in the countries of the former Soviet Union and Eastern Bloc.

In the mid-1990s Lithuania's rate reached 45.6 falling to 40.2 in 2004. Lithuania's suicide age profile is untypical, rising to the 45-54 group and declining thereafter, though this result is to do with the dominance of men in the figures. Lithuanian men have a suicide rate of 70.1 which is five times the rate for women. Men aged 45-54 have a suicide rate of 129.3. Hungary shows a similar pattern though the gender differential is less at 3.7 times. The age profile is also more in keeping with other countries. Hungary's suicide rate rose steadily from 1955 (20.6), peaked at 44.9 in 1980 and fell to 27.7 by 2003. Ukraine's rate is much the same now as it was in the early 1980s, though there was a rise in the rate during the 1990s, to a peak of 29.6. The gender difference is even more marked than in Lithuania at six times. The Russian Federation follows the Ukraine pattern quite closely only at a higher level with a rate of 34.3 in 2004. The gender differential in rates is also six times. Belarus is much the same and has a rate of 35.1 though suicide trends have been getting steadily worse since 1990.

Like Lithuania, the other Baltic states have suicide rates that peaked in the mid-1990s but not at quite such a high level. Latvia's rate is now 24.3 (2004) compared to Estonia's rate of 27.3 (2002). The gender differential in both countries is over five times (male to female) and they have similar age profiles for suicide rates. Estonia, however, has higher rates among the lower age groups. For men aged 25-34 the Latvian rate is 37.1 but it is 57.1 for the equivalent group in Estonia. Not all former Eastern-bloc countries have high suicide rates, however. Romania has a rate of 12.5 (2004), Moldova 16.7 and the Czech Republic 15.5. Poland stands out for having a steady upward trend line from 1955 onwards. The rate for women has been quite stable since 1970 (a very slight rise over time) but the rate for men has risen from 9.6 (1955) to 26.7 (2003) increasing the differential from three to six times. The age profile is such that the highest rate of suicide is for the 45-54 group. Croatia's rate has declined gradually since the mid-1980s and stood at 19.6 by 2004. The male suicide rate is three times the female rate.

A recent report on the state of mental health in the European Union discussed differences in suicide rates across what were then the 15 countries of the EU

plus Norway (European Commission, 2004). For 1997, the report shows that rates vary from 3 in Greece to 24 in Finland. The UK was third lowest with a rate of 7 and Ireland was 8th highest at 13. The report recognizes the problem of differences in death certification so looks at suicide combined with deaths from events of 'undetermined intent' many of which will be suicides. This dramatically alters the position for Portugal, pushing it into the top half rather than second from the bottom. The impact is less great for other countries though substantial for the UK.

Trends over time are examined for the period 1980 to 1999. There was a strong decrease in suicide rates for women across all countries except Spain and Luxembourg. The trend was especially strong for Denmark, and strong for Sweden, Austria and the UK. For men, rates increased strongly in Ireland and less so in Spain and Luxembourg, and marginally in Norway and Greece. The overall rate for the UK declined very slightly, but for some other countries the trend was strong: Sweden, Denmark, Austria, Finland and Portugal. The report comments: 'it could be argued that the Irish suicide rate has not really increased, but that there has been a cultural change towards suicide. If such a hypothesis were true, this should correspond also to a drop in deaths from events of undetermined intent. This is not the case, however, in Ireland where deaths from events of undetermined intent among men increased by 14 per cent between 1995 and 2000.' (European Commission, 2004: 26)

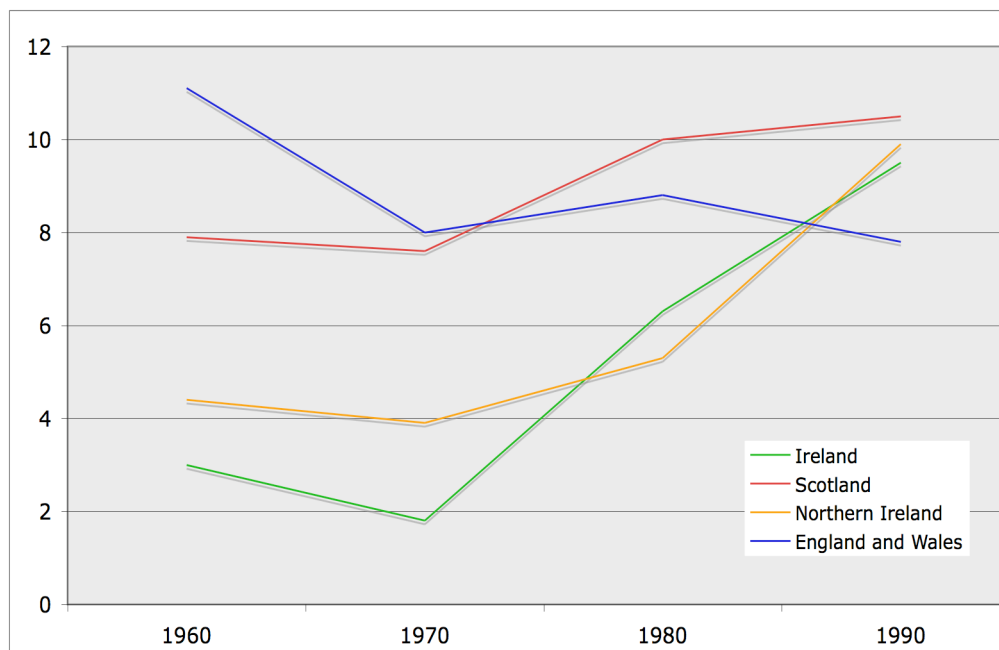
The age profile for death rates for suicide varies widely across EU countries. In Ireland the rate for men 0-64 years exceeds that for men over 65 by a considerable margin but it is the only country where this is the case. The widest difference in rates between these two age groups is for Austria; the least difference is in the UK (based on 1997 figures). Luxembourg is the only country where female rates of suicide in the younger of the two age bands exceed that for the older band. The greatest difference is again in Austria. When gender is looked at in the 15-24 years age group, males have four times the rate of females in Ireland and Finland.

The report finds no relationship between suicide, risk of poverty and

unemployment, and comments that Ireland, the country with the best economic trend in the period 1980-2000, has had the highest increase in suicides. On the other hand, there was an increase in alcohol consumption levels during this time and an increase in the rate of drug-related deaths (as in Greece). Over a twenty year period to 2001, pure alcohol consumption is estimated to have gone up by over fifty per cent in Ireland whereas in most countries (except Luxembourg and Finland) there was a substantial decline (e.g. Italy, Spain, and France). The UK experienced a minor drop in consumption. The report cites an estimate that half of all deaths from intentional and unintentional injury across the EU are related to alcohol consumption.

Lester *et al* (1997) compared suicide trends in Northern Ireland, England and Wales, Scotland and Ireland over a thirty year period from 1960. They used data gathered by the World Health Organisation which do not appear to include 'events of undetermined intent' as suicides. The trends are summarized in Figure 3 below. The authors looked at gender and age, and explored possible statistical relationships with unemployment, marriage and birth rates.

In Ireland, suicide rates rose for men and women, unlike in Scotland and England and Wales where rates rose for men only (marginally so in the case of England and Wales). In every country the male-to-female ratio of suicide rates went up: in other words gender differences became more marked. Because suicide rates rose (by more than 2.5 times) for men *and* women in Ireland, Lester *et al* suggest, following Kelleher and Daly (1990), that the overall increase 'may be a result of a tendency for coroners to certify suicidal death more accurately in Ireland during this period' (1997: 304). This is supported by Walsh *et al* (1990) who argue that about one third of the increase in suicide in the Republic between 1968 and 1987 was due to improved Central Statistics Office coding of coroners' findings.

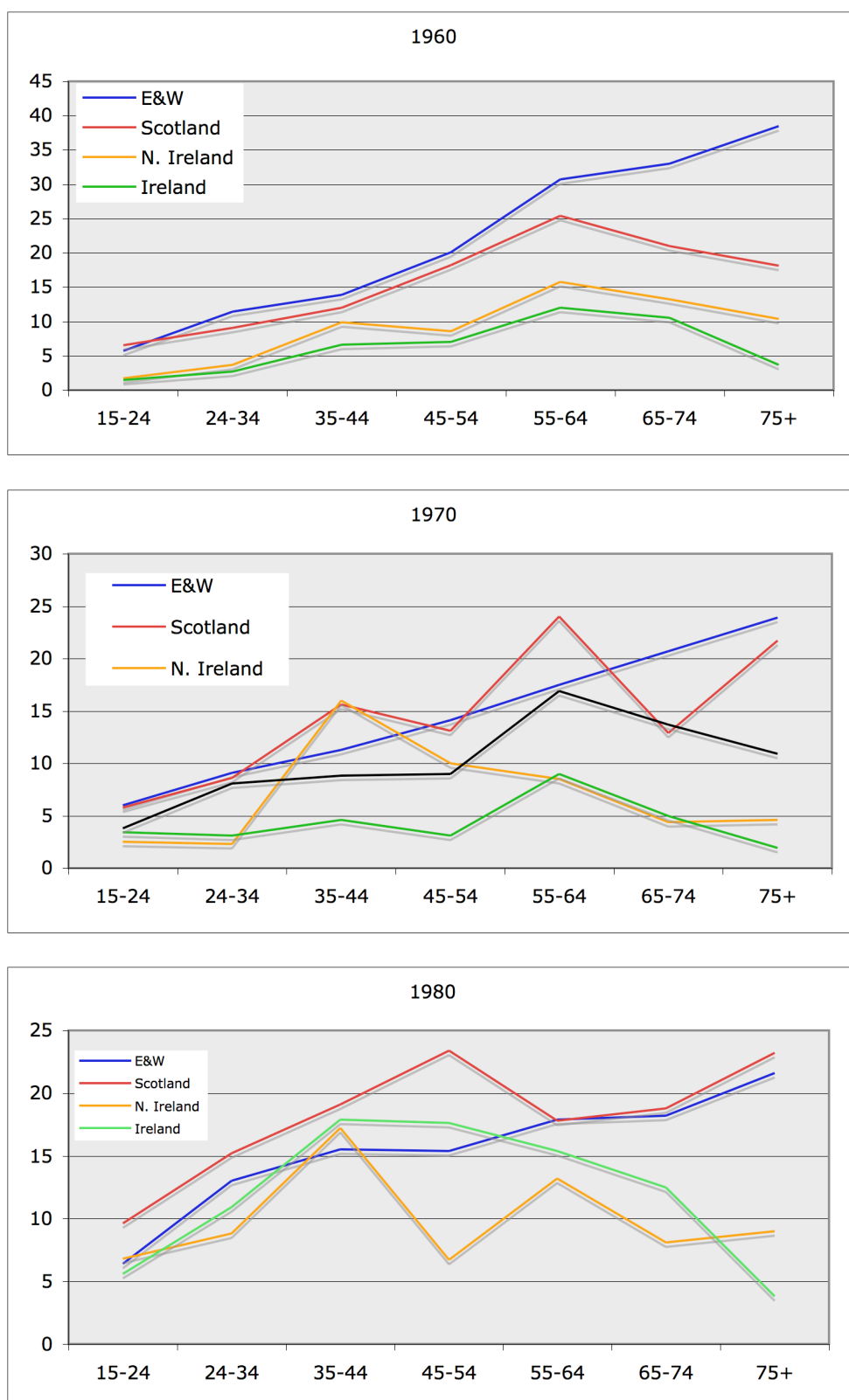
Figure 3: Suicide rates 1960-1990

Source: Compiled from data in Lester *et al* (1997)

Lester *et al* came up with somewhat contradictory results for marriage and unemployment. Rates of marriage were positively associated with suicide rates for men and women in Ireland but negatively so for the other jurisdictions. The unemployment rates of women in Northern Ireland and Ireland were negatively associated with suicide whereas they were positively associated in the case of Scotland and England and Wales. For men in every country, unemployment was positively associated with suicide. The analysis ends on a speculative note that perhaps 'differences in the provision of mental health services between the regions could be responsible for some of the regional differences identified' (1997: 304). The conflict in Northern Ireland is not mentioned at all, which is rather surprising given Lester's earlier work correlating suicide rates and conflict-related deaths (2002).

The age-related data presented by Lester *et al* show how Northern Ireland's profile has changed relative to the other countries since 1960. Prior to the onset of the conflict, Northern Ireland's suicide rates across the age bands matched the profile of the Republic of Ireland albeit at a higher level (Figure 4). Scotland and England and Wales were similar except for the over 65s.

Figure 4: Suicide age profiles by country



Source: Lester *et al* (1997) and Forty-sixth Annual Report of the Registrar General 1967

The chart for 1970 includes an immediate pre-conflict profile for Northern Ireland for the year 1967. Again this matches the shape of the Republic of Ireland profile for 1970 but at double the rates for most ages. The Northern Ireland suicide rate fell to 3.9 in 1970 and in terms of age was much closer to the Republic's profile with the exception of 35-54 year olds. Comparing 1967 and 1970 there is a distinct shift in the profile towards the younger age groups (especially the 35-44 age group). By 1980, rates in the Republic have more than tripled for the 35-54 groups and the shape of the profile is most similar to Northern Ireland with the clear exception of the 45-54 group. For the last date in the series (1990) the peak rate for both the Republic and Northern Ireland is for the 55-64 age group. In generational terms this is the same cohort that peaks twenty years earlier in 1970 for Northern Ireland as the 35-44 age group. In 1980 however, this cohort (45-54) has a low suicide rate.

The question remains, how reliable are the trends observed above? One of the factors that receives little attention in Lester *et al*'s analysis is variations in the method of suicide over time and the impact on the recording of suicide. As Neeleman and Wessely (1997) show, the likelihood of a premature death being registered as a suicide varies widely by circumstance. They looked at coroners' verdicts in England and Wales, comparing the ratio of 'open' (undetermined) to 'suicide' findings for different methods. They found that:

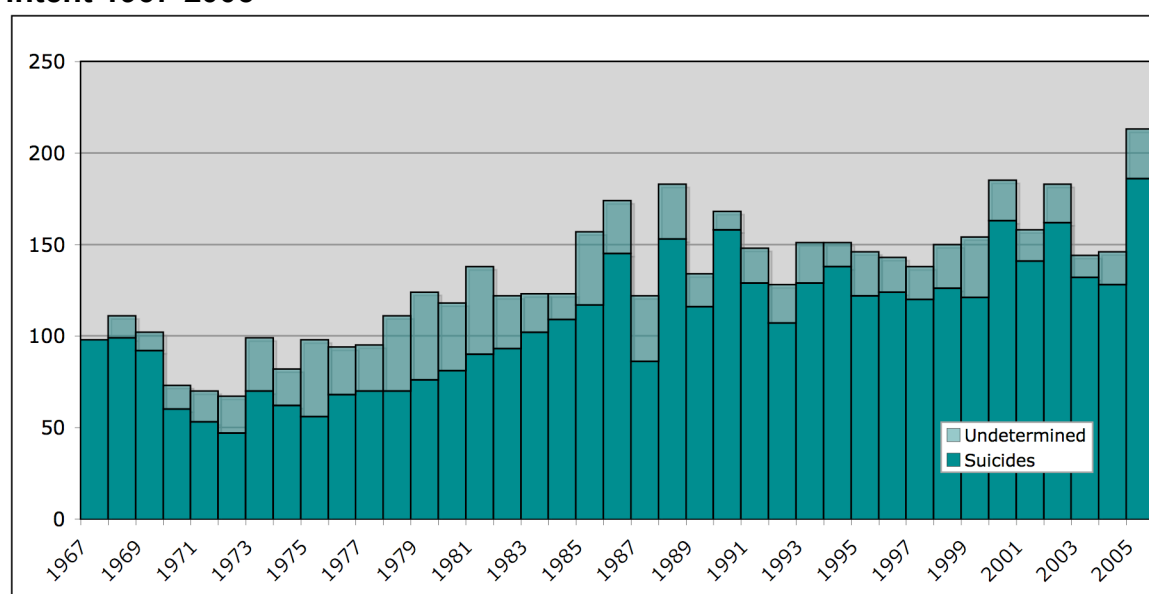
[C]ompared with deaths by hanging, the open-suicide ratio was higher in cases of drug overdose, jumping from heights, other violent methods and especially drowning. This pattern applied to male and female deaths but the open-suicide ratio for female deaths through other violent means was substantially higher than it was for male deaths. Male deaths involving gas-poisoning were less likely than male hanging deaths to receive an open verdict while the reverse applied to female deaths. (Neeleman and Wessely, 1997: 469)

The open-suicide ratio was higher for younger people, women and for incidents such as drowning and falling/jumping from heights. In England and Wales, while overall suicide rates were declining the proportion of suicides accounted for by hanging and gas poisoning doubled for both men and women. Controlling for age, gender and method, however, Neeleman and Wessely still found that open verdicts became more likely in England and

Wales for the period examined, a trend that was unique for the eight countries used for comparison. They suggest that the explanation lies in the judgements made by doctors and coroners. Some of this debate has been resolved by the inclusion of 'events of undetermined intent' in published suicide statistics in more recent years, but it is still the case that trends over time and between countries are uncertain.

Figure 5 shows the number of recorded suicides and 'events of undetermined intent' for Northern Ireland since 1967. There was a sharp decline in the suicides registered in the early years of the conflict: the numbers halved in four years. There was a similarly dramatic change between 1979 and 1987 when the numbers more than doubled, from 70 to 145. For much of the 1990s the annual number of recorded suicides stabilized at just above 120. Since 1999 the trend has been somewhat erratic but with three of the highest numbers ever recorded occurring in the last six years.

Figure 5: Number of recorded suicides and deaths of undetermined intent 1967-2005



Source: Registrar General Northern Ireland, Annual Reports.

The practice of putting deaths from intentional self-harm/injury with deaths of undetermined intent was followed in the latest National Statistics Office

analysis of suicide in the UK (Brock *et al*, 2006). Overall, suicide rates have been falling for the UK and, indeed, reached a 30-year low in 2003 (National Statistics Press Release, 10 March 2005). But the story varies considerably for different parts of the UK, as illustrated above. At the beginning of the 1980s, Northern Ireland had the lowest suicide rate (5.3) of all the countries in the UK (Scotland 10.0), and a lower rate than the Republic of Ireland (6.3) (Lester *et al*, 1997). The only exception was for women aged 15-44 where the Northern Ireland rate was above that for Wales and England (Bunting and Kelly, 1998: 9).

Bunting and Kelly (1998) compared suicide trends across the UK between 1982 and 1996 using age-standardised death rates, for men and women separately and for the two age-groups 15–44 and 45 and over. For these four categories suicide rates went down in all countries in the UK, except for the category, men aged 15-44. The English trend for this category rose steadily to the early 1990s but declined thereafter, unlike in the other countries where the rates continued to climb (albeit unevenly). Northern Ireland overtook the English rate by 1996. Suicide rates for 15-44 year old men increased by 50 per cent in Northern Ireland.

As Brock *et al* (2006) show, Scotland has by far the highest suicide rates for men and women, reaching 32.8 for men in 1998/2000 (three year rolling average) falling back to 30.0 for 2002/04. Northern Ireland's rate for men was the lowest (18.1) compared to all the UK countries and all the English regions at the start of the 1990s. But it overtook the English rate around 1998 and is now exactly in line with the UK average for 2002/04 (18.3). The rate increased from 1996/98 and began to fall again in 2001/03. The same trend can be seen for Wales and to a lesser extent Scotland.

Taking the two periods 1991-1997 and 1998-2004, Brock *et al*'s analysis shows the suicide rate for women aged 15-44 in Northern Ireland increased by about 20 per cent while the UK increase was 3 per cent. For all other age groups suicide rates for women fell between the two periods. The same trend applies to men in Northern Ireland. These time periods are potentially useful

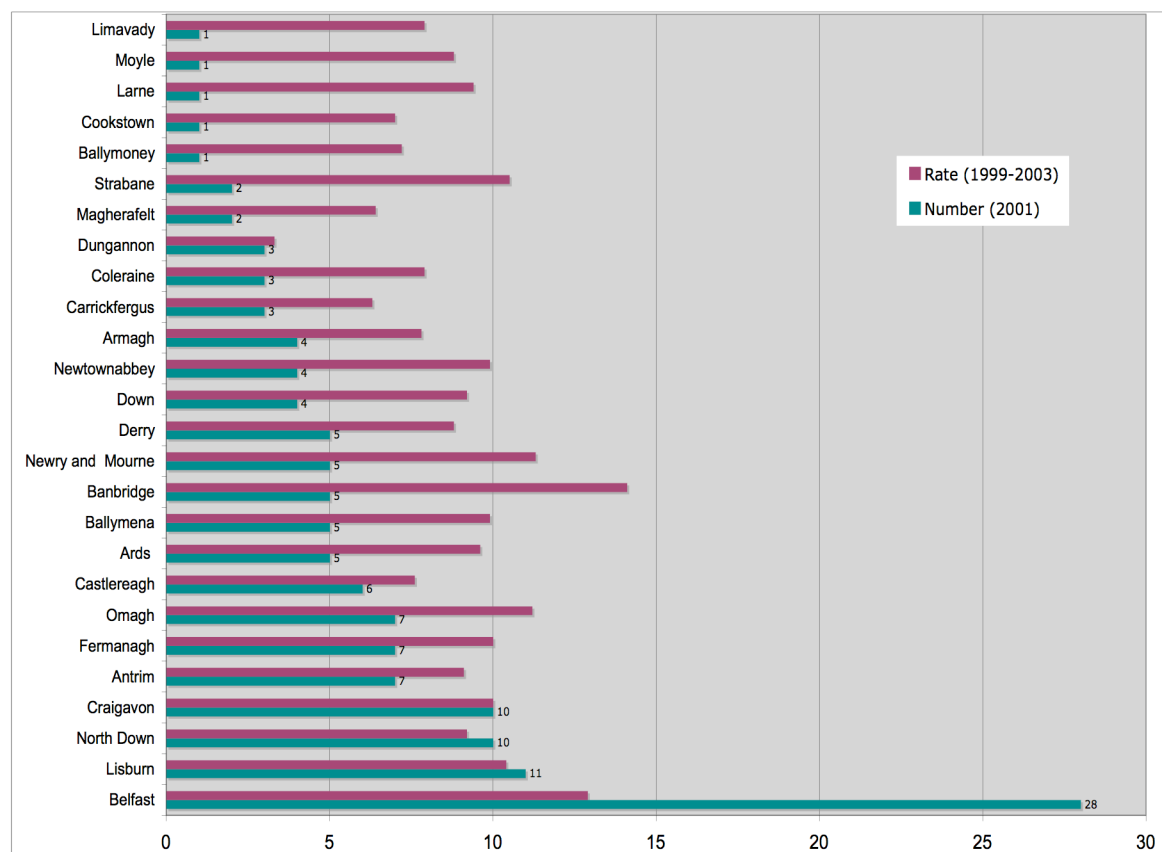
in terms of the impact of the conflict as they fall either side of the 1998 Agreement. In the first period male suicide rates for Northern Ireland's parliamentary constituencies are all within 25 per cent of the overall UK rate with the exception of three constituencies whose rates were between 25 and 49 per cent lower. In the second period, however, the position has changed so that only two constituencies have rates 25-49 per cent below the average for the UK, while one is now 25-49 per cent higher and two (Belfast North and Belfast West) are 50 per cent or more higher than the average. In the first period, Northern Ireland had no constituencies with male suicide rates in the top twenty, whereas Scotland had fourteen, including the highest rate of 43 in Glasgow City.

The local areas selected for comparison across the UK are not strictly comparable in Brock *et al*'s analysis. Local and Unitary Authorities were used for England and Wales, Council Areas for Scotland, and Parliamentary Constituencies for Northern Ireland – a total of 426 areas, but those with less than ten suicides in the relevant periods were excluded (2 areas for 1991-1997 and 3 areas for 1998-2004). In the post 1998 period Belfast West had climbed from 259th to 13th place with a rate of 34.2 for men; Belfast North was ranked 319th in the pre-1998 period and 11th thereafter (1998-2004) with a rate of 35.4. A similar picture is presented by the suicide rates for women. In the first period, three constituencies have rates that are 25-49 per cent lower than the UK average while the remainder are within 25 per cent of the average. In the second period Belfast West had emerged with a rate (for women) 50 per cent or more higher than the UK average and Belfast East and Belfast North were in the 25-49 per cent above range.

Using local authority areas only, Fitzpatrick *et al* (2001) mapped suicides for men and women across the UK for 1991-1997. While most of Scotland was shaded as 'very high' for males, all of Northern Ireland was 'not significant' apart from Belfast, shaded as 'very low'. A more recent analysis of suicides by local authority area in Northern Ireland is presented in the Draft Suicide Prevention report published (DHSSPS 2006, para 2.12). The district council area with the highest suicide rate for the 1999-2003 period was Banbridge

(14.1). As can be seen in Figure 6, Banbridge was one of five council areas for which 5 suicides were registered in 2001 (excluding events of undetermined intent). Between 1999 and 2003, a total of 719 suicides were registered for Northern Ireland as a whole, of which 25 were Banbridge and 158 in Belfast. Although the numbers for many rural areas are small, the rates are nevertheless high, raising the question of whether there is a distinctive rural suicide problem associated with rural isolation and/or the particular problems facing farmers and rural communities.

Figure 6: Rates and numbers of suicides by district council



Of all the local areas examined by Brock *et al* the Shetland Islands had the highest suicide rate for men for 1998-2004 (47.1 per 100,000 population). But this was on the basis of 30 deaths recorded as suicide over seven years. Glasgow City, ranked worst in 1991-1997, recorded 964 suicides (706 men

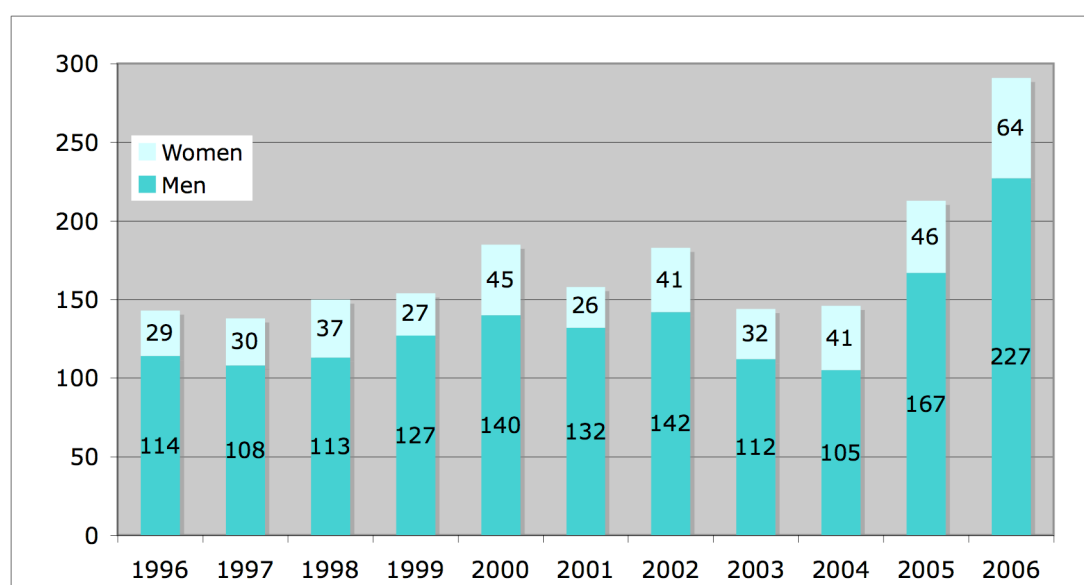
and 258 women) for the years 1991-1997 and a further 912 (664 men, 248 women) for 1998-2004. This compares to 93 suicides (75 men and 18 women) in Belfast North and 79 (71 men and 8 women) in Belfast West in the same period.

Section 6

The Social Characteristics of Suicides in Northern Ireland

The numbers of suicides recorded for Northern Ireland each year over the past eleven years are shown in Figure 7 below. A total of 1,905 deaths were recorded as resulting from intentional self-harm or where the intent was undetermined, including the lowest number of 138 in 1997 and the highest number, 291 in 2006. Between these two dates, there was a 110 per cent increase in the number of men taking their own lives and a 113 per cent increase for women. The increase in the total number of suicides in Northern Ireland between 2003 and 2006 was 102 per cent. Given that the annual numbers are relatively small and affected by recording practices, trends are more satisfactorily shown using rolling averages over several years. Figure 8 uses three year rolling averages and shows that 2004-06 had the highest average figure for the period and 1996-98 the lowest. Between 2002-04 and 2004-06 the increase was 37 per cent, a significant rise in a short period.

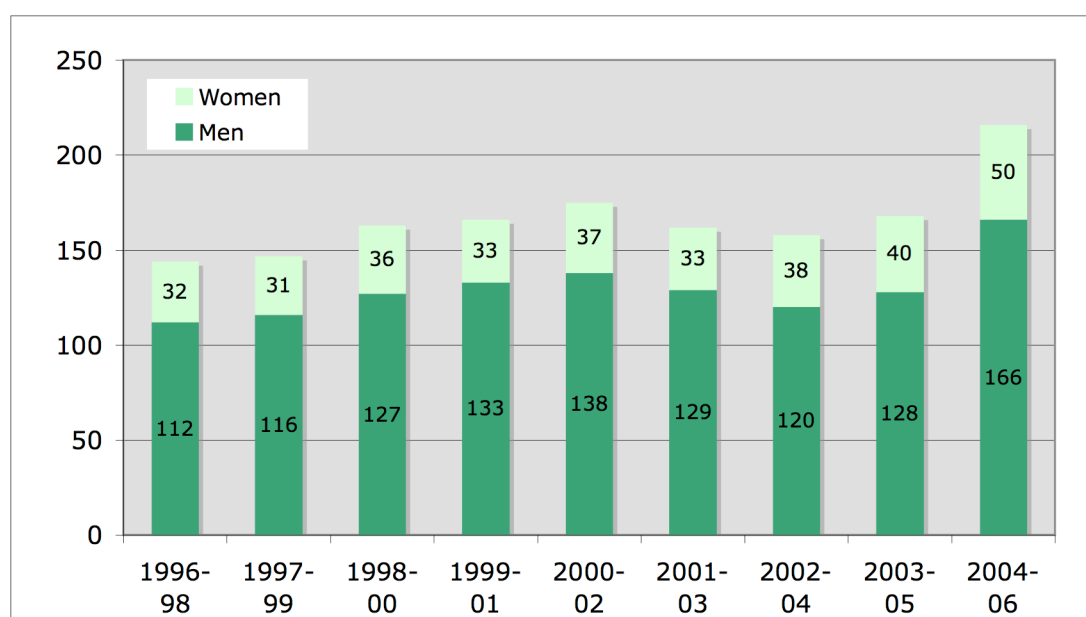
Figure 7: Gender of suicides



Source: *Registrar General Northern Ireland, Annual Report 2005*. Belfast: Northern Ireland Statistics and Research Agency, 2006; Mortality Statistics, NISRA 22 March 2007.

A detailed breakdown by age groups shows that recent increases in the numbers and rates of suicide are due mainly to the rise in self-harm among

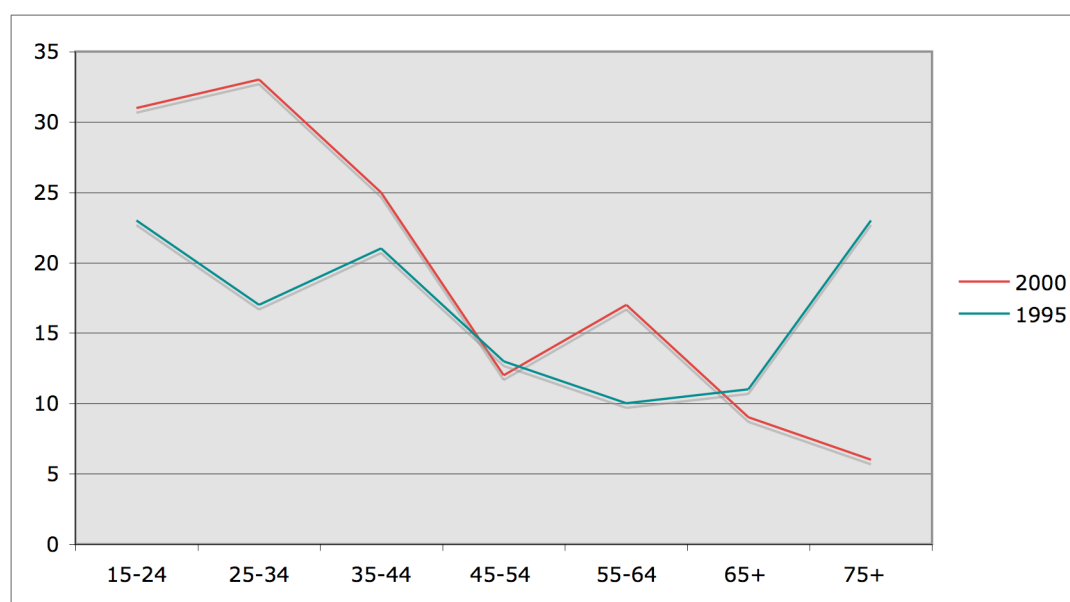
Figure 8: Gender of suicides, three year rolling averages



Source: Compiled from *Registrar General Northern Ireland, Annual Report 2005*. Belfast: Northern Ireland Statistics and Research Agency, 2006.

younger people. Figures 9 and 10 show the age profile of suicide rates for men and women respectively. Two years are compared representing the recent period of increase. The suicide rate for 25-34 year old men doubles between the two years. It rises by 35 per cent for the youngest age group and by 70 per cent for the 55-64 age group. By the year 2000 the rate for the 75+ group was down to a quarter of what it was for the 75+ group.

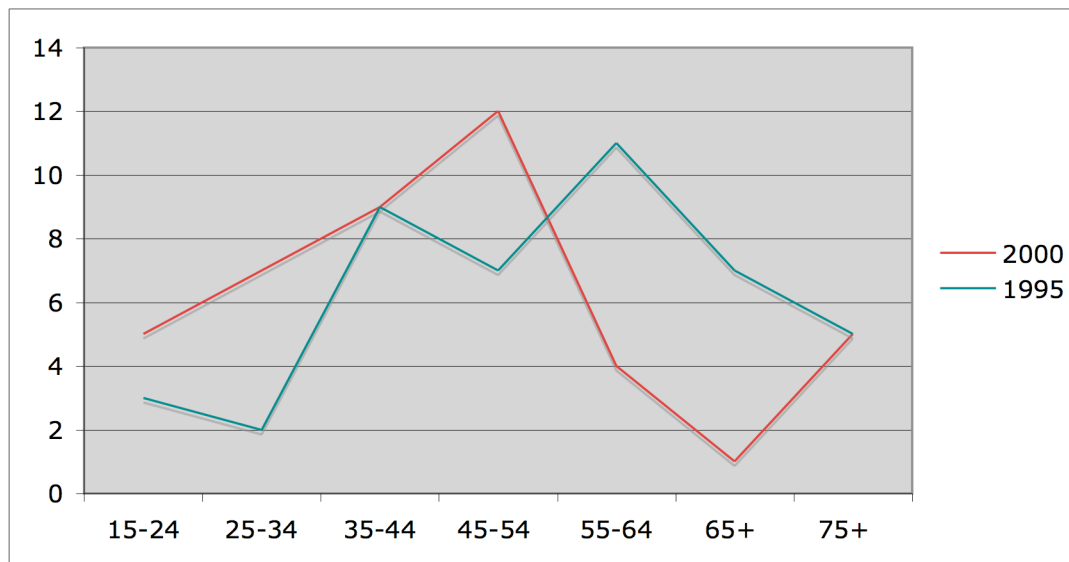
Figure 9: Age profile of suicide rates for men



Source: Compiled from Samaritans (2006) *Information Resource Pack 2006*.

For women there is a similar increase in the 25-34 year old group (the rate more than trebles) but the falls in suicide rates come in the 55-64 and 65+ groups Figure 10).

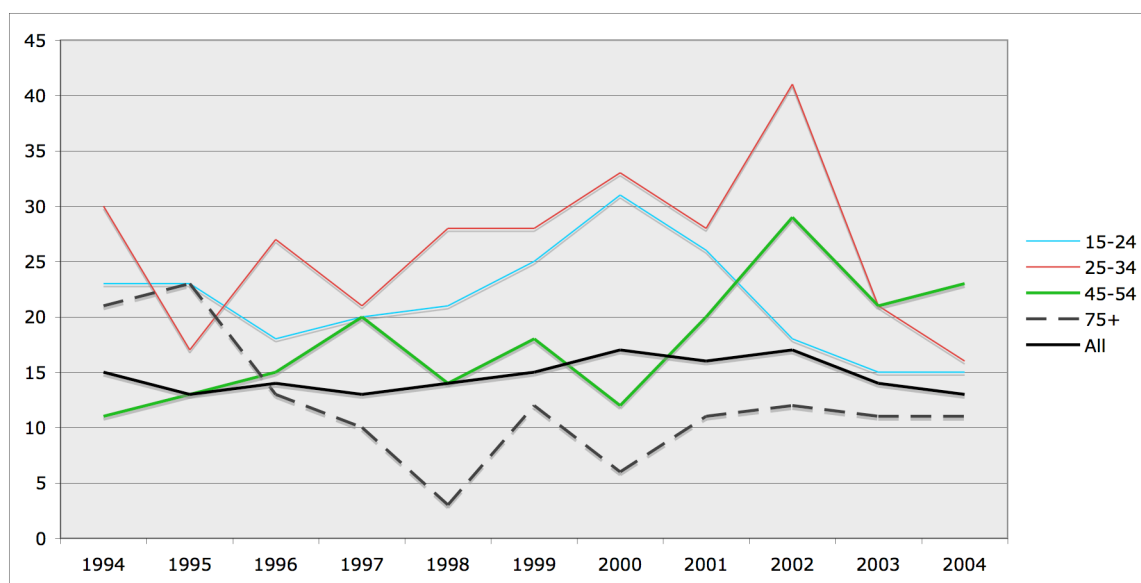
Figure 10: Age profile of suicide rates for women



Source: Compiled from Samaritans (2006) *Information Resource Pack 2006*.

Figure 11 shows how the male suicide rate for selected age groups has varied over the past ten years. The 75+ group began the period with an above

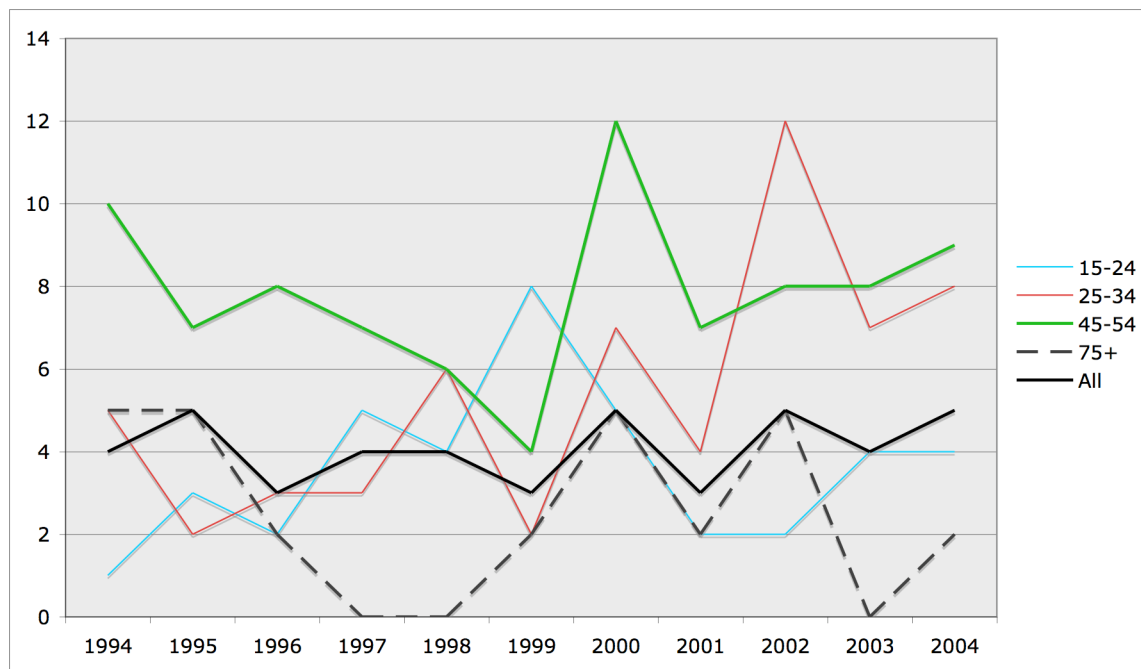
Figure 11: Male suicide rates by age



Source: Compiled from Samaritans (2006) *Information Resource Pack 2006*.

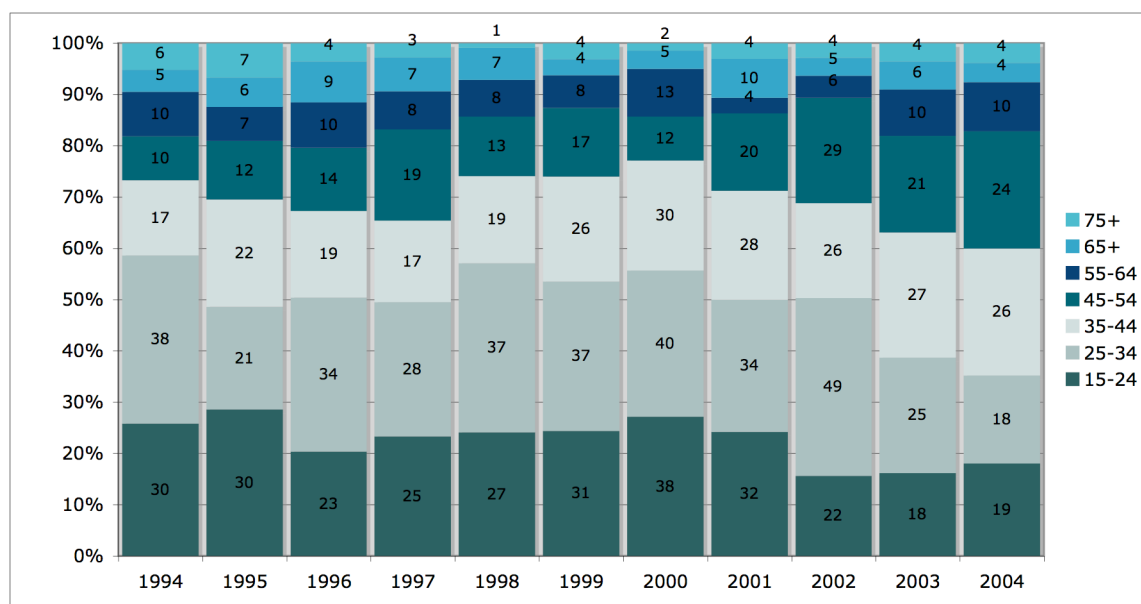
average rate but, since 1997 has had a below average rate. The rise in rates for the younger age groups is very clear, although the groups peak in different years. The female rates follow a roughly similar pattern (Figure 12).

Figure 12: Female suicide rates by age

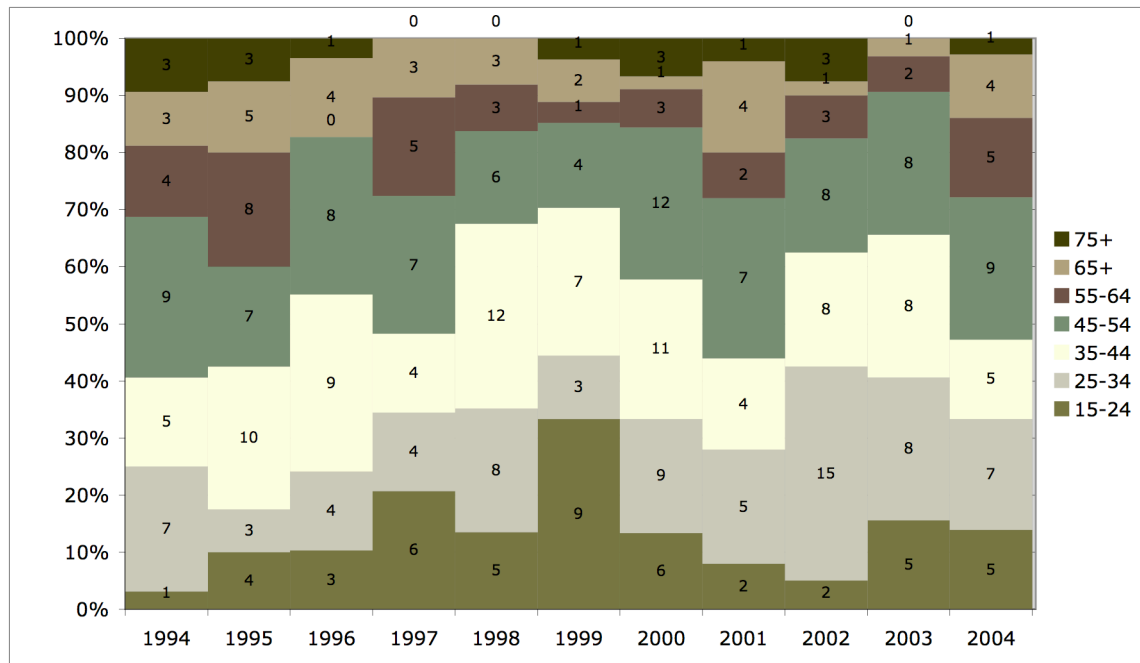


Source: Compiled from Samaritans (2006) *Information Resource Pack 2006*.

Figure 13: Number of male suicides by age, 1994-2004



Source: Compiled from Samaritans (2006) *Information Resource Pack 2006*.

Figure 14: Number of female suicides by age, 1994-2004

Source: Compiled from Samaritans (2006) *Information Resource Pack 2006*.

The contribution of each age group to the overall number of suicides is illustrated in Figures 13 and 14 for men and women respectively. The values shown in each column are for the numbers of suicides in the corresponding age group but it can be seen that proportionately the younger age groups account for the majority of suicides: over three-quarters (77%) of all male suicides were below the age of 45 in 2000 though the proportion has declined since then. For women, it is the 25 to 55 years olds that account for the majority of suicides (71% in 2000).

A fuller picture of the characteristics of suicides is published by the National Confidential Inquiry (NCI). Since 1996, the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness at Manchester University has been gathering data on all suicides in the UK. When notified of a suicide, the NCI seeks to establish if the person was in contact with mental health services within the last twelve months. If so, the suicide becomes an Inquiry case and the relevant psychiatrist is asked to complete a 28-page questionnaire that focuses on the patient's treatment status but also provides

a picture of the social situation. Northern Ireland participates in the NCI but the most recent report on the last five years (April 2000 to December 2004) covers only England and Wales (National Confidential Inquiry, 2006).

Little over a quarter of all suicides become Inquiry cases (27% over five years). Compared to all suicides in England and Wales, the ratio of male to female Inquiry cases is around 2:1 rather than 3:1, indicating that women suicides are relatively more likely to have had recent contact with mental health services. The NCI report provides a wealth of information about people taking their own lives, the circumstances they were in, their history of mental ill-health and their engagement with mental health services. About half of Inquiry cases experience a significant life event in the few months preceding the suicide, with relationship problems accounting for a half of these, accommodation problems 13 per cent and work problems including unemployment a further 11 per cent (NCI, 2006: 45). 'Abnormalities of mental state or recent behaviour' was found in 63 per cent of Inquiry cases, split between depressive illness and emotional distress. Twenty-one per cent of the sample were misusing *both* drugs and alcohol, 44 per cent alcohol alone, and 68 per cent had a history of self-harm. Nearly half were living alone, 69 per cent were not currently married, and 68 per cent were either unemployed (40%) or long-term sick. Fourteen per cent were in-patients and the Inquiry cases included 55 prisoners under NHS care at the time they took their own lives. Just under half (46%) were diagnosed with affective disorder ('bipolar disorder or depression'). Of all Inquiry cases, a half (49%) had been in contact with services within a week of their death and one fifth (19%) within 24 hours.

Data from the NCI for the 1997-2002 period is included in McClelland (2005: 77-8). Compared to Scotland and England and Wales, slightly higher proportions of Northern Ireland's suicides were shown to have been in contact with mental health services in the last 12 months. They were significantly more likely to have a history of alcohol (59%) and drug misuse (36%), and 21 per cent were regarded as alcohol dependent (England and Wales, 9%). A third were living alone (significantly fewer than England and Wales) and 55 per cent were unemployed or long-term sick. Thirty-nine per cent were

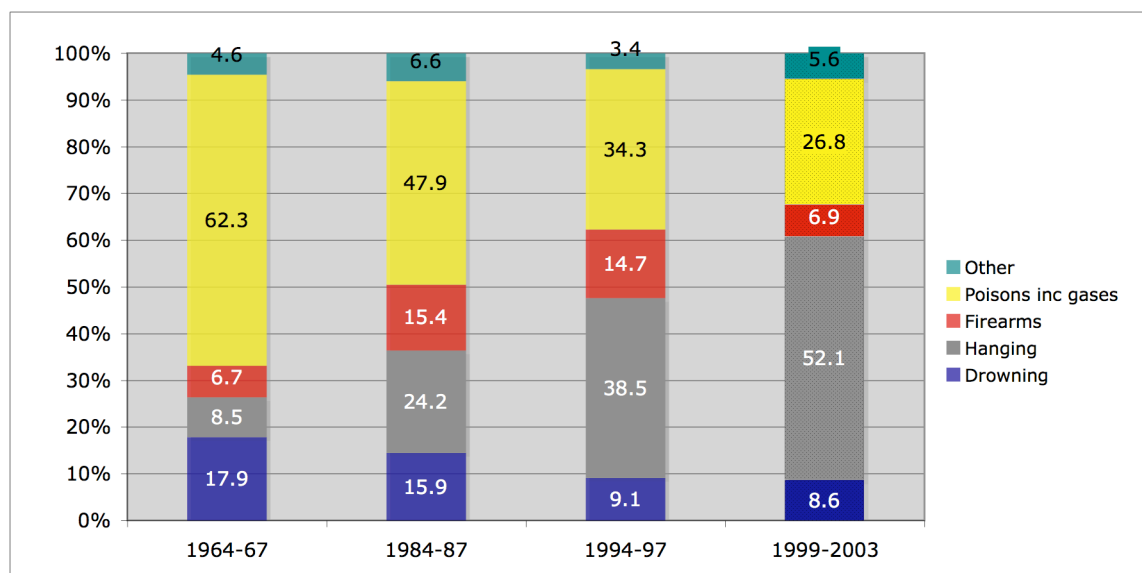
diagnosed with affective disorder.

Finally, there is a class profile to suicides. For men aged 20-64 in social class V, the risk of suicide was seven times that for men in social class 1 (based on men in Northern Ireland 1991-93) (Hillyard *et al*, 2005: 105).

Method of suicide

Little attention is given to the method of suicide in the literature on Northern Ireland. The Draft Suicide Prevention Strategy gives a chart covering the five year period 1999-2003, based on suicides and events of undetermined intent. This shows that 'hanging, strangulation and suffocation' account for more than half of all suicides (52%) and self-poisoning a further quarter (27%). Nine per cent of suicides are attributed to drowning and seven per cent to firearms. The latter method is of particular interest as the conflict meant that Northern Ireland became a heavily armed society.

Figure 15: Suicides by method over time



Source: Registrar General Annual Reports and DHSSPS (2006).

Using Registrar General Annual Reports, Figure 15 compares suicide method for three four year periods, one in the 1960s and the others in the 1980s and 1990s. Although not strictly comparable the data from the Draft Suicide

Prevention Strategy report are added in the fourth column. Again, the figures (for the first three columns) should be used with caution as they are based on suicides excluding events of undetermined intent. The trend for hanging etc is in line with Britain (Neeleman and Wessely) but the figures for poisons are not. The pattern for firearms, before and during the conflict and post-1998, are potentially significant as they indicate a substantial conflict-related effect.

In summary, there was a sharp drop in the number of recorded suicides at the start of the conflict but since then the broad trend has been upwards both in terms of numbers and rates. Whether these observations reflect real suicide trends or are the outcome of changes in reporting and recording practices, cannot be determined from the literature. It would not be surprising to find that the early years of the conflict had a major impact on suicide *registration* given the breakdown of state authority in those very geographical areas where, on the basis of more recent evidence, higher suicide rates prevail.

There has been an increase in Northern Ireland's suicide rate since the mid-1990s, an increase accounted for by younger people, particularly men, taking their own lives and this trend may have begun a downturn. The 2005 figures, however, establish a new high point. The recent rise in male suicide rates coincides with the peace process and the 1998 Agreement but is also in line with similar increases in Wales and Scotland. Over the last thirty years, however, Northern Ireland's suicide trends and profiles more closely match those of the Republic of Ireland. Finally, there are indications that the conflict impacted on the method of suicide with firearms playing a larger role.

Section 7

Explaining Suicide Trends

Brock *et al*'s examination of suicide trends explored the relationship of suicide to deprivation, but only for England and Wales. The conclusion was that 'for both men and women, suicide rates for those living in the most deprived areas were double those living in the least deprived' (2006: 16). The same exercise was carried out for Northern Ireland in the consultation paper on suicide. This came up with similar findings, namely that 'in deprived areas the age standardised suicide rate over the last five years is 14.9 per 100,000 persons compared to a rate of 8.5 per 100,000 persons in non-deprived areas. When focusing solely on economic deprivation comparisons the suicide rate gap increased even further to 17.0 per 100,000 persons in economically deprived areas as opposed to a rate of 8.2 suicides per 100,000 persons in non-economically deprived areas' (DHSSPS, 2006: para, 2.9.).

An analysis of suicides based on Section 75 categories,²² found that 15-34 year old men had a rate of 50.1 for economically deprived areas and 21.6 for non-deprived areas (Information Analysis Directorate, n.d.). It also found a differential impact on Catholics though this was heavily qualified as a large proportion of Catholics are living in what were defined as 'mixed' areas. The study concluded that 'the apparent differential impact in predominantly Catholic areas may actually be due to the deprivation/rurality of these areas' (Information Analysis Directorate, n.d.: 18)

While this is clearly a significant observation – and corresponds with other findings on the relationship between socio-economic groups and premature deaths, especially deaths from external causes (Kenway *et al* 2006: 106) – it does not help explain *trends* in suicide.

²² Section 75 of the Northern Ireland Act 1998 refers to nine categories of equality: Age, Marital status, Men and Women generally, Persons with a disability, Persons with dependants, Political opinion, Racial Group, Religious Belief, Sexual Orientation.

One of the arguments in the sociological literature is that it is not 'deprivation' as such that is associated with suicide, but the social isolation that often accompanies aspects of deprivation. This was the conclusion of Sainsbury's study of London carried out in the 1950s (Sainsbury, 1971). The evidence of this study was that 'indigenous poverty does not foster suicide'. What mattered most was social isolation: 'the social and cultural isolation of the immigrant; the solitude of old age arising from lack of contemporaries to share values and outlook; the unemployed's sense of social rejection; the ostracism resulting from infringement of a social taboo by divorce or a criminal act, or any similar activity that might diminish relatedness to the community.' (Sainsbury, 1971: 254)

Compared to Dorling and Gunnell, the latest National Statistics study was a basic analysis of the social factors that are associated with suicide. In their study of the 'spatial components of despair', Dorling and Gunnell (2003) used three measures to describe 'social integration' (or the lack of): the proportion of people who are single, the proportion not in work and the proportion who have recently migrated. These measures were then related to suicide data at parliamentary constituency level by age and gender over the period 1981 to 2000. A number of models were developed to predict the suicide levels in every constituency. The researchers found that,

by accounting for the varying influence of just three social indicators of isolation for the different age groups, sexes and at different time periods, it is possible to predict the number of deaths due to suicide and undetermined accidents across a great many areas quite closely. (Dorling and Gunnell, 2003: 455)

Inward migration was a good predictor of suicide rates for most groups other than young men and women in the 25-34 group. Lack of work was particularly associated with suicide for men aged 25-44 and young women. The effect of the proportion of single people in an area had most impact for those over the age of 34, though this measure may have been compromised by people being defined as 'single' (*i.e.* not married) yet living with someone.

War and suicide

There is a specific debate in the research literature over the relationship between war and suicide, a debate that has been ongoing since Durkheim's observations on nineteenth century Europe. Durkheim drew a number of conclusions about suicide that are of interest to this review. He showed that, contrary to the findings above, 'Catholicism reduces the tendency to suicide while Protestantism increases it' (Durkheim, 2002: 320). The Catholic countries of Ireland, Spain and Italy were found to have the lowest rates of suicide (2.1 in Ireland's case in the 1880s). These three countries were the only ones where the numbers of homicides exceeded suicides – in Spain's case by three times. Ireland had twice as many homicides than suicides each year on average during the 1880s. From this, Durkheim concluded that high rates of homicide confer 'a sort of immunity against suicide' (Durkheim, 2002: 317). On the other hand, there were countries and regions within countries where high rates of suicides existed alongside low homicide rates, and yet others where suicide and homicide rates were both high:

suicide sometimes coexists with homicide, sometimes they are mutually exclusive; sometimes they react under the same conditions in the same way, sometimes in opposite ways, and the antagonistic cases are the most numerous. (Durkheim, 2002: 322)

Durkheim proposed that wars acted to 'restrain' the development of suicides (2002: 318). He observed that in wartime, all crimes appear to decline, *except* that is the crime of homicide. In wartime the more typical pattern, therefore, was one of high homicide and low suicide. Wars 'rouse collective sentiments, stimulate partisan spirit and patriotism, political and national faith, alike, and ... cause a stronger integration of society' (Durkheim, 2002: 166). When violence ceases, there is a 'vacuum' and suicide increases – an argument explicitly made in relation to Northern Ireland at the time of the 1998 Agreement (British Medical Journal, 1998), though Durkheim suggested that war-related social integration 'may not be purely momentary, but may sometimes outlive its immediate causes, especially when it is intense' (2002: 167). Reviewing recent sociological research, Stack (2000) argues that Durkheim's observations do not hold for more recent violent conflicts.

Nevertheless, Durkheim's basic idea remains a strong current in contemporary research (British Medical Journal, 1998).

Bills and Li (2005) correlated homicide and suicide for 65 countries and found that overall, the relationship was weak. It was positive for European countries and negative for the Americas and the Asian Pacific Region but the classic war-suicide pattern identified by Durkheim was found for El Salvador, Colombia and the Philippines. On the other hand Sri Lanka's civil war coexists with a high suicide rate. They conclude, 'The complex relationship between war and suicide may reflect in part the varying effects of conflict on peoples' attitudes towards death and dying in different societies and cultures' (Bills and Li, 2005: 843). This at least opens up the possibility that the type of war or conflict is important in terms of integrating effects.

Marshall (1981) looked at the effect of war on political integration in relation to suicide for the United States between 1933 and 1976, predicting that the second world war would depress suicide rates whereas the Korean and Vietnam wars would not. While the US suicide rates matched the prediction, Marshall suggests that this was more to do with the effects of the level of economic activity and unemployment than political integration induced by war.

Another study focused on the second world war and suicide in Scotland – 1931-52 was the period covered (Henderson *et al*, 2006). The long-term trend for both men and women over this period was for the suicide rate to fall, substantially so for men. Between 1940 and 1943, however, the male suicide rate *increased*, contrary to the main Durkheimian argument. The biggest increases were for men under 45 years old, especially those under 35. Female rates were more stable though women aged 35-44 had an elevated rate for two years in the early 1940s. When the principal method of suicide was examined it was found that 'firearms and explosives' was the only method that increased significantly during the war. The authors conclude: 'Younger men are the groups most likely to be called to arms, and to have access to guns. It seems likely, therefore, that the stresses of being a potential combatant, and access to lethal methods of selfharm, were

important contributors. This is supported by the minimal impact the war had on female suicide trends.’ (Henderson *et al*, 2006: 173)

Van Tubergen and Ultee (2006) also argue for a refinement of Durkheim’s argument in the light of the experience of the second world war. They observed that suicides in the Netherlands were at a high level in 1940 and 1945 which they explain in terms of the higher propensity to suicide among those who expected to be socially excluded as a result of German occupation and subsequent liberation. They identify two such groups: Jews at the start of the war and ‘political delinquents’ at the end of the war; both groups had high suicide rates at the relevant time.

Another example of suicides increasing during war comes from the Balkans. Selakovic-Bursic *et al* (2006) examined suicides in Serbia and Montenegro, looking in particular at the wars of 1991-4 and 1999 (the period of NATO bombing). They make the important point that Durkheim’s argument about war and suicide was based on a type of war involving country against country. Within-country conflicts or civil wars – the most common type of conflict in the last quarter of the twentieth century (Hillyard *et al*, 2005: 23-5) – are unlikely to have the same dynamics regarding social integration. As in the Scottish study, the availability of firearms during and after the war years was an important factor in explaining the elevated suicide rates but unlike Scotland these were associated with older rather than younger age groups. Selakovic-Bursic *et al* concentrate on what was happening with male suicide trends yet, untypically, the male/female suicide ratio was low (2:1) compared to many countries and actually dropped slightly during the first war period. The authors provide no explanation for why female suicides increased relative to male suicides during the first war period.

Suicide and the Northern Ireland conflict

There are two recent studies that deal with suicide and conflict-related deaths in the Northern Ireland context. One of these is based on suicide rates

(Lester, 2002) and the other on suicide numbers and rates (McGowan *et al*, 2005). The former appears to be based on suicides without including undetermined deaths. For the period 1965 and 1997, Lester found that suicide rates and conflict deaths were significantly associated: suicide rates were higher when conflict deaths were lower ($r=-.51$). The fall in suicides at the onset of the 'Troubles' and its possible association with community polarisation and aggression was noted by Lyons as early as 1972. Kelly *et al* (2003) looked at anti-depressant prescribing practices and suicide rates, and found that the suicide rate for those aged under 30 was inversely related to the number of persons charged with terrorist offences. The conclusion was that a continuing decrease in terrorist offences may increase the suicide rate in those under 30 years, at least in the short term. There is also a study by McCrea (1996) that indirectly associates the conflict with suicide by arguing that it had a negative impact on economic development and hence on employment levels. This fits with Marshall's argument in relation to the United States reviewed above. It also relates to a whole set of arguments about the economic impacts of the conflict (see Hillyard, 2005).

McGowan *et al* based their study on coroners' suicide verdicts, so excluded undetermined deaths. For conflict deaths they used McKittrick *et al* (1999) which includes some deaths that occurred outside Northern Ireland. This will have caused minor statistical distortions to calculations of population standardized rates. The study looked at age-related data, associating age of suicide with the total of those killed in the conflict and covering the years 1966 to 1999. The strongest association was found for the 35-44 age group ($r=-.517$). It is not clear why the authors explore an age related association of this kind, as the classic argument from Durkheim concerns the perpetrators of homicide (and those taking their own lives), not the victims. Male and female suicides were found to be inversely associated ($r=-.42$; $r=-.44$) with conflict deaths over the whole period. But the authors qualify their findings by noting that 'graphical representation of the relationship shows two differing trends – the peak in homicide rates between 1970 and 1978 matched by a flat though gradually increasing trend in suicide rather than a more obvious inverse association' (McGowan *et al*, 2005: 403). They also acknowledge that

coroners may differ in their judgements which, in turn, impacts on the reliability of suicide data, but this is not seen as a critical issue.

McGowan *et al* suggest that in the early years of the conflict especially, 'civil unrest led to extreme polarization of communities and the "ghettoization" of large parts of Northern Ireland ... We propose that the "Troubles" affected a social cohesion and ghettoization that had the effect of protecting its residents from suicide.' (2005: 404) In making the same observation about suicide rates and conflict deaths, Fay *et al* (1997) suggest that far from protecting individuals, the conflict effectively suppressed the traumas of war that began to be expressed through the growth in victims groups in the 1990s, as well as in greater manifestations of individual psychological distress, depression and suicide.

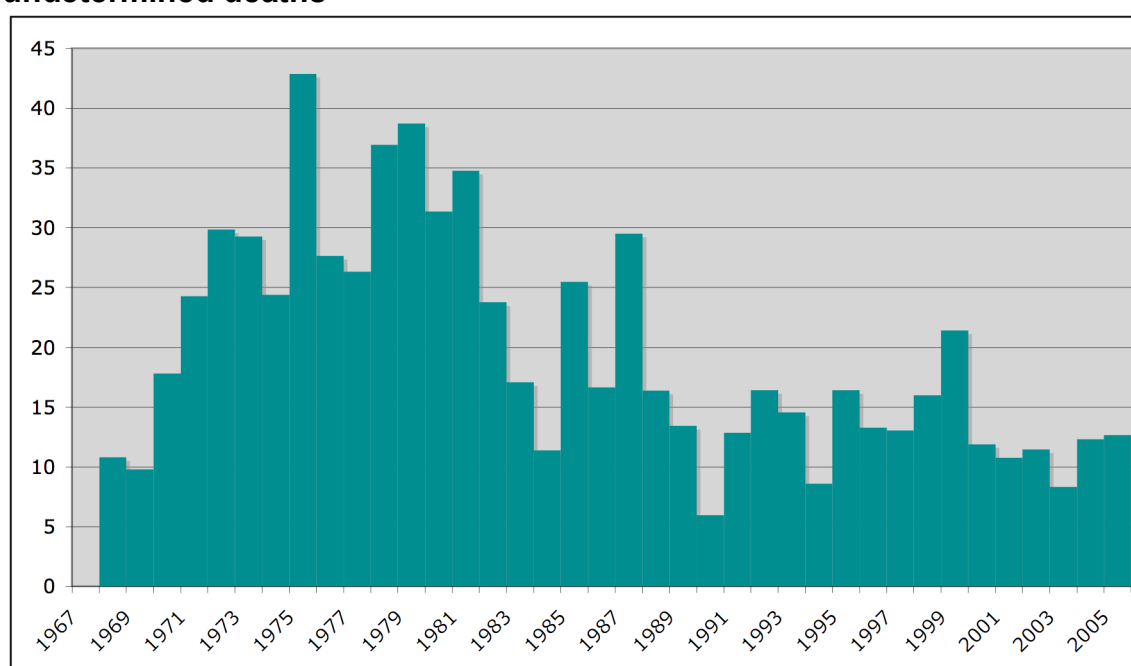
The idea that social cohesion is strong in Northern Ireland due to the conflict is picked up in a study that compared suicide notes from the United States and Northern Ireland. While there were more similarities than differences in the suicide notes examined, the Northern Ireland notes revealed a greater emphasis on family and interpersonal relationships. They 'communicated issues around escaping from pain, distress, and feelings of loss and desertion from their closest companion (or other ideal) more often than those from the United States' (63% and 30% respectively) (O'Connor and Leenaars, 2004: 345).

Much of the confidence of McGowan *et al*'s conclusion rests on accepting the figures that show suicides falling by half after 1969, while conflict deaths rose dramatically in the early 1970s – half of all conflict deaths occurring by 1976. The suicide records are questionable, however, as the level of conflict and unrest was such that there is a strong likelihood that processes of registration were affected.

One possibility is that the fall in coroner determined suicides was due to more deaths being returned with open verdicts and registered as undetermined. Deaths registered as 'events of undetermined intent' formed a higher

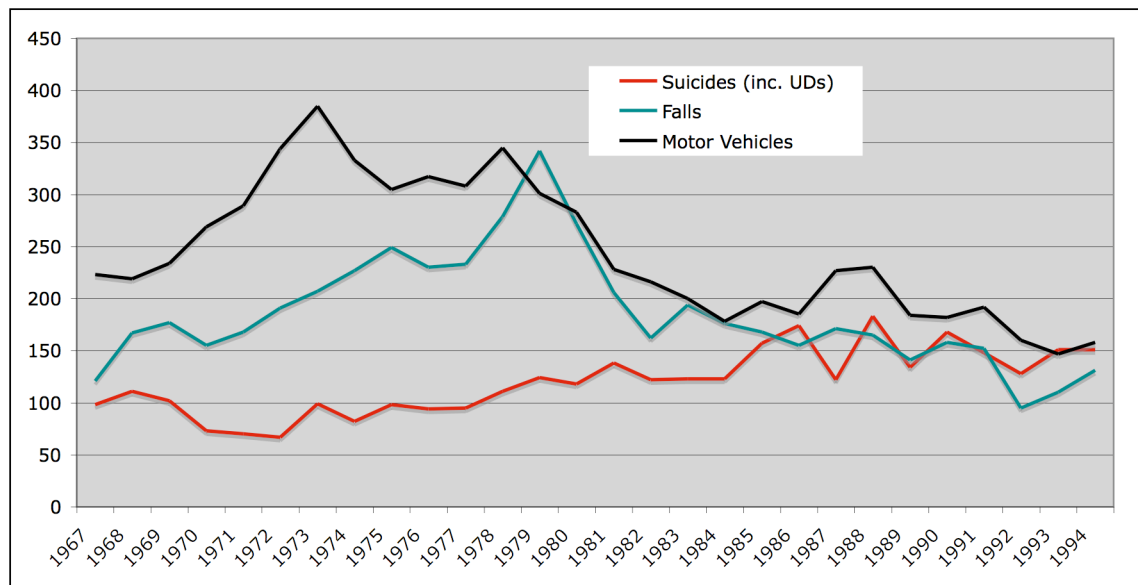
proportion of all suicides and undetermined deaths in the early years of the conflict but from the late 1980s there was a more consistent relationship between the two (see Figure 16). These trends do not appear to be associated with the number of recorded suicides, however. The correlation between undetermined deaths and suicides from 1967 to 1985 suggests there is no association at all between the two ($r=-.086$).

Figure 16: 'Undetermined intent' as a proportion of all suicides and undetermined deaths



Source: Compiled from Registrar General Annual Reports

Another possibility is that some suicides may have been registered as 'accidental' deaths. Historically, the largest category of violent accidental deaths is from motor vehicle accidents, followed by 'falls'. The latter can be traced as a single category in Registrar General reports up to 1994, but thereafter it becomes more difficult. Figure 17 puts these deaths alongside suicides (including undetermined deaths) for the period 1967-94. It is striking how these three causes of death diverge in the 1970s but converge in the 1980s. By 1994 suicides have caught up with deaths from motor vehicle accidents.

Figure 17: Violent accidental deaths and suicides

Source: Registrar General's Annual Reports

One of debates in the international literature on suicide is over car crash deaths, especially when the incident involves a vehicle occupied by one person. It has been suggested that up to 5 per cent of all car accident fatalities may be suicides, or at least parasuicides. Such motor vehicle 'accidents' are thought to be especially characteristic of people engaging in the type of self-destructive behaviour associated with heavy consumption of alcohol and drugs, or those self-absorbed with depression or personal problems (Peck and Warner, 1995). Researchers have therefore sought to reconstruct the psychological state of those killed in single-occupancy vehicle crashes to see how closely this resembles what is known about the mental state of suicides. Another approach is to follow up what is sometimes referred to as the 'Werther effect'²³ whereby a well-publicised suicide is followed by a series of imitation suicides. Following Marilyn Munroe's suicide, for example, there was a 12 per cent increase in suicides in the United States. So imitation is thought to be an important process in relation to suicide that can be investigated in relation to car crashes.

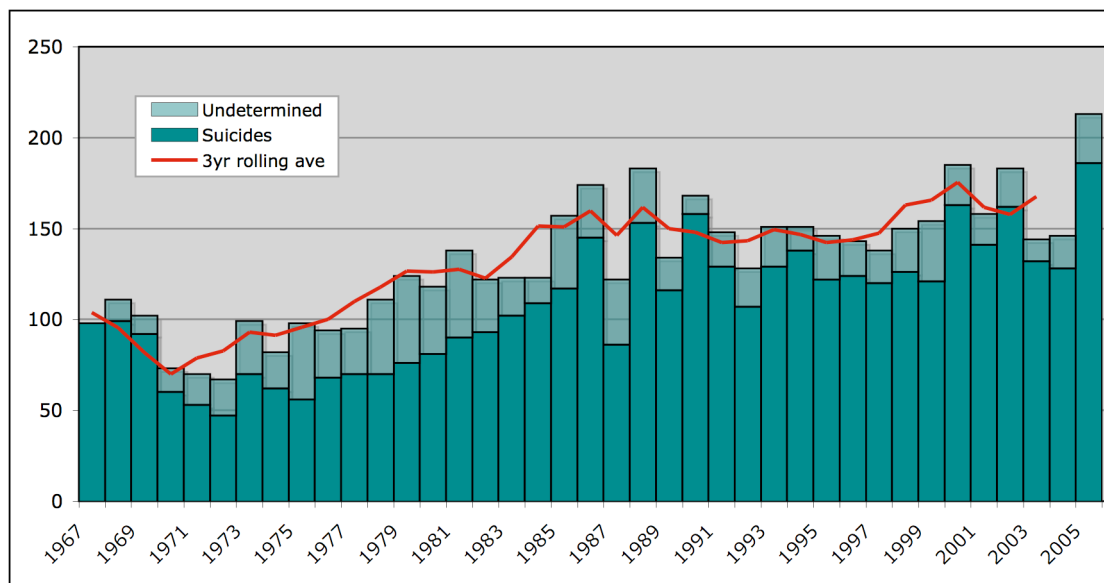
²³ Goethe's novel *The Sorrows of Young Werther*, published in 1774 was thought to have led to a spate of suicides imitating the book – hence the so-called Werther effect. Thorson and Öberg, 2003 argue, however, that there is no evidence that the novel had this effect.

In his study of car crashes in California, Phillips (1979) found that fatalities rose considerably following suicides publicized in the press, especially on the third day after the story first appeared. Car crash deaths increased in line with the amount of publicity given and the effect was strongest in the area where the suicide took place. He also found that the imitation carried across age so that young suicides were followed by young car crash fatalities, while older suicides led to more older driver deaths. When suicide and murder stories were compared, Phillips found that different types of crashes seemed to be triggered – suicides led to more single occupancy deaths of drivers only, while murders led to multiple vehicle crashes, with driver and passenger deaths (Phillips, 1979: 1167).

The data in Figure 17 show no statistically significant relationship between ‘falls’ and suicides, but the association between motor vehicle deaths and suicides is highly significant (-0.694 , $p=0.001$) and warrants further investigation.

From Figure 18 it can be seen that it was not until 1984 that the number of registered suicides rose to the 1968 level. In the late 1960s, poisonings (including from gases) accounted for almost two-thirds of all suicides.

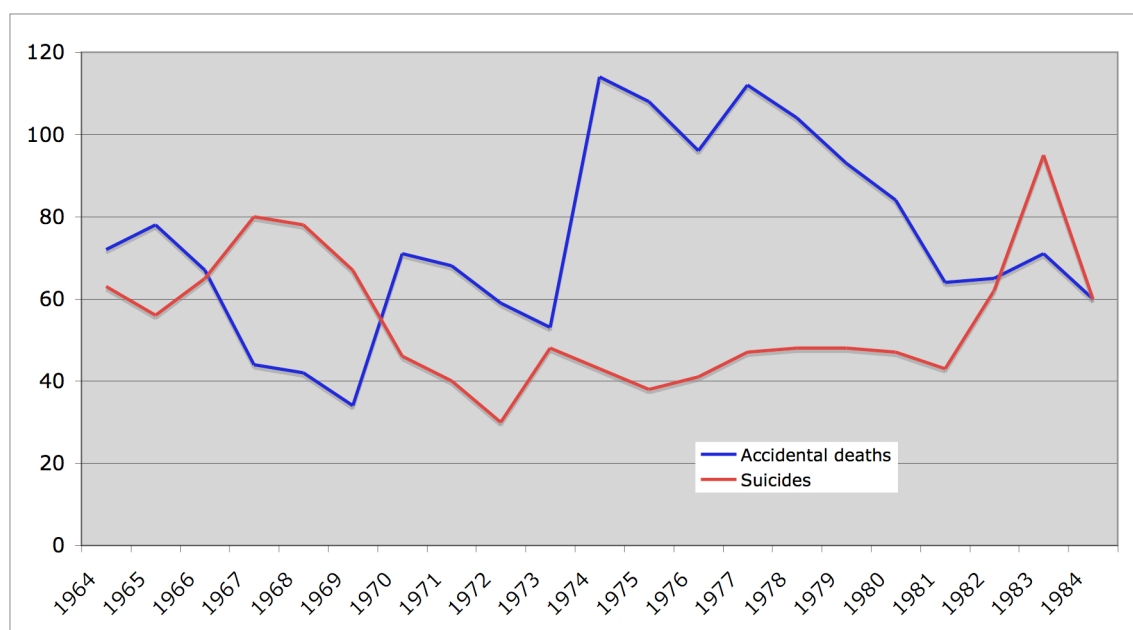
Figure 18: Undetermined deaths and suicides, 3yr rolling averages



Source: Registrar General Annual Reports

Eighty per cent of all suicides were from poisoning or drowning, 'soft' methods that are regarded as particularly prone to interpretation and therefore variable registration. Deaths from poisoning and drowning were therefore examined in more detail. Figure 19 shows the trends for registered accidental and suicide deaths attributable to drownings and poisonings (including from gases) between 1964 and 1984. Two periods are of particular interest. First, between 1967 and 1972 there was a sharp fall in suicides from poisoning and drowning. From 1973 onwards the numbers are steadier until a sudden increase between 1981 and 1983. The cross-over point with deaths from poisoning and drowning registered as 'accidental' occurs in 1982.

Figure 19: Registered deaths from poisoning and drowning



Source: Registrar General Annual Reports

Table 1: Suicides and accidental deaths, Pearson correlation values

	1967-82	1967-72
Drowning	-0.267	-0.170
Poisoning	-0.681**	-0.853*
Poison gases	-0.308	-0.759
All poisons	-0.609*	-0.929**
All poisoning and drowning	-0.581*	-0.781

*Significant at .05 level (2-tailed); **significant at .01 level (2-tailed)

Table 1 shows a number of correlation values for the two time periods 1967-82 and 1967-72. The association between the number of 'suicides' and 'accidents' each year for the short time period 1967-72 is highly significant for 'all poisons' ($p=.01$) and for 'poisoning' ($p=.05$), but not for the other categories. Taking the longer time period, the correlation values are highly significant for poisoning and significant for all poisons and 'all poisoning and drowning'. This clearly merits further investigation and points to a different 'troubles' effect than that proposed by McGowan *et al.* Whatever the arguments about the integrating effects of the conflict within communities, the early years of polarization between communities and the alienation from state authority and institutions, may well have affected the reporting and registration of potential suicides, leading to more deaths being classified as 'accidental'.

While care is needed in making comparisons between societies in conflict, the early years of Northern Ireland's 'troubles' arguably have some similarities with the situation pertaining in Israel and Palestine. One of the main points running through Dabbagh's study of suicide in the West Bank, referred to earlier, is how conflict disrupts civil authority and bureaucracy. Conflict, particularly militarized conflict, is very disruptive to the medical, legal and bureaucratic processes involved in establishing a suicide. In general she found many discrepancies between community, hospital, media and police knowledge and recording of suicide. Conflict-related poor recording of suicide was compounded by other issues. For instance, Dabbagh is sceptical of the

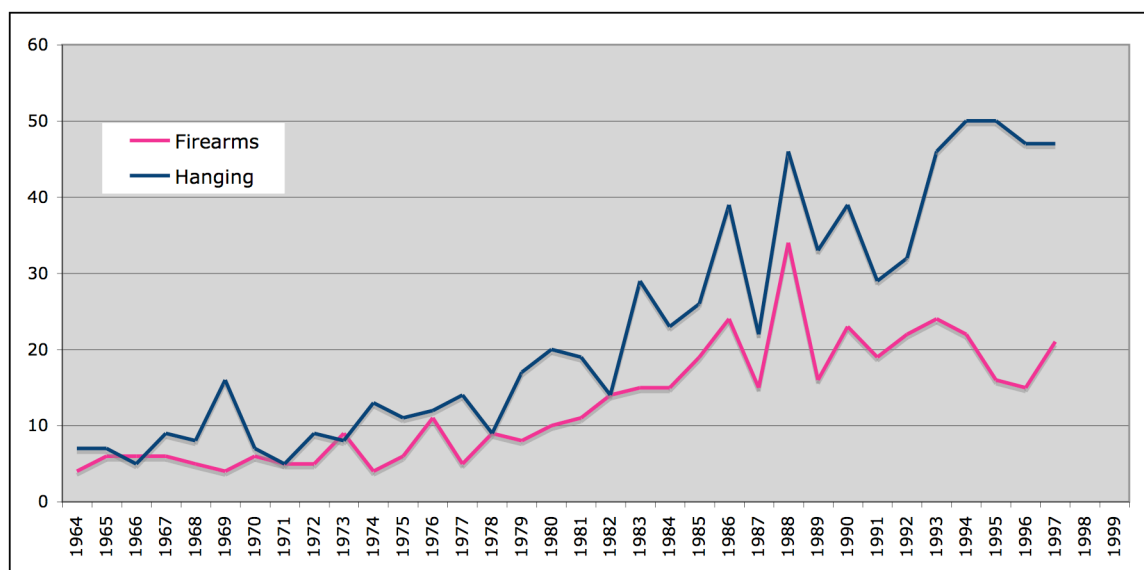
claim that low numbers of suicides during the month of Ramadan are to do with the psychological and socially integrative impact of religious observance; rather, she suggests, it results from the fact that health care professionals and police are fasting (Dabbagh, 2005: 98).

Section 8

Suicide and Transition to Peace

No single year marks an end to the Northern Ireland conflict as such. It is more useful to think of a *process of transition* to peace that is characterized by gradual change and reductions in the forms of violence typical of the 1970s, 1980s and much of the 1990s. Marked social and political divisions remain, but the way conflict is expressed is clearly changing: most violence is no longer militarized, and it is now more focused on the boundaries between communities and within communities themselves. These changing political and social relationships, as well as recent economic change, provide the context for seeking explanations for suicide trends over the last decade.

Figure 20: Number of suicides by firearms and hanging



Source: Registrar General Annual Reports

As noted earlier, the proportion of suicides by firearms and hanging grew in the 1980s and 1990s, for hanging especially. Hanging has replaced poisoning as the dominant method of suicide and now accounts for over half of all suicides in Northern Ireland. It is also the most common method in England and Wales.

Figure 20 charts the growth in the number of suicides in Northern Ireland by firearms and hanging. These two methods are highly correlated over the period shown ($r=.855$, $p=.001$) and even more so up to 1993 ($r=.924$, $p=.001$), after which firearms decline. Where firearms are relatively easy to acquire, such as in the U.S., they become the dominant method of suicide. In Northern Ireland this is not necessarily a 'troubles'-related affect: it could reflect the levels of ownership of shotguns for hunting used by farmers and others, but the downturn in the proportion of suicides by firearms suggests otherwise. Clearly, this is worth further investigation.

The growth of hanging (including suffocation) as a method of suicide is associated with the relative ease with which it can be carried out from commonly available materials and community settings, even in institutional settings such as prisons and hospitals. The trend may also reflect the efforts that have been made to make poisoning more difficult. In a study of suicides by hanging carried out in Bristol, Oxford and Manchester it was found that about 6 per cent of the total took place in prisons and hospitals (Bennewith *et al*, 2005). Some 'hanging' suicides involved drug overdoses as well.

The vast majority of prison suicides are by hanging – 92 per cent of the 804 people, including 93 young people (1997-2003), who took their own lives in English prisons over the ten year period from 1995 did so by hanging (Howard League, 2005: 4; Hansard, 16 July 2003, col. 372). In Northern Ireland's prisons, 'deaths are almost universally by hanging', although the McClelland Report, which examined six prison suicides in the specific period 2002-04, does not provide figures for past years (McClelland, 2005: 35). Seventeen prisoners took their own lives during the 1990s in Northern Ireland, with some indications of a growing rate of suicide in the last ten years (Hansard, 23 October 2000: col. 23W; McClelland, 2005).

Three women have taken their own lives in Northern Ireland's prisons since 1996, all of whom were found hanging (Scruton and Moore, 2004). Typically the institutional response to self-harming by women prisoners is a special regime often involving use of punishment cells, long periods of isolation, and

'anti-suicide suits', while simple measures such as anti-ligature windows are absent. The regime was found to be so negative that it is questionable that the term suicide applies (Scruton and Moore, 2005).

Vulnerable communities

There is an assumption that the transition to peace involves a reduction in social and political integration across the board within protestant/unionist and catholic/nationalist communities, and that this is allowing suicide rates to rise (McGowan *et al*, 2005). This is too simple. Some peoples and communities were relatively untouched by the conflict, while others lived in neighbourhoods on a quasi war footing for decades. Divisions within the communities may be as important as divisions between them. Any theorizing around polarization and social integration needs to take account of wide variations in experience.

While the impact of conflicts have many universal features, it is clear that some communities experienced the conflict more intensely than others, and in different ways (Hillyard *et al*, 2005). As has been acknowledged in the context of mental health there is a 'clear link between poor mental health and living in those neighbourhoods which both are economically disadvantaged and have experienced greater exposure to the Troubles' (Department of Health, Social Services and Public Safety, 2003: 19). The patterns of violent deaths and personal experience of conflict are strongly associated with geographical areas with the highest rates of poverty and multiple deprivation (Fay *et al*, 1999). A number of studies by Cairns and Wilson (1991; Wilson and Cairns, 1992; Cairns, 1996) found a link between the level of political violence in different areas and psychological wellbeing. Earlier, attention was drawn to very high rates of suicides in some areas of Northern Ireland, in particular North and West Belfast parliamentary constituencies. The finding that suicide rates are twice as high (and more for some age groups) in areas of economic deprivation provides further evidence of the need to look into this relationship more precisely, as it is by no means clear that all disadvantaged areas are affected to the same extent or in quite the same way. Snyder (1992) found

that suicide and unemployment were significantly associated for men for two age groups only (15-24 and 45-54) but no association was found for women. Also, O'Connor and Sheehy's finding (1997) on the similarity of female suicide rates for Northern Ireland with those in the UK and Ireland raises interesting questions about the variable impact of the 'Troubles' by gender.

There have been few attempts to construct a geography of the 'Troubles'. This may be because relevant data are unavailable or because 'troubled areas' were so much a part of common sense knowledge that it was unnecessary to define them in terms of victimization, violent incidents and/or perpetrators. Lack of appropriate data appears to be the main reason for not incorporating a measure of the 'Troubles' into the Noble index of multiple deprivation (Noble *et al*, 2001) But there is some evidence that begins to link experience of the conflict with socio-economic circumstances and hence spatial concentrations of multiple deprivation. The Poverty and Social Exclusion study (Hillyard *et al*, 2003), for example, constructed a measure of 'extreme violence' which combined several factors: witnessing a murder, the death of a close relative, and injury to self or a close relative. Those who had experienced 'extreme violence' had much higher poverty rates than the general population. They also experience greater levels of medium and high stress Hillyard *et al* 2005: 130-140).

Area-based analyses raise problems that are both theoretical and practical (Tomlinson and Kelly, 2003). Those who argue that area effects are real and important are typically supportive of area-based policy interventions (Smith *et al*, 2001). They argue that a 'disadvantaged area' means something more than a collection of disadvantaged individuals (Spicker, 2001). The validity or otherwise of area-based approaches are clearly of special interest in Northern Ireland where social and spatial polarisation are intense, and where the sense of territorial allegiance and belonging are strong. In terms of psychosocial factors the stresses that are involved in maintaining, challenging or negotiating social and territorial boundaries are especially acute at community interface areas. There is some evidence of worsening interface tensions in the last ten years (Jarman, 2002).

Such emphasis on the social organization of communities is not common currency in the public debates around suicide in Northern Ireland. Rather the emphasis is on specific individual pathologies or on a lingering 'Troubles' effect, such as the trauma of those caught up in violent events or the personal consequences of the punitive activities of paramilitary groups especially in relation to young men in North Belfast (BBC News, 16 and 17 February, 2004). But a more fruitful line of inquiry may be the social processes within confined communities that lead to clusters of suicides. The ideas of 'contagion' and imitation have a long history in suicide research, as noted earlier, with recent research claiming that 10 per cent of all suicides may be explained in this way (Gould *et al*, 1989; McKenzie *et al*, 2005).

The 'two communities' are not necessarily under the same influences as regards social and political integration, or have similar propensities to social isolation. The capacities for resilience and mutual support will vary. The communities themselves are divided in terms of class, religion and political affiliations, and have different demographic profiles. The religions vary in the extent of the allegiance they attract and their influence within communities over time. Protestantism was always thought to be less of a protective factor against suicide than Catholicism (Durkheim, 2002: 342-4) It is often commented that the economically disadvantaged protestant communities, particularly in Belfast, lack 'community infrastructure' and social capital, that the loyalist paramilitary groups have been unable to develop a strong political organization and ideology to challenge the major unionist parties, and that the loyalist areas are dominated by intra-paramilitary turf wars. Recent intra-loyalist conflict has involved forced moves and family separations, raising insecurity and social isolation. More broadly, the transition to peace and the problems surrounding political compromise have presented unionism with challenges out of which a unifying and integrating response has not been forthcoming. All of this does suggest less coherence and less integration, but the tendencies described are nothing new and are intrinsic to the conflict rather than a post-conflict development. For a war or conflict to be integrating,

it needs to be popular and unifying across all aspects of everyday life; few would claim this of the Northern Ireland conflict.

Nor should it be assumed that the 'nationalist community' was more integrated ten, fifteen or twenty years ago than it is at the present time. The growth of republicanism as a political force might suggest greater political integration in the present than in the 1970s and 1980s. But there are other forces at work such as a decline in the authority of Catholicism, improvement in the integration of Catholics in the labour market, and what some regard as a loss of idealism associated with political compromise and the peace process. Experience of the conflict has often led to divorce and separation, difficulties in finding work (especially for ex-prisoners) and migration, all of which point to social isolation rather than social integration, and which may help to explain the finding that Catholics are more at risk of suicide than Protestants. The peace process has also raised expectations, both political and economic, yet these expectations may seem not to have been fulfilled for younger people living in the most marginalized neighbourhoods.

The above points highlight the fact that there is no research to date that amounts to a detailed *sociological* autopsy of contemporary suicide in Northern Ireland. While there is a rich body of available data on the protective and indicative factors that are related to suicide, this has not been applied in a systematic way that relates to specific (and different) local communities and populations, notwithstanding the widespread view that there is a direct connection between the areas worst affected by conflict, poor mental health and suicide. Further, there is a lack of qualitative research exploring how families and local communities cope with depression, self-harming and suicide, and how knowledge of, and attitudes towards potential sources of help vary.

From vulnerable areas to individuals at risk

While area-based research on local communities is essential, social problems are not always sufficiently concentrated to justify local area-based *interventions* (which have become more prevalent since the late 1990s). To illustrate, the 20 per cent most disadvantaged electoral wards in 2001 captured only 40 per cent of child poverty and the worst 10 per cent, a quarter of child poverty. In the mental health field, depression and anxiety are estimated to affect between a fifth and a quarter of the population at any one time according to the Bamford Report (2006). The prevalence figures for mental health problems in Northern Ireland are thought to be at least 25 per cent higher than in England. One indication of the difference is that the proportion of people in Northern Ireland in receipt of Disability Allowance for mental health reasons is three times the figure for Britain. The Northern Ireland figure doubled between February 1998 and 2006 (Kenway *et al*, 2006: 111). Certainly the use of prescribed sedatives, tranquillisers and anti-depressants runs at very high levels – 22 per cent of the population have used these drugs compared to 12 per cent in the Irish Republic. The volume of prescribed anti-depressants almost doubled between 1989 and 1993, but then trebled between 1993 and 2000 (National Advisory Committee on Drugs, 2003). Over the ten year period 1989-1999, there was a 5.7 fold increase in the volume of prescribed antidepressants (Kelly *et al*, 2003). In 2005, 1.4 million anti-depressant prescription items were issued in Northern Ireland, or .78 prescription items per head (Hansard, 2 May 2006, col. 1478W).

There is no clear evidence as to whether such increases are a reflection of a greater recognition of mental health needs by professionals, a change in the willingness of people to seek help, or a real change in the prevalence of mental illness. But the high levels of prescriptions bring into sharp focus contemporary debates around pharmaceutical-based responses to problems such as depression. On the one hand there is the argument that the increase in antidepressant prescribing in Northern Ireland could be associated with a reduction in the suicide rate. One study found a statistically significant association (for the years 1989-1999) between antidepressant prescribing and

a decrease in the suicide rate in the population over 30 years of age (but no association for those aged under 30 years) (Kelly *et al*, 2003). Against this, there were over 4,700 antidepressant-related deaths in the decade up to 2002 in England and Wales, 80 per cent of which were recorded as suicides. Donovan *et al* (1999) examined 222 suicides from Britain, Northern Ireland and the Republic of Ireland occurring in the early 1990s, and found that 18.5 per cent had been prescribed an antidepressant within one month of the suicide. Comparing selective serotonin reuptake inhibitors and tricyclic antidepressants, it was found that suicide by any method was more likely following prescription of the former, but this may have been a reflection of prescribing practice rather than of the drug itself. There is now a 'Prozac backlash' (Glenmullen, 2000), fuelled by official warnings against the use of selective serotonin re-uptake inhibitors for children and even backed up by the manufacturers themselves.²⁴ Such concern is likely to lend support to those supporting a shift in policy from pharmaceuticals towards 'talk'-based responses. Further research is needed to explain anti-depressant prescribing trends and to evaluate the efficacy of this intervention in relation to self-harming and suicide.

The growth in prescriptions for anti-depressants in the past decade, it is widely believed, has been matched by a parallel growth in illicit drug use. Higgins and McElrath (2000) challenge the view that the 1990s ceasefires led to a rapid growth in illicit drugs use as, they argue, the evidence is simply not available. The 'trouble with peace' is that it led to a redeployment of police resources which had the affect of increasing drug seizures and arrests. Some paramilitary groups were also developing new roles reflecting their differing drugs ideologies (Higgins and McElrath, 2000: 55). The drugs 'epidemic' was more a matter of discovery and media exposure. The ceasefires allowed greater awareness and public debate to surface around drugs but did not lead to, or coincide with, a sudden surge in illicit drug use. The only exception to this is heroin, for which there is evidence of increased notifications. But there

²⁴ GlaxoSmithKline, manufacturers of the leading SSRI, Seroxat (19 million prescriptions for which were written in Britain in 2003), wrote to all doctors in May 2006 warning of the risk of suicide associated with the use of the drug for some adults. *The Guardian*, 13 May 2006. There is also a concern over Tamiflu (made by Roche) which is implicated in 54 deaths in Japan since 2001. The Japanese health ministry has warned doctors not to prescribe the drug to teenagers. *The Guardian* 22 March 2007.

is no evidence that this development can be related specifically to transition to peace.

A less sceptical view is put forward in a further review of the evidence four years later. Drug use was found to have increased, even 'flourished', with an enhanced role for some of the paramilitary organisations. Northern Ireland has been ill-prepared for this in terms of drugs policies and harm reduction strategies (Higgins *et al*, 2004).

The consumption of alcohol has also increased from the 1990s with the proportion of men drinking 'above sensible levels' rising from 9 per cent in 1986 to 19 per cent in 2000. For women the figure rose from 3 to 9 per cent. By 2000, 9 per cent of male drinkers were consuming 'dangerous' levels of alcohol (Northern Ireland Statistics and Research Agency, 2002; Health Promotion Agency for Northern Ireland, 2002).

Such patterns indicate that over the past decade in Northern Ireland key risk factors traditionally associated with suicide at the individual level – depression, alcohol and drugs problems – have all increased. Other known risk factors such as relationship breakdown (Fernquist, 2003) and sexual abuse need to be addressed. But the key challenge at this level is to explore any evidence of higher than average prevalence of risk factors among those who were in the frontline of violence, whether actively or passively. One would expect that individuals involved in carrying out violent acts, those involved in policing violence and managing prisoners, ambulance and fire crews dealing with death and injury after bombings and shootings, and those unwittingly caught up in violent incidents, the bereaved and injured, are all at risk of above average trauma and stress-related effects. The latter do not necessarily manifest as psychological issues, but may emerge as physical morbidity and premature death from heart disease or cancers (Wilkinson, 1996).

Not surprisingly, research on the mental health affects, particularly suicide, for those in the front line of military and civil conflict is controversial. It also has

consequences for public policy. For example, in November 2005, more than 5,000 former and serving police officers launched a class action suing their employer on the grounds that they were not adequately protected from 'injuries' including post-traumatic stress disorder, anxiety, and depression which they argue are predictable psychiatric consequences of 'the extremely traumatic nature of their duties' (Police Federation, 2005). Searches carried out for this review revealed only one reference to suicide among police officers in Northern Ireland. This was on the Police Federation's website which states: 'levels of stress-related illness have been higher than in any other police force: almost 70 officers have committed suicide, many of them with RUC-issued weapons'. (www.policefed-ni.org.uk) Gilligan (2006) cites a study by Patterson *et al* (2001) based on interviews with 20 retired RUC officers, nine of whom were assessed as psychologically distressed. Two of their interviewees wondered 'what was it all for?' and felt particularly depressed because of the 1998 Agreement's provisions for the early release of prisoners (Gilligan, 2006: 330). There is some evidence that the children of police officers have special psychological needs arising from their parent's police service and a specialist Child and Adolescent Therapy Service has been established to address these needs (Black, 2004).

Similarly, there is an ongoing debate over the impact of the war in Iraq and how PTSD should be understood (Wessley, 2005). The US Army has been accused of covering up a 'suicide crisis' and of failing to investigate adequately a number of murder-suicides involving soldiers returning from frontline operations in Iraq (*Newsweek* 20 Feb. 2004). There is contradictory research surrounding the war in Iraq. A team working for Defence Medical Services examined the mental health of 254 members of the UK's Air Assault Brigade deployed in Iraq and found an *improvement* following combat, contrary to Hoge *et al* (2004). They conclude: 'where there are highly selected forces with high morale involved in focused operations with positive outcomes, whatever the immediate political context, participation in war fighting may sometimes not necessarily be as deleterious to psychological well-being as has previously been thought' (Hughes *et al*, 2005: 537). Other research has found that depression is more common than PTSD among

British ex-service personnel (Iversen *et al*, 2005).

Combat Stress, the ex-Services Mental Welfare Society, claims that the largest single group needing help are from Northern Ireland and many of these are ex-Ulster Defence Regiment personnel who remain concerned about their personal security (BBC News 27 September 2005). No supporting evidence appears to be publicly available. Suicides among UK regular armed forces are analysed annually by the Defence Analytical Services Agency (DASA). The latest report states that suicide rates for men are lower than in the general population except for young men (<20) for whom the risk of suicide is 50 per cent higher. Taking all armed forces suicides from 1984 to 2005 (a total of 638), 26 per cent were open verdicts, a much higher rate than for all suicides in Northern Ireland (DASA, 2006). Unfortunately, no attempt is made to relate the data to combat experience or service in Northern Ireland though parliamentary questions have been raised over the deaths of particular individuals (see Hansard, 12 December 2002, col. 427W). The suicide figures have been questioned in the context of four deaths at Deepcut barracks which highlighted other deaths and issues of institutionalised bullying. As one MP put it,

Young soldiers are dying needlessly in barracks in Great Britain and Northern Ireland, in Germany and Bosnia... In many regiments, there is evidence of a culture of extreme bullying, routine violence and sexual harassment that constitutes torture and inhuman and degrading treatment. (Hansard, 4 February 2003, col. 3WH)

Since 1990, 1,748 armed forces personnel died of non-natural causes in or around barracks and 100 of these were firearms related. The implication is that some armed forces 'suicides' are either manslaughter or murder, and that some 'accidents' are in fact suicides.

No studies of suicide among prison officers, ambulance crews or the fire service in Northern Ireland could be traced. Occasionally, evidence of occupational stress among prison officers emerges. In 2003 the Northern Ireland Affairs Committee heard evidence on absenteeism in the Prison Service which was running at 11 per cent at the time. Half of this was

attributed to anxiety and depression; it was also related to low morale due to political tensions over the segregation of prisoners (Northern Ireland Affairs Committee, 2004). A systematic review of the health of ambulance service personnel found high PTSD scores and high anxiety compared to general populations but many studies suffer from poor sampling and statistical testing (Sterud *et al*, 2006). The review included one study of ambulance personnel in Northern Ireland. This looked at early retirements by cause, comparing ambulance staff with other health service workers. Compared to studies elsewhere, Rodgers (1998) found the highest proportion of ambulance retirements due to mental disorders, a high proportion of which were related to problems with alcohol. Somewhat tentatively, Rodgers concludes: 'Perhaps the multiple shooting and bombing incidents which in the past have occurred frequently in N. Ireland may partly explain the higher incidence of mental disorders at retirement of the ambulance personnel in the present study compared to those cited in other studies.' (1998: 129)

Very high rates of imprisonment and long-term sentences in the past will have taken their toll on relationships and mental health. Shirlow *et al* (2005) argue that the transition to peace has led to a greater willingness on the part of ex-prisoners and former combatants to acknowledge psychological impacts and mental health problems. They interviewed 150 Loyalist and 150 Republican former prisoners (and half that number of relatives) and found that 39 per cent of Republicans relatives and 28 per cent of Loyalist relatives felt that imprisonment had negatively affected their relationship with the prisoners. 'Serious psychological trauma' was reported, though the form of questions asked is unclear. There were differences between Loyalists and Republicans in this respect, with higher proportions of Republican prisoners (24%) and relatives (28%) than Loyalists (17% and 8%) reporting trauma. The issue of suicide was not explored, though there have been suicides among former political prisoners. With no clear victory or defeat, and with faltering political development, ex-police officers are not the only ones struggling to make sense of the transition to peace and asking what people fought and died for.

Horgan and Kilkelly (2005) review the evidence on how children have been

affected by a parent's imprisonment relating to the conflict. Two studies report that children were damaged emotionally by not being told the full story behind why the parent was in prison. A study of the children of Loyalist former prisoners found that 'they suffered depression, anxiety and panic attacks as well as general confusion and worry. Teachers, parents and children themselves noticed changes in behaviour including an increased tendency towards violence and a withdrawal from friends.' (Horgan and Kilkelly, 2005: 11) Children/ex-prisoner relationships were difficult. It has also been shown that teachers and other professionals have little comprehension of the issues facing ex-prisoners and their children (Kilkelly *et al*, 2004). These findings reflect the concern in the international literature about how some of the effects of traumatic experiences are passed on to other family members, especially children – the 'intergenerational transmission of trauma' (Bar-On, 1996; Dulmus and Wodarski, 2000).²⁵ In their group work with families living in areas worst affected by Northern Ireland's conflict, Burrows and Keenan (2004: 111) identify 'a gap in current thinking in relation to the complex parent–child relationship in times of political conflict'. If child trauma is recognized at all, it tends to be 'individualised through counselling or medication'. But this ignores the fact that 'children here are born into an already traumatised environment' (2004: 112) and how intergenerational trauma is transmitted through processes of attachment, memory, re-enactment, family and community responses. The authors refer to youth suicide as an example of how traumatic events are consciously or subconsciously re-enacted. The work of the NOVA project also reflects these perspectives (Murphy and Stewart, 2006).

Mental health services and the conflict

As Northern Ireland gradually emerges from conflict, the debate has grown over the identification of conflict-related psychological damage and appropriate responses through mental health services. Curran and Miller (2001) argue that psychiatric services have always been in good shape in

²⁵ Children have, of course, been traumatised directly from specific incidents. See McDermott *et al* (2004).

Northern Ireland. There has been no shortage of candidates to fill psychiatric posts, hospital and community services are 'generous' compared to Great Britain, doctors are well-respected and they have 'gathered the experience of dealing with victims of violence, learned best classification systems of psychological reactions to trauma and developed treatment techniques to best apply in different and individual circumstances'. (2001: 73) But, they argue, the need for conflict-related responses is not as great as people imagine as only 6 per cent of referrals and admissions at the Mater Hospital – located in an area of Belfast that has experienced a third of all conflict deaths – can be seen as connected to violence (see also Loughrey, 1997). The vast majority of the clinical practice, therefore,

is the same as that of colleagues elsewhere in the British Isles ... Our people who commit parasuicidal acts seem to do so by reason of the same litany of life's vicissitudes as anywhere else... In psychological post-mortem studies and observations we have not noted any correlation between the community violence and the personal circumstances of the victims of completed suicide and we assume the reasons for the high suicide rate are similar to those in other jurisdictions. (2001: 75-6)

While people and services have coped well, Curran and Miller do observe 'a rising trend in people seeking acknowledgement of victimhood' associated with the decline in violence (2001: 79).

The conflict may have had little impact on the psychiatric case load at the Mater Hospital, but there is a broadly held view within the health and social care professions that the effects of 'the troubles' are much wider than people realise and have not properly registered on services. A Northern Ireland Social Services Inspectorate report (1998: 4) spoke of 'an ever widening circle of individuals affected, socially, psychologically and economically ... The ripples are endless and no-one knows the total number of people affected'. This is supported by much of the research and evidence presented earlier, from survey data on poor mental health to high rates of consumption of alcohol and prescription and other drugs, and of course the prevalence of suicide itself.

This points to a discrepancy between widespread mental health needs and the provision of services, including possible issues over the form and nature of mental health services and interventions. Put simply, there appears to be a gap between those with the strongest mental health needs living in the areas most affected by conflict and the professionals who provide mental health services (Hayes and Campbell, 2005: 118-128). The possible exception here are GPs who are responding to depression and anxiety by prescribing ever higher quantities of anti-depressants. This is not simply a communications gap; one of not knowing where to go, who to contact and what to expect on arrival. It is also about the distance between the 'neutrality' of professionals and the perspectives within local communities that arise from their experiences of conflict (see, for example, Murphy and Stewart's (2006) work addressing the community trauma of the Holy Cross dispute).

In relation to suicide prevention the Draft Suicide Prevention Strategy Report notes the need for the promotion of safer prescribing of antidepressants. It also notes that a training programme in depression awareness for GPs was not delivered by the target date of September 2004. In fact most of the Report's targeted actions to 2008 involve bridging gaps between high risk individuals, community and voluntary groups and professionals. There is less clarity over specific action points. For instance, what will be done with better linkages when they are established? How will vulnerable men's emotional talk capacity be improved? The strategy does not recognize that young women have specific needs and vulnerabilities in relation to harming and attempted suicide. No new programmes to complement or challenge pharmaceutical approaches to mental health are mentioned in the Report. While community and voluntary groups are seen as key bridges between high risk people and professionals, there seems to be no commitment to strengthen community capacities and networks, including networks with those outside Northern Ireland. Similarly, there appears to be no intention to pull together in a systematic way the knowledge and experience of community leaders and those bereaved through suicide. Finally, the Report could do more to recognise the importance of suicide imitation and the role of media (see Samaritans, 2002). There is a target to agree reporting guidelines with

journalists and to 'develop and implement positive media messages', but no attempt to target the approach in ways that are meaningful to key risk groups and communities. In particular, there is a need to engage with new media and how younger people use these.

These observations fit with one of the main themes running through this review, that the conflict radically altered the nature and quality of relationships between state bodies and those communities and individuals now recognised as most affected by decades of various forms of violence. Changes in these relationships have shaped the registration of suicides, the recognition of the suicide problem and the speed and nature of the responses to it.

Section 9

Conclusion

Has the Northern Ireland conflict affected mental health and suicide? There are two simple answers to this question running through the literature reviewed in this report. The first is that 'the troubles' have not had much effect: there was no obvious growth in mental illness, suicides went down and direct experience of trauma was modest. The conflict had few consequences for, and little impact on, services and generally people have coped well. Hence Northern Ireland's mental health and suicide profiles today reflect those of any other 'normal' population, albeit one with traditionally high levels of social disadvantage.

The second answer is that 'the troubles' affected everything. The whole society has been traumatised, brutalisation is common, resistance to change engrained, and depression and anxiety are widespread. It is only in recent years that the full effects are coming to light through the work of victims' groups, new demands on services and mass medication with anti-depressants. In particular, suicides have risen and fallen in line with conflict killings, and it is only to be expected that suicide rates have gone up as murder has declined. The aggressions of homicide become internalised and more people kill themselves.

Inevitably the picture is more contradictory than either of these two scenarios. People in Northern Ireland report higher levels of happiness than in many other parts of Europe and elsewhere. Yet this sits alongside high levels of unhappiness and psychological distress. Wars do damage to people and places, and the refugee (or 'internal displacement') experience contributes further to the cocktail of economic distortion, non-employment and social disruption, including intimate partner violence, and associated chronic levels of fatigue, inability to enjoy life, anxiety and depression. In most societies the burden of the latter falls disproportionately on women who are more likely than men to contemplate suicide, but less likely to carry it out.

Modern types of violent conflicts do not appear to generate the same levels of social and political integration traditionally associated with national mobilisations for war between countries. Contemporary conflicts are often ideologically incoherent and divisive *within* the fighting parties as well as between them. Maintaining military capacity and civilian support is messier and more of a struggle, causing further divisions and insecurities. Trauma is particularly high in populations fleeing conflict or who are forced to move through intimidation and violence. Conflict related trauma has been shown to have long-term effects which are still being understood in terms of physical and mental consequences. Increased rates of suicide have been associated with both the immediate and longer-term consequences of conflicts, especially in situations where it is difficult for populations to re-establish themselves economically. But evidence is by no means complete on these points. Further, researchers are divided over the concept, measurement and applicability of Post Traumatic Stress Disorder.

For some, the recognition of PTSD represents a major advance in understanding and dealing with the consequences of a range of unexpected events, including disasters, and the experience of violence arising from political conflicts. For others, the popularisation of PTSD constitutes the unnecessary medicalisation of distress on a global scale, and may even do more harm than good. Northern Ireland is clearly caught up in this argument as doctors, therapists and others compare their practices and debate their contributions to people's private troubles and Northern Ireland's transition to peace. This is of some importance to suicide as when conflicts end people are confronted even more starkly by the question, 'what was it all for?', whether those people were in the frontlines of the conflict or bereaved as a result of it.

The evidence that experience of the conflict is associated with poorer mental health is strong. Population-based surveys show several things. First, those who experienced most violence have significantly higher rates of depression than those with little or no experience. People whose areas had been heavily affected by violence had very high rates of depression. Another point is that,

as the transition to peace progressed, people were more willing to report these associations. So the relationship between conflict experience and poor mental health, and between lack of conflict experience and good mental health, is well-established.

How important this is to suicide is less certain. Most people who take their own lives are known to be suffering from depression. But only a minority are being treated for a recognized disorder or illness. Women suicides are much more likely than men to have been diagnosed with depression, though women are significantly less likely than men to kill themselves. Understanding suicide simply as the outcome of psychological sickness or in terms of biology, however, provides only part of the picture.

Research on suicide relies heavily on official data and it has long been recognized that the reliability of that data is questionable. Some researchers abandon the use of official statistics altogether as they can never adequately reveal the nature and extent of deaths by suicide. Others argue that what is important is the social processes through which a suicide statistic is arrived at. These processes change over time as legal, religious, medical, commercial and bureaucratic definitions and practices develop. They also vary between countries notwithstanding international attempts to standardize the classification of deaths and to assemble a credible international set of data.

In Northern Ireland as elsewhere, there is a considerable discrepancy between the number of suicides that are thought to occur in a given year and those that come to be registered and published in reports and press releases. Registrations are lower than occurrences and proposals are on the table for how practices could be improved, including changes to the role of Coroners, doctors and the General Register Office. It is not really sensible to establish suicide reduction targets when the statistical representation of suicide has not been settled. That does not mean, of course, holding back on the objective of preventing suicides.

The occurrence/registration difference is not the only problem, however. The

way in which evidence of self-harming is currently captured means that knowledge of the problem is very limited. Most self-harming does not come to the attention of health and social care professionals. This is a known issue and progress is needed as a matter of priority so that the ways in which anxiety, distress and depression are being experienced and expressed by younger people can be better understood and supported.

A large section of this report dealt with trends in recorded suicides globally and within Britain and Ireland. The standard data sets allow analysis by age and gender and the profiles for both these dimensions vary radically between countries and regions and over time. Some of the differences can be seen to reflect recording practices. Others, according to the literature, can be understood in terms of religion, rapid social change, gender relations, culture or the availability of the means of suicide.

Even within the European Union statistical reliability is quite uneven. The boundary between 'suicides' and deaths for which the intention is unclear shifts from one country to another. In any event, no clear explanation is advanced for the age and gender differences between countries, and suicide rates across the EU are not related to unemployment and risk of poverty. Male suicide rates are moving in different directions in different countries with the strongest increase belonging to Ireland where young men are four times as likely to take their own lives as women. One significant factor in Ireland's upward trend is alcohol consumption which rose by more than 50 per cent between 1981 and 2001. Alcohol is thought to be related to around half of all suicides and suspected suicides.

Northern Ireland's suicide trends bear closer resemblance to those in the Irish Republic than those in Scotland, Wales or England, and this holds not only for the overall trend but also for age profiles over time. Unemployment is associated with male suicide for all five jurisdictions. One important finding is the high concentration of increased male suicides in Northern Ireland after 1998. Before 1998, no parliamentary constituency in Northern Ireland came anywhere near Scotland which had fourteen of the top twenty worst areas for

suicides in the UK. But after 1998, North Belfast had gone from 319th to 11th place and West Belfast from 259th to 13th.

Section 6 presented a detailed examination of suicide trends in Northern Ireland. According to the official statistics there was a sharp decline in suicides at the start of the conflict, followed by a broad upward trend since then. That trend becomes more definite in the 1990s, with younger men accounting for most of the change. It was also shown that proportionally firearms became more prevalent as a method of suicide during the conflict, but have recently declined in importance.

It is this overall trend that has been used by a number of researchers to claim that there is a direct association between suicide and the conflict, and to suggest that the post-1998 rise in suicides is the result of a reduction in the high level of 'wartime' social cohesion. So central is this claim to the concerns of this review that the arguments and explanations surrounding it, as well as the data themselves, were carefully scrutinised. From the analysis of suicide method and accidental deaths data, evidence is presented that puts a serious question mark over the reliability of the suicide figures for the early years of the conflict and beyond. An alternative argument is put forward that 'the troubles' did affect suicide but not in the way that those who take the data for granted believe. More plausibly, the conflict affected the process of registration such that some suicides were recorded as 'accidental deaths' instead.

Support for this argument comes from the fact that there is a highly significant inverse statistical relationship between suicides and accidental deaths from car crashes – the biggest category of accidental deaths – over the entire period 1967-1994. Car crashes are important because research has shown how they are implicated in the imitation of suicide. There was no relationship between suicides and the second biggest category – 'falls'. This merits further investigation.

The argument is further strengthened by the statistical relationships between

suicides and accidental deaths for poisoning. Strong inverse relationships were found between suicides by poisoning and accidental deaths recorded for poisoning. This was found for the short period covering the dramatic decline in recorded suicides in the early years of the conflict and over the period 1967-1982. Again, this ought to be explored more closely along with the finding that there is a strong positive correlation between suicides by firearms and suicides by hanging from 1964 onwards.

Hanging/suffocation is now the dominant method by which people take their own lives. Because the means and opportunity are generally available, hanging is the method of suicide used in institutional settings such as hospitals and prisons. Suicides of people in the care and custody of the state are among the most preventable of suicides. No-one should die in these circumstance.

Having questioned the suicide/conflict deaths statistical relationship, the idea that the conflict increased social cohesion which then declined after the ceasefires must also be questioned. Reduced social cohesion leads to more suicides, the argument runs. The explanation may be neat and simple but it sits uneasily with the patterns of social and political division and change. Any generalisations around polarization and social integration need to take account of wide variations in experience. Further research is needed that can examine more precisely how suicide relates to neighbourhood characteristics and broader evidence on social change.

As has been suggested, a 'troubles effect' may be operating in the last ten years or so, as people ask 'what was it all for?', and lose their political and social bearings in the uncertain world of transition to peace. The familiar old world of the conflict, with its rules of engagement, its clear enemies and friends, and its rights and wrongs, gives way to doubts about crossing lines, unthinkable compromises, new risks, as well as, perhaps, to unfulfilled optimism. This puts community and religious leaders, political representatives and other significant contributors to political culture, in a special position in relation to suicide. People have to be convinced, and reminded, that the future

is worth it, especially when they are surrounded by everyday signs that it might not be.

The ideas of 'contagion' and imitation have a long history in suicide research. This could be explored using a number of methods but it would be especially useful to work with those bereaved by suicide to find out more about 'chains' of related suicides, and to systematically collate the knowledge and experience of the bereaved and community leaders. It was suggested earlier that a 'sociological autopsy' is needed that sheds light on the successes and failures of the social processes of isolation, help seeking, and support that surround suicide. There is a basic lack of qualitative research exploring how families and local communities cope with depression, self-harming and suicide.

A further aspect of the cultural context of suicide, of particular relevance to younger people, is the way in which suicide is represented, even celebrated, in popular culture. There are well over a thousand pop songs about suicide, while very few are explicitly opposed to suicide. Again, there appears to be very little research in this area.²⁶ More shape could be given to work with mass media so as to reduce suicide imitation and to encourage good mental health. A greater understanding of how younger people use communications and other media is essential if they are to be engaged in relation to suicide awareness and prevention, and mental well-being more broadly.

Then there are some much wider concerns raised by the research. Why is there such a reliance on anti-depressants and what explains the growth in prescribing? There is no clear evidence as to whether such increases reflect a greater recognition of mental health needs by professionals, relate to the marketing strategies of pharmaceutical companies, a change in the willingness of people to seek help, or a real change in the prevalence of mental illness.

²⁶ Jamieson (2003) argues that the rise in suicide among younger age groups in the United States is partly explained by the increased portrayal of suicide in American films and increased access to those films.

Similar questions can be asked about alcohol consumption. Why has it risen so much and what is to be done about it?

Although specific risk groups have been defined in the suicide prevention strategy, the evidence base appears to be weak. A number of small projects need to be carried with those occupational and other groups who were in the frontline of conflict – including ex-prisoners – to provide better evidence of mental health needs and suicide risk. There is also the suggestion that the particular stresses of frontline activity have led to higher rates of physical illness and premature death. Again, this ought to be investigated.

One of the issues around which there needs to be more clarity is ‘trauma’ and its transmission horizontally and through the generations. For instance it would be useful to gather up best practice from the range of practitioners and projects assessing and working with trauma.

In conclusion, the evidence reviewed in this report points to a general conclusion that the conflict shaped the suicide problem in significant ways in the past and its legacies continue to influence the challenge of reducing suicide in the future. In particular, changes in the relationships between state bodies and the communities and individuals most affected by the conflict have impacted on the registration of suicides, the recognition of the suicide problem and the speed and nature of the responses to it.

Summary of recommendations for further research

- A sociological autopsy of suicides is needed to shed light on the risk factors associated with social context, including community, neighbourhood and family experience.
- There is a serious gap in qualitative research that might explore, for example, how families and local communities cope with depression, self-harming and suicide, and how knowledge of, and attitudes towards potential sources of help vary.
- Research is needed that can examine more precisely how suicide relates to economic deprivation, neighbourhood characteristics, and broader evidence on social change, including changes in social isolation and integration.
- The question of whether rural suicides are distinctive needs to be looked at.
- There is a lack of systematic evidence concerning the prevalence of known risk factors for depression and suicide among those who were in the frontline of violence in past decades. A number of small projects need to be carried with relevant occupational and other groups – including ex-prisoners – to provide better evidence of mental health needs and suicide risk. Similar work needs to be carried out on premature death and physical illness for the same groups.
- There is a need to gather up research data and best practice from the range of practitioners and projects assessing and working with conflict-related trauma.
- There is a basic lack of research and information on self-harming among younger people which needs to be addressed.
- The ideas of suicide ‘contagion’ and imitation need to be explored, particularly in relation to young people and the popular cultures that surround depression, anxiety and suicide.
- Further research is needed to explain anti-depressant prescribing trends and to evaluate the efficacy of this intervention in relation to self-harming and suicide.
- Similar questions need to be answered about alcohol consumption. Why has it risen so much and what is to be done about it?
- Research is needed on suicides involving firearms.
- The relationship between accidental deaths and suicides by particular methods, notably poisoning, needs to be researched in more detail.
- The close statistical relationship between motor vehicle deaths and suicides needs further investigation.
- The feasibility of establishing a parasuicide register for Northern Ireland in cooperation with the Cork-based National Parasuicide Registry should be investigated.

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Appendix

Method of Review

The literature search was based on:

- a) Two specialist suicide journals, *Archives of Suicide Research* and *Suicide and Life-Threatening Behavior*.
- b) Known primary sources, tracking the work of key international experts and those working on mental health and suicide in British and Irish contexts.
- c) Catalogues, libraries and databases, including:
 - ArticleFirst, OCLC FirstSearch
 - Applied Social Sciences Index and Abstracts
 - ChildData
 - Cochrane Library
 - Digital Dissertations/Dissertation Abstracts and Index to Theses
 - Economic and Social Data Service
 - IBSS – International Bibliography of the Social Sciences
 - JSTOR
 - Medline
 - ScienceDirect
- d) Government departmental sources.
- e) Parliamentary debates and records.
- f) EU and UN sources.
- g) Non-academic sources, such as work carried out by voluntary and community organizations.

Literature selection

Search results were reviewed on the basis of titles and abstracts. Items were selected or rejected according to judgements based on the three main questions described in the introduction. Additional judgements were made regarding the type and range of data used, the time period involved and the standing of authors. General work on mental health and/or suicide providing overviews and international comparisons was prioritized. Specific work on war/conflict and mental health and suicide was also prioritized. Special attention was given to studies of suicide and suicide data relating to Britain and Ireland.

The literature was organized thematically reflecting the structure of the final report. Some supplementary searching was carried out to address specific questions that arose during the writing of the first draft.

Search terms

The search terms used are listed below. Primary terms are shown in bold. These were put into two groups: terms associated with mental health and those associated with Northern Ireland, war, conflict etc. Combining terms across the groups produced many repeat items. Secondary terms were combined with the primary terms in order to develop particular themes. Much of the resulting literature was too specific to the secondary topic (and countries of no direct interest or comparability) to inform the aims of the review.

Primary search terms	
List 1	List 2
Northern Ireland Conflict Troubles War	Anxiety Depression Mental Health Parasuicide Post Traumatic Stress Disorder Self-harm Suicide Trauma
Secondary search terms	
List 1	List 2
Army Combatants Homicide Insecurity Killing Murder Peace Police Prison/ers Security Terrorism/t Victims Violence	Alcohol abuse Child abuse Children Deprivation Divorce Drug abuse Ethnic Loneliness Poverty Sectarian Separation Sex abuse Social cohesion Social division Social fragmentation Social isolation Unemployment Well-being Young people Youth