Submission No. 8
(Youth Suicide)
Date: 22/04/2010

My apologies for the lateness of this submission. I only became aware of this inquiry when I heard comments on ABC radio (20/4/2010) concerning poor use of existing services by young people at risk of suicide.
I have had extensive experience assisting some of Australia's most 'at risk' young people and have rarely had difficulty encouraging them to access the services where I have worked.
I shall keep my comments very brief however I should be happy to expand on my views to the committee.

ABS suicide data shows us that overall men comprise about 80% of Australian suicide deaths. Amongst the young < 25y/o males are about 85% of deaths.
Greater access to mental health services are often cited as crucial to reducing suicide deaths. Mental health services in Australia focus on treatment of mental illness.
Most of the men who commit suicide are not mentally ill and referral of these men to mental health services is actually very harmful and significantly increases their risk of suicide. Men typically kill themselves due to severe social stressors eg loss of a relationship, loss of or failure to gain employment, financial problems, sexual abuse or physical assault.
The factors I look for in determining suicide risk in young men are as follows

1/ A real or perceived injustice
2/ A failure to recognise the risk by services
3/ An expressed desire to be decisive
4/ Negative contact with figures of authority

A referral to a mental health service for a young man presenting with these factors is harmful because the mental health assessment will focus upon issues related to psychosis and then very bluntly ask whether the young man is actually planning to kill themselves. A young man without psychosis will not have the symptoms that lead to mental health intervention. The young man is also highly unlikely to be open about their degree of suicidality. They will then be sent away.
Men say to me that the above process makes them feel that their problem has not been understood and that people think they are 'nuts'. Inducing these emotional states increase male feelings of hopelessness and hence risk of suicide. The attachment I have added from Hansard is from a man (Greg Wilton) for whom this process lead to his death.

In the 1990's I completed a database of all suicide deaths in Victoria 1990-95 by age gender and postcode. What this data showed me was that there are strong links between social disadvantage and male suicide. Examination of suicide data over the past 110 years shows a strong correlation between male employment rates and suicide. The same correlation did not appear with female suicide.
The disparity between young male and young female suicide in areas of disadvantage were enormous often greater than 20:1. In some rural areas young female suicide was unknown (within the five years of my study).

The support of men at risk of suicide is most often best provided not by psychologists, GP's or psychiatrists but by social workers who are adept at engaging distressed men and boys. Social workers will also have the skills and contacts to advocate re housing, social services and relationship support. These services need to be provided very promptly. At present our community health counsellors do not provide 'crisis' support. In fact no free services will provide crisis support to persons who are not acutely mentally unwell.

A change in role for community health counselling to incorporate crisis intervention is needed. We also need to enhance the skills and willingness of frontline workers dealing with men at risk of suicide. There is very little or no training for support workers in strategies to engage and assist men at risk of suicide. In the social work training I completed in the 1990' I completed three semesters of study on women's health. There was no similar component dealing with men. In my course I was one of only four men out of seventy students. The other students and most of the lecturers had little knowledge of or expertise in dealing with men at risk. In my fieldwork group I was asked to demonstrate tactics and strategies that I developed to assist men.

An example of how to get men to come to support services is as follows.
Most (but not all) men at risk will be referred to support services by women, (aunts, mothers, sisters, girlfriends etc.). The referrer will often say to me 'I'm really worried for X but he won't come and talk. I say 'tell X exactly this',

1/ The service is strictly confidential
2/ I am not a 'shrink'
3/ I am not a 'wanker'
4/ If he doesn't like what I have to say after five minutes he can xxxx off!

I find in most cases men and boys will then come and we have a chance to deal with some of the emotional and practical issues, which are inducing the feelings of hopelessness, which push males to suicide.

I have focussed on men without mental illness in my submission. I do not dismiss as unimportant the many people who self-harm or die who do have mental illnesses or the high rates of self-harming behaviour amongst young women. I see these clients as well. Rather I should like to point out to the committee the poor service provision for the persons making up the greatest proportion of people who die by suicide in Australia.

Submitted 21/4/2010