THE EPIDEMIC IN YOUTH SUICIDE

RESEARCH BULLETIN NO 1/96

LINDA WOODROW

QUEENSLAND PARLIAMENTARY LIBRARY
Publications and Resources Section

BRISBANE
January 1996
ISSN 1325-1341
ISBN 0 7242 6801 4
ABSTRACT

Australia has one of the highest rates of youth suicide in the world, and Queensland’s rate of death by suicide is higher than the national average. Suicide was the leading cause of death for young Queensland males in 1994. Young Aboriginal men and young men living in rural and remote parts of the state have rates of death by suicide that are two to three times the national average. The proportion of deaths in young males due to suicide has been steadily increasing for the last twenty years.

This Research Bulletin outlines the principal characteristics of young suicides, examines the reasons for the rising rates of youth suicide, and canvasses options for reducing those rates.
Linda Woodrow studied at University of Queensland and Queensland University of Technology. She holds a Bachelor of Arts degree with majors in sociology and government. She has worked as a research officer with Queensland Parliamentary Library, and in a wide range of fields from opera production to mining exploration.

Linda is the author of *The Permaculture Home Garden* (Penguin, 1996) and is currently working on her second book, *Ritual, Culture and Community*. She lives in a rural area.

# CONTENTS

1. INTRODUCTION ........................................................................................................... 1

2. THE SIZE OF THE EPIDEMIC .................................................................................... 5

3. WHO ARE THEY? ........................................................................................................ 11
   3.1 THE VAST MAJORITY ARE MALE .......................................................................... 11
   3.2 MOST ARE YOUNG ............................................................................................... 15
   3.3 MANY ARE DEPRESSED .................................................................................. 15
   3.4 TOO MANY LIVE IN RURAL AND REMOTE AREAS ........................................... 16
   3.5 MOST ARE ALCOHOL AFFECTED ................................................................. 19
   3.6 A FEW ARE CANNABIS AFFECTED ................................................................. 21
   3.7 MANY ARE UNEMPLOYED ................................................................................ 22
   3.8 THEY ARE LIKELY TO HAVE TRIED BEFORE .................................................. 24
   3.9 SOME ARE MENTALLY ILL ............................................................................. 24
   3.10 SOME ARE OFFENDERS .............................................................................. 26
   3.11 TOO MANY ARE ABORIGINAL .................................................................... 26
   3.12 THEY COME FROM ORDINARY FAMILIES ................................................... 27

4. WHY? ............................................................................................................................ 28
   4.1 UNEMPLOYMENT - THERE’S NO FUTURE ON THE DOLE ................................. 28
   4.2 HOPELESSNESS - THE WORLD IS GOING DOWN THE GURGLER ................. 29
   4.3 YOUTH CULTURE - LIFE SUCKS .................................................................... 29
   4.4 SELF-ABUSE - GETTING OFF YOUR FACE ...................................................... 30
   4.5 MODELS OF MASCULINITY ........................................................................... 30
   4.6 AVAILABILITY OF MEANS ............................................................................. 31
   4.7 SOCIETAL CHANGES ....................................................................................... 32

5. WHAT CAN BE DONE .................................................................................................. 34
   5.1 SOCIOLOGY ....................................................................................................... 35
   5.2 PSYCHOLOGY .................................................................................................... 36
   5.3 PSYCHIATRY ..................................................................................................... 37
   5.4 EPIDEMIOLOGY AND RESEARCH ................................................................... 38
   5.5 RESTRICTION OF MEANS ............................................................................. 38
   5.6 CURRENT PROGRAMS ..................................................................................... 39

6. CONCLUSION ................................................................................................................. 42

BIBLIOGRAPHY ................................................................................................................. 43

APPENDIX A .................................................................................................................. 1

APPENDIX B .................................................................................................................. 1

APPENDIX C .................................................................................................................. 1

APPENDIX D .................................................................................................................. 1
1. INTRODUCTION

On 1st August 1995 Jason Bayley turned twenty. On 20th August, in the early hours of the morning, he committed suicide. Jason is part of what the National Injury Surveillance Unit is now calling an epidemic in suicide amongst young men.1

Australia has one of the highest rates of youth suicide in the world and Queensland’s rate is significantly above the national average overall, and over double the national rate in some regions. Suicide is now the leading cause of death amongst 15 to 24 year olds in Queensland. It is the contribution made by young men like Jason that has led to the steep rise. As Dr Michael Dudley says, “The trend is that young males aged 15 to 24 are killing themselves at three times the rate that they were doing so 30 years ago”.2

Jason very closely fitted the profile of many of these young men. He was tall, intelligent, good looking, and although in retrospect he could be identified as having many of the known risk factors, he shared them with so many of his generation that his suicide was totally unexpected.

He was troubled, worried about the state of Australia and the world and cynical about the prospects of his generation “fixing it up”. But as numerous surveys have shown, these are characteristics that are so common that they are “normal” in modern youth.

He had a job, which he loved, as a first year apprentice mechanic, but it had taken him several years to secure it and he was very frightened of losing it. He was very aware of the youth unemployment rates and the stigma attached to being “on the dole”. Unemployment rates, particularly the relative disadvantage borne by youth, and even more by youth in some geographic areas, are strongly correlated with suicide rates.3

Alcohol was a big part of his social life. He routinely spent most weekends going out with mates, to the pub or to grab a carton and watch a football game on television. He was contemptuous of drink drivers or those who let drinking interfere

---


with their work performance. He was not a solitary, morose, or aggressive drunk, but he was regularly drunk. However, as the National Health and Medical Research Council has noted with reference to a survey conducted in South Australia, “*binge drinking on weekends could almost be considered to be the norm for men aged 18 to 24 years*”.

He was inclined, particularly when he had been drinking, to indulge in impulsive and risk-taking behaviour - to show-off his physical prowess and bravery. Researchers suggest that this is not unusual behaviour: “*Young suicides are reported to have displayed a high level of risk taking and impulsivity prior to death.*” However risk-taking is also not unusual behaviour for young men in our culture. Young Australian men have a much higher rate of fatality due to all injuries than young women - 75 compared to 19 per 100,000 in 1994 in the ABS category ‘Accidents, poisonings and violence’.

Jason was not, in any way that his family or friends could discern, mentally ill. Secretary of Australian National Lifeline, Margaret Appleby, says that the majority of young suicides “*do not have a diagnosable mental illness. They are people just like you and I*”.

In the majority of cases it is the additional burden of depression, anxiety and hopelessness that a particular precipitating event adds to an already overburdened system that “causes” a young person to suicide. In Jason’s case it was an arrest for drink-driving. The most common precipitating event is the loss of a significant relationship - usually romantic. However “disciplinary crises”, with the police or (in the case of younger suicides) with parents or school, are also very common.

None of Jason’s friends or family recall him talking about suicide. This is not uncommon. Studies indicate that only about one-third of suicides give any warning of their intention. However, in common with most of his peers, it would have been

---


a familiar notion to him: “increasingly teenagers believe that suicide is simply a reasonable option to be chosen or not when circumstance demands”.8

One of the greatest tragedies in youth suicide is the number of “suicide survivors”-those left behind to grieve. Jason left at least twelve people for whom suicide will be a lifelong preoccupation. Pierre Baume suggests this is conservative9. For most of these survivors, it is the most traumatic and significant experience of their lives.

Jon and Sue Stebbins said “our whole life changed irreversibly and dramatically”10. A search for causes and apportioning blame are especially evident in reactions. For Jason, like most, the causes may be found not only in personal and private circumstances, but also in social and cultural ones.

Anger is one of the normal stages of grief, and is normally heightened in the case of a young suicide11. Jon and Sue Stebbins reported that their survey indicated that:

Anger is a very common emotion amongst the survivors of suicide...anger directed at those who had information about the possibility of suicide and did not appear to act on it...there was a strong plea across the groups for action on the community ignorance and misconceptions about suicide.12

Rightly or wrongly, much of this anger is directed at government and government instrumentalities - those who were in a position to “do something” and failed to do so. This is particularly so in the case of young males once it is realized that a particular bereavement is not just a personal tragedy but part of a much wider epidemic. The opinion of Dr Stephen Phillips, State President of the AMA that “…the Australian community has an understandable ‘out of sight, out of mind’ attitude to suicide. The community can’t be held responsible for this but governments can. It’s purely a matter of political and bureaucratic will,”13 is shared by most survivors.


12 Jon and Sue Stebbins, p.31.

Suicide produces something like 5,500 “survivors” in Queensland every year, which means 55,000 or so in the last decade, people for whom lowering the rate is a priority community issue.

This Research Bulletin examines the issue of youth suicide from the various perspectives introduced above. Recent trends in suicide statistics are outlined, with emphasis on the principal characteristics of young suicides. The explanations that have been proposed for the increasing rate of youth suicide, and recommended and actual strategies for reducing those rates, are also examined.
2. THE SIZE OF THE EPIDEMIC

The points in the box below outline the key features of recent trends in youth suicide. Each point is exemplified in turn in the pages that follow.

- **Australia has one of the highest rates of youth suicide in the world.**
- **The national rate of youth suicide has almost trebled in the past 40 years.**
- **Young males outnumber young females by over six to one.**
- **The proportion of all male youth deaths due to suicide has increased from 18% in 1985 to 27% in 1994.**
- **In 1994, for the fourth consecutive year, more Australians died by suicide than by motor vehicle accident - 1,830 compared to 1,369.**
- **Queensland’s rate of death by suicide is higher than the national average.**
- **Suicide was the leading cause of death in Queensland for young males aged 15 to 24 in 1994.**
Australia has one of the highest rates of youth suicide in the industrialised western world.

Table 1: Suicide death rates (per 100,000 of population) among 15 to 24 year-olds, latest available data, 1989-92

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand</td>
<td>1991</td>
<td>38.7</td>
<td>5.8</td>
</tr>
<tr>
<td>Finland</td>
<td>1992</td>
<td>35.2</td>
<td>8.3</td>
</tr>
<tr>
<td>Canada</td>
<td>1991</td>
<td>27.7</td>
<td>4.0</td>
</tr>
<tr>
<td>Norway</td>
<td>1991</td>
<td>27.4</td>
<td>4.5</td>
</tr>
<tr>
<td>Australia</td>
<td>1992</td>
<td>25.6</td>
<td>5.0</td>
</tr>
<tr>
<td>Austria</td>
<td>1992</td>
<td>24.4</td>
<td>6.1</td>
</tr>
<tr>
<td>Switzerland</td>
<td>1992</td>
<td>23.1</td>
<td>6.3</td>
</tr>
<tr>
<td>United States of America</td>
<td>1990</td>
<td>22.0</td>
<td>3.9</td>
</tr>
<tr>
<td>Ireland</td>
<td>1991</td>
<td>19.1</td>
<td>1.3</td>
</tr>
<tr>
<td>Belgium</td>
<td>1989</td>
<td>17.3</td>
<td>3.9</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>1992</td>
<td>15.6</td>
<td>4.8</td>
</tr>
<tr>
<td>France</td>
<td>1991</td>
<td>15.0</td>
<td>4.1</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>1992</td>
<td>14.8</td>
<td>2.8</td>
</tr>
<tr>
<td>Sweden</td>
<td>1990</td>
<td>14.7</td>
<td>5.3</td>
</tr>
<tr>
<td>Germany</td>
<td>1991</td>
<td>14.4</td>
<td>3.6</td>
</tr>
<tr>
<td>Denmark</td>
<td>1992</td>
<td>12.6</td>
<td>3.4</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>1992</td>
<td>12.2</td>
<td>2.3</td>
</tr>
<tr>
<td>Singapore</td>
<td>1991</td>
<td>10.9</td>
<td>7.4</td>
</tr>
<tr>
<td>Japan</td>
<td>1992</td>
<td>10.2</td>
<td>4.7</td>
</tr>
<tr>
<td>Netherlands</td>
<td>1991</td>
<td>9.8</td>
<td>3.6</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>1991</td>
<td>7.3</td>
<td>5.6</td>
</tr>
<tr>
<td>Spain</td>
<td>1990</td>
<td>7.1</td>
<td>1.7</td>
</tr>
<tr>
<td>Israel</td>
<td>1990</td>
<td>6.7</td>
<td>3.3</td>
</tr>
<tr>
<td>Argentina</td>
<td>1990</td>
<td>6.6</td>
<td>3.5</td>
</tr>
<tr>
<td>Italy</td>
<td>1990</td>
<td>5.9</td>
<td>2.0</td>
</tr>
<tr>
<td>Portugal</td>
<td>1992</td>
<td>5.7</td>
<td>2.1</td>
</tr>
<tr>
<td>Greece</td>
<td>1991</td>
<td>4.0</td>
<td>7.0</td>
</tr>
</tbody>
</table>

- The Australian national rate of youth (15-24) suicide has almost trebled in the past 40 years
- The rate of young males outnumbers young females by over six to one.

**Figure 1** Male suicide rates for specific age groups, 1907-1990

Source: Morrell, p.7.
The proportion of all male youth (15-24 years) deaths due to suicide has increased from 18% in 1985 to 27% in 1994.

### Table 2 Deaths by Suicide in Australia 1985 and 1994

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number 1985</th>
<th>Number 1994</th>
<th>Rate(^a) 1985</th>
<th>Rate(^a) 1994</th>
<th>Proportion(^b) 1985</th>
<th>Proportion(^b) 1994</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-24</td>
<td>325</td>
<td>374</td>
<td>64</td>
<td>57</td>
<td>24</td>
<td>27</td>
</tr>
<tr>
<td>25-44</td>
<td>596</td>
<td>768</td>
<td>126</td>
<td>184</td>
<td>25</td>
<td>28</td>
</tr>
<tr>
<td>45-54</td>
<td>170</td>
<td>270</td>
<td>66</td>
<td>68</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>55-64</td>
<td>159</td>
<td>173</td>
<td>61</td>
<td>47</td>
<td>23</td>
<td>27</td>
</tr>
<tr>
<td>65-74</td>
<td>113</td>
<td>141</td>
<td>42</td>
<td>32</td>
<td>24</td>
<td>28</td>
</tr>
<tr>
<td>75-84</td>
<td>60</td>
<td>78</td>
<td>37</td>
<td>28</td>
<td>30</td>
<td>27</td>
</tr>
</tbody>
</table>

\(^a\) number per 100,000  
\(^b\) % of deaths within each age group


In 1994, for the fourth consecutive year, more Australians died by suicide than by motor vehicle accident - 1,830 compared to 1,369.

### Figure 2 Comparison of Deaths caused by Suicide, Motor Vehicle Accidents (MVA), and AIDS, Australia 1994

Queensland’s rate of death by suicide is higher than the national average.

Table 3 Suicide rates per 100,000 estimated resident population, for selected age groups, by State and Territory, 1994

<table>
<thead>
<tr>
<th></th>
<th>15-24</th>
<th></th>
<th>25-44</th>
<th></th>
<th>All Ages</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>male</td>
<td>female</td>
<td>male</td>
<td>female</td>
<td>male</td>
<td>female</td>
</tr>
<tr>
<td>NSW</td>
<td>25.1</td>
<td>4.3</td>
<td>28.3</td>
<td>6.5</td>
<td>20.9</td>
<td>5.0</td>
</tr>
<tr>
<td>Victoria</td>
<td>23.1</td>
<td>3.6</td>
<td>24.0</td>
<td>6.7</td>
<td>18.1</td>
<td>4.9</td>
</tr>
<tr>
<td>Qld</td>
<td>32.6</td>
<td>7.2</td>
<td>29.8</td>
<td>7.2</td>
<td>22.8</td>
<td>5.6</td>
</tr>
<tr>
<td>SA</td>
<td>22.9</td>
<td>3.9</td>
<td>27.7</td>
<td>5.8</td>
<td>19.2</td>
<td>3.9</td>
</tr>
<tr>
<td>WA</td>
<td>32.5</td>
<td>0.8</td>
<td>32.5</td>
<td>6.7</td>
<td>22.0</td>
<td>3.4</td>
</tr>
<tr>
<td>Tasmania</td>
<td>44.8</td>
<td>0.0</td>
<td>22.8</td>
<td>7.0</td>
<td>26.9</td>
<td>2.9</td>
</tr>
<tr>
<td>NT</td>
<td>20.8</td>
<td>0.0</td>
<td>31.5</td>
<td>0.0</td>
<td>20.3</td>
<td>1.2</td>
</tr>
<tr>
<td>ACT</td>
<td>13.7</td>
<td>10.9</td>
<td>32.0</td>
<td>12.0</td>
<td>17.2</td>
<td>6.7</td>
</tr>
<tr>
<td>Australia</td>
<td>26.8</td>
<td>4.3</td>
<td>27.8</td>
<td>6.7</td>
<td>20.6</td>
<td>4.8</td>
</tr>
</tbody>
</table>


Suicide was the leading cause of death in Queensland for young males aged 15 to 24 in 1994.

Figure 3 Four Leading Causes of Death in Queensland 15-24 Year Olds

Variation within Queensland

Some Queensland regions and districts have rates of death by suicide that are well above the national average.

The following ABS Statistical Sub-Divisions had rates that were significantly greater or significantly lower than the national average in 1991-92:

- Gold Coast City (177% of the national average)
- Far North SD Balance (161%)
- Logan City (59%)
- Pine Rivers Shire (53%)
- Darling Downs (70%)\(^{14}\)

Figure 4 illustrates regional suicide rates for Queensland 1990-1992. However these are Queensland Health regions which are not necessarily identical to ABS regions.

**Figure 4** Suicide rates per year for Queensland and Queensland Health regions, 1990-1992.


3. WHO ARE THEY?

3.1 THE VAST MAJORITY ARE MALE

The rate of suicide overall would, at present, be lower than at any time this century but for the contribution of one specific group - late adolescent and young adult males - young men aged eighteen, nineteen and twenty. Queensland rates for young women are at present less than one sixth of young male rates. Because of the low numbers, the rates for young women tend to fluctuate widely year by year, but there is no sign of a general upward trend. Rates for middle aged people, of both sexes, have been dropping steadily since the mid to late 1960’s. In contrast, rates for young males have shown a steep upward rise since the early 1970’s, which shows no signs of abating.\(^\text{15}\)

Every suicidal person, of any age or sex, warrants concern. But it is the rates in young men that warrant alarm.

It is often suggested that the reason why completed suicides are so overwhelmingly male is that males tend to use much more violent and “successful” methods - methods like firearms and hanging that leave little or no room for medical intervention and rescue. Females, in contrast, tend to use methods like poisoning, that leave a comparatively large window of opportunity to be recorded in the statistics as a suicide attempt rather than as a completed suicide (see Table 4). There has been a slight increase in the percentage of females using hanging as a method in the last ten years\(^\text{16}\). However in most cases “females are continuing to use poisons for self-harm but, with less toxicity in the products available, their attempts are now more likely to result in hospitalisation than in death.”\(^\text{17}\)

\(^{15}\) Morrell, p. 38.

\(^{16}\) Commonwealth Department of Human Services and Health, *Youth Suicide in Australia: A Background Monograph*, AGPS, Canberra, 1995, p. 17.

\(^{17}\) Commonwealth Department of Human Services and Health, p. 13.
Table 4  Methods of suicide, Australia, 1988-1992

<table>
<thead>
<tr>
<th>Methods of suicide</th>
<th>Males 15-24 years</th>
<th>Males All ages</th>
<th>Females 15-24 years</th>
<th>Females All ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Poisoning by solid or liquid substances</td>
<td>7.8</td>
<td>12.2</td>
<td>28.6</td>
<td>38.4</td>
</tr>
<tr>
<td>Poisoning by gases in domestic use</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.4</td>
</tr>
<tr>
<td>Poisoning by other gases and vapours</td>
<td>17.3</td>
<td>21.9</td>
<td>14.9</td>
<td>12.9</td>
</tr>
<tr>
<td>Hanging, strangulation and suffocation</td>
<td>31.4</td>
<td>26.5</td>
<td>24.3</td>
<td>20.6</td>
</tr>
<tr>
<td>Submersion (drowning)</td>
<td>0.9</td>
<td>1.9</td>
<td>1.8</td>
<td>5.7</td>
</tr>
<tr>
<td>Firearms and explosives</td>
<td>30.9</td>
<td>26.4</td>
<td>12.8</td>
<td>6.2</td>
</tr>
<tr>
<td>Cutting and piercing instruments</td>
<td>0.8</td>
<td>1.8</td>
<td>1.2</td>
<td>1.9</td>
</tr>
<tr>
<td>Jumping from a high place</td>
<td>3.7</td>
<td>3.8</td>
<td>9.4</td>
<td>7.1</td>
</tr>
<tr>
<td>Other unspecified means</td>
<td>7.0</td>
<td>5.3</td>
<td>6.7</td>
<td>6.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>


The argument is that female suicide rates are not showing the same sharp rise only because increasing numbers attempting suicide are being offset by improvement in medical treatment:

...*since most frequently men use violence of guns and women use self-poisoning to suicide, the chances of women surviving serious suicide attempts are now greater than men because of advances in intensive care medical technology.*\(^{18}\)

Reliable, comprehensive statistics on attempted suicide are virtually impossible to obtain. The statistic that the rate of attempted suicide is five to six times higher in females than in males is often quoted but rarely substantiated.

Hospital data provide an indication of the numbers of people who are hospitalised for self-inflicted injury. Hospital separations [ie people who are discharged or transferred for any reason (including death)] in this category are certainly higher for females than for males, but not by orders of magnitude. In Queensland in 1993/94, there were 496 females as against 352 males in the 15 to 24 age group (see Figure 5).\(^{19}\) A similar degree of difference was recorded in South Australia.\(^{20}\)

---

\(^{18}\) Riaz Hassan, ‘Unlived lives: Trends in youth suicide’ in *Preventing Youth Suicide*, p.6.

\(^{19}\) Queensland Department of Health, Epidemiology and Health Information Branch, *Hospital Morbidity*, National Social Health Database, 1993/94.
Clearly, many suicide attempts are not recorded in hospital separation data. Whereas a significant proportion of attempts by poisoning (the predominant female method) would result in in-patient care, attempts by firearm or by hanging (the predominant male methods) would most often result in either death or in little or no injury. This is supported by noting that the rate of hospital admissions for males due to attempts by poisoning is vastly disproportionate to their use of this method in completed suicide (See Table 5). It could well be that male rates of attempted suicide are, like their rates of completed suicide, much higher than female rates, but that the methods that males tend to use do not result in hospital records.

**Table 5** Hospital separation rates for self-inflicted injury (per 100,000 of population) among 15 to 24 year olds, New South Wales, 1991-1992.

<table>
<thead>
<tr>
<th>Method</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor vehicle exhaust</td>
<td>4.1</td>
<td>*</td>
<td>2.2</td>
</tr>
<tr>
<td>Hanging</td>
<td>2.6</td>
<td>*</td>
<td>1.5</td>
</tr>
<tr>
<td>Firearms</td>
<td>2.1</td>
<td>*</td>
<td>1.3</td>
</tr>
<tr>
<td>Poison (solid/liquid)</td>
<td>67.3</td>
<td>123.9</td>
<td>95</td>
</tr>
<tr>
<td>Cutting/piercing</td>
<td>20.4</td>
<td>11.6</td>
<td>16.1</td>
</tr>
<tr>
<td>Other</td>
<td>8.1</td>
<td>4.0</td>
<td>6.1</td>
</tr>
</tbody>
</table>

* Individual case count is from 1 to 3 inclusive

Source: Harrison and Cripps (1994a), in Commonwealth Department of Human Services and Health, *Youth Suicide in Australia, A Background Monograph*, p.16.

---

The issue of gender differences in suicidal behaviour is significant in the identification of target groups and consequent allocation of resources in suicide prevention programs. The Queensland Health Department’s *Young People at Risk* program (see Appendix B) focusses on young men and women equally:

*However, in focussing on the high suicide rates for young men it is important that young women and their issues are not overlooked, as it is estimated that the attempted suicide rate for young women is up to five times that of young men.*

By contrast the priority populations in the Commonwealth’s suicide prevention program are males aged 15 to 34, and males aged 65 and older, reflecting the disproportionate number of male suicides in those age groups.

While suicide attempts are of serious concern, and prior attempts are a prime risk factor for suicide, those at greatest risk of death are overwhelmingly male.

*Male gender is unequivocally the most distinctive characteristic of suicide victims.*

---


3.2 **Most Are Young**

Suicide is a characteristic not just of males, but of young males. Once aged over 24, a young man will not experience a higher risk until he is over eighty years old, and males over eighty account for less than 3% of all suicides. Rates for men of middle age - 40 to 69 - are declining. Between 1971 and 1992, years of potential life lost due to suicide in males increased by 37%, whereas in females it decreased by 33%. However the proportionate contribution of suicide to years of life lost over the same period increased 2.4 times (i.e., by 142%) for males and 1.3 times (27%) for females.

*The highest rate of increase in suicide rate in recent years has been in the 15-24 year age group.*

3.3 **Many Are Depressed**

Reliable and comparable measures of how common depression is in young suicides are difficult to find, because depression is differently defined in every study. Silburn, Zubrick and Hayward, in a comprehensive study of young suicides in Western Australia between 1986 and 1988, found that 71% were reported by family and friends to have been depressed for more than a fortnight prior to their death. Drs Cantor and Slater found that in Queensland suicides between 1990 and 1992, depression was mentioned in only 32% of cases, but they stressed that this should be considered a minimal and unreliable estimate, since it relied upon police inquiries having sought information about the psychological state.

Several overseas and Australian studies have found that depression is common in young suicides, although it is usually only identified post mortem. Goldney, in 1993, reviewed the literature on youth suicide and concluded that the most common psychiatric diagnosis made after death was depression, and that it was present in the majority of cases.

---


However, it is unlikely that most cases of depression have a biological cause. According to Professor Brent Waters,

\[
\text{most depressions suffered by suicidal people, especially young people, don’t have a biological basis. Instead, they’re ... ‘environmental depressions’ - caused by an accumulation of life experiences recent and past.}^{28}
\]

\textit{Depression caused not by biological or physiological factors, but by their experience of life, is common in young suicides.}

### 3.4 TOO MANY LIVE IN RURAL AND REMOTE AREAS

Although the largest numbers of young suicides occur in Brisbane and Queensland’s other major cities, the highest per capita rates occur in rural and remote areas. The chance of a young man in a remote area of Queensland suiciding is nearly two and a half times that of his Brisbane counterpart, and over eleven times that of a young Brisbane woman. While lower than the rural and remote rates, youth suicide rates in the major provincial and rural centres are still significantly higher than the Brisbane rates. These are illustrated in Figure 6 for the 15-19 and 20-24 age groups. Statistics for all age groups are presented in Table 6.

**Figure 6** Youth Suicide: Capital City, Urban, Rural and Remote Rates Compared - Queensland 1991-92

![Graph showing youth suicide rates by location and age group.](image)

Source: National Injury Surveillance Unit, unpublished data

---

\textsuperscript{28} Nikki Barrowclough, ‘Postcards from the edge’, \textit{Good Weekend}, 30 April 1994, p.33.
Table 6 Suicide Death Rates per 100,000 1991-1992 Queensland.

<table>
<thead>
<tr>
<th>Age</th>
<th>Capital City</th>
<th>Major Urban</th>
<th>Rural Major</th>
<th>Rural Other</th>
<th>Remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>17.0</td>
<td>31.3</td>
<td>28.9</td>
<td>33.6</td>
<td>51.2</td>
<td>24.8</td>
</tr>
<tr>
<td>20-24</td>
<td>35.2</td>
<td>44.4</td>
<td>45.7</td>
<td>54.2</td>
<td>84.2</td>
<td>42.6</td>
</tr>
<tr>
<td>25-29</td>
<td>32.7</td>
<td>32.4</td>
<td>22.4</td>
<td>33.2</td>
<td>*</td>
<td>31.2</td>
</tr>
<tr>
<td>30-34</td>
<td>30.0</td>
<td>43.7</td>
<td>20.3</td>
<td>38.1</td>
<td>*</td>
<td>32.6</td>
</tr>
<tr>
<td>35-39</td>
<td>30.9</td>
<td>36.6</td>
<td>31.3</td>
<td>37.7</td>
<td>38.8</td>
<td>33.1</td>
</tr>
<tr>
<td>40-44</td>
<td>27.1</td>
<td>40.8</td>
<td>26.8</td>
<td>28.9</td>
<td>*</td>
<td>30.0</td>
</tr>
<tr>
<td>45-49</td>
<td>14.7</td>
<td>33.0</td>
<td>51.7</td>
<td>8.2</td>
<td>*</td>
<td>23.1</td>
</tr>
<tr>
<td>50-54</td>
<td>28.3</td>
<td>24.4</td>
<td>35.3</td>
<td>33.4</td>
<td>*</td>
<td>30.7</td>
</tr>
<tr>
<td>55-59</td>
<td>22.6</td>
<td>34.3</td>
<td>48.9</td>
<td>25.0</td>
<td>*</td>
<td>29.8</td>
</tr>
<tr>
<td>60-64</td>
<td>20.7</td>
<td>21.7</td>
<td>39.5</td>
<td>26.4</td>
<td>*</td>
<td>25.0</td>
</tr>
<tr>
<td>65-69</td>
<td>29.4</td>
<td>26.6</td>
<td>49.4</td>
<td>47.8</td>
<td>*</td>
<td>35.3</td>
</tr>
<tr>
<td>70-74</td>
<td>20.6</td>
<td>38.4</td>
<td>26.8</td>
<td>37.9</td>
<td>*</td>
<td>28.4</td>
</tr>
<tr>
<td>75+</td>
<td>42.8</td>
<td>43.4</td>
<td>52.4</td>
<td>36.1</td>
<td>*</td>
<td>43.2</td>
</tr>
<tr>
<td>Total</td>
<td>24.6</td>
<td>32.3</td>
<td>32.0</td>
<td>30.2</td>
<td>37.9</td>
<td>28.5</td>
</tr>
</tbody>
</table>

(Rates where counts are <4 are shown as *) Based on place of usual residence and usual residence populations and Department of Primary Industries Rural and Remote Area Classification. Rates are Average Annual Rates.

Source: National Injury Surveillance Unit, unpublished data

Other states report a similar difference in remote, rural and urban suicide rates. Even more alarmingly, rural and remote areas are showing a steeper rise in rates. A study by Dr Michael Dudley of 15 to 19 year old males in NSW found that while suicide rates in rural cities had gone up two to three times in the 25 year period between 1964 and 1988, those in rural shires and municipalities had gone up about sixfold in the same period.²⁹

Figure 7 Suicide numbers and rates for 15-19 year olds by area of residence, New South Wales, 1964-1988

(a) Males

(b) Females

Source: Dudley et al., p.30.

Young Queenslanders who live in rural and remote parts of the state have an even higher risk of dying by suicide than the already high risk borne by young urban and provincial city dwellers.
3.5 **Most are alcohol affected**

Several studies have confirmed that alcohol is involved in over half of all youth suicides. Silburn, Zubrick and Hayward found alcohol in the blood of half of all young suicides in Western Australia between 1986 and 1988.\(^{30}\) In 60% of cases family and/or friends reported a history of heavy drinking.\(^{31}\) The NSW Standing Committee on Social Issues heard evidence in its inquiry into suicide in rural NSW that:

... in a majority of suicides alcohol is involved. Because alcohol is a depressant, feelings of low self-worth and depression are heightened while the normal caution and control is eroded.\(^{32}\)

Cantor and Slater found alcohol was a contributing factor in 39% of suicides in Queensland between 1990 and 1992, but indicated that due to police reporting and blood sampling practices, rates are “likely to be higher in reality”\(^{33}\). Their study does not give a breakdown of alcohol presence by age or sex, but all indications are that the rate in young males would be significantly higher than the overall rate, which would result in a prevalence similar to that found in Western Australia.

Studies in the USA have found that the increasing rate of youth suicide has been accompanied by an increase in the number of young suicides that are alcohol affected, from 12.9% in 1969 to 46% in 1983. The entire excess of youth suicides over the 1968 rate would be eliminated if the alcohol-affected suicides were removed.\(^{34}\)

Studies comparing blood and urine alcohol content have found that the alcohol was not consumed immediately before the suicide, as a form of Dutch courage, but rather over a period of many hours some considerable time before death. The implication of this is that alcohol is substantially involved not only in the act, but also in the decision to commit suicide. P. James found that:

*in the great majority of cases alcohol had been consumed some hours before, and that in only four instances was the alcohol most likely to have been taken just*

---

30 Silburn, Zubrick and Hayward, p.80.

31 Silburn, Zubrick and Hayward, p.83.


33 Cantor and Slater, p. 27.

prior to death. In most cases of suicide associated with high blood alcohol levels
the records indicated that the act had been committed either during, or in the
early hours of the morning following a period of alcohol consumption.\textsuperscript{35}

An alcohol-affected decision to suicide may be particularly likely if a person is still
awake some hours after stopping drinking, such as when arrested in an alcohol-
affected state. Mental changes following a period of intoxication may make an
impulsive decision to suicide more likely.\textsuperscript{36}

In both the Queensland and the Western Australian studies, carbon monoxide
poisoning was the predominant method chosen by alcohol-affected suicides. This
may relate to the accessibility and lack of prior planning required for this method.

The Western Australian researchers calculated that a pattern of heavy drinking had
the second highest relative risk of suicide, among the factors identified in their
study. The relative risk for suicide was increased by a factor of 8.8 in those who
consumed at least six standard drinks per day, and by 30 times in those who had
made a prior suicide attempt.\textsuperscript{37}

\textbf{Figure 8} Relative risk estimates for suicide in the 14-24 year age group, Western
Australia, 1968-1988

\begin{figure}
\centering
\includegraphics[width=0.8\textwidth]{figure8}
\caption{Relative risk estimates for suicide in the 14-24 year age group, Western
Australia, 1968-1988}
\end{figure}

Source: Silburn, Zubrick and Hayward, p.83.

\textit{A pattern of heavy or binge drinking is one of the very few risk factors for
suicide that is substantial enough to be useful in prediction.}

\textsuperscript{35} P. James, 1966, cited in Hayward et al., p.256.

\textsuperscript{36} P. James, 1966, cited in Hayward et al., p.256.

\textsuperscript{37} Silburn, Zubrick and Hayward, p.82.
3.6 A FEW ARE CANNABIS AFFECTED

Cannabis was found in the blood of 4% of all Western Australian youth suicides between 1986 and 1988.\(^{38}\) It was found in 6% of Queensland suicides between 1990 and 1992.\(^{39}\) Other drugs, where present, were usually present in lethal doses or combinations: that is, they were used as the suicide method itself.

An estimate of how these rates relate to the general rate in the community at large is difficult. This is partly because since cannabis is illegal, surveys of background rates and frequency of consumption are unreliable, and also because cannabis metabolisation is highly idiosyncratic. The time it can remain detectable in the blood varies from individual to individual.

Nevertheless, the rates of cannabis detection quoted in the first paragraph are probably quite low, given that about 12% of 14-19 year olds and 19% of 20-24 year olds are estimated to use cannabis weekly.\(^{40}\) About 18% of male 16 year old NSW secondary students report weekly use\(^{41}\) and 23% of male NSW TAFE students report at least weekly use.\(^{42}\)

The NSW Standing Committee on Social Issues heard evidence that alcohol and marijuana together “may be likely to precipitate or exacerbate depression”\(^{43}\).

However Hall, Solowij and Lemon have stated:

> There is good evidence that chronic, heavy alcohol use increases the risk of premature mortality from accidents, suicide and violence. There is no comparable evidence for chronic cannabis use...\(^{44}\)

Warren Hamilton, the supervisor of the toxicology laboratory at the John Tonge Centre in Brisbane, confirmed that, in his experience, evidence of cannabis usage alone is relatively rare in suicide victims.\(^{45}\)

\(^{38}\) Silburn, Zubrick and Hayward, p.79.

\(^{39}\) Cantor and Slater, p.27.


\(^{41}\) Donnelly and Hall, p.19.

\(^{42}\) Donnelly and Hall, p.25.

\(^{43}\) NSW Legislative Council, Standing Committee on Social Issues, p.72.

3.7 Many are Unemployed

The unemployed, and those in relatively insecure employment sectors, are massively over-represented in suicide statistics. Amongst the Queensland unemployed, the rate of suicide was 57.1 per 100,000, over three times the state average in 1990-92. The next highest occupational category, after pensioners and unemployed, was labourers, factory and trade workers: unskilled workers with relatively low job security. Young men with a strong work ethic, and whose identity is very tied up with their job, often living in rural areas where there is culturally induced “shame” in being a “dole bludger” are prime candidates.

Figure 9 Suicide by occupation, Queensland, 1990-1992

Source: Cantor and Slater, p.15.

Unemployment rates, however, do not correlate with suicide rates for all people at all times. As Krupinski and colleagues point out, there have been periods this century of high unemployment without high suicide rates, and conversely periods


46 Cantor and Slater, p.15.
when suicide rates rose against a background of relatively full employment. Female suicide rates do not show any clear direct relationship to unemployment rates.

The strong relationship appears to be between relative rates of male youth unemployment and rates of male youth suicide. That is, at places or at times when young males are more likely to be unemployed than the general population, young male suicide rates rise. As Stephen Morrell says, “as the relative prevalence of unemployment among 20-24 year old males has increased, so has their relative risk of suicide”. Riaz Hassan suggests that the duration of unemployment is especially significant for suicide. Suicide rates amongst young males doubled in the period when the average duration of unemployment rose from 3.9 weeks to 30.6 weeks.

**Figure 10** Male suicide and unemployment rate ratios, 20-24 year olds, Australia, 1966-1990


---


48 Morrell, p.38.

49 Hassan, p.6.
3.8 **They Are Likely to Have Tried Before**

For many young suicides, their final attempt will not be their first. Warning in the form of a prior attempt only occurs in a minority of suicides, but it is still one of the best predictors, especially for young females. Cantor and Slater found that a prior attempt was recorded for 11% of completed suicides. However their study did not focus on youth suicides. The Western Australian study of youth suicides found a prior attempt in 33% of cases, most of them female. A prior attempt increased the risk of suicide by 30 times (see Figure 8).

3.9 **Some Are Mentally Ill**

The prevalence of a diagnosable mental illness in young suicide is controversial. The statistic that “Overseas and recent Australian research has indicated that up to 90 per cent of young people who suicide have evidence of psychiatric illness before their death,” is very widely cited. However this statistic is a bit like the assertion that there are nearly always clouds in the sky when it rains. In the absence of a painful terminal illness, (which is rare in young people), or a strong ideological motivation (such as in hunger strikes), the decision to die is itself diagnostic of mental disorder.

A significant minority of young suicides have a mental illness such as schizophrenia, major depression, or manic depression, which was or could have been diagnosed before their death. Such people have a high suicide mortality rate, according to R.D. Goldney, “about a 10 times greater risk of suicide than the general population...” A somewhat larger percentage are suffering from conditions like depression, hostility, or heavy drinking, that mental health workers would diagnose as mental illness, but that the general public or the sufferers themselves may not consider as such. It is often only with the added significance given to them post mortem that

---

50 Cantor and Slater, p.27.

51 Silburn et al., pp.80,81.

52 Commonwealth Department of Human Services and Health, *Youth Suicide in Australia*, p.3; see also Yvonne White, ‘Youth suicide’, *The Medical Journal of Australia*, vol.163, p.146, August 1995.

such conditions are seen as evidence of pre-existing mental illness. Prior to a suicide the same behaviours are often seen as “normal adolescent traumas”. 54

A study of adolescent suicides in Tasmania found “no evidence of a high incidence of psychiatric disorder in the younger sample”. 55 Only a minority (21% and 27% respectively) of suicides in the Queensland and Western Australian studies had any history of mental health treatment. 56

There is evidence of a relationship between suicide and certain organic or biological factors which are also related to mental illness. For example, many mental illnesses, such as schizophrenia, commonly have their onset in late adolescence. Also, low levels of some neurotransmitters (chemicals in the cerebro-spinal fluid) have been identified in those who are depressed and in those who commit suicide or who attempt suicide. 57 There is evidence from autopsy research in the United States that the brains of people who have committed suicide have a reduction in serotonin levels in the orbital cortex area. Low levels of serotonin are associated with depression, and “More than 95% of people who commit suicide show these changes in the brain at autopsy” 58. Such research may eventually lead to diagnostic tests to identify those that are potentially suicidal.

However while such factors may make some individuals more susceptible to suicidal impulses, it is unlikely the current rise in youth suicide rates is primarily caused by an increasing incidence of biological or genetic mental illness. It may, however indicate that the mental health of young people in general is suffering due to pressures generated by environmental, social, economic and cultural issues. Unfortunately there are no reliable statistics on trends in mental health which could be used to confirm or refute this possibility. 59

---

54 Jon and Sue Stebbins, p.24.

55 Haines et al., p.43.

56 Cantor and Slater, p.27; and Silburn et al., p.80.

57 Goldney, ‘Suicide in men’, p.31.

58 ‘A new understanding of suicide’, Quantum, ABC Television, 30 August 1995. [extract from script which described research by Dr John Mann of New York State Psychiatric Institute.]

3.10  **SOME ARE OFFENDERS**

Research carried out by the Australian Institute of Criminology indicates that the suicide rate of people in custody is about 13 times that of the general population, and in police custody (particularly police lock-ups) the rate is about 20 times greater.\(^{60}\) However apart from the elevated rates, suicides in custody exhibit several characteristics in common with those amongst the general population. They are nearly all male. Most are young. They usually occur within the first three hours of incarceration, as an immediate response to a situational crisis. They are usually under the influence of alcohol. A significant minority have a diagnosable mental illness, and a history of prior attempts is mildly predictive.\(^{61}\)

Researchers have found that “depression was predictive of suicide attempts in girls but not in boys, while the reverse was true for acting-out behaviours [ie. anti-social behaviour]”\(^{62}\). This means that while girls at increased risk of suicide are likely to come to the attention of mental health workers, boys are more likely to come to the attention of police. This is supported by Kosky, Sawyer and Gowland’s finding that the level of psychomorbidity in a group of adolescents seen in correctional settings was equal to that seen in the clinic setting, and approximately four times that experienced in the general community.\(^{63}\)

Case study material suggests a scenario in which a young man who is drunk and clinically, but not obviously, depressed, is apprehended by the police after a conflict with a girlfriend or a family member, is a common precursor to suicide.\(^{64}\)

3.11  **TOO MANY ARE ABORIGINAL**

Drs Cantor and Slater found that the suicide rate for male Aborigines or Torres Strait Islanders between 15 and 29 in Queensland in 1990 to 1992 was 70.1 per

---


\(^{64}\) Haines, Hart and Williams, pp.42-43; Silburn, Zubrick and Hayward, p.85; Cantor and Slater, pp.15-30.
100,000, over double the rate for the general population.\textsuperscript{65} The Western Australian study of youth suicides between 1986 and 1988 similarly found young Aboriginal males grossly over-represented.\textsuperscript{66} The true rates may be even higher, since aboriginality is not routinely recorded in coroners’ reports.

Lack of records also makes it difficult to determine how these rates compare over time. However evidence suggests that suicide was rare in traditional Aboriginal communities.\textsuperscript{67} High rates in young Aboriginal men seem to be a modern phenomenon.

### 3.12 They Come From Ordinary Families

Margaret Appleby emphasises that “Suicidal thoughts, feelings and actions can effect anyone from any social class, religious group, age or level of society”.\textsuperscript{68} However the chance of suicide is increased where serious relationship problems occur in families, including physical abuse, parental separation, divorce or remarriage, and changes in living conditions and custodial arrangements.\textsuperscript{69}

Hassan reviewed several studies which point to a link between suicidal behaviour and parent-child relationships.\textsuperscript{70} Suicidal children often exhibit a lack of a close emotional relationship with their parents. Hassan considered that recent trends in Australian family attributes are likely to have exacerbated the strains in parent/child relationships. These include declining family size, increases in divorce and the number of single parent families, and increasing educational attainment and expectations of parents, all of which result in “more intensive emotional, economic and social investments in children”.\textsuperscript{71}

\textsuperscript{65} Cantor and Slater, p.19.

\textsuperscript{66} Silburn, Zubrick and Hayward, p.76.

\textsuperscript{67} Pierre Baume, ‘Developing a national suicide strategy for Australia’, in \textit{Suicide Prevention}, p.64.

\textsuperscript{68} Appleby and Condonis, p.14.


\textsuperscript{70} Hassan, pp.8-10.

\textsuperscript{71} Hassan, p.9.
4. WHY?

The causes of suicide are the subject of ongoing debate (eg. see Hassan, and Raphael and Martinek). From suicide statistics and from surveys of young people it is possible to identify factors whose prevalence in suicidal people is above average, or which are associated with suicidal thoughts and actions.

4.1 UNEMPLOYMENT - THERE’S NO FUTURE ON THE DOLE

Young people leaving school are entering a society in which places in tertiary education and training are limited and competition for them is fierce. Youth unemployment is running at 24% and rising. The number of jobs available for unskilled young people is estimated to have dropped from 600,000 in 1966 to 240,000 in 1992, the same period over which suicide rates have escalated. What youth employment there is tends to be clustered in the service sector industries, and is low-skill, low-paid, insecure, part-time or casual, highly competitive, and lacking in a career path. Analysts believe that these are not temporary or isolated characteristics, but the necessary outcome of structural changes in the Australian economy.

The decline in rural economies, helped by drought and dropping commodity prices, has created rates of youth unemployment in rural areas that are much higher than the state average. Family properties are becoming less and less able to support several generations at once. Local opportunities for education and training are not available in many areas, and parents can no longer afford to support their adolescent and young adult children in education or training away from home. A lack of useful occupations, combined with a lack of affordable entertainment and recreational facilities leads to boredom and adrenaline-seeking risk-taking behaviour.

---


73 Adrienne Millbank, Youth Issues, Background Paper No.9, Department of the Parliamentary Library, Canberra, 1993, p.3.


75 Millbank, pp. 3-4.

Youth unemployment is deeply depressing for many young people. Hugh Mackay found that young unemployed people consistently reported that “life without a job feels like life without meaning”.

4.2 Hopelessness - The World Is Going Down the Gurgler

Several surveys now have shown that an attitude of fear and pessimism about the future of Western civilisation and the world is prevalent in young people. They see the world as “going down the gurgler”.

Perhaps even more importantly, they feel powerless to stop it. Unlike the arrogant self-assurance of the youth culture of the 1960’s and 1970’s, today’s young people are not eager to get their hands on the reins. They feel alienated from politics and unhopeful about the prospects for effecting change through political processes. In 1978, 90% of a survey of young people knew which party they would vote for. In 1989, Hugh Mackay found, as reported by Millbank, “a virtual complete lack of enthusiasm at the prospect of voting, and lack of particular interest among those interviewed as to how they would vote when they had to.”

Fatalistic attitudes - depression combined with a sense of powerlessness - are prominent characteristics of young suicides, and are becoming more common in young people generally.

4.3 Youth Culture - Life Sucks

A period during which young people feel an overwhelming need to be acceptable to peers, to conform to peer culture, is well documented by psychologists. Whether it is a cause or effect of perceptions of the future, the prevailing youth culture today is one of negativity and cynicism. It is not acceptable in peer groups to express enthusiasm or passion for anything. “Life sucks” is the appropriate attitude. A recent survey by the Clemenger group of companies found a youth culture that “showed no passion for issues or for life itself”.

---


79 Millbank, p.27.

Repeated expression of views of negativity and cynicism could lead to development of emotional states consistent with them. A youth culture of depression may create depressed individuals. A youth culture that accepts suicide as normal may create suicidal individuals. This culture is evident in the suicide of high profile role models like Kurt Cobain. It has been well established by researchers that modeling and contagion are important mechanisms in youth suicide.  

4.4 SELF-ABUSE - GETTING OFF YOUR FACE

Researchers for the Commonwealth Government drug offensive have found that Australian teenagers see nothing wrong with “getting off your face” and consider hangovers a badge of honour. By 15 years of age, as many as 38%, and by 16 over half of young males are exhibiting a binge pattern of alcohol abuse.

There is also evidence that rates of alcohol abuse amongst young people are higher in rural areas. Boredom is the reason most often cited. In most rural areas and even in many urban areas, “the major social feature [is] the local pub, and many young people feel there is no alternative entertainment to drinking alcohol”.

4.5 MODELS OF MASCULINITY

The vast preponderance of males in youth suicide statistics has led one researcher to surmise that “adolescent maleness itself might be viewed as pathogenic”.

Firstly, cultural definitions of masculinity, especially in rural areas, make unemployment more damaging to male than to female self-esteem. Unemployed

---


84 Millbank, p.17.

85 S. Forrest, 1988, cited in Dudley et al., p.32; NSW Legislative Council, Standing Committee in Social Issues, p.72-73.

86 NSW Legislative Council, Standing Committee on Social Issues, p.73.

87 Patience, p.59.
males have a narrower range of alternate ways to fill their time that are consistent with their image of appropriate male pursuits. As Dr Graham Martin says:

*I think that kind of rise in the figures for young males must relate to the self esteem that males can’t get from their usual pursuits, so that if males are blocked from gaining work and if historically males have always gained their self esteem from the work environment more than from interpersonal relationships, then they’re going to be really struggling.*

Secondly, males may be less likely to seek help for mental illness or for depression, seeing it as a sign or weakness, particularly in conservative rural communities where personal privacy is difficult to guarantee.

*Given the apparent reluctance of many rural people, particularly farmers, to disclose personal problems and to strive to maintain a sense of resilience and resoluteness, it is conceivable that those most at risk of mental distress and possible suicide would not contemplate seeking assistance from the local rural counsellor.*

Thirdly, definitions of physical courage may be at the root of the propensity of males to use violent and definite means to suicide. The same kind of physical courage that made young men resolute in going over the trenches in Gallipoli may be making them resolute in their suicide attempts.

### 4.6 Availability of Means

Numerous studies concur with Dudley’s conclusion that:

*Where a method is restricted the rates by that method go down. The evidence about whether other methods are substituted vary. In the youth area most of the studies say no, substitution does not occur.*

Drs Chris Cantor and Penelope Slater conducted research into the impact of Queensland’s *Weapons Act 1990*, which took effect on 1 January 1992, on the rate of suicide by firearm, and the rate of suicide overall. Their conclusion was that:

*These results provide preliminary evidence that firearm control legislation, including a 28-day ‘cooling-off’ period before firearm purchase, reduces suicide rates, especially among younger adult men.*

---

88 ‘You might as well live’, SBS Television.

89 NSW Legislative Council, Standing Committee on Social Issues, p. 23.

90 Dr Michael Dudley, speaking in, ‘You might as well live’, SBS Television.
Many researchers suggest that the major impact to be made on suicide rates is by restriction of the availability of means by impulsive or intoxicated people. Vehicle modifications to restrict carbon monoxide poisoning, better standards for prescription and packaging of drugs, and further restriction of firearms are the most common suggestions.

4.7 Societal Changes

One of the world’s leading researchers in suicide, R.F.W. Diekstra, has suggested that:

A society which is subject to the following conditions is at a high risk for an increase in suicides over and above the rate that can be considered ‘normal’ for that society:

- economic instability or deprivation (unemployment);
- breakdown of traditional family group structure;
- interpersonal violence/increase in criminal behaviour;
- secularisation;
- increasing substance use/abuse

It is a myth that societies with a high homicide rate have a low suicide rate. High levels of all kinds of violence in societies are strongly correlated with high suicide rates. As Riaz Hassan says:

The marked increase in suicide among the young has been accompanied by a rise in other serious problems such as homicide, drug abuse, alcohol abuse, delinquency and crime - all of which are a barometer of social stress.

At the same time, an increase in the proportion of families where both parents work full-time, and in the proportion of their time that parents spend at work, may be decreasing the amount of “quality” time that they have available to spend with their


94 Hassan, p.10.
families. Annie Crowe, the president of Kings Cross Youth Resources, believes that:

_Australians don’t seem to get the same pleasure from their children...I think [children] intrude on ‘the good life’. I don’t think they’re integrated into community life. I’m arguing that we really haven’t got the kind of warm and embracing culture the French and Italians have, for example. Our culture is built around more selfish, self-interested needs._95

Hassan makes a similar point in saying that parents want children to fulfil their expectations, but increasingly do not provide the positive emotional support that is required. Children who are unable to meet their parents’ expectations are especially in need of support.96

Eckersley has also considered ways that modern Western culture is failing young people:

_Robbed of the broader, even transcendent, levels of meaning in our lives, many of us rely heavily on more personal levels of meaning, producing one of the hallmarks of the modern age: a desperate, even pathological, self-preoccupation with our looks, our careers, sex lives, personal relationships, personal development, health and fitness, our children (as extensions of ourselves) and so on. The risk is that this reliance makes us more vulnerable to a “collapse of meaning” when things go wrong in our personal lives._97

... Most young people today seem happy enough and intent on enjoying and getting on with their lives, but as a generation they display a cynicism, wariness, impatience and social passivity or disengagement that betray their concerns and apprehension about life.97

The epidemic nature of the rise in youth suicide rates has led some researchers to speculate the existence of a gene, virus, nutritional deficiency, or environmental toxin. A much more plausible theory is that an extremely high and fast rising level of background economic, social, and cultural factors has created an “at risk” population that comprises ALL young males. It then needs only a few individual factors - a precipitating event, an aberrant mental state, and easily available means - to fall like Lotto balls at the same time and place, and a mortality is a likely result. If everyone is playing with fire, someone is going to get burned.

---

95 Annie Crowe, quoted in Barrowclough, p.34.

96 Hassan, pp.8,10.

97 Eckersley, p.17.
5. WHAT CAN BE DONE

It is not possible to predict which individuals will suicide. As Robert Goldney says, even using well-known risk factors, the chance of successful prediction is little, if any, better than chance. This is because the primary risk-factors are so widespread that they are endemic in the young male population, and because the number of people who actually commit suicide is a relatively low proportion of the population. Nevertheless it is possible to identify and target “at risk” groups, those who are over-represented in suicide statistics.

There are four easily identifiable populations at significantly greater risk of death by suicide than the general population:

- young Aboriginal and Torres Strait Islander males
- young males who have been charged with an offence
- young people of both sexes who have been diagnosed with a mental illness
- young people of both sexes who have already made an attempt on their life.

There is little controversy that, since they can be identified, these populations should be targeted for suicide prevention strategies.

However although the rates of suicide in these populations are extremely high, they are themselves small populations, so they represent a relatively small proportion of the total number of suicides. Any program to significantly reduce rates must also address suicide in the general population of young males.

Unfortunately further delineation of those with heightened risk has defied the best efforts of researchers. This is well illustrated by a project in the United States where three hundred members of the American Association of Suicidology, armed with comprehensive case histories, were asked to assign relative vulnerability to suicide to each of the subjects. The result was that “the degree of vulnerability assigned to those who did suicide was actually lower than that expected by chance”. Existing measures neither pick a significant proportion of those who commit suicide, nor separate them from a vastly greater number who do not. Suicide prevention programmes must of necessity target risk factors that are widespread in the general population.

---


Which risk factors should be targetted, and how, is a controversial subject. Diana Bagnall says:

_The debate about suicide prevention falls roughly into three camps: sociology, which regards suicide as a social and cultural malaise and argues for improving the social environment of young people; psychology, which believes that the risk of suicide can be lowered if young people are taught how to deal with difficult emotions and stressful situations; and psychiatry, which says that scarce mental health resources should be focused on treating clinical depression._

To these two further approaches may be added:

- epidemiology and research, which argues that “the most important task...is to co-ordinate data and to ensure that information which has been gleaned so far is disseminated not only to clinicians in the field, but also to the community in general”

- means reduction, which argues that in practical terms the major reductions in suicide rates that have been achieved in other countries and times have been by restriction of the availability and lethality of means.

There is no consensus on the relative merits of each of these approaches, or on the relative priority of measures advocated within them. A full discussion of the debate is beyond the scope of this paper. What follows is a brief outline of the kind of measures that are available for consideration.

### 5.1 Sociology

This approach incorporates measures designed to:

- alleviate youth unemployment and expand opportunities for education and training, with particular emphasis on rural areas;
- alleviate boredom by providing appropriate recreation, entertainment, and sporting facilities for young people, and by providing access to useful occupations other than employment, again with particular emphasis on rural areas;
- provide alternate venues for social interaction where alcohol consumption is not a focus of activity, again particularly in rural areas;

---

100 Bagnall, p18.


• engender confidence in young people that the ‘big’ problems - greenhouse gases, ozone depletion, environment, AIDS, nuclear proliferation etc. - are not insurmountable;

• alleviate fatalism by engaging young people in positive action, including political action; and

• expand opportunities for expression of an active youth culture, in dance, art, music, literature and performance.

The sociological approach is not the easiest one. It is based on the belief that:

*There are no simple answers. We must address our efforts to alleviate the despair and hopelessness which is the basis for most suicides. Furthermore we must encourage all members of society to believe that suicide is not the normative way in which to proceed when one is emotionally distressed.*

However the sociological approach has the advantage that many of these measures are also advocated in response to youth problems other than suicide, such as substance abuse, vandalism, juvenile delinquency, and anti-social behaviour.

### 5.2 PSYCHOLOGY

This approach incorporates programs designed to:

• educate young people about how to recognise and deal appropriately with stress and depression, through school counselling and youth organisations;

• develop and promote models of masculinity that do not incorporate pathogenic factors such as emotional repression, lack of communication skills, violence, and lack of relationship skills;

• provide counselling services for young people in disciplinary, relationship, family, financial or employment crises, particularly in rural areas, and develop referral protocols for police, general practitioners, and employment agencies;

• provide support for marginalised young people, and

• educate young people about the risks involved in alcohol abuse.

This approach has the advantage that models for youth education and counselling services are well developed and researched. In many cases services already exist and require only additional funding to be expanded.

---

5.3 **Psychiatry**

This approach is exemplified in programs to:

- expand mental health services targeting young people, particularly in rural areas;
- provide follow-up including mental health treatment for those who attempt suicide in hospitals and after release;
- expand mental health assessment and services to young people apprehended by police, in custody, and in juvenile detention centres, and
- improve the focus and accessibility of mental health services to needs of males on the basis that “It would appear that existing mental health treatment services address female needs, and that male mental needs (e.g. for alcohol abuse treatment) are poorly developed and rarely used”.

This approach has the advantage that mental health practitioners are professionally trained to address suicidal tendencies. The AMA National Conference (See Appendix A) proposed that the Federal Government establish a National Suicide Prevention Centre, and that Federal and State Governments “urgently establish additional child and adolescent mental health services”.

The psychiatric approach has the disadvantage that the stigma and cultural associations attached to mental illness make it doubtful that a significant number of young men at risk, particularly young rural men, would use such services, even if they were amply provided. As Dr Michael Dudley notes:

> It is possible that they would see such programs, as they would see help-seeking in general, as an alternative for the weak, and avoid or dismiss them.

Anthony Davis adds:

> Some of the most needy adolescents will prove to be the most difficult to engage in treatment and provide a challenge to the effectiveness of modern services.

---


105 White, p.146.

106 Dudley et al., p.33.

5.4 EPIDEMIOLOGY AND RESEARCH

Most people involved with the issue of youth suicide agree that:

*The inadequacy of local data to describe the nature and extent of this relatively recent phenomenon has been a major handicap to the development of a common approach.*

The role of the coroner in this process is of particular importance. The development and computerisation of the coroner’s database in Western Australia is one of the major reasons that so much of the recent and relevant research is emanating from Western Australia.

Policy options for improving statistical bases include:

- computerisation of coroners’ records;
- amendment of the relevant legislation to improve the epidemiological usefulness of coroners’ databases; and
- improved funding to youth suicide research bodies.

5.5 RESTRICTION OF MEANS

Numerous studies have confirmed the efficacy of means restriction in reducing suicide rates. Restrictions on the prescription and packaging of barbiturates in 1967 led to a sudden and dramatic reduction in suicide rates in Australia. Lester and Murrell compared suicide rates in different US states with the severity of gun control measures, and found that rates were lower in those states with the most restrictive laws. The phasing out of coal gas in UK in the 1960’s, and its replacement with detoxified domestic gas led to a substantial and sustained reduction in suicide rates. Queensland’s Weapons Act 1990 appears to have had an impact on suicide rates in non-rural areas, where fewer households would have already had a gun before the legislation came into effect.

---


109 Morrell, p.36.

110 D. Lester and M.E. Murrell, 1982, cited in Haines et al., p.38.


Measures that come under this heading include:

- restrictions on the prescription size and packaging of potentially lethal drugs;
- vehicle design modifications to include automatic idling cut-off devices, slot shaped exhaust pipes that do not admit a hose, and reduction of the carbon monoxide oxidising capacity of engines;
- further restrictions on firearm ownership, and laws regarding the storage of guns and ammunition; and
- erection of barriers at often-used jumping points on bridges and buildings.

Many of the programs suggested are not specific to youth suicide prevention. This means both that enhancement of existing youth services and mental health facilities could lead to reductions in youth suicide, and that specific youth suicide prevention programmes could result in additional ‘spin-off’ benefits to related policy areas.

5.6 **CURRENT PROGRAMS**

Appendices B-D contain copies of published suicide prevention programs in Queensland, Western Australia and the Commonwealth.

**Queensland**

The Queensland program, entitled *Young People at Risk: Access, Prevention and Action*, was outlined in an information paper issued by Queensland Health in March 1995, which is reproduced in Appendix B.

Pilot programs have been established in four Queensland Health regions:

- South West, based on Roma, Charleville, St George and Cunnamulla,
- Brisbane South, based primarily on Logan City,
- West Moreton, based on Esk, Laidley, Boonah and Moreton Shires, Ipswich and Goodna, and
- Wide Bay, based on several provincial centres including Maryborough, Bundaberg, Mundubbera and Nanango

An additional program has been commenced at Yarrabah Aboriginal Council.

Community input will be obtained from Local Action Reference Groups, “informed people at the local level who are trained to identify at risk young people and may be the first point of contact for an at-risk young person”. Members will include school guidance officers, teachers, ministers, general practitioners, health staff, police and others.

Each region will have a Multidisciplinary Action Team which will “receive highly specialised training” in order to in turn provide training for local people, and
support for young people. This team will work with project staff specifically employed to facilitate the program. Specific projects in each region will focus on the identification of young people at risk, and appropriate methods of intervention.

The Queensland Government will fund the program initially for three years, starting with $1.5 million in 1994/95.

The Department of Psychiatry of the University of Queensland will participate in the collection and analysis of data, and will conduct a review of the program.

Further details are in the Information Paper reproduced in Appendix B.

**Western Australia**

The Western Australian program was developed by a broad-based working party in 1988. The implementation of the working party’s recommendations has been overseen by an advisory committee and supported by a specific budget allocation every year since then, totalling $1.5 million in the five years to 1993.

A copy of the committee’s program for 1993-1995 is included as Appendix C. A detailed description of the program is available in a paper by Sven Silburn and Stephen Zubrick.\(^{113}\)

The Western Australian approach is described as a “broadly based public health model”.\(^ {114}\) It has five key areas of implementation:

- research, to develop a comprehensive database to identify needs, trends and risk factors;
- extending treatment and support services, initially to identified high-risk groups;
- establishing preventative roles for schools and other agencies dealing with youth. Specific training has been provided to teachers and school counsellors;
- developing measures to reduce suicide contagion. These include establishing media reporting standards, and providing extra personnel to localities with a high risk of young people modelling suicidal behaviour (eg. immediately after a suicide has occurred); and
- investigating legal issues concerning suicide.\(^ {115}\)

---


\(^{114}\) Silburn and Zubrick, p.48.

\(^{115}\) Silburn and Zubrick, pp.50-52.
The Commonwealth

The 1995/96 Federal Budget included the following proposed funding for Youth Suicide, within the Health Care Access program of the Human Services and Health Portfolio:

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995/96</td>
<td>$1.3 million</td>
</tr>
<tr>
<td>1996/97</td>
<td>$1.3 million</td>
</tr>
<tr>
<td>1997/98</td>
<td>$1.3 million</td>
</tr>
<tr>
<td>1998/99</td>
<td>$3.5 million(^{116})</td>
</tr>
</tbody>
</table>

In 1995, this funding will be supplemented by an additional $6 million from existing allocations for the National Mental Health Strategy.

Key aspects of the program are:
- pilot projects targeted at high risk groups
- training for health and youth workers
- understanding the causes of youth suicide.

The Commonwealth also has a program within the National Mental Health Policy, with the goal of reducing the rate of suicide among people with mental disorders. The program is outlined in *Better Health Outcomes for Australians*, published by the Department of Human Services and Health. The relevant section is reproduced in Appendix D.

Briefly, the program has targets of reducing overall suicide rates by 15% within ten years, and reducing the suicide rates in people suffering with schizophrenia and other psychoses by 25% within ten years.

The program has three levels of strategies:
- research and database development, considering matters such as suicide patterns, risk factors and precursors of suicide;
- primary prevention strategies, eg firearm control issues, and intervention in high-risk situations; and
- secondary prevention strategies, eg. increased public awareness of and improved treatment for those suffering from depression or more serious psychoses, and for those who have attempted suicide.\(^{117}\)

---


6. CONCLUSION

The seriousness of the problem of youth suicide in Australia has led to several current initiatives as described in this paper.

A key question, as posed by Silburn and Zubrick in their outline of the program in Western Australia, is “whether or not these changes have made any difference in preventing suicide and self-harm”.

Perhaps it is too early to judge the answer to this question. On the face of it, the number of young Australian men who have taken their lives has remained stubbornly fixed at around 375 per year for the last five years (except for a small dip in 1993). However many of the programs are still at a pilot stage. In most cases they are yet to be evaluated, refined, and adopted on a broader scale.

At an individual level, the devastation caused by each suicide means that each one prevented avoids a huge, if unknown, cost to relatives and friends and indirectly to the whole community. Sue Stebbins expressed her personal impact in these words:

> I was completely devastated and shattered when he died... In retrospect I feel I was in shock throughout the whole of that first year... It wasn’t until the second year that the painful reality started to slowly emerge... that I would never be able to share my life again with him. This brought the most intense physical and emotional pain... I felt powerless, with no control over what happened.

However she went on to say

> ...early after Matthew’s death I made a commitment to life; to fight with every bit of energy and determination I could to survive. It has been a tough journey, but I now know I will make it.

The goal of the many suicide programs now underway in Australia is that many if not all of those considering suicide will see that they too can “make it”, and that their relatives and friends will be able to “make it” with them rather than without them. Ultimately, the challenge is “to make Australia a more favourable environment in which to nurture its young”.

---

118 Silburn and Zubrick, p.52.

119 Jon and Sue Stebbins, p.24.

120 Bret Hart, ‘An approach to the issue of youth suicide and attempted suicide in Western Australia’, in Preventing Youth Suicide, p.64.
BIBLIOGRAPHY

Appleby, Margaret and Condonis, Margaret, Hearing the Cry: Suicide Prevention, R.O.S.E. Education Training and Consultancy, Narellan, NSW, 1990.
Barrowclough, Nikki, ‘Postcards from the edge’, Good Weekend, 30 April 1994, pp.30-34.


Hall, W., ‘Substance abuse,’ in Jorm, A.F. (ed), Men and Mental Health, National Health and Medical Research Council, Canberra, 1995, pp.36-44.


Queensland Department of Health, Epidemiology and Health Information Branch, *Hospital Morbidity*, National Social Health Database, 1993/94.


APPENDIX A

Australian Medical Association Position Statement on Youth Suicide


AMA position statement on youth suicide

1. Youth Suicide is an Australian public health crisis which requires a coordinated national intervention strategy
   The AMA calls on the Federal Government to urgently establish a properly funded National Suicide Prevention Centre (NSPC).
   The NSPC would be a national clearinghouse for suicide data. In addition it would collate, undertake and evaluate research,
   develop education and training strategies and provide guidelines for suicide prevention programs.

2. Effective intervention programs are essential, including (inter alia):
   a. Street outreach and referral;
   b. Needs assessment
   c. Supportive relationships; and
   d. Availability of role models.

3. The AMA must play a key role in the intervention and prevention of suicide. Ninety per cent of young people who
   commit suicide had evidence of psychiatric illness in retrospect. The AMA recommends Federal and State Governments that they
   urgently establish additional child and adolescent mental health services.

4. The AMA urges governments to promote professional knowledge and skills in the management of youth suicide and to
   publicise the available services to the community.

5. Reducing access to easy means of suicide has been shown to substantially reduce the overall death rate. Accordingly, the
   AMA should actively promote safety measures such as stricter firearm control, vehicle modifications to prevent carbon
   monoxide poisoning, and safer packaging of pharmaceuticals and prescriber education.
APPENDIX B

Young People at Risk: Access Prevention and Action Program.

The Epidemic in Youth Suicide
APPENDIX C

Prevention of Youth Suicide in Western Australia: Recommended Strategy and Programs for 1993-1995.


1. RECOMMENDED GENERAL AND LEGISLATIVE MEASURES

1.1 Youth suicide prevention should continue to be developed within a broad public health framework, but with a more specific focus on promotion of positive mental health for young people and their families, including access to good mental health services.

1.2 A comprehensive prevention strategy and programs should be developed and promoted by the Health Department. To be effective the strategy would need to be centrally coordinated and regionally implemented. It should include:

Primary Prevention:
* A strategy to promote positive mental health for young people and their families.

Secondary Prevention:
* Adequately resourced programs to ensure that all staff working with youth have the knowledge, skills and competences:
  - to recognise the signs of emotional distress in young people;
  - to understand the significance of behaviours;
  - to manage appropriately attend to, refer on [or consult and treat] disturbed or at risk’ young people.

Tertiary Prevention:
* Staff and resources to strengthen local mental health services:
  - making access to local help easier, more familiar and ‘user-friendly’ for young people, and follow-up more speedy and better coordinated.

1.3 The Health Department of Western Australia should accept overall responsibility for the implementation of this strategy. It is necessary for a single Department to address the urgent need for formal mechanisms to ensure effective
implementation of such a strategy by coordinating inter-departmental, inter-agency and inter-professional efforts to reduce suicide and self-harm by WA young people. [In this work there would almost certainly be a continuing role for a body such as the Youth Suicide Advisory Committee, in monitoring developments and advising and assisting the Minister for Health].

1.4 The State should require clear guidelines, procedures and systems to be put in place in relevant sectors to deal with youth in crisis, to avoid ad hoc and uncoordinated responses.

(Ex: Liaison structures, and procedures for referral, should be developed between hospital, school and community agencies to ensure effective two-way communication regarding youth at risk. Full-time social workers will be required to make this work].

1.5 More effective measures should be introduced to control access to fire-arms and other frequently used means of deliberate self harm or self-destruction:

a. There is a need for: standardised firearms legislation; a clear policy on firearms and ammunition being kept under lock and key, and effective measures to address the number of unlicensed firearms in Western Australia.

b. Encourage doctors to review their policies on prescribing for young people, the types of medication prescribed and the volume contained in each prescription.

c. Existing controls on sales of alcohol and toxic volatile substances and the use of illegal drugs should be more effectively enforced.

1.6 Encourage local government, business, employers and community groups to become active and to accept responsibility for inter-agency cooperation in youth suicide prevention, the promotion of positive mental health and the development of innovative approaches for disadvantaged youth in each area.

2. IMPROVEMENT OF EXISTING SERVICES

2.1 Effective means should be found for consulting young people about the nature, form and user-friendliness of services, and for ensuring adequate youth [including Aboriginal youth] representation on boards or committees of agencies providing youth services.

2.2 Ensure age-appropriate adult support for vulnerable young people, and the development of peer-support systems and networks.

2.3 Given the proven effectiveness of pilot placements of Social Work Staff in the Accident and Emergency Departments of Sir Charles Gairdner and Royal Perth Hospitals, to provide counselling, support and follow-up to youth who have attempted suicide, all hospitals should be required to provide adequate Social Work back-up as part of mainstream emergency services.

2.4 Existing Child and Adolescent Mental Health Services should be strengthened and families and service providers in schools and community based
agencies should have access to local emergency psychiatric services for assessment of youth perceived to be at risk of suicide.

The recommendations of the Report of the Ministerial Task Force to Review Child and Adolescent Psychiatric Services in Western Australia, Developments in Child and Adolescent Mental Health Services [1992] concerning the need for improved services for young people at risk should be implemented as a matter of urgency.

2.5 That the original recommendations of the Youth Suicide Working Party on the containment of suicide clusters should be reinforced by requiring that specific resources are allocated, [particularly in country regions and contained communities like schools], to ensure continuity of arrangements and available trained staff to implement community response plans to contain suicide clusters. [The role of Samaritans and other agencies in networking and providing support for vulnerable individuals and families, should be recognised, encouraged and given financial assistance].

2.6 Better community and schools-based services for survivors and affected family members should be encouraged and developed, for example by providing resources for training local volunteers and promoting the role of voluntary organisations such as The Society of Compassionate Friends and Samaritan Befrienders.

3. EDUCATION AND TRAINING INITIATIVES

3.1 Schools and educational institutions should be encouraged to ensure adequate and effective representation of young people on relevant committees, to prevent the sense of alienation of many young people who feel that they are excluded from decision-making affecting their lives, and are unable to change things for the better.

3.2 Given that low-academic attainment and early departure from school are major risk factors that they should be given new terms of reference.

in youth suicide and related morbidity, priority should be given to the allocation of resources to develop incentives for young people to continue in education, by offering a wider range of options for them to develop skills and possibilities for achievement.

3.3 The out-of-hours use of school premises and sports facilities for a wider range of community youth and family educational and recreational activities should be facilitated, to promote a greater sense of commitment to schools as community resources.

3.4 Print, radio and television media should be encouraged to project a more positive [not problem-orientated] image of young people, to prevent the tendency for adolescence to be portrayed as inherently fraught with difficulty and conflict for young people and their parents, and to prevent young people being scapegoated for society’s ills.
3.5 Specific educational programs should be directed at the Media and Politicians to prevent sensationalist reporting and the perpetuation of myths, by informing them about the underlying issues and risk factors in youth suicide and affecting the mental health and well-being of young people generally.

3.6 Ensure that better use is made of existing services in schools, [eg. Managing Student Behaviour Courses], to develop the confidence and competence of staff in dealing with difficult, disruptive and disturbed young people.

3.7 Pre-service and In-service Education and Training in the identification and appropriate assistance of young people at risk of suicide, should be made a requirement for the appointment of all staff dealing with young people [in the helping professions, schools, social work, community organisations, police and corrective services].

3.8 Adequate funding and staff should be provided to ensure the effective continuation of and ongoing support of the existing State-wide training for trainers in schools and in service training for teachers to deal more effectively with prevention of youth suicide, and for the provisions of adequate schools-based counselling services for distressed young people.

3.9 Specific resources should be allocated for the development of a manual for community groups and agencies to assist staff development and establishment of systems for:-
- identification of youth ‘at risk’
- identification of behavioural indicators
- guidelines for procedures for dealing with crises by local groups

3.10 Youth suicide prevention strategies in schools and community education should be integrated into broad educational programs on child and adolescent mental health and the promotion of positive mental health for young people and their families, linked to general Child and Adolescent Mental Health Services. [These should include emphasis on the fact that mental health is about growth, acquiring life-skills to cope with life changes, and deal with drugs and alcohol, relationships, sexuality and parenting].

3.11 Given the increasing prevalence of psycho-social causes as the main contributing factors in general morbidity and mortality among young people, specific resources should be set aside to promote education of parents and professionals about psycho-social morbidity.

4. RESEARCH ON PREVENTION OF YOUTH SUICIDE & DELIBERATE SELF-HARM

4.1 There should be continued funding of basic epidemiological research on adolescent mental health, deliberate self-harm and suicide, and for the improvement of local data-collection and surveillance systems, in order the more successfully to identify needs, measure trends, advance our current knowledge about antecedent
risk factors, and plan for the establishment and evaluation of effective clinical and community interventions.

4.2 There should be funding provided for operational research on well planned pilot schemes to reduce the risk of youth suicide and self-harm, and for proper evaluation of current services and community-based interventions with young people at risk of suicide.

4.3 There should be specific funding for pilot interventions and community-based schemes targeted at unschooled, marginalised, and Aboriginal youth, particularly in country and rural areas of Western Australia.

4.4 Resources should be provided to facilitate the production and publication of relevant research reports, to dispel myths about youth suicide and to ensure that the results of research are made available to service providers, educators, the media, government and politicians.

5. PROPOSED REPORTING STRUCTURES & MECHANISMS FOR ADMINISTRATION

It was proposed that the present Youth Suicide Advisory Committee and Executive Group should be renamed respectively the Youth Suicide Prevention Advisory Board and the Management Group, and

In summary the Committee proposes:

5.1 The Minister for Health should mandate a new Youth Suicide Prevention Advisory Board, with clear terms of reference and authority.

5.2 Membership of the Advisory Board:
The membership of the Advisory Board should comprise representatives of three groups:-

* Departmental representatives with specific responsibility for youth suicide
* Representatives of Expert Working Groups
* Members of the Management Group plus full-time Secretary/Administrator.

5.3 The Advisory Board’s Role:
In general the Board’s role would be to advise, make recommendations and report directly to the Minister for Health.

5.4 Management Group:
The membership of the Management Group should comprise:

* An independent chairperson
* An executive elected from among members of the Advisory Board
* A full-time Secretary/Administrator.
5.5 The Role of the Management Group:
* To manage and implement proposals of the Board;
* To act on behalf of the Advisory Board between meetings of the Board;
* To report to the Advisory Board and to the Minister for Health;
* To co-ordinate functional, community-based, interdisciplinary groups, at local level, [but not specified as Local Government];
* To co-ordinate expertise-based working groups [Research, Education, Services];
* To oversee implementation of recommendations, monitor and evaluate outcomes.

5.6 Funding of Youth Suicide Prevention Advisory Board:
* The Advisory Board should have only a small maintenance budget for secretarial and administrative functions.
* Other funding initiatives should be owned by relevant departments.

5.7 Proposed Structure:

MINISTER FOR HEALTH ←----------> OTHER MINISTERS

YOUTH SUICIDE PREVENTION ADVISORY BOARD
 MANAGEMENT GROUP: Independent Chairman of YSPAB, Executive Group Elected from YSPAB, Secretary/Administrator (half-time)

ADVISORY BOARD: Independent Chairman of Advisory Board, Representatives of Expert Working Groups, Representatives of relevant Government Departments, Representatives of Strategic Community Agencies, Secretary/Administrator

FUNCTIONAL LOCAL INTER-AGENCY PREVENTION GROUPS REPRESENTING STRATEGIC COMMUNITY AGENCIES
Suicide Prevention Targets and Strategies of the Commonwealth Department of Human Services and Health


**Suicide**

*Goal*

- Reduce the rate of suicide among young people with mental disorders

*Targets*

Reduce by 15% expected Australian suicide rates over ten years.

Reduce by 25% the suicide rates in people suffering with schizophrenia and other psychoses over ten years.

Develop appropriate outcome measures by the end of 1995.

*Indicators*

Mortality rates due to suicide.

Crude and cause-specific mortality rates in people suffering with schizophrenia and other psychoses.

*Priority populations*

Males aged 15-34

Males aged 65 and older.
**DEVELOPMENT OF DATA BASELINES**

**Strategies**

- State governments, in collaboration with State coronial offices, relevant professional groups and NGOs, consumers and carers, should develop consultative councils to review all completed suicides, to raise community awareness of the level of risk and precursors of suicide and to provide reports to health care professionals and yearly bulletin of deaths due to suicide.

  *Key Result:* Operational consultative councils in each State by 1995.

- Commonwealth and State/Territory governments should develop a research network of Australian mental health epidemiologists to work collaboratively with AIHW and ABS to facilitate:
  - establishment of baseline prevalence rates for suicide attempts and related psychiatric disorders in the Australian general population both in adults and in young people; and
  - study of depression and related conditions in primary care including aspects of recognition and treatment.

  *Key Result:* A research network of Australian mental health epidemiologists operationalised by 1995.

**PRIMARY PREVENTION**

**Strategies**

- Commonwealth and State/Territory governments should encourage further community debate on legislation to restrict the use of firearms for non-essential purposes and to ensure that firing mechanisms are stored securely and separately.

  *Key Result:* Consensus on legislation across States and Territories on the use of firearms operational by the year 2000.

- State health and education departments should develop and implement protocols for specialist mental health service intervention, and investigate the effectiveness of other strategies such as peer support, in schools where a high-risk situation is perceived to exist (for example, where a suicide has occurred) to prevent development of mental health problems and ‘copy-cat’ suicides.

  *Key Result:* Implementation of protocols between educational authorities and health authorities by the year 2000.
SECONDARY PREVENTION

Strategies

• Commonwealth and State/Territory governments, in collaboration with relevant professional groups and the divisions of general practice, encourage the improved recognition and treatment of depression and related conditions in primary care through:

  — development and implementation of best practice guidelines for recognition and management of depression in general practice and community mental health services; and

  — provision of incentives for general practitioners to participate in continuing education on management of psychiatric problems presenting in primary care.

Key Result: An increased rate of recognition and treatment of depression and related conditions by 50% by the year 2000.

• Commonwealth and State/Territory governments, in collaboration with public hospitals and mental health service providers, should encourage the better management of suicide attempts through improved access to health services and the development of specific management protocols which include assessment by adequately trained staff and community follow-up.

Key Result: The implementation of specific management protocols in 90% of people presenting to accident and emergency departments after suicide attempts by the year 2000.

• Commonwealth and State/Territory governments, in conjunction with relevant professional and community groups, should enhance community recognition of depression and related disorders through the further development of depression awareness campaigns.

Key Result: Increased attendance at primary health care services for treatment of depression and related conditions.
Commonwealth and State/Territory governments should collaborate with key professional groups (including Royal Australian and New Zealand College of Psychiatrists (RANZCP), Australian Psychological Society (APS), relevant nursing groups), relevant NGOs and consumers and carers, to improve the management of suicide attempts and ideation in patients with schizophrenia and other psychoses through:

— the development of best practice guidelines for managing suicide attempts and ideation in patients in specialist public and private psychiatric care; and

— the provision of incentives for specialist mental health staff to participate in continuing education on the assessment and management of suicide attempts and ideation.

*Key Results:* A reduction in the rate of suicide attempts and repeated suicide attempts in people with schizophrenia, other psychoses and severe affective disorders by 25% over ten years.