HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Aspects of youth suicide

CANBERRA

Friday, 28 February 1997

OFFICIAL HANSARD REPORT

CANBERRA

HOUSE OF REPRESENTATIVES STANDING COMMITTEE
ON FAMILY AND COMMUNITY AFFAIRS

Members:

Mr Slipper (Chairman)
Mr Quick (Deputy Chairman)

Mr Ross Cameron
Ms Ellis
Mrs Elson
Mr Forrest
Mrs Elizabeth Grace
Mrs De-Anne Kelly
Mr Kerr
Ms Macklin
Mr Marek
Mr Allan Morris
Dr Nelson
Mrs Vale
Mrs West

HOUSE OF REPRESENTATIVESSTANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

(Seminar)

Aspects of youth suicide seminar

CANBERRA

Friday, 28 February 1997

Present

Mr Slipper (Chairman)

Mr Ross Cameron	Mr Allan Morris
Ms Ellis	Dr Nelson
Mr Forrest	Mr Quick
Mrs Elizabeth Grace	Mrs Vale
Mrs De-Anne Kelly	Mrs West
Ms Macklin	

The committee met at 9.25 a.m.

Mr Slipper took the chair.

MEMBERS AND SENATORS ATTENDING (Other than Committee Members)

Mr Kerry Bartlett, MP
Mr Paul Evans—representing Ms Trish Worth, MP
Mr Martin Ferguson, MP
Ms Teresa Gambaro, MP
Hon. Bob Halverson, MP
Hon. Neil O'Keefe, MP
Hon. Roger Price, MP
Dr Andrew Southcott, MP—representing the Minister for Health and Family Services
Mr Warren Truss, MP
Mr Barry Wakelin, MP
Senator Jeannie Ferris
Senator Eggleston

ORGANISATIONS AND INDIVIDUALS ATTENDING

Associate Professor Pierre Baume—Australian Institute for Suicide Research and Prevention
Professor Michael Carr-Gregg—Centre for Adolescent Health
Mr Michael Chaaya—NSW Youth Advisory Council
Ms Kirsten Cross—Australian Medical Association
Reverend Bob Dunlop—Wesley Mission Youth Force
Dr Richard Eckersley—CSIRO
Mr Gordon Gregory—National Rural Health Alliance
Dr James Harrison—Australian Institute of Health and Welfare
Ms Heather Horntvedt—Parents of Lesbians and Gays
Mr Tony Humphrey—Suicide Prevention Australia
Ms Gail Kilby—The Rose Foundation
Professor Robert Kosky—Adelaide Women's and Children's Hospital
Mr Kilner Mason—The Mason Picture Company (works with Salvation Army)
Mr David Matthews—Pathways
Mr David McKie—NSW Department of School Education
Ms Coral McLean—Holy Family Education Centre
Father Peter Norden—Jesuit Social Services
Mr Julian Pocock—Australian Youth Policy Action Coalition
Mr Phil Pringle—Christian City Church
Mr Neile Robinson—Sutherland Shire Council
Ms Diana Sands—Southern Highlands Bereavement Service
Dr Meg Smith—Youth Suicide Prevention Advisory Group
Mr Alan Staines—Suicide Prevention Australia
Mr Eric Tresize—National Summit on Suicide
Mr Bruce Turley—Lifeline Australia
Mr Derek Williams—Gay and Lesbian Teachers Association
Colonel Don Woodland—Salvation Army
Mr Ian Wright—Victoria Country Youth Services Inc.

CHAIRMAN (Mr Slipper)—Prime Minister, Mr Speaker, invited guests and colleagues. At the outset, I would like to thank everyone for coming along today to this seminar being organised by the House of Representatives Standing Committee on Family and Community Affairs on the topic of aspects of youth suicide.

Personally, I must say that I am shocked by the statistics in Australia which show that over the last 15 years the level of youth suicide has continued to rise to a stage where we now have a level of youth suicide amongst the highest in the industrialised world. Suicide generally is a problem in Australia. Every day we have six completed suicides and 180 attempted suicides. Young males and young people in rural and regional areas are those most at risk. There has been a 50 per cent increase in the number of young males lost to youth suicide between the years 1979 and 1993.

Mental illness is a cause in over 90 per cent of cases. Tragically, Aboriginal and Torres Strait Islander young people are 40 per cent more likely to fall victim to youth suicide than those in the general community. Statistics have indicated that unemployment, family and other interpersonal problems, physical and/or sexual abuse, homelessness and history of substance abuse are all implicated as causes of youth suicide. It is interesting that while young males seem to commit suicide more often, there is little difference between the genders in the number of attempted suicides.

The Prime Minister has come along this morning to lend his imprimatur to these proceedings. The Prime Minister's government has already recognised, in the last budget, the magnitude of the tragedy of youth suicide and that more needed to be done. In fact, $19 million was allocated to the national youth suicide strategy in addition to the $13 million already available. This $19 million will go to rural and regional youth counselling, kids' help line and Lifeline, programs for parents, education and training programs and research. I might add that other government departments also have programs which assist in the reduction of the number of youth suicides in this country.

Clearly, as a community, we recognise that youth suicide is a major problem, and against this backdrop we have organised this seminar with a view to achieving practical and decisive suggestions to the government on how we can move along further our nation's response to the tragedy of youth suicide.

I must say that we are particularly fortunate to have been able to attract four presenters who are absolute experts in their fields. I would like to welcome formally Dr James Harrison, Associate Professor Pierre Baume, Professor Robert Kosky and Dr Meg Smith, OAM. I know we are all looking forward to listening to their contributions with a view to pooling our collective ideas when making recommendations to the government for the future.

I must say also that I am pleased that we have a very broad cross-section of the Australian community present. There are many people who have expertise in the area of youth suicide, those at the coalface, who know what the problem is and what our response as a community should be. I would like to, on behalf of the committee and the parliament, formally welcome all of you here. Later in the day, of course, you will have the opportunity of participating in what is effectively a round table discussion.

It is not our aim that this seminar should be a talkfest; it is not intended that we should simply come along here and talk because we need to move the debate along; we need to build on the strategies already in place because I believe that youth suicide is one of the greatest social problems confronting Australia in 1997. Suicide is tragic. There is a personal effect on all of those associated with the person who dies. Families, friends and society are affected.

Only last month, on the Sunshine Coast where I am from, a young man committed suicide. A month or so later his father and his sister both committed suicide leaving suicide notes saying that they were simply unable to come to terms with the loss of their loved one.

So, as elected representatives, we have a responsibility to do whatever we can to stem the tide. Young people are our nation's most valuable asset. We have to care for them and protect them; we have to try to nurture them to make sure they are able to take their role as effective members of our society.

Now, we do have many members of our committee here, and I would like to briefly introduce them briefly. We have the Deputy Chairman, Mr Quick, a Labor member from Tasmania; Dr Brendan Nelson, a Liberal member from Bradfield in New South Wales; Ms Ellis, the Labor member for Namadgi; Ms Macklin from Victoria, a Labor member; Mrs Vale from New South Wales, a Liberal member; Mr Allan Morris, the Labor member for Newcastle; Mrs Elizabeth Grace, a Liberal member from Brisbane, and we also have Mrs West, hiding over there in the corner, who is a Liberal member from Brisbane as well. We will have other members and senators coming to join us during the day, and I would like to welcome them.

At the end of the proceedings, we intend to write a summary report. We will then make recommendations and focus on where we can go as a nation to further stem the tide of the tragedy of youth suicide.

I must say in particular I am very honoured that the Prime Minister has been able to make time in his very busy program to come along to talk to us and to officially open this seminar on the topic of aspects of youth suicide. The Prime Minister, over his very long parliamentary career, has been a keen advocate of the family, and suicide is one of the tragedies confronting Australian families of today. In fact, the Prime Minister upon taking office was instrumental in changing the name of our committee from the community affairs committee to that of the family and community affairs committee. His government has done much to stem the tide of youth suicide and, by agreeing to open the proceedings this morning, the Prime Minister is demonstrating his personal concern. So, ladies and gentlemen, I would ask you to give a very warm welcome to the honourable the Prime Minister of Australia, John Howard.

Mr HOWARD—Thank you very much, Mr Peter Slipper. To my ministerial colleagues Senator Amanda Vanstone and Senator John Herron, Mr Speaker, my other parliamentary colleagues, and ladies and gentlemen, I want to congratulate the standing committee on its initiative in organising today's seminar. I am particularly pleased that the seminar takes place against a completely bipartisan background and involving, as it does, people from the Australian community who in different ways, and some in a very sad and tragic way, have been touched by youth suicide.

I have been a member of parliament now for almost 23 years, and I have interviewed thousands of constituents about literally hundreds, if not thousands, of different problems. And of all the interviews I have had, one that has lived with me for years, and I think always will, was an interview with a mother and a father of a young man who had taken his life in my electorate in Gladesville. There was a sense of bewilderment, sadness and despair, a questioning of the parenting skills and the way in which that young man had been brought up. There had been a desire on the part of those two very devoted parents who—according to all the criteria as they understood it, and I

must say on their explanation to me as I understood it—had done the right thing by their child but, despite all of that, he had taken his life.

It was certainly one of the most difficult and yet the most revealing of interviews that I have conducted as a member of parliament. And, as I say, I have remembered it. It brought home to me as directly as it could, as a local member of parliament, the tremendous social problem and the tremendous failure, I guess, that the high rate of youth suicide in Australia represents.

Now I do not pretend as leader of the government that we have all the magical solutions, and I am not coming here to say that what has been tried in the past was completely wrong and what we are going to try is completely right. It is not one of those issues. And I am sure that the committee in its treatment of it will understand that everybody, government and opposition members alike, approach this with a positive sense, and a sense of commitment and goodwill.

We have undertaken a number of commitments, as Peter mentioned: we have allocated some additional resources; we have put additional resources into a youth homelessness pilot project which seeks to address some of the problems of youth homelessness; we have different strategies in the area of youth unemployment; we have of course committed ourselves to an $18 million to $19 million program over a period of three years, and on top of that we have put some additional resources into parenting education. We have also tried to address in different ways the problems and challenges of domestic violence.

There are many tributaries, I suppose, to the problem. Family breakdown is obviously a huge part of it. If people feel that the environment in which they live has failed, that sense of failure can infect them. Mental health is clearly a key element in youth suicide. Youth unemployment is clearly a key element. I think too easy access to firearms in the past has made it easier for some people in a desperate state of mind to take their lives.

There would have to be a whole number of explanations as to why we should have, to our great shame, such a high youth suicide rate, particularly amongst young men. It really is quite extraordinary that, in a country in which in so many other ways we can say we are doing better than many others, in this area we are really demonstrably doing much worse.

As to the kind of approach that will be required to bring about an improvement, I think we have to be realistic in setting the goals. The goal can be to bring about an improvement. We are not going to get rid of it altogether. We are never going to be that successful, but it does involve pooling the resources of people involved and pooling the resources of the great private welfare sector of Australia, and those organisations are represented here today. It means pooling the experience of members of parliament from all parties who have dealt with this at a personal level; it means drawing on the experience of the medical profession and academics who have studied the patterns and the behaviour; it also means, of course, drawing on the very sad experiences of parents, siblings, friends

and associates who have lost loved ones through their own hands.

This is one of those social challenges that really is outside the normal constraints of government so far as the bottom line is concerned. That does not mean, of course, that in any area there is an unlimited source of money. But it is one of those things which marks the kind of society we are. If we have such a high youth suicide rate there must be something fundamentally wrong that we have to try and put right, and I believe that this seminar can make a contribution towards it. The people on the standing committee represent all parts of Australia. They represent people who understand, in different areas of society, the difficulties that are faced by these sorts of social problems. I know that all of them bring a sense of very strong personal commitment and a very strong sense of goodwill towards the committee's task.

Youth suicide is very much about the failure of our society to offer young people sufficient hope, because there is a sense of helplessness, a sense that there is little hope, a sense of despair and a sense that you are not useful—you feel alienated and you feel unwanted. I do not pretend to be anything other than an amateur psychologist. I do not pretend for a moment that I have anything other than an everyday understanding of human nature, but it does seem to me, and I leave this thought with you, that it is that sense of hopelessness and feeling of no self-worth which perhaps more than anything bring about the conditions of mind that lead to a person taking their life.

In a society which has so many young people who display such tremendous optimism and enthusiasm and hope about the future, it seems to all of us quite incomprehensible that—side by side with those people who look forward to the years ahead with boundless enthusiasm, a capacity almost to solve and conquer any problem, of the belief that the generation that has gone before them has forgotten more than they have ever learned, and that tremendous self-confidence that we encounter in so many young people in Australia which is so endearing and attractive—there should also be people who feel so out of it, so ignored and so deprived of participation in the life of the community that they should feel the pressure to take their own lives.

I hope today's seminar makes a contribution towards addressing some of those problems. I want to say on behalf of the government that we do regard this as a very important issue. It is an issue that we will treat in a completely non-political and completely bipartisan fashion. It is one of those issues that ought to sit astride party political differences. I know it has in the past, and I know that members of both the government and the opposition here today are determined that that will be the case now and into the future.

I want to join Peter Slipper in welcoming all of those people from the community who are here to share their experiences, to pool their information with others. I hope out of this seminar comes some very useful advice. I am here today to demonstrate my personal interest in this issue, the personal support I have for it, the commitment of the government, and I will be very interested to hear what comes out of it. I can promise you that it will be very conscientiously and very intensively addressed.

I have great pleasure in declaring the seminar open. I am sorry I cannot stay any longer. I have one or two other things to do today, including going back to Sydney for a few things. I do wish the seminar well; thank you very much for inviting me. I hope out of it comes a number of important initiatives which will in a practical way address a distressing mark against the good name, the compassion and the decency of Australian society. Thank you.

CHAIRMAN—Thank you very much, Prime Minister. As the Prime Minister said, he can be with us only for a short time.

Before I introduce Dr James Harrison, our first presenter, I thought I might outline the general proceedings for the day. Most of you should have a program. We will have each of our presenters speaking for 20 minutes. As when we speak in the Main Committee, the clocks will run. I would invite the presenters to bear in mind that we have a very tight time frame, and that the clocks here will show how many minutes they have left out of their 20. Following each presentation, we will have 25 minutes of questions. I would ask that, in the first instance, those who are members of our committee ask their questions. Then, in the afternoon, we will move to a general discussion of the issues and invite everyone here to participate.

Without further delay, though, I would like to invite Dr James Harrison to come forward. Dr Harrison has directed the National Injury Surveillance Unit of the Australian Institute of Health and Welfare since its formation in 1990. He is a clinical senior lecturer in the Department of Public Health at Flinders University and, before taking up his present position, he was a research medical officer at the National Institute for Occupational Health and Safety for several years. During that time he directed the first national study of work-related fatalities. Dr Harrison has published widely in occupational health and safety and public health, and he will be concentrating on the demographic picture of youth suicide. I would ask you to welcome Dr Harrison.

Dr HARRISON—Thank you, Mr Slipper. Mr Prime Minister, Speaker, Chairman, members and senators, ladies and gentlemen: I am delighted to be here. A meeting like this really signals the significance with which this issue is quite properly being regarded.

The job that I have been asked to do is to describe the demographic features, demographic aspects of youth suicide in Australia, time trends, international comparisons and so on. In many ways, mine is the easy job. This is the who, what, where. The difficult issues are the why and how to fix it, and the seminar as a whole is to deal with that.

Before I do start, though, I would like to raise the issue of, if you like, terms and definitions. The seminar is about youth suicide. I do think we need to keep in mind the question of what we mean by suicide. This may well come up in discussion later, and I do not want to labour it now. In the instance of a young person, or any person, who clearly deliberately plans their own self-destruction, undertakes that and leaves evidence that they intended to do so, there are no questions, we all understand what we are talking about.

But there is a much wider range of behaviours and circumstances that extend well

beyond that realm, that extend into cases where there is ambiguity about the intent involved in a person taking their own life, that extend into circumstances where the method leaves ambiguity as to their intent, that extend into circumstances where the co-involvement of alcohol or drugs may make it unclear whether the person was capable of intending to commit suicide.

Furthermore, an act that looks suicidal may have been undertaken without the intent to die, yet may be important nonetheless. An event may lead to death or may not lead to death. It may not even lead to injury, but may have put a person at great risk of being injured or dying. Such an event is equally important. It signals distress and is, indeed, one of the strongest predictors for later suicide.

Finally, there is a whole range of behaviours that we hear about that are very risky and that sometimes might look as if they are being undertaken with reckless indifference to outcome: newspaper stories about train surfing, goading police into high speed car chases, glue sniffing, and so on. These behaviours all form part of a realm which is much broader than those that I mentioned at the outset. We need to recognise that what we are dealing with here is, in some ways, the tip of the iceberg.

The following slides were then shown—

Dr HARRISON—To make the most of the time I have, I would like to move through some of the issues—some of which have been alluded to already—to try and set a scene. The first chart shows the total numbers of deaths that occurred in a range of ages—15 to 24 years—that we might regard as young people, as youth, in Australia in 1995, the most recent year for which we had data. Of the total deaths of young males at that age, one-quarter were attributed to suicide; for females, 17 per cent were attributed to suicide. That represents—to put it in terms that may be still more compelling—350 deaths of young men and 84 deaths of young women.

As I said, the deaths themselves are in some sense the tip of an iceberg. We do not have anywhere near such a good sense of the other parts of the iceberg. We do have some sense of those cases which resulted in hospital admission for apparently self-destructive or suicide attempting behaviour. Overall, there are about 10 times as many hospital admissions for this sort of problem as there are deaths—about five times as many for males and about 35 times as many for females.

You have probably by now all heard things about the dramatic rise in the reported rates of suicide for young males over about the last 30 years. In many ways, the information that is shown in the chart is the reason we are all here. It shows recorded suicide rates in Australia for the period from the early 1920s until the mid-1990s. Putting aside a dip during the Second World War which has probably complex explanations, we can see that, for young males, the rates were pretty constant for most of the century—at a little under 10 per 100,000 people of that age per year—until about 1960. Since about 1960 those rates for young males have roughly trebled.

I point out that in the last five or so years shown on the chart what seems to have been a steepening upward trend for 20 or 30 years seems to have tailed off. In many ways that is great; that is excellent news. One would certainly not want it to have continued upward. Whether, however, that turns out to be a step in a longer upward trend, a plateauing or the beginning of a downturn one cannot really say. One can make some guesses, and I am sure that there are some people here whose guesses would be more educated than mine. Nonetheless, it is important to note that there is evidence of at least a tailing off of the increase.

There is a sharply contrasting picture for females, with much less change in those rates. There are lower rates throughout and much less change. I note, however, that there was roughly a doubling of rates for young females between the rates in the 1950s and the rates we have seen more recently.

The next slide looks a bit muddier, but I am showing it because it further underscores the issue. The thinner lines that I have overlaid on the previous chart are figures for all ages, rather than just for the 15- to 24-year-old age group. The rise can be seen for the 15- to 24-year-olds, and the figures for males of all ages. We can see that for most of this century, rates at older ages were much higher than the rates reported for 15- to 24-year-old males. That is not so any more. The rates for 15- to 24-year-olds are now higher than those seen at older ages.

That rise has been going on for 30 years or so. The strong social interest in recognising that problem and trying to do something about it extends back nowhere near that far. There is a bit of a question, then, as to why that issue is now being looked at, if it could have been looked at earlier, and so on.

One of the reasons for putting up the next chart—in which in red I am showing death rates for young males, aged 15 to 24, for motor vehicle accidents and, in blue, the same line we saw in a previous chart, their suicide rates—is that in a sense there was something else going on in terms of major health problems in this age group for much of this century, apart from the period during and around the Second World War when petrol rationing was the main reason road deaths dropped. There was a largely uncontrolled epidemic of motor vehicle deaths for 50 years. Since 1970, there has been a dramatic improvement—and that just did not come about by chance. That is the second reason I put this chart up.

That turnaround in road injury was the outcome of a transformation in social approach to dealing with road injury, from a hand wringing, finger wagging mentality that was present in the 1950s and 1960s to a situation during the 1960s, and certainly by the late 1960s, where this problem was being recognised as a social problem, money was being put into it and there was systematic rigour being brought to its study and to the identification of interventions. The pay-off is evident.

In terms of the suicide problem, we are now somewhere close to the stage that motor vehicle injury was in about the late 1960s. There are now the signs of social commitment, of recognition that this is a major problem. There is investment of much more substantial resources into the area and there is the bringing to bear of a more rigorous and structured approach to trying to understand and prevent the problem.

To further underscore the transformation that has happened across age groups this century in terms of suicide, the next chart is a slightly different one with age groups across the bottom and rates up the side. I have charted the pictures that one would have seen at three periods this century—1930 is in red, 1960 in blue and 1990 in green. Traditionally it has been taught, stemming from work of Durkheim and others a century ago—and this is the century of the publication of one of Durkheim's major works—that suicide rates rose with age, particularly for males. The chart shows that was pretty much the case in Australia in 1930. By 1990, however, it is certainly not true. Suicide rates rise rapidly in adolescence and then there is not much change in the rest of life, though there are high rates in the very elderly. It is a dramatic difference.

Another point I would like to make here is that the change between 1930 and 1960 was largely in terms of reduction in rates for the older males—the middle aged and elderly. The change since 1960 is much more in the rise in rates for the young. Those figures have all been rates. Numbers of cases are, of course, important. The chart which shows numbers of suicides recorded for males and for females, by each single year of age, in 1995 is telling. It shows the predominance of suicide cases among young and early middle aged adult males. The age profile, of the concentration of the problem among the young, is also seen for people who are admitted to hospital after suicide related

behaviours. That chart shows the highest peaks in the 15- to 24-year group for females and similar heights for the next age group up.

Suicide and risk of suicide is not evenly spread through the community. I am showing slides that give a few little insights into some of the ways in which there are high and low risk groups. I would like to be able to show more. Many of the things that we know or strongly suspect are important risk factors for suicide are not well described, or not described at all, in the major information sources available to us. Some are, however.

We all know that Aboriginal health status is poorer than that of the general community in many respect. It is certainly very different from the experience of the general community, according to the available deaths data. The chart shows that the aboriginal suicide rates, which are in green, seem to be even more sharply concentrated among the young than is the case for the general community.

There are all sorts of questions about information reliability, such as the completeness of identification of Aboriginal people among the deaths. Nonetheless, this information—which is the best information of this sort available—is certainly indicative that rates of suicide amongst young Aborigines are, if anything, higher than in the general community. The problem is even more sharply restricted to young adults.

I would like to move now to the means by which people commit suicide. Some of these issues have sharp differences and variations in how these are distributed. Some of them have implications for prevention. The left two bars on the transparency are describing proportions of different methods of suicide among deaths. The right two bars are similarly describing proportions among hospital in-patient admissions for suicide related behaviours. In each case, males and females are described separately.

You can see that there are some differences among the deaths of the males and females, but there is a broad similarity, and likewise among the hospital in-patient cases. The biggest difference is that self-inflicted harm—following from poisoning with solids and liquids; that is, largely medications, drugs, heroin and so on—in the hospital in-patients forms a much bigger proportion of the total cases than among the deaths. To a large degree this is reflecting the lower lethality of that method. Of a certain number of people who overdose or take medications in large doses or poison themselves in other ways, a larger proportion survive than is the case for a similar number of people who turn a firearm upon themselves or hang themselves. Those methods—using firearms, hanging, carbon monoxide poisoning from motor vehicle exhausts—are highly lethal methods. Highly lethal methods, not surprisingly, make up a large proportion of the deaths.

That is the situation at one point in time. What has been happening over time, in terms of the use of those methods, is perhaps the second most dramatic point that I would make after the absolute rise in youth suicide is to be seen. This is for young males in Australia from 1979 to 1995. Looking at time trends and the rates of suicide using various methods, clearly the most dramatic thing is a roughly fivefold increase in the recorded rate of suicide by hanging in young males in Australia over that period. There was a very large jump in the mid-1980s, which a number of us are concerned may be reflecting something

other than a true rise in the rates, some change in the way things were being recorded. Certainly a steady upward trend before that and an even steeper upward trend more recently.

Conversely for firearms, there was a welcome downturn and some changes in other categories. There is another group, an unspecified group, which is a ragbag. Hidden in that are some still not huge but quite important rises in suicides by jumping in front of moving objects and jumping from high places.

I will finish by looking at a few aspects of the variation of suicide according to place. Here we can see rates of suicide, again for young males, in the most recent year in each of the states and territories of Australia. The rate for Australia is in the red line, and we can see there is some variation in rates. The short lines are intended to indicate the range over which one might expect these rates to vary year to year for reasons of chance. You can see that none of the states really differed by a great extent from the national average in that year. If one looked at the next year or an earlier year, one might just as well find the Northern Territory up near the Australian rate and, say, Tasmania a bit lower or a bit higher.

We do look, over time, at the state specific rates. We do see some evidence of state specific differences in this age group. For example, the Tasmanian rates have tended to be somewhat higher than the Australian rates. The numbers of cases in many of the jurisdictions are a bit small and there is a lot of variation from year to year.

Perhaps more interestingly, and this is something that has been given attention in a number of studies of youth suicide, there has been another way of looking at place. Here we distinguish people whose usual residence is in a capital city, another major urban centre, a rural city, the rural hinterland, a remote city or the remote hinterland. The pink shaded bars on the transparency represent the suicide rates in each of those types of areas for males of all ages, while the blue bars represent rates for males in the group we have been looking at—the 15- to 24-year-old group.

The obvious, dramatic thing is that in comparison with capital cities, where most of the population lives, there are markedly higher rates evident in the rural hinterland and the remote hinterland. I particularly emphasise the rural hinterland information. There are a lot of cases there. That is a large and important proportion of the total.

There are differences not only in the rates between these sorts of regions but in the mixture of methods that have been used to undertake suicide in these regions; that is, with the 15- to 24-year-old group. We can see there in the rural hinterland and the remote hinterland that firearms are a much more prominent means of suicide than they are in the capital city group, where self-poisoning is a more prominent method. However, I would emphasise that, in terms of total numbers of youth suicides by means of firearms, the number in the capital cities is about the same as the total of the number in the ‘Rural Other’ and ‘Remote Other’ groups, simply because many more people live in capital cities.

I will just finish this brief survey of looking at variations of suicide by place. There is a simple message to be taken from this. The point that I am wanting to make is that this is a chart of those figures that we often hear about of Australia's youth suicide rate in relation to suicide rates from other countries.

This is taken from an edition, not the most recent edition, but the one before last, of the World Health Organisation summary volume on this. It does not actually matter very much which recent edition it is from—I will mention the reasons in a minute—but on the left there are figures relating to males and on the right there are figures for females. This includes most of the countries that are reported in that publication, recognising that there are no figures for more than three-quarters of all the countries in the world published in that source. It is mainly European countries, North America, Australia and New Zealand and a couple of other countries that are reported.

For young adult males aged 15 to 24, we can see the Australian figure up there. It is certainly not the highest reported at that time. I think the important issue is that it is in the upper third or in the upper quarter of the figures. It is in the upper group. Females are not ranked quite so high amongst the reported countries, but they are certainly nowhere near the lowest, which is what I think we perhaps ought to be looking at as a benchmark.

I have compared these figures with the figures from the most recently published edition. Australia's ranking in terms of youth suicide is perhaps one or two notches down in the most recent one, and the females are actually somewhat further down. These figures, as indicated by these bars, can be expected to vary a lot from year to year. The fundamental message is that rates are pretty high in Australia. They are much higher than we would like them to be for those young adult males. That is where I would like to leave it. Thank you for your attention. I look forward to a very interesting and successful meeting.

CHAIRMAN—I would just like to thank the Prime Minister for attending this morning. Regrettably, he must leave. Thank you very much, Dr Harrison. The way we will probably handle this is that initially members of the committee will ask questions during the 25-minute segment, because the purpose of the seminar is to enable us to produce a summary and make recommendations. Then this afternoon we will have a more general discussion.

I have a couple of questions of Dr Harrison. I could not quite see how Australia compared with other countries, particularly in relation to rural deaths. So my question of Dr Harrison is: how does Australia's loss of rural and regional youth compare with the loss of rural and regional youth in other countries of similar size, for example, the United States and Canada?

Dr HARRISON—It may be that one of the other speakers has more information on this than I do. While there is some evidence of rates being higher in rural and remote areas in some other comparable countries, as to the absolute comparisons of the degree of excess that is evident for Australia's rural youth compared with the degree of excess that is evident in some other countries, I am afraid I do not have that in mind. I do not recall

having seen that comparison done in the literature.

CHAIRMAN—There is a very substantial number of people who attempt to commit suicide, and a relatively smaller number of people who complete suicide. What proportion of those who attempt suicide are seeking to end their lives as opposed to drawing attention to themselves or asking for help, and so on?

Dr HARRISON—I am going to have to be a bit evasive on that. There is quite an important problem in this whole area of, if you like, suicidology or suicide study about nomenclature and about using terms in a way that is sufficiently precise so that those sorts of comparisons can be derived. Indeed, this is something that is being recognised by the international community. A substantial proposal has recently been published on a more rigorous form of nomenclature in the area that would help us to distinguish these important and importantly different categories in a better way than we can now. In a sense, it is difficult to draw those sorts of conclusions from literature where people may well have meant rather different things or, effectively, used rather different criteria to distinguish these groups.

I would also emphasise that a conscious intent to result in self-annihilation, self-destruction, while clearly an important issue, is not the only important issue. The sorts of pressures or tensions or circumstances that drive people to want to look as if they are trying to self-annihilate are as important in their own way. I think it may be that Professor Kosky would have some more specific information on that.

CHAIRMAN—The last question I have before I invite questions from other members of the committee is that obviously over the last 15 years the level of youth suicide in this country has gone up dramatically until we are, if not at the top, certainly well up towards the top of the industrialised countries. What circumstances have existed in Australia that perhaps do not exist in other countries which have propelled us up towards the top of this terrible table?

Dr HARRISON—There is something that I did not really describe, through limits of time. Australia is really not alone in that trajectory—in having had that rise in youth suicide rates. There are quite a number of other countries, and, in particular, a group of countries that in many ways are quite similar to Australia—New Zealand, Canada, the United States—which, in the postwar period have seen rises in youth suicide rates of similar magnitude. There are other countries where a similar rise has not been reported. So the question perhaps is a bit more broad. It can be framed as: what is it that the group of countries in which this phenomenon has been seen might have in common?

The observation has been made by a couple of people that very prominent among the group of countries that have seen this change are the New World English-speaking countries. They are not the only countries that have seen this change, but they are prominent amongst them. A rise has been seen, let us say, in Scotland, England and Wales and Northern Ireland, but not to anywhere near the same extent. In trying to find an understanding or the origin of your question, I think it is important not to look exclusively for phenomena that are specific to Australia. I think we do need to look more generally at

that.

CHAIRMAN—Mr Quick, do you have a question?

Mr QUICK—Dr Harrison, we have seen a huge number of people being hospitalised and a small proportion of people committing suicide and actually being successful. Could you comment on the statistical links between hospital admission and the recurrence of attempted suicide and the potential success at suicide at the later stage?

Dr HARRISON—The recurrence of suicide is strong. A past history of attempted suicide or suicidal behaviour is one of the strongest known predictors. There are different estimates from different studies, but it could be 10 times or 30 times. The likelihood of people who have attempted suicide once going on to later attempts and successful attempts is in that order of excess risk.

Mr QUICK—Linked to that is my last question. We often hear talk in the media about suicide clustering. Have any studies been done into that to see whether it is a furphy or an urban myth or whether it actually occurs—especially in the case of young people, with peer pressure now being enormous?

Dr HARRISON—There have been quite a number of studies. Certainly, in the case of the ones that I am aware of, the results have been some this way and some that way in terms of the strength of them. On balance my sense says that there is something in it, but that it may be in particular circumstances, in particular settings and for particular groups that that is a more important consideration. Again, I suspect that that may be something that Bob Kosky might be looking into; I do not know.

CHAIRMAN—We will now have questions from Ms Ellis, Mr Cameron, Ms Macklin, Mrs West, Mr Morris and Dr Nelson in that order. Ms Ellis?

Ms ELLIS—Dr Harrison, have there been any studies on, or considerations of, those people who may have had a history of diagnosed mental illness who subsequently commit suicide, in terms of trying to define the reasons that may have led them down that path? I do not wish to separate them out from the general statistic, but it would seem to me that sometimes those people are far more easily identifiable for a possible course of reason than those who have no mental illness, therefore leaving a puzzle as to why they may have done it. Have there been any studies down that track?

Dr HARRISON—Yes. In some ways it is a difficult area. The first thing is that there is an emerging literature in other countries, and more recently in Australia, about the general community's mental state. What emerges from that is that there is really quite a high proportion of young people—we are talking about today—who could attract a diagnosis if they were looked at.

Ms ELLIS—Yes, certainly.

Dr HARRISON—In most of these studies the majority of those people who could

attract a psychiatric diagnosis of one sort or another do not; they have never been treated, they have never come to notice or had a diagnosis ascribed to them. It is only a tiny proportion of those people who do go on to commit suicide. However, the likelihood of those people going on to commit suicide is higher than it is for the general community. That heightened ratio is even larger—or is at least as high, I should say; I cannot distinguish that—for those who have had a psychiatric diagnosis, a history of certain psychiatric diagnoses. Again, I would defer to Professor Kosky, a professor of psychiatry. Those who have had certain psychiatric diagnoses do have quite markedly heightened risks of suicide.

The catch in using that information for prevention is that there is such a large fraction of the community—so many people—who can attract these various diagnoses, that to regard them all as, if you like, potential suicides and therefore the target for specific suicide interventions is a very big ask.

Mr ROSS CAMERON—In the demographic analysis you looked at age, gender and place. I have two questions. Firstly, are there any correlations between the rate of suicide and, say, ethnicity, religious affiliation and economic circumstances? Secondly, I understood from what you said that statistics were available for the more developed nations; is there a correlation between the rate of suicide and the level of economic development?

Dr HARRISON—The answer is yes, yes and yes, I think, to the three indicators that you raised. There is a large number of social and demographic factors that I simply did not have time to point to. For example, there is quite a strong relationship with marital status, in that those who are currently married have the lowest rates, those who are divorced or separated have the highest rates, and those who never married are in between. In regard to unemployment, there is considerable evidence—much more strongly affecting males than females. As to socioeconomic status, it is generally the case that the higher the socioeconomic status, the lower the suicide rate. There is not a hugely strong slope in the Australian data. There is a long history on religious affiliation; I will not go into it, but that has been looked at for a hundred years. Relating that question to the one of international comparisons that you asked about, in general—certainly among the European countries—there are much, much lower rates reported among the predominantly southern European and predominantly Catholic or orthodox countries than in the northern European, predominantly Protestant countries, and much has been made of that over time.

In terms of international comparisons, amongst the reported rates, the highest rates are in the former USSR and satellite countries and adjacent countries—Finland, for example. Among the reported rates, those countries have the highest rates—certainly for males. To what extent that is to do with economic circumstances and to what extent it is to do with other factors is a little difficult to say.

The highest reported rates for females are actually in predominantly Chinese countries. There is some data for selected non-urban Chinese areas, which have the highest rates for females. Female rates in Singapore are high. In fact, it is really only among the predominantly Chinese cultures that female rates tend to be higher than male rates.

CHAIRMAN—Ms Macklin?

Ms MACKLIN—You talked about family status from the point of view of being married or not married, but given that most young people are not married what can you tell us about their particular family circumstances?

Dr HARRISON—That is a good question; I do not think I have got something to offer on that in terms of Australian data. Are you suggesting whether there is a difference if they are still living with their family or living apart, and so on?

Ms MACKLIN—Yes.

Dr HARRISON—I do not have something on that. A lot of the things that we can talk about or can't talk about in the sorts of studies that I am describing depend utterly on whether certain bits of information are or are not recorded in things like the routine deaths data. And that sort of information, along with many other issues, is not. I will just put in a plug here by saying that to be able to look at things like that we do depend on better information sources. A lot of that sort of information is recorded by coroners, who look at most of these cases. But the information recorded by coroners is difficult to get at; it tends not to have been computerised and not in a systematic manner. There are some efforts at specific state levels and there are efforts at the national level at the moment involving all the coroners to try and put together a national comprehensive collection of information from coroner records. And special attention is being given right now to the development of the part of that data set that would give information relevant to suicide. Many of these issues will be covered by that.

Ms MACKLIN—Do you have any further information on employment status?

Mr HARRISON—On employment status? The most recent study, in fact by Colin Mathers, looked at the young adult males. He found that suicide rates were significantly lower than average among those who were designated as students, and a little bit higher, but not significantly so, in those who were recorded as unemployed or other, but the numbers were such that he could not disaggregate it further for males.

CHAIRMAN—Mrs West.

Mrs WEST—Your statistics are based on recognised and identifiable suicide. Could there be a hidden element where people do not want to identify their death or the death of their child as suicide?

Dr HARRISON—Yes, there could be. The question of the reliability of suicide statistics and, more so, of the statistics on non-fatal suicide is a major sub-theme in the area. I think that, in summary, the consensus from the literature is that suicide mortality statistics are probably reliable enough so that these very big transformations that we are seeing over time are probably not due simply to a changing willingness to identify either on the part of, let us say, the near and dear or on the part of officials who are gatekeepers to the information.

It is not an entirely resolved question. It is still legitimate to ask to what extent the dramatic rise in youth male suicide in Australia could be attributable to an increasing willingness to so identify. Two points there: even if it is the case, there is very little evidence that there is over-ascertainment, so that the current recent rates are certainly not going to be any lower than what we are seeing.

Mrs WEST—No, but they could be higher.

Dr HARRISON—The second question is about whether the historical ones might have been a bit higher than they are looking now. I think there would be value in looking again at that. There are things like this coronial information system which will give a better insight into that sort of thing. But my personal hunch is that that is probably not a dramatic thing for the deaths data.

However, for hospitals separations data, it is an entirely different picture. There were a couple of slides that I would have shown, had I had a little bit more time. I will describe them now. In a recent year of hospital separations data, looking at the group that could be called suicide or attempted suicide, in one state there was an apparent rate for young adults twice as high as the national average, or for a cluster of other states.

A little more excavation in the data finds that, as I showed you, most of the hospital admissions for suicide related behaviours involve overdoses or drugs and medications. There is another part of the coding classification, called accidental poisoning, where you can put cases from poisoning. We looked at that part of the classification for this same state; there are almost no cases there in that state. If you add the two parts of the classification together, that one state's figures were the same as the Australian rates in all others.

As far as I can tell from talking to the people involved, that related essentially to a subtle difference to do with terms and definitions, getting back to that issue I was harping on before. In that state, the process was that whenever somebody had taken an overdose, the question that was being asked was did they intend to take the medication, or the drug, or inject the heroin. If the answer was yes, they intended to do that, we will call it a self-inflicted injury and we will put it in with the suicide ones.

In all of the other states, the approach was to say, well yes, a person has had an overdose, but did they intend to kill themselves, or did they intend to do themselves harm, and to allocate them to accidental or suicide on that basis. Simply on that difference of definition, there was an apparent twofold difference between one state's rate and another state's rate. There are very important issues there in ways in which the data can be misleading.

CHAIRMAN—Mr Morris.

Mr ALLAN MORRIS—Dr Harrison, firstly thank you for being illuminating, but I want you to break those figures down some more for us and perhaps you might be able to in material provided later. I say that for a couple of reasons. Looking at those figures

with, say, Aboriginal and non-Aboriginal, remote, non-remote and city, there is a perception—and I want you to comment and see if it is reinforced by your knowledge—that young Aboriginals that are in rural properties and so on have a lower rate than young Aboriginals in metropolitan urban settings. On the other hand, rates for young men with sexual difficulties—homosexual and the like—are much higher in isolated communities than they are in metropolitan communities.

In effect, your figures do not reflect either of those kinds of parameters and therefore they could give a false impression of the kinds of forces that are at work. The same thing may well apply to employment and homelessness. I think that was the question that Ms Macklin asked.

Are those kinds of thoughts echoed in your experiences or your knowledge? Secondly, do you have any further breakdowns that may be available for us to read, rather than necessarily for presentation. That may help us to focus in on those kinds of forces which we are told are at work but which we often find hard to substantiate.

Dr HARRISON—It is difficult, when doing an overview, to get into all of the specific areas. I think there are several themes, of which you have raised some that are both needing research and on which some research has been done. For example in terms of the interactions going on within the Aboriginal community, I think we have learnt a lot from the work of Ernest Hunter, who has looked at transformations in communities as various disrupting forces take effect. He was focusing principally on the Kimberley region—and I am hugely oversimplifying a very rich body of research.

In a sense, he was describing a pattern following a significant disruption, namely being shifted off the pastoral properties to fringe townships. In the first generation that had already achieved adulthood by the time it happened, there was evidence of increasing violence but it was essentially interpersonal violence. A generation later, the generation that were being born into the disrupted communities were turning violence on themselves to a larger extent. There are bodies of research looking at that sort of thing. The issue of sexuality, particularly the intersection of sexuality and Aboriginality, is not something that I know about. I do not know of literature on that. There may be literature but I do not know it.

Dr NELSON—In terms of the international comparisons, I presume that the 1992 figures you put up were for completed suicides. Is there any international comparative data for attempts as well as for completed suicides? Does Australia, for example, as a proportion of total attempts, have a higher completion rate? I also understand there was a bimodal distribution in terms of youth suicide. Whilst many were socially insular and antisocial young people who were not a part of any group, more or less, there was also—and I represent an area where we have a fair bit of this sort of phenomenon—the school prefect, the high achiever, who gets a TER of 90 and thinks that he has failed. Could you just address those two things for me?

Dr HARRISON—The first more than the second. I am not so familiar with the literature with the second. The international comparisons are tough enough with the

mortality data. I think that there is a substantial body of literature where people have been trying to study comparability of international literature on that area. There was a massive series of studies done in the Nordic countries, going into excruciating detail, so that people could feel confident that the apparent differences between Norway and Sweden or Norway and Denmark were real differences of behaviour and not just statistical artefacts. They concluded that they were real differences in the mortality data. Even there they were finding that that was as far they could go. The uncertainties about administrative differences—who goes to hospitals rather than not going to hospitals; how things are counted—were so big they were feeling much less confident about their ability to draw meaningful conclusions from hospital separations data.

That has been found here. Tony Davis and Bob Kosky have published a paper looking at comparisons between Adelaide and Perth, finding in an Adelaide hospital dramatic differences in apparent attempted suicide relating to an administrative change. With Tony Davis, Bob Kosky has published a paper looking at comparisons between Adelaide and Perth, finding in an Adelaide hospital dramatic differences in apparent attempted suicide relating to an administrative change. It really is tough going beyond the deaths for those international comparisons without getting completely overwhelmed by the problem of comparability.

Mrs VALE—I am particularly interested in the statistical analysis that you had regarding the increase of suicides on your time lines since 1921. I particularly notice the rise that began in the 1960s. Is there any correlation, do you think? Has there been any research done on the increasing prevalence of drugs, especially marijuana, in our culture from that time? I say this because I left school in 1960 and at that time there was certainly no availability of drugs in my school, yet for my brothers and sisters who came through after me there was certainly an increase. Drugs were becoming accessible, marijuana specifically. Would you have any comment on that?

Dr HARRISON—As to the long-term time trends, I do not have specific things to contribute. What I can say is that the drug that is found most frequently and most prominently at post-mortem of people who have committed suicide is alcohol, far and away, even in the young groups. Yes, there are other drugs found. But even in the case of those who have also overdosed on something like heroin, alcohol is the biggie.

Mrs VALE—Has there been any research done in regard to that? Has there been any history of, say, taking marijuana in the victim? Do you inquire further back?

Dr HARRISON—Yes, there is. I am not sure how much Australian literature there is, but internationally there is certainly literature showing that a history of non-therapeutic use of drugs and so on is one of the risk factors. It is not as strong generally as a history of previous attempted suicide or in-patient psychiatric care and so on, but it is one of the substantial risk factors that is in the literature.

Mrs VALE—There is certainly a decline in the suicide rates during what seemed to be the war years. Do you have comment on that?

Dr HARRISON—I do. It was a much more dramatic decline. It was a very dramatic decline for men just a little bit older than the group I was charting today, for men between about 20 and 60—the age group that were mostly involved as combatants. There are two elements of the explanation, and their relative weights is something that I do not know and I would like to find out. One is a statistical artefact, and that is that the population figures on which the rates were based were based on census figures that assumed that no soldiers went overseas to fight. They were not deducted, if you like, from the population estimates during that period, and I have not yet laid my hands on good figures to enable me to do corrections for that.

The other side of that problem is that deaths that occurred to those men while they were overseas, whether the deaths were in the course of combat or from suicide or anything else, were never registered, were never recorded, in the Australian figures during that period from September 1939 until mid-1947. That is one potential component.

The other component is something that has been reported in the literature very widely. The conventional wisdom widely reported and found in many places is that suicide rates tend to decline during periods of conflict. The sociological explanations advanced are along the lines of the tribe all pulling together against the external threat and reasons to live to do with that. That certainly has been reported in many but not all settings. I think the issue of the role of war is probably a bit more complex.

I just noticed in passing, in looking at the most recent edition of the WHO summary of statistics, that they had included data for a series of years for Croatia, including the period of the recent war in Croatia. In fact, the suicide rates for young males rose during the period of conflict there. Whether that is something to do—assuming it is not an artefact—with the type of war, being an internal rending of the fabric of society war rather than a going overseas to fight war or somebody invading country type war, I do not know. But those are the two broad explanations.

CHAIRMAN—Thank you very much for that.

Short adjournment

CHAIRMAN—Our next speaker is Associate Professor Pierre Baume, who is from Queensland, where he has been for eight years at Griffith University. Professor Baume is associate professor at that university and was appointed Foundation Director of the Australian Institute for Suicide Research and Prevention in August 1995. The institute is based at the Belmont Hospital in Brisbane and began operations in January 1996.

Pierre Baume was previously Chairman of the National Health and Medical Research Council Suicide Prevention Committee, a position which he held from 1992 to 1995. He represented Australia at the United Nations in 1993 to develop a charter for suicide prevention. He previously held the position of Dean of the Faculty of Nursing and Health Services at Griffith University from 1989 to 1995.

Professor Baume has had hands-on experience in dealing with people who are

bereaved as a result of youth suicide and in fact he is the coordinator of the Brisbane Bereaved by Suicide Support Group. As one would expect, he is someone who has spoken widely and written widely. He is the author of a number of articles. He focuses his research in the area of suicide prevention and postvention with an emphasis on the bereaved by suicide.

Professor Baume has received a number of ministerial appointments at state and federal level and is therefore clearly recognised as one of our nation's greatest experts in this tragic field. I now invite Professor Baume to come forward to deliver his presentation. Ladies and gentlemen, please welcome Professor Baume.

Prof. BAUME—Thank you very much for giving me the opportunity to talk with you today. I am going to actually start by keeping you in the dark as much as I can!

The following slides were then shown—

Prof. BAUME—One of the issues will be picked up by Professor Kosky. I noticed this morning everybody is referring back to him. It is always good to have somebody behind you in case you cannot respond to any of the questions, and then hopefully the next speaker will be able to do that.

The quote from Voltaire which says that the man who in a fit of melancholy kills himself today would have wished to have lived had he waited a week, probably reflects more in this case the impulsivity and impulsiveness of issues that relate to young people specifically as opposed to what we might find in more adult populations. I will come back to this issue later on.

Dr Harrison gave us this morning a very brief overview of statistics, and I am going to do an even briefer approach to this because it is actually congruent with the issues that I want to raise in terms of social and cultural factors affecting suicide rates. First of all, I want to stress here that in terms of overall suicide rates if we take a picture for 100 years or so the rates are approximately the same as they were 100 years ago for the total population. For males and females, the ratio is about 4:1, and, as you can see from this slide, at the end of the last century it was approximately what it is today.

The next slide shows a different picture—to some extent one that was shown by Dr Harrison, but in here I want to actually pick up a couple of issues because I will refer back to this graph later on in my talk about cultural factors. This one refers more to the rise in suicide in the 1960s, and I think a member actually mentioned this issue earlier.

That was primarily associated with the amount of barbiturate prescriptions that were handed out to young people, and older people as well. We know that a significant proportion of the suicides at that particular time related to this problem. So it was not illicit drugs; it was specifically prescription drugs. When we introduced safer prescription drugs in terms of benzodiazepams like valium and so forth the rates as a consequence of barbiturates which were subsequently reduced in terms of prescription reduced significantly. Then we saw a rise again in males but a continued decline in female rates.

I will come back to this issue, as I said, in a moment. We have seen a continuous rise in young male suicide versus female, so much so that now the ratio is about 7:1 for young male suicide versus young female suicide, and there is an issue here in terms of gender in terms of cultural and social factors too.

In terms of international comparison, I know this is not very clearly in focus but the white column here represents Australia. It was mentioned this morning that eastern European countries like Russia and Slovenia and so forth have much higher rates than Australia in terms of young people's suicide. You will notice that on the right-hand side there is also another country which is much closer to us, and that is New Zealand. The suicide rate in that country is significantly higher in young males than it is in Australia—although, for those of you who may be interested in interstate comparison, the New Zealand rate of suicide in young males is about the same as it is in Queensland.

It is not because I am actually based in Queensland at the moment that I am somehow biased but that Queensland has demonstrated, for example, rates significantly above the national average, sometimes up to 40 per cent above the national average since the early 1970s. I think it is also very significant for us to comprehend why there are some state variations. Someone this morning asked whether there are significant differences in cultures between countries and maybe we need to look at how cultures and integration of culture and migration in Australia may have influenced our rates.

I would like also to point out to you here a number of countries that are on the left side of this graph, which are Greece, Portugal, Italy and Spain, which are more southern European countries. You will notice that their relations rate is significantly lower than that of Australia for that age group. Once again, I will come back to this, and I would like you to remember these countries later on when we talk about social and cultural factors and migration issues.

One other suggestion which has been put forward by a number of people when I show this slide is that perhaps one of the things we should be doing in Australia is actually increasing migration from countries of this nature—Greece, Portugal and Italy—so that it would actually reduce our suicide rate in young people.

I am not wishing to specifically comment on the issue of migration, but you will also note that in states of Australia where there is a higher migration from those countries—that is, primarily the southern states of Australia—the rates of suicide are significantly lower than in states where the migration from these countries is lower, namely, Queensland and Tasmania.

As was stated also, the issue of culture and Aboriginality is a factor and we know that Aboriginal suicides—from those that we were able to collect—are significantly high, especially in young male populations.

We also talked briefly this morning about rural versus metropolitan areas, and I want to stress here that in terms of these rates we have seen a significant shift in the last 15 years in that young age group in small towns, specifically in much smaller towns like those with fewer than 4,000 people. This has been a gradual shift that has been seen across the country and there are some pockets where obviously the rates are smaller.

But I also want to stress in these two following slides that the difference also lies in terms of age groups. When we look at ages 15 to 24 I do not think we should jump to conclusions, especially when we look at prevention issues, that this is a homogenous group because we know that a 15-year-old is significantly different from a 24- or 25-year-old and that there are many factors that contribute to their behaviour and/or may be able to assist them in terms of prevention.

In terms of rural suicide, what we have noted in fact is that the significant rise was in the 15- to 19-year age group, and you can see that here we have got rates of nearly 50 per 100,000 which is significantly above the national average. When we look at the next slide and the 20 to 24 years age group we are looking at rates of nearly 70 per 100,000 in

metropolitan areas. So you can see from those two different age groups that they are different issues and that the problems may be different and in different spots across Australia.

The issue of method was also raised. We now know that hanging, followed by carbon monoxide poisoning and then a much lower rate of firearms in third place are now contributing to the majority of all suicide. We also know that selection of method differs from different places and we know that in country areas suicide by firearms is much more significant, especially in rural Queensland, than it is in the rest of Australia.

The factor of causes of suicide obviously is something that we want to discuss today, but I think we also need to think about what it means when we talk about causes. Perhaps what we imagine or what we assume is that we are going to find a single factor. However, here in terms of suicide and trying to define what we mean by suicide, we need to see it as a behavioural outcome. It is not an illness, and it is a process by which we have social, physiological, neurobiological, cultural and other factors that will contribute to produce an end result.

These contributing factors carry very unequal weights and none of them, or no single one of them, has been demonstrated to be necessary or sufficient to cause suicide. I think this is an issue which I would like to stress personally, and this is reflected in international literature.

So it is very much a multifactoral process and there are a number of factors, one of which is mental illness which will be specifically described by Professor Kosky in a moment, but there are also individual predisposing factors and social factors that we are now going to briefly look at.

Those risk factors also need to be comprehended in the total picture of suicide, and one which should also be included is the after-effect of suicide, because the number of people that kill themselves is high and we should be concerned with that, but the numbers of people who are left behind in the aftermath of suicide are significantly higher. It has been estimated to be 10 to 12 times higher in terms of individuals that are closely affiliated with the death of that person, and as yet we have little data in Australia about the effect of that type of death.

In terms of international data, we know that increased guilt, responsibility and shame and stigma are significant, and we also know from a number of studies that where suicide does occur in a family the subsequent possibilities of another suicide occurring may arise at anything between 10 to 20 times higher than in normal populations. So those families are of concern and once a suicide has occurred there may be a much higher risk than in any other families.

But we also need to see this in terms of, in this topic we are discussing today, the social context. That is, we have noticed certainly for young people and in areas where there is a lot of conflict that there is an increased level of stress—that sometimes there are reduced abilities for some individuals or a group to cope with social adversities, and that

for many, especially in rural areas or even in low SES situations, there is a weakening of networks of interpersonal support, especially when there is family breakdown or when there is youth homelessness and so forth.

There may be also interference in terms of health seeking behaviour or delivery of services, as we know. In terms of rural situations there may be limitations and difficulties in terms of accessing young people—young males especially. We also know, in a very ad hoc way actually, that even though many adults will see a GP or some form of specialist some time at least a month or two before they die, this is not always the case with young males. We know from our own data where we have just studied about 4,000 cases that very few of these actually ever consulted anybody prior to their death.

So I think this is very significant because when you deliver services you have to make an assumption, of course, that those people are accessing those services and therefore that you can make a difference, but if they are not accessing the services and/or the individual professional then it is very difficult for that professional to intervene.

The other factors are also global. In terms of the international literature, this is what we can summarise. In countries where we have compared more recent contributory data with older data, we have seen that in areas where there are high rates of suicide there is also an association of increased divorce rate, there are lower populations under 15, there is higher unemployment, there is high female employment and there is an extremely high increase of alcohol consumption, which was mentioned by Dr Harrison this morning and I need to stress again. The issues of unwanted pregnancies is a factor and, of course, the issue of religion that was mentioned this morning.

This is not necessarily specific to maybe states or regions but overall in the countries that have been studied it appears that religious activities and a decrease of religious activities by younger people may have led to different moral values and also a perceived social disintegration whereby in the past churches or religious activities may have provided some form of social havens. But there is also an increased permissiveness towards suicide and that suicide may be an acceptable way out. Certainly, in the young population that may be the case.

There is also a demonstrated increase in substance use and abuse. Here I would like to focus, specifically, on legal substances as opposed to illicit substances, and I would be quite happy to take questions on that later on. But there are also issues of access to lethal means. We know that there is a strong relationship when a young person who is impulsive who may be abusing alcohol and who may have suffered a significant loss has access to a lethal mean like a firearm. Because of the impulsiveness and the lack of, I suppose, ability for us to intervene at that point, the person's risk to die is significantly increased.

In terms of families specifically, there have been international studies that show that there have been some changes in terms of composition of those families where suicides have occurred, but often there has been a death several months or maybe a year before the suicide takes place.

There has also been a significant increase in separation and divorce but here I think we need to see it in terms of a loss and a perceived loss of that young person of an appropriate form of attachment and also support. And there are other types of losses: people who move away from the traditional family home, and I refer here to young people in rural Australia where older brothers and sisters may move away to the city to study in universities and they are leaving their younger brothers and sisters at home. And they may well have been the only individuals who provided the kind of support for that young person.

The issue of violence, especially sexual and physical abuse, is noted in sometimes up to 50 per cent of cases of suicide attempts, where those individuals have had previous abuse of some form. Admittedly, this is an issue that you will find in mental illness too but there is a significant proportion of individuals who present with mental illness and depression who have had a history of physical and sexual abuse.

Family discord is reported in many situations in a study that we have just completed in Queensland. We have noted that in comparing families where a suicide has occurred as opposed to other forms of death up to 70 per cent of the families where the suicide occurred have some family conflict and a lot of interpersonal problems between the young person and a parent or guardian, which leads to significant—or less—cohesiveness and support within the family. Once again, we also note that mental illness in those families tends to be far more common than in the broader population.

In terms of stressful life events, although there are studies that seem to balance each other out, I think it is fair to say that when you start to research literature you find that there are some studies that support that point while others actually do not support it.

The issue of previous attempt is a major factor and so are major life events such as a loss and conflict with parents. The next one I want to stress is that of loss of boyfriend or girlfriend. In a study we have just completed in Queensland of 4,000 cases we found that in nearly 65 per cent of all those cases a significant loss or break-up in a relationship occurred within one month of a death. So it appears that loss and the inability to be supported and or to cope with that type of situation may be a factor. Loss of a parent either through divorce or some other form of loss is significant, and changes in school or moving from one school to another may be another stressful factor.

The other issue of social support and isolation is important. It appears that those individuals who tend to be more isolated are at greater risk. At the same time we have studies that demonstrate quite clearly that sometimes even high social support may not necessarily be a protector but, in the main, social support is seen to be a significant protector, especially for those individuals that have already been diagnosed with some form of mental illness.

The next one is that of social skill. In populations of those who attempt or engage in suicidal behaviour and from the data that we have on those who complete suicide there is a demonstration of some impaired social skills. Obviously, there are always exceptions to this rule but in general it appears more frequently in this population, and they have a

tendency to have difficulty with peer relationship and interaction and also, with some of these individuals, especially those who attempt, this seems to go on for a long period of time.

The issue also of exploring whether those young people have less ability to solve specific, difficult problems appears to be significant in some studies, where those individuals show a deficiency in coping styles but generally their problem solving skills are poor. But once again it cannot always be generalised to every person.

The issue of culture is a factor which has been observed, although we still have some lack of information in these areas, especially in terms of having noted that Western nations, those that are more wealthy, actually have seen an increase in suicide rates while the others have either kept a similar rate or their rates have gone down. We know in terms of Aboriginality that social alienation and anomie that take place in Aboriginal communities are significant.

In terms of employment and income, this is another factor that is interesting. There is some positive correlation here with unemployment but, at best, it is probably said to be quite weak. And even though there is high unemployment in young people, I think what we found is that in countries where there is high unemployment and high median income such as Australia we have higher rates of suicide. We can observe that there are more people who are unemployed who attempt and complete suicide, and there is a high correlation between countries with high GDPs and high suicide rates. But overall, I think it is fair to say that these are mixed results and that the correlation with unemployment specifically is very weak and that we need to have a look at other correlations—especially when you have mental illness and lack of social support as well as unemployment it becomes a significant factor.

Finally, I just want to stress an Australian study that was untaken in Western Australia that shows quite clearly here that in terms of a risk factor previous attempt is much stronger, followed by heavy drinking, followed by depression—and unemployment is very weak.

And in terms of contagion and imitation, which is an important factor, we know that direct exposure, person to person, that is, when a suicide occurs in a family or in a school system or the rates seem so to be associated with an increase following that exposure. It is similar in terms of the media and the discussion of suicide in a public space. Even when methods are not selected, it appears that the more you raise suicide in a public forum the more likely you are to see suicide rates go up, especially in the young population.

To summarise, there are a number of issues that we can discuss under social and cultural factors, but I think it is fair to say that these should not ever be seen in total isolation, that we need to see the whole picture of suicide: intent, risk factors, suicidal behaviours in general and if the presence of matter on this actually contributes to some of these very important social characteristics. Thank you very much.

CHAIRMAN—Thank you. Professor Baume has outlined very clearly a lot of the causes of youth suicide. Professor, could you tell us what we should do about it?

Prof. BAUME—I will have to say we should do something about it. I think it is fair to say that when you are dealing with such a complex phenomenon the answers are likely to be just as complex, and that maybe we should not try to simplify our suicide prevention strategies too much. Certainly, when we look at issues like what I have just presented, and what Professor Kosky will present in a moment, it is quite clear that what we may not have done well so far is to try to put everything together and to actually have some kind of vision that brings you forward, that is, to monitor what it is that we do about suicide prevention and to try to be as effective and as efficient as possible to try to reduce the rates. It may not necessarily be that we should spend lots and lots of money. It may well be that what we need to do is to be more informed about what is going on specifically in this country as opposed to relying heavily on international data, which at times is useful but at times may be misleading because we know that there are some specific social characteristics that are unique to this country, and therefore our approach ought to be unique but at the same time we can be guided by studies that have been done overseas. The message I would like to put forward is that we need a unified approach to suicide prevention and not a piecemeal, ad hoc approach which we have tended to have in the past.

CHAIRMAN—Thank you. One of our colleagues, who is not a member of the committee, Ms Gambaro, had a question. As she is not allowed to ask it, I am going to ask it on her behalf. The Internet, of course, is becoming increasingly used by young people and a lot of people will 'often chat' to people in other parts of the world. To what extent would young people planning suicide get some ideas about suicide from the Internet and to what extent would they 'talk' to other young people about suicide on the Internet?

Prof. BAUME—The Internet is probably an underrated approach to publicising suicide. We have actually done a significant study in this area in the last few months and we found to our horror in a way that you can find every possible way on how to complete suicide and the cheapest possible way, including which shop you can buy certain goods at that will assist you in dying. These are linked specifically to individuals that are interacting on the Internet about suicide issues. They will have people somewhere else in the country or internationally who will say, 'Look, if you really want to die, look at this page because it gives you all the menus that you can use, the quickest way to do it, the nicest way and the one that suits you best.'

I think that the problem with that is that, whilst the Internet is full of great information, at the same time it is totally uncontrolled. If you have individuals who perceive that the Internet is the only way they can actually interact because, as we have stated earlier, some of these individuals have difficulty in social interaction and they see that having a computer interface may be able to help them, then what they start to do is go on the Internet and write each other suicide notes. Then they respond to the suicide notes. In the past suicide notes have been primarily read by families after the event, sometimes just before the event, or by the police or by individuals who are interested in research. But now they seem to be actually tabled here for thousands and millions of

people to read. And then there are issues that those young people that are involved in these interactive discussions are unable to address, and so they address them in the same inadequate and inappropriate way that they are dealing with issues for themselves. We have observed a number of individuals who died in front of us, actually on the Net, who actually said, 'I am now going to kill myself, this is the way I am going to do it, and this is the last time I am going to actually give you a message.' And then individuals who have known these young people who have died have, later on, a week later or so, confirmed that young person has died.

And this is completely out of check, out of control, and often those young people do not talk to anyone else. They say, 'I have tried to ring Lifeline, or I have tried to speak to a psychiatrist, and they have not been helpful. They just do not understand how young people really feel and all they do is try to tell me what to do, but they just do not really understand me, and you guys on the Net really understand me, because you are feeling the same way.'

CHAIRMAN—I will ask Mrs Grace to ask a question, because she missed out in the previous question period, then Mr Quick, Dr Nelson, Ms Ellis, Mr Cameron, Mrs West and Mrs Vale.

Mrs GRACE—In one of your last slides, you pointed out that previous attempts at suicide was the highest rate of eventual suicide. Has anybody gone into why they attempted suicide and what was the reason for the attempt? My theory would be that, righto, we have had a couple of goes, we are really going to make sure of it this time, and so there has to be another underlying factor that they attempt it in the first place. Is that correct?

Prof. BAUME—I think Dr Harrison has already partly answered some of that question this morning. The issue of suicide attempt and completed suicide needs to be taken in context. There appears to be an overlap between the two, but I think the overlap is small rather than large. Even though we know individuals who complete suicide have attempted at least once before, and in fact the literature supports that approximately 60 per cent of people who complete suicide have attempted before, and our own research suggests the same, at the same time, predicting out of those who have attempted who is going to complete suicide makes it difficult, because often there is a change of method whereby, in terms of the attempt, the method may have been much less lethal and there was some ability to intervene. The other factor is, if we only have an overlap of 10 per cent or 15 per cent, then, even though we have a very, very high risk population and probably one that we can target best, we still do not have a full picture and we still have a lot of individuals who attempt who will never turn up to emergency departments, and a lot of individuals who keep this very much a secret.

Often when you talk to parents, for example, at the funeral of somebody who has died from suicide, their child, then the friends of that child will go to the parents at the end of a funeral or a few days later and say, 'Well, you know, little Johnny actually attempted suicide a couple of times before, but we never wanted to tell you that because we did not think it was appropriate, and we did not want to worry you.' And this is very

common. In fact, 150 families that we interviewed recently demonstrated this, that in a majority of cases they found out after the funeral that their child had actually attempted suicide, and often nobody else knew about it.

So this world of secrecy, which is very often very common in young males especially, makes it very difficult for intervention, and also to bring those people out of the woodwork, if you like, to try to intervene with. So the population that we see in hospitals is probably one of the best populations that we have to try to intervene, but at the same time may not necessarily be representative of everyone that we should be addressing.

So I think we need to research it more. We need to do better studies to try to compare and also to follow up those individuals who have attempted over a long period of time and to see how many actually go on to complete. As Dr Harrison pointed out this morning, our dilemma is that, whilst we are starting to put together some registers of suicide, which we still do not have—we do have one in Queensland but, apart from that, nobody really has a comprehensive suicide register—we have even less information about suicide attempts. And hospital emergency will only see some of the attempts. Sometimes GPs will see the others; sometimes no health professionals will see them. And it is sometimes very difficult then to follow up or to manage individuals that you cannot see or you cannot access.

Mr QUICK—You mentioned the weakening of networks of interpersonal support. My question is about the institutional children. We seem to have more and more in foster care and other people outside their family network are being responsible for them. What is the incidence of suicide amongst those young people?

Prof. BAUME—We do not have strong evidence to show that that kind of arrangement may necessarily cause the rates in young people to go up. I think it is also fair to say that you should not just have a family for the sake of having a family. We know in many situations, and the data supports this, that there are a lot of marriages which hold together because there are kids, but it is not necessarily, if you like, happy for them or where there is necessarily a lot of support between the individuals in that family context.

If the family is very dysfunctional, it may well be that a foster care arrangement may be far more supportive, caring and understanding than a dysfunctional family where there is an intense amount of conflict and where there are vulnerabilities that develop because the young people do not have the significant bonds of attachment that are supposed to take place at that age.

At the moment, from our own data, we do not have significant evidence to show that individuals who are in the foster care situations are necessarily more at risk. I think we need to see that it is always a multifactoral issue, so that often people are placed in foster care because there is a lot of abuse in the family and that there may be some of those antecedents where abuse and maybe the development of depressive illness, which was maybe not managed or picked up appropriately, where those individuals may end up

in foster care. When they die, we make an immediate assumption that if there had been a normal family they would not have died. I do not think we can jump to those conclusions and I think we need to be very cautious in coming to specific conclusions, because there is always a need for us to try to find the one unique cause and once we put our finger on it then we can cure it, but this is not simple. This is a behaviour outcome and not an illness, and therefore we are never going to have one simple solution.

CHAIRMAN—We should bear in mind the constraints of time and keep questions short and, if possible, the answers short, whilst still wanting a full answer.

Dr NELSON—Is there any research in which you are engaged or of which you are aware which assesses the impact that the euthanasia debate we are currently having in Australia is having on the attitudes of young people to suicide?

The second thing is that, whilst the Victorian government's task force on suicide is obviously commendable, should this not be a national activity and should there not be some focus nationally based for coordinating the research, treatment and prevention of suicide and all the various economic, political and social aspects attached to it?

Prof. BAUME—Thank you very much for those questions. I think they are very important and pertinent to this discussion. I just want to say, Mr Chairman, that it is a bit unfair because those questions require for me to be comprehensive in my response and the member actually gave me two questions and not one.

The first I will answer because it relates to euthanasia and it is probably an easier one, although it is a very complex topic and there is sometimes blurring in terms of assisted suicide issues versus euthanasia. This time the issue of euthanasia has been focused more specifically in the area of terminal illness and older individuals rather than younger people. Certainly I am not aware of specific studies that have demonstrated or studied the relationship between euthanasia and suicide. However, I can talk to you about a study that was done in Europe a couple of years ago by Diekstra and others. They have actually interviewed young people, and I think some colleagues have mentioned the fact that we have a tendency to be patronising in this field of suicide prevention and we never actually find out from young people what they actually need and what the whole issue of suicide actually means.

In this particular study they asked them whether in fact incurable diseases or terminal illness were seen as an important factor in whether a young person would actually complete suicide if they were diagnosed with a terminal illness. They also asked the same question of an adult population. They found there was actually no difference in the responses between the adult and the young people. However, the difference they found was when the young people versus the adults were asked questions about unemployment, about breaking up of a personal and intimate relationship and, for example, issues of unwanted pregnancies and lack of support within the family context. On all these questions, the young people said they would complete suicide in those situations, whereas the adult population stated that was not a significant issue. That is very important because there are very few studies that look not just at psychiatric sub-populations or populations

that have attempted suicide but at the general population, at what young people are thinking and feeling about particular interactive events.

With regard to the next part—the issue of the task force set up by Premier Kennett in Victoria—it is important that we take into context that suicide is such a difficult issue that it may require us to tackle it nationally. It probably would be a good idea for us to have a national task force and to try to involve the states and territories—not just having a Commonwealth push and then some state doing their own thing. One of the things that has been difficult in suicide prevention all over the world is that lots of people are doing some very good things and lots of people are doing many different things. As yet, we have no clear understanding of what is going to be the best approach. One of the things we discussed at the United Nations was the fact that people within member countries kept saying, 'There is a lack of cohesion in our approach to suicide prevention and a lack of integration of programs and services but also a lack of realisation of what is actually going on and what kind of vision and leadership we are providing for supporting suicide prevention.'

We also have to bear in mind the factor of contagion and imitation when we deal with the issue of suicide and start to publicise it—and this is an issue which I have raised with the Premier of Victoria because there has been a high profile for the issue of suicide in Victoria because of the consultation process taking place. We know from studies—such as a recent publication that came out only a month ago which showed that when they started to intervene in school and talk about suicide, it started to glorify the issue of suicide—that when you start to talk about things like this in schools, instead of saying, 'This is a bad thing and we should not be engaging in it,' all the young people start to identify with a person who died and to express suicidal thoughts and—some of them—even suicidal intent as well as a suicidal plan.

So there are a lot of things that we still have not answered for ourselves. There are a lot of questions we need to answer and to ask. Above all, we need some more specific data and cohesive data collection about what is going on in this country before we are able to say, 'Let us spend $20 million on this because we know this is a particular problem.' Most of the time we are walking with at least one eye covered and, hopefully, the other one is open. But, in the majority of cases, we are walking blindly in this area.

CHAIRMAN—Thank you very much. I am quite happy for answers to be comprehensive. I was only asking that they could also be as concise as possible.

Ms ELLIS—Professor, you have just begun to touch on the point of my question which is the increased permissiveness of suicide as an option. I would like to get your views on the role the media has to play in this, how we depict young people in the media generally when we think about their self-esteem and their levels of self recognition and, along with that, how important do we consider the issue of suicide in its depiction within the media—going back to a couple of comments you were making a moment ago.

Prof. BAUME—The issue of the public discussion and debate about suicide is a controversial one. Looking at what is depicted in newspapers or on live television, in

television stories and movies and so forth, it varies, depending on the studies that have been done. At every stage of whatever area we want to look at or to become interested in, we need to see that the underlying themes and issues that relate to suicidal behaviour are multifactoral. That is, we may at times be dealing with some vulnerable populations of young people who have already had a previous attempt, have difficulties in their home, are vulnerable because of failure issues in terms of their growing up process and have some depressive illness as well. Suicide may become an option for those individuals when you start to discuss it, especially if they have an inability to access someone else to support them and/or if they are in a milieu that is not going to provide support. You never quite know who is listening, who is watching and how they are going to resolve the issue of suicide or what it means for them.

In a number of studies it has been shown that some young people actually do not know that suicide will kill them. They see suicide as a problem-solving tool that will resolve a lot of hopelessness that is faced, but not that it necessarily means death or something that equates to death itself. I think we need to appreciate that obviously suicide leads to death when we talk about completed suicide. But, when we start talking about so many people who attempt suicide, it is quite clear for those who are less informed that many of these people do not die, so what is the hassle?

I think we need to take it in context. I would be the last person to say we should ban terrible music that I might not like but somebody likes or that we should ban depictions of things. It is quite clear, though, that when you actually depict a suicide story in terms of the methods and you actually see where the hero dies from suicide then all you are doing is glorifying suicide and making it an acceptable form of death.

Mr ROSS CAMERON—Thank you, Professor. I have two questions. The first one is: the response of most government committees—or one of the responses—to a problem is an education campaign. It does seem to me that in this instance it may be exactly what we do not need. I am interested in your response in terms of what our response to this problem is. The second question relates to your answer to Dr Nelson's question. You talked about the permissiveness of the culture in accepting suicide as an appropriate response. I guess one of the issues we are asking about is: what are the circumstances under which a young person says, 'Taking my life is an appropriate response to this external challenge I face.' Dr Nelson asked about the impact of euthanasia; I would also ask about the impact of abortion.

If we say, as a culture, 'About 80,000 times a year in Australia an appropriate response to an unwanted pregnancy is to terminate the pregnancy,' we are saying more and more as a culture that an appropriate response to suffering in a really difficult terminal illness is to terminate life. Are we sending, through those collective decisions, a message to say that the taking of a human life is an appropriate response to a difficult or a complex problem?

Prof. BAUME—Thank you for this most comprehensive question. I will be very brief in responding. Recently I was in a cab going to a conference on suicide. The cab

driver asked me where I was going and what the conference was about. He said to me, 'You know, that is the best thing for those young people who commit suicide. They're much better off dead, and we should not interfere.' He said that he knows a lot of young people who are miserable and homeless and who are destructive and aggressive. He and his friends all agree that those people are much better off dead. That is the first issue I want to respond to.

The next part is about other social factors, beliefs and values that we may have as a society. I could easily answer by saying that I could not possibly comment because it is too difficult for me to answer. I think we need to take it in context. If you are looking at unwanted pregnancies or issues of abortion and so forth, these relate primarily to women. If you want to compare this with the rates of suicide in young women then, as we see, it is actually seven times lower than that of males. That does not necessarily mean that the suicidal behaviour is less frequent in females, because we probably could say that suicidal behaviour is similar in both genders. We are far better at emergency medicine these days to be able to pick up especially those who take overdoses—and we also see that the lethality of the mean is an important factor. We also see that the impulsivity of young males is significantly higher than in females, and so forth.

In the context of those social problems or social boundaries that we want to set for ourselves, we do not have specific evidence to show that we are going to have a huge rate of suicide as a result of this if we loosen our value system. It is more so what kind of support. I talked about religion before. In terms of those religious issues that I have been describing in literature, it is more so in terms of social integration and the kind of support structure that those things provide rather than a set of values or beliefs that people have. There is a big difference between believing that suicide is an acceptable thing and believing that abortion is an acceptable thing.

Mrs WEST—I was interested in your opinion: do you think the professional medical assistance or knowledge of methodologies in treating suicide are improving?

Prof. BAUME—That is an interesting question. I think we have generally become more effective in managing emergency situations and we have taken some measures in the broader public health context as well to try to limit certain substances that are lethal, for example, the use of barbiturates and so forth and replacing them with some things that are less lethal.

I think that at times it is difficult to necessarily know whether we are more effective, especially if we know that young people, young males, will not go and see a GP or they will not go and see a health specialist. It is very hard then to try to intervene with those individuals. I think there is now a much greater awareness and recognition that depressive illness is now perceived to be far more frequent in young people and therefore the medical professions, especially psychiatrists, and some GPs have recognised this needs to be managed better.

There is also recognition among some that the newer antidepressants, for example, may be as effective as the older tricyclics, but at the same time even if they may be a

little less effective in some areas they are at least far less lethal. But we still have states and territories in this country and some prescribers who actually prescribe large copious amounts of antidepressants like tricyclics, which we know are quite lethal if they are taken in large doses.

I can tell you in our own database we found that it is quite extraordinary to see that we are still prescribing large amounts of very dangerous medication when there is now medication available which is less lethal and just as effective. Similarly, there is the issue of even more accessible drugs, like paracetamol or Panadol, which for $2.80 should do the trick, so if you can die for $2.80 you do not even need antidepressants. It is a very easily accessible type of medication. Yet, if some of us try to intervene and say that we should do something so that those particular medications are less lethal, people say that this is not economically friendly and they would like to move on to something more exciting.

CHAIRMAN—Thank you, Professor. Regrettably we are out of time for this particular segment, but I will give those members who did not get the opportunity of asking a question of Professor Baume the first opportunity of asking questions of Professor Kosky. Professor, thank you very much for joining us and for your address, which we found very interesting.

Our next speaker is Professor Kosky, to whom earlier speakers seem to have referred regularly. He is from the Department of Psychiatry at the Women's and Children's Hospital in Adelaide, South Australia.

Professor Kosky is a graduate of Melbourne and Monash universities and trained in psychiatry in the United Kingdom and in this country. His doctoral studies were on suicidal behaviour in children and adolescents and thus he is obviously an ideal speaker for our seminar today. He is the Foundation Professor in Child Psychiatry at the University of Adelaide and Chairman of the Division of Mental Health at the Women's and Children's Hospital in that city.

Main research interests are youth suicide, young people in the juvenile justice system and the development of public health models for early intervention. He is the author of numerous published papers and senior editor of *Mental health and illness: a textbook for health science students* and *Breaking out: challenges in adolescent mental health in Australia*. I think that Professor Kosky has a wonderful contribution to make to our seminar today and I would invite him to address us on psychological and psychiatric factors.

Prof. KOSKY—Thank you very much, Chairman. It is a privilege to be here. Thank you for asking me. I have to begin my talk with a couple of little caveats. One is that this is a very complex area. I have tried to focus on a couple on things that might have practical implications for you. I am also aware that there are very great expectations and that there might be many more questions than what there are answers in what I have to say. I have many more questions really than most people in this room.

The following slides were then shown—

Prof. KOSKY—The Prime Minister mentioned the fact that amongst all the good indicators, very fine health indicators of your people in this country, the one that stands out is why there should be this opposite trend for suicide in young people. The question really comes down to: why do young people kill themselves? That is the question to which I want to address this talk.

One would have thought that the simplest way of doing this would be to ask young people themselves why they actually try to kill themselves. G. van Ireland and I, some years ago, interviewed 20 young people who had actually survived a life-threatening suicide attempt and these were the sorts of answers we got. Nine of them could not give us any reason at all. One was reasonably rational, another perhaps rational. Then things like: so I will not get the cane from my father; I am better off dead; to sleep for a long time; a voice told me to kill myself; everyone blames me; I am a burden on the family; the devil is in me; I am just hopeless; I am angry; I am sad and angry. What is happening here is people are describing feeling states. They are not describing rational reasons. One of them in particular had a schizophrenic illness—a voice told me to kill myself. The others were, as any clinician will recognise, seriously depressed.

The conundrum that the clinician faces is expressed in these words by Albert Camus, 'Suicide, like a great work of art, is prepared in the silence of the heart.' What we are dealing with—the mystery of suicide—lies hidden and buried in the minds of the people, beyond words for most of them.

So how to approach this? Well, one of the ways of approaching it is to try to look at a whole lot of people who have attempted suicide and see what possible common factors they express to psychiatrists about what was wrong with them. So Steve Zubrick, Sven Silburn and I did a study of about over a thousand young people who were referred to a child psychiatry service and the psychiatrists were asked to fill out a form about what they thought the young people were talking about.

This slide summarises a massive amount of data. The green is all the young people, the 1,149 young people, who were referred to us. The purple is those who reported symptoms of depression: sadness, tearfulness, irritability, poor sleep patterns, loss of interest in things that they were previously interested in, apathy, loss of appetite, sleeping in—that sort of picture. Then there are those who reported suicidal ideation, by which I mean persistent thoughts. I mean, everybody thinks about suicide at some point. It is a universal phenomenon of living to think about suicide, but when those thoughts start to crowd out all the other thoughts and when they persistently occupy the mind of the person then we would say that they were suicidal. You can see that they form that little pink circle there. Those who have made a suicide attempt are the hot spot in the middle.

The point that I want to get over about this slide is that all of the people who were suicidal, with the very small exception of 10, who were probably human error in recording the details, lie within the depressed circle. None of the people who were suicidal did not have the symptoms of depression. That is the first point I want to make to you.

Clearly, many of the depressed children were not suicidal and had never been suicidal. So we tried to compare the depressed children, 480, with those who were depressed and suicidal. These are the things that they did not differ on. They did not differ on the fact that most of them were over puberty. There was no difference in the social class of the families. They came from all professional groups and all areas of the social spectrum. They did not differ in the countries of their birth, in the ordinal position in which they lived in the families.

They did not differ in whether they were adopted or not. They did not differ in migration. They did not differ in the numbers of stress or the types of stress that were on the family in terms of acute stress—notice that included divorce. They did not differ in extra family stresses—natural catastrophes. The levels of emotional symptoms were the same and conduct symptoms—lying, stealing, violence and so on, running away, substance abuse. All these things were in the depressed children and maybe influencing their depression, but they did not seem to be pushing them into a suicidal mode. I think that is an important sort of observation.

Where they did differ was—and this is a relative difference but it is a very significant one statistically—that the ones with the suicidal ideation and the ones with suicide attempts had very high levels of family discord. What we mean by family discord is tension in the family going on persistently over a long period of time—argumentativeness, lack of support of individual members and sometimes violence. The depressed children had this but nowhere near as high as in the suicidally depressed children. In the other referrals it was pretty low.

This seemed to form a complex, one part of which was depression and the other part was family discord. Some very recent studies by Maria Kovacs and other groups in America have shown that this complex lasts. It persists on into life. In the middle of it is a suicidal contemplation, which is formed by the product of these two things, and that suicidal contemplation depends upon the levels of depression and the levels of family discord which alter over time, but if the two of them are going up and down the suicidal potential is still there. On this complex are played out a number of different things in life—loss, and that can spark a suicidal attempt; alcohol, a spark. Treatment may be a good thing, which prevents a suicidal attempt. Some of the suicidal attempts are fatal.

I will address the question of the relationship between suicidal attempts and suicide at some time, perhaps in question time. This means that something has to be done and I want to return to this. I have constructed this model of those major findings. I think it is helpful—it is to me—if we put on one axis of a graph symptoms of depression. As that goes up and there are more symptoms of depression or those symptoms get more severe, then you have an increase in suicidal potential. On the other axis is family discord, chronic family discord, not acute, and as that increases so does suicide potential.

This suggests that for general purposes people who do not have depressive symptoms and do not have family discord are safe from suicide. But there are some people who kill themselves who have massive depression occurring out of the blue and no family discord. These are the sorts of cases where it comes as a complete shock to

everybody and a surprise and nobody can ever work it out. They had a hidden depression. So that is approximately safe. There are those children who come from such appalling family circumstances that they kill themselves to escape. But on the whole it is this combination of factors. I must emphasise that I am talking here about the way the young people see the situation, not about the way an observer sees the situation, which is what Pierre was talking about.

I believe that that has some direct implications for action and for yourselves, if I can be so presumptuous. But we have got to reduce the depression axis. The way to do that is very clear and very well known in public health. It is early identification and early effective treatment. Who sees these young people? If they see them, we have to educate them so they know what they are doing and we have to maybe look at some high risk groups.

Going back to who sees them, these are the results of a survey we did in South Australia. We asked adolescents who they had seen for health problems in the six months prior to the survey. Out of 100 well adolescents, 46 had been to see a GP in the six months prior to the survey. Half of the well adolescents—this is mental health well—had been to see a GP. This is a much larger number than had been to see other services in our community.

Of the children who had mental health problems identified on our questionnaire, major mental health problems, 50 per cent had been to see a GP. Others had gone to hospital casualty and some had gone to the school guidance officer. These are the key people. In particular, the GP is the lynch pin of the primary health care system. The question then arises: can the GPs identify young people who are depressed? Can they treat them adequately?

The question of screening is an important one, I think, because we have identified certain groups who are at very high risk. Amongst those are young people who are in custody and held in detention centres. They have probably around 50 times the risk of suicide. So it seems useful to pick out some of those groups and screen them for depression and get them into mental health care. You should know that if you go into a juvenile justice centre your chances of actually getting to see a doctor for anything are less than if you were in the community.

Early treatment: we must get our balance between primary care and tertiary services right because we must watch out that in the de-institutionalisation and the de-bedding of hospitals we have not forgotten about adolescents who never had enough beds. It may be that the need for adolescents is the opposite direction of the need of the older people, that is, for more tertiary services. I might say that this area is almost totally absent in most of rural Australia.

The family discord axis is a much tougher nut to crack. I am not a social scientist. Therefore, it is out of my realm really to make comment about this. However, I will just say some things. It is very easy for us to assume that when families break up it is because of the clash of personalities of the people involved, the parents. There is an industry

around helping that relationship work, and that may be very valuable. However, our own studies have shown that the families we are talking about here are families in distress or in stress. They are families who are very often single parented. They are families who are very often working, dependent for very long hours of work or for pensions. They are families who have a significant burden of care of other sick people—including elderly adults and young sick children—and also they are large families.

That is just in our little study. What I am talking about, really, are practical issues and how to help them. I think that we very much need to figure out whether it is relationships or practical interventions that are needed. I might say that the American publications have recently taken that up. A writer—Sylvia Ann Hewlitt—has written a book called *When the bough breaks*, which is very good reading in terms of looking at issues like child care, help and so on.

The idea of enhancing the family so that it can help is very important. I must say that, for families which have a suicidal young person in them, the burden of care is phenomenally difficult. We cannot forget that they are doing most of the caring, and the pressure and tension is enormous. We must work out ways to enhance their ability to care.

Finally, there is the issue that all governments face of social responsibility. It is a question of what is more important: the relationships and feelings of the people versus the need to maintain an economic state. Could I put in a plea for government to ask the community at various levels what they want from government? This was conducted some years ago in Western Australia. The issues that came up were things like a sense of safety, a sense of responsibility, a sense of identity and history, and these things. I think that these coalesce around the issues of enhancing them and helping them in stressful circumstances. So those are the two things: cut down the depression axis and cut down the family discord axis.

This is put on to remind me that what I have just said to you is very straightforward and seems very simple. This is a plea to understand that those who look after depressed and suicidal young people are literally sitting on time bombs. That is extraordinarily difficult and hard. This applies to their parents and to the other members of the family—siblings and so on.

This is a drawing by a suicidal young person of what he could not express. You can see up the back death coming; this is how he felt. This reminds us that, when I say depression, what I am talking about is a feeling state which is so intense and profound that some people cannot exist with it. The state of melancholia, of anxiety and of apathy, which is a withdrawal from all that, is very great. Depression results from and has to be understood as a product—state of being—that happens when human relationships break down. Human relationships are what give our life meaning. When those relationships break down, the meaning is lost.

They can break down in very simple ways such as loss and things happening which remove things which are loved from you. They can break down because the mind itself is breaking down and withdrawing, as in the case of psychosis. That is why schizophrenia is

such a major problem in relation to depression. And they can break down from a long history of growing up feeling frustrated in love and frustrated in the ability to love; growing up different and feeling that the community is widening, drifting, parting from you. In all those cases, the relationships start to tear, come apart. In the end, what forms is what I have glibly so far called depression. Thanks very much.

CHAIRMAN—Thank you very much, Professor Kosky, for that very thought-provoking address. My question to start the question time off relates to what you said about the roles of government. I am interested in knowing what you think the government should now do over and above or in substitution for what has already been announced. Suicide prevention, as the Prime Minister said, is very much a bipartisan issue. What we need to do is get it right.

Prof. KOSKY—The government has done a lot so far, and the previous government did a lot too. I think that all those things are very important. I know that Meg Smith, who is sitting over there, will be able to say something about that. I think, though, there are two areas of deficiency. One is that there is a deficiency of research. We simply are not approaching this in the same rational, clear-headed way that we approached, for instance, the road traffic problem that James mentioned, which is such an amazing public health success, and we are not approaching it in the way that we have approached the HIV-AIDS issue. I think that this is now the public health issue in young people. We will be lucky to get the road traffic fatality rate down much lower. Therefore, I take up Dr Nelson's point that I think there needs to be a national think-tank of some sort about this and, in particular, a national body which looks at other research issues and what needs to be known.

Mrs VALE—Professor Baume stated that there are something like 30 per cent more attempted suicides than there are actual suicides that are committed. Is there any program in place that you know of which helps and assists these young people? I mean the 30 per cent that actually—

Prof. KOSKY—I have got those figures that James was asked about. We have just done a survey of young people in South Australia. They have reported on the numbers of them who have made a suicide attempt which has required medical and nursing care, which is a good indicator. These are high school students from year 8 through to year 11. One in 50 report having made an attempt like that: that is one in every class or two classes. The numbers who are admitted to hospital—which are the official attempted suicide figures—are one in 500. The numbers of suicides are one in 5,000. That is the sort of pyramid. The help that is given to those who come to hospitals is probably good—that is one in 500. The help given to the others, one in 50, who really do not, is probably fairly small.

One of the issues here is that we do not know the relationship between all those things: we do not know the relationship between suicide, attempted suicide that gets into hospital, and attempted suicide that does not get into hospital. We do not know what that dynamic is. I think they are all very closely linked over time. In many cases, it is just luck.

Mrs VALE—Hence the need for the research that you suggested?

Prof. KOSKY—Yes.

CHAIRMAN—Mrs Kelly has joined us. I do not think you were here at the opening. Welcome.

Mrs DE-ANNE KELLY—Professor Kosky, I was very interested in your depression axis, the importance of early identification through the use of GPs being educated and also the family discord axis. Professor Baume explained that the greatest rise in youth suicide has been in the 14- to 19-year- old group, and in towns with a population of less than 4,000 where there is unlikely to be a GP. How do we approach that very difficult situation when there is a rise in that particular age group?

Prof. KOSKY—That is in terms of rates. In terms of absolute numbers, of course, the number of deaths in small rural areas is relatively small compared with, say, Sydney. Nevertheless, it is an issue. I think one of the things that a lot of people are putting their mind to at the moment is the use of telemedicine, telepsychiatry issues in how to get to remote areas and how to get help to remote areas. I think we are going to have to use technology, because we will never get enough people to get into those areas.

CHAIRMAN—Actually, the committee is having an inquiry at the moment into telemedicine, and we have had some evidence concerning the advantages of telepsychiatry—so I think I agree with you.

Mr ALLAN MORRIS—For a person who says he is not a social scientist your observations on social science were in fact very profound, so the question I wanted to ask is partly what I wanted to ask Professor Baume. He indicated, as you are aware, the shift in the last 30 years on some factors like church and secular. I suggest there is also another factor, which is the growth of economic thinking, technocrats and the way we deal with people, and the growth of the philosophy of individuation, where it is every person for themselves. Putting that back into your factor family enhancement and family stress, do you see any correlation with people in those families feeling that they are alone, that they have to solve their own problems, that there is not much support available and that that in fact becomes a factor of isolation within the community of individuals, including young people?

Prof. KOSKY—I place the second priority in research for the area in trying to understand what it is that brings family into stress which then overwhelms them so that they cannot then cope with their kids. I do not think we know what is going on. I might say that that is different from the first part of your question related to individuality in the community. I am not sure that that is in fact so. As a clinician I have to say to you that young people seem to be less liberal—not more liberal; less free to be themselves—now than they were some time ago.

Mr ALLAN MORRIS—Yes, the point I was trying to make was the axis on one hand where we are talking publicly about individuation but we have got youth in very

powerful subcultures almost as a reaction to individuation. That seems to be the case, whether it is heavy metal, Internet or whatever. There seems to be a whole set of subcultures, dress codes, sport codes. At the same time when adults are talking about the philosophy of individuation and economic rationalism, our youth are actually turning to a quite different culture.

Prof. KOSKY—Yes. I think that with this conformity—this need to conform—we must not underestimate the power of the pressure of peers to conform to stereotypes that they imagine are important. That conformity, I think, that pressure, has increased as you say and I think therefore that to be different and to grow up differently is much harder for young people—and this may be true in remote and rural areas as well. So I think that they are put under a lot more pressure.

Mr ALLAN MORRIS—It may be two axes: individuation and subcultures.

Prof. KOSKY—You are right. You should be the social scientist.

Mr ALLAN MORRIS—I am just a politician.

CHAIRMAN—Perhaps he is.

Mr QUICK—I am interested in the things you and Professor Baume have been talking about, about how we alert people and the screening process and the effect that might have on sort of copycat and that sort of thing, and the allocation of resources so that we do not have six case managers looking after one particular family or child and they do not actually talk together and there is not this cross-fertilisation of ideas. As a former school teacher, I understand the problems of the identification of children at risk and being unable to get resources into schools at an early age. We want to strengthen the net so that the number of children and families affected is going to be diminished. Do we have enough resources now and it is just that they are in the wrong places, or do we need a wholesale refocusing, or do we need a huge number of resources to be put in?

Prof. KOSKY—I think we need to have a refocusing of the resources on young people—I do think that—and particularly mental health resources, because this is a public health problem. We also need to understand that teachers and parents are not very good at identifying problems in their children. There is good research on that. Parents are too close and teachers are too busy, I think, so they overlook a lot of young people who are depressed and so there needs to be some sort of education campaign there.

In terms of the connections, yes, the sectors that we have got currently: how did they arise? They arose by some history, and I am not sure whether they are actually welfare, juvenile justice. Our studies for instance have shown that 50 per cent of the young people in the South Australian juvenile justice detention centres have major mental health problems. Are they mental health issues or are they juvenile justice issues?

Mrs WEST—That was very interesting. The last artwork that you brought forward posed a very interesting visual image. Have you done any research into where the children

get the ideas from for suicide? Is it drawing a long bow to say that from 1961 when the rates of suicide increased that also correlated with the advent of television into many homes and that it could be a contributing factor because they might not have thought of it if they had not seen it somewhere else? Is there any research on that topic?

Prof. KOSKY—In Western Australia we looked at the youngest children who attempted suicide or who actually failed suicide attempts.

CHAIRMAN—How old were they?

Prof. KOSKY—The youngest was five. He had wanted to die because he felt his mother did not love him, which was not in fact true. He had developed this idea. He asked an older boy how to tie a noose. The others who are young walked in front of traffic or jumped off buildings or cut themselves or put a plastic bag over their head. I do not think they got this from television. I think they just did it.

CHAIRMAN—Professor, excuse my cutting in there. We have been concentrating on adolescent suicide, when we refer to youth suicide—those aged from 15 to 24. How large a problem is youth suicide with respect to younger children from age five upwards? It would have to be reasonably rare?

Prof. KOSKY—Very rare indeed. Suicide thinking does not really start until about 12 or 13 years of age. We actually did a study on whether it was related to puberty, because that seemed to be a reasonable thought, but our study—Steve Zubrick did it with me—is the only one I know in the world that actually showed it was not. It was related to age, and the chronological age was 13. That is a very significant age in our society.

CHAIRMAN—Would it not be that age 13 is tied up with puberty?

Prof. KOSKY—No, age 13 is tied up with going from primary school to high school. For instance, in the juvenile justice system in South Australia, of those who are in there, 80 per cent did not bridge the gap between primary and high school. It is a very, very powerful rite of passage and very significant.

CHAIRMAN—A tragic one too at times?

Prof. KOSKY—Yes. That raises issues about how that should be bridged.

CHAIRMAN—How should it?

Prof. KOSKY—From a simple person, an answer would be some sort of middle school.

Ms MACKLIN—Please repeat that?

Prof. KOSKY—Middle school.

CHAIRMAN—Some sort of middle school. I suppose the way we used to have in society at one stage.

Ms ELLIS—Professor, there has not been any mention as yet today by anybody about the gay and lesbian community and maybe their connection or their concern with youth suicide. Given that we are seemingly concentrating on statistics affecting young males in that young age group, do you have any thoughts on whether the sexual development of our young people, particularly the male at that age, has had any signs of being a contributing factor? Are we addressing and holding onto that sort of educational and information aspect of their lives sufficiently, do you think, if there are in fact any noteworthy indications of concern?

Prof. KOSKY—I will answer you question at two levels. The first is that there have been fairly extensive studies of the issue of whether gay people are over-represented in suicide figures. Mainly, we are talking about males because males suicide six times more often than females. The overseas studies have looked at deaths, and they have tried to work out whether the people who died were homosexual. They have interviewed friends, relatives and parents and so on. The answer from those studies is that there is no over-representation. However, the question that comes to my mind is that if somebody has killed themselves because they do not want anyone to know they are gay then—

Ms ELLIS—That is my point.

Prof. KOSKY—Why should anyone know. I think those studies are subject to qualification.

The second level is clinical practice, and in clinical practice there can be no doubt that most clinicians feel that there may well be an over-representation of people who have ambiguous sexuality or concerns about their sexuality amongst the suicidal population. Certainly, anecdotally, there can be many, many examples. This is a question that has not been adequately researched. It is a question of absolute paramount importance, and we should research it.

The problem here is the issues that were raised earlier of growing up in a state of conformity and feeling different. I think that that clearly can make people vulnerable to depression. On the second axis of family discord, unfortunately, allowing parents to know can in some cases create family discord so that the support is removed. That is why I think it is very important for gay people to have what they regard as their family—that is, the family of their gay world. For people to say that that is not a family affects them greatly.

Ms MACKLIN—Going back to the families under stress issue: I think some of the things you said about sick children caring for the sick elderly and so on do lend themselves to government support so that is very useful. Another area that really seems to be eluding governments of all persuasions is the predominance of abuse within families. I do not think you mentioned that as one of the reasons for discord. I wondered if you had any advice for us about things that we could do either at a national level or even by the

states.

Prof. KOSKY—It is one of the extreme forms of discord, and certainly it is referred to by suicidal young people that they see their parents arguing and violence occurs. Sometimes the children themselves are the targets of that violence.

My own view is that violence occurs as a catastrophic reaction to people who are overwhelmed by stress that they cannot deal with. Some of those reasons are within them. They do not have the capacity to deal with them intellectually or in other ways and they have not been adequately parented themselves so they cannot prevent themselves from expressing anger. But I think we have to consider that that only occurs under times of stress from other reasons.

The most common cause that I have found clinically is money. People like this are arguing quite often in a situation where they cannot budget and do not know how to budget and money is just simply drifting away and they are blaming each other for what is happening. I see it not as a relationship issue but a symptom of a practical issue.

Mr ROSS CAMERON—I was interested in your original quote from Camus about a sense of mystery and the secret quietness of the heart and that kind of thing. I noted Professor Baume was talking about suicide as being a behavioural outcome rather than a sort of discrete illness or something like that, with the idea that there were lots of different things that would go into that mix of factors which would produce that outcome.

I guess one of my concerns, and what I am interested in your view on, is that we as a government, I think, like to feel that we can throw a certain amount of money at a problem and we can somehow fix it. We like to have this feeling that there is this capacity to act in a decisive way to solve a problem from a public policy standpoint. It seems like a good individual quality relationship of commitment between an older person and a young person may be a vital ingredient here. That is my question: do we need to say there is a limit, there are some areas where governments are not good at providing the vital ingredient needed in a situation like this? How do we get the community committed in a much more constructive way than spending vast sums of money?

Prof. KOSKY—There are some very good questions in there. Let me answer one by saying that what appears to be impossible may never be. Leon Dash, an American journalist, has spent time with an absolutely down family in Harlem, New York and has tried to work out why they are impossibly addicted to drugs, their children have gone off the rails and everything like that. He says that the bottom line ends up being not class, not race, but illiteracy. They are all illiterate and they cannot get in. So he reframes their problems as an educational problem. That sort of reframing is necessary, but it can only come out of research.

The second issue was about community. I believe that the community needs to be talked to, and it is up to individual members to ask what the community wants. In Canada, Dan Offord was asked by the Montreal government to look at how to cure delinquency in some place. He went around and asked all the people. What they wanted was a swimming

pool. He put in the swimming pool. The people then had to learn to swim. Then they had to have swimming coaches. Then they had to have swimming teams. This whole thing arose from the community, and they produced community swimming teams. I do not think we, sitting in this room, can often know what the solutions are. But people—especially in rural areas—often know what the solutions are, and they need a voice to speak. It is up to government to find a way in which people can speak.

CHAIRMAN—Thank you very much, Professor, for that address and also for answering the question so fully. You have given us a lot of food for thought, and I daresay it will help us greatly in preparing our summary report of proceedings today.

The next speaker—our last presenter—is a lady who is also very well qualified. I invite Dr Meg Smith to come forward. Dr Smith is currently the Chairman of the Youth Suicide Prevention Advisory Group of the Commonwealth Department of Health and Family Services. She is also a senior lecturer at the University of Western Sydney, teaching criminology, youth work, mental health studies and counselling. She is a registered psychologist, vice-president of the New South Wales Association for Mental Health and a member of the professional development advisory group, the Australian Psychological Society. She also contributes to the work of the guardianship board of New South Wales and the national mental health education and training workshops.

She has previously been a member of the National Health and Medical Research Council working party on the identification, assessment, prevention, diagnosis and management of depression in young people, of the Disability Advisory Council of Australia and of the Disability Council of New South Wales. She also has personal experience working in the fields of depression and suicide and wrote her doctoral thesis on social and psychological effects of manic-depressive illness. For all of her efforts and her wonderful work, Dr Smith was honoured by Her Majesty the Queen, when she received the medal of the Order of Australia in 1990 for services to community health. I ask you to give a welcome to Dr Smith.

Dr SMITH—Well after that build-up, I have something else to add: I am a statistic. I am a surviving statistic. I attempted suicide when I was a young person. I did not see it as suicide. I just wanted to escape a social event I could not handle, which happened to be my boyfriend's 21st birthday—great present for him. Listening to the speakers today, I guess I probably had quite a number of risk factors going for me, which is probably why the education faculty of the University of New England, where I was a student, looked at me after they did the initial psychological testing which they did of all new students and shook their heads and said, 'You are going to have some problems. We do not know what to suggest, but you are going to have some problems.' That was really all the indication I had that I was probably at high risk of having some difficulties at the university.

I was isolated. I was a country girl at university. No-one in my family had ever been to university, so nobody in my family could help me when problems started to arise. I have manic-depressive illness and my first episode just happened to come on in my first year at university. I had no idea what it was. I had had to go away from my home to go

to university, so I was moving away from my home and my family support, and I had no coping techniques whatsoever. I had studied hard, I had got myself to university and I really did not know very much about emotional management.

Fortunately, there was a student counsellor, so I went off to see that counsellor who in due course referred me on to the local GP who in due course prescribed tricyclic antidepressants. I remember that, in the process of prescribing the antidepressants, he indicated in non-verbal ways that these things were dangerous and that I should not take too many of them, and all that kind of stuff. So I got the message fairly loud and clear that I was being given something that was dangerous. Eventually things got too bad. By that stage I was also on valium, which was around in the 1970s—those lovely peaks that we saw on the charts earlier of all those young women like me who attempted suicide with an overdose of tricyclic antidepressants and diazepam—and, of course, there was alcohol.

At university, one drinks quite a lot of alcohol. I visited the Australian National University the other day and, sure enough, they were selling huge flagons of dry red, the sort of stuff that we used drink in the 1970s—

CHAIRMAN—They are still doing it, are they?

Dr SMITH—Yes, they are still doing it, at $7.95 a flagon—cheap death. And, of course, there are over-the-counter drugs. There was a local chemist on the campus and one day, when things got too bad, I collected up all my pills, got my bottle of grog, collected all the over-the-counter pills and drove off into the countryside. Fortunately, I did not know that if you take such a combination all together then eventually it is all going to come up. So I survived the attempt. It was pure luck.

What did help after the attempt and what did help to stop me attempting suicide a bit earlier? I did have access to a skilled counsellor at the University of New England. In the 1970s the University of New England was one of the first universities to appoint counsellors—trained people who actually knew something about depression and young people. I had access to the GP and medication. Unfortunately, for me the tricyclic antidepressants did not help all that much. But that was all I really had and, when I look back, I think there were lots of other things that probably would have prevented the suicide attempt in the first place.

I had friends, but they really had no information about depression and how to help. In the 1970s, if you made a suicide attempt, if you talked about being depressed, if you talked about having something wrong with your head, people accused you of manipulating them and they got very fearful and said, 'You should go off and see a shrink,' and very frightening things like that. If I had had friends who understood about depression and could have helped, that would have helped quite a bit; and, also, if there had been a bit more community acceptance and compassion for young people in crisis. If kids make a self-harm attempt—this was the case in the past and still is in some places today—they are often seen as making a bid for attention or manipulating people. People get very angry if you harm yourself. They say, 'Look at how much trouble you have caused,' and things

like that.

The other thing is that, although I had a sympathetic counsellor, I could only really see him for about two hours a week. That was pretty extensive, but it left a lot of time when I was actually on my own and unable to say to people, 'I feel bloody awful. What is there that I can do?' whereas if I had had 24-hour access to a sympathetic person, I would have had someone to ring up, and a safe place to be. If you are feeling freaked, if you are feeling impulses to harm yourself, you need to be in a safe place. We tend to think that psychiatric hospitals are safe places and, really, psychiatric hospitals can be really frightening, scary places for young people who are experiencing depression.

That was not my last episode of depression. I had a later episode of depression and I did not attempt suicide that time, although I was in fact acutely suicidal. I remember thinking one day, 'For the last three hours I have thought of 101 ways to kill myself.' I did not attempt any of them, but the thoughts were certainly much more active than they had been during the time when I did attempt suicide. By that stage I was involved with the women's health centre. The people who were working there understood how dreadful I was and they insisted I come along to the centre every day. They would come and pick me up and I would say, 'No, no, I am worthless, I do not want to be there,' and what have you. They got me making the tea, doing the photocopying and all that kind of stuff, which distracted me from the suicidal thoughts.

Interestingly, it has been mentioned that there are fewer suicide attempts in war. The health centre was feeling a bit beleaguered—this was in the 1980s—and there was certainly a sense that I had to pull together with my comrades, that I could not let them down by being silly, by not pulling my weight, and what have you. So maybe there is something about the war mentality that does add to your credibility so that you think, 'Hey, I have to put my personal problems aside. I have to pull with everybody else and do something with the community.' The other thing they did was set limits on me. They said, 'You have to come to work. You have to be here. We expect you to do things and to take some responsibility.'

One of the things about depression is that everything is very formless; it is like a black amoeba. If people say, 'You will do this, you will do that and you will do that,' it actually puts some structure on the day and helps you to get away from the black cloud that is over you. The other thing was that, by that stage, I was aware of the danger of suicide, because there was open discussion by my friends, my family and professional workers of how to get help if I was suicidal. It was openly talked about; they would say, 'If you have these thoughts, please ring me up. If you feel like harming yourself, do this. There is always somebody there to help.' So I was very aware that there was a risk and that there was something I could do. By then, of course, I also had some understanding of what depression was and how to cope.

One of the striking things about young people who are going through their first depressive episode is that they do not understand what depression is and they do not talk about depression in the same way that adults talk about depression. In my case, by that stage, I had had some ideas about not believing everything that you think; that if you

think you are going to kill yourself, you do not have to believe that you have to kill yourself and you do not actually do it; that thoughts of death are part of an illness and there is some treatment for that illness; that, rather than trying to analyse why you are feeling so bloody awful, you get distracted, do something pleasant, go for a walk with a friend, or what have you; and that medication does help, it is available and it is effective. I had also learnt by then that not being alone is very helpful—if I am with other helpful people, I am much less likely to harm myself—and that it will actually end.

One of the things I tell my clients when I am talking about depression is that it takes a lot of guts to get help. That is a message we have to get across to young people. It is not an admission of weakness to go and seek help and to talk to somebody. It takes a lot of courage to go up to somebody and say, 'I feel bloody awful. Please, can you help me?' We really ought to be getting that message across and rewarding people for getting help. At present, we punish them for getting help. We say, 'You're weak. You are going off to see a shrink. You must be going crazy,' and what have you. We have to acknowledge that it takes a lot of courage to get help.

The other thing that helped me in my second episode of depression was that I had a lot of support to cope with the emotional impact of major mental illness. We know that young people who have a major mental illness are very vulnerable to suicide. It is emotionally devastating to be told that you have a mental illness. It is a stigmatising illness. Often, people cannot tell you what is going to happen, whether you are going to get worse, whether your life is over, whether there are going to be areas of life which are just closed to you from now on because you have a serious illness?

Fortunately for me, by the time my second episode of illness came along we had comprehensive mental health services. I live in the inner city of Sydney, not in some remote rural area, so I had access to trained mental health workers. The difference with my second episode of depression was that I had 24-hour sympathetic support. Mental illness, depressive illness and people feeling awful require a lot of intensive labour. It is not a matter of just going off to see a doctor. It is also a matter of saying, 'Who is going to be around?' You need a whole network of people around.

Pierre Baume mentioned some cultural issues. I think there are some issues about how we talk about depression and suicide. I have a friend who is Mediterranean. She comes from southern Europe, which is one of the areas mentioned as having a low suicide rate. One of the things she said is that it is okay to express emotion and to talk about it; that feelings are valid and healthy. I come from the dour British tradition, so people did not talk about feelings in my family. When feelings started to come up, they were pretty alien to me and I did not understand them.

The following slides were then shown—

Dr SMITH—There are a number of groups who are at risk of suicide. As the Prime Minister remarked this morning, a suicide attempt by a young person should tell us that the normal social and emotional supports for that young person have not worked.

We have heard a lot today about why it is that a young person in distress has not been able to get help before life appeared so intolerable that suicide was attempted. We know that young people who do seek help and support when going through an emotional crisis or a depressive episode do learn from the experience and they develop coping strategies which help in future crises. The depression may not get any better, but the person does not kill themselves.

If we look at these particular groups of people, the kinds of supports they are going to need are probably going to be a bit different and the issues are different. I think Brendan Nelson mentioned the school prefect syndrome, with which I could really identify. In the national suicide strategy we have not talked very much about the competent, high achieving young people. These people are at high risk because they see themselves as coping and achieving well on their own. When a crisis comes along which they cannot cope with and which causes enough emotional stress to damage their existing coping strategies, they often do not get picked up by people around them. They are seen as coping; they cannot talk about the fact that they are not coping, so by the time they make a suicide attempt people say, 'Why? What happened? There was nothing wrong.' These are the people who cannot admit that they need help. They have done so well so far, so when they do get around to feeling that they cannot cope it is seen as an enormous failure to have to ask for help. They make life easy for everybody else. They do not want to be a problem to anybody anymore; they just want to remove themselves from all the problems that they cannot cope with.

Young gay men and lesbians are at risk because their developing awareness of their sexuality may be at odds with their home community. It is particularly a problem in country towns or remote areas where these young people do not have access to the range of social lifestyles that are available in urban areas.

One of the issues involved in developing a lifestyle is that you need role models. You need to look at people and say, 'Yes, I want to be like so and so. This is a nice person; I would like to be like that person,' and what have you. One of the striking things about young gay men and lesbians is that they often do not have role models. They develop an awareness that they are attracted to people of the same sex, but they simply do not know how to go about forming friendships or how to cope with friendships.

Of course young people go through quite a lot of talking with each other, saying things such as, 'Did you go out with him last night?' and 'What happened?', and all that sort of stuff. Most of us who are heterosexual have probably talked about our friends, about the problems we have been having. Quite a lot of young gay men and lesbians say that when they were younger they could not talk with their friends about the problems they were having in gay or lesbian relationships.

I now turn to Aboriginal and Torres Strait Islander young people. I teach in the Aboriginal rural education program at the University of Western Sydney. One of the things that struck me from a lot of the Aboriginal students we got into the course was the enormous burden of disability and death in their families. It seemed to be that in many Aboriginal and Torres Strait Islander communities young, competent, capable people carry an enormous burden in looking after other people in the community. The more damaged the community, the more stress is put on competent people who can help out other people in the community.

I remember talking to one student who was in her early twenties; everybody in her family had problems. She had one brother in jail, her mother was dying from cancer, her father had heart problems, and she had two sisters who had severe drug problems. She was struggling to cope with a university course and, of course, had been the only person in her family to go to university. So she had enormous stress on her. She would come to me and say, 'I am sorry, I cannot get that essay in because my father is in hospital,' or 'I have to go and visit my brother in jail,'—this kind of stuff. So there is enormous stress for people in those communities.

In relation to marginalised or homeless young people, kids who leave home are leaving not just home but also their schooling, their neighbours and local friends that they might have had. They are often very, very isolated. Many young people leave home because of abuse in the home. Often they leave home without having much in the way of coping techniques, so they end up in a fairly isolated place and they may not be able to learn emotional techniques. The other thing is that kids who have left home because of emotional abuse and violence are often very wary of trusting adults, so it becomes very hard for them to confide in an adult. They often do not have much respect for adults who can help.

If we look at social support and young people, it is natural for young people to move away from family supports—and I think we have to recognise that. One of the issues is that parents often feel, 'This kid should have come to talk to me. Why didn't they come and talk to me?' It is actually quite natural for kids to move away from home and to seek potential partners or form emotional bonds with other people. It seems that the kids who do make it through adolescence—let's face it, quite a lot of kids do make it through adolescence without making suicide attempts or having a rough time—do so because they have managed to form good relationships with other people outside the family, as well as developing their relationships within the family.

If we are going to look at services we have to look at where particular groups of young people seek support when they are in crisis and why it is that some young people cannot get supports or access supports. We certainly heard evidence today that in some remote areas there simply is not the support that is available in urban areas. For example, if a young person moves away from their home town they are going to be geographically isolated from their previous systems of support.

In relation to homelessness and family breakdown, young people who escape domestic violence by leaving home do get cut off from other social and community

supports. So that creates an added burden for these particular young people.

I turn to labelling of services. I am involved in a mental health work force training group. One of the issues that keeps coming up is that we should have more mental health services. Kids do not access mental health services. We have heard a lot of evidence about that. They perceive mental health services as being only for crazy people, so they are much more likely to go and talk to the casual guy down at the youth drop-in centre than they are to go and talk to the counsellor at the community health centre which is labelled 'mental health'.

In relation to inappropriate services, often in country towns there are limited services available and—okay—some community services service quite a range of people. Services which are attractive to middle aged couples may not be attractive to young single people. Also, services which require appointments, for example, during school or work time, may be inaccessible to young people. So a lot of professional services are simply not geared to the needs of young people.

Kids generally lack knowledge about what help is available. I had a phone call late last night from a young person who said, 'My boyfriend is really depressed. I am really worried about him. I am scared that he is going to take an overdose or do something really silly. Where do we go?' She in fact lived in an area where there are a lot of really good services. She had no idea what was actually available.

So kids often do not know what help is available for emotional problems. I guess that fits in with the general community literacy, if you like, about mental health; most of us do not have much mental health literacy. We do not really know what the benefits of counselling for depression actually are and we do not know what anti-depressant drugs actually do. If you have not had the experience of counselling, then you cannot anticipate what help counselling could be in a time of crisis or depression.

Some of the issues which have emerged so far from the national suicide strategy and the previous 'here for life program' are that there are a few things that are good about services, but there are also a few gaps in the services. One of the crucial things is linking youth services and recreation services with mental health services. We tend to compartmentalise mental health. Certainly one of the striking things that has come out of some of the services that we have funded has been that the local youth worker does not talk to the psychiatrist at the community health centre, and the local sports and recreation group does not talk to the youth worker or the psychiatrist, or what have you. We have got to have much more linking between recreation services and youth services and mental health services. I know that health and welfare service people tend to talk to each other, but often services which kids do access, like sport and recreation, do not tend to link in with health services.

There has been a fair bit of focus on the suicide aftermath rather than on the recognition of distress and the prevention of suicide attempts. One of the things that comes from that is that kids tend to learn about suicide and the stress it causes and how dramatic it all is and all that kind of stuff, and it is an option, rather than learning about

what you actually do when you are depressed and going through a crisis and things like that. For every report that is in the paper about suicide, I would really like to see half a dozen reports about young people who overcame adversity in their particular local area. I would like to see some success stories about how people have actually survived particular things and the kind of help they have received and all that sort of stuff.

I think a couple of the speakers today have actually mentioned the reluctance to identify distress in young people as depressive illness. I think the National Health and Medical Research Council is in the process of producing *Clinical Practice Guidelines for Depression in Young People*. One of the things that came out of this working party, which I was involved in, was that a lot of professional workers do not see depression as a real issue for young people. They see it as 'something you will get over'. They do not see it as a serious illness. I certainly commend that publication to you.

The other thing is acceptance of peers as first contact for young people in distress. We do not really need all that many more six-year trained professionals. What we need is more community literacy about how to help someone who is depressed. Young people will often go and talk to each other before they will go and talk to a professional. So we really need to get down to young people in the community so that they can actually help the person get into the right channels for treatment, if you like.

Lastly, we need appropriate places where young people can escape domestic problems and seek places of safety. It does not really matter if the kid goes down to the local youth refuge for help if he or she is going to get some help down there. Certainly one of the issues—particularly in more affluent areas, I suppose—is that parents often want to keep the distress within the family. It is a case of going off and seeing a respectable psychiatrist or what have you. Whereas often for kids it is the person they feel comfortable with who is probably going to help them the most. We really need diversity there. We really need to be looking at the particular groups of young people and saying, 'Okay, what is going to be the first line of contact for this young person? Is it going to be a friend? Is it going to be the local youth worker? Is it going to be the DJ on the radio station? Where are they going to go for help?'I might leave it there actually, to leave some time for questions.

CHAIRMAN—Thank you very much, Dr Smith, for your contribution. I found your contribution particularly moving, given your revelation of your own personal circumstances and your own personal experiences. The fact that you are such a successful survivor makes you a great role model for many other young people who have gone through similar problems. I was also impressed with your presentation generally and the way in which you have been approaching the subject of support services and what we need to do. What worries me, though, is that successive governments have endeavoured to do a lot—I think Professor Kosky said that governments have done a lot—yet we find that over the past 15 years the level of youth suicide has been going up rather than down. I would hate to think what the level would be if we were not doing the kind of work that you are doing, but what more can we do as a community?

Dr SMITH—I think one of the issues is getting the community to take

responsibility for people in distress. I think that there is a tendency in our society to compartmentalise mental health problems. If you are sick, you go and see a doctor. If you are emotionally sick, you go and see a psychiatrist, or what have you. That basically means that people around you do not take any responsibility. We are responsible for our kids in the community, and that means being responsible for young kids who are in distress, young people who are going through rough times. It means taking the time and making the emotional effort—because it does take emotional effort—to actually do something.

The other thing is that we really have to get suicide prevention targeted at every level of government. Local councils have a great role to play, as do state governments, as does the Commonwealth government, as does every community group that is involved with young people or people in general.

I am reminded of some of the successful campaigns we have had. The AIDS prevention campaign, I guess, is a classic one where there has been quite a lot of awareness. It struck me the other day when I was speaking to a young person who knew how to not get AIDS—you know, you wear a condom and you do not share needles and all that kind of stuff—that that message had got through. But this young person happened to be quite seriously depressed and she did not know where to go for help. I thought: we have managed to get the advertising message across that there are three simple things you do to protect yourself against AIDS. Maybe preventing suicide is not that simple, but maybe it is. Maybe we need a sort of depression awareness campaign, if you like, that says that depression is an illness, it is treatable, there are places you can go for help. Family and friends can help—talk to someone.

But we need to get across some fairly simple messages so that when people are in crisis they do not want to escape to nothing which, of course in the case of young people, often means death.

CHAIRMAN—Could your Youth Suicide Prevention Advisory Group recommend to the government such a campaign?

Dr SMITH—I think we should definitely do that, and I think there are a couple of members of the Youth Suicide Advisory Group here today who would agree with me on that. Alan and David I can see in the public gallery there.

CHAIRMAN—Mrs West and then Mr Quick.

Mrs WEST—That was very interesting. In my area in Bowman—

CHAIRMAN—Which is on the south side of Brisbane as you head towards the Gold Coast, but not quite there.

Dr SMITH—My family lives up there.

Mrs WEST—There is high youth unemployment and a large number of homeless

youth. We have got a very supportive youth network, but the way they are dealing with youth in some cases is, I feel, inappropriate in that allegations are made against parents by the youth or by the child, and some are as young as 13, the bureaucrats or the health workers act on their trust and do not inform the parents of where the child is or what the situation is.

I find there are sometimes inappropriate behaviours being set up and communicated with other children because these children then go and tell other children how to do it. And they often put them into a community home where they are away from their family and they have a wonderful time. But they destroy property, they incite riotous behaviour with neighbours, and I feel sometimes our health workers or youth workers are not fully aware of the consequences of putting like-minded youth together in a suburban situation. Their parents cannot access them; the bureaucrats will not tell them where they are. The police are caught in the middle. I have been talking to the health working community and they sort of say, yes, a third of the children often end up back at home, but two-thirds of them continue on in this disparate lifestyle.

How can you improve on this circumstance and what measures do you think can be embarked upon to make sure that the continuing decline of two-thirds of these youth does not go towards a suicide tendency?

Dr SMITH—I think one of the issues is that depression in young people has often been seen as something that has been caused by family problems. It often becomes a chicken and egg situation where, sure, there may well be stress in the family or there may not be, but having a kid in the family who is depressed creates its own stress. And I think one of the issues is that young people are often encouraged by health and youth workers to find the cause of their depression, if you like, or find the cause of why they are feeling so bloody awful. And I think it is very easy when you are depressed to blame somebody: you know, 'The reason I am feeling so dreadful is because my parents were really dreadful, or something like that, or because I had a rough time at school or because society is giving me a hard time or because the government is not doing anything', or what have you. There are all sorts of things you can blame.

It is not really a very constructive way to approach it. The important thing is to say, okay, you need social supports, rather than cutting off particular social supports by saying parents are bad and dreadful, what can we actually do to work out some space for everybody so that a kid gets to see parents but may not be living with them or might need some extra space or what have you.

But I think trying to find causes and blaming other people is a very destructive way of handling depression. Certainly for some kids who develop depressive illness there is no cause, it is genetic. You know, some people like me are going to have a propensity to develop a depressive illness regardless of what is going on around them. Sure, stress will make it worse, but lack of social support is going to make it even worse. So removing a kid from a stressful environment but at the same time depriving them of the social support they might have got from their parents can also be damaging in the long run.

Mr QUICK—The youth suicide prevention initiative has almost, what, a year to go and we are about to have a national youth suicide strategy for another three years.

Dr SMITH—That is where we will be going, yes.

Mr QUICK—And Jeff Kennett has established a task force on youth suicide. Are there examples in Australia where the networks are really working? Can you cite that, for example, Goulburn has something that is working really well? How often do we have to reinvent the wheel, how often do we have to drag the money bag out and say, 'There is some money, you can go and solve the problem'? Are there examples in cities where it is working and rural areas where it is working, that we as members of parliament and service providers can say, 'Let us go along and have a look and listen to what the young people are saying, what the service providers are saying, so that we do not have to keep dragging bags of money out but perhaps can be relocating resources.'

Dr SMITH—I think that is a very important question. When I first got involved in the Youth Suicide Prevention Advisory Group, people came together from all over the country and talked about the projects that they had been running from 10 years ago. There are some very good projects throughout Australia that are targeting particular groups of young people, and they are showing benefits. The problem is that we do not know about the benefits. We tend to see in the media that there are reports of suicide. What we do not tend to see is that in inner city Melbourne, for example, there is a really good program looking at young street kids. They are using outreach workers and they are achieving quite a lot with young people in that area. What we do not see in the newspapers is that in inner city Sydney there is a really good block targeting kids who have made previous attempts or that at Flinders Medical Centre in South Australia there is a very good mood disorders unit specifically for young people.

We really need to be disseminating this information so that people do not reinvent the wheel. That is not to say that we do not need more research, but I think that in addition to the research we actually need to publicise what we have already done and to get kids to evaluate the programs. Yes, the Cell Block Theatre in Sydney was really good because it did this, this, this and this, but I need that, that and that as well. We really do need to disseminate the information.

Mr QUICK—I am a former school teacher. When I went through teachers college and university you were not taught anything about this. When you have kids there from 8 to 3, do we need to alter the education of teachers? The AMA and the GPs, have they been—

Dr SMITH—There is a large program targeting GPs. There is also an enormous amount of money that has gone into hospital and health protocols because often if young kids self-harm they turn up at the emergency department and get a fairly punitive overworked doctor who thinks that people who self-harm are a bloody nuisance. So there is a great lot going into targeting doctors, because they often are going to be one of the front-line people when a kid turns up in some type of crisis.

Schools are very important because kids will often identify with a teacher they get on well with. If kids get some message that it is okay to talk about depression, it is okay to talk about feelings and this particular teacher or that particular teacher or the counsellor knows something about depression and what you can do, that is actually very useful. The way I went to see the student counsellor was because one of my university lecturers said, 'This is depression, this is what it is about, help is available, you can get help.' So I went to see him after the class and said, 'I think I have got some of those symptoms. Where do I go?'

Getting across the message that depression is a set of symptoms and there are things that you can do about it I think really has to start at almost primary school level, because kids get depressed.

Mr QUICK—But then, for example, what if the teacher needs to access services? Because it is another department you have to go through the bureaucratic maze and, because there might only be so many guidance officers or something within a particular area and they are not available today and the crisis is today and it has to be resolved today, there is nobody there and the kid gets second best or gets short-changed and they think, 'Oh well, bugger it, I will go off and do it.'

Dr SMITH—Yes. That is where we need very flexible, innovative services for young kids. If you are looking at services for young people, they have to be free, they have to be accessible and they have to be pretty flexible. I welcome the government's initiative to start funding telephone counselling lines because if there is a number they can ring, that is cheap. They can talk to somebody and at least there is somebody to start talking through some of the issues with before they can get that appointment. Health centres that have a waiting list of three months are not going to suit the needs of young people; they have to be seen pretty instantly.

CHAIRMAN—Those telephone services would assist rural and regional youth as well.

Dr SMITH—Absolutely.

Mrs VALE—Just by way of background, my electorate of Hughes takes in Sutherland shire, which I think still has one of the highest rates of youth suicide in Australia, and it was one of the reasons I actually got involved in politics. The conundrum for me is that Sutherland shire is probably one of the most affluent areas. We probably have, relatively, one of the lowest youth unemployment levels in Australia. The young people that appear to be suiciding in my electorate are children who come from what you would call traditional families, and at least from the outside do not appear to be dysfunctional in any way. I say 'do not appear to be' because I do not know if there is any research that has been done on it. Of course, some of the areas are very high mortgage belt areas, so there could be the money problems that Professor Kosky has referred to, which could be underlying and hidden. Again, this need for research and information I really do see as one of the major problems.

One of the things that I just wanted to put to you that I understood from Professor

Baume is that youth suicide awareness programs that perhaps go into schools could glorify suicide and therefore encourage young people to pursue that course. Just in recent times in our electorate we have actually put a program in schools on youth suicide awareness where we feel that kids often talk to other kids about doing it. The idea is that you can educate the kids at school so if they get the symptoms—and there seem to be certain symptoms that children do signal—they can therefore refer their mates on, as you were saying, to perhaps a school counsellor or somebody who can help them.

Also, part of that suicide awareness program is teachers who are also suicide aware. It is part of the program, and one of the representatives of that program is here with us today. I would like you to comment on the disparity with what Dr Baume said and what we are finding in the schools. An 18-year-old student has actually has the experience of having three of her friends commit suicide. This is just phenomenal. I have lived for over 50 years and I have not had one of my friends commit suicide, yet here is a young person of 18 and she has had three of her school friends commit suicide. But she said that when she went through this suicide awareness program she was quite angry at the adult world. She said, 'If the signals are so clear, why did you not tell me before?' This was the anger that came from her and this was the feedback. I would just like your comments on that.

Dr SMITH—I think we need to reframe suicide prevention. I would like to call it depression awareness or youth in crisis. I think the title of the previous strategy, which was called Here for Life, really has much more of a connotation of, if you are having problems, embrace life, let us do something about it. I think that, rather than focus on the statistics of suicide and what have you—all that tells young people is that suicide is an option, whereas—if you are talking about these being symptoms of depression, these are symptoms of stress, these are things you can do about it and what have you, you are focusing much more on coping techniques and strategies.

I think part of the problem with affluent families is that they tend to be very much more self-contained. They have the access to and can afford to buy the services, if you like, so kids do not tend to get linked into community services. I asked my youth health class the same question, 'How many of you know somebody who has suicided?', and half the class—15 out of 30 kids—knew somebody personally who had suicided. Three of the kids in that class had attempted suicide. They are doing a youth work degree, so maybe that is why they are in there, I do not know, but it shocked me.

Interestingly enough, some of the kids who had not attempted suicide were street kids. They had got the desire to do youth work because they had actually had a really good youth worker and they thought this was pretty fantastic and wanted to be just like him.

One of the things that came up in the discussion was that one of the kids said, 'Well, in some ways, because my family was pretty disadvantaged and there was a lot of abuse and all that kind of stuff, we got to know a lot of health professionals like the welfare workers and what have you.' So when these kids were going through trauma, they had welfare workers to talk to because this was a family that was identified as being at

high risk, whereas kids who had been at private schools and were high achievers, when they started to experience problems with depression, they felt that they had to cope with it on their own. That was when they thought it would not be such a problem if they just got themselves out of the way.

Dr NELSON—Along similar lines to the question that I put to Professor Baume—and I feel you just confirmed it, I must say, but it crystallised it in my mind when I heard Dr Harrison speak this morning in terms of road trauma—we started off with road trauma by looking at seat belts and the design of roads. Initially it was a fairly uncoordinated thing, and then eventually we had a national road safety campaign and a national road trauma authority which coordinated activities in relation to alcohol, seat belts, design of cars, driver education, all of the things which together have resulted over a 10-15 year period in a significant reduction in the number of deaths from road trauma.

The way I see it at the moment—whether it is the mood disorder clinic in Adelaide or whether it is the very good youth programs that run in the western suburbs of Sydney—is that it is all very uncoordinated. The things that the government is doing, extending commitments of the previous government and building on them—as good as they are—I feel are in danger of failing because there is not a national coordination focus for it. I have been campaigning, as has Ms Vale, for a national office for youth attached to the Prime Minister's department, but at least some national suicide investigation and prevention centre. So I would ask you about your attitude to that.

Related to a more specific issue, I have to say that I meet people every day who say, 'I have been to St John Ambulance'; and I go along and I kiss babies and I present certificates to people who have a first aid certificate and are very proud of them—and rightly so—so if you fall down and have a heart attack the chances are that you are going to be right. But the community is very ignorant of the warning signs in relation to depressive illness. Is it possible to educate the adult community in Australia with an education campaign which makes them aware of the problems that ring warning bells, particularly with depression in young people, without at the same time encouraging copycat behaviour or actually soliciting unhealthy behaviours in young people? Is that possible?

Dr SMITH—I think it is entirely possible. I was handed this book by Eric as I came in today, a freebie, and I was flicking through this and thinking that this should be on the reading list of every university study; perhaps it should be required reading for every adult in Australian society. I think I would change the title, though. I do not think I would call it *Suicide—help*; I think I would put something along the lines of 'How to help a young person who is depressed', or 'Going through a rough time—how to help', or something like that as part of their reframing. But the content of it is excellent. It really is like the St John's first aid manual of, 'This is what you do, these are the warning signs.'

I remember writing an article about 10 years ago called *How to help a friend who's depressed*. It was run off on the local university photocopier. I found that I kept running off more and more copies because it was the thing that people most wanted.

People I think are willing to help people who are depressed, but they do not know what to do and they do not feel there is permission or that they are qualified enough—that only a real health professional could help. But there is a campaign in the United States actually called the DART program—depression, research and treatment—and they have put out quite a lot of catchy leaflets. One of the ones that I like most of all is a kind of poster that young people can relate to, and it is called, 'How to help a friend who is depressed'. It does not mention suicide at all. What it talks about is how to help a friend who is depressed. It is a poster type of thing and it can be folded up and used as a leaflet or it can be put up as a poster. They have just been swamped with requests for it through the United States. It has now been funded by one of the drug companies, I think.

I think the important thing is to get across very simple, effective techniques, just the same as we have for what to do if somebody is having a heart attack. Depression is a fatal illness, and I think we have to get that message across. I do not know what the thing for heart attack was but, if someone is having a heart attack, pretty well everyone knows that you get this person to hospital and to help as soon as possible.

Dr NELSON—But is it possible to run a public education campaign which educates adults and teachers and critical people in particular, obviously, but without eliciting at risk behaviour in young people? You know what people are like. If they see an advertisement that says, 'If you're having a heart attack, if you feel sick and have got a pain and all this', all of a sudden people say, 'I think it is me'. Is it possible to do that with depression, targeting the education of adults about the problems, particularly of young people, without actually eliciting at risk behaviour in young people?

Dr SMITH—I think one of the realities about ways of suiciding is that we cannot possibly prevent people killing themselves. Okay, gun control, for example, is one case in point. Okay, as a nation we are spending millions of dollars buying back lethal guns, but we are not buying back every gun in the community. It only takes the .22 rifle sitting on top of the kitchen cabinet in some rural home and some young man who cannot talk to anyone, does not know what he is going through, to actually kill himself.

Even if you got rid of every gun, you can still go to the chemist, and there are always going to be things you can buy over the counter. We cannot get rid of alcohol. We cannot get rid of tall buildings that people can walk off. We cannot get rid of traffic that people can walk under.

So I think we actually have to look at what leads up to suicide, and we have to start right at the very beginning. If you have got a problem, you go and talk to someone. If the problem is really serious, then maybe medication can help. If the medication does not help, maybe there are different people you can talk to. Maybe techniques like exercising and taking vitamins or what have you can help as well. But I think what we have to do is to start talking about the feelings because that is what young people are talking about. That is what Professor Kosky was saying. Young people talk about feelings—'I felt like I didn't want to be here'. So I think we have to address the problem at the feeling level and we have to start educating adults that, when young people start expressing these feelings, this is what you can actually do.

Dr NELSON—And you can do that without actually creating behaviour in young people? You can start talking about drug taking and sleeping in or sudden changes in eating habits and all the other things that we might identify with depression—listening to certain sorts of music and so on? We can do all that and we can talk about it without actually encouraging this sort of behaviour; is that what you are saying?

Dr SMITH—I think we can if we give positive alternatives. Young people who are depressed do not want to be depressed. Nobody wants to feel bloody awful, but the problem is that a lot of young kids do not know how to stop feeling awful. Okay, you learn very quickly that if you get drunk it blots it out for a few hours, and then you feel dreadful the next day so you get drunk again. Young people learn very quickly that there are things that you can get from the chemist that are going to put you to sleep and stuff. What they do not know, what they have not learned, is that talking to somebody can help, that there are trained people around who can help, that the teacher at your local high school knows how to help. The youth worker knows how to help. There is somebody down at the community health centre that knows how to help. The lady next door might know how to help. So we have got to get that message across.

Dr NELSON—Thank you.

CHAIRMAN—Thank you very much, Dr Nelson, and thank you very much, Dr Smith. We will now adjourn for lunch. I suggest we come back at about 2.15 p.m.

Luncheon adjournment

CHAIRMAN—We have decided to do something a little different this afternoon. We want to make it clear that this is not to be a talkfest dominated by members of parliament, even though this is a meeting of our standing committee. Members of our committee have volunteered to move back to the seats where community representatives are sitting, and they are very welcome to come forward into the two horseshoes of seats and then maybe the next row. Members will be in the back row. We obviously have not got enough seats here for everyone, so it is really a case of first in, best dressed.

The clock is running and we must finish this segment at 3.30 p.m. I will get the proceedings under way and, as people join us, they can participate in the proceedings. Before I initiate a general discussion, I understand we have got here Professor Michael Carr-Gregg of the Centre for Adolescent Studies at the University of Melbourne who would like to make a very brief opening statement. We are taking a transcript of today's proceedings, because we want to gather any pearls of wisdom to cast forth so that we are able to pool these for the overall good of national discussion on this important topic.

Prof. CARR-GREGG—I just want to acknowledge and express our special thanks to one of the committee members, Brendan Nelson, for his outstanding leadership in this area. We know that he has been responsible in large part for bringing us all together today. I just want to acknowledge the role that he has played.

CHAIRMAN—Did he write this speech?

Prof. CARR-GREGG—No. The second thing I want to say is that I welcome the emphasis that has been on depression today. As a person who is interested in adolescent mental health, it has been apparent to me for some time now that there is not widespread recognition that the most common psychiatric problem in young people is depression. If you look at the incidence of depression, you find that almost two-thirds of the people who have suicided, certainly in Victoria, were suffering from depression. So I welcome that emphasis.

There are a couple of other issues which were raised which I would like to comment on. One is the Internet issue. We have clients in Melbourne who last year downloaded from the Internet pictures of Kurt Cobain's autopsy, along with his suicide note. I checked before coming here that the pictures of the autopsy have been taken off, but the suicide note is still freely available for any young person to download. So I think that is an important issue.

CHAIRMAN—I think that is sick, if that is available.

Prof. CARR-GREGG—The other issue I wish to raise is the role of the VCE in particular in Victoria in creating the school prefect syndrome that Dr Nelson addressed. There have been a number of young people in Victoria who have clearly buckled under the pressure of the current system of assessment. My 17-year-old son did one subject in VCE last year in Victoria and he was subjected to one year of continuous assessment, not one year of continuous learning. I am delighted to say that the Victorian Minister for Education has initiated an inquiry into that assessment system, and perhaps the committee might like to spend some time looking at that issue.

The other issue is that the Centre for Adolescent Health has conducted a lot of research into depression. Not only is it clearly significant in the incidence of youth suicide, but we believe we have some very useful information in relation to its role in other health compromising behaviours. A research project of some 2,500 young people in years 7, 9 and 11 reveals that depression seemed to be a key indicator in the number of young people abusing drugs. In particular, we found that young people who were depressed were twice as likely to smoke cigarettes as those people who were not depressed. They were three times more likely to abuse alcohol and other drugs in a manner which was hazardous to adults—let alone to young people.

So what we are suggesting is that there is co-occurrence of health compromising behaviour in depression and that many of the inquiries that have looked at single risk factor issues such as smoking really need to broaden their horizons and start looking at depression as well.

In conclusion, I wanted to say that I have just recently come back from a fairly extensive tour of rural Victoria, where I spent a lot of time talking to some young people. It is quite clear to me that one of the biggest problems in depression in those young people is that mental illness in the rural areas still appears to be regarded very much as a moral failing rather than, in fact, an illness that needs to be treated and dealt with. Thank you, Mr Chairman.

CHAIRMAN—Thank you. Are there any comments? Would anyone like to make a contribution or suggestion?

Mr WILLIAMS—I am here with two hats. I am here as a school teacher, employed by the New South Wales Department of School Education. I am also here on behalf of an organisation called the Gay and Lesbian Teachers and Students Association. I was very pleased to see this issue get up today. For a while I did not think it was going to. The reason I am particularly pleased is that this week—and some people might have been aware of this from the news—a 13-year-old boy at Cranbrook High School in Penrith had attempted suicide three times because of serious problems, both at home and at school, in relation to his quite obvious homosexuality.

The boy, from about the age of 10, had started exhibiting mannerisms that made the parents believe that there might be something unusual about him. He was a very effeminate boy. He is quite tall and mature for his age. He will be 14 in a few weeks. This boy was bashed by his father and called an 'effing faggot' on a regular basis. He was, in fact, hospitalised because of his injuries to the extent that the mother has divorced the husband and has ordered him out of the home under police escort. The older brother bashed the boy and went to school and told the other school mates that this boy was gay, and they bashed him. This boy has only one friend in the world, and that is his mum.

We have had to arrange for this boy to be transferred out of the school. We could not persuade him to go back to the school. He is in the refuge for five days a week going to a safe school, and the other two days of the week he is going back into the western suburbs to live with mum. The home they live in has been vandalised. There has been graffiti sprayed on the front driveway. The telephone wires and powerlines have been cut. The windows are smashed on a regular basis. Penrith police are forever taking photographs of the damage, but they never manage to catch the perpetrators. The reason I mention all this is that you can see how a person—aged 13—might consider suicide after such a background.

Like any other teenager, a young gay or lesbian person would generally look at four strong areas of support: the home and family, which should be the strongest and most reliable—clearly not in this boy's case—the peer group, which is a tremendously strong influence in a young person's life, the church and the school. In the case of young homosexual people, it can often arise that three of those areas are not available to them. The home and family may evict them because of their putative or actual homosexuality, the church may condemn them and the peer group will probably bash them. That only leaves school. If school cannot help that child, then they are in real trouble.

What can be done about it? We are talking about one of the most marginalised, stigmatised and disenfranchised groups in the community, and we are also looking at a group in society which is discriminated against legislatively across Australia. We have a different age of consent in every state in Australia—21 in Western Australia, none in Tasmania, 16 in the ACT, 18 in New South Wales. We are treated specially by legislation. Antidiscrimination legislation is different in every state. It seems there is something so special about us that we cannot be treated equally across Australia. A young person will

perceive this and think of themselves as being different. We need to get consistency in legislation across Australia in a number of areas, like which side of the road you give way to—in Melbourne it is to the left and in New South Wales it is to the right—or drink driving: how much alcohol you have to drink to break the law in one state is different in another. We need to get that rationalised so that we can provide a stable basis for other things to occur.

There are a number of statistics that show to what extent suicide ideation does occur in Australia amongst gay and lesbian youth. Because of the nature of the sample, these cannot be gathered using AGB McNair surveys where you go into the class and say 'Hands up all the homosexual students, come out here for a survey'. If you ran a survey along those lines, you would find the number of homosexual teenagers in Australia was zero. We know that is not the case. In order to conduct research—which has already been acknowledged as badly needed—we cannot go through those typical surveys of 'Hands up, who is the homosexual who is being suicidal today?' We need to find other ways of getting this information.

The *Out of the Blue* report released by the New South Wales Police has information about suicide ideation by homosexuals. *The Young Lesbian Report* has figures. The Gay and Lesbian Teachers and Students Association had a $30,000 federal grant in 1993 which had several hundred responses from young people. That was a one-year pilot grant which is now finished. While we were there, we got a lot of people referred from the Kids Helpline. We have two young people from our organisation who have been asked to sit on the advisory council for the Kids Helpline. A lot of people do not ring the Kids Helpline but will ring us, because we cater specifically for their needs.

It is my belief that, as part of the national strategy so ardently and eloquently advocated by Dr Nelson, we do need a national approach to a number of areas, in particular gay and lesbian youth. I propose that we reactivate our pilot and make it a national hotline with a 1800 number accessible from anywhere in Australia. The infrastructure is still there—the phones and the office. The willingness is still there. The kids who get home at 3 o'clock and want to talk about the problems they have had at school before mum and dad get home cannot talk to anybody. That is our position.

CHAIRMAN—Thank you for that. I do not want to inhibit anyone's contribution as we go into this discussion, but we have got a substantial number of people here: could we try to limit the contributions to, perhaps, ten minutes. If you have got something else to say we will try to give you a little more time, but if you can condense it and make it more concise that might be in everyone's interest.

There is a gentleman here who had his hand up.

Mr CHAAYA—I am not necessarily here on behalf of any particular organisation, but Coral McLean from the Holy Family Centre, who sits on my left, is someone who has an enormous amount of experience at the coalface in terms of youth suicide. My experience is that I spent a year in 1995 as part of my undergraduate year and wrote an honours thesis on the political dimension of youth suicide. Prior to that, I spent four years

as a member of the New South Wales Youth Advisory Council. That is where my background is in terms of youth affairs.

I take this opportunity to thank both you and the committee for the invitation today. I think it has been a very thought provoking discussion, and I commend the speakers for their presentations. One initial observation that I would like to point out, however, is that if you take a quick look around the room you will see that there are certainly no young people here today. I do not know whether that was a deliberate attempt—

CHAIRMAN—Youth is relative, and we extended a wide range of invitations.

Mr CHAAYA—Youth is relative, certainly, but I would hate to ask the people in this room right now how many are under the age of 24. It is perhaps something that the committee deliberately—

CHAIRMAN—Four or five people have volunteered. I do not know whether they are telling the truth.

Mr CHAAYA—What I am raising is just a question of consultation. I would like to think that this committee will not be limiting its future report or recommendations to the government to this seminar today. It certainly has been very useful, but I would like to see this consultation take place on a bigger and wider scale.

CHAIRMAN—One of the options that we have as a committee is to seek a reference from the Minister for Health and Family Services to have a full inquiry into the subject of youth suicide. That would, of course, involve public hearings in all capital cities and receiving submissions from all sectors of the community, including youth. The reason we have the seminar today, though, is to test the temperature of the water just to see if we could make a contribution to the government's response to the youth suicide tragedy. There was no attempt to exclude any sector of the community. Indeed, we have endeavoured to be—the secretary would confirm this—as inclusive as possible.

Mr CHAAYA—Thank you for that clarification, Mr Chairman. In which case, I think everyone here would certainly agree that that would be a step in the right direction in terms of the further basis for consultation. The issue which I want to raise is something which I had to tackle in my honours year in writing about the issue of youth suicide. I had the privilege of being able to engage in some first-hand research in the areas of Dubbo, Wollongong, Mt Druitt and Marrickville with two types of sample groups. One I referred to as the medico group. It was predominantly made up of people such as Professor Kosky, Pierre Baume and the other speakers we have had today in terms of a clinical or a medical policy type approach to the issue. The other I referred to as the clinic group. It was basically young people, predominantly in youth refuges. Some were involved in alternative schooling, et cetera, or were from education centres such as the Holy Family Education Centre in Mt Druitt. They had either attempted suicide or had something to say about the issue.

What came out of my research was that there is certainly a great deal of interest in this area in literature. I am sure the speakers today can tell you that there is an enormous amount of reading in the area of youth suicide. There are so many dimensions and facets to the issue, and the complexity of the issues is certainly far-ranging. That was highlighted today.

The point I would like to get across to the committee is that, if anything is done, there is a recognition of the fact that there seems to be a divide in the literature about whether this is really a mental illness problem or just a social malaise which becomes part and parcel of government's social responsibilities in terms of dealing with youth affairs or with any sector of the community. I would like to think that we can have a collaborative approach which involves psychiatrists, teachers, researchers, academics, youth workers and community health workers—the whole gamut. I would hate to think that the previous debates, about whether or not youth suicide is purely a mental illness or a factor which should attract the attention of anyone involved in social and youth work, were put aside. In terms of a collaborative national effort, I would see that there would be a cross-portfolio multidisciplinary approach to the issue—one which looks at the broader dimensions, the social issues which Pierre Baume so well illustrated earlier today, complemented by the clinical focus which I am sure cannot be underestimated either. That is the only point I would like to make, and I commend that.

CHAIRMAN—I think our presenters made it clear that, while mental illness was an element of the problem, it was not the only problem. I think your fears are probably misplaced—I hope so, anyway.

Mr CHAAYA—The reason I raise it is that it seemed the focus was on responses in a mental health paradigm or a mental health framework, whether it be consulting with GPs or training GPs, for example, about the primary intervention strategies they can use. Why not extend that to teachers, to youth and community workers, et cetera? It is understandable that coming from Professor Kosky's point of view that is his area of expertise and that would be what he should be recommending. Similarly, with Dr Smith's presentation about depression and the need for a mental health approach, again, I just wanted to make that clear.

CHAIRMAN—Could you let us have a copy of your thesis?

Mr CHAAYA—I would be quite happy to do that, Mr Chairman.

CHAIRMAN—If you could pass it on to the secretary, that would be appreciated.

Mr ROBINSON—I am a youth worker with the Sutherland Shire Council in Sydney.

CHAIRMAN—You would know Mrs Vale.

Mr ROBINSON—I do, very well. I have a model that might be helpful at a federal level. We did some research, probably less than 12 months ago, and realised that

there were so many different responses to youth suicide that it was almost ridiculous; that it was all uncoordinated. It was almost A competition in some ways trying to resolve it. Local government sponsored bringing all those groups together and we actually had what we call a youth suicide partnership day. We had 25 school counsellors, local psychologists, people from mental health and also from adolescent health, people from funeral parlours, local members of parliament, all the youth and community workers in our area and various other people that do not come to mind now.

Since then that group has chosen a smaller group to implement what came up from that day, to consult with those people again as to whether this was their appropriate response. There is plenty of space for input from those people. That is what is happening locally. It is interesting that everyone is talking about depression because there is a coping with depression course being offered through high schools and so forth.

Also, the other thing is just some ways for parents and teachers to be able to quickly identify who are the resources in our community that we can access—something we can put on teachers' walls, something we can give to parents and so forth so they can identify behaviour. In a sense, I am fairly solutions based rather than theory based. I think it was Brendan Nelson who spoke before about some sort of coordinated response. We have Victoria already doing something. But the dilemma I have is that if you do something nationally I think you have to make sure you are inclusive all the way through of every level of government, community groups and so forth. That is what we tried to do at a local level.

The other thing I think you need to look at is trying to gather together what is already happening, hear what is happening out there already. I am giving you some anecdotal evidence of what is happening. Gather that up so that can be given somewhere else, so that I can then read about it in the Sutherland shire and say, 'This is a great idea in Perth. Let's trial something similar to that,' along with a whole lot of information of what is the up-to-date thinking in various areas. That has been the dilemma for all of our local workers—this socialisation stuff that we were talking about before. When do we talk to young people? School counsellors are saying, 'What do we do? Do we bring people in to talk about the subject or not?'

Another other thing, too, is to have a clearing house somewhere where we can get information. This is where I am in two minds as a youth worker. I believe in consulting young people but I am also hearing a lot about—Meg talked about it before—making it so normal that it is a normal response and how you do that and how you consult with young people. I believe in consulting young people, but I am still in two minds about how you do that. Maybe it is part of the response. We want to hear from young people about some of the underlying things. What are the solutions?

It is like the Labor government when they had that Priority One program in 1985. As a young person—I was an older young person—I felt really important because of that. It fell off, which was a shame. There were some statements in it like, 'We value young people'. It was about the culture of valuing people. That is a completely different edge altogether. The guys from AYPAC might have some more to say about that. Also, maybe

there needs to be some funding towards initiating some best practice. Let us keep thinking about it and let us keep churning through what is best practice and so forth.

CHAIRMAN—I think there is some funding included in the government strategy amongst the $19 million of expenditure announced in the budget. The committee is actually going to have a briefing at its next meeting from the Department of Health and Family Services on exactly how that money is going to be spent.

Mr ROBINSON—That would be good if that is clearly able to be identified by local groups or regional groups as well. There have been some good initiatives with Lifeline and so forth. I went to a meeting of 25 school councils and they were very stressed from having so many incidents of suicide. It would be good for youth workers to be able to say, 'Okay, we can get some funding to trial something we want to do.' Council just funded $2,000 for that depression course I mentioned before because we have not been able to find any other funding anywhere else to do it. But maybe that is a project for local government anyway.

CHAIRMAN—How many people reside in the Sutherland shire?

Mr ROBINSON—There are 200,000 and there are 37,000 young people. We had sixty people at the partnership.

CHAIRMAN—And young people are people between—

Mr ROBINSON—The ages of 12 and 25.

CHAIRMAN—A message for any of us over 25 is that we are old, is it?

Mr ROBINSON—You certainly are not classed as a youth.

CHAIRMAN—I think that was the point the gentleman was making here. Any further questions or comments?

Mr WRIGHT—I am from Victoria Country Youth Services. My particular interest is rural communities.

CHAIRMAN—Where are you actually from?

Mr WRIGHT—Ballarat. The organisation covers about 60 per cent of rural Victoria and we have a particular emphasis on communities of up to 4,000 or 5,000. So we know about the very small communities that do not have services.

There are just a few points I would make briefly. The first one is that any response to rural youth suicide needs to be looked at in the context of the massive changes that occur in rural areas. There is enormous social change going on. It is an international issue; it is not just an Australian issue. It is impacting at all sorts of levels of rural communities. I was very pleased yesterday in a meeting with the staff of the Hon. John Anderson to

hear about the attitude that is developing there in terms of looking at rural communities wholistically, that is very exciting I think, rather than simply agricultural resources for the nation.

Related to that is the issue of hope and valuing of young people. I think this goes well beyond rural communities, but I see it in my case in rural communities—that is, young people often lack hope. There can be a real sense of hopelessness about their futures, particularly in rural communities, and there is not a lot being done to actually give them that sense of hope and responsibility in those communities. On a much broader social level, it is about how we value young people in our whole society. Young people get an awful lot of messages that they are not well valued and I think that is a massive national problem.

The second point I would make is that any response to this issue needs to be integrated into existing services. Far too often we see new initiatives come from state and federal levels. They do not take account of what is already in place. They do not work through existing structures. They come in and overlay another structure which then disappears two or three years down the track. I would be making a very strong bid that any resources that go into this area go in through existing structures and actually reinforce and broaden the capacity of those structures.

CHAIRMAN—For example, what structures?

Mr WRIGHT—In our instance, we have a number of services on the ground in Victoria and I would be arguing for funding to go into expanding those services or providing ancillary services within those existing community based structures.

CHAIRMAN—But can you give us specifics of a couple of the services you are referring to?

Mr WRIGHT—Yes. Our organisation, for one, has regional workers who work across a whole range of small communities. Our organisation—and this sounds like a crude plea for resources but it is not—knows the rural community extremely well and we would be in a good position to take on additional staff to become specialists in this area or to provide training or to facilitate the delivery of training into small communities through those sorts of networks that already are in place.

There is a whole range of regional services, regional organisations that are doing some of this work. They would all be in a position to take on existing resources and existing staff. They already know their communities. They already have those links. They already know the networks. So to deliver a good response those structures are already in place.

The final point I would make is to endorse the national strategy. I think that is essential. We are all familiar, those of us who work in the field of any sort of human service delivery, with the problem that comes up time and again of a variety of services being funded from a diversity of sources—often not knowing what each one is doing. So a

national strategy provides the potential, particularly in this area, to have a coordinated response.

As part of that, some thought could be given to the point that was raised earlier about having some sort of national database of best practice, which could be available through the Internet. Databases of best practice do exist but often they are as inaccessible as any other services. That is a real problem. So that is a practical response I think this committee could look at.

CHAIRMAN—Thank you. When inviting people to speak, I would like you to know that any member of parliament who is not a member of our committee is welcome to participate.

Mr GREGORY—I am not sure whether I should follow on from Ian Wright, because there is a possibility that the rural push will seem to be over-represented.

CHAIRMAN—I think the rural areas are certainly over-represented with youth suicides.

Mr GREGORY—Working as I do for the National Rural Health Alliance, I cannot imagine—

CHAIRMAN—Whereabouts are you based?

Mr GREGORY—I am based in Canberra. I am one half of the staff of the National Rural Health Alliance. We are a peak body of 18 national organisations representing the providers and consumers of rural and remote health services such as allied health, nursing, the Royal Flying Doctor Service, and Aboriginal and health services. I work as an advocate, with another person, for the alliance in Canberra.

I want to do two things: firstly, table a document for the committee's interest and, secondly, make a comment. The document I want to table—which is fresh off the print yesterday—is the *Communique and Recommendations from the 4th National Rural Health Conference*, which ended in Perth a fortnight ago. It was the biggest ever meeting held on general rural and remote health issues in Australia. We had between 750 and 800 people there from all parts of rural and remote Australia. It contains recommendations, many of which pertain in a general sense, and a few of which pertain in a much more specific sense, to mental health and youth suicide in particular. So if I could table one of those.

CHAIRMAN—The committee would be pleased to receive a copy of that.

Mr GREGORY—The second thing that I wish to do without trying the patience of the chairperson is to make a comment about rural and remote areas. There was an emergence this morning of what I thought was a very useful element of this whole complex issue, which is new to me, and that is a focus on depression awareness—education about depression. Following on from what Ian has said, I would like to make some comments which perhaps take the issue of depression back one step further and

analyse some of the reasons why depression is caused in rural and remote areas and is caused in a different way in rural and remote areas. However complex the causes of rural youth suicide, we have been reminded today that there is a range of adverse conditions—of which suicide is only one—which are different and which act differently in rural and remote areas. The difference in many cases is worse; there is a difference in degree.

These conditions which are different, and in many cases are worse in rural and remote areas, include mental illness because of the visibility of the matter and the way that stigma applies. Other ones, I would assert, which are also different include infringing sexual norms and sexually related illnesses. There is even an apparently mundane issue such as loneliness. Loneliness is different qualitatively in rural and remote areas. Clearly one has fewer support networks to go to—apart from one's immediate family, hopefully.

What these examples do, I would assert, is to emphasise the fact that equivalent conditions or problems do not have equivalent effect in rural and remote areas. The responses to these equivalent conditions, therefore, need to be greater or different. They need to be relevant to rural and remote areas, and they need to be culturally appropriate to rural and remote areas. Therefore, it is particularly important that we develop and apply programs which, in the case of the organisation for which I work, are related to the general health and wellbeing across the board and meet the particular needs of rural and remote communities. I have been impressed this morning with the number of people who have said: ask the people. Somebody actually said: ask the people especially in rural and remote areas, because they are particularly well equipped to tell you what their community needs.

We know what we need to do. We need to ask the people, and we need to design services which fit. The reality in rural and remote areas is the reverse; that is, services are decaying. There is a rationalisation of businesses; there is a loss of jobs; there is a general malaise and continuation of the decline, which is certainly not new but which is now arguably worse than it has ever been before, simply because of the numbers. That leads to the anomie, which was described by somebody this morning, which applies severely in rural and remote areas.

It has been a delight to hear reference this morning to the bipartisan political nature of support for tackling the problem of general youth suicide. How I wish there was bipartisan political support for doing something to care for rural and remote communities, to try to have an explicit policy for the development of rural and regional areas which made them better places in which to live and work. I wish, too, that the drain of people and professionals, doctors and every other health professional, from rural and remote areas was not so severe, so it was not so hard to recruit new people.

The point I am making is that the equity and the safety net and the redistributive ends of the welfare state, in my view, truly justify the means. Yet we seem to be in a new age, where the welfare state is becoming something that is tainted. We seem to be withdrawing from what someone referred to this morning as the social responsibility of the governments. In my view the social responsibility of the governments covers not only an issue as immediate and as devastating as youth suicide but also all of those people who

are in rural and remote areas, for whom the alliance is an advocate, who are suffering.

There is not strong bipartisan political support to do something meaningful, sustainable and long term to make rural and regional areas decent places in which to live. If you want a social reason, we have it in this room. If you want an economic reason, then I will give you two: first, a third of the people of Australia live there and, second, a large proportion of our export income is generated there.

CHAIRMAN—Mr Pringle, would you like to make a comment?

Mr PRINGLE—No.

CHAIRMAN—Mr Mason, would you like to make a comment?

Mr MASON—Yes. My interest in the aspects of youth suicide was nurtured by the Salvation Army, which asked my company to create an advertising campaign designed to highlight the problem of youth suicide. It was to educate all people of the signs of youth in trouble. The Salvos came to us late last year.

This briefing was given to us and, as we began to prepare a campaign and delved further into the subject matter, we realised we could not responsibly write a campaign without knowing the full facts. Most of you know the facts, but I think we should take a moment to repeat some of them.

Australia has the fourth highest youth suicide rate in the world; that is, 16 young lives per 100,000 people. We have the highest suicide rate in the OECD and, based on the figures supplied today, there are six people killing themselves per day. That is 2,190 young people losing their lives annually. Compared with car accidents and AIDS victims, more young people die taking their own lives.

Why? Why do they do it? We went into this and we believe that a lot of young people think they have no purpose in life. They do not think they are achieving anything. They have a feeling of isolation and nothing to look forward to, particularly in the rural areas. Our youth is pessimistic about the future, and they do not seem to have any respect for our past. Some are even rejecting the church and the effects of multiculturalism in Australia.

We thought of a possible answer, and it is a little stab in the dark. We, as Australians, see constant change. For example, if there is a change of government, they change the policies of the former government. There are people who want to change our flag and they want to change our constitution. There are some politicians who even want to change our national anthem.

These continual changes of the goal posts on the political landscape must have a detrimental effect on our youth, as it diminishes the history of our country. There are warning signs our youth are giving us when they start morbidly talking about death and dying. They give hints verbally or in written form. They even threaten suicide to the

young people around them.

Our youth are in trouble when they start doing the following. They start giving away their prized possessions: their bike, their CDs or whatever they consider their closest things. They start being reckless. They drive faster. They might go bungee jumping. Mind you, I do bungee jumping and I am not going to kill myself. I did it four times, and I do not know why. But they start doing reckless things. They also withdraw from their family and friends. Other signs to look for in our youth are mood changes, depression—and we have all talked about that today—low self-esteem and an inability to deal with the present and a pre-occupation with the past. They talk about the past and they do not talk about the future.

We believe prevention is possible. Everyone here today is the beginning of an important step in the right direction to solve the problems of youth suicide in Australia. I understand that the media reporting of suicides can increase the numbers of youths killing themselves. However, we do need to communicate by advertising. We know advertising cannot solve the problem of youth suicide, but what it can do is bring a heightened, unified social awareness to it and direct that awareness into a positive social force.

Like an AIDS campaign or an anti-racist campaign, advertising can engineer a response to modify psychological behaviour based on so many disparate needs. Advertising can, and should, be used to create an awareness that the government cares about the problem. We believe that, if we symbolically portray the overall problem of attitude and lead people to information and concerned programs already in existence, then we have set in motion a powerful force for positive action and concern.

CHAIRMAN—That is what an earlier speaker said—to link into existing bodies and existing programs.

Mr MASON—That is right. We need to tell people. I heard speakers today talking about the fact that they are there, but no-one knows they are there. We are saying: educate people and tell them they are there. We have to set in motion a powerful force for positive action and concern. Posters, billboards, bus signs—we have all seen that sort of advertising and it can carry the same message as television campaigns. It should be a simple message, one that everyone can understand, and it should not stigmatise, lecture or preach.

CHAIRMAN—I wonder if you might be able to wind up pretty quickly, please?

Mr MASON—I am—I have one and a half pages to go. We believe a properly executed campaign will leave all Australians to reflect—

CHAIRMAN—Perhaps you could precis it.

Mr MASON—If you do not mind, I have come down here today for this. Can I have one more minute, please?

CHAIRMAN—One more minute.

Mr MASON—It is too late when a young person has died. They are dead and they leave behind their families and friends in total grief. Money is spent on counselling the people left behind, at great expense to our community. It is not just the monetary expense. It is a young person who has died, who cannot mother or father future generations. This is the greatest loss for us as Australians.

We must act quickly and decisively from today to ensure whatever is done to educate Australians on this problem is also carried directly into the schools to teach our youth how to cope with life with its up and downs. We as adults have been through it, and will continue to go through it, until the day we die. Our youth is demonstrating to us that they cannot cope with life in general and we must show them the way. We must ask all Australians, whether they be parents or single, to watch out for the warning signs. We must educate Australians as to what those signs are and how to prevent youth suicide. Thank you.

CHAIRMAN—On the question of warning signs, do those who have had experience in this field feel that, if families and friends were more aware of the warnings signs and more able to recognise them, we would be able to save a lot more young people? Yes? That is a general feeling in the room, is it?

Mr MASON—That is what I am trying to say.

Mr HUMPHREY—I have to disagree to a certain extent. I am the parent of a suicide who was aged 23. We knew that there was a risk, we knew that the warning signs were there. But you cannot look after the person 24 hours a day. You cannot be around to make sure that you are there at the trigger point, so to speak. The question is: what do you do when you know? That is the very difficult question to answer. I think we have to put in place—

CHAIRMAN—What is the answer?

Mr HUMPHREY—We have to look at educating people to reveal their state of mind. We have to look at helping them to reveal to you what their problems are and helping them to solve the problems. We have to educate them in ways of solving problems themselves. We also have to educate them in how to learn in schools, not just what to learn, so that when they are going through the educational process, which is creating an aura of stress these days in secondary schools, they understand how better to get through the studying and make sure that they get their qualifications to move on, which might seem to be an unsurmountable problem.

CHAIRMAN—Can I pose a question to you? While I was sitting at the head table here I was handed a letter. It was marked ‘For my eyes only’ and it was from a man of almost 78. He referred to the fact that he had contemplated suicide twice, in Broken Hill in 1938 and in Bangkok in 1966. That reference was in passing only. Then he said that his own son suicided in November 1995—his fifth attempt. There were no drugs, he had no

women, no lack of a job. He just wanted to quit the hassles of modern society in our country. What kind of advice would you give to a parent who may not have known about those previous attempts and who thought that his or her child did not have any particular problems?

Mr HUMPHREY—That is certainly one of the most difficult questions to answer. I guess that all that a parent can do, basically, is to show how much they care about the person and to indicate to them that they are valued, not only by their family but by the rest of society, and that they have a contribution to make. But that can be very difficult when the person is suffering from intense depression and has a kind of tunnel vision where they cannot see anything else but wanting to relieve that state of mind and to get some peace from what is going on inside their heads which is simply focused thoughts on killing themselves.

CHAIRMAN—Thank you for coming along, having suffered the tragedy that you have experienced. By participating and by acting as a support to other people you are really making a contribution to saving other young people. I thank you for that, on behalf of the committee and of everyone here.

Mr HUMPHREY—Thank you. As well as being a board member of Suicide Prevention Australia, I am Chairman of the New South Wales Association for Mental Health and President of Club Speranza, which is a consumer alliance of people who have been touched by suicide. I do have some other comments I would like to make.

CHAIRMAN—Thank you. I will come back to you.

Father NORDEN—Mr Chairman, I wanted to make two very specific points, one of which picks up your question about those who have attempted suicide. We were told this morning that 60 per cent of people who complete suicide are recorded as having made previous attempts. I think we run the risk in general discussions about this topic, of failing to take action in areas where we do have some knowledge and of distributing that knowledge effectively.

Recently, Jesuit Social Services completed a research study of the Catholic hospital system. There are 57 Catholic hospitals throughout the country. We looked at Catholic health care's response to attempted suicide. We found a very mixed response. But the report, which I can table and make available for members of the committee, found that there was a very real danger in a holistic approach not being taken.

Many times, young people came into casualty after an overdose or self-damaging behaviour. They were stitched up or their tummies were baled out and, within 24 hours or less, having not even been received into the hospital, they were back out on the street. That happened in some of the hospitals we investigated. In others, they had a better response, such as the availability of 24-hour mental health assessment, not necessarily by a psychiatrist, which would be very expensive especially in smaller hospitals, but by people suitably trained in psychiatry—a psychiatric nurse, for instance. Unless mental health assessment is available when someone comes in after an identified suicide attempt, it is

very difficult for the health professionals to take further steps.

We also found some hospitals had the capacity to engage something of that youth culture. A person in crisis who has just attempted suicide and finds himself or herself in casualty is obviously going to be very difficult to engage, especially by unknown professionals in white coats. But if, for instance, the public hospital had someone who could engage in that youth culture, who might be wearing a tee-shirt and jeans but who might be a psychiatric social worker, we found that that was a very effective approach.

We would suggest that, if 60 per cent of people who complete suicide have attempted suicide, many of them would have come to the attention of the public hospital system. We should be seeing that the public hospital systems have the capacity to respond. Many of them do not, often to do with financial constraints from state governments.

The second area I wanted to mention briefly is that, as we well know, many people who have serious mental illness are not engaged by health professionals in any way. The recent national mental health report highlighted this when it indicated that 50 per cent of people in Australia with a serious mental illness are not receiving any assistance at all, either from the mental health professionals or public hospitals, or even from general practitioners. Young people particularly are going to be amongst that population of 50 per cent, because of the difficulties of engaging young people who might be depressed and considering suicide.

So I think we need to develop skills within the community that can effectively provide professional services, whether they be mental health services or other helping professional services to young people. That means being able to engage in that youth culture. One of the initiatives that we are involved in in Melbourne is the demonstration project, partly funded by the federal government, which is looking at young people who have a mental illness, who are not receiving assistance with that mental illness and are then self-medicating, often using heroin. The ready availability of heroin in Australia at the present time, higher quality and much cheaper price, combined with the alienation that many young people experience and especially with the increasing rates of youth unemployment, are raising the significance of young people with a dual disability.

So we are trying to target that particular group and model a way of intervening. It is no use talking about effective intervention with youth suicide unless we are going to be able to engage in that youth culture in various ways. That means having not youth workers, who often do not have the professional skills, it means having clinical workers able to engage in that youth culture. If we rely on youth workers to do this job we will not go beyond the crisis intervention. We have to move it further so that we can develop models of professionals, mental health and drug and alcohol professionals, being able to engage effectively with young people in crisis.

CHAIRMAN—Thank you, Father Norden.

Mr MATTHEWS—I coordinate a youth support service in Canberra as my job but I am involved in a range of other activities in the youth affairs area. I have spent the

last two years being the young spokesperson for AYPAC, which is the national youth peak body for the non-government youth sector. I also represent AYPAC on the federal government's youth suicide prevention advisory group.

I just wanted to make a brief comment in relation to a comment that the chairperson made today, which was about the idea of an inquiry about youth suicide. I guess my personal response to that would be that I would not be in favour of that myself, because, while such a process may have a lot of potential benefits, I think it also may have potential harm as well, particularly in raising expectations about what the community can actually do about this problem and what a long haul it is going to be solve it. That is just a general comment on the idea of having an inquiry.

What I would encourage all members of this committee to do is to look at their own previous work in this sort of area, most particularly the inquiry into the aspects of youth homelessness report which was undertaken under the chairmanship of Allan Morris. Whilst that was focused on youth homelessness and not youth suicide, all of the issues are there in the report: the lack of response, the mishmash of federal and state government responses, the issues relating to family breakdown, the difficulties on the family unit and historical developments which are placing increasing pressures on young people, such as youth unemployment. I think quite clearly there does need to be more research, and Pierre Baume and others have raised some of the areas in which there needs to be more research done, but quite clearly there is work that we can do straight away. There are strategies which we can look at doing straight away. The idea of having some national coordination with cooperation from the states is the best umbrella in which to do a lot of that work.

One other process which I would like to draw attention to as well is the Royal Commission into Black Deaths in Custody, which again is a very important issue in the whole area of suicide. Again, statistics have been given this morning about how suicide is particularly affecting Aboriginal young people, particularly younger Aboriginal young people, which was a concern. If that is in any way reflected through the age groups as people get older, then that is going to be a very disturbing trend.

CHAIRMAN—How old would a younger Aboriginal person be?

Mr MATTHEWS—On one of the graphs that was put up earlier on, I think 18 to 25 was one of the major age groups that had a high limit. With one of the graphs for the Aboriginal young people it was 14 to 18, so it was even at a slightly earlier stage, which from my point of view is very disturbing. The recommendations from the Aboriginal deaths in custody report are all there again in black and white for us to read, as are all the other reports that have been done. I think it is time we revisited what has been done and start acting on those strategies, rather than looking at starting another process which may end up disappointing people.

Mr HUMPHREY—I just wanted to take up a few issues from the consumer point of view. One that particularly comes to mind in relation to my own daughter was the fact that very often people who are suicidal had made a plan and they seem to be okay before they actually complete the action. That is what happened in my daughter's case. So it

makes it very difficult sometimes, even when you know what the circumstances are, to be aware that there is a danger period. Meg Smith also referred to this in another context, I think, of when people come out of hospital. They can appear to be okay and then they suicide after they come out of hospital, because they do not want to go back again to that sort of environment. This is when they appear to be in a stage of everybody thinking the person is okay now so we can relax our vigilance on that subject.

I just wanted to raise a few issues in relation to some surveys that we have done that support some of the things that have been said today. One in particular is in relation to the establishment of what I am calling, for want of a better word, an overall commission which would be able to have a sort of coordinating and overseeing role about suicide issues right throughout the country. There should be a national triple digit emergency referral and information telecommunications system. There should be a national consumer professional service relationship partnership model. There should be time out healing centres or what we call friendly houses. In the first episode of when a person makes an attempt and they might be transported immediately to hospital and put into a psych ward, it is a very frightening situation for them. I think this situation can be avoided if there is a place for people to go which is not a hospital but where they can be looked after in a comfortable, supportive way. And the same thing when people leave hospital, that they need a halfway house before they go back to the circumstances which caused them to enter hospital in the first place.

I think we should have a national wellness academy and suicide research institute. These are the sorts of things that Robert Kosky was talking about. I think we should be joint venturing and cooperating with New Zealand in terms of spending money and getting together on looking at common problems and not wasting resources. As Kosky said, we need to concentrate on the high risk areas, which are basically involved in looking at states of depression and people who have made one or more attempts, because that is an extremely high risk area. He also mentioned the idea of GP education, but I think we have to be very careful about that in putting programs onto GPs which they may not be able to cope with.

Professor Vaughan Carr at Newcastle the other day was talking about the problem the GPs have in time considerations in being able to deal with all of these issues, and it is a great expectation that we have that they will be able to deal with the problem. On top of that, there is a tendency to pass people off and refer them to somewhere else to look after them. Especially when doctors are very busy and trying to deal with a number of patients and they have to refer someone on, that process can be repeated when you need to have access to services which can deal with the problem immediately, as Meg Smith was pointing out earlier. They have to have immediate access to responsive services. That is why we are trying to build up a partnership arrangement between people who are understanding and supportive of the expense combined with ready access to service providers.

I have already mentioned the aspect of teaching problem solving and encouraging people to reveal their personal problems so that others can take it on board and help them through the situation.

Col. WOODLAND—I just want to quickly say that I am an unlearned man but of 36 years, although when my friend at the back says that if you are over 25 you are old, then I am going for the aged pension when I leave here.

For many years I have been involved in the trauma area developing chaplaincy services within the statutory bodies throughout Australia. For 11½ years I was the senior chaplain with the New South Wales fire service. In that time I worked in this area of recovery. One stage we went through in Sydney saw an average of three people a week jumping in front of trains, so we were working from that side of it. Just very quickly I will say that in the emergency service side there has come along a program—and there will be mental health professionals here today well aware of the critical incident stress factor that 20 years ago was almost unknown. Today it is a part of support; it comes in the occupational, health and safety programs of some of our services.

What I am suggesting is that, out of the simple basics of critical incident stress which are probably known to just about everybody in this room, is there not a factor that can be applied to the suicide? For the emergency service worker for many years the fact that disturbed him was that he was not aware of what was going on inside him when he had the normal reaction to a critical incident.

As for service personnel, I served 13½ years as a military chaplain. The same thing happened there, but we began to become educated and understanding of what happens in the critical incident field. I have a program that very simply outlines the mental, physical and cognitive reaction to critical incident stress. When these people know what is happening, 99 times out of a hundred they can cope. It is when they do not know what is happening that problems arise. This brings us back to the educational aspect that has been mentioned, whether our young people should be given something saying that these are the symptoms of a critical incident.

When we say critical incident, I am not talking about a fire or Port Arthur or something like that; I am talking about a marriage breakdown or breakdown in the family structure. That to that young person is a critical incident. Anything that is outside, what is the professional status of it? Anything that is outside the normal can sometimes be classified and can produce the same effects of critical incident. If the young people know that, 'I am feeling depressed or angry' or they are feeling a particular way, that this is a perfectly normal reaction to an abnormal situation, I would like to believe that our young people of Australia today would have the capacity, when they understand what is happening, to cope with what is happening.

The second point that I would like to leave with you is that, being the old-fashioned guy that I am, I would like to challenge this group of people here today to look at the whole person when we are talking about them, when we are looking at recovery, when are looking at support. The whole person—body, mind and spirit. I know some of you are saying, 'Here comes the religion bit'. If you want a religion, there are in excess of 7,000 of them. You can have a ball with religions. I am talking about the spirit of life itself. I call it the third dimension. When we start looking at the physical aspects and we start looking at the emotional and the cognitive aspects, please take the other dimension

into being as well. It is no use trying to deal with two-thirds of the person.

If I could just finish up by saying it was interesting today to see, from some of the statistics that were put up on the screen, that in the 1960s we began to go down. Could I suggest here—and I will stick my neck out, it is pretty solid—that that was when society began to unravel, when we took away the corner posts of society and community? Today we have a nation that is going down the track but not really quite sure where we are heading. I think of the rally driver who was going along and the navigator said, 'You'd better pull over, I think we are lost.' He said, 'I can't; we are making such good time.' Let us identify where we are going and, for some of us here, let us put some of the guidelines back into place.

What were we talking about today, 15 onwards—it is too late by the time they are 15, dear folks. We need to be looking at them when they are three, five, six, when the foundation of their life is going into place, when their sense of values is being established. If we get back to that, then we will give our young people a fair go at life.

CHAIRMAN—Speaking personally, I think there is a lot of truth in what you say. Ms Kilby, please.

Ms KILBY—I just want to make a couple of quick comments. I represent an organisation called Rose. I would like to speak on behalf of a young person who cannot be here but who would have loved to have been here, a young girl from Tasmania called Kelli Farrow. Kelli is actually a colleague of mine. She has just had her 18th birthday and was just nominated—or selected, sorry—as Young Tasmanian of the Year. Kelli's work is in youth suicide prevention. She sometimes feels that she is a little patronised and that her invitations to conferences are a little bit tokenistic—they are her words, not mine—but I agree with her sometimes. Her catchcry for her work is, 'Young people talk to each other and young people do not want their friends to die.'

I wish to simply say that so often we have these meetings about young people rather than with them, and that greatly concerns me because I do know they do not want their friends to die. I am very conscious when I run seminars with young people and with parents and with clergy that we are reinventing the wheel over and over again. I would speak to 100 parents a week, if I could, and communicate to them in a very real and I think understandable way—I think it is understandable—what suicide is about for a young person, how that person feels and what they need and what that parent can do.

Now we have not got all the answers, of course, but there is a lot of frustration for people like myself who deliver the service, who stands up in front of 100 people as regularly as I can possibly get a venue. And we do not get government funding. I find these days I spend more time writing submissions than I spend refining my programs to make them better to be communicated to people. I find that very frustrating.

What I also become conscious of now, as a member of this kind of community here, is how many familiar faces I keep on seeing. I have this desire sometimes to rush over and say, 'What are you actually doing with the people in the community; can we

have our own little seminar and sit down and look very closely at what we actually communicate to the community, rather than spending our time working on the big picture?' Because that is the other side of what this lovely gentleman was just talking about—actually delivering it.

Lastly, I talk to lots of people who have been bereaved by suicide. My local survivor group, for example, said to me, 'Can we come down to Canberra on Friday with you?' They find sometimes that they do not understand how to access the services that are there. I know they are there. I spend my life at my seminars giving out phone numbers of excellent local counsellors, and I am sure many of you here do the same thing. You find someone you really treasure, and you will say to the local school counsellor or teacher, 'This fellow is just terrific; send your young person there; they will actually get something real.' I think there is not enough of that being done.

I have asked my local hospital for a flow chart—I even offered to laminate it for them—of how an average mum or dad, you know, who has just done their basic schooling and is not a genius, can access the services for themselves, or even for their elderly parent who may be suicidal or depressed. I feel there is a lot of frustration that that is not being communicated.

We have a program, we have many of these things available. I have great colleagues; many of them volunteer their time. I am sure if people here jumped out of their seats they would probably feel the same way, that so often we are delivering things but just cannot get to the next step.

CHAIRMAN—There often seem to be a lot of separate islands in the sea, though. Everyone is doing good work, but perhaps not enough coordination?

Ms KILBY—Yes, you want to swap phone numbers.

CHAIRMAN—Exchange of information and research. Before you finish, though, Gail, can you just tell us what the Rose Foundation is?

Ms KILBY—I began working with Margaret Appleby, who has been doing this work now for over 10 years—and I know many people today actually know Margaret's work. She is very much on about talking with people in the community. We formed the foundation because we had a number of small community groups and agencies who wanted to sponsor specific projects for the community—for example, someone who wanted to run a clergy day in their local area.We are on about writing specific things for those groups to educate them. They want to come to days like that and actually swap phone numbers and link the community together.

They want to come to days like that and swap phone numbers and link the community together. Because so often you find—we have run seminars for the Salvation Army and other sorts of groups, and they all want to do their bit—that they are islands. By drawing them all together in community groups, you actually access them at once.

CHAIRMAN—Thank you very much.

Mr TURLEY—I live and work in Melbourne. A lot of the comments I was going to make have already been picked up, so I will not repeat those. But one of the key issues that we see very strongly with our own service involvement is this one of continuity or lack of continuity of care. It seems that there are lots of worthwhile things being done in various pockets around the community, but what we notice with a lot of folk who access our services—especially given that one of our roles is to link people with other sources of support—is that a lot of young people keep coming back to us, saying, 'We approached' either ourselves or other folk, 'in crises. It didn't get beyond the next step', or they are falling between the cracks in the system. One of the key things that I would like to see is some more coordinated way of mapping the ways in which various service delivery points actually link in with each other and combine to help young people through the journey they take from the immediate crisis to ongoing supports.

Even for those of us who are involved with the youth suicide advisory group, one of the concerns we have is that there are a lot of very worthwhile individual projects in there—we are doing something with hospital protocols up here, something with suicide attempters down there and in various parts of the country—but the question of how all this comes together in terms of the overall fabric of support is a really critical issue. A lot of young people we work with become quite cynical about the process, saying, 'We present for help. We get help in the immediate crisis but not beyond that point.'

The second issue in relation to that is services involved in providing ongoing referrals—a lot of agencies feel very nervous about responding to young people at risk of suicide. The comments we get back are things like, 'We don't do suicide.' That comment came from a major university counselling service saying, 'Our counsellors are not equipped to deal with that issue.' So it seems that one of the difficulties in making referrals is somehow finding agencies which also have the confidence to pick up on the issues.

I wanted to make a couple of other comments briefly. A few folk have referred to suicide survivors or people bereaved by suicide—one of the projects we have been involved in with the State Coroner's Office in Victoria is interviewing some families that have been bereaved by suicide to ask them what was helpful and unhelpful about the supports they received from services and from health care providers. There are a lot of interesting findings that are going to come out of that, which will be put in the form of some guidelines for health care providers. But one of the things we noticed was that people who had been through the experience felt really empowered to be asked about what their experiences had taught them that could be valuable to others. It seems to me that there is a great untapped resource in there. We have had glimpses of that with various folk this morning as well, but we could make more use of it in terms of telling us what was helpful.

The final thing I want to touch on briefly is my concern about not having full evaluations of the programs that we do—telephone services have been as guilty as anyone

in this area. There is lots of anecdotal evidence about things that work or do not work but, in a lot of areas, we really lack a solid body of reliable evaluation data that tells us what is working and what is not working and where we need to make changes. One of the things I would make a plea for is that there are strong evaluation components built into any programs that are developed, so that we can have a clearer body of understanding that can take us forward to the next step.

CHAIRMAN—Thank you very much.

Dr ECKERSLEY—I am with CSIRO but I want to stress that I am speaking in a personal capacity, for two reasons. Firstly, most of the work I have done in areas relevant to this has been done in a personal capacity in my own time. Secondly, what I am about to say is intensely political, although in a bipartisan sense. To say these sorts of things might be what some colleagues in the federal public service would call a CLM—a career limiting move.

I want to make explicit what has been implicit in a lot of what has been said this morning and this afternoon. It follows on very much, Mr Chairman, from the letter you quoted and also from what Colonel Woodland said. If we look at trends in per capita gross national product over the course of this century, we have seen something like a fourfold increase in real wealth, on average, for Australians.

That four-fold increase has been associated in quite complex and subtle ways both as a cause and an effect with an increasing individualism, materialism and consumerism. Those sorts of cultural values and patterns that we have seen accentuated over that time I think have contributed to the loss or erosion of the personal, social and spiritual relationships that, as Professor Robert Kosky said, tend to give meaning to our lives. Increasingly we seek meaning in our lives in intensively individualistic personal ways. One element of this is the fact that we tend to heighten people's expectations of what they are entitled to and what they expect from life in ways that, increasingly, as a society, we are unable to meet. This issue of expectations has not really been mentioned all that much but it does relate to things like the role of the media in our lives and the world view it projects and so on.

Some of the recent surveys that I have read show that young people may be moving away from that situation. They are beginning to reject the paths taken by their parents and older siblings and they are actually lowering their aspirations and expectations. Richard King, the writer who won recently—a couple of years ago—the Australian Vogel literary prize for young writers said, in explaining the disappointment his characters felt about life, that:

My generation was promised so much; advertising promised so much; the lucky country promised so much. We reached adulthood and found it was not there.

I want to suggest that this might actually offer an opportunity for us. Maybe young people are rejecting the pathways of their older brothers and sisters because they do not want to become disappointed. Richard King's comments would suggest that but I think it provides us with an opportunity to turn that into a much more positive development in encouraging young people to have quite different values and priorities from those that have governed

the country over the last 50 or so years.

Ms CROSS—My name is Kirsten Cross and I work with the Australian Medical Association. I have got a couple of points that I want to add to the discussion that has gone on so far. I do not want to be negative but to me there is a downside to trying to give parents the skills to identify warning signs or whatever. The relationship of parents and children is so important and if you add suspicion from the parents to that relationship it can damage it. We see that in drug situations and we see it particularly in eating disorders. When a young person is suffering and withdrawing and the parent is aware of what is going on, they just walk on eggshells and the whole relationship gets more and more distant and becomes less supportive rather than more. I do not think there is an inherent problem with equipping parents with skills but I think we have to do that in a careful way so that it does not actually jeopardise the relationship.

The other thing I wanted to say was about coordination which I think is also really important. There has been a lot of talk about that, especially at the national level. I have been involved in youth affairs for quite some years and the similarities between what we are doing now in terms of youth suicide and what happened, say, post Burdekin in 1989 with youth homelessness does strike me enormously in terms of this incredible number and range of programs that have been set up across the country. Nobody really has any clue what is going on or what is working where or what is not working. We are duplicating stuff and commentators recently have said that even after all the money and the time and the effort and the commitment that was put in on youth homelessness, there is an increasing number of homeless young people. We have a greater proportion now of people who are homeless than we did in 1989 when this whole thing began. I think we should really learn from that lesson and set these things up properly to begin with.

I guess another one of my favourite subjects is about involving young people in decisions that we make about them. Everybody around this room would acknowledge that part of the fundamental problems with youth suicide is low self esteem and that young people are not valuing themselves. But when we stand up and say we are going to talk about youth suicide, we do not value the opinions of the young people who have experienced it or who are suffering. We are reinforcing the message that those experiences or opinions are worthless. I think that that is a terrible thing to do. If we are going to say that young people need to be valued more and that we do care about them, then one of the things we have to do is talk to them and with them.There has been a lot of stuff in terms of research and stats and what this tendency is or what that tendency is. Part of the whole idea of talking to young people is to see this as a problem of individuals. If we look at the kind of stats that we get through on youth suicide then basically we can say that if you are male, young, Aboriginal, unemployed, gay, mentally ill, live in a rural area, listen to Nirvana, have low serotonin levels, were abused as a child, have a drug or an alcohol problem, were bullied at school, have recently visited a general practitioner, one of your family members has died and you have been dumped by your boyfriend because you are gay then you are a suicide candidate.

Terrific! I mean for those three people that fit all of that category we should not have any problem at all targeting them. We have to get away from this idea of saying

these are the big factors and combining them. It is an individual problem. When we talk about the numbers of 15- to 24-year-olds in this country, it is something over two million. I would defy anybody to find a young person that did not have one of those factors. We have to really focus on people, not on this big picture idea of stats and tendencies and those things.

CHAIRMAN—Thank you very much for that and thank you very much for participating during this segment. We will adjourn now for a quarter of an hour and return at 3.45 p.m.

Short adjournment

CHAIRMAN—I would just like to invite this gentleman here to commence his contribution. We have 74 minutes and 45 seconds before we must finish and people have planes to catch, so I would like to keep the show moving. What we will do is continue to have contributions from participants and then towards the end I am going to invite each of our three remaining presenters to sum up in perhaps five minutes so that we are able to get on the record any input that they are able to bring to this seminar as a result of the contributions made by others.

I must say that if any of you have material that you would like us to have, feel free to let us have that. Or if you would like to write us some kind of report or express some views which may not have been expressed this afternoon, then please feel free to contact Bjarne Nordin, the secretary.

Mr TRESIZE—Thank you, Mr Chairman. I am the Chairman of the Central Coast Suicide Summit Committee, which was honoured by being invited to be here today and also promoted, I noticed, by the paperwork to the national suicide summit committee, so some have greatness thrust upon us.

In 1996 on the central coast of New South Wales we began to realise that we had a tragedy occurring in our community. Within five weeks we had had nine suicides and, as the year progressed, we realised that this rate, though it was abating slightly, was continuing. The coroner who was directly involved with the problems that were occurring with suicide and had to deal with the inquests—and who happened to be a personal friend of mine—called me in and asked me whether we could do something about this increase in suicide, which at that stage was showing a threefold increase on the previous year.

In discussing it, we realised that it was important that we did a number of things, and that a number of issues were addressed. First, we believed that it would be important for us to make the community aware of the fact that we had a crisis. We tried to do this in as guarded a way as we possibly could, and we did use the press as a means of letting the public know what the problem was. As the year went on, we realised that the increase in suicide was continuing and by the halfway mark in the year we were double the previous year's rate.

It was decided that we would call a seminar on the central coast so that we could

get together all those people who were involved—either professionally in providing services or products in that field of prevention—and the consumers. We did this by calling the Wesley Mission's Youth Force and Reverend Bob Dunlop, who is here today, to come and address the issue for us. We had over 100 people register for that seminar, and it was indeed a great success from the point of view of making the public aware and also bringing together the people who had the resources to do something about dealing with the crisis.

It was also decided at that meeting that there should be some form of meeting called within the community to try and garrison our resources and our forces together to do something about addressing the issue of suicide on the central coast. It was unanimously agreed at that meeting that we would convene a summit, and that was held on 15 November last.

Three hundred and thirty people attended that event on the day. Ninety different government and private organisations attended and 15 different organisations made their information or their services available in booths that were arranged in the Central Coast Leagues Club where this was convened. It was made known to both the state and federal governments that we were holding this summit, and it was supported by both governments. Representatives from both the parliament and the government attended from both the federal and state levels. We had, I think, nine politicians there on the day. Heads of various governments—

CHAIRMAN—Our colleague, Jim Lloyd, was there, wasn't he?

Mr TRESIZE—Jim Lloyd was there. Jim has been a mighty supporter all the way through and a very important man for the success of this program. The day was a success in all senses. It was addressed by professionals. Professor Pierre Baume, who is with us today, was one of four major speakers who addressed us on that day. There was a time of public input as well, similar to what we are doing now in this session, where the public were able to convey the feeling out there in the community to the professionals providing services. They were asking the professionals to address their pain and to look at the overall problem of suicide on the central coast.

A report was written on this. It was properly recorded, Subsequently, that report has been before the Premier of New South Wales. We have convened two meetings with him. The report and other findings that have come out of discussions we have had with members of his office on the Central Coast have been made widely available. We are now working with the New South Wales Premier's Office, providing extra information to him on the new strategy for youth suicide which is being put together in that state.

A copy of that report is available here, Mr Chairman. Together with it are papers supporting what has happened since then. It has proved that by bringing the community together—as our friend Neil here said earlier—and making the community aware of the fact that they are a major player in the issue of any strategies that must be developed for suicide prevention, it made it possible for those people to have an input. It also gave government and private agencies an opportunity to be heard and to be seen as who they

are and what they are able to provide in the way of answers to the problem of suicide, particularly in our case on the central coast. Those people have reported further, and that is available in this document. I made that available to you out in the foyer this morning. If you need more copies of that, it is available.

We hope what we have got in there will constitute, from a community level, the real sense we have that communities and governments and government agencies must run parallel in providing answers to the issue of suicide. I agree with everything that has been said by the professionals here today. Everything they are doing is important. What the community—the consumers—is suffering and has to say is equally important. If we are going to provide any long lasting answer to the issue of suicide in Australia, we must be able to get those two major player groups together and get them seen as vitally important one to the other in producing answers to the problem.

CHAIRMAN—Thank you very much for that, Mr Tresize. I understand you have given enough copies to the secretary of our committee to circulate to all of our members a copy of that report. I daresay, if you have got some extra copies here, you will be happy to provide them to other participants.

Mr TRESIZE—I think there are two or three copies left outside.

CHAIRMAN—Thank you very much.

Ms HORNTVEDT—I am the founder of the Parents and Friends of Lesbians and Gays, Sydney, New South Wales. Recently our Prime Minister, Mr Howard, was quoted as saying that he would be extremely disappointed if one of his children came out and told him they were gay but he loves his children and would not alienate them. Thirteen and a half years ago, my eldest son came home and told me he was gay. Like Mr Howard, I love my children and I did not alienate my son. I educated myself. For the past seven years, I have been running a support group for parents whose gay and lesbian children come out to them.

Not all the parents feel like Mr Howard and me. A lot of those parents alienate those children; a lot of those children end up as suicide statistics. A lot of our parents come to us for support because they have found a suicide note and their children are on life support systems, and a lot of those parents come to us too late.

We have one mother at the moment whose son died 20 months ago from suicide because he could not stand the persecution in Tamworth, a country town in New South Wales, any longer. School contributed a lot to the harassment. I believe we are the only heterosexual support group with the knowledge of homosexuality that is helping families all over Australia. From one mother who started seeing parents in her home seven years ago I now have support groups all over Australia except the Northern Territory, and I have a list here of contacts, which I would like to table.

CHAIRMAN—Thank you.

Ms HORNTVEDT—We are offering a resource. We are helping to keep families together and therefore we are helping to save young gay suicides. But we have no government funding, we have never had any government funding. We are volunteers, we are stretched to the limit and there are very few of us.

Earlier on today, Professor Kosky said, 'I ask you, the community, to tell the government what you want.' Well, I want funding, I want help. I want help from this seminar to keep doing what I have built up over the last seven years. Dr Meg Smith said, 'You don't have to be an academic; you just need to let people know there is someone out there to listen, someone else to give support, someone on the other end of the phone.' That is what we are doing. We cannot do it any longer without some funding. That is why I am here today. We must value every life.

In New South Wales I believe we are being definitely recognised as a major resource, otherwise we would not have so many referrals from community health centres, from the sexual health departments of public hospitals, from the police department. I was invited to the launch of the *Out of the Blue* report in February 1995, put together by the Fahey government. I would like to table a copy of that. It is only a copy because we are an unfunded group, but I am sure that you will be able to get an original from the New South Wales government. We get referrals from Lifeline, from school counsellors, from GPs, from psychiatrists. We are being used as a very valuable resource, but we cannot go on any longer without any funds.

So please, please listen to this one mother who has taken one big step and not just walked a little way but we have gone right round Australia. Let us pool the resources we already have. There have been people here today with resources. Let us pool them and I am sure that we can start to get the statistics down in youth suicide.

CHAIRMAN—Thank you very much. I was wondering if Reverend Bob Dunlop would like to make a comment.

Rev. Bob DUNLOP—Thank you very much for the opportunity. I was going to put my hand up. We have heard a lot of doom and gloom today I think, and a lot of the statistics are pretty disturbing and I am not sure that they hold out or give a lot of hope. I just wonder—and I speak as someone who had 18 years with Lifeline and I spent a lot of my life as a face to face counsellor—how many people in this room today really believe that suicide is preventable or how many of us believe that we would like to think suicide is preventable but we do not quite believe it because we do not know how we are going to prevent suicide.

I believe that it is preventable. I am not a research person and I never have been, but I have recently done a research of all of the literature that I could get my hands on, including the stuff that is on the Internet—and there are something like 300,000 entries on the Internet in relation to suicide. Fairly consistently, I read something there that I have not heard today. That is: most suicidal people do not want to die, that suicide is not about dying; it is about escaping the pain and that something like 80 per cent of these suicidal people tell us they are crying out for help and these are the warning signs referred to

earlier.

We have heard about the road toll and the success that has been achieved with the road toll over the last 10 or 15 years. Interestingly, if you went back 10 or 15 years and talked to people in Australia about halving the road toll, they would laugh at you. When they first asked people in Australia to wear seat belts, they got quite annoyed and thought it was an invasion of privacy. We have had much bigger invasions of privacy—like breathalysers—that have resulted in the road toll being reduced. We have also heard about the successful AIDS education program which, I believe, is gaining worldwide acclaim with its results in Australia.

Somebody made brief mention of another thing that has been successful over the last 10 or 15 years: CPR and mouth-to-mouth resuscitation. I was a boy scout years ago, and they did not know about these things then. I do not know when they came in, but we must be saving many lives in Australia now because we are teaching people to do something as simple as CPR and mouth-to-mouth resuscitation. I believe the same kind of thing can apply to suicide. We need all this research, understanding and investigation but we can also do something to help the suicidal person at their point of need if they are crying out for help and if they do not want to die. We can apply something that we call, 'the CPR of suicide'.

I would like to finish by saying that it disturbs me sometimes to hear us talking about youth suicide all the time. I know that youth suicide is probably our biggest problem per capita, but in the latest ABS figures for 1995 the largest number was the next age group—the 25- to 44-year age group. They actually have the highest rate in those figures. We are talking there about a group of Australians who are the young marrieds with families. In many cases, their suicides are not just suicides; they are murder-suicides. I hope that we can apply what we apply to youth suicide to this next age group and to all the others—the highest per capita group were 80-year-plus males.

Dr SOUTHCOTT—I have a question to Professor Baume. You mentioned earlier in your presentation the role of the media in terms of youth suicide, and that is an area that is not directly a role for government. There is quite a lot of research that shows that media reports of youth suicide can lead to an upsurge in youth suicide. How well do you believe the print and electronic media in Australia have addressed this problem? I welcome comments from our other members of the panel as well.

Prof. BAUME—As you rightly point out, internationally there is a large body of evidence that seems to indicate that talking about suicide or describing suicide events—especially when we relate methods of suicide in newsprint or in television stories—can lead individuals to engage in suicidal behaviours. It is evident that a large population of those individuals that are not suicidal are not going to turn around and undertake suicidal behaviour by witnessing a suicide. But there may well be vulnerable individuals who see suggestions of suicide and—as someone before made the comment—we should not get too carried away by heavy metal music or other types of things.

There are two quick comments I want to make. First, someone mentioned the death

of Kurt Cobain who was the lead singer of a rock group called Nirvana some time ago. It is true there is a lot of information on the Internet about Kurt Cobain's death. The autopsy report is available. Pictures showing how he died as well as his suicide notes have been made available. I think there are a number of things that need to be said about this before we get too carried away.

The first is that, in fact, the rate of suicide following stories about Kurt Cobain's death once he died actually decreased, and this is actually documented in the scientific literature. And the reason for that—one of the hypothesised reasons, I should say—is that MTV in the United States certainly became very quickly aware following advice that this may actually increase the suicide rate, so they started to talk about it but not in a glorified fashion. They actually started to say suicide is not necessarily an appropriate way of resolving the problem and actually dealt with it in a nationwide approach, and it seemed certainly to have had a positive effect.

These two comments raise two new issues. The first is that it is true that there sometimes is a correlation when you televise or when you reproduce information about this, when you have vulnerable individuals or when you have heroes—like Romeo and Juliet, I guess. And we are actually monitoring this at the moment at the institute to see whether for the next few months when the movie is being shown in Australia it is actually going to make a difference. The suicide notes that we are collecting and other types of information will reveal if there is any kind of correlation.

Certainly in other studies that are being done in West Germany, for example, where the hero actually suicides at the end, you have high spates of suicide following it. But going back to the issue of Kurt Cobain's death, it actually focused a large number of his followers so that young people were talking to young people about not glorifying the death by suicide and that there are other alternatives and that those alternatives can be solved by getting help from counsellors and so forth. They also talked about the negative aspects of suicide and the grief which a lot of his friends now endure, that is, once Kurt is dead then he no longer can write music and he can no longer be productive to society. So it seemed to be a message which was heard so that, in a way, in this dyadic event of publicising suicide, you can have some positive outcome, provided the media is informed about it.

I do not necessarily agree with you that government can do nothing about helping or assisting or providing direction for the media. I think that we should have freedom in this respect, but at the same time I think it is important for us to be responsible as a society and that if we know that certain things that we are doing may engage or encourage this kind of self-destructive behaviour perhaps we should refrain from it or approach it in such a way that we are going to have a positive outcome rather than a negative outcome.

CHAIRMAN—Thank you.

Mr STAINES—I represent Suicide Prevention Australia, a national organisation comprising professionals and consumers around Australia. I just want to preface my remarks by saying that I want to thank you and the members of the House of

Representatives committee for running this forum. I think it has been an excellent day. With the calibre of the presenters, I think we have all benefited from sharing our information together.

Suicide Prevention Australia since 1992 has been conducting national conferences. This year—I thought I would let everyone know if you do not already know—the national conference is co-sponsored by SPA and the International Association for Suicide Prevention, and many of those here today will be taking part in that conference. It is all outlined in the latest edition of the SPA magazine *Let's Live*.

What the national executive committee of SPA have been considering this year and each year is a national awareness week to coincide with the national conference. It is interesting to compare another association overseas, the American Association of Suicidology, who conduct an annual awareness week. It would be worth while trying to get an evaluation of how effective that program is and for, I suppose, the government, if they were considering doing a national awareness campaign, to explore that with the American association.

I endorse what has been said—Brendan Nelson mentioned the establishment of a national approach—about a national coordination unit to bring about an awareness of the warning signs and what have you.

Bob has already highlighted the amount of money spent on the AIDS campaign and the national road toll. When we consider that on the latest ABS figures, 2,367 suicides in Australia, all ages, now exceeds that of road accidents, I think we have got a pretty strong case to put to government that there should be at least equal amount of money allocated for suicide prevention. I think the budget for suicide prevention in Australia is far below what it should be when compared with the money that we spend on the likes of the AIDS campaign and also the national road toll.

I endorse what has already been said too about the evaluation of programs. It is very important that we not only conduct these programs but that they be evaluated to see the effectiveness. I think there has been too much duplication of services and the re-invention of the wheel, so to speak. With the national body, I think we could look at all of those aspects, bring together all of the key players in suicide prevention in Australia and have a more effective intervention amongst all of those throughout Australia.

In closing, I would just like to endorse what has been said by Richard Eckersley and Colonel Woodland in regard to looking at the holistic approach. I think we have got to look at the whole person—the physical, emotional and spiritual aspect. I would just thank everyone for participating today and I have really enjoyed participating here.

CHAIRMAN—Thank you. We will have this gentleman here and then Dr Nelson, I think, wants to make a brief comment.

Mr McKIE—I am a leader of student counselling in the New South Wales Department of School Education. There are just a couple of points I would like to make in

terms of the issue of trying to prevent youth suicide. We have many school counsellors in New South Wales who are involved at the local level with groups that have already been mentioned, such as Sutherland, and they are trying to work again with a lot of community work and seminars that are called all around New South Wales.

I think one of the issues that comes back from that is that there is a lot of energy out there to do a lot of things, but people are quite concerned often that they are not sure which way to go, that there seems to be more and more an issue over a debate about whether you go this way or you go that way. I think that getting some sort of overall direction is a very important outcome of any discussion.

From our experience, no matter what approach is put in, it is very important that that program builds on programs. I am talking now about if we do anything in schools. It is very important that that program builds on other programs existing in the schools that are actually building quite effective communication and interpersonal skills. In fact, it is not the program that puts it in; it is an adjunct to whatever else is going on. I think that is an important thing. Unless that strong body is already there, I think you need to be looking at just how effective any adjunct program might be, so I will just put that as a point.

Many people have spoken about the need for whatever programs are there to be well researched and for the evaluations of those programs to be made widely available, because trying to get the information to make judgments about what to do is very important.

In relation to the issue about whether suicide prevention should even be taught in schools, Mr Chairman, I would like to draw the committee's attention to an article in the *Australia New Zealand Journal of Psychiatry Vol. 30 No. 5* of October last year titled 'Arguments for and against teaching suicide prevention in schools'. I believe that article is well worth looking at for someone weighing up the fors and against that particular approach. But it is more of that type of material that I believe is going to be useful for people making decisions in the debate.

There have been many groups mentioned in terms of having their needs met. Getting a collection of those is very important as well, but there is one group that I have not heard mentioned specifically—the students from families which are significantly affected by mental illness—and the needs to specifically support them. Many issues and intervention strategies have come up so far in discussion, and that is a group that is often very difficult to interact with. I think that particular issue is there. There is no doubt about the rural support to workers who are out there; workers who are often employed and working with a particular organisation. There is the support to those workers. Again, I would just like to reinforce those cases where all the best efforts have not been able to stop a suicide completion. I think then that what is there for the support of the families and those close to that person, including the workers, is a very important part of any overall strategy.

CHAIRMAN—Thank you. Dr Nelson, briefly.

Dr NELSON—Mr Chairman, I wanted to make a comment on my previous life—my wife would say my better life—as distinct from my present one. The gentleman here representing New South Wales mental health mentioned that, when young people, and not so young, were depressed and visited doctors, the doctors did not have the time to deal with the problem. I think he may have alluded to the fact that some doctors are not adequately skilled to deal with the problem—general practitioners specifically. I would like to make a couple of points.

The first is that it is a very dangerous proposition to allow ourselves—any of us—to think that the problem is too hard and that for some reason, whether it is the doctor's billing system, the appointment system or the doctor's training, we should say, 'Well, we ought to give up on the doctors.' If you go back to Professor Kosky's remarks this morning, almost 50 per cent of those who attempted or completed suicide had actually visited a general practitioner: it was the general practitioners, followed by the school counsellors and, I think, teachers or parents followed after that.

One of the things that I would put to you is that the problem can be overcome. At the moment, it comes back to the lack of coordination to which I referred earlier. At the moment we have some administrative divisions of general practice funded by programs established by the previous government—and continued by this one—which allow general practitioners to increase their skills in the area of mental health, particularly in recognising depressive illness in people. The government has $400 million budgeted over the four years of the forward estimates for what is called a 'better practice payments program'. At the moment it is nothing more than an income subsidy program for general practitioners, many of whom, understandably, like it. The government has now said that about 20 per cent of that money will be made specifically available to doctors who achieve immunisation targets in their local area, and that I strongly support. So, too, I would suggest to this group and I suggest to the government of the day that a proportion of that money could actually be spent on breaking the cycle to which you referred earlier on—that is, that the doctors could actually be paid an additional payment for particular classes of patients that present with these problems.

I practised in general practice for 13 years. When a person who has a psychiatric illness, particularly depression, and is in a dysfunctional family comes in to see you, it destroys your day. Your blood pressure goes up immediately because you know that the rest of your day is going to be chaotic. Unsurprisingly, a number of doctors respond to that situation by being dismissive of what is a serious problem.

What we can actually do as a government, and I think we should do, is make a proportion of that $320 million available to require doctors to do a core amount of their now compulsory postgraduate continuing education in mental health. We can also pay doctors to spend, for example, a six-month or a 12-month period increasing their skills and knowledge in this area with people like Professor Kosky. We can also spend some of that money in giving doctors the opportunity to spend time educating themselves about the services available in the community which they need to deal with these sorts of problems. I realise that is a micro issue that I have now focused on, but that is the way we need to be moving. I just emphasise to you: do not, under any circumstances, say, 'Give up on the

doctors. They're too busy. All they want to see are sore throats, chest infections and things like that.'

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CHAIRMAN—Thank you very much. We will have to finish this segment at about 4.35 because we are going to invite each of our three remaining presenters to give a five-minute presentation. Because Dr Smith must depart at 4.45 and because she is a lady, we will ask her to sum up after the next speaker.

Mr POCOCK—I am from AYPAC, the Australian Youth Policy and Action Coalition. There are a couple of things I think need to be on the record. Richard Eckersley talked about—and Richard and I have often had debates about these things so he will not mind me having a bit of a go—young people rejecting the pathways of their parents and older generations. I think we need to be careful when we talk in that language because, in my view, it is more a fact of pathways not being there any more for young people. Young people stay in their family home longer and youth unemployment is a much more substantial problem now than it was 30 or 40 years ago. So in our view it is not a matter of young people rejecting pathways; it is a matter of pathways drying up.

In relation to issues around whether or not this committee should have a public inquiry into youth suicide, our view would be that that is basically a dangerous thing to do and probably will not add in a really qualitative way to the information that this committee can have available to it. So we would not support a public inquiry.

In relation to Brendan Nelson's suggestion around an office of youth affairs or at least some sort of national strategy or task force to deal with it, we give both of those a tick and think that is a useful suggestion.

In relation to a number of comments made throughout the day about the youth services that are out there, I think it needs to be asserted that there are not a lot of youth services out there. If you compare what is going on at a community level now in Australia with 25 or 30 years ago, there are actually far fewer general youth services for young people to drop into and where they can develop mentors within the community. It is really only being left up to groups like the Salvos and others to provide some holistic youth servicing in the community.

Governments have withdrawn from that type of traditional youth servicing and replaced it with specialist and focused youth servicing. A good example of that is in the labour market program area and in the employment area where the government funds case managers not to work with young people in a holistic sense but to work with them in a very narrow employment focus sense. That is making it more difficult for youth services

and youth workers to make those general connections with other services and other practitioners, and develop a holistic approach to caring for young people.

In relation to the point that people have made—and I think a couple of committee members have made—about governments putting substantial amounts of money towards the problem, again, that is a falsehood. No government is putting substantial amounts of money towards the prevention of youth suicide, or youth servicing, and we need to reject that myth.

CHAIRMAN—I suppose it depends on what you consider to be a considerable amount of money. You might say $19 million on top of the $13 million already allocated is not enough, but most people would consider it is a considerable amount, although perhaps not adequate.

Mr POCOCK—Other people have done it so let us just compare that sort of financial effort to the financial effort we put into trying to lower the road toll. I think you will see in those terms that it is a very minuscule amount of resources that we are putting into it.

CHAIRMAN—Just on the point that you made against a public inquiry, the only way that this committee is actually able, beyond our seminar and summary report, to make a contribution to the government's suicide prevention strategies is by having a public inquiry. We can certainly draw together the sentiments expressed today, and we can make recommendations on the basis of the substance of this one-day seminar, but we would clearly be limited by comments that have been made today. It would be rather difficult for us to go over the evidence given to previous inquiries, such as the one chaired by our colleague Mr Morris, and incorporate those recommendations in our recommendations out of today.

It could be that even if the information has already been given to government, it was given some time ago. Perhaps it has not had the attention that some people would consider it ought to have, and one benefit of an inquiry is that that could focus community attention and the attention of the government once more on this important subject. That is just perhaps the other side of the coin.

Mr POCOCK—That being so, I leave that matter in your hands to determine.

CHAIRMAN—It is actually in the hands of the Minister for Health and Family Services. We would have to go and seek an inquiry reference but he would have to give it to us. But he is a pretty good minister.

Mr POCOCK—He is. The final comment I wanted to make is that the government, if they are serious about issues like suicide, need also to think about the impact of other decisions they are making in other areas. For instance, recent decisions in the Austudy area—where they have raised the age of independence to 25—are creating a false reality. Young people are independent before they are 25. Those sorts of decisions are placing an enormous extra burden on families. They create family discord of exactly

the sort we want to prevent, if we want to prevent suicide.

Ms SANDS—I wanted to say a word about those families where there has been a completed suicide. In a number of the families I see, there is more than one suicide or various suicide attempts that have taken place. Intervention in those families does not have to be a very costly exercise. In fact, through support groups and counselling, differences can happen and people in those families can find a new way of understanding the suicide which is not negative to their own growth. It is important that we understand that the families that are bereaved by suicide carry a very big load and, in any kind of media coverage put out there, you would want to be very careful not to increase the load of guilt they are already trying to deal with. Things like warning signs can produce a lot of guilt in those people. They will feel they should have seen those things, and yet probably in about 50 per cent of the cases they would say that they did not see those things. But, in retrospect, maybe they were there. So I think we must be very mindful not to increase the burden.

CHAIRMAN—Thank you very much.

Mr PRINGLE—I would like to think that we are focusing on building up the answers as much as on attacking the problem. The findings that Mr Kosky demonstrated were, if I understood it correctly, basically saying that family disorder or crisis were the primary background—even taking depression into account as well. At the bottom of the list, if my eyesight was serving me well, were Spain, Portugal and Italy. Certainly, the Italians have fostered family life as a general cultural event, it would seem, and also fostered an emotionally free environment for expression in that family life. Whatever the government can do to reinforce and help strengthen families throughout the nation and ease the burden—if money is the primary aggravator for those areas—then easing that load—

CHAIRMAN—I think strengthening the family is on the government's agenda.

Mr PRINGLE—Yes. That is a noble aspiration. The issue of those that were low on the scale with the rates of suicide leads into an area that is a little more fuzzy. I am involved with hosting suicide prevention breakfasts around the country where we invite leaders of a community together and address them about how these things could be addressed—from our point of view anyway. We talk about fuzzier areas than direct programs—although we are involved in programs to reach out to young people, especially in these areas of crisis. But we need to foster a spiritual culture that engages faith and hope and love for Australian people a lot more.

I think one of the most recent examples that brought it home pretty clearly to me was Kieren Perkins in his 1,500 metre dash, where we heard the commentator get converted half way through. But there seems to be a feeling that we do not believe in our young people, really, until they prove that they are believable, until they prove themselves in that kind of pressure—I guess the Kylie Minogues and these others who have left the country. Winning is dangerous sometimes in this environment, but losing is even more, and they are feeling it.

A culture of congratulations, a culture where we believe in our young people, where we congratulate them on their successes, no matter what our prejudices or opinions are about them, will be a lot better environment for them. There is a need for a sense of love. You will often hear the cry of a person who is contemplating suicide: 'I do not feel loved. My mother does not love me like she loves my brother who has died, so I am going to do it too.' There is a need for acceptance without having to meet any predetermined criteria, and then the sense of hope.

These three things are from Paul the Apostle. He says these are the three greatest things that there are and that the greatest of them is love. But I think a sense of vision for young people has to arise—that there is hope for their future, that they can make it, that there is a way through some of the problems that they are facing. I believe that it is incumbent upon the leadership of our nation—whether in government, religious leadership or educational leadership, sporting leadership, any of these areas—to model these qualities very firmly to our young people.

CHAIRMAN—Thank you. Mr Morris.

Mr ALLAN MORRIS—I actually think it is relevant that some of the committee members also indicate some of their views and experiences. But for those of you who have forgotten what it is like, I remind you of the book that was produced in the last parliament by the committee on youth homelessness. Many of you have read it; many of you were involved in it. Professor Kosky was one of our extremely useful witnesses. I suggest you go back and read it, because about half of what you have said today is actually in there already and is sitting on government agendas, not being addressed. If half of what is in it was done, half of the issues today would not be on your agendas. That is the first point.

The second point is that there is a real danger of us doing something very, very bad as a society and as a community right now. Let us look into our souls and look at the postwar generation. When I was younger we called it a generation gap; it was our parents' fault. Now we are older, it is the kids' fault. Amazing how the baby boomers have moved their way through and turned the world upside down!

We talk about the families. The fact is that the modern nuclear family is a postwar phenomenon. The family in Italy, Spain, Portugal and Greece is very extended. When I was a kid my family included parents, friends, all kinds of people. I had uncles and aunties everywhere who were never uncles or aunties, but they were part of my family. Nowadays we live in urban sprawl as nuclear families with poor resources, poor facilities and where a hold bunch of strangers come together. Grandma and grandad and uncles and aunties were all an hour, two hours, a day, a week away. The idea that somehow we support the family is a bit mythological.

We can then go further and start talking about sense of value. We start saying to our kids, particularly ones who are under stress, 'Listen, fellas, young women: mutual obligation. Work for the dole.' What are we talking about? This is about giving them esteem and a sense of value? Mutual obligation? Think about what we are doing. We are

ripping away systems—access to justice, Family Court counselling, all the things that we were supposed to provide we are actually tearing away. We have ripped away the families that used to be there. We are now ripping away the support structures that replace the families. Eventually all we get is a whole bunch of individuals who are measured for achievement, success or failure, by a TER, by looking beautiful, by having a good relationship, by all those external objective non-human criteria. The fact is that our grandkids and our great grandkids are all going to fail, or an awful lot of them are going to fail, and it will not be their fault.

The fact is that this is not about suicide; it is about where we are going in building and carrying on our society. I think one of the comments that was made earlier which was really quite stunning was that a person who is gay cannot have a family. They do not have a family; they are not allowed to have one. We start talking about families. Families are what people make them. Families are not about bits of paper or licences; they are about relationships.

I think Professor Kosky's comment earlier—and this is my concern, Mr Chairman—that if no-one sees you, if no-one acknowledges you, if no-one bumps you and says, 'Hello', do you really exist? No. I think Professor Kosky said that without relationships we do not exist. Our relationships we define ourselves by how we treat each other, not by laws, by government, by legislation or licences, but by what we do as people. Families are in fact a collection of people who come together and treat each other as close relations. I think it is about time we started to accept how we live, not how we might like to project.

Mr Chairman, as a committee we cannot do an inquiry until we go back to the report and say to the government, 'What the hell are you doing about this stuff? Until you do something about it, we cannot ask the minister for further references.' We would end up asking the same questions again, because half of what we would want is already there.

CHAIRMAN—It is a different minister, and I must say that I do not agree with everything that Allan said, but time will preclude my disagreeing or agreeing with him on the various aspects of what he said. We really are going to have to wind up. Two people want to make very brief statements, but if we do not finish almost immediately we are going to lose Dr Smith, and that would be a terrible thing.

Mr WILLIAMS—I would like to table two documents which I neglected to in my earlier contribution. One is the *Schoolwatch Report*, written by Jackie Griffin, which is an investigation into violence and harassment against gay and lesbian teenagers in Australian schools. That has been handed out to all the members and senators and is also available from our association in Sydney, the Gay and Lesbian Teachers and Students Association. The other document is an evaluation by the department of employment, education and training of the youth hotline I referred to which has also been made available to members and senators.

CHAIRMAN—Thank you.

Mr HUMPHREY—I just want to raise one quick issue, Mr Chairman, which has not been raised before. We had been talking about juvenile justice issues just peripherally, but another very important relationship that needs to be considered in relation to young people is that between the police and young people. There is a lot of hostility from certain sections of the adolescent population towards the police. One of the organisations that I am working with is the Police Community Youth Clubs Limited in New South Wales. There are only 54 clubs now in New South Wales, but they are a very good mechanism for establishing and building a better and more harmonious relationship with the police and also, as a consequence, juvenile justice services.

CHAIRMAN—Thank you very much. I think today has been very educational for all of us. I think as politicians and as elected representatives we have to realise that we do not have a monopoly of good ideas or commonsense, and that is why seminars of this nature are of immense benefit to us in making recommendations to the government.

I must say that by having such a full input from everyone in the room over a couple of hours we are able to gather together some ideas and pool our collective wisdom. That will assist us in considering the transcript of today's proceedings when deciding what recommendations we make to the government.

We have had four wonderful presenters and we have three left—we have lost Dr Harrison who has had to leave. I think it would be a wonderful way of capping the afternoon if we invited each of our three remaining experts to sum up and comment on some of the remarks made by those of us around the room. Dr Smith?

Dr SMITH—It is very hard, actually, to sum up. I, myself, have learnt a hell of a lot today, so thank you for your input. I come away with more ideas.

I think the main thing that has come out for me today is that we have to get back to the basic premise that young people are vulnerable. We, as adults in this society, are responsible for the care and wellbeing of our young people. Our young people are dependent on government, family and community to provide services, to provide resources and to lobby for the things they need. I think one of the most frightening things about being a young person in Australia today is often you lack a voice, or often your concerns are not seen as terribly important in the concerns of the nation. I think the message that I want to say loud and clear to the committee is: let us remember that young people are vulnerable.

Secondly, leading on from that—and I think the point was made much earlier by one of our younger members—we need to involve young people who have experienced suicidal thoughts. Today as people said, 'Thank you for your presentation. It was so nice to get away from all of the statistics,' I thought, 'Here am I in my late 40s. How come it has taken me 30-odd years to be able to say how I felt when I was suicidal?'

Nobody asked me at the time what was going on, what would have helped or what could have helped. I think one of the most significant comments today came from Colonel Woodland who said that if you can understand it, you can learn to cope with it.

I think that goes for the nation as a whole. If we understand what young people are going through and what happens to young people when they are in distress then we can help them to learn to cope with it and better still we can put aside resources so that the services are there to help them to learn to cope with it.

I tried to, in typical academic lecturer mode, get down to some fairly key points and I think the first thing is commitment. It seems to me that everybody in this room is committed to doing something about preventing youth suicide. That is wonderful. That is fine. I think the message from today is we need to get more people in Australia committed to preventing youth suicide. We need to expand the responsibility and the commitment so that everybody starts to take responsibility for the issue and to do something about it.

The second point, I think, is understanding and I think that covers things like research. One of the things that I have learnt today is there are a lot more programs going on than even I knew about. There are a lot of things going on out there and we need to start to disseminate information quickly about what programs are working, what is effective and what are the best ways to prevent young people taking their lives.

We also need to understand what kind of stresses young people are under and I think one of the things I have learnt in my years of working with young people in stress is that the stresses for young people are different depending on where they are coming from, which area of Australia they are in and what have you, but sometimes they are common.

We need to understand a lot more about depression and I think that certainly some of the comments that have been made today indicate that there is a lot more we need to know about how young people experience depression and what is the most appropriate way to help them. We also need to understand just what feelings about suicide actually are because then we are better able to understand what we can actually do about it and we need to understand what actually can be done. I think Brendan Nelson's fear was that we are going to say it is all too difficult; let's put it aside; it is too difficult to get this and that done. Things can be done. Things are effective. It is not hopeless.

The third point, I think, is education. I think education needs to happen on a number of levels. It certainly needs to happen on a personal level. Rather than teaching youth suicide prevention in schools, at church groups, in youth groups or in the local soccer club, I think what we need to teach is personal coping skills: if you are having hassles, what can you actually do about it. There is another companion—volume I suppose—that goes with the NHMRC depression document and that is called *Blue Days* which is being produced by Streetwise Comics. It is basically saying, 'You are feeling blue. What can you do to cope'. It is basically aimed at young people who read comics and what have you. We need to get the message out in appropriate ways to young people how to cope.

The second thing, I think, is how we educate the community on how to cope. I have been busy doing radio interviews and the thing that struck me about the three radio interviews that I did was that the journalists asked how people can help, how parents can help, how teachers can help and what have you. Again it is like community first aid. We

need to get simple ideas out there so people know what to do. One of the most frightening things I experienced when I was going through severe depression was that people were terrified to go near me. They were terrified that if they said the wrong thing I would suicide right then and there and they would be responsible. We have to educate people how to cope. You can do a lot of very simple things when somebody is going through a rough time. You do not have to be afraid of it.

I guess most importantly we need action. That may need money. It may be resources. It may mean emotional effort. We certainly need continuity of services. One of the things that has come up a lot in the youth suicide prevention advisory group is that many community groups out there are doing good things, but when their funding gets cut they cannot continue the service. We end up with a patchwork of services instead of a continuation of services. We need to make sure that services are available and that means constant monitoring and evaluation to make sure the services continue to be there. We need to ensure that community initiatives do happen. I think again it gets back to taking responsibility. We need to encourage communities to take the initiative and to do something.

We also need to evaluate. Some things are not going to work; some things are going to work. Some things are going to work better than others. Some things might work in your community, but they may not work in my community. Evaluation is crucial. We need to be very critical of what we are doing. I think, to take up the Prime Minister's point, let us be non-partisan about this.

I might have a particular approach because I trained as a psychologist in the medical model, and you might have a different approach. I think what we have to do is say, 'Well, your approach might be better for some groups of people; my approach might be better for some other young groups of people.' We really need to be non-partisan. That sometimes might mean referring people to see someone whom, personally, we would not see ourselves. I found myself in that situation yesterday. I referred a young person onto a doctor that I probably would not see myself, but I could see that this doctor would be ideal for this particular young person.

CHAIRMAN—Thank you very much, Dr Smith.

Prof. BAUME—Firstly, I would like to thank everyone who has been responsible for inviting me here to share my feelings, experiences and thoughts about this issue. Secondly, I want to stress for *Hansard* that I do not see myself as an expert but rather as somebody who will continue to learn about this issue, because I think it is far too complex at this time for me to call myself an expert.

The issues that have been addressed today—by the colleagues who presented their cases as well as those individuals who shared their thoughts and ideas—reflect that obviously all of us are committed to wanting to do something about suicide prevention. This reaffirms that there is an issue and there is a problem. However, perhaps I would also like to be not less positive about some of these issues. That is, if we had a problem—such as a big tragedy where 300 or 400 or maybe 500 young people were to commit suicide

tomorrow—then I am sure there would be an immediate national response and an immediate coordinated and integrated approach to try to address this problem so that it would never happen again. Indeed, we have seen that with far fewer people being killed in a particular incident recently.

We do know that the number of people who die in homicides is significantly smaller than the number of people who commit suicide, and still today we are deliberating whether we should have a public inquiry about suicide. We are still contemplating whether, in fact, we should do anything at all. We are still yet to have a national suicide prevention authority or anything that actually provides guidance and leadership in this area. I think it is time for us to do something. In a way, I certainly would like to thank the Prime Minister for opening the seminar today and for demonstrating a bipartisan commitment and also a commitment on the part of government to want to address this very important issue.

As I stressed this morning, the issue is much wider than how it affects young people. It also involves a family and it also involves those who are left in this aftermath. These number in much greater numbers than those individuals who die, because these represent merely the tip of the iceberg.

If it is possible, yes I would like call for some form of suicide prevention authority. I do not think it will necessarily answer all the problem. What I would like to see is what I perceive to be suicide prevention out of control actually being structured more effectively. We could use resources more appropriately and we could have some effective outcomes. Because, at the end of the day, unless we address this multifactoral problem as a multifactoral problem, we are still going to continue to have a bandaid approach. We are still going to continue to focus on single issues and believe that, if we just fix depression, we will fix everything else. Clearly that is not so. Certainly the last 30 years shows us this.

As Professor Kosky said, and others have said it too, it is much bigger than just depression. There is also family discord. Our own studies are demonstrating quite clearly family discord and family dysfunction and difficulties within the family structure. Where there is a presence of depression, you have a very lethal mixture.

But there is also the issue of grief which has been raised and which often—and still today to some extent—was left on the backburner. We have a tendency to focus on the tragic death itself, leaving the aftermath to somebody else—perhaps to some community services that might pick it up, although certainly there is no appropriate funding for it. I run a group in Brisbane for those bereaved by suicide, which we have supported on a voluntary basis for the last six years. We have not managed to receive any funds of any kind for all the hundreds of people who have attended those groups, and it is because the issue of grief is still not something which we perceive to be important.

I would like to support in their entirety the comments made by Dr Brendan Nelson about the approach, and the funding of $400 million and so forth available for GPs, and the details which he outlined. Also, perhaps to some extent we should not have a public

inquiry but at the same time I think we should have it because, unless we do something, we are going to continue to have a lot of rhetoric and very little action. We do have some action, and it is true the government does spend money—and the previous government did too—but I fear that is still not integrated in a way that will have positive results. At the same time, we still have a lot of groups who are very good at lobbying and will be able to re-direct the funding. At the end of the day, are we actually going to see a difference? A lot of people around today have called for evaluations of the programs we run and best practice models and so forth.

Also, the issue of feelings has been raised as a very important aspect. But I would like to go further, because feelings are an expression—as was stated earlier—but sometimes you have a troubled mind as well. We also need to look at the thoughts that are derived from the feelings, and the actions that are derived from the thoughts. Because suicide is more than just a feeling. You may feel hopeless and have this terrible feeling that things are not going well and that maybe there is no hope, but the thoughts that come to you about wanting to kill yourself because you cannot deal with those factors are also critically important. If those thoughts turn into the action of self destruction, they become a possible tragedy. So we should not separate feelings but should look at issues in a more holistic fashion—as was pointed out—in terms of thoughts, feelings and action and try to coordinate some activities that will actually yield some outcome.

In terms of spending, before I am able to commit myself to supporting the notion of pouring more money into suicide prevention—which I probably think we should—there are a lot of things we need to do first. We need to open our eyes before we start to know which direction to take. That is why I think that, if we have such a thing as a National Suicide Prevention Authority, it may well be a venue that politicians, media and the public as a whole can use as a conduit to gather more information and to be directed in particular areas. Because there may already be many resources and much effort being put into a lot of activities which some of us are unaware of and which often are neither integrated nor well connected and go amiss.

Sometimes somebody shouts loud enough—and I can give you lots of instances where monies have been spent in recent months on particular services or geographical spots in Australia because people said, ‘We have a real problem.’ It is my job to produce evidence in terms of data, and I can assure you that some of these areas were funded inappropriately, because they did not have a suicide problem—but they certainly had a lot of issues to raise—and there was no funding and no resources in areas where there were some specific problems. We can continue what we do, but we might contribute to either maintaining the rate or maybe even forcing it to increase. So we need to reflect, to open our eyes and be more productive and visionary in what we want to do. Thank you very much.

CHAIRMAN—Thank you, Professor.

Prof. KOSKY—Thank you very much. It has been a long but extraordinarily interesting day as far as I am concerned. Firstly, I want to thank the Prime Minister because I believe that his appearance here this morning was an historic one. I want to

thank him on behalf of all my patients, of all the patients of all the other people, of all the young people who are out there suffering and of all the young people who have died. I believe his presence here was a gesture towards them, and I think it is a very important one.

Secondly, I want to thank the members of the committee and you, Mr Chairman, for bringing us together. We learn from listening and it has been an occasion in which I have learned from listening. I think this is a process which must keep on going in some way for all of us.

Thirdly, I want to say that I feel very concerned about the level of services that are provided for young people in Australia. I do not believe that they are adequate in any measure whatsoever. I am concerned—and I could even use the word 'frightened'—that the national mental health strategy, which is due to end in 1998, will leave those services in the present state that they are without any help. Parents carry the burden of care. They need adequate back-up services. Every parent who has had a child and who has been in trouble will, I am sure, give you that message. I think that to leave the situation historically under-funded and under-resourced would be a disaster.

Fourthly, I was deeply impressed by what Dr Nelson had to say, and I think that I agree with much of it. I do believe there is a need for a national policy advisory group at a very high level to funnel what we talk about up to levels where actions can take place. The government has a social responsibility in this area, and the presence of the Prime Minister indicates that they take that very seriously. I think what they need is policy advice. We need to set up something for that.

Finally, I am not a doomsayer about today's youth. On almost every measure, they are better than ever before. They are much safer for you and me on the roads than what they used to be and what we were. They are much more responsible in many ways and they are healthier. What we need to do—and I think the Prime Minister alluded to this in his original heartfelt remarks, which seemed to me to be off-the-cuff rather than prepared—is identify that small group who are struggling. We need to identify them and pick them out, and we need to help them. Because, at the moment, our figures suggest that we are not helping them. We are failing to help them, despite everything. We need to think again very much about who they are and what their needs are and how best those needs can be met. Thank you very much.

CHAIRMAN—Thank you very much, Professor Kosky. We are almost out of time. I think it has been a very worthwhile day. I hope that you agree. We have a lot of ideas and we have had some points of view put to us that we had not, as a committee, heard before. The committee will get the *Hansard* report. We will, as a committee, read what the proceedings of the day said. We will then come together and decide what sort of response we will make. I want to give you a pledge that it will be a non-partisan response. I must say that this is an issue which has united members of our committee on both sides of politics. We are determined to assist the government to move forward in the area of youth suicide prevention strategies. Without your help, we would not have been able to make that response to the government and to give that advice to the government.

All of us have benefited immensely from the presentations made by our guest speakers today—Dr Harrison, Professor Baume, Professor Kosky and Dr Smith. I would like everyone here to join with me to give a vote of thanks to our presenters who have done such a wonderful job, and who have set the parameters for what was a very worthwhile discussion.

In closing, I would like to thank in particular our secretary, Bjarne Nordin, and other members of the secretariat staff, and also *Hansard* which has done an outstanding job in trying to put together the contributions made by many voices *Hansard* would not usually recognise. Thank you very much to all our speakers for attending today. We greatly appreciate it. Let us hope that today's proceedings will assist this nation in confronting what I believe is one of the greatest social issues it faces in 1997—that of youth suicide. Thank you.

Committee adjourned at 5.01 p.m.