CHAPTER FOUR

FACTORS ASSOCIATED WITH SUICIDE

Throughout the Inquiry the Committee has heard that no one single factor can explain suicide. The Committee has been told of many contributory factors that are relevant and which are inextricably linked to the mental resilience of the individual.

In a recent publication, the New South Wales Department of Health categorises groups at risk of suicide by age, gender, physical illness, mental health problems and mental disorder, major mental illnesses, alcohol and drug abuse, and those who are marginalised and isolated. Rural male youths are also identified as an at risk group (NSW Health, 1993a:2-3). Submissions to the Inquiry as well as oral testimony have further identified family or relationship breakdown, unemployment, financial hardship, issues relating to sexuality, access to methods of suicide, limited access to services, violence and abuse and the fragmentation of communities, as potentially increasing the risk of suicide among certain people.

The Committee also notes, and has discussed in Chapter One, that the study of suicide and suicidal behaviour can cross many disciplines. Psychiatry, sociology and biology can all be relevant to an understanding of the complexities of suicide.

In acknowledging all of the factors identified above as relevant to the identification of risk factors to suicide, the Committee notes that few people falling into these categories will suicide or be particularly susceptible to the stresses and emotional disturbances associated with the personal, social and economic factors identified above. Issues such as genetic or pre-existing vulnerability to depression and other mental disorders, a history of prior suicide attempts and the coping abilities, resources or supports of a particular individual can be particularly relevant. Accordingly, the Committee acknowledges that there is a need for further research and investigation to advance society's understanding of suicide and suicidal behaviour. This issue will be addressed later in this chapter.

The following discussion will attempt to identify the various factors that have been brought to the Committee's attention as being significant to suicide. The discussion will then address such factors from a mental health perspective and then from a social and psychosocial perspective. Throughout this section the Committee will look at each issue generally and then in light of the specific

experiences of rural communities. Finally, an examination of the possible causes of the increase of suicide in rural areas will be presented.

4.1 SUICIDE AS A MENTAL HEALTH ISSUE

Evidence presented to the Inquiry has indicated that up to 90% of people who suicide have a mental disorder. In most cases, they suffer from a major and profound depression. A small but significant proportion of those who suicide suffer from psychotic disorders such as manic depressive illness (or bipolar affective disorder) and schizophrenia. As Raphael for the National Health and Medical Research Council (NHMRC, 1993:68) found,

> *there is evidence that, while social factors influence suicide, the vast number of suicides are associated with mental illness, particularly severe depression, but also schizophrenia, and at other times, other disorders.*

This finding was echoed by a witness before the Committee, Dr Michael Dudley, who explained in his evidence that completed suicide in the absence of a psychiatric disorder is rare. The most common diagnoses are depression (40-60%), chronic alcoholism (20%) and schizophrenia (10%) (Evidence, February, 1994). Moreover, according to the NSW Health Department (1993a), up to 15% of people with manic depressive illness die by suicide and up to 10% of people with schizophrenia die by suicide (1993:3).

Schizophrenia is a serious mental illness affecting approximately 1% of the population and which commonly has its first episode in late adolescence or early adulthood. It is frequently associated with considerable depression and social withdrawal.

Depression is a term used to describe a number of disorders and can be either biological or a response to external factors. Raphael for the NHMRC (1993:49) defines depression in the following terms,

> *depression is one of the spectrum of mood disorders and is characterised by low or depressed mood, loss of interest in usual activities and is often accompanied by a range of symptoms. Some are somatic, for example appetite and weight disturbance, others psychological, for example difficulty concentrating and negative thoughts. Depression may take many forms, ranging from the severe syndromes of uni and bipolar illness (i.e. manic depression), which are relatively less frequent, to the much more common forms of depressive illness.*

The Committee understands that *bipolar affective disorder* or manic depression is a biological disorder associated with genetic vulnerability. The sufferer may experience despair and hopelessness during depressive episodes alternating with episodes of elation and high spiritedness (hypomania) and feelings of relative equilibrium during phases of normal mood.

Unipolar affective disorder is also a biological form of depression which may also have hereditary vulnerability. It differs from bipolar affective disorder in that there are no episodes of mania or hypomania, such as where a sufferer experiences at one time periods of intense "highs" and at other times periods of dreadful and despairing "lows".

Whilst not fitting into the category of bi or unipolar disorders, depression can nevertheless still be biological or endogenous, implying that no specific cause can be identified. This form of depression may be treated, with varying success, with medication, as well as appropriate counselling.

The Committee recognises that some categories of depressive disorders, in the absence of biological or genetic factors, can also be related to psychosocial and environmental factors (NHMRC, 1993:176). Depression in this context, may be referred to as *exogenous depression,* non-endongenous depression or, more simply, reactive or situational depression. Episodes of this depression can be secondary to experiences of loss, or can be a response to a particularly difficult or stressful situation. It can be especially profound in some individuals.

Raphael for the NHMRC further observes that contributing agents to depression can be a "complex mix of biological, including genetic, psychological and social factors" (1993:52).

Evidence presented to the Committee, as well as numerous studies, have identified a number of factors which may precipitate depression. Specific examples include loss of a loved one, loss of one's job and chronic unemployment, social disadvantage, poverty and financial hardship, family or relationship breakdown, violence, issues relating to sexuality, and loss of self-esteem, all of which may trigger or contribute to depression. It can be manifested in feelings of despair, hopelessness, helplessness, worthlessness and pessimism and in some cases lead to self-destructive behaviour. As a document prepared by the NSW Health Department observes,

> *coupled with multiple life stresses or loss, depression and other mental illness is the most dangerous contributor to suicide injury* (NSW Health Department, 1993a:3)

The factors that may precipitate depression will be discussed in further detail below.

As indicated earlier, whilst many people suffer depression, emotional distress, and chronic and severe stress and anxiety, not all suicide. The Committee recognises that a person's perceived *coping skills, levels and supports* can be fundamental to a decision to suicide. The Committee has been told, for instance that,

> *anyone experiencing high levels of emotional hurt and pain is at risk of becoming suicidal. The risk is compounded if they do not have well-developed coping mechanisms* (Wendy Orr, Evidence, 9 June 1994).

Depressed children and young people whose coping abilities may be less developed than adults can be even further vulnerable to suicidal ideation and behaviour.

The Committee has further heard that one of the major risk indicators for suicide is a history of previous attempts. Dr Phillip Hazell, giving evidence to the Committee (Evidence, 30 August, 1994) explained that,

> *If I am assessing a person for suicide risk, the fact that they have done it before is the biggest factor that will determine my action.*

4.1.1 Mental Health in Rural Communities

Few studies have dealt specifically with the issue of the mental health of people living in rural New South Wales, or indeed, rural Australia. Yellowlees and Hemming (1992:152) observe that in relation to research into psychiatric disorders,

> *it is not surprising that there has been such an absence of research interest in rural psychiatric disorders, as most research projects emanate from metropolitan centres, and most researchers live in major urban areas.*

Studies that have addressed the issue of rural mental health maintain that the incidence of mental health problems in country areas would appear to be higher than in urban centres. According to Lawrence and Williams (1990:42),

> *rural people experience 28 per cent more hypertension and psychiatric disorder than do city-dwelling Australians.*

That same study also found that

> *rural and remote area populations exhibit higher than average levels of premature mortality and death through ischaemic heart disease, cancer,* ***suicide,*** *tuberculosis and malnutrition* (Lawrence and Williams, 1990:42, citing Lawrence 1988, emphasis added).

In his briefing to the Committee, Professor Yellowlees acknowledged that a common myth about the country is that there is no mental illness. According to him, mental illness is as prevalent in the country as it is in the city. However, mental illness in rural areas is not so readily identified and treated because there are fewer services (Briefing, 26 July, 1994). The Committee has heard also that there is a greater denial about mental illness among rural communities, especially by males. These issues will be addressed in further detail below.

The Report of the Human Rights and Equal Opportunity Tribunal on Mental Health and Human Rights observed in relation to Australia as a whole, that people living outside the major urban centres and in small rural towns and remote areas have a number of special needs in relation to mental health. The Report (1993:678) argued that

> *isolation, social factors associated with small scale communities and the effects of recent, severe rural recession can all exacerbate mental health problems.*

Evidence before the Committee both in terms of oral testimony and written submissions has supported the findings that people in rural areas of New South Wales would appear to have high levels of mental health problems. Dr Michael Dudley, a witness before the Committee who, along with other specialists, has undertaken extensive research into urban and rural suicide trends among young people, stated in his evidence that,

> *it would be likely at present that there would be high rates of depression in most rural communities. In other words, quite a high percentage of people would have depressive problems* (Evidence, 10 February, 1994).

Moreover it has been submitted that,

> *rural doctors have reported a decline in the health status of rural people, with increased reports [of]... depression, anxiety and alcohol abuse* (Submission 33).

Davis (1992:97) has also observed that depression is particularly prevalent amongst children in economically struggling rural areas.

A further submission to the Inquiry, from the Far West Mental Health Service noted that it is now a myth that rural lifestyle is synonymous with reduced stress and better health. According to that submission, the fact that more people in urban areas are treated for psychiatric disorder than in rural areas, has led to a presumption that there are higher levels of psychopathology in urban than in rural areas. The author maintains that this is not true, and reasons that

> *psychopathology is often calculated on bed occupancy rates in psychiatric hospitals. As there are more of these hospitals in the cities, it is not surprising that this view is maintained. Rural folk are also less likely to attend for treatment fearing confidentiality issues in small towns. Also some small rural towns lack mental health workers, so much psychopathology either goes unnoticed or is tolerated by the community* (Submission Number 45).

As was discussed in Chapter Three, much of the Committee's research has shown that the major increases in suicide in rural areas have been among young men. Dudley *et al.*'s study on youth suicide in New South Wales has clearly demonstrated this. According to the authors,

> *the question of whether these suicided rural adolescents are suffering major depressions is moot. It is the authors' opinion that the magnitude of the recent change is unlikely to be accounted for by a rise in the rate of the endogenous (biological) form of depression, though it is likely that major depressions of other origins would contribute to the outcome in many of these adolescents* (Dudley *et al.*, 1992:87).

The implications of this assertion are that other, external factors may be linked to the apparent rises in such suicides. The following discussion will examine other, extraneous factors, which have been brought to the Committee's attention as significant to suicide.

4.1.2 The Stigma of Mental Illness and Suicide

Much of the evidence received by the Committee has indicated that a major obstacle to any effective prevention campaign aimed at reducing the incidence of suicide is the enormous stigma that can attach to, and discrimination aimed at, a person with a mental illness, a person who has attempted suicide, and to the family members of a person who has completed suicide. The Committee's

research has shown that people falling into these categories are often labelled by community members and even professionals as "weird", "crazy", "mad", "dangerous" or "failures". Consequently, many become isolated and marginalised, feared and misunderstood by the wider community. For the families of people who have suicided, their considerable grief is often compounded by the shame and guilt they are made to feel from "judgements" of others as to their alleged responsibility or blameworthiness for the suicide. Alternatively, for these families, there can be an enormous sense of isolation as others avoid contact with them for fear of raising the issue.

Evidence presented to the Committee has suggested that many of these factors can be heightened in rural communities. In relation to mental health generally, it has been suggested that, because of the country ideal of self-reliance, mental illness is less likely to be recognised, accepted or understood in rural areas as it is viewed by some as a "moral failing" (Dudley *et al.*, 1992:87).

Further, a common issue raised during the Inquiry is that in small communities in particular, there is a risk that personal issues such as mental or emotional disorders and attempted suicides lack confidentiality and may become the focus of speculation.

However, it is also the case that those in rural areas who are directly affected by a suicide are often reluctant to speak about the event. As a representative from the NSW Farmers' Association commented in evidence before the Committee ,

> *one of the things we have found as we have tried to go out there and get more details is that there is a wall of silence whenever there has been a suicide* (Terry Ryan, Evidence, 26 July, 1994).

A number of submissions to the Inquiry have highlighted the problems of stigmatisation of people in rural areas whose family members may have suicided. As one person wrote (Submission 27),

> *I have experienced being stigmatised following my son's death... It's "not nice", so people don't want to discuss it, newspapers won't print articles or letters, suicide is referred to as "the accident" and due to the stigma, people will not come forward readily to seek assistance.*

The stigma that attaches to both mental illness and suicide, together with the issues highlighted above, has meant that many people in overwhelming distress and despair fail to seek help and therefore become at considerable risk of

suicide. This was highlighted in a submission from a rural mental health service (Submission 20) which noted that

> *rates of completed suicide among known clients are particularly low... However, we are informed of completed suicides from time to time of people we have never seen.*

4.2 SUICIDE AS A SOCIAL ISSUE

The Committee has heard during the Inquiry that suicide can have a "social dimension". The Committee notes, however, that the extent to which social factors, especially financial and employment related issues, play a role in suicide is a matter of debate among professionals and community members alike.

The discussion below will highlight some of the factors that have been brought to the Committee's attention for consideration. It will identify a number of factors that are linked to the social dimension of suicide. These factors will be considered firstly from a general perspective and then in the context of rural life.

Evidence to the Committee from Dr Noel Wilton, Director of Mental Health Services for the NSW Department of Health, stated that,

> *there are two components [to suicide]. The first is that the evidence now is that over 90% of people have a diagnosable mental disorder at the time they commit suicide, a lot of this being depression. But there appears to be another social dimension that runs parallel and which often is perhaps the precipitant to suicide. If someone is depressed and then goes to take this action, one usually finds some social stressor, whether it be family dysfunction or whether it be other social issues - unemployment or other sorts of things that come in on this - one speculates that at times people with a mental disorder alone will take this action. Probably, most particularly among youths, one would suggest you need a combination of precipitant and some state of mind which allows you to commit suicide* (Evidence, 26 July 1994).

Evidence presented to the Committee has indicated that external influences such as loss, relationship problems, financial circumstances, family situation and isolation may profoundly affect both the physical and mental well-being of a person and may, among some individuals, contribute to decisions to suicide.

This has also been confirmed by the findings of Raphael for the National Health and Medical Research Council (1993:68) who notes in relation to depression in particular that,

> *while in many depressions, particularly major depression and those depressions that are more 'endogenous' in form, genetic factors play a part, psychosocial and environmental factors relating to parenting, parental discord and stressful life events, especially loss, all contribute to shape depression outcomes.*

The issue of availability of certain methods of suicide, considered by some to be an actual contributory factor to suicide, has also been raised in recent times, as an area of increased concern and will be discussed later in this chapter.

The Committee acknowledges that because of the complex nature of suicide, the list of social factors is by no means exhaustive nor should it be assumed that such factors, *in isolation*, can be considered as a *sole* contributory factor to suicide. As the discussion has indicated earlier, a multitude of often interacting factors may contribute to an individual's decision to suicide, many of which are inextricably linked to the mental well-being of an individual.

The Committee is also mindful that not everyone who may experience one or more of these factors will experience depression much less suicide. Research has yet to identify the actual reason why some distressed, despairing or marginalised people choose suicide as an option and others in similar predicaments do not. As Dr Phillip Hazell explained to the Committee,

> *why some people should resort to suicide under [stressful] circumstances, and others do not, is a question that begs answering. It probably has something to do with pre-existing vulnerability. Yet the nature of that vulnerability is poorly understood* (Evidence, 30 August, 1994).

Nevertheless the issues identified below have been brought to the Committee's attention as possible precipitants to major depression, stress and profound anxiety and therefore as *risk* factors to suicide.

4.2.1 Socio-Economic Disadvantage, Financial Hardship and Unemployment

A number of studies have highlighted that risk of suicide, as with mental health problems generally, may be increased for those who are socially disadvantaged. The Report of the National Health Strategy (1992:10), notes that, of all people in the community, those of low socioeconomic background have a poorer health

status than those in the higher bracket Raphael for the National Health and Medical Research Council (1993:72) further observes that

> *suicide has no class barriers, but higher levels of morbidity and lack of access to resources may increase risk for those who are socially disadvantaged and facing high levels of life stress, such as the unemployed and those suffering physical ill health. The special risk and needs of the disadvantaged need to be taken into account in suicide prevention programs.*

Whilst social disadvantage may significantly contribute to the mental ill-health of a person, the report of the Human Rights and Equal Opportunity Commission (HREOC), entitled Human Rights and Mental Illness (1993:845) also found that

> *mental illness may lead to social disadvantage through downward social drift, incapacity to work, lack of access to adequate living standards and poorer quality of life.*

The relationship between unemployment specifically, being a major indicator of socio-economic disadvantage, and suicide, and unemployment and mental health generally, has been considered in a number of studies and reports (Human Rights and Equal Opportunity Commission, 1993, and Morrell *et al.*, 1993). It is suggested that unemployment and ensuing social disadvantage can detrimentally affect a person's health, including their mental health, and may therefore heighten the risk of suicide. Low-self esteem, feelings of worthlessness and despair, as well as stress and anxiety brought about by financial worries, are conditions commonly associated with unemployment. According to the National Health and Medical Research Council (1993:176),

> *the social crisis of high and continuing unemployment constitutes an ongoing risk to mental health for those affected, both through the demoralisation and the effects of poverty that usually ensue. Depression is a substantial risk and is often heightened by lack of workplace redundancy support to community mental health programs for the unemployed.*

The Report of the Human Rights and Equal Opportunity Commission into Mental Illness and Human Rights similarly found that unemployment is a particular stressor, both for the mentally ill and those who are at risk of mental illness. It may lead to or exacerbate depression, anxiety and other mental disorders (HREOC, 1993:846). Further, it has been found that the mental health of the whole family deteriorates when a member is out of work (Kerr, 1982:6).

Whilst a number of witnesses have indicated that unemployment may be a significant risk factor to suicide, it is difficult to determine the numbers of unemployed people who suicide because unemployment status is not formally recorded on death certificates. As Associate Professor Burnley, a witness before the Committee, explained in evidence (22 March, 1994),

> *on the death certificate we do not have the unemployment status. We have "other" and "not stated" and a "not in the work force" category, but not a formally "unemployed" category.*

In their study, Suicide and Unemployment in Australia 1907-1990, Morrell *et al.* (1993) acknowledged that the relationship between unemployment in itself and suicide is complex and it is difficult to establish conclusively an unequivocal causal relationship. However, the authors (1993:755) also argued that, according to their study,

> *while the aggregate data show that the suicide/unemployment relationship is not a simple year-by-year correlation, the present study strongly supports the hypothesis that unemployment is significant as a predisposing factor for increasing the risk of suicide, especially in males.*

In his evidence to the Committee, Dr Phillip Hazell cautioned against trying to find a *causal* link between suicide and unemployment or financial disadvantage such as that brought about by economic recession. He argued in relation to young people specifically that

> *it is important to acknowledge the role of social stress amongst young people. There has been an association drawn between increasing unemployment rates in young people, particularly in rural settings, and the way this parallels the increase in suicide rates. I would like to... caution the Committee, however, on drawing inferences about mechanisms of causality. There are certainly correlations but whether the two are causally related is another question* (Evidence, 30 August, 1994).

■ The Rural Situation

A great deal of oral testimony, particularly anecdotal evidence, and many written submissions have suggested consistently to the Committee that socio-economic disadvantage and hardship, including unemployment, are significant identifiable risk factors to suicide among people in rural regions throughout New South Wales. Evidence has been presented to indicate that these factors can be

significant precipitants to exogenous depression and, when combined with other factors such as isolation and alcohol abuse, can heighten the risk of suicide among certain rural residents. Regional mental health and community workers have indicated to the Committee that there appears to be an increased sense of hopelessness, despondency and despair among rural communities today, as a result of the rural downturn and the drought, with many young people in particular believing that they will never get a job.

Much of the Committee's information suggests that the most recent recession has had a particularly profound affect on rural communities. Unemployment in many areas has risen and many farming businesses have been forced to alter drastically their farming practices, shut down, sell, or be sold by foreclosing banks because of very high interest rates, the fall in the price of commodities, and the ongoing rural downturn, which some commentators have argued is the worst in 50 years (Cooper, 1992:138).

These factors, together with years of crippling and persistent drought in many areas, have meant that many rural communities have experienced enormous financial hardship and social disadvantage over the last five to ten years.

The social effect of poverty and unemployment on rural communities has been the subject of a number of studies. In their analysis Lawrence and Williams (1990:41) state that

> *rural poverty is more widespread and of a more chronic form than is urban poverty. Those in poverty in rural regions exhibit greater social and health problems than the urban-dwelling poor. This is especially so for those in remote regions. One reason poverty is often so entrenched in rural areas is that unemployment and underemployment levels are higher in rural than urban areas and job opportunities (the range of jobs and their availability) are also more restricted in rural settings.*

Many of the submissions to the Inquiry identify the increased financial hardship of rural communities as one of the major identifiable risk factors to suicide. A submission from the Orana Community Health Services, for instance, notes that in that district families are suffering from acute financial difficulties which, along with depression and family breakdown, have resulted in increased rates of suicide and violence, drug and alcohol problems and general health problems (Submission 1).

Severe economic circumstances, brought about by the rural recession were highlighted in the submission of the New South Wales Farmers Association as a possible cause for increase in farm suicides in New South Wales and across

Australia (Submission 2). In their submission to the Inquiry, Margaret Appleby, Raymond King and Russell Kay observed that among the causes for suicide in rural areas are the severe economic recession and rising unemployment. The Committee has also been told that unemployed youth may have an increased susceptibility to poor mental health, such as low self-esteem, and to mental illnesses such as depression (Submission 45).

Oral testimony to the Inquiry has supported these observations. In his evidence to the Committee, Dr Michael Dudley considered that economic reasons, relating to the rural downturn and recession, impacted upon rural suicide rates. His research moreover indicates that the dramatic increase in suicide in rural areas of New South Wales over the last few years may be partly attributable to the fact that

> *the Australian rural sector has suffered a major economic downturn over the last 25 years... This has been correspondingly reflected in unemployment and poverty, a drift of school leavers and the older labour force from the inland to the coast, restriction of government and some non-government services to the larger centres and the decline of small country towns* (Dudley *et al.*, 1992:86)

Further evidence in relation to young people and suicide specifically, from representatives of Suicide Prevention Australia (formerly the National Youth Foundation) concurred with these observations. According to the organisation's Chief Officer, in relation to the causes of suicide and its increase in rural areas, "the downturn in the rural sector... is very paramount. That has had a dire effect" (Evidence, 9 May 1994:26).

As the Committee noted in Chapter Two, there has been significant internal migration throughout rural New South Wales in recent times as people look for work and other opportunities. Rolley and Humphrey (1993:245) observe that

> *the dominant trend in this out-migration has been marked population loss in the 15-19 year age group. This consists mainly of school leavers seeking job training, further education, or employment opportunities in large regional centres or capital cities.*

For the young people remaining in those communities, the consequences can be devastating. In his evidence to the Committee, Professor Brent Waters observed that the indications from his co-research into suicide among young people in rural areas is that suicide is rising in those communities that are "shrinking" or "dying". The witness (Evidence, 26 April 1994) stated that,

> *just from looking at the information we gained the impression that really high suicide rates were among the communities that seemed to be getting small over time. We believe we have sufficient information to be able to identify communities that have been shrinking. In other words, they have gone from communities of 10, 000 to communities of 4, 000 over the last decade or so. We have put that in the context of the decline in the rural economy, changing employment prospects in the country and career opportunities and all those sort of things to see whether we can get an index of community decline. The indications that we have at the moment are that the rise is greatest in those communities that are shrinking.*

The Committee recognises that compounding the problems noted above and adding to the sense of hopelessness among many rural communities is the very limited opportunity for tertiary education in rural areas. In his study, Rural Youth Suicide, Graham noted that only 7% of males and 10% of females from rural schools enter into post-secondary education, well below that of urban based students. He argues (1993:6-7) that

> *unless families are financially 'well off' the cost to send an adolescent to tertiary education is often unable to be met and the long distances the adolescent has to travel to go to such an institution is in itself... very discouraging. Often the result is the adolescent leaves school, becomes unemployed and faces the associated issues of being unemployed.*

In relation to suicides among farmers specifically, it has been observed that

> *the most recent rural recession has left many farmers mentally exhausted and unable to cope with the continued pressure... Farmer suicides [nationally] rose by 67% in 1990* (Cooper, 1992:137 and 139).

Farmer suicides have also been considered in a study by Associate Professor Ian Burnley. In his evidence to the Committee he observed that the **suicide mortality rate among farmers in New South Wales is currently about two and a half times the state average in the age group 25 to 39 years.** Burnley further informed the Committee that in the age group 40 to 64 years the mortality of farmers is also elevated, as it is with manual workers and workers in transport and communication (Evidence, 22 March 1994). He also suggested that the substantial increase in rural suicide in recent years by young males was among those in the agricultural sector, the classification being farmers, forestry workers and associated occupations (Evidence, 22 March 1994).

Evidence provided by Mr Terry Ryan of the NSW Farmers' Association supports these observations. According to Mr Ryan,

> *over the past few years the number of phone calls in the category of either threatened murders or threatened suicides has increased. There is a direct correlation between suicide and prosperity in agriculture* (Evidence, 26 July, 1994).

In a document tabled in evidence to this Inquiry, the stress on farmers themselves was graphically illustrated in a personal letter, detailing the suicide of three people and the attempted suicide of another, all of whom were farming people. These events took place within the space of one year and within the same region. According to the impressions of the author of the letter who was a friend of each and the person who managed to prevent the attempted suicide from becoming a completed one, the suicides and the attempted suicide were related to the financial strains and demands placed upon the victims. In relation to one of the suicides the author wrote:

> *although [the victim] told me he had a good harvest, he said a few months after, that once the banks had their cut he was broke. A few months later he was found dead in a paddock.*

He further wrote that the second suicide

> *involved a farmer in his 60s who could not handle bank pressure and was found hanged in his shed.*

Of the attempted suicide the author stated that

> *one... night a friend who had received a letter from [the] Bank... saying they were going to sell his farm decided to end it all. He... was very upset when a friend knocked on the door.*

Further evidence to the Committee from a former farmer who once had a very prosperous business but whose mounting debt meant that she was forced to leave her farm, detailed the devastating effect this event has had on her whole family.

She told the Committee that,

> *in November 1992, my husband and I were driving back from seeing [the Rural Counsellor in town] about our farming enterprise collapsing even further, when my husband, in a quiet and restrained voice said, "you know, I get these very strong feelings and they are quite frightening. Sometimes I feel as if I should shoot you and the children and then turn the gun on myself.*

The Committee is of the view that financial pressures and loss contribute significantly to depression, anxiety, and a sense of hopelessness among some farmers. For those whose coping abilities are weakened because of continuing stress, and who consider all avenues for relief to be closed, financial pressures must be taken into account as a *significant risk factor.* In this context it is pertinent to note Raphael's (1994:8) observations that

> *personal financial loss and disadvantage [have] been described as contributing [to suicide] and clinical anecdotes validate its significance for individuals of all social classes, for instance from those playing the stockmarket, to those of marginal financial status. Sainsbury (1955) suggested that sudden changes in social and economic conditions may play a significant part in suicide.*

In examining this evidence the Committee is mindful that there is little quantitative research which would establish a definitive causal relationship between levels of financial hardship in the country, including unemployment and financial stress, and suicide. Nevertheless, in view of the wealth of information presented to the Committee on this issue, including that from experts and health professionals, the Committee considers that financial hardship, financial stress and unemployment cannot be discounted when identifying possible suicide risk factors. This is particularly so for those people who may be especially vulnerable to psychological distress.

4.2.2 Isolation

Isolation is considered to be a major risk factor for suicide. The NSW Health Department (1993a:3) observes that

> *marginalised and isolated groups in society may be identified as being at risk of suicide. People in prison custody, some cultural groups and others who feel different and less a part of, or less well supported in society may be more at risk.*

Significantly, the National Health Goals and Targets Implementation Working Group on Mental Health has found that social isolation in adults appears to be the leading extraneous factor associated with suicide (contained in Submission 42).

In recent times the isolation of certain groups has become all the more pronounced with the fragmentation of communities and the breakdown of traditional support networks. Mackay (1993:16) argues that,

> *much of the impact of social, cultural and technological change has had the effect of isolating us from each other. In particular, the widespread breakdown of families and the shrinking of households has contributed to the emergence of loneliness as a major social problem.*

- **Rural Isolation**

Isolation is a significant factor for many people in rural areas. According to the submission from Lifeline Central West Inc based in Bathurst, "the single greatest problem facing people in this area is isolation and the relative lack of support services" (Submission 40).

Further, in their study on rural youth suicide trends, Dudley *et al.* suggest that rural families suffer the "tyranny of distance" which is felt in a number of areas. Among these are access to essential services, cultural enrichment, education and health resources, including mental health resources (Dudley *et al.*, 1992:86). According to the authors,

> *rural youth experience a variety of health risks associated with this isolation or with rural life generally. These include life transition problems associated with a lack of local tertiary opportunities, higher levels of hidden domestic violence, homicide, possibly higher alcohol consumption and greater availability of firearms* (Dudley *et al.*, 1992:86).

Evidence to the Committee indicates that country people, particularly males, are reluctant to disclose their feelings of distress, depression and anxiety. This factor will be highlighted in further detail below but at this point it is significant to note that denial or repression of emotions among these groups might further compound a sense of isolation and add to suicide risk.

4.2.3 Family Breakdown and Dysfunction

The Committee has heard throughout the Inquiry that family breakdown and discord may significantly heighten mental health problems for some and therefore increase the risk of suicide. In his evidence before the Committee, State Coroner Mr Greg Glass stated that, in his opinion, a major contributing factor to suicide, particularly among men, is the

> *breakdown of the family unit. It's family discord, divorce, separation, and... so many men cannot cope with that situation* (Evidence, 9 May, 1994).

According to Professor Robert Goldney of the University of Adelaide, mental illness is the most important contributing factor to suicide but he explained that,

> *if you have mental illness but no chronic family discord, then you are protected to some extent but if you have both, you are behind the eight ball* (Sydney Morning Herald, 7 September, 1993).

More recently, Professor Kosky, together with Professor Goldney (1994:186-187) argued, particularly in relation to youth suicide, that

> *psychiatric illness is probably a necessary cause of suicide in youth, although it is by no means a sufficient cause. Interpersonal and family discord play significant roles in the precipitation of events and actions which lead to suicide... The context in which depressive illnesses activate suicidal ideation usually relates to a disturbed family environment.*

Parental or marital discord was cited as a significant contributing factor to mental or emotional difficulties among children and adolescents by the Human Rights and Equal Opportunity Commission in its Report on Mental Illness. That report stated that

> *there is a great deal of evidence concerning the distressing and disturbing effect that parental arguments and domestic violence have on children - with work from many senior psychiatrists suggesting that this is one of the more powerful negative influences contributing to child psychopathology* (HREOC, 1993: 851).

The submission from the New South Wales Health Department (Submission 42) contains a document of the National Mental Health Goals and Targets Program. That document states that among younger people family dysfunction appears to be the leading extraneous factor associated with depression.

- **Rural Family Pressures**

Evidence before the Committee has indicated that family breakdown is of particular concern in rural communities. It has been suggested that this situation has been all the more heightened by the enormous hardships currently faced by many families in the country. However, unlike previous generations, who may also have experienced hardships, the buffering or protective effect of a large, supportive extended family no longer exists for many rural families today.

A number of submissions to the Inquiry, as well as oral testimony, have indicated that many family breakdowns in rural areas are related to the rural crisis. Evidence (26 July, 1994) was provided indicating that

> *farmers traditionally had one of the lowest divorce rates in Australia, reflecting a generally conservative society. They were small business people reliant on each other in various areas. That divorce rate, or separation rate, has been increasing over time... Many of the wives are not prepared to put up with the hell of going through poverty through downturns again.*

The Committee also heard from another witness that the enormous financial stresses facing her family, which ultimately lead to the repossession of the farm, resulted in the breakdown of her marriage.

Dudley *et al.*'s research indicates that the financial pressure faced by many rural families is having serious effects on members, including young people. The researchers argue that

> *stressed rural families may place pressure on adolescents to leave home at an earlier age and perhaps in more critical circumstances than their urban counterparts* (Dudley *et al.*, 1992:86).

Evidence to the Committee from a social worker in Lismore indicated that a significant issue with adolescent suicide and suicide attempts in rural areas is the distress and hostility they feel when their parents separate (Evidence, February 28, 1994). The Committee also heard in Young that a large proportion

of suicides in that town were related to family breakdown, and therefore a reaction to significant interpersonal loss (Evidence, 8 June, 1994).

4.2.4 Substance Abuse

The Committee understands that substance abuse, particularly alcohol, can play a significant part in a person's decision to suicide. The Committee's research shows that the excessive use of alcohol or drugs may be symptomatic of deeper problems and it may also exacerbate suicidal behaviour by causing impaired judgement. The NSW Department of Health (1993a:3) observes that "alcohol is frequently a precursor for suicide and attempted suicide". The Committee has been told, for example, that alcohol induced depression among older people is a particular concern.

In relation to young people specifically, research from North America has indicated that an increase in suicides among that group in the 1970s and 1980s

> *closely paralleled the increase in use and substance abuse among young persons and is now regarded by the American researchers as the single most common denomination of those at risk* (Hassan, 1992:11).

Alcohol and marijuana are both depressants. Evidence was received to indicate that they may be likely to precipitate or exacerbate depression when used together. In this regard, one witness suggested that, "the combination of alcohol and marijuana would be crucial" (Burnley, Evidence, 22 March, 1994).

- **Substance Abuse in Rural Communities**

The Committee understands that substance abuse, particularly alcohol abuse, is a significant area of concern in rural New South Wales. Although further study is required to determine exact levels of alcohol abuse in rural areas, it has been suggested that the issue may have considerable implications for the level of suicide in country regions of the state. In relation to Australia generally, it has been found that, per capita of adult population, rural people consume approximately 30% more alcohol and tobacco than the urban adult population (Lawrence and Williams, 1990:42). Moreover, Forrest (1988) notes that rates of alcohol abuse are higher in rural areas.

Anecdotal evidence presented to the Committee during its hearings in rural areas suggested that a variety of substances, as well as alcohol, are being abused

among certain groups in some rural communities. These include marijuana, rohypnol, petrol and alcohol.

In relation to the possible reasons for increases in suicide among young people in rural areas Dudley *et al.* observe (1992:32-33) that,

> *there is some suggestion that the rates of alcohol abuse are higher in rural areas... in which case the likelihood of firearm death in the vulnerable may be compounded. Brent et al. (1987) in their study of deaths of 10 to 19 year olds in Allegheny County, Pennsylvania, showed that firearms and alcohol are risk factors for suicide.* ***Suicide victims who used firearms were about five times more likely to have been drinking than those who used other means*** (Emphasis added).

A number of the Committee's submissions have noted the significant role alcohol can play in a person's decision to suicide. A submission from Albury, for instance stated 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* (Submission 27).

A further submission which looked primarily at the experiences of suicides in Broken Hill noted that the impact of alcohol in risk taking behaviour such as suicide must be recognised as a major thrust in preventing youth suicides in rural settings (Submission 13).

Oral testimony has also addressed the issue of alcohol abuse and suicide. In both Young and Broken Hill, for instance, the Committee heard that alcohol played a significant factor in a person's decision to suicide.

Of further and related concern to the Committee in this context is the apparent high level of "binge drinking" among young people in country towns. School students themselves told the Committee that boredom often leads adolescents to binge drink. Moreover, with a major social feature of some towns being the local pub, many young people feel there is no alternative entertainment to drinking alcohol (Evidence, 8 June, 1994). Young males in particular felt that pressure to join with peers in such social activity is the alternative to social isolation. As Professor Waters indicated to the Human Rights and Equal Opportunity Commission's Inquiry into Human Rights and Mental Illness (1992:639),

> *there's tremendous stress on rural families... A key ingredient is alcohol use... Just about everything harmful young people do to themselves they are much more likely to do in an intoxicated state.*

4.2.5 Violence

Victims of violence and abuse, including childhood abuse and sexual abuse, have been identified as a group particularly at risk of mental disorders, such as major depression and, therefore, of suicide. The NHMRC (1993:175) reports that

> *violence and abuse have an enormous negative impact as one of the major factors contributing to many psychiatric disorders.*

The Suicide Awareness Training Manual (1994:24) produced by Rose Education also explains that

> *a person who is experiencing domestic violence, abuse of any kind (emotional, physical, verbal or sexual) may be suicidal. A child who is neglected may feel quite suicidal.*

The Committee has heard that among the range of disorders and disturbances experienced by a victim of violence and in particular a victim of sexual violence are anxiety, panic attacks, phobias, depression, obsessive compulsive disorder, nightmares and multiple personality disorders, and for some the violence may be a trigger to schizophrenia (Evidence, 12 August, 1994).

Further, a recent study undertaken by Rigby and Slee (1993) which observed the health effects of bullying on student victims found that 15% of the 770 students identified themselves as victims and these respondents were more likely to feel depressed or worthless or to perceive life to be not worth living. These victimised students were two to three times more likely to indicate that they had considered "doing away with themselves", wished they were dead and had the recurring idea of suicide.

■ Violence in Rural Communities

Evidence presented to the Committee has indicated that violence is a particular concern in certain rural regions. Wallace (1986) and Coorey (1987) maintain that the incidence of domestic violence is higher in rural areas than in urban areas because of the higher incidence of poverty and unemployment (cited in

Lawrence and Williams, 1990:42). Moreover, a submission provided by the Far West Health Service reports that in that region there are high rates of domestic violence and incest (Submission 45).

In their study of victims of violence and psychiatric disorder Yellowlees and Kaushik (1992) found that the high rates of alcohol abuse in rural New South Wales are probably related, at least in part, to the high rates of domestic violence, sexual assault and incest in certain areas. Their study suggested the probability of a cycle of alcohol abuse in men leading to domestic violence and sexual abuse of women and children. According to the authors,

> *this may contribute to [women and children] becoming anxious and depressed. The rates [of this study] of the major functional psychiatric disorders were similar to those seen nationally* (Yellowlees and Kaushik, 1992:198).

4.2.6 Access to Methods

The issue of whether access to methods is a contributing factor to high suicide rates among certain groups in rural communities is one that generates much debate. Some argue that the availability of certain lethal methods, in themselves, can be a cause of death whilst others maintain that a suicidal person will use any means once he or she has made the decision to suicide. A number of studies both here and overseas have addressed these arguments.

In their study, Lester and Abe (1989), reviewing the work of Kreitman, found that the decline in the suicide rate in the 1960s and 1970s in Great Britain could be attributed to the detoxification of domestic gas, and that more recent analyses have confirmed this conclusion. The authors argued

> *that as the carbon monoxide was removed from domestic gas, first by cleaning the coal gas and then by substituting natural gas, the gas became less toxic. The use of domestic gas for suicide declined dramatically, accounting for the decline in the overall suicide rate, and very little displacement to other methods of suicide appeared to take place* (Lester and Abe, 1989:180).

Lester and Abe further found that data from Japan from 1969 to 1982 indicated that as domestic gas was detoxified, its use for suicide declined. In addition there was no evidence that would-be suicides switched to alternative methods for suicide (Lester and Abe, 1989:180).

According to the authors,

> *these data support those published on the detoxification of domestic gas in England and Wales and the effects of the imposition of emission controls on cars and the availability of handguns in the United States. It appears that when a method of suicide is made less available by restricting access to it or by rendering it less lethal, its use for suicide drops* (Lester and Abe, 1989:181).

Data on suicide deaths in Australia during the 1960s and 1970s show a sharp increase in numbers of those deaths, particularly among women. This rise has been attributed to the ready availability of barbiturates during that time. As restrictions came to be placed on the availability of these drugs, the suicide levels declined.

In their 1992 study, Firearm Suicides in Australia, Snowden and Harris found some evidence to suggest that the higher the level of firearm ownership in a state, the greater its rate of suicide by firearms. Their research also found the level of suicide to be higher in those states with larger rural populations. However, the authors note that these states have less rigid gun laws. According to the authors, "imposing stricter firearms legislation was followed by a fall in the firearm suicide rate in South Australia" (Snowden and Harris, 1992:83).

More recently, de Moore *et al.* (1994) completed an eight year study based upon the survivors of self-inflicted firearm injuries who presented at Sydney's Westmead Hospital. The authors found that most patients in the study shot themselves impulsively in a crisis, were not psychotic and had ready access to a firearm. A "background of discontent and an intense stress led to an impulsive act of shooting" (1994). The research led de Moore *et al.* to conclude that it was unusual for the shooting to be well planned (1994:423).

Other information available to the Committee would appear to refute the view that access to methods is a significant contributory factor of suicide. A study undertaken in the Netherlands, for instance, noted that when carbon monoxide in domestic gas was reduced, suicides by these methods decreased but the overall suicide rate increased, "with poisoning, hanging and drowning becoming more common as gas poisoning became less popular" (Mason, 1990:127 cited in Submission 17). In addition, a number of community witnesses to the Committee have commented that a suicidal person will merely substitute one method of suicide where another is unavailable. A submission from the Sporting Shooters Association of Australia (New South Wales) Inc. for instance notes that the World Health Organisation has indicated that the removal of an easily

favoured method of suicide is not likely to affect substantially the overall suicide rate as people will select other methods.

In their study, Cantor and Lewin (1992) argue that availability alone does not adequately explain the use of a method, including firearms. The authors maintain that

> *tradition or some other social or cultural factors determine method as much as availability* (Cantor and Lewin, 1992:507).

In evidence before the Committee, Ms Rebecca Peters from the Coalition for Gun Control indicated specifically in relation to firearms that

> *gun control is a means of reducing the suicide rate in* ***a culture where guns are a common means*** *of committing suicide. You need to be dealing with all those things* (Evidence, 26 July, 1994, emphasis added).

- **Rural Access to Methods**

Throughout this Inquiry a substantial number of oral and written submissions have raised the issue of firearms especially, and their accessibility, in relation to rural suicides. As has been discussed, the Committee's statistical information indicates that, although showing some decline, firearms represent the most frequently used method of suicide by young males in rural regions.

The Committee has heard that, for many rural families, particularly those on farms, firearms are a common part of their everyday lives, are easily accessible and knowledge of their use is relatively sophisticated from an early age. Thus, according to one witness,

> *I think it would be self-evident that in rural areas a firearm would be a preferred method of choice of people who were intent on suicide, so the figures in that context would be expected* (Evidence, 26 July, 1994).

It is these factors according to Dudley *et al.* (1992) which partly explain the high rate of firearm deaths in rural areas over the last two decades, where gun ownership in those regions is approximately three times higher than in urban areas. According to the authors,

> *there is a strong link between firearm availability and firearm suicides, assaults and crime in urban and rural Australia, as there*

> *is overseas... We believe that our study strongly supports the need for more stringent gun controls. The matter deserves serious attention, since the use of firearms is one of the more preventable methods of suicide, and those denied access to one method do not automatically choose another* (Dudley *et al.*, 1992:87).

In his evidence to the Committee, Professor Brent Waters argued that a major cause of increased suicide in rural New South Wales among young males (especially those in rural municipalities and shires) is the ready availability of firearms. The witness acknowledged that whilst firearms have always been available in rural communities, it was his understanding that,

> *the police believe that the sheer numbers of guns [have] been increasing steadily over time... in the rural areas as well as in the cities... I think there is a reasonable role for guns in the country. I think vermin control is certainly a valid concept but I do not understand why people cannot take greater care with guns. I do not know what is so offensive about having to register firearms and being permitted to purchase firearms for authorised reasons, like vermin control for instance. Why, if you have a gun, do you not also have to demonstrate you have a place to lock it away, and that it falls within a certain set of parameters?* (Waters, evidence, 26 April, 1994).

A submission to the Committee from the Sporting Shooters' Association of Australia (New South Wales) Inc., however, argues that gun availability has no recognisable effect on overall suicide (Submission 17). The submission from Appleby, King and Kay argues also that as there is evidence of an increase in the numbers of people suiciding by hanging it is erroneous to focus solely on gun control (Submission 47).

As well as the issue of firearms the Committee has heard some testimony regarding the use of insecticides and fertilisers as a means of poisoning suicides among some rural people. It has been suggested that the availability and accessibility of these lethal chemicals in rural areas means that they can be readily used for intentional self-harm.

Whilst not necessarily specific to rural areas the Committee's attention has been drawn to the lethality of abuse of anti-depressants as well as to seemingly harmless medications such as paracetamol. Somerville (1994:1) argues that among young women in particular there are marked increases in the use of paracetamol for suicide attempts despite the decline in self-poisoning with other minor tranquillisers and sedatives.

4.2.7 Issues Relating to Sexuality

Throughout the Inquiry, the Committee has heard that bisexuals, lesbians and gay men are at particular risk of suicide. According to the United States Department of Health and Human Services Task Force on Youth Suicide Report (1989)

> *the suicide rate for gay and lesbian youth may be two to three times higher than for other young people. Gay youth face a hostile and condemning environment, verbal and physical abuse, and rejection and isolation from families and peers... The traumatic consequences of these external pressures make... [gay youth] more vulnerable than other youth to a variety of psychosocial problems and self-destructive behaviour, including substance abuse, depression, relationship conflicts and school failure each of which are factors for suicidal feelings and behaviour.*

Although little research has been done on the issue in Australia, a number of submissions to the Inquiry, as well as oral testimony, expressed great concern about the extent of suicide among bisexuals and homosexuals, particularly young bisexuals and homosexuals in the community. Furthermore, concern has also been expressed about the lack of academic and medical research that investigates the relationship between suicide and a person's difficulty in coping with their sexual identity (Submission 52).

■ Sexuality Issues in a Rural Environment

The Committee has received a number of submissions as well as oral testimony examining the issue of homosexuality and suicide among country people. A submission from a gay man living in a country town, for example, considered the general intolerance of homosexuality within rural communities as being a significant reason for young men in those areas suiciding. According to the author,

> *a rural youth does not have access to a visible gay community. He is probably not aware of gays (or "acceptable" gays) in the community. Because of family ties or obligations, economic circumstances or a love for "the country" he may not contemplate a move to the city as a feasible solution. He therefore suffers an extreme sense of isolation, probably a hatred for himself (because he has been brought up to hate gays) and a*

> *sense of worthlessness (because he has been brought up without any respect for gays). These factors are a potent combination for suicide* (Submission 21).

A further submission has stated that young adolescent males living in country towns may experience difficulties in confronting their sexuality. The author states that

> *the country kid who is gay has no role models and he has no-one in whom he can confide. There are no social outlets. He is young and alienated. Usually he is at school or unemployed, but either way, he is socially trapped... It seems to this observer of rural life that the age of highest incidence of youth suicide among young men is no coincidence* (Submission 52).

The Committee has also heard in evidence that

> *in conservative communities in rural areas, especially where there is a high sex imbalance - where the ratio may be ten males to one female - there could be problems with acceptance of different male sexuality. That has been suggested but has not been proved yet. I am not sure how one would prove that... Perhaps if there is less tolerance for differences, given the wider changes in society that could be a possibility. But that is purely hypothesis only, at least as far as Australia is concerned at this stage* (Evidence, 22 March, 1994).

The Committee has been told that often young gay males suffer taunting or intimidation from peers even from pre-adolescent years and may develop a sense of rejection and self-rejection.

4.2.8 Gender and Culture

Much research indicates that suicide has a peculiar gender orientation. Although females tend to make more attempts, men are more "successful" (NSW Health, 1993a3). One reason suggested for this discrepancy is that men tend to use more violent means, such as firearms, which are more likely to be fatal than the drug overdoses which are a more common method among women.

It has also been observed that men, more often than women, tend to internalise depressive feelings rather than talk about them. It is argued that our culture does not encourage men to cry or openly demonstrate feelings of sadness and

despair, for to do so suggests some sort of "weakness" or "failing". Depressed or despairing men therefore do not actively seek out counselling. This "bottling up" of emotions can have dire consequences in later manifestations of destructive and self-destructive behaviour. Women may apparently attempt suicide, using non-lethal means, as an appeal for help; for men, such an appeal would be seen as weakness, and unsuccessful suicide as failure.

It has been argued that traditional gender roles are particularly pronounced in rural areas or, as one submission observed, are a result of "rural socialisation", particularly of males (Submission 40). Part of this socialisation is the "typical" rural attitude, especially among men, of keeping problems and concerns to oneself. As the Committee has been told,

> *traditional views related to gender roles remain predominant in the majority of rural people. This places enormous strains on individuals when they perceive themselves to be inadequate in their role and also prevents that person from seriously considering alternatives. These roles are reinforced by closest associates such as other farmers or members of the same small town. The concept of "saving face" is extremely important and some people will die before they bring "shame" on themselves* (Submission 40).

Dudley *et al.'s* research makes similar observations. According to those researchers, the combination of the so-called "bush culture" of self-reliance and the perpetuation of the stereotypical male role is, in the present economic climate especially, producing potentially negative circumstances for many communities. They argue that

> *there is a stark disparity in rural areas between traditional views about sex roles and male self-reliance (which perhaps is most enduring in these areas) and the reality of high diminishing opportunities and rewards [e.g. high youth unemployment and people being forced off the land]* (Dudley *et al.*, 1992:87).

This factor, together with the notion that mental illness may be seen by many in rural areas who uphold the self-reliance ideal, as a moral failing, may contribute to men in distress failing to seek help. In his evidence to the Committee, Professor Waters argued

> *there is probably no place in Australia where the value of male self-reliance is higher than in the country. Young males in country areas probably feel even more trapped because they feel depression is a sign of real weakness. They feel very ashamed to*

> *talk about how hopeless and useless they are feeling about the future* (Evidence, 26 April, 1994).

Although accurate data on attempted suicide are limited, as indicated in Chapter Three, there is much literature, as well as evidence presented before the Committee, to suggest that women make more attempts at suicide than men. It has been suggested that in their attempts many of these women, particularly young women, are "crying out for help". The Committee understands that many young women experience feelings of low-self esteem, which is often manifested in eating disorders. It has been suggested that, for many young women, disorders such as anorexia nervosa and bulimia nervosa may be actual suicide attempts by way of starvation. Whilst now being encouraged to achieve in education and employment, many girls and young women still face traditional pressures to marry and raise families. As Sommerville (1994:3) argues,

> *simultaneously girls believe that in order to achieve all that they aspire to, they must remain beautiful, thin and sexy. Their role models appear in the mainstream magazines, alongside such articles as "How to be independent in your career" and "80 ways to please the boys".... At the same time they may well be reading books, watching movies or listening to music which deals directly with suicide.*

Evidence was not presented to the Committee to suggest that these issues are more pressing for rural women, including young women, than for their urban counterparts. However, given the observations made by a number of commentators that traditional gender roles are still strong within rural communities, the effect of external pressures and expectations placed on women and girls from those areas needs to be considered.

4.2.9 Media

In recent times the media have been examined as a factor significant to the issue of suicide, particularly among young people. It has been suggested that media **reporting** of suicide, especially that which is graphic, may have the effect of influencing certain people to copy the act - so-called "copy-cat", or cluster suicides. North American research has found that there is an increase in suicides immediately following the reporting or publishing of a suicide story (Philips and Carstensen, 1986). Other research, however indicates that media reporting may only partly explain the problem of cluster suicides.

According to Goldney (1989),

> *even so-called neutral reporting of suicide may be followed by an increase in susceptible persons. This suggests that the increase may not be simply a result of imitation or contagion, but a more subtle acceptance that suicide may be a normal course of action.*

Media **influences** are also considered relevant, particularly in the case of rural suicides among young people. As observed above, media images can be relevant to how a person, particularly a young person, may view and value him or herself. A perceived inability to conform to say the standard of a lifestyle or body image, as set by the media, can instil in some young people a sense of failure, and compound feelings of low self-esteem and low self-worth. The Committee is concerned at the narrow status accorded females in certain areas of our society, for example in acceptable body-images for woman, as promoted by the fashion industry and through certain advertising. It endorses the Department of Education Girls' Education Strategy and initiatives to develop girls' self-esteem.

In his evidence to the Committee Professor Brent Waters addressed the issue of the media and its impact on young people in rural and remote areas of New South Wales. He stated that,

> *there is some interesting data that suggest that the rate of depression across the whole world has been rising in the developed nations since the Second World War, at a time when individual autonomy and personal wealth has been steadily increasing. But the other thing that has been happening over that time is the information explosion... people now set their aspirations not based on what they see next door in their community or what has happened within their family... All those old things still set them but [aspirations] are also set by a remote media driven image of what the world could be like for them. When some people do not meet those unrealistically high goals it pushes them towards a sense of failure* (Evidence, 26 April 1994).

For young people in rural and remote areas, the unattainable media images that they are constantly presented with can generate much frustration and feelings of hopelessness. To quote further from Waters' evidence (Evidence, 26 April, 1994),

> *people can sustain enormous hardship if they are not confronted daily by how their life could be different. The media pipes into*

> *people's homes a popular culture, particularly if we are talking about young people, which is inaccessible, because it simply does not happen in whatever local town it is. It is the culture of Sydney, Melbourne, Los Angeles... It presents everything as rosy and optimistic and accessible. Then young people feel extremely remote from that kind of culture. That is a real problem.*

4.2.10 Age

Suicide risk appears to be particularly pronounced in certain age groups. Raphael (1994:13) observes that,

> *age variables are clearly relevant in that rates may be substantially different in different age groups and for different behaviours, for instance high rates of completed suicides in young males... and in older men.*

Hassan has found that, in the past, suicide in Australia was positively correlated with age with the risk of suicide increasing with age. However, the author has also observed that

> *since 1964 suicide risk has significantly increased in two theatres of life - the very young and the very old. In the same period, there has been a relative and absolute decline in the suicide rate of people aged between 35 and 60. We thus have a curious situation in this respect. The suicide rate of the cohort which is now parenting the teenagers has experienced a remarkable decline over the past 30 years* (Hassan, 1992:2).

As the Committee noted in Chapter Three, high rates of suicide are evident among the older age group, but the relationship between suicide and old age is ever changing with the ageing population (NSW Health Department, 1993:2). Moreover, as was reported earlier, Baume has noted that "the decreasing rate in the elderly overall has been at the expense of the youth" (Baume, 1994:4).

Recent studies have shown that 15-24 year old males have become, in recent times, a particularly at risk group; in fact suicide amongst this age group is the highest in the industrialised world (World Health Organisation).

In attempting to analyse the high rate of suicide among young people in New South Wales, the NSW Health Department (1993:2) suggests that

> *it is conceivable that the young are less well protected in coping with distress, recognising depression and understanding how to find help because of their limited experience. Rapid social change and high unemployment rates may also be significant for this group.*

In relation to the rate of unemployment for instance, among young people in New South Wales the National Youth Affairs Research Scheme and the Australian Bureau of Statistics (1993:55) have found that

> *the unemployment rate among 15 to 25 years olds was higher at 18 per cent than for the total population (11 per cent). While young people made up 23 per cent of the total labour force, the 111, 800 young people looking for work made up 37 per cent of all unemployed.*

From a purely mental health perspective Haliburn (1993:45) observes that

> *all indicators of emotional illness rise sharply during mid to late adolescence.... Onset of schizophrenia occurs before the age of 25 years in approximately 60% of those affected... Onset of manic depressive disorder occurs between the ages of 10 and 19 years in approximately 30% of those affected .*

4.3 PERSONAL FACTORS

4.3.1 Physical Illness

Many studies have found that people with a medical or physical illness are an at risk group for suicide. The NHMRC has found, for instance, that people living with HIV/AIDS have a high suicide risk. It has similarly been observed that some studies show that patients with cancer and other medical conditions are also at risk (NHMRC, 1993:69). Further,

> *coroners report that significant numbers of older people experience periods of suffering from physical and terminal illness prior to dying by suicide* (NSW Health Department, 1993a:3).

The Committee has heard that the health status of rural people is generally lower than urban dwellers and many experience greater levels of physical illness

than their city counterparts. However, information is not available to indicate that rural areas experience high rates of suicide that are specifically associated with physical illness.

Much of the evidence presented to the Committee by way of oral testimony and through submissions did not address the issue of physical illness as a cause that was peculiar to suicide in rural regions. Whilst the Committee is not dismissing physical illness as significant to suicide in certain individuals it considers that, in light of the limited evidence specifically relating to rural areas, it is not in a position to make recommendations.

4.3.2 Loss: Bereavement

The loss of a loved one through death has been identified as causing profound sadness and depression in many individuals and may act as a precipitant "for disorders or episodes of disorder" in those who are especially vulnerable, heightening risk of suicide (NHMRC, 1993:167). Indeed, a number of the witnesses who gave evidence before the Committee and who had lost a child or relative to suicide indicated that they themselves felt "like killing themselves" at various stages of the grieving process. Issues relating to survivors of suicide will be examined in further detail in Chapter Five.

For many children and young people, the death of a parent can be enormously traumatic, leaving a sense of abandonment and loss that can result in serious depression. Raphael (1994:23) observes that

> *rejection and loss are common themes, particularly as precipitants of suicide. The loss may occur as an expected bereavement, for example, the death of a partner in later life, or it may be unexpected loss, bringing with it additional elements of trauma and a potentially traumatic process of grieving.*

4.3.3 Loss: Relationships

Relationship breakups have been further identified as a risk factor for suicide among certain individuals. To quote further from Raphael (1994:23),

> *rejection through divorce, separation or the break-up of a relationship brings not only loss but the pain of rejection and is likely to be a precipitant as well. Significant research work has shown that particularly for older single males with a history of substance abuse, the likelihood of loss being a precipitant of*

> *suicide behaviour is quite high. In younger males and females, rejection in terms of the break-up of a relationship, particularly of peer relationships (girlfriend or boyfriend) may be significant to precipitate a significant suicidal act.*

Oral testimony presented to the Committee has supported this observation and a great deal of information has been presented relating to the enormous impact that breaking up with a boyfriend or girlfriend can have on vulnerable young people. The Suicide Awareness Training Manual (1994:24) maintains that for adolescents, broken relationships are particularly significant.

The Committee's evidence in rural centres, from both mental health professionals and community members alike, indicated that for many young people, and for young men especially, a relationship break up was a significant factor for suicide, attempted suicide and suicidal ideation.

4.4 ABORIGINAL PEOPLE AND SUICIDE

The issue of Aboriginal suicides in rural New South Wales has been addressed in a number of submissions and by a number of witnesses in evidence before the Committee. Data supplied to the Committee from the Australian Bureau of Statistics indicate that the number of suicides among Aborigines, both men and women, in rural New South Wales from 1981 to 1992 was twenty nine.

However, much of the information presented during the Inquiry has indicated that suicides among Aboriginal people, particularly in country areas, are underestimated. A submission to the Inquiry from the Orana Community Health Services (Submission 1) noted for example that

> *Aboriginality is strongly suspected as being undernumerated in the inpatients statistics for a number of reasons. It must also be considered that as many as 30% of Aboriginal deaths may be misclassified as non-Aboriginal deaths... which could result in underestimation of the number of Aboriginal suicides.* ***Overall the rate of suicide... is significantly higher in Aboriginal people than in non-Aboriginal people*** (emphasis added).

The Committee understands that it has only been recently that relevant state bodies have been breaking down suicide rates by race of origin (Waters evidence, 26 April, 1994). Nevertheless, according to a witness appearing before the Committee, the rate of suicides among Aboriginal people in rural areas is "certainly high".

The witness stated:

> *there is a problem with the data here. All of the mortality and general data that we get from the certificate information is that there is an under-recording. What that means is that with quite a number of Aborigines the data is simply in the non-Aboriginal population. The death certificate data up to now has not been adequate to give the trends with young Aborigines, unfortunately, or with all Aborigines* (Burnley, Evidence, 22 March, 1994).

Evidence to the Committee from Aboriginal health workers indicated that suicide among Aboriginal people in rural areas is underestimated and one witness explained, "the problem is getting worse" (Evidence, 12 August, 1994).

In relation to the issue of identifying trends in suicide among Aboriginal communities, Aboriginal health workers observed in their evidence that there is a problem "getting Aboriginal people to identify as Aboriginal". This has implications for both the recording of completed suicides, where families do not identify the deceased as being Aboriginal, and attempted suicides, where the person who made the attempt did not identify him or herself as Aboriginal. As this witness stated, many Aboriginal people, who have been subjected to offensive comments such as "how much Aboriginal have you got in you?", "you don't look Aboriginal" and "are you a half-caste?" hold back from identifying themselves as Aboriginal, even to health workers (Evidence, 29 March, 1994). The witness further stated that many non-Aboriginal health workers do not want to ask whether someone is Aboriginal because they do not wish to appear offensive.

The Committee has also been told that whilst there appear to be high rates of attempted suicide among some rural Aboriginal communities, Aboriginal people do not tend to present at hospitals for treatment for self-inflicted injuries (Evidence, 11 August, 1994).

Numerous witnesses have indicated to the Committee that for many Aborigines, self-destructive behaviours such as alcohol abuse and, among young people, petrol sniffing, may be suicidal behaviour. As Ms Sandra Bailey, Chief Executive Officer of the New South Wales Aboriginal Health Resource Co-op Limited, (Evidence, 30 August, 1994) explained to the Committee,

> *when an Aboriginal man dies at the age of 34 from alcohol abuse that is still self-destruction, and it is just as serious as someone who may have slashed his or her wrists.*

In relation to suicide specifically, a number of witnesses before the Committee have indicated that suicide is not traditionally part of Aboriginal culture (Evidence, 29 April, 1994). Indeed, Eastwell has observed that among many groups such as in Arnhem Land and the Central Australian Desert, Aboriginal dialects have no word for 'suicide' (Eastwell, 1982, cited in Clayer and Czechowicz, 1991:683). Aboriginal commentators maintain that it is essentially a phenomenon that has emerged since European colonisation (see Brice *et al.*, 1991:160). However, another witness told the Committee that among one particular tribe, suicidal behaviour was noted among some women members, who in mourning the death of a baby, walked into a river and drowned (Evidence, 11 August, 1994).

The Committee has heard throughout the Inquiry that the general issue of mental illness among Aboriginal people is very complex. As the Human Rights and Equal Opportunity Commission's Inquiry in Human Rights and Mental Illness (1993:692) found,

> *mental illness among Australia's indigenous people cannot be understood in the same terms as mental illness among non-Aboriginal Australians, because of their unique culture and their experience as dispossessed people.*

A witness before that Inquiry also commented (HREOC, 1993:694),

> *an Aboriginal perception of mental health is holistic, there is no need to compartmentalise... Aboriginal mental health should not be viewed from a medical model of abnormality.*

Official data on the level of mental illness among Aboriginal people are limited. Thus, as the Royal Commission into Aboriginal Deaths in Custody recognises (1991, Vol 4:223), this makes

> *any accurate estimation of psychiatric morbidity rates and the occurrence of specific psychiatric diseases extremely difficult. However, our research suggests that the prevalence of major mental disorders is at least as high... among Aboriginal people as among non-Aboriginal people.*

However, despite this, mental distress among Aboriginal people goes largely "unnoticed, undiagnosed and untreated" (Royal Commission into Aboriginal Deaths in Custody: 1991, Vol. 4:223). In some instances, the matter becomes one for the police and the criminal justice system (Evidence, 30 August, 1994). Moreover, according to an Aboriginal Health Education Officer in Dubbo, Aboriginal people suffer the same level of mental illness as non-Aboriginal

people but their under-utilisation of services makes it very difficult to measure this exactly.

It has been highlighted that many of the mental health problems experienced by Aboriginal people are inextricably linked to external social and cultural factors. This was pointed out in the Report of the Royal Commission into Aboriginal Deaths In Custody (1991:251)

Factors such as dispossession, forced separation of children and families (an issue which still has considerable impact on Aboriginal communities), on-going social and economic disadvantage and racism have all contributed to a high level of social distress among Aboriginal people today, leading many to engage in self-destructive and suicidal behaviour (Evidence, 12 August, 1994). Aboriginal people themselves have commented to the Committee that conventional European based perceptions of mental disorders, including psychiatric diagnoses and management, often fail to serve Aboriginal people adequately because they do not recognise the enormous significance of such cultural and social dislocation on the psychological well-being of Aborigines.

Substance abuse, particularly alcohol, among Aboriginal communities has been highlighted throughout this Inquiry as significant to the issue of mental health. As well as acting as a depressant in some people and, in others, precipitating violent and aggressive behaviour, the effects of substance abuse such as alcohol can result in "brain damage or other psychological deficits directly related to [the] substance abuse" (HREOC, 1993:770). Further, as noted earlier, substance abuse can also be an indication of deeper emotional distress and disorder.

The Committee has heard that the problems identified above are especially compounded for Aboriginal people living in rural and remote areas where relevant services are limited, and those that are available are predominantly of a non-specialist nature and have traditionally targeted a non-Aboriginal client group. Whilst Aboriginal mental illness and suicide rates in rural areas are difficult to obtain, evidence presented to the Committee indicates that the issue is one of major concern among Aboriginal communities.

Detailed studies undertaken by Hunter in the Kimberley region of Western Australia confirmed that completed suicide and suicide attempts have been increasing among Aboriginal communities, including in rural and remote regions. Of particular concern are the numbers of young Aboriginal people committing suicide and engaging in risk-taking and self-destructive behaviour. Dr Hunter's research found that in the 1960s there was one suicide in the Kimberleys, climbing to three in the 1970s and in the 1980s there were 21. In his evidence

to the Human Rights and Equal Opportunity Inquiry, Hunter (1993:708) observed that

> *this is a substantial increase. We also see an increase in violence against women, and we see an increase in self-mutilation. Now, this is occurring amongst a group of people who are getting younger. If we look at the suicides up to 1988, two of 17 were aged 20 or less. In 1988 and 1989 there were eight suicides, and six of those were aged 20 or less.*

Moreover, a South Australian study undertaken by Clayer and Czechowicz (1991) shows that, in that state, suicide among the Aboriginal population in urban areas has shown a marked increase between the years 1981 and 1988, and suicide by Aborigines from rural backgrounds also shows an increase in incidence (1991:684). According to the authors (1991:684),

> *other factors such as sex and age, appear to be relevant. In common with non-Aboriginal populations, Aboriginal women die from suicide far less frequently than do men. Age appears to be statistically relevant... in that 71.4% of the Aboriginal suicides occur in people under the age of 29, compared with 34.8% of suicides in the non-Aboriginal population.*

Testimony to this Committee supports the fact of suicide as an increasing concern among Aboriginal communities, including in New South Wales and particularly among the young. According to a witness from Wagga Wagga (Evidence, 22 March, 1994),

> *what I have heard from [Aborigines] is that there are suicides but suicides are not readily identified. There is a lot of risk-taking behaviour, as with alcohol and to some extent drugs, but also other risk taking behaviour with cars and so on... They are becoming more and more concerned.*

Giving evidence in relation to suicide among young people, in particular, another witness stated that,

> *I do not think there is any reason to think that the rate of suicide among Aboriginal young people is any lower than it is among non-Aboriginal young people. It is probably higher and other studies that have looked at the differences between Aboriginal and non-Aboriginal communities suggest that generally it is higher. So I think it is probably of more concern* (Evidence, 26 April, 1994).

Overall, the findings of the Royal Commission into Aboriginal Deaths in Custody were that the majority of Aboriginal people who died whilst in custody, including police and prison custody, did so as a result of suicide. Many of those who were the subject of the Inquiry died in New South Wales country towns. That report described the serious and profound depression, despair and anxiety experienced by Aborigines who are incarcerated; commonly a manifestation of the level of depression and despair experienced by Aborigines in the wider community.

4.5 POSSIBLE CAUSES FOR THE INCREASE IN SUICIDES IN RURAL AREAS

In this section the Committee proposes to examine the possible causes for the increase in suicides in rural areas among certain groups. The Committee considers that just as the causes of suicide or the identification of potential risk factors are complex and multifactorial, so too are the reasons for the increase in suicide among certain groups. Consequently, as Hassan (1992:14) explains,

> *the domain of discourse in the study of suicidal behaviour is multidisciplinary which requires integration of data from psychiatry, psychology, biology and sociology, in order to advance our understanding of the multifaceted problem and to evolve practical and effective strategies for suicide prevention.*

The Committee recognises that the presence of a mental illness can play a critical role in a person's decision to suicide. However, as many of our witnesses have indicated, measuring the *exact* extent of mental illness among the target group for this Inquiry, namely rural people, is difficult for a number of reasons. Consequently, trying to determine whether the extent of mental illness in rural communities has *increased* becomes a particularly complex exercise. Were suicide only the result of mental illness we would be forced to ask why country people, as indicated in suicide levels, especially among the young, are apparently more prone to mental illness than those living in urban settings.

Based on the evidence received, however, mental illness is a concern in rural communities, with levels at least as high as in urban areas. The problem lies in the fact that mental illness in rural areas may not be so readily identifiable, acknowledged, treated or managed, which can therefore heighten suicide risk. These issues will be addressed in greater detail in the following chapter on strategies for prevention.

In their detailed analysis of suicide among young rural people, Dudley *et al.* concluded that it is unlikely that the rise in rates among that group could be accounted for by a rise in the rate of endogenous depression. Major depression

of "other origins would contribute to the suicide of many of these adolescents" (Dudley *et al.,* 1992:87). The authors further argued that many of the subjects could be expected to have depressive features in association with other diagnoses, such as conduct problems and a family history of chronic discord, mental illness and suicidal behaviour.

Further evidence to the Committee noted that the possibility for increases in suicides among certain groups in rural areas, may have arisen because of better recording practices and a greater inclination on the part of coroners to make findings of suicide. Hassan (1992:5) maintains in relation to increases in youth suicide that

> *there is evidence which suggests that in recent years Australian coroners have categorised more unexpected deaths as suicide than before... These patterns if applied to adolescent suicides would suggest that at least some increase in the suicide rate is a statistical artefact. Due to increasing social differentiation and social structural changes young persons these days participate more visibly in the public domain and consequently it is more difficult for the family to conceal their suicide than it was twenty or thirty years ago. The author's research on coronial classification supports the recent observations of Robert Kosky that there has been a moderate trend among coroners to classify a verdict of suicide for young persons, but that there has also been a real rise in youth suicide ... From the author's work it seems that there has been a gradual increase in youth suicide.*

In their analysis Dudley *et al.* argue that although some shift in coroners' verdicts from "undetermined" to "suicide" is discernible in recent years, they note that the principal problem with suicide reporting is underreporting. Moreover, their experience of reviewing 94 NSW coroners' files for youth suicide from 1988 to 1989 (25 being rural)

> *revealed only two cases of questionable suicide classification (neither of which were in rural areas). However, a change in coroners' verdicts could be a minor contributory factor to the observed trend, particularly to the low base rate* (Dudley *et al.,* 1992:156).

That same study speculated other possible reasons for the high rate of youth suicide in rural settings. These include the following:

- the effect of the major economic downturn on the rural sector over the last 25 years and the ensuing unemployment, poverty, drift in school

leavers and the older labour force from the inland to the coast, restriction of government and some non-government services to the larger centres and the decline of small country towns;

- isolation and the consequent marginalisation from essential services, cultural enrichment, education and health resources;

- the changing perception of the bush and the difficulty in maintaining the notion of self-reliance and resilience, in the face of diminished opportunities, particularly among males; and

- the availability and accessibility of firearms, combined with the possibility that there may be greater alcohol consumption in rural areas (Dudley *et al.*, 1992).

Anecdotal evidence provided throughout the Inquiry, and in relation to all age groups, would tend to support these observations. Time and again witnesses suggested to the Committee that the devastating effect of the rural recession and the current drought, increased family breakdowns, the enormous isolation of many rural people and the limited opportunities all contributed to the considerable sense of hopelessness, helplessness, stress and despair within certain groups and communities. In many instances witnesses related suicides directly to these events. Moreover, in both evidence and written submissions, the Committee's attention was frequently drawn to the high levels of alcohol consumption and the availability of the means to suicide, particularly firearms, both of which are common features in rural communities, as factors which can impact on a depressed and despairing person's decision to suicide.

Whilst most of the evidence received by the Committee tended to emphasise that the major suicide problem in rural areas is among young men, evidence received by Associate Professor Ian Burnley, as well as the findings of his recent study, suggest that suicide levels are elevated among farmers and related workers. In his study, Differential and Spatial Aspects of Suicide Mortality in New South Wales and Sydney, 1980 to 1991 (1994:303) Burnley argues that

> *the link between higher male suicide in farming and industrial occupations might reflect the stresses associated with restructuring and economic competition in the 1980s among cohorts born the 1930s onwards... but it may give support for an older body of theory which associates suicide with a loss of status. Ready access to firearms may contribute to the higher mortality in farming and in inland country areas.*

Further evidence submitted to the Committee noted the emerging area of concern of homosexuality as being relevant to an understanding of some of the contributory factors to suicide in rural areas particularly among young men. The Committee notes that further research is clearly needed to determine fully whether the issue of homosexuality among rural males is related to an increase in suicide among that group.

The impact of the media in recent decades, and the constant yet unattainable messages it often projects regarding measures of success, wealth and beauty, have been suggested as contributing in some way to increases in suicidal behaviour especially among youth. The inability to achieve the ideals set by the media and the advertising industry has meant that many experience a sense of failure and despondency.

However, the Committee notes, and has discussed earlier in this chapter, that drawing definitive conclusions about specific causes of suicide, especially in relation to social factors, can be particularly complex. One witness commented to the Committee in relation to this issue that

> *at this stage we do not have any satisfactory explanatory mechanism for why there has been an increase* (Evidence, 30 August, 1994).

Nevertheless the gravity of the issue necessitates that the many factors identified above should not be overlooked in the attempt to understand more fully the tragedy of suicide and to develop ways of preventing its prevalence, including among those in rural areas. Ongoing and specific research that explores the complex relationship between mental health, social issues, suicide and emerging risk groups must therefore be actively developed and supported. In its submission to the Inquiry, the NSW Health Department (Submission 42) attached a draft document from the National Mental Health Goals and Targets. In that document a number of draft strategies for suicide reduction and prevention were outlined. Among them are that

- *Governments should support the development of a national strategy on suicide prevention [and]*
- *Governments should support the development of a national 'clearing house' and research centre for suicide research and prevention.*

The Committee also notes that among the strategies outlined in the Outline of the National Health and Medical Research Council Draft National Strategy for the Prevention of Suicide are:

- *the promotion and co-ordination [of] research into the causes of suicidal behaviour, the risk factors involved and methods of prevention [and]*

- *the coordination [of] suicide prevention efforts across Australia.* (NHMRC, Suicide Prevention Working Party, 1994).

The Committee strongly endorses these initiatives. It also notes Baume's comments (1994:14) that

> *it is hoped that the new National Mental Health Policy... the Australian Health Ministers Advisory Committee and the NHMRC will ensure that a more integrated approach to the prevention of suicide would take place in the future and support the establishment of a national strategy for suicide prevention, hence providing a national framework for a coordinated approach to suicide prevention and postvention.*

As discussed in Section 3.1, the Committee supports the proposal in the Outline of the National Health and Medical Research Council Draft Strategy for the Prevention of Suicide that there be developed a national database concerning the patterns and prevalence of suicidal behaviours and state based registers then established which report to the central database.

Suicide is deserving of resource allocation not just of itself, or because of the pain and grief caused to families, but because of an indication of broader mental and social traumas that need to be addressed for the benefit of society as a whole. For every individual who suicides society needs to bear some of the responsibility and look to effective means to prevent further suicides occurring.

RECOMMENDATION 4

> **That the Minister for Health urge the Australian Health Ministers' Council to support the development of a National Strategy on Suicide Prevention.**

RECOMMENDATION 5

That the Minister for Health urge the Australian Health Ministers' Council to:

- **develop a National Centre for Suicide Research. A major component of the work of the Centre should be to examine suicide issues specifically related to rural communities;**

- **develop a national database for the collection and analysis of the incidence and prevalence of suicide and attempted suicide. Following the establishment of the national database, the Minister for Health should develop a register in New South Wales to provide suicide and attempted suicide data to the national database.**