STANDING COMMITTEE ON SOCIAL ISSUES

Legislative Council, Parliament of New South Wales

SUICIDE IN RURAL NEW SOUTH WALES

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MEMBERSHIP OF THE STANDING COMMITTEE ON SOCIAL ISSUES

Hon Dr Marlene Goldsmith, MLC (Chairman)	Liberal Party
Hon Ann Symonds, MLC (Deputy Chairperson)	Australian Labor Party
Hon Franca Arena, MLC	Australian Labor Party
Hon Lloyd Coleman, MLC	National Party
Hon Keith Enderbury, MLC	Australian Labor Party
Hon Elisabeth Kirkby, MLC	Australian Democrats
Hon Doug Moppett, MLC	National Party
Rev The Hon Fred Nile, MLC	Call to Australia Party
Hon John Ryan, MLC	Liberal Party
Hon Helen Sham-Ho, MLC	Liberal Party

SECRETARIAT

Dr Jennifer Knight	Committee Director
Ms Alexandra Shehadie	Senior Project Officer
Mr Glen Baird	Senior Project Officer
Ms Annie Marshall	Committee Officer

FUNCTIONS OF THE STANDING COMMITTEE ON SOCIAL ISSUES

The functions of the Committee are to inquire into, consider, and report to the Legislative Council on:

- any proposal, matter or thing concerned with the social development of the people in all areas of NSW
- the equality of access to the services and benefits provided by the government and non-government sector to the people in all areas of NSW
- the opportunities available to the people in all areas of NSW to attain their optimum level of personal development
- and the role of government in promoting the welfare of the people in all areas of NSW.

OPERATIONS OF THE COMMITTEE

Matters for inquiry may be referred to the Committee by resolution of the Legislative Council, a Minister of the Crown, or by way of relevant annual reports and petitions.

The Committee has the legislative power to:

- summon witnesses
- make visits of inspection
- call upon the services of government organisations and their staff, with the consent of the appropriate minister
- accept written submissions concerning inquiries from any person or organisation
- conduct hearings

ACKNOWLEDGMENTS

The Standing Committee on Social Issues wishes to record its appreciation for the many thoughtful written submissions and evidence received from members of the public, experts and a wide range of organisations, upon which this Report strongly relies.

The Committee's gratitude is also extended to the valuable advice and assistance which the Committee received throughout the Inquiry from representatives of the NSW Department of Health.

Mr Stephen Morrell, of the Department of Public Health, University of Sydney supplied the Committee with much of the data used to create many of the graphs contained in this Report. The Committee is extremely grateful to him.

The staff of the Parliamentary Library were, as always, helpful and resourceful to the Committee. In particular, the Committee wishes to give special thanks to Mr John Wilkinson, who prepared invaluable research material for this Report.

Finally, the Committee wishes to place on record its great appreciation to all those people who wrote or presented verbal evidence regarding the tragic loss to suicide of a loved one.

TERMS OF REFERENCE

SUICIDE IN RURAL NEW SOUTH WALES

That the Standing Committee on Social Issues inquire into and report on:

- the extent and nature of suicide in rural New South Wales;
- possible causes for the increase in suicides in rural New South Wales;
- the provision of relevant services; and
- strategies for the prevention of such suicides.

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CHAIRMAN'S FOREWORD

The Inquiry into Suicide in Rural New South Wales was a particularly challenging and complex one for the Standing Committee on Social Issues. Given the nature of the subject it was also distressing. Apart from the tragic loss of too many lives to suicide in rural areas, witnesses and submissions spoke of the hardships being experienced by rural communities today, in the wake of rural recession and devastating drought, and the ensuing stress, despair and depression of many people, including the young.

Far more than a job, farming and grazing have been a way of life, a culture handed down from generation to generation. Within the span of a single generation, that culture has been grievously damaged, and much of inland Australia is haemorrhaging its youth.

In spite of the tragedy and suffering, Members were inspired by the courage and determination of those who had lost loved ones to suicide, people who were willing to revisit painful events by speaking to the Committee, in the hope of assisting others.

This report addresses a range of issues relevant to suicide in rural areas. The Committee has adopted a broad approach to suicide, examining the issue from both a mental health and a social perspective. The Committee recognises that suicide is a relatively rare event but increases in the rates among certain groups in rural New South Wales means that effective preventative strategies must be established. Indeed, much of the decline in fatal motor vehicle accidents, which suicide deaths now exceed, has been as a result of constructive prevention campaigns.

Although this Inquiry has specifically examined suicide in rural New South Wales, strategies for prevention require collaboration between both Federal and State Governments, and the community sector. As the Committee heard, suicide, especially among our young people, is a problem which all Australians need to address.

As a society, we need to enhance our knowledge of all the possible causes that might lead a person to take his or her life; break down the stigma associated with mental disorder, psychological and emotional distress; provide people who do suffer such disorder or distress with appropriate services, and, I believe, learn to become more caring and compassionate.

My thanks are due to the Members of the Committee, who, as in past Inquiries, demonstrated strong commitment to dealing with the issues, a commitment to which the unanimity achieved in this report is strong testament. Given the rural

focus of this Inquiry, Members were required to attend numerous hearings, including frequent travel to country areas to hear testimony. In spite of their many Parliamentary responsibilities, Committee Members fulfilled these commitments.

The Committee staff have, as always, provided the professional support to make this report a reality. While Director Dr Jennifer Knight, Senior Project Officer Glen Baird and Committee Officer Annie Marshall all contributed, particular commendation must go to Senior Project Officer Alexandra Shehadie who carried the primary responsibility for this Report.

Last but not least, I would like to thank our courageous witnesses. Their contributions to the Report have been invaluable.

Hon Dr Marlene Goldsmith, MLC
Chairman

EXECUTIVE SUMMARY

This Report represents the results of an extensive Inquiry by the Legislative Council Standing Committee on Social Issues into Suicide in Rural New South Wales. The Inquiry was referred to the Committee by the Hon Ian Armstrong, MP, OBE, Deputy Premier, Minister for Public Works and Minister for Ports.

The Inquiry presented particular challenges to the Committee, both in terms of its extensiveness and in the sensitive nature of its subject matter. Further, the issue of suicide in rural New South Wales has only recently been the subject of detailed research and study, with specific literature on the topic being limited.

Traditionally, suicide has been a subject that is little discussed or, as has been the case in some families and communities, even acknowledged. The stigma associated with suicide, attempted suicide and mental illness generally, has meant that these issues have, for many decades, has been associated with intolerance, ignorance and prejudice. The Committee heard that, for rural areas especially, such matters have been compounded by the conservative and sometimes insular nature that has often characterised these communities. Tragically, the suicide of a family member has been a source of shame and guilt for many families.

In the course of its Inquiry the Committee received over 60 written submissions and heard testimony from over 80 witnesses in hearings conducted in Sydney, Lismore, Young, Parkes, Cobar, Broken Hill, Dubbo and Wagga Wagga. A briefing was also provided by a psychiatrist from South Australia by way of a teleconference, pioneering the use of this technology for the Parliamentary Committee process in New South Wales.

The Committee acknowledges that many communities in rural New South Wales, like many other such communities throughout Australia, have experienced enormous hardship, both financial and social, in recent times. The Committee has been told that much of this has been as a result of rural adjustment and the subsequent rural recession as well as the devastating drought. Since the Inquiry began, the Committee has heard of the increased demoralisation and despondency among many farmers and farming families.

Chapter Two of the Report examines the situation of rural communities today, including population migrations, issues relating to banks, the Rural Adjustment Scheme and the services provided by rural counsellors. A number of recommendations relating to these issues are detailed in Chapter Two, including those that relate to the facilitation of the mediation scheme between banks and

farmers, farmers' applications to the Rural Adjustment Scheme and the continuation of funding and support for rural counsellors.

It is against the backdrop of the experiences of rural communities that the Report examines the issue of suicide and the reasons for the increase in suicides among certain groups.

In recent years there has been increasing concern about the high levels of suicide in Australia, particularly by young people. Among this group Australia has one of the highest suicide rates in the industrialised world. Completed suicide is largely a male phenomenon; females, however, have higher rates of attempted suicide. The report will explore this issue.

Recent research has shown that the most marked increases in suicide in New South Wales have occurred among young males in rural areas, especially the smaller and remote centres. Further research has indicated that rates of suicide among farmers and related workers have also increased in New South Wales.

Chapter Three examines statistics on suicide, particularly in relation to the situation in New South Wales. That Chapter also considers the various methods used in suicide among people in rural areas. The data provided show that, although there is a discernible overall decline in firearms as a method of suicide, it nevertheless remains the most common method among rural males. Dudley *et al.'s* research demonstrates that among young males in remote regions of the state, firearm suicides have increased. The Committee's investigations also reveal that overall, hanging as a method of suicide in rural areas has shown a marked increase in recent times.

Having reviewed the available data, Chapter Three recognises that suicide is both a national and state problem that requires collaboration between both jurisdictions on data collection. This issue is further examined in Chapter Four.

Chapter Four examines the factors associated with suicide, especially in rural areas and explores the possible reasons for the increase in suicides among certain groups in rural communities. Research reveals suicide to be a complex problem that generally involves a number of factors.

This Chapter examines the issue of suicide from both a mental health perspective and from a sociological and psychosocial perspective. In considering the evidence and the research the Committee recognises that recent or prolonged mental illness can play a crucial factor in a person's decision to suicide. It also considers that mental illness may be a result of a number of factors including those that are biological and genetic and those that are related to environmental or external

influences. These issues are further explored in relation to the experience of rural communities.

Chapter Four considers the possible influence of a number of social factors on suicide rates including the rural recession, unemployment, the impact of the drought, isolation, "rural culture", family and relationship issues, alcohol and other substance abuse, access to methods, violence, issues relating to gender and sexuality, loss and bereavement and the influence of the media. The effect of these factors on feelings of hopelessness, helplessness, despair, stress and anxiety, and their impact upon suicide risk is examined in detail.

In the final section of the Chapter social and psychosocial factors are considered in relation to the reasons for the possible increases in suicide in rural communities.

The Committee recognises that isolating specific and definitive causes of suicide can be extremely complex. Although identifying a range of factors brought to its attention as being significant to suicide, it recommends that there be further research undertaken both at a national and state level, including the establishment of a National Centre for Suicide Research, to enhance society's understanding of the problem.

The Committee also recommends that the Minister for Health urge the Australian Health Ministers' Council to develop a national database for the collection and analysis of the incidence and prevalence of suicide and attempted suicide. It also recommends that there be established in New South Wales a register that will provide suicide and attempted suicide data to the agency responsible for coordinating the national database.

Chapter Five explores strategies for the prevention of suicides in rural New South Wales, including the provision of relevant services. At the outset the Committee recognises that suicide issues must be accorded priority within the Government and therefore recommends that a senior position be created within the Department of Health to liaise with the proposed National Centre for Suicide Research, undertake relevant research and develop appropriate initiatives and strategies for prevention of suicide, giving priority to rural communities.

The Committee acknowledges that community education is a major component of any strategy which aims to raise awareness of the issue of suicide and mental health. The Committee recognises that enhancing the public's awareness about this issue can contribute to suicide prevention. The Committee notes that a national community education strategy (Communications Strategy for Mental Health), focusing on breaking down the stigma of mental illness, is soon to be developed, and is supported by the NSW Department of Health. The Committee strongly

supports this initiative and has recommended that rural communities be targeted as a priority within the strategy.

The Committee also recognises that education about, and identification of, suicide risk is also fundamental to suicide prevention. It therefore recommends that relevant education programs be developed for those likely to come in contact with vulnerable people. Among those who the Committee considers should participate in these programs are professionals such as general practitioners, teachers, social workers, youth workers, as well as members of the clergy, community workers and community members. This should be in addition to public education campaigns.

As the Committee's investigations have revealed, local initiatives in the area of suicide awareness and prevention are important in empowering and educating communities about the issue of suicide. The Committee therefore recommends that the establishment of local Suicide Prevention Taskforces throughout New South Wales be encouraged. It envisages that the proposed senior officer will also act as the Coordinator of these Taskforces and assist in the exchange of information among them.

Access to methods of suicide is a matter that has been seriously considered by the Committee. Evidence received indicated that the issue of firearms in particular is of major concern in this regard, given their greater accessibility in rural areas, compared with urban areas. The Committee endorses the establishment of a Firearms Advisory Committee and recommends that it have broad representation. The Committee further recommends that the Firearms Advisory Committee examine a range of issues relevant to firearm accessibility, ownership and use, firearm ownership and mental illness, and the development of education campaigns about gun safety and suicide risk, especially in relation to rural areas.

As the data indicate, hanging as a method of suicide in rural areas has increased. Little research was available to the Committee to explain this phenomenon. As such, the Committee recommends that further study be undertaken in this area, including the exploration of possible strategies for prevention.

Evidence was also received concerning the ease of access of certain prescription drugs such as Rohypnol and other benzodiazepines and the packaging of certain medications such as antidepressants. Given that poisoning by way of drug overdose is a common method of suicide and attempted suicide among women, including in rural areas, the Committee recommends that the Minister for Health urge the Australian Health Ministers' Council to investigate the ease of prescriptions of these drugs and the classification and packaging of antidepressants as a means of suicide prevention. It also recommends that the issue of health warnings on certain medications, including paracetamol, be examined.

Chapter Five extensively examines the provision of mental health services to people in rural communities. The Committee recognises that traditionally, mental health services have been limited in rural regions with clients having to travel vast distances to access them.

In this Chapter, the Committee acknowledges recent funding increases by the Minister for Health for mental health services, including for those in rural New South Wales. It endorses these increases and recommends that the Minister remain accountable for the equity of the provision of mental health services throughout the state. The Committee also recommends that, in light of the recent funding increases, the mental health needs of rural people continue to be evaluated and addressed at least biennially.

The Committee heard throughout the Inquiry of the limited number of psychiatrists practising in rural areas. To address this problem the Committee recommends that incentives be developed to encourage more psychiatrists to practise in these regions and further, that district mental health services continue to develop psychiatric outreach services. It also recommends that liaison psychiatry services continue to be enhanced to ensure that mainstream health professionals in rural areas are able to consult about the mental health care of clients, including young people. Having had the benefit of viewing a telemedicine conferencing facility, the Committee recommends that this technology be utilised as a means of assessing mentally ill clients as well as training mental health workers in rural and remote regions. The Committee does not however, recommend that telemedicine conferences be used as an alternative to psychiatric treatment.

Throughout the Inquiry the Committee received testimony from families and friends of victims of suicide (known as survivors) in rural areas. Some of these people related difficulties in accessing bereavement counselling in spite of the fact they themselves felt suicidal following the death of their loved one. Accordingly the Committee recommends that district health services, in collaboration with appropriate community organisations, develop bereavement counselling services for family members and friends of suicide victims. It also recommends that the proposed senior officer and the local Suicide Prevention Taskforces encourage the establishment of local suicide support groups in rural areas.

The Committee's investigations have revealed that suicide and attempted suicide among Aboriginal people, especially in rural areas, have traditionally been underestimated. Misclassification of deaths, incorrect racial identification of a deceased, and, in the case of attempted suicides, a reluctance among Aboriginal people to access what are considered essentially non-Aboriginal services, have been identified as possible reasons for this underestimation. Nevertheless evidence received by the Committee has suggested that suicide and attempted suicide rates

among Aboriginal people in rural New South Wales are at least as high or even higher than among non-Aboriginal people.

The Committee heard that the general issue of mental illness among Aboriginal Australians is complex. The Royal Commission into Aboriginal Deaths in Custody found that the prevalence of major mental disorders among Aboriginal people is at least as high as among non-Aboriginal people. The Committee further heard that mental illness and psychological distress among Aboriginal people cannot be seen in isolation from other factors such as dispossession of land, systemic racism, substance abuse and ongoing social and economic disadvantage.

The Report acknowledges the recent funding increases to Aboriginal mental health from the Minister for Health, some of which will impact upon rural areas of New South Wales. Whilst endorsing the funding increases and recommending their swift implementation, the Committee also recommends that the mental health needs of Aboriginal people in rural and remote areas be evaluated and addressed at least biennially, and within a culturally appropriate framework. The Committee received evidence of the need for non-Aboriginal health workers, including mental health workers, to be educated on issues relevant to Aboriginal culture. Accordingly, the Committee recommends that an ongoing, accessible and mandatory education and training program that includes Aboriginal cultural awareness, be developed for those non-Aboriginal mental health workers, especially in rural areas, who are likely to come into contact with Aboriginal clients.

In conclusion, the Committee hopes that recognising and understanding the problem of suicide and mental health issues, improving data collection, appropriately resourcing services and addressing the issue of access to the means of suicide, in a framework of ongoing collaboration between government and the community, will significantly impact on the levels of suicide in our rural sector.

RECOMMENDATIONS

RECOMMENDATION 1

That the Minister for Agriculture and Fisheries and the Minister for Consumer Affairs:

- **urge banks to mediate with farmers as soon as it becomes evident that financial hardship is occurring and not at the point of foreclosure; and**

- **continue to urge banking organisations to make reasonable allowances for the repayment of loans by viable farmers experiencing financial hardship as a result of the rural downturn and current drought.**

RECOMMENDATION 2

That the Minister for Agriculture negotiate with the Federal Minister for Primary Industries and Energy to ensure that the operation of the Rural Adjustment Scheme maximises positive and swift responses to farmers' applications.

RECOMMENDATION 3

That the Minister for Agriculture and Fisheries, in liaison with the Federal Minister for Primary Industries and Energy, ensure that funding for rural counsellors continue and that there be developed sensitive and locally-based campaigns to publicise the services provided by rural counsellors for farming families.

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.**

RECOMMENDATION 6

That a senior position be created within the Mental Health Branch of the New South Wales Health Department to deal with issues of suicide and suicide prevention and that appropriate resources be available to the designated officer to undertake his or her duties.

RECOMMENDATION 7

That the duties of the Senior Officer referred to in Recommendation 6 be:

- **to liaise and consult with a range of relevant departmental, professional, community and rural representatives on issues relevant to suicide prevention;**

- **to liaise and consult with the proposed National Centre for Suicide Research;**

- **to monitor suicide rates (including suicide attempts) throughout the state;**

- **to develop and implement strategies and initiatives for suicide prevention;**

- to monitor the outcomes of suicide prevention strategies and initiatives;
- to act as State Coordinator for local and regionally-based Suicide Prevention Taskforces (see Recommendation 21); and
- to undertake relevant research.

RECOMMENDATION 8

That the Senior Officer referred to in Recommendation 6 monitor the effects of the following factors on suicide rates in New South Wales: mental illness, unemployment, poverty, financial pressure and the rural crisis, isolation, family and/or relationship breakdown, violence, alcohol and substance abuse, drought, issues relating to sexuality, the media, loss, issues affecting Aboriginal people and any other relevant social factor and, in consultation with relevant Government and non-government groups and professionals, as well as the proposed National Centre for Suicide Research (Recommendation 5) develop appropriate strategies, the outcomes of which are to be routinely monitored.

RECOMMENDATION 9

That the Minister for Health urge the Australian Health Ministers' Council to ensure that the interests and needs of rural people, including farmers, young people, people living in remote communities and Aboriginal people, are included as a priority in the proposed National Community Education Strategy on raising awareness of and reducing the stigma associated with mental disorders.

RECOMMENDATION 10

That the Minister for Health ensure that the New South Wales component of the National Community Education Program aimed at raising awareness of mental disorders targets rural communities as a priority, including farming communities, young people, people living in remote areas and, in consultation with Aboriginal organisations and Aboriginal communities, Aboriginal people of New South Wales. Issues relevant to suicidal risk

behaviour, such as depression, should be addressed in that strategy, and information about relevant support services, as well as the encouragement to utilise those services, should be provided.

RECOMMENDATION 11

That the Minister for Health, in consultation with the Australian Press Council, urge media organisations to continue to report any matters relating to suicide in a responsible and non-sensational manner.

RECOMMENDATION 12

That the Minister for Police and Emergency Services convene, as a matter of urgency, the Firearms Advisory Committee to advise him on issues relevant to firearms.

RECOMMENDATION 13

That the Minister for Police and Emergency Services ensure that representation on the Firearms Advisory Committee be broad based, including for example, representatives of sporting shooters, the farming community, the police service, proponents of gun control, experts in domestic violence, health professionals and victims groups.

RECOMMENDATION 14

That the Minister for Police and Emergency Services ensure that the tasks of the Firearms Advisory Committee include the following:

- **an examination of the recommendations of the Cabinet Office Discussion Paper on Mental Illness and Firearms Misuse;**
- **an examination of the need for full and proper training in safe firearm use before a person may obtain a firearm licence and the inclusion in that training program of a compulsory suicide awareness component;**

- the development of a specific, accessible and ongoing community education program which examines the dangers of firearm misuse, and which targets as a priority, rural areas of New South Wales. Awareness of the possibility of suicide risk and firearm accessibility, especially among young people, should be emphasised in this education program;

- an examination of the effectiveness of Section 12 of the Firearms Act, 1989, (as amended by the Firearms Legislation (Amendment) Act, 1992) relating to the safe keeping of firearms and ammunition, especially in relation to rural areas; and

- an examination of the Western Australian firearm licensing system.

RECOMMENDATION 15

That the Minister for Agriculture and Fisheries develop, as a matter of urgency, an assistance scheme for farmers, to enable farmers to utilise the services of the Department of Agriculture when disposing of their stock.

RECOMMENDATION 16

That the Minister for Health raise with the Australian Health Ministers' Council, as a means of suicide and attempted suicide prevention, the need to investigate the packaging and classification of, and the health warnings on, certain medications, including antidepressants, and the ease of gaining prescriptions for medications particularly benzodiazepines.

RECOMMENDATION 17

That the proposed Senior Officer referred to in Recommendation 6, in collaboration with the proposed National Centre for Suicide Research (see Recommendation 5), investigate the causes for the increase in suicide deaths by hanging, especially in rural areas.

RECOMMENDATION 18

That the Minister for Health, the Minister for Education, Training and Youth Affairs and the Minister for Community Services, in consultation and collaboration with relevant suicide awareness education and training organisations:

- **develop a state-wide, ongoing program of suicide awareness education and training for relevant professionals, including primary care providers, and community members, targeting rural areas of New South Wales; and**
- **develop appropriate strategies to encourage a wide range of professionals and community members throughout rural New South Wales to attend the programs.**

RECOMMENDATION 19

That the Minister for Education, Training and Youth Affairs, in collaboration with the Minister for Health, introduce a component into the Personal Development, Health and Physical Education strand of the Years 7 - 10 curriculum that addresses issues specifically relating to mental health. The topics to be canvassed in that course should include:

- **the identification of depression;**
- **the destigmatisation of mental disorders;**
- **the enhancement of coping skills;**
- **seeking out help; and**
- **drug and alcohol issues.**

RECOMMENDATION 20

That the Minister for Health and the Minister for Education, Training and Youth Affairs conduct a review and evaluation of the effectiveness of

suicide prevention programs that specifically target school students in New South Wales.

RECOMMENDATION 21

That the Minister for Health encourage communities in the establishment of local Suicide Prevention Taskforces throughout the New South Wales Department of Health Districts, with particular emphasis on those rural areas where suicide rates are high. The Taskforces should be made up of a wide range of relevant professionals, including general practitioners, nurses, hospital personnel, teachers and school counsellors, as well as community, business and church representatives. Where there is an apparent need, Taskforces are to give particular emphasis to the identification of risk factors among young people.

RECOMMENDATION 22

That the aims and objectives of Suicide Prevention Taskforces be developed by local communities and may include the following:

- acting as an information resource centre;
- offering education for suicide awareness;
- offering appropriate referral;
- liaising with other relevant organisations; and
- developing community initiatives for suicide prevention.

RECOMMENDATION 23

That, as part of the role in developing and implementing suicide prevention strategies and initiatives, the Senior Officer referred to in Recommendation 6 act as coordinator for local Suicide Prevention Taskforces and:

- facilitate the exchange of information, ideas and initiatives among local Taskforces;

- provide, or where necessary, assist in the provision of, relevant training as required;
- allocate funding grants for the realisation of Taskforce initiatives and monitor the outcomes of these initiatives;
- travel to rural areas to meet and discuss relevant issues with local Taskforces; and
- provide support for Suicide Prevention Taskforces throughout the state.
- act, where necessary, as a Taskforce representative to remote areas.

RECOMMENDATION 24

That the Minister for Health ensure that there be equity in the provision of mental health services across the state.

RECOMMENDATION 25

That the Minister for Health ensure that the goals and strategies for Rural Mental Health Services, outlined in the NSW Government response to the Human Rights and Equal Opportunity Commission Report into the Human Rights of People with Mental Illness and the mental health initiatives put forth in the specific budget package for Mental Health Services in New South Wales, especially those relating to people living in rural areas, are implemented as soon as possible and as a matter of priority.

RECOMMENDATION 26

That the Minister for Health, in collaboration with other relevant Ministers and non-government organisations, ensure that the mental health needs of people in all rural areas of New South Wales continue to be evaluated and addressed at least biennially. Special attention should be given to the needs of those in remote regions, young people and farmers.

(In evaluating and addressing the mental health needs of people in rural areas regard should be had to the following issues as proposed by the NSW Health Department, namely that each community in New South Wales should be able to offer:

- **counselling services in employment, unemployment and education settings;**
- **non-judgemental health services that are easily accessed;**
- **access to 24 hour information and a referral system for mental health issues;**
- **a health and welfare workforce trained in suicide prevention; and**
- **support groups for people bereaved by suicide.)**

RECOMMENDATION 27

That the Minister for Health ensure that the goals and strategies for child and adolescent Mental Health Services, particularly those which are relevant to rural young people and outlined in the NSW Government response to the Human Rights and Equal Opportunity Commission Report into the Human Rights of People with Mental Illness, and the initiatives for child and adolescent mental health contained in the specific budget package for Mental Health Services are implemented as soon as possible and as a matter of priority.

(Among the goals to be implemented are that the NSW Health Department:

- **provide $1.2 million a year to fund services for vulnerable families with young children and adolescents;**
- **expand specialised child and adolescent mental health services in rural areas;**
- **undertake research to improve cross-agency management and support for children of parents with mental illness or personality disorders;**
- **fund non-government organisations that assist children with mentally ill parents;**

- co-ordinate child care for children with mentally ill parents; and
- develop a police youth strategy which specifically includes young people with a mental illness).

RECOMMENDATION 28

That the Minister for Health ensure that the mental health needs of young people in all rural areas throughout New South Wales, including those in remote regions, continue to be evaluated and addressed at least biennially. In meeting this recommendation consultation with those government and non-government organisations which specifically target young people should take place.

RECOMMENDATION 29

That the Minister for Health:

- in collaboration with the Royal Australian and New Zealand College of Psychiatrists, develop incentives to encourage psychiatrists to establish practices in rural areas of New South Wales;
- ensure that health services throughout New South Wales continue to develop outreach psychiatric services for people, including children and adolescents, living in rural and remote regions; and
- continue to enhance liaison psychiatry services to ensure mainstream health professionals in rural areas are able to consult about the mental health care of clients, including young people.

RECOMMENDATION 30

That the Minister for Health develop a network of telemedicine conference facilities to contribute to psychiatric and other specialist mental health services to people living in rural and remote areas who have a psychiatric disorder. The telemedicine facilities would be used for assessments and

consultations for the psychiatrically ill and for training and education of relevant workers in rural and remote areas.

RECOMMENDATION 31

That the Minister for Health ensure that bereavement counselling services are available, through the area and district mental health services, to family members and friends of those who have suicided. Such services are to be developed collaboratively with appropriate community organisations and the district health services.

RECOMMENDATION 32

That the Senior Officer referred to in Recommendation 6, along with local Suicide Prevention Taskforces (see Recommendation 21) encourage the establishment of suicide support groups in rural communities where there is an identifiable need.

RECOMMENDATION 33

That the Minister for Education, Training and Youth Affairs urge principals of rural schools, in consultation with teachers, school counsellors and relevant community organisations, to develop Critical Incident Management Plans relating to suicide.

RECOMMENDATION 34

That the Minister for Health ensure that the goals and strategies for Aboriginal Mental Health Services, outlined in the NSW Government response to the Human Rights and Equal Opportunity Commission Report into the Human Rights of People with Mental Illness and the initiatives for Aboriginal mental health contained in the specific budget package for Mental Health Services are implemented as soon as possible and as a matter of priority.

(Among the goals to be implemented are that the NSW Health Department:

- **dedicate 1% of the global health budget to Aboriginal health needs;**
- **expand services for Aboriginal and Torres Strait Islanders by employing more Aboriginal hospital liaison workers and at least 20 extra Aboriginal mental health workers, including rural areas of New South Wales;**
- **develop liaison programs in key areas of the state, including rural areas of New South Wales;**
- **offer mental health training to Aboriginal health workers throughout rural areas of New South Wales; and**
- **establish the Aboriginal Health Education and Applied Research Centre at Prince Henry Hospital).**

RECOMMENDATION 35

That the Minister for Health ensure that the mental health needs of Aboriginal people, particularly those in all rural and remote areas of New South Wales, continue to be evaluated and addressed, at least biennially within a culturally appropriate framework.

RECOMMENDATION 36

That the Minister for Health, in consultation with relevant Aboriginal organisations and Aboriginal mental health workers, develop an education and training program for non-Aboriginal mental health workers, including those in rural New South Wales, to address Aboriginal cultural awareness and other relevant issues. Such a program should be mandatory and conducted at reasonable times for all Departmental non-Aboriginal mental health workers who are likely to come in contact with Aboriginal clients.

GLOSSARY

Benzodiazepine Drugs

A group of drugs, known as minor tranquillisers which have the capacity to reduce anxiety and are sometimes hypnotic in effect. These drugs include chlordiazepoxide (Librium), diazepam (Valium) and flunitrazepam (Rohypnol).

Depression

A mood disorder or disturbance. Depressive illness is characterised by feelings of intense sadness, despair, despondency, hopelessness, anxiety and guilt. Things formally felt to be pleasurable are no longer so. Depression causes sleep disturbances, loss of appetite, fatigue and reduced sexual desire. It can be endogenous (biological) or exogenous (reactive).

The National Mental Health and Research Council observes that depression may take many forms, ranging from the severe syndromes of uni and bipolar illness, which are relatively less frequent, to the much more common forms of depressive disorders, resulting from adverse experience or significant loss.

Endogenous

Literally, this term refers to something arising from within. In mental health terms it refers to a disorder in which genetic or biological in nature factors may be pre-determinant.

Exogenous

Literally, this term means growing or originating from outside. In mental health terms it refers to a disorder that can be precipitated by, develop from or be influenced by external or environmental factors.

Prevention

. **Primary**	Primary prevention aims at creating conditions that build a state of health and well-being for everyone.
. **Secondary**	Secondary prevention refers generally to the intervention strategies that are put in place at the earliest signs of a problem or whenever a person or group is identified as 'at risk', thus reducing the likelihood of the development of ill-health.
. **Tertiary**	Tertiary prevention refers to the prevention of people "getting sick again" and its purpose is to rehabilitate, reconstruct and treat. Tertiary services are specialist health services, such as mental health services.
Rural	For the purpose of this study, rural refers to all those areas of the state that do not include the Sydney, Newcastle and Wollongong statistical sub-divisions.
Postvention	Action that is taken after a suicide, to prevent further suicides occurring among those who may have been aware of the deceased and his or her suicidal actions.
Schizophrenia	A major psychiatric disorder, the essential features of which can include psychotic symptoms during the active phase of the illness and impaired functioning. At some point in the illness there may be delusions, hallucinations, or certain other disturbances affecting thought processes and perception.
Suicide Attempter	A person who has attempted suicide.

Suicide Survivor	A survivor of suicide is a person who has had someone significant in their lives commit suicide. Rose Education observes that a survivor can be an entire school if a student from that school dies by suicide, or an entire community if the community is small and the person well known.
Submissions	Written or video material supplied to the Committee by individuals and organisations containing the authors' views in relation to the Inquiry.
Witnesses	People summonsed by the Committee to give evidence at formal Hearings concerning the Inquiry. Witnesses can also refer to people who are invited to brief the Committee on issues pertinent to the Inquiry.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND TO THE INQUIRY

On 22 March, 1994, the Standing Committee on Social Issues resolved to adopt Terms of Reference for an Inquiry into Suicide in Rural New South Wales.

The Terms of Reference for the Inquiry are that

The Standing Committee on Social Issues inquire and report on:

- *the extent and nature of suicide in rural New South Wales;*
- *possible causes for the increase in suicides in rural New South Wales;*
- *the provision of relevant services;*
- *strategies for the prevention of such suicides.*

The Inquiry into Suicide in Rural New South Wales was referred to the Committee by the Hon Ian Armstrong, MP, Deputy Premier, Minister for Public Works and Minister for Ports. It originally stemmed from his concern over the marked escalation in the number of suicides, particularly among young males within the specific region bounded by the local governments of Boorowa, Harden, Young, Cootamundra, Temora, Wyalong, Condobolin, Forbes and Parkes. After some preliminary research, most of which is contained in the Committee's Issues Paper, Violence in Society, it was determined that the issue of rural suicides be considered in relation to New South Wales country areas as a whole.

This Report is the result of that Inquiry.

During the Inquiry the Committee received 60 submissions and heard testimony from 88 witnesses. Evidence was taken in Parliament House, Sydney, as well as in Lismore, Young, Parkes, Cobar, Broken Hill, Dubbo and Wagga Wagga. In those country centres some witnesses travelled from outlying and remote regions to give evidence to the Committee. The Committee also received a briefing by way of a teleconference both as a means of hearing from an interstate expert and viewing the technology.

During its hearings, the Committee sought evidence from a range of people. Among them were senior Health Department officers, psychiatrists, psychologists, social workers, academics, rural counsellors, farmers, representatives of rural women's groups, general practitioners, coroners, police officers, school teachers, school students, members of the clergy and numerous community members who had formed local groups and developed local initiatives to address the incidence of suicide and attempted suicide in their regions.

The Committee also heard evidence and received submissions from bereaved parents, spouses and relatives whose child, spouse, sibling or relation had suicided. The willingness of these witnesses in particular to relate their experiences, in spite of their considerable grief and loss, is something for which all Members of the Committee are extremely grateful. Indeed, much of their evidence provided some of the most powerful testimony received by the Committee.

From the outset, this Inquiry presented particular challenges to the Committee. Few studies to date have directly addressed the issue of suicide in Rural New South Wales within such a broad context as that required by our Terms of Reference. Some studies that have examined the issue have essentially done so from local perspectives; that is, they have looked at the experiences of a specific town or region. Other studies have outlined the issue of suicide in general reports relating to the health and welfare of rural communities.

The most extensive study to date has been that undertaken by Dr Michael Dudley, Professor Brent Waters, Mr John Howard and Mr Norman Kelk (1992) who examined suicide trends among young people in urban and rural areas. The preliminary findings of that study will be referred to throughout this Report. Suffice to say at this point, that the authors have found that the incidence of suicide among young people in country regions of New South Wales has increased at significantly higher rates than that among their urban counterparts.

Recently, Associate Professor Burnley published the findings of his study Differential and Spatial Aspects of Suicide Mortality in New South Wales and Sydney, 1980 to 1991 that examined, among other issues, suicide in rural areas of New South Wales and suicide among certain occupational groups including farmers and related workers. That study will also be referred to throughout the Report.

It is beyond doubt that any suicide is a terrible tragedy. For Australia as a whole, that tragedy is clearly borne out by the fact that as a nation we have one of the highest suicide rates among young people in the Western world.

Although it is recognised that suicide is still a relatively rare event in comparison to say, death by cancer (although it is high in comparison to murder),

> *for the younger age groups which have low levels of mortality, the suicide rate of 16 per 100,000 population, competes with road accidents as the leading cause of death* (ABS, 1994:55).

Raphael (1994:3) further notes that

> *it is nevertheless clear that suicide itself is a major cause of death in Australia and also a major cause of preventable mortality... Differential and rising rates in young males are a cause of great concern and point to the need for research to urgently focus on understanding the aetiology of these rises, and implementing [specific] as well as general prevention measures. Such approaches need however to be set in the context of tackling the problem of suicide for all age groups, and the issues for women as well as men.*

1.2 DEFINING "RURAL"

The discussion in the following chapters will describe how rural Australia has undergone considerable change over the last few decades, often resulting in a transformation of the character and needs of many country communities. Thus, some commentators (Rolley and Humphreys, 1993:243, citing Dunleavy, 1982)) maintain, that it is no longer possible to differentiate urban from rural since "economic and social systems characterising rural areas have become remoulded along the same lines as the rest of society."

Nevertheless, the Committee notes that there are fundamental differences which do set rural communities apart from urban centres. It has been observed for instance, that

> *despite their diversity, the hallmark of rural areas in Australia is typically large distances, inaccessibility, and low population thresholds which operate to constrain human activities and levels of well-being* (Rolley and Humphrey 1993:243).

The Committee also notes that, unlike urban areas, a major feature of rural regions is their involvement in, and reliance upon primary production, such as agriculture, mining, forestry and fishing (Epps and Sorensen, 1993:2).

For the purposes of this Inquiry the Committee has defined "rural" to include all areas of New South Wales, **except** the Sydney statistical division (including the Blue Mountains and Gosford), the Newcastle statistical sub-division and the Wollongong statistical sub-division.

1.3 DEFINING "SUICIDE"

According to Shneidman (1985:203), suicide is

> *a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which suicide is perceived as the best solution.*

Kosky *et al.* (1992:97) further observe that

> *suicidal behaviour can be interpreted as a manifestation of distress associated with loss or abandonment, a release from despair, an expression of hostility or revenge, an appeal for help, a wish to test fate or to be reunited with a loved one, or a response to the disordered thinking of a psychotic illness or drug intoxication.*

The "multidimensional" nature of suicide means that attempting to pinpoint an *exact* cause for a suicidal event can become particularly complex. As the Report will demonstrate, there are many issues and factors, often interacting, that can lead a person to suicide.

Following the enactment of the Crimes (Mental Disorder) Amendment Act, 1983, suicide and attempted suicide are now no longer criminal offences in New South Wales. Further, since the introduction of the Coroners Act, 1980,

> *it is no longer necessary for an inquest to be held in all cases of suicide... Where the inquest is dispensed with the death is classified by the court staff who examine the evidence and decide whether the death is a suicide or some other category of death such as accidental death* (NSW Bureau of Crime Statistics and Research, 1990:1).

In his evidence to the Committee, State Coroner, Mr Greg Glass (Evidence, 9 May, 1994) stated that

> *any death which is an apparent suicide must be reported to the Coroner... [however]... If he comes to the view that there are no suspicious*

> *circumstances, and... [the family]... do not press for an inquiry... he has power to dispense with an inquest.*

Evidence presented to the Committee has indicated that some events, such as fatal single occupant motor vehicle accidents, especially those which occur at night and on country roads, and some drug overdoses may in fact be suicides. Because it is often difficult in these instances to conclusively distinguish between suicide and accidental death, it has been suggested that the actual number of suicides reported and recorded may be underestimated.

The Committee has also heard that suicidal behaviour may take an indirect or more subtle form than the obvious instances of deliberate self-harm. Anorexia nervosa, alcohol and other substance abuse, and engaging repeatedly in risk-taking behaviour, have been cited as possible examples of suicidal activities.

Because of the multifaceted nature of suicide the study of suicidal behaviour can cross different disciplines. Sociology, psychiatry and biology can all be relevant in the study of suicide and suicidal behaviour. The influence of the sociological study of suicide has been recognised by Maris (1992:2111) who states that

> *sociology itself grew out of Emile Durkheim's argument that suicide rates are social facts and reflect variation in social regulation and social interaction.*

Freud and later Menniger emphasised the importance of the psychoanalytic approach to the study of suicidal behaviour and argued that all suicides are

> *based on hate or revenge (a wish to kill); on depression, melancholia or hopelessness (a wish to die); or on guilt or shame (a wish to be killed)* (Maris, 1992:2111).

As Dr Michael Dudley (Evidence, 10 February, 1994) told the Committee in his evidence,

> *suicide is a complex problem... This matter requires a psychiatric analysis but also requires a sociological and cultural analysis... This matter certainly requires that type of analysis in the rural setting.*

The Committee notes that, with the differing approaches to the study of suicidal behaviour, there can be debate as to the *source* of many of the factors associated with suicide. Some argue that suicide is essentially a health issue, the major cause being psychiatric illness. Others, however, argue that suicide is a social malaise and has links with such factors as unemployment, poverty and deprivation, family breakdown, violence and substance abuse. According to this latter view, those

issues cause a person to suffer depression, feelings of hopelessness and low self-esteem, and consequently put some at risk of suicide. In a recent article, Professor Brent Waters addressed this issue in relation to young people specifically, and suicide. He argued that

> *those who espouse a strong psychiatric diagnosis point of view are focusing mainly on the person's emotional state immediately prior to the suicide. Those who have a social science perspective are usually focussing more on how the young person's life had unfolded in the months and years prior to the suicide and what can be done to prevent the same happening to other young people* (Waters, 1994:5).

In his evidence to the Committee, Professor Waters (Evidence, 26 April, 1994) further commented that,

> *I think it is really more a problem with terms than anything else. There is a small proportion of young people [for instance] who kill themselves who have what everyone would agree is a mental illness. They have got schizophrenia or they have got manic depression. They are really in the minority. The studies show very clearly that the vast majority of people who suicide, when you get information from their family... were hopeless, worthless, run down, depressed... Now the whole debate revolves around whether depression is a mental illness, with capital letters, which you treat with drugs and that sort of thing or whether it is a social malaise. But I do not think anyone argues about whether they are depressed... it takes a particular mind set to feel that trapped.*

In recognising the multidisciplinary nature of the study of suicide and suicidal behaviour Hassan (1992:14) observes that there needs to be *integration* of data from psychiatry, psychology, biology and sociology to advance society's understanding of this complex problem.

1.4 SCOPE OF THE REPORT

The following discussion will demonstrate that suicide in any community, be it urban or rural, is a complex issue that requires the careful development and implementation of practical and sensitive initiatives and strategies. Initially, Chapter Two will provide a brief overview of the experiences of many rural communities today, including an examination of the effects of rural adjustment, the rural downturn and the drought.

In Chapter Three the Report will present a statistical analysis of suicide rates firstly Australia wide and then in relation to rural areas of New South Wales. Some comparison of suicide rates in rural and urban areas will also be given. The Chapter will also provide data on suicide methods in rural areas.

Chapter Four will examine the factors associated with suicide. In this section the Committee will look at the issue firstly from a mental health perspective and then from a social, economic and cultural perspective. The Chapter will highlight specifically these issues in light of the experiences of rural communities. In presenting all of the issues contained in Chapter Four the Committee will emphasise that no one factor contributes to suicide nor can all suicides *always* be explained simply as resulting *either* from a mental illness *or* from purely social, economic and cultural factors. As Chapter Five will show, further research needs to be developed and resourced to enhance society's understanding of the tragedy of suicide.

Chapter Five will also examine the issue of mental health services in rural areas. Throughout the Report appropriate recommendations will be made that will serve to guide Government policy on the issue of suicide prevention, particularly in rural regions.

The Committee recognises that suicide prevention must be considered at a national level. This issue is examined in Chapters Four and Five. However, it also considers that much can be done at a state level, for rural communities as well as urban centres, to assist in both the reduction of suicide rates and in the minimisation of risk factors.

CHAPTER TWO

A PROFILE OF RURAL COMMUNITIES IN CHANGING ECONOMIC TIMES

2.1 ECONOMIC CHANGES IN THE RURAL SECTOR

In recent decades, rural New South Wales has undergone considerable change, socially, economically, demographically and culturally. Such change is part of a greater trend occurring throughout the Australian rural sector as a whole. According to Sorensen and Epps (1993:30),

> *the types and proportions of goods and services produced in many localities or towns are rapidly changing. Recreational and residential uses of the countryside are also expanding rapidly in some localities to supplement or displace traditional uses. Some rural areas witness declining production of rural commodities while others experience rapidly expanding output. Other places are quarantined altogether from human interference. As a consequence of these processes, there is a substantial movement of people within rural Australia from less favoured localities to those that offer better employment or quality of life prospects. Many of these changes are bound up with progressive internationalisation of the Australian economy. We are getting to the stage where the future of rural areas depends significantly on the decisions of foreign investors over this, that or the other feedlot, abattoir, mine smelter, holiday resort or golf course.*

Farming and agriculture for instance, once considered the "very backbone" of Australia, particularly rural Australia, have undergone a number of fundamental changes. Wilkinson (1994) notes that contributing to these changes is the fact that during the 1950 - 1970 period the position of agriculture in overall world trade began its decline. He observes that agricultural produce had formed 45% of world trade in 1913, falling to 36% by 1953 and 21% by 1973 (Wilkinson, 1994:4-5). The author further highlights that the development and wider use of synthetic fibres had an enormous impact on the Australian wool-growing trade and concludes that

> *prices, and profits from rural production overall, most of which was exported, began to drop* (Wilkinson, 1994:5).

Moreover, the expansion of the role played by other sectors such as manufacturing, financial services and mining significantly impacted upon the importance of the

rural sector in relation to Australia's export earnings. Consequently, as Lawrence and Williams observe, agriculture contributed about 90% of export earnings in 1950 but by 1988 it contributed about 34% (Lawrence and Williams, 1990:39).

Many of the structural changes which have occurred over the last few decades have meant that farming today has become less a way of life and more like any other business (Sorensen and Epps, 1993:30). Rolley and Humphreys note that agriculture has become dominated by agribusiness corporations, resulting in the marginalisation of family farms. The authors argue that,

> *as agriculture has become streamlined, the rural sector has become less important as an employer. Farmers and farm workers have become displaced, a direct consequence of the application of new technologies... Paralleling these changes, farmers are continually experiencing a cost-price freeze... the prices received by farmers from the sale of their products are growing at a slower rate than the process paid by farmers for the inputs to agriculture [thereby reducing] farm incomes* (Rolley and Humphreys, 1993:244).

Lawrence and Williams have further found that agriculture now only employs 5% of the labour force whereas 70% of the labour force is employed in the provision of service. The authors maintain that the number of farmers and farm workers which stood at 477,000 in 1950 has fallen, as at 1989, to 389,000 (Lawrence and Williams, 1990:39).

2.2 THE RURAL DOWNTURN AND THE DROUGHT

The impact of the current rural downturn, or as some commentators would refer to it, the "rural crisis", has both accelerated and compounded the serious impact of these changes on many rural and farming communities. Walmsley (1993:51) notes that talk of a crisis is not new:

> *there was the 'wheat crisis' in the late 1960s, a 'wool crisis' in the early 1970s, and a 'beef crisis' in the mid-1970s.*

However, this crisis is different in that,

> *severe deterioration in internal markets has coincided with significant socioeconomic restructuring within the rural sector* (Walmsley, 1993:51).

Walmsley argues that four factors are behind the current crisis. These are:

- *the agricultural policies of advanced Western countries and the way in which this has distorted commodity prices;*
- *import substitution in many Third World countries and the way in which this has reduced the growth of exports;*
- *the worldwide recession; and*
- *the imposition of high interest rates* (Walmsley, 1993:51).

On top of these factors, **rural areas throughout New South Wales have experienced years of extreme, unrelenting and debilitating drought**. Currently the drought covers 93% of the state of New South Wales and the costs, both economic and social, have been enormous.

The Committee has heard that with this current crisis the situation for many people living in rural areas, including in rural New South Wales, is more difficult than in previous decades. It has been observed that,

> *the rural community has always had to battle against the elements and other factors, but the current rural crisis has been caused by a unique situation in which all the usual factors are occurring together. Interest rates have been high (sometimes over 20%) for a number of years, commodity prices have fallen dramatically, costs are continually increasing, government funds which previously have been used to provide relief have become tight, and farmers have faced both flood and drought in recent years* (Orr, 1992:2).

During the 1990-1991 period, 658 farmers in New South Wales left the land (Wilkinson, 1994:1).

The changes to, and crises of, the rural sector in Australia have resulted in significant internal migration of people, including the farming population, who have drifted to the larger regional centres and cities in search of work (Lawrence and Williams, 1990:39). The most recent recession has meant that the difficulties being experienced by those directly involved in agriculture are significantly impacting on the populations of many regional communities and consequently on decisions to move. Thus:

> *in the absence of countervailing tendencies in employment in rural towns and villages, there is contraction of regional economic*

> *activity and subsequent population loss* (Lawrence and Williams, 1990:38).

Rolley and Humphreys (1993:247) also recognise that,

> *for each person leaving agriculture, there is the potential loss of at least one other person from the towns which service the farms. A decline in farm population means a reduced demand for goods and services supplied by the retail service sector of the small rural townships.*

For rural New South Wales specifically, there would appear to be an increased population movement from inland regions to urban areas and coastal townships. Salt in his report for Coopers and Lybrand Consultants found that among those municipalities in provincial New South Wales that recorded greatest net migration gain over the period 1976-1989 were communities along the coast extending from Eurobadalla in the south to Tweed in the north: the primary focus being Shoalhaven, Tweed, Coffs Harbour, Hastings and Ballina (Salt, 1992:19). The author also found that,

> *at the other end of the spectrum, those municipalities that recorded most net migration loss in provincial New South Wales figure prominently on the national scale. These include Wollongong, Newcastle and Broken Hill... Many of the remaining parts of New South Wales where net migration losses have been high over the last 15 years include inland agricultural service townships, namely Goulburn, Narrabri, Parkes, Lachlan, Grafton and Bland* (Salt, 1992:19).

Population movements away from rural areas, together with the downturn in agricultural productivity and declining industries, services and job opportunities can have an enormous impact on the viability of many communities. Lawrence and Williams (1990:40) argue that,

> *currently about one third of Australia's country towns are in decline, associated with population movements and government rationalisation... while there was evidence of a 'population turnaround' (urban-to-rural migration) in the 1970s the older pattern of rural-to-urban migration has re-emerged in the 1980s and more importantly is likely to continue into the 1990s.*

This situation has had massive implications for the "welfare and well-being" of many rural communities, particularly in inland rural and remote areas. Whilst

poverty and disadvantage has often characterised many areas of rural Australia, including rural New South Wales,

> *declining employment opportunities, depopulation, and reduced services associated with rural restructuring exacerbate the hardships experienced by an already disadvantaged section of the nation's population... Chronic poverty, such as that which occurs when the profitability of farming activities remains at a low level for a long period has become the hallmark of many inland, isolated areas and small country towns* (Rolley and Humphreys, 1993:248).

In a paper tabled to the Committee in evidence regarding the situation in Broken Hill, an essentially mining town, the following was noted:

> *Broken Hill is a good example of the dynamics of decline. Once the local mines employed over 5,000 men. Gradually over the last 10 years retrenchments have commenced and the domino effect of decline started... Approximately 1,000 workers are employed today with the ever concerning threat of further redundancies. Adolescents of Broken Hill who were once guaranteed a job on the mines are now almost certainly guaranteed they will not* (Graham,1993:5, tabled 13 July 1994).

The Committee has heard in evidence of the often "strained" or difficult relationship experienced by some rural people, particularly between farmers and banking organisations. The very high interest rates throughout the 1980s, the ability of banks to set very high risk margins to these interest rates, together with the simultaneous drop in commodity prices and the extensive period of drought, has meant that many borrowers have been faced with considerable difficulty in discharging outstanding debts. For some farmers, as the Committee heard in (in camera) evidence and by way of written submissions, the pursuit of a debt by a bank was often vigorous, with the result being foreclosure.

Many of these issues were covered in the 1991 report of the Standing Committee on Finance and Public Administration on Banking and Deregulation and the follow-up 1992 Review of Certain Recommendations of the Banking Inquiry Report, by the Standing Committee on Banking, Finance and Public Administration. Both reports documented the often tense relationship members of the rural sector have had with banks during the period of the rural downturn. Moreover, the latter report observed that,

> *drought in some regions will have a significant impact and many farmers will continue to experience severe hardship. Consequently it can be expected the relationship between banks and farming*

> *customers will remain under pressure* (Standing Committee on Banking, Finance and Public Administration, 1992:24).

The Committee was told that many of the procedures of some banks result in decisions being made that would affect farming clients, by personnel who may have limited knowledge of local or rural issues. Because of the bureaucratic nature of banking organisations, particularly in relation to the delegation of lending powers, rural branches of banks may not have authority to approve loans over a certain amount. Consequently, decisions of farming loans may not necessarily be made in the local area by those fully understanding or appreciating local conditions. Decisions to foreclose on the loans by seizing collateral may also be made outside the local area by banking personnel with limited expertise in, or understanding of, the farming sector and the experiences of farmers.

Evidence to the Review of the Banking Inquiry however, noted that in recent times there has been some improvement to this situation with a number of banks implementing rural specific courses for relevant personnel or establishing rural finance teams, and others supplying rural specific information to rural branches. That Inquiry (1992:34) heard that

> *farming organisations acknowledged the improvement in expertise within banks to deal with rural customers but considered the overall picture was still variable with some banks doing better than others while even the best banks could do more.*

It has been put to the Committee that farmers need to have accessible, independent financial advice to be able to assess adequately the long-term implications and possible outcomes of any loan arrangement that they may enter into. It has also been suggested that banks themselves need to

> *increase their capacity to provide expert assistance to the farming sector by expanding the quality of their resources in rural branches. Emphasis should be given to enhancing the financial knowledge and farm risk management skills of rural staff* (Standing Committee on Banking, Finance and Public Administration, 1992:34).

According to the Australian Bankers Association (ABA) banks themselves have developed a number of initiatives to assist financially pressured farmers. The ABA (Submission 60) indicated to the Committee in its submission that,

> *banks continue to offer, on a case by case basis, flexible financial arrangements, or where genuine hardship cases exit, concessional terms. A range of flexible financing arrangements are being used to help viable farmers through difficult times. These include helping*

> *farmers rationalise loans, extending terms, tailoring loans to the cash flow characteristics of farmers, on some loans reducing rates of interest, writing down loans, differential pricing on components of the same loan (i.e. utilisation of zero or low interest rates on the portion of a loan which cannot be serviced in the short-term), margin concessions to ensure that viable farmers experiencing financial problems through no fault of their own remain in the industry, and negotiating to meet interest only payments.*

Whilst the Committee acknowledges the importance and value of these practices it recognises that they may not be universal to all banks and some may nevertheless vigorously pursue farmers for outstanding debts. The Report of the Review of the Banking Inquiry (1992:27) found that whilst foreclosure of farms is a last resort by banks,

> *in some cases farmers face significant pressure to leave, including pressure which is imposed by banks.*

Moreover, evidence to that Inquiry by the National Farmers Federation indicated that,

> *if we see a continual recovery in the farm sector, then we would expect to see a number of farms coming on the market either under pressure from the bank or simply because the proprietor has reached the realisation that there is no opportunity for recovery and has made their own decision* (Standing Committee on Banking, Finance and Public Administration, 1992:28).

In its submission to this Committee the ABA drew specific attention to a debt mediation scheme, established in 1987 with the National Farmers Federation. The ABA has advised the Committee that the scheme encourages farmers to obtain independent financial advice on the options available to them and then, together with the bank, put in place an appropriate financial plan. However, it concedes that the reality is that some farmers have to leave the industry.

Recently, the Sydney Morning Herald (15 October, 1994) reported that the ABA does not support the establishment of a compulsory mediation scheme. However, it was also reported that

> *the banks will pay for mediators to be appointed to help financiers and farmers reach agreements on how debts can be repaid. Before starting any repossessions, the banks will advise farmers of their right to mediation under the Farmers Assessment Scheme, with farmers in drought-affected areas getting the service at no cost.*

The Committee hopes that this mediation scheme will go some way to assist farmers experiencing financial hardship as a result of the drought and the rural downturn. It recommends that the Ministers for Agriculture and Consumer Affairs urge banks to enter into mediation with farmers as soon as it becomes evident that financial hardship is occurring and not at the point of foreclosure.

In light of the current and debilitating drought the Committee notes that members of both the State and Federal Governments have met with the banks in an effort to encourage them to consider the drought in their dealings with farmers, including in their provision of finance and in their pursuit of debts. The Committee considers that for many farmers who are experiencing financial difficulties because of the drought as well as the rural downturn, Ministers at both State and Federal levels should continue to urge banks to make all reasonable allowances for loan repayments and to continue to utilise the option of foreclosure only as a last resort.

RECOMMENDATION 1

That the Minister for Agriculture and Fisheries and the Minister for Consumer Affairs:

- **urge banks to mediate with farmers as soon as it becomes evident that financial hardship is occurring and not at the point of foreclosure; and**

- **continue to urge banking organisations to make reasonable allowances for the repayment of loans by viable farmers experiencing financial hardship as a result of the rural downturn and current drought.**

2.3 SOCIAL AND CULTURAL FACTORS RELEVANT TO RURAL COMMUNITIES

The Committee has heard that, for many rural communities, isolation and a lack of services and recreation alternatives are a traditional and common feature. Many rural residents have had to endure travelling long distances to access a particular service or have had to "go without". For young people in particular, isolation and limited services can lead to boredom and even substance abuse and possible participation in risk taking behaviour. The Committee heard in evidence for instance, that where there are few alternatives to entertainment and a major focus of a town is a local pub, drinking may become a frequent form of leisure and social interaction for young people.

In recent times, the economic and demographic changes that have occurred throughout rural Australia have been accompanied by social and cultural changes, including the breakdown in rural culture and traditions. So-called "country-mindedness", such as the close-knit sense of community, the "mateship", and the self-reliance, would appear to be less of a feature of many rural communities than in previous years (Sorensen and Epps, 1993:30). Like contemporary society generally, traditional family structures are also changing. Single-person households, single-parents and other non-nuclear families are becoming more common in rural areas than they once were (Rolley and Humphrey, 1993:246).

Whilst these cultural changes in themselves may not be considered a negative factor, when coupled with economic, demographic and other social changes they can create a kind of uncertainty in already "vulnerable" or stressed communities.

Throughout the Committee's investigations, Members have heard of the enormous personal costs that have arisen as a result of the rural changes and, in particular, the rural crisis. Certain farming properties, for instance, which have been in families for generations, are increasingly vulnerable to being sold or repossessed where owners can no longer meet enormous debts. The loss of a farm therefore can mean to many the loss of one's business and home and also one's family identity and history. A representative from the Union of Farmers has highlighted to the Committee the enormous implications to agriculture and farming communities that could arise should a new generation of farmers be lost.

Evidence has been given to the Committee indicating that financially struggling farming families who are remaining on their properties do so at great sacrifice: many are cutting their living expenses including essentials such as food and clothing, restricting or denying their children's educational opportunities and many women are taking jobs in the local town to supplement the family income. Oral testimony to the Committee from members and former members of the farming community has emphasised the severe stress, anxiety and depression that this situation has created. Committee Members have heard evidence of family breakdowns, the onset of physical illness and the enormous emotional pressures placed on young people whose families' farms have been lost or are under threat (Evidence, 11 August 1994).

Evidence was, for example, presented to the Committee of a farming family who could not afford to purchase a pair of shoes for their daughter. Consequently, she could not attend school (Evidence, 30 August, 1994). The Committee also heard of a farming family whose inability to discharge an enormous debt and who were vigorously pursued by the bank for the monies owed, forced them to take their son from his tertiary study. The marriage also subsequently broke down (Evidence, 11 August, 1994)

The Interim Report of the Social Development Committee, Parliament of South Australia on Rural Poverty in South Australia, demonstrated the strains being placed upon children of farmers struggling in the current down-turn. Evidence to that Inquiry revealed that,

> *some children blamed themselves for their family's financial difficulties. Believing that they were a financial drain on the family, the Committee was told that some children had approached their school counsellor to find out how they could be adopted or fostered out. It was also reported that the rural crisis was placing a severe psychological strain on children and that a number had attempted to commit suicide* (Parliament of South Australia, 1994:15).

2.4 GROWTH AREAS

Whilst generally acknowledged that parts of rural Australia, including rural New South Wales, have been experiencing a crisis, Walmsley (1993:52) notes that

> *it must be remembered that not all areas of the rural sector are depressed. Returns in some industries are reasonable, especially where producers have a significant level of equity and are therefore insulated from the effect of high interest rates.*

Moreover, the last decade has witnessed the development of so-called "hub" towns or key regional development centres. These towns are the major service providers for a range of outlying rural communities.

Key factors in the development of these towns have been the success of some major manufacturing industries, such as in Kempsey (Akubra Hats), Nowra (rubber) and Taree (motor vehicle parts). The transfer of the NSW Department of Agriculture from Sydney to Orange, the combined positive influence of the educational institution at Armidale with the festival/tourism promotions in Tamworth and on the North Coast, have all resulted in increased employment and income stability in these regional areas.

As a further example of growth in some rural centres, information supplied by the Young Shire Council notes (1993:6) that

> *during 1993, fifty one development applications were processed (in Young), which although slightly down from 1992, represented a substantial increase in value, to $5,078,400. Thirty one applications were received for commercial development, from minor changes of use in the business district, to expansions of new*

> *businesses... The most important factor associated with these particular developments is that the majority of the work was carried out by local contractors and that additional permanent employment was created in the town.*

These examples are consistent with the evidence received by the Committee which indicated that the more prosperous major rural centres have suffered comparatively less during the period of rural downturn, than the smaller and more remote rural communities.

The effects of the current drought however have meant that growth for a number of regional areas may be problematic or negative. The Sydney Morning Herald reporting on the $65 million drought package released by the State government (14 October, 1994:1) stated that

> *rural businesses and regional unemployment [will be] both reaching crisis point if the drought continued for more than six months with some smaller towns never recovering.*

2.5 RURAL FINANCIAL ASSISTANCE SCHEMES

A number of schemes have been established over time to assist people on the land facing financial hardship. Among those are the Rural Adjustment Scheme (RAS) and the service provided by rural counsellors.

2.5.1 Rural Adjustment Scheme

The Rural Adjustment Scheme (RAS) began in 1976 (having developed from the Rural Reconstruction Scheme of 1971), in response to the "structural adjustment" of the nation's farming and agriculture sector. Following the gradual contraction of Australia's export markets and the decline in the international prices of commodities, there was greater need among increasing numbers of farmers for government assistance.

Fundamental to the establishment of the Rural Adjustment Scheme was "helping unviable producers depart from the land and, in turn, helping viable producers remain operational" (Wilkinson, 1994:6). However, as Stayner (1994) observes,

> *the detached description of farm adjustment as an inevitable consequence of national and international forces is little comfort, of course, to those farm families who unwillingly find themselves as the central characters on the process.*

Currently, and following a number of revisions, the RAS is funded through the Federal Department of Primary Industries and Energy but is administered by the States through a Rural Assistance Authority, under the responsibility of the Minister for Agriculture.

Wilkinson (1994:6-7) outlines the present objectives of the RAS as concerned with providing the following:

- support to farmers who have prospects of sustainable long-term profitability;
- support to ensure that farmers become financially independent of the initially-provided support;
- grants of subsidies for interest payable loans;
- grants of subsidies for the purposes of farm training, planning, appraisal and support services;
- support to farmers without prospects of sustainable long-term profitability, to leave the farm sector;
- a Farm Household Support Scheme to provide finance to farm families to meet living expenses if they are unable to obtain commercial finance; and
- drought relief through the Pilot Drought Scheme.

For the years 1992-1994 the NSW Rural Assistance Authority approved financial aid of $110 million to 10,750 primary producers under all categories of the RAS.

The Committee understands that, in recent times, the RAS has come under increased scrutiny by members of the faming community, in particular those who consider its criteria and guidelines for assistance too strict. The Committee has been informed for instance that,

> *the Rural Adjustment Scheme... is marketed subtly as a subsidisation of rural people, but very few rural people are eligible because* ***viability*** *is a term without reference or parameters... Nobody understands the rules, because nobody knows the rules. Furthermore, the rules or guidelines are simply not available in written form to applicants. It is a bureaucratic nightmare, promoted as a saviour of country people who are in fact, ineligible* (Union of Farmers Incorporated, 1994:2).

The Committee notes that currently the Senate Standing Committee on Rural and Regional Affairs is conducting an Inquiry into the Rural Adjustment Scheme. The Terms of Reference of that Inquiry are that the Senate Standing Committee inquire and report on:

> *(a) the adequacy of the Rural Adjustment Scheme, including its current guidelines and operations, in meeting the present and future needs of primary producers suffering from prolonged adverse circumstances beyond their control;*
>
> *(b) the extent of rural debt, the nature and serviceability of that debt and its social, economic and ecological consequences; and*
>
> *(c) what mechanisms should be recommended for the management of rural reconstruction and the contributing roles of government, the financial sector and industry.*

The Committee notes that the Senate Standing Committee is due to report on its findings in late 1994. It is hoped that the report of that Inquiry will address many of the concerns members of farming communities have with the RAS, especially when so many of them are suffering under the crippling drought.

The Committee observes that recently, following a request by NSW Premier Fahey, the Federal Government has eased the eligibility criteria for drought-effected NSW farmers under the Rural Adjustment Scheme. The Sydney Morning Herald reports that a farm enterprise could be eligible if it suffered extreme financial difficulty due to drought conditions in two of the past three years. However, some areas, which are nevertheless drought affected, remain ineligible.

The Committee is concerned that the recent drought will compound the hardship, stresses and anxieties of many families already suffering because of downturn. It therefore proposes that the Minister for Agriculture monitor the operation of the RAS in New South Wales, so as to ensure that positive responses to farmers applications are maximised.

RECOMMENDATION 2

> **That the Minister for Agriculture negotiate with the Federal Minister for Primary Industries and Energy to ensure that the operation of the Rural Adjustment Scheme maximises positive and swift responses to farmers' applications.**

2.5.2 Rural Counsellors

Rural counselling services were established throughout Australia in 1986. In New South Wales they are located in 26 centres. Funding is provided from both the Federal Government, through the Department of Primary Industries and Energy (DPIE) and from the New South Wales Department of Agriculture. Community-based advisory groups also provide some resources and act as employer to the counsellors. Rural counsellors are independent of financial institutions, welfare agencies and government and the service provided is free of charge. Counsellors can travel to properties for consultations and will provide on-going assistance if required.

The assistance which rural counsellors can provide includes the following:

- assessment of a farmer's current financial position;
- cash flow budgeting;
- reviews of contracts with lending institutions;
- loan applications;
- communication with lenders;
- information on government assistance schemes, including the Rural Adjustment Scheme;
- information on Social Security and other welfare benefits;
- assistance with family decision-making; and
- personal or family counselling where required, or referral to appropriate services (DPIE, undated:2).

A major function of the rural counsellor is to help a family identify and assess the available options open to them in trying to discharge a debt and to assist in the negotiation process with the lender.

The Committee spoke with a number of rural counsellors during the course of the Inquiry, all of whom described the financial struggles of many farming families today. Some of the rural counsellors with whom the Committee spoke indicated that, among their clients, none had been known to suicide. However, a submission provided by another rural counsellor referred to the suicide of a client. It was suggested to the Committee that the few suicides known directly to counsellors

may indicate that rural counsellors are in fact performing some sort of preventative role (Evidence, 9 June, 1994). Being able to talk with someone who can offer assistance can, in many instances, relieve at least some of the stress and pressure felt by those in financial difficulties, by exploring possible strategies and alternatives. However, given the apparent reluctance of many rural people, particularly farmers, to disclose personal problems and to strive to maintain a sense of resilience and resoluteness, it is conceivable that those most at risk of mental distress and possible suicide would not contemplate seeking assistance from the local rural counsellor. The Committee therefore considers it essential that the role of rural counsellors be actively and sensitively publicised throughout rural and farming communities, with such publicity providing assurances of confidentiality.

RECOMMENDATION 3

That the Minister for Agriculture and Fisheries, in liaison with the Federal Minister for Primary Industries and Energy, ensure that funding for rural counsellors continue and that there be developed sensitive and locally-based campaigns to publicise the services provided by rural counsellors for farming families.

2.6 CONCLUSION

The major structural changes that have occurred throughout rural communities today, along with the severe rural downturn and crippling drought have resulted in considerable uncertainty, hardship and suffering for many rural individuals and families. This has been clearly borne out by the literature as well as the evidence received by the Committee. Against this backdrop the Committee will consider a number of issues significant to suicide in rural New South Wales.

CHAPTER THREE

THE EXTENT AND NATURE OF SUICIDE

3.1 DATA COLLECTION - SUICIDE AND ATTEMPTED SUICIDE

The submission from the New South Wales Health Department advises that death data generally, are derived from the Form of Information of Death and the medical certificate. The cause of death is certified by a registered medical practitioner or the Coroner (Submission, 42). Crowe (1994:2) states that

> *statistics on deaths from suicide have been compiled by the Australian Bureau of Statistics (ABS) for many years as part of its Cause of Death collection. The source of data are deaths registered by the Registrar of Births, Deaths and Marriages in each of the States/Territories. The ABS is the agency responsible for coding the causes of death for each of the States/Territories and releasing both State specific and national data mortality from this data source.*

However, because society's understanding of suicide is incomplete, an expert witness has indicated to the Committee that

> *we need a better database and better information about what is going on... there is no centralised database for suicide collection in Australia and the National Medical Research Council working party on suicide has been at pains to emphasise that we need such a centralised data collection process* (Dudley Evidence, 10 February, 1994).

Further evidence and submissions to the Committee have supported this view.

In his address to the National Conference on Suicide Prevention in February 1994, Associate Professor Pierre Baume indicated that specific data collection at a national level for both suicide and attempted suicide is critical to the effectiveness of a national policy on suicide prevention.

The Committee's investigations have revealed that it is very difficult to calculate rates of attempted suicides. According to Baume (1994:6),

> *metaphorically, completed suicides are just the tip of the self-destructive iceberg, we need also to consider attempted suicide... Although various attempts have been made to define accurately the incidence of suicide in Australia, the same cannot be said about*

> *attempted suicide. There is a paucity of data on the rate of attempted suicide in Australia, not only because distinguishing intentional from unintentional death is inordinately difficult, but also because no register exists at this time to provide accurate data.*

For New South Wales specifically, the NSW Department of Health has acknowledged that the extent to which people attempt suicide is less discernible than those who complete (1993a:2). The Department estimate that generally "between 20 and 100 attempts are made for each completed suicide" (1993a:2).

Burnley (1994:303) further observes that the rate of attempted suicide in New South Wales,

> ***especially (among) women** is much higher [than completed suicide], and one factor in the large sex difference may be that women and men use different means of attempting suicide, with women having more chance of recovery* (emphasis added).

The Committee's investigations show that this is largely the case for both rural and urban areas.

The Committee understands that there are a number of reasons why attempted suicides may be under-recorded and why hospital data may vary from estimates. These are that:

- *patients do not always disclose that injuries were intended;*
- *many attempts do not result in injuries which require in-patient medical and nursing care;*
- *many presentations are to out-patient mental health services and some of the latter presentations may be some time after the actual suicide attempt; [and]*
- *some attempted suicides never come to the attention of health authorities* (NSW Health, 1993a:2)

It appears that compounding the problem of effective data collection is that "suicide and attempted suicide are reported on a less formal basis in a number of areas" (NSW Health, Submission 42).

In an effort to address the problems associated with the collection of attempted suicide statistics, the Committee has been informed that within 18 months (from April 1994) a standardised Accident and Emergency dataset will be introduced into

hospitals in New South Wales. The dataset will also include a code for suicide ideation and an injury surveillance dataset for injury, poisoning and trauma presentations with an intent field in the coding (NSW Health Department, Submission 42). The Committee hopes that the implementation of this dataset will significantly improve the collection of attempted suicide information and go some way to assist in an understanding of the causes of this event. The National Injury Surveillance Unit in Adelaide also incorporates data from those hospitals that collect data on injury presentations at their Emergency Departments, offering a further information base.

The Department of Health has further reported that submissions are being considered to pilot attempted suicide surveillance in at least one rural region of New South Wales (Submission 42).

Given that one of the major identifiable risk factors to a completed suicide is a previous attempt, the Committee considers that any person presenting to a hospital or other health facility with self-inflicted injuries must be properly assessed and referred as soon as possible to appropriate treatment and counselling. There should also be follow-up. This naturally raises the issue of hospital and other relevant health personnel being appropriately trained in suicide risk identification and intervention. These issues are addressed in Chapter Five.

Whilst supporting the Department of Health initiatives to improve attempted suicide data collection, the Committee also considers, and will highlight further in Chapter Four, that attempted and completed suicide are such serious events of themselves, that they require both national and state attention. As such, it considers that there is a need for a specific data and research facility at the national level that would work collaboratively with states in the collation and analysis of suicide and attempted suicide statistics.

Accordingly, it supports the proposal put forward in the Outline of the National Health and Medical Research Council Draft National Strategy for the Prevention of Suicide (1994:2) for the development of

> *a national data base concerning the patterns and prevalence of suicidal behaviours, [including the establishment] of state based suicide registers which report to a central data collection.*

This issue is addressed further in Section 4.5 of the report.

3.2 THE EXTENT OF SUICIDE

3.2.1 Overseas

The Committee notes that international comparisons on suicide rates can be complex because of different recording practices and methods of data collection. Nevertheless there appears to be a great deal of evidence to suggest that rises in suicide among young people, especially young men, are becoming a growing and tragic trend in many overseas nations. It appears that youth suicide is more common in those countries that are otherwise relatively stable and free from overall turmoil and unrest. Recent World Health Organisation figures show that, as well as Australia, the other high ranking countries for youth suicide include New Zealand, Norway, Canada and Finland. It is reported that, among young people aged 15-24 years, suicide has risen in 11 out of 14 industrialised countries over the last 20 years - more than doubling in Spain and Norway (UNICEF, 1993:45). Recent reports from the United Kingdom indicate that suicides among young men, particularly those in the 15-24 year age group have increased by more than 80% in ten years (Guardian Weekly, November 14, 1993).

Cantor and Coory (1993) observe that, in recent times, rises in suicides in *rural* areas have been reported not only in parts of Australia, but in overseas countries as well. A study by Crombie (1991) has found that between 1974 and 1986 the remote northern highlands of Scotland had a greater suicide rate than other areas of Scotland (Cited in Cantor and Coory, 1993:382). It has also been reported that higher rates of suicide are present in rural parts of south-western Greece, Sweden and Manitoba, Canada, where the focus of the study was on childhood and adolescent suicides (Cantor and Coory 1993:382). The Committee was also advised in one submission that "in some part of the United States, rural suicide rates among young people are 3 per 100 per month" (Submission 1).

It has been reported that in the United Kingdom,

> *farmers are nearly twice as likely to kill themselves as the average person, and their suicide rate is fourth highest behind vets, dentists and pharmacists* (Guardian Weekly, March 27, 1994).

It is further noted that, in the United Kingdom, the Department of Health has recently funded psychiatrists to investigate the high level of suicides among farmers and others living in rural areas.

In the United States, a study of Kentucky farmers between 1979 and 1985 found higher rates of suicides in farmers among older age groups, especially in the over 65 age group (Cantor and Coory, 1993:382).

3.2.2 Australia

Experts and community representatives alike consider suicide to be a major public health and community problem confronting Australia today. It is now well documented that Australia has one of the highest *youth* suicide rates in the industrialised world and suicide is a leading cause of death among young males (Baume, 1994:2).

However, the Committee has heard that, since 1904, the percentage of suicide as a proportion of all deaths has remained relatively constant (Baume, 1994:2). The difference now, compared with earlier decades, is that there has been a shift in the overall rate so that now suicide is particularly high among young people. This issue is examined further in the discussion in this section on age.

Looking at trends over the last 10 years, Australian Bureau of Statistics data indicate that, generally, there has been some upward trend in the national suicide rate since 1982. The Bureau reports that, as a percentage of total deaths, suicides increased from 1.5% in that year to 1.9% in 1992. The Bureau (1994a:1) explains that

> *on an age standardised basis... the increase over the decade 1982 - 1992 was 7.5 per cent, indicating that a change in age composition explains some of the upward trend.*

There have been 22,372 deaths by suicide over the past 11 years (ABS, 1994a:1). Male suicides contributed to 78% of all suicide deaths for that period and the number of male suicides in all age groups has been consistently higher than females. (ABS, 1994a:3).

- **Age**

Research, as well as evidence presented to the Committee, indicates that the rates of suicide among certain groups have shifted within the overall rate. Whereas in previous decades suicide risk tended to increase with age, that risk appears to have increased among the young, in particular, and among the very old. As the Report will subsequently indicate, the suicide rate among people aged between 35 and 60 years has shown a marked decline (Hassan, 1992:2). Baume (1994:4) further notes that

> *the decreasing rate [of suicide] in the elderly has been at the expense of youth.*

The Australian Bureau of Statistics identifies an increasing trend in suicide in the 15-24 year age group, particularly among males, Australia wide. Crowe (1994:4) notes that,

> *the male rate has increased from 19 deaths per 100,000 of the male population in that age group in 1982 to 27 deaths (per 100,000) in 1992. This compares to 3 female deaths (per 100,000) in the same group in 1982 increasing to 6 deaths (per 100,000) in 1992.*

- **Urban/Rural**

The Australian Bureau of Statistics further reports that suicide rates for men of *all* ages and for women differ little between rural and urban locations. However, for young men in rural areas the suicide rate is considerably higher (ABS, 1994b:58).

Information from Crowe (1994:4) indicates that

> *at the total level there is not a large variation between the rate of suicide in urban and rural areas. However, when looking at the age specific suicide rate there are significant differences for males in the 15-24 year age group. The highest rate for male suicides in this age group was 38 deaths per 100,000 of population in rural areas and 27 deaths in urban areas in 1988. After showing a decline in 1989 both rates have resumed these levels in subsequent years.*

The most notable increases have occurred in the smaller rural towns with populations of less than 4,000 (Dudley *et al.*, 1994).

Silburn and Zubrick's (1994:5) observations would tend to support these findings. They maintain that, relative to metropolitan areas, higher rates of suicide among the young occur in the rural regions of Australia. In their 1991 study of youth suicide specifically in Western Australia, Silburn and Zubrick found that the highest rates, particularly among males, occurred in the more remote and isolated areas of the state.

More recent research has suggested that the suicide rate in rural Western Australia has "tripled during the period 1986 to 1991 from 10.8 per 100,000 in 1986 to 28.1 per 100,000 in 1991" (Suicide Prevention Australia, 1994:2). Suicide Prevention Australia (1994:2) further reports that

> *the rate for the 20 to 24 year olds doubled from 1987 to 1992 (24.6 per 100,000).*

However, Cantor and Coory (1991) observed in their study of suicide rates in Queensland, that the rise in suicides in rural areas is not entirely the case for all Australian states. In that study the authors did not find a statistically significant excess specifically of rural youth suicides in Queensland. They concluded that rural populations in Queensland have suicide mortality rates similar to metropolitan and provincial areas. Referring to the study undertaken by Dudley *et al.* which found striking increases in the youth suicide rate in rural municipalities and shires in New South Wales the authors observed:

> *why in the young age groups our findings are not consistent with the New South Wales study is unclear. It is possible that the insidious rise in male youth suicide clearly detected in New South Wales may have been masked by the cross-sectional design of our study* (Cantor and Coory, 1991:384).

Consequently, the authors call for further studies of this nature, including data from other states.

Recently Dudley, Waters and Kelk have released some of their findings in relation to an Australia-wide study entitled Suicide Among Young Australians: 1964-1991: Urban-Rural Trends (1994, unpublished). This study represents a follow-up of their earlier research which examined suicide trends among young people in urban and rural areas of New South Wales.

Whilst conceding that data collection and analysis for the state of Queensland is still in progress the authors (1994:4) argue that

> *the suicide rate in males 15-19 and 20-24 years has significantly risen in Queensland from 1964 to 1991, from 5.9 to 23.0 and from 16.6 to 37.3 respectively. Considering the 15-24 year combined male group, there is an approximately threefold increase in Brisbane (9.5 to 26.9), and high rates with substantial numbers of suicides are recorded on the Gold and Sunshine Coasts (ranging from 30.2 to 53.1 per 100,000). Provincial city (greater than 25,000) and large town (greater than 4,000) rates are generally not higher than the rates of these first two groups, and it is unclear whether there has been an increase over the twenty-five years in these settings. This is not so, however, for towns and locations less than 4,000 where there has been a steady increase throughout the whole period, from 2.4 to a final high figure of 82.8 in 1991, with substantial numbers to support this trend.*

In relation to Victoria, Dudley *et al.* (1994) observe that, whilst female rates have not significantly changed, the suicide rate in males 15-19 and 20-24 years has

risen markedly over the period, from 3.7 to 16.0 and from 8.8 to 28.5 (1994:3). Among this group there is a

> *significant trend among those in rural areas... though not always in a linear fashion. In the cities greater than 25,000 the rate went up from 4.5 to 20.4, with a decrease in the last three year epoch; in towns greater than 4,000 from 6.5 to 30.4; and in locations less than 4,000 people from 4.4 to 34.1 in 1984-1988 and 119.0 in 1989-1991... Also of note is the fourfold rise in Melbourne from 5.9 to 19.4, and a fivefold rise in Geelong (though suicide and population numbers in the latter are smaller)* (Dudley *et al.*, 1994:4).

According to the authors, smaller states such as South Australia have "also followed suit in young male trends"(Dudley, *et al.* 1994:4).

3.2.3 New South Wales

The NSW Department of Health (1993a:1) has reported that

> *in the last two years [from 1993] suicide has become the leading cause of injury related death in NSW - overtaking road trauma, which for many decades had claimed more lives in NSW than any other cause of injury.*

The Department further observes that the number of suicide deaths in this state fell from 767 deaths in 1991 to 732 deaths in 1992 (1993a:1). Although the Committee is encouraged by this drop, it nevertheless considers that suicide rates in New South Wales remain at unacceptable levels.

Based upon evidence received by the Committee, as well as other research, the Committee's investigations indicate that most completed suicides are committed by males. The research also indicates that, in recent times, suicide rates for certain groups of rural people, most notably young men, appear to have increased at higher rates than that of their urban counterparts. Morrell explained in his evidence to the Committee that

> *the number of actual suicides in women per year is about the order of 30... these are very small numbers, [and] you get big kinds of variations in the rates... so it... reflects the statistical instability... [However], since the mid-1980s male suicide rates across all ages have been increasing. In rural areas they have been increasing at a much greater rate than the urban rates have been increasing so*

that overall... you are looking at about 20 events per one hundred thousand.

The following discussion will examine suicide rates in New South Wales, with particular emphasis on rural areas. Much of the statistical information presented below has been provided to the Committee by Mr Stephen Morrell of the Department of Public Health, University of Sydney. The Committee is extremely grateful to him for allowing his data to be utilised in this Report.

Other data referred to below have been prepared for the Committee by the Australian Bureau of Statistics (ABS). Relevant sections of that data refer to the categories of "urban", "major rural" and "other rural". According to the ABS' definition, "urban" refers to the statistical divisions of Sydney, Wollongong and Newcastle and "major rural" refers to the statistical local areas of Albury, Armidale, Bathurst, Broken Hill, Casino, Coffs Harbour, Deniliquin, Dubbo, Glen Innes, Goulburn, Grafton, Greater Lithgow, Greater Taree, Griffith, Hastings, Lismore, Orange, Queanbeyan, Shoalhaven, Tamworth and Wagga Wagga. "Other rural" refers to the remainder of the state and therefore includes "non-major" centres, including the smaller and remote areas of New South Wales. When citing figures from the ABS that deal with these areas, the Report will refer to them as "smaller rural areas".

The Committee will also present information provided by Dr Michael Dudley, Professor Brent Waters and Mr Norman Kelk, that deals specifically with young people. The Committee is most appreciative to the authors for these data being made available to it.

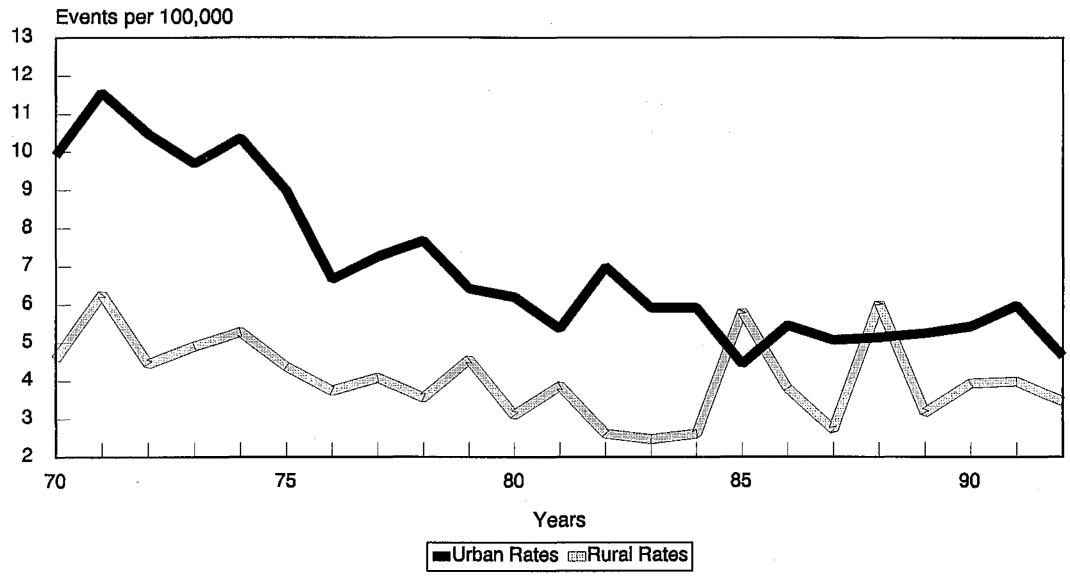
- **Females: Age Adjusted (15 to 64 year range)**

The Committee's investigations have shown that, whilst the rate of suicide among females is lower than males, their attempt rate is greater. This issue is discussed further throughout the Report.

For New South Wales, the overall suicide rate among women in rural areas from 1970 to 1992 has remained relatively low, dropping marginally from 4.58 per 100,000 population to 3.46 per 100,000 population over this time period. The suicide rate for women in urban areas has shown a more marked overall decline from 9.92 per 100,000 population in 1970 to 4.65 per 100,000 population in 1992. Figure 1 indicates these trends. As the most notable suicide trends, particularly in rural areas, are occurring among men and as much of the Committee's evidence has concerned suicide deaths in relation to this group, the following discussion will concentrate essentially on suicide mortality of males. Age related graphs regarding suicide rates among women are reproduced in Appendix Three.

Figure 1

NSW Suicide Deaths - Female - 1970 to 1992
Age Adjusted (range 15 to 64 years)



Source: Morrell, 1994 (unpublished)

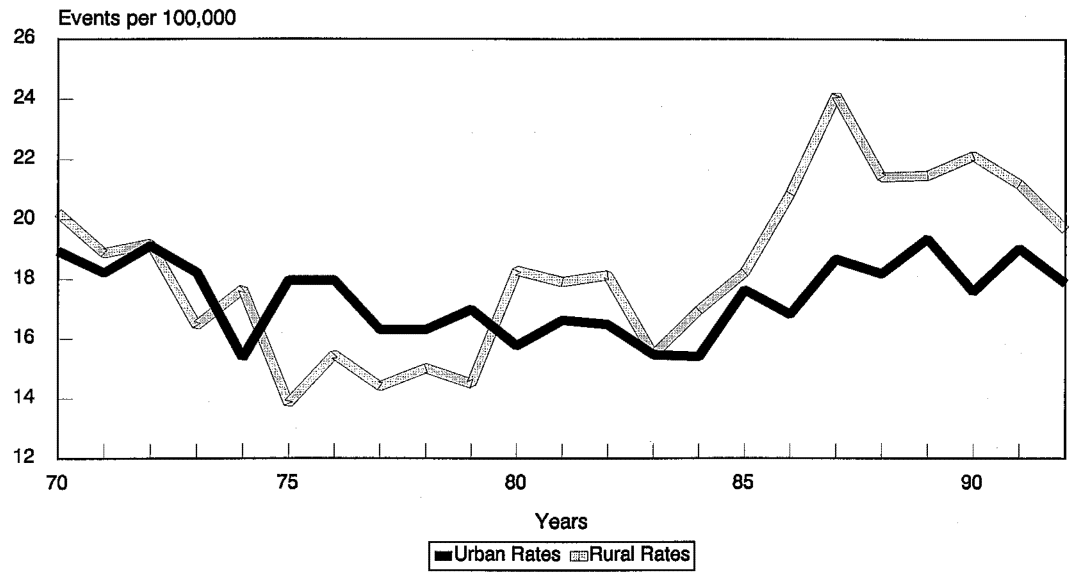
■ Males: Age Adjusted (15 to 64 year range)

In contrast to the suicide rates for women, Morrell's age adjusted suicide rates for men are at higher levels both in urban and rural areas. In relation to male suicides for urban areas, the rate has remained fairly stable from 1970, when it was 18.95 per 100,000, declining to 17.87 per 100,000 in 1992. Throughout the two decades analysed the rate peaked in 1989 at 19.36 per 100,000 population.

The information for the rate of suicides among men in rural areas, appears to paint a more complex picture. In 1970 the rate was 20.23 per 100,000 population, higher than the rate for urban males in that period. However, from 1975 the rate dropped below the urban rate, to 13.83, and remained under the urban rate until 1980 when it showed a marked rise to 18.29 per 100,000 population. This rise continued to 24.13 per 100,000 population in 1987. Although since that time the rate has declined slightly (in 1992, for example, it was 19.68 per 100,000 population), it still remains above the suicide rate for urban males. Figure 2 indicates the trends for age adjusted suicide deaths for urban and rural males.

Figure 2

NSW Suicide Deaths - Male - 1970 to 1992
Age Adjusted (range 15 to 64 years)



Source: Morrell, 1994 (unpublished)

■ Males: 45 to 64 years

Figure 3 refers to suicide deaths among males in New South Wales between the ages of 45 and 64 years. The information provided by Morrell shows that among men in this age group living in urban areas, the suicide rate has shown a steady decline since 1970 when the rate was 30.69 per 100,000, dropping to 20.21 per 100,000 population in 1992.

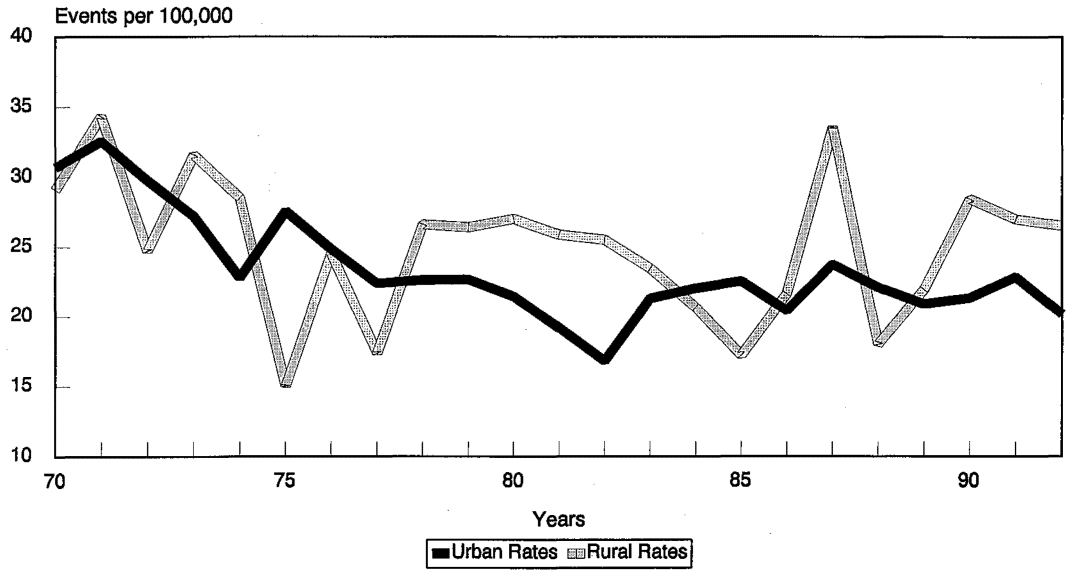
As with the information presented in Figure 2, rates of suicide deaths among rural males between the ages of 45-64 years would appear to be more complex and indicate more dramatic peaks and troughs than the rates for their urban counterparts.

Following a drop in the rate in 1977 to 17.37 per 100,000, the suicide rate rose and remained consistently above urban levels until 1984. The rate peaked in 1987 at 33.56 per 100,000, and dropped again in 1988 to 18.03 per 100,000 per

population. Of concern however, is the steady rise since 1989 with the suicide rate rising from 21.94 per 100,000 in that year to 26.51 in 1992.

Figure 3

NSW Suicide Deaths - Male - 1970 to 1992
45 to 64 years



Source: Morrell, 1994 (unpublished)

- **Males: 25 to 44 years**

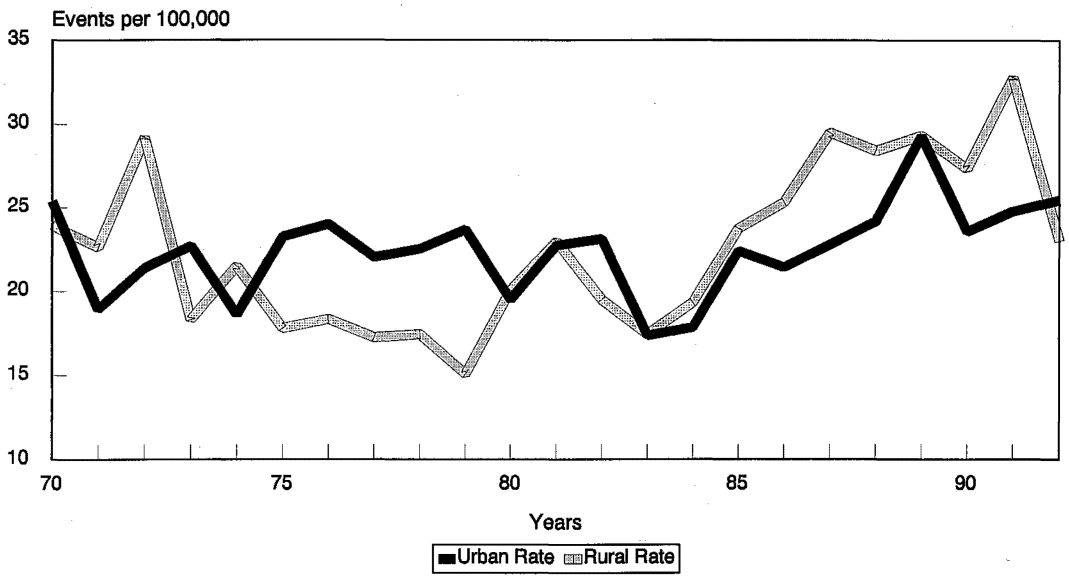
For the rural male population in the 25-44 year age group, the increase in suicides occurring over the 20 year period has been in a linear fashion. As Morrell observed in evidence before the Committee,

> *25 to 44 year old males have increased not so much more dramatically than urban rates, but they are still higher, around about 30 to 35 events per hundred thousand.*

As Figure 4 shows there was a decline in deaths in 1992. Data for 1993 and 1994 are unavailable at this stage therefore conclusions as to trends cannot as yet be made.

Figure 4

NSW Suicide Deaths - Male - 1970 to 1992
25 to 44 years



Source: Morrell, 1994 (unpublished)

In his recent study Differential and Spatial Aspects of Suicide Mortality in New South Wales and Sydney, 1980 to 1991, Dr Burnley of the University of New South Wales examined, among other issues, suicide mortality trends in New South Wales among males by major occupation groups for the periods, 1980 to 1985 and 1986 to 1989.

His findings for the 25 to 39 year age group were that

> *mortality in the professional and related workers category was significantly low in the age range 25-39, but was significantly high among farmers and related workers, transport workers and tradesmen, production process workers and labourers in the second period [1986-1989]* (Burnley, 1994:296).

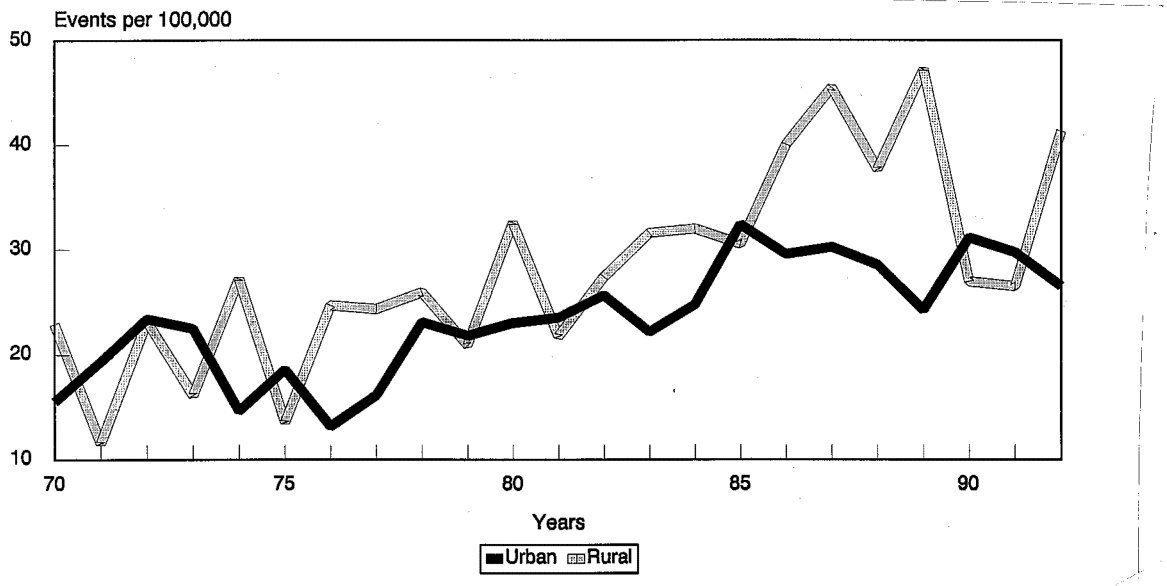
Burnley notes that suicide deaths among farmers and related workers in the 40 to 64 year age group for the periods 1980 to 1985 and 1986 to 1989 were also "significantly high" (Burnley, 1994:297).

■ Males: 20 to 24 years

The Committee's investigations indicate that suicide rates would appear to be of particular concern among 20 to 24 year old males. As information provided by Morrell shows, reproduced at Figure 5, suicide rates for this cohort in both urban and rural areas indicate an overall increase in the twenty year period. For rural areas in particular, the rise appears to have commenced in 1982 when the rate was 27.41 per 100,000 population, peaking in 1989 at 47.23 per 100,000 population. As the figure shows, there was a decline in the rate in 1990 to 26.98 per 100,000 population, but the rate has since risen again to 41.30 per 100,000 population in 1992. In contrast, the suicide rate among the 20 to 24 year urban cohort for the year 1992 was 26.56 per 100,000 population.

Figure 5

NSW Suicide Deaths - Male - 1970 to 1992
20 to 24 years



Source: Morrell, 1994 (unpublished)

More detailed information on suicides for this age cohort living in rural areas other than major rural cities and municipalities has been reproduced in Figure 6 from information prepared for the Committee by the Australian Bureau of Statistics. This graph shows that, in the smaller rural centres and regions of New South Wales, there is a discernible increase in the suicide rate for the male 20-24 year age group with the rate increasing from 14.2 per 100,000 (resident) population in 1971 to

59.9 per 100,000 population in 1992. In contrast, the ABS urban suicide rates for this age group increased from 19.9 to 25.9 per 100,000 population during the same time period.

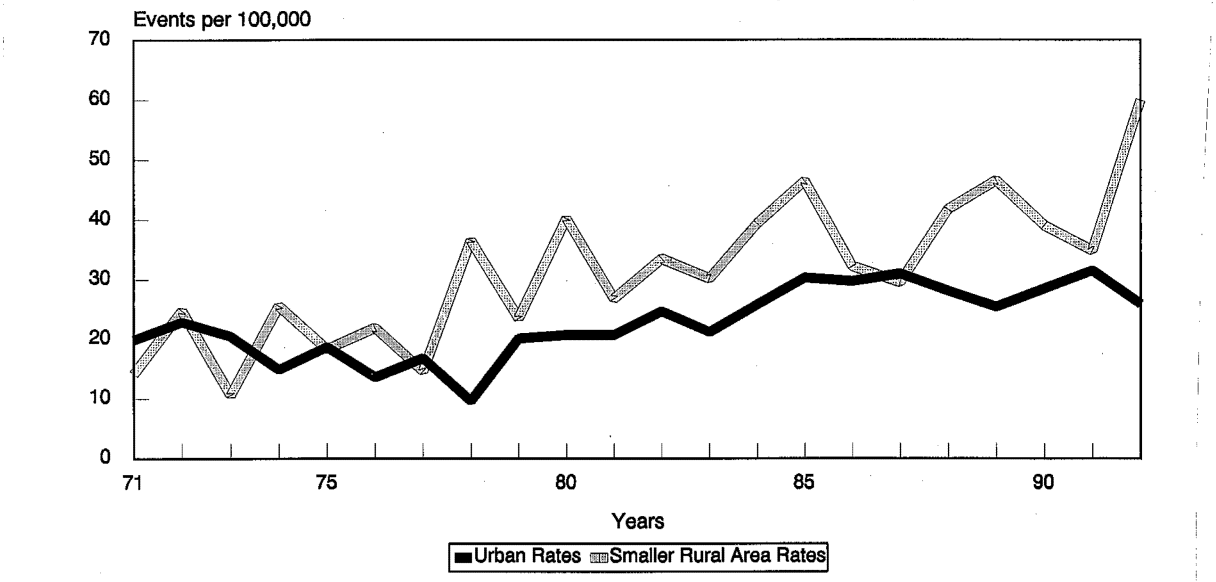
Recent research undertaken by Dudley *et al.* (1994:3) shows that the rates among 20 to 24 year old males

> *in smaller rural settings in New South Wales, have... substantially risen (though not always in a linear fashion) over the 28 [year reference period, 1964-1991] from 18.6 to 43.3 per 100,000 in towns with populations between 4,000 and 25,000 and from 5.2 to 40.7 in towns less than 4,000.*

Figure 6

NSW Suicide Deaths - Male - Urban and Smaller Rural Areas
1971 to 1992

20 to 24 years



Source: Australian Bureau of Statistics, 1994c (unpublished)

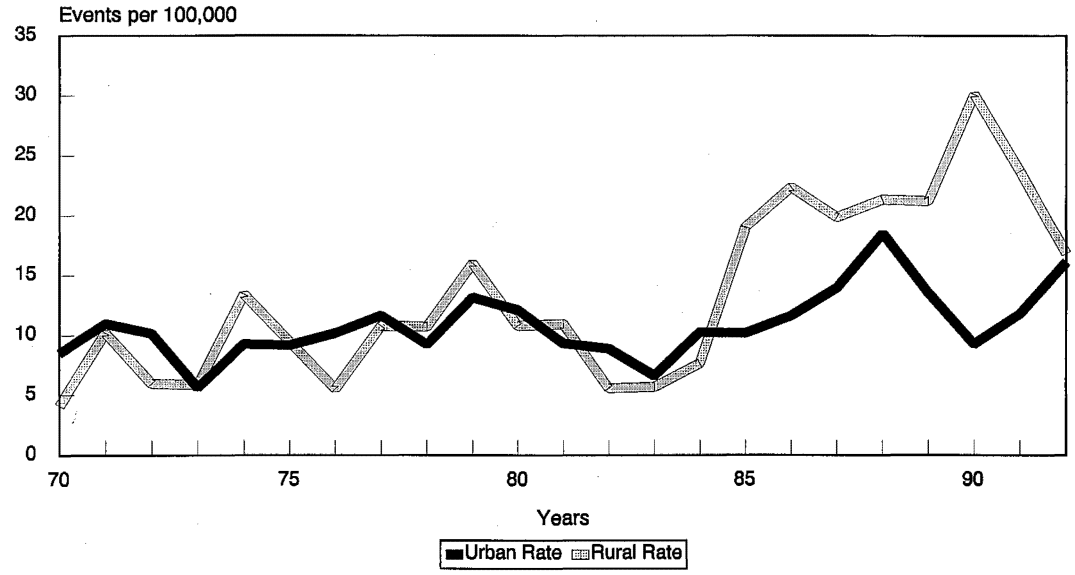
■ Males: 15 to 19 years

Information supplied by Morrell for rural regions generally and reproduced in Figure 7 shows that suicide rates for rural males between 15-19 years have been consistently higher than their urban counterparts since 1985, peaking in 1990 at

30.09 per 100,000. Since 1992, however, the rate appears to have declined but nevertheless remains substantially higher than previous years. As the discussion of the 25-44 age cohort proposed, lack of 1993 and 1994 data suggests that it is too early to predict if this decline is the beginning of a downward trend.

Figure 7

NSW Suicide Deaths - Male - 1970 to 1992
15 to 19 years



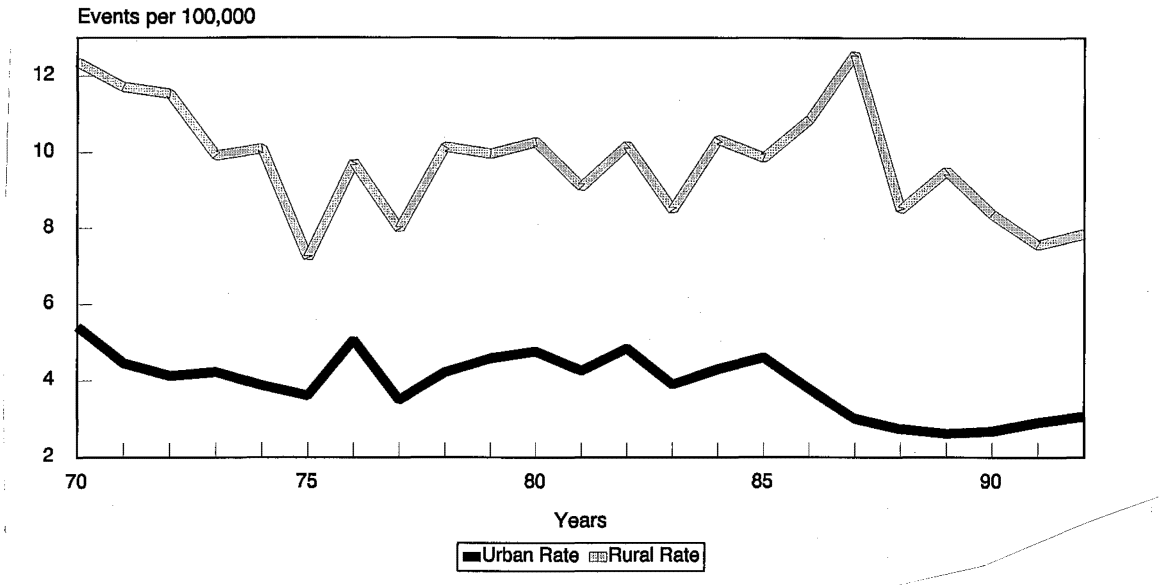
Source: Morrell, 1994 (unpublished)

Other information provided by the ABS shows that throughout the 1980s there has been a steady increase in suicide deaths among 15-19 year old males in "other rural" areas. However, the information supplied suggests that the rate has declined in 1991 and 1992. Suicide deaths however, for this group in "major rural" areas show an increase.

In 1992 Dr Michael Dudley *et al.* presented their findings in relation to an extensive and detailed study, Youth Suicide in New South Wales: Urban-Rural Trends. Examining data from 1964 to 1988, the authors found that the rate of suicide among 15-19 year old males in rural cities had more than doubled, from 5.1 to 12.5 per 100,000 per year and, in rural municipalities and shires, the rate increased fivefold, from 3.9 to 20.7 per 100,000. As Dudley *et al.* observe there was "no significant change" in the suicide rates of 15-19 year old or 10-14 year old females. For Sydney, the suicide rate of 15-19 year old males showed an increase

Figure 8

NSW Suicide Deaths - Male - Firearms - 1970 to 1992
Age Adjusted (range 15 to 64 years)



Source: Morrell, 1994 (unpublished)

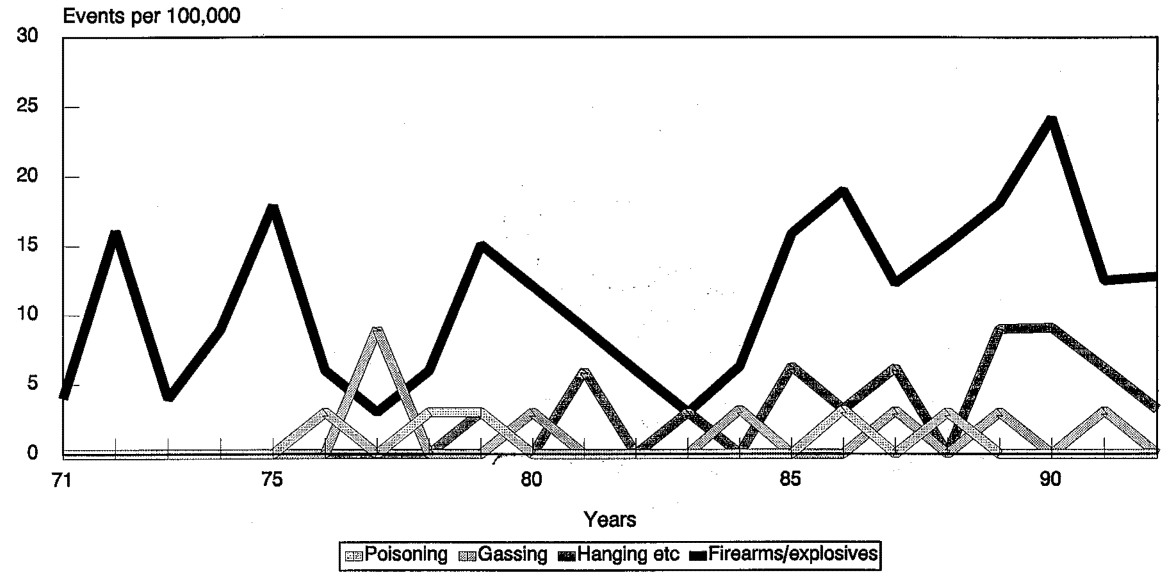
For the overall ages of 10 to 80 years and over, ABS data indicate that firearm suicides in other rural areas of New South Wales (that is, the smaller regions) have remained fairly constant, with a rate of 13.8 per 100,000 in 1971 increasing slightly to 14.1 per 100,000 in 1992. Firearm suicide rates overall, for males living in major rural areas have shown some decline from 12.1 per 100,000 in 1971 to 5.4 per 100,000 in 1992.

Among certain age groups in rural communities however, firearm suicides tend to be high, particularly in comparison to such suicides in urban areas and in comparison to certain other methods used in the rural environment.

ABS data indicate that among the **15 to 19 year age** group living in the smaller rural areas suicide by "firearms and explosives" has, since 1985 especially, remained consistently higher than other methods used, including hanging, gassing, poisoning and drowning. Figure 9 shows this trend. For major rural areas, ABS data suggest that firearm and explosives suicides for this age group show no discernible trend for the twenty year period. However, during this period it did remain above the comparable rates for males in urban regions.

Figure 9

NSW Method of Suicide - Male - Smaller Rural Areas
1971 to 1992
15 - 19 Years



Source: Australian Bureau of Statistics, 1994c (unpublished)

Dudley *et al.'s* research (1992:83) for the period 1964 to 1988 found that suicide by firearms has risen most substantially, from 3.4 to 5.6 per 100,000 per year for 15-19 year old males. The authors (1992:84) further note that

> *the rate of suicide by firearms has not risen significantly in rural cities* ***but in rural municipalities and shires the rates have risen fivefold from 2.8 to 14.8*** (emphasis added).

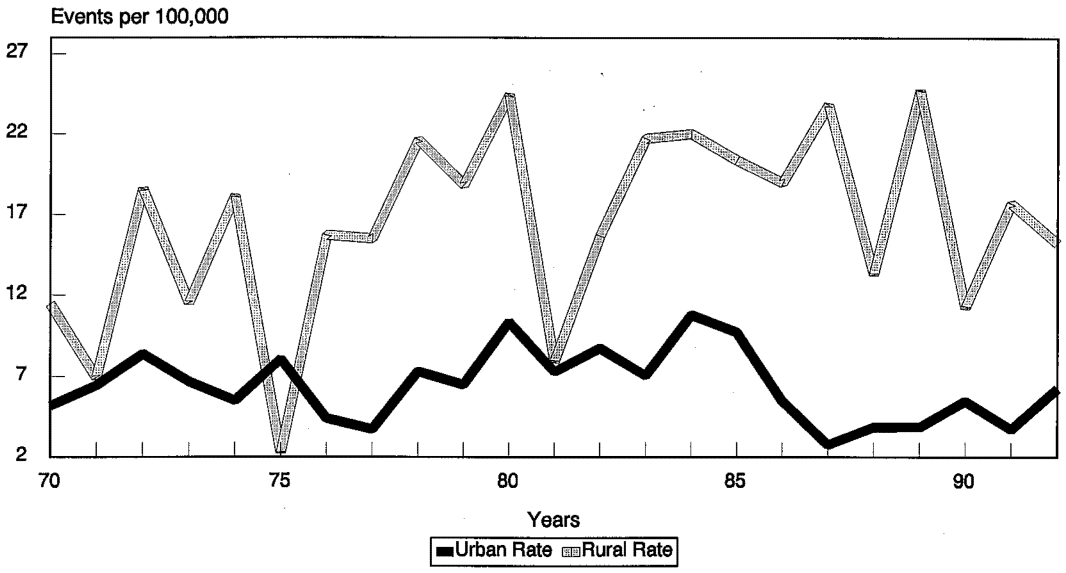
The authors further note that female numbers among this age group and in rural municipalities and shires are "too small to draw conclusions" (Dudley *et al.*, 1992:86).

For the **20 to 24 year** male age group, Morrell's data indicate a consistently higher rate of firearm suicide among the rural cohort than the urban cohort. However, as Morrell (Evidence, 9 May, 1994:57) himself explained in his evidence,

> *the 20 to 24 year old firearm suicide rates... are about three or four times higher than the city rates, but [they are] showing no real increases [for] the whole period.*

Figure 10

NSW Suicide Deaths - Male - Firearms - 1970 to 1992
20 to 24 years



Source: Morrell, 1994 (unpublished)

Figure 10 reproduces Morrell's information for this age group.

ABS data for this male age group dealing specifically with those from the smaller rural communities demonstrate a particularly high "firearm and explosive" suicide rate compared to both major rural areas and urban areas. In 1992 the rate of firearm suicides for this cohort in "other rural" or smaller areas was 18.7 per 100,000 of estimated resident population; in "major rural" areas it was 16.6 estimated resident population and in "urban" areas it was 6.4 per 100,000.

Evidence to the Committee notes that, for the **15 to 24 year** rural male age group collectively, the use of firearm suicides has in fact declined slightly as a percentage of suicide deaths since 1980 (Dr George Rubin, Evidence, 26 July, 1994). Nevertheless as Dr Rubin told the Committee,

> *[use of firearms] is still by far the most common method used in rural areas.*

Dr Burnley's research further shows that in the inland regions of New South Wales, guns were used to suicide by over 50% of the male 15 to 24 year age group compared to only 18 per cent in Sydney (1994:297).

In relation to the male group **25 to 64 years** Dr Rubin (Evidence, 26 July 1994) further explained to the Committee that

> *firearms, again, are the most common [suicide method] but it is declining and equalising with the other methods.*

He also noted in his evidence (26 July, 1994) that

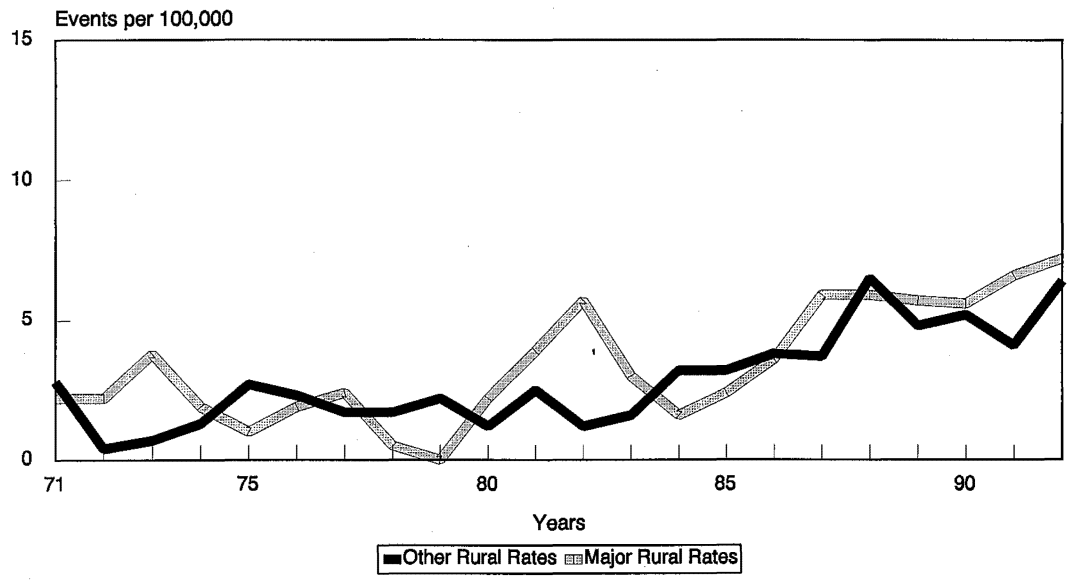
> *for males in the 65-plus age group again firearms [are] the most common cause but it is declining and again becoming very close to the other methods in males...* ***but it seems for rural males aged 15 to 24 that there is still a preponderance of use of firearms as the method of suicide and that is different to the pattern*** (emphasis added).

3.3.2 Hanging

The Committee's investigations indicate that hanging has increasingly become a relatively common method of suicide among people in rural areas. Morrell's data show that, since the 1980s and as a proportion of the total suicide rate, there has been an upward trend in this method of suicide among **rural males.** Data from the ABS, shown in Figure Eleven, demonstrate that hanging suicides among males in major rural areas have risen from 2.2 per 100,000 resident population in 1971 to 7.2 per 100,000 in 1992. For the "other rural" or smaller areas the rate for hanging suicides among males was 2.8 per 100,000 in 1971 rising to 6.4 per 100,000 in 1992.

Figure 11

NSW Suicide Deaths - Male - Hanging - 1971 to 1992
10 to 80+ years



Source: Australian Bureau of Statistics, 1994c (unpublished)

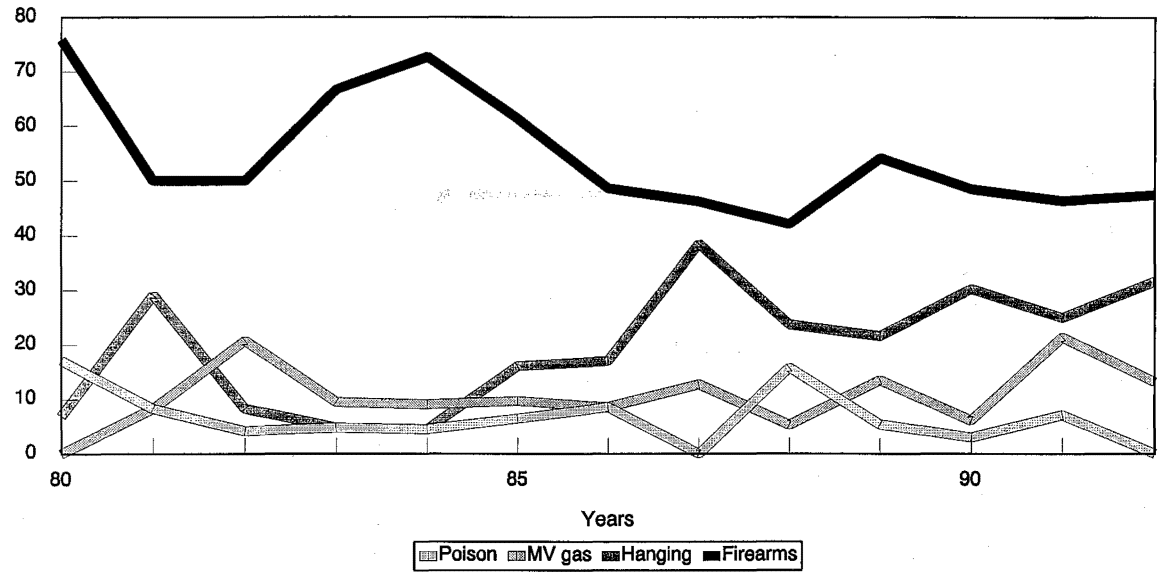
The Committee has been told that among the 15 to 24 year old male rural population hanging is the second major cause of suicide death, behind firearms and, since 1980, there is a discernible increase in its use as a suicide method (Dr George Rubin, Evidence, 26 July, 1994).

A graph depicting this trend, tabled in evidence by Dr George Rubin, is reproduced at Figure 12.

Figure 12

NSW Method of Suicide - Male, Rural Residents - 1980 to 1992

15 - 24 Year Olds: % using each method



Source: NSW Department of Health, 1994 (unpublished)

Dudley *et al.* (1992:85) further note that, from 1964 to 1988, among the 15 to 19 year old rural male group specifically,

> *there has... been a substantial increase in male hanging suicides.*

According to Morrell's evidence to the Committee (Evidence, 9 May, 1994)

> *hanging is becoming an increasingly important means of committing suicide in both rural and urban areas in males. This is all ages.*

3.3.3 Poisoning

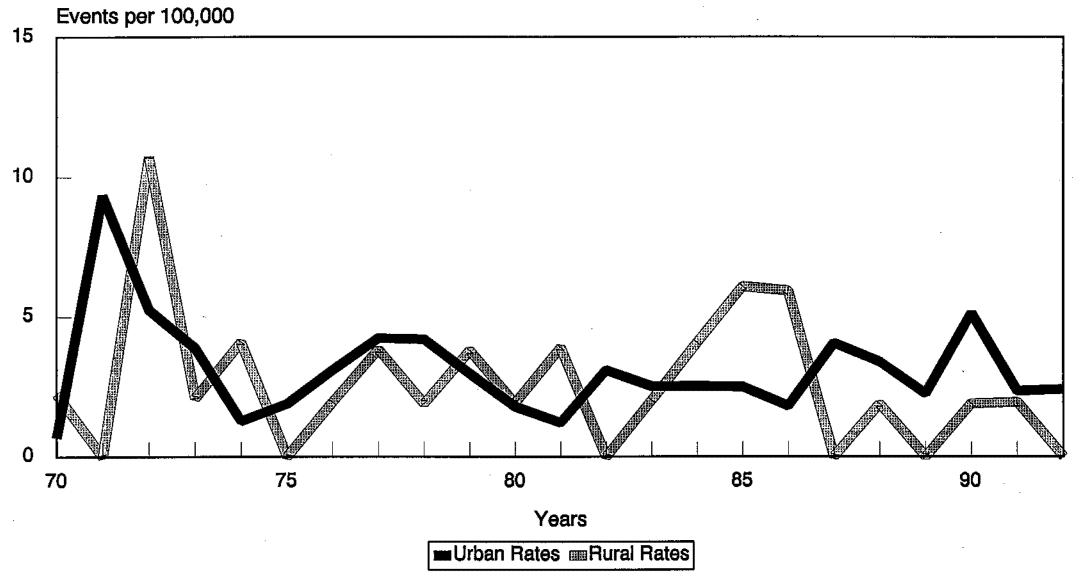
The Committee has heard that poisoning is the most common method of suicide among women in both urban and rural settings. Crowe (1994:5) observes, in relation to Australia generally, that

APPENDIX THREE

GRAPHS ON FEMALE SUICIDE

Figure 13

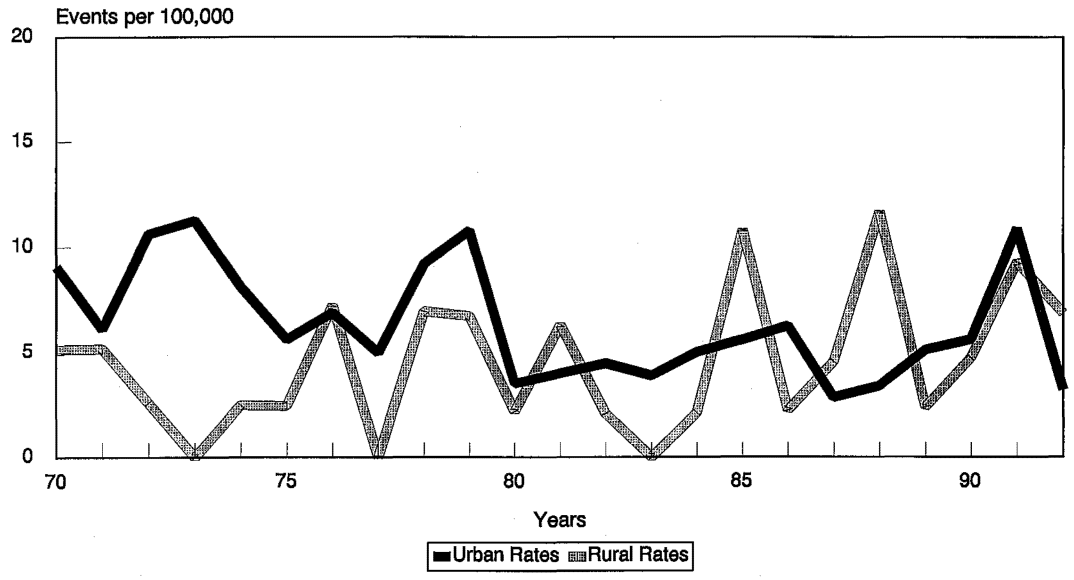
NSW Suicide Deaths - Female - 1970 to 1992
15 to 19 years



Source: Morrell, 1994 (unpublished)

Figure 14

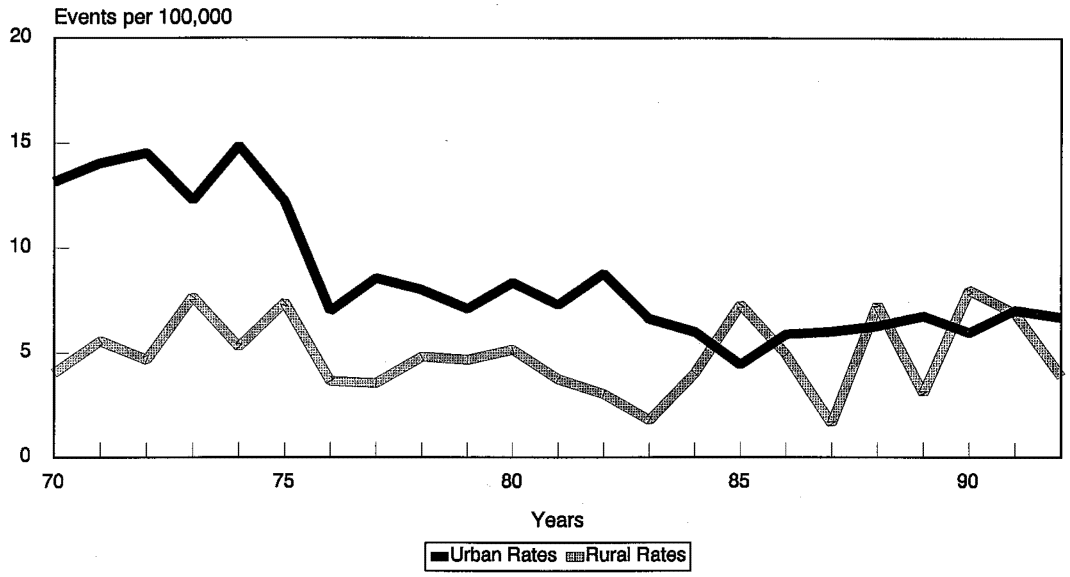
NSW Suicide Deaths - Female - 1970 to 1992
20 to 24 years



Source: Morrell, 1994 (unpublished)

Figure 15

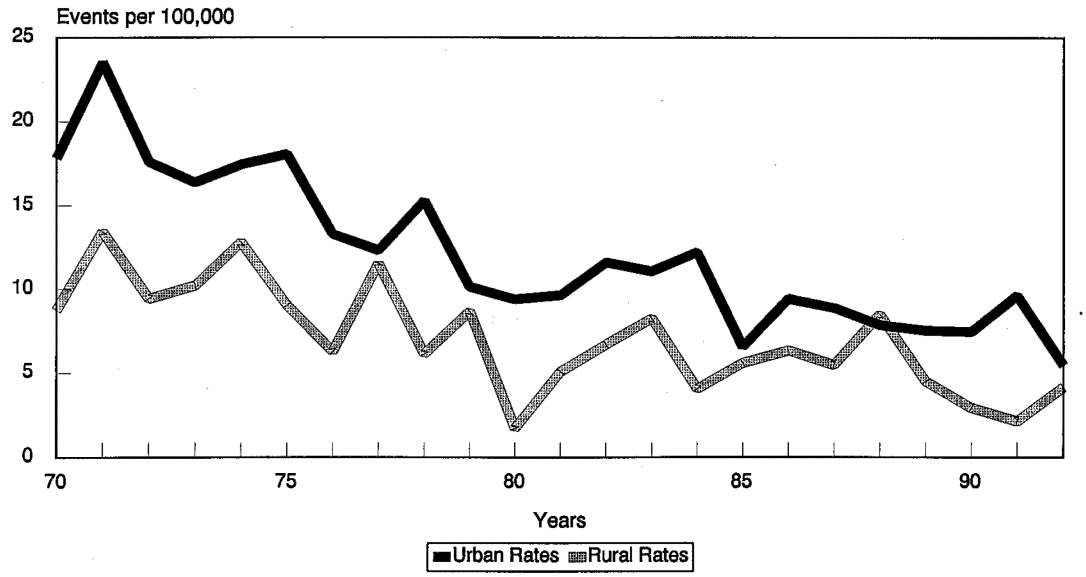
NSW Suicide Deaths - Female - 1970 to 1992
25 to 44 years



Source: Morrell, 1994 (unpublished)

Figure 16

NSW Suicide Deaths - Female - 1970 to 1992
45 to 64 years



Source: Morrell, 1994 (unpublished)

PUBLICATIONS BY THE STANDING COMMITTEE ON SOCIAL ISSUES

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Report No. 3	*Medically Acquired H.I.V.* October 1991
Report No. 4	*Juvenile Justice in New South Wales* May 1992
Report No. 5	*Births, Deaths and Marriages: An Open Register?* March 1993
Report No. 6	*Sexual Violence: The Hidden Crime* *Inquiry into the Incidence of* *Sexual Offences in New South Wales: Part I* December 1993
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which they considered to be "modest" and there was no change in Newcastle or Wollongong (Dudley *et al.*, 1992:83).

Dudley, Waters and Kelk's (1994:3) most recent research however, indicates that

> *male 15 to 19 year rates in smaller rural settings in New South Wales have continued to rise over the three years 1989-1991, reaching a peak of 41.9 per 100,000* ***in towns less than 4,000*** (emphasis added).

The authors further maintain that an examination of the differences in suicide rates between coastal and inland rates in New South Wales

> *shows no significant trends for female rates, but higher increases in rates for males aged 15-24 living inland (15 to 19 years, 5.6 to 26.6; 20 to 24 years, 11.4 to 32.1), than for males living in coastal areas, though this latter group have also suffered increases (15 to 19 years, 7.6 to 12.7; 20 to 24 years, 18.3 to 28.5)* (Dudley *et al.*, 1994:6).

In their 1994 study, which is Australia-wide, Dudley *et al.* (1994:7) note the significance of declining populations of young people and the stable or rising numbers of youth suicide rates in smaller rural areas throughout all of Australia. The authors state that

> *this leads to the calculation of higher rates in these areas; it also leads to greater instability in the rates in these areas from one five year period to another. However, we believe the figures bear witness to the untold final stories of young people and their families in declining or disintegrating rural communities. In New South Wales, there has been a pronounced move from the inland areas to the coast in recent years, the latter areas being relatively resource-rich. An initial investigation in New South Wales shows that young people in inland areas have had greater increases of rates than those in coastal areas, thus supporting the hypothesis that social disadvantage may be of particular importance in contributing to suicide among young males* (Dudley *et al.*, 1994:7).

In examining the age **15 to 24 year male** age group collectively, Burnley (1994:297) observes that

> *mortality rates of males in the 15-24 age group were significantly high in all the inland statistical divisions in the state, with the exception of the Central Western division... Mortality rates were*

> *particularly high in the Far Western Division which includes Broken Hill.*

- **The Elderly**

Suicide among the elderly population of New South Wales, particularly among males, has traditionally been high in comparison to other age groups.

The NSW Health Department has observed that

> *a study of the relationship between suicide and old age from 1961 to 1985 shows that older men over 85 years had the highest rate and that the highest rates for women were recorded between age 55 and 79 years* (NSW Health, 1993a:2, citing Hassan and Carr, 1987).

Nevertheless the Health Department also observes that the relationship between suicide and old age is ever changing with the ageing population.

Whilst the Committee was provided with some evidence of elderly suicides in certain areas of rural New South Wales (including five geriatric male suicides on the lower north coast), it has been unable to discern any overall trends for the state. This should not, however, preclude further investigation and research in the area of suicide among the elderly in rural New South Wales.

3.3 METHODS OF SUICIDE

3.3.1 Firearms

As noted both in the research and the evidence received by the Committee, suicide by way of firearms is essentially a male phenomenon. Whilst some women certainly do commit suicide by this method, the numbers are comparatively small. The following discussion will therefore concentrate primarily on male firearm suicides.

Morrell's data presented in Figure Eight show that firearm suicides among rural males (**age adjusted, 15-64 years range**) have been consistently higher than such suicides committed by urban males during the period 1970 to 1992. Since 1988 rates of firearm suicides among rural males overall have shown a relative decline; in 1992 they represented 7.86 per 100,000 suicide deaths among this group. For urban males in 1992 this rate was 3.07 per 100,000.

> *the predominant method of suicide for females continues to be poisoning by solid or liquid substances but this has decreased from 47% of total female suicides in 1982 to 39% in 1992.*

Dudley *et al.'s* (1992:85) research regarding suicide among young people between the years 1964 and 1998 found that for New South Wales,

> *poisoning is the only method in which the number of female suicides exceeds that of male suicides.*

Oral testimony has been received by the Committee which suggests that certain poisoning suicides, for both males and females, in rural areas, may have been as a result of the ingestion of farming chemicals.

3.3.4 Other Methods

The Australian Bureau of Statistics categorises other methods of suicide as including suicide by inhaling gases, drowning, cutting and piercing instruments, jumping from a high place and suicide by other and unspecified means. Of those, suicide by inhaling gases for males in "major rural" areas would appear to be increasing: in 1971 suicide by this method was 2.2 per 100,000 resident population, rising to 4.4 per 100,000 in 1981 and increasing further to 6.5 per 100,000 in 1992. For "other rural" areas the rate also indicates some rise from 2.8 per 100,000 population in 1971 to 4.8 per 100,000 in 1992.

For women in rural areas the numbers are too small to detect any real discernible trend for these other methods of suicide.

Whilst not always appearing in official statistics, the Committee has received some testimony to suggest that certain events such as single vehicle motor accidents, particularly those on country roads, and where the driver has collided with a tree or even a truck, may in fact be suicides. In the absence of a suicide note or some other overwhelming evidence, it is often the case that such events are recorded as "accidents".

3.4 SUICIDE AMONG ABORIGINES

The Committee's investigations have shown that until very recently official data concerning suicide mortality among Aborigines essentially underestimate the problem and are therefore unreliable. This is especially so for Aborigines in rural communities.

The Royal Commission into Aboriginal Deaths in Custody found that many incarcerated Aborigines had died as a result of self-inflicted harm. This was often brought about because of a lack of proper care on the part of the police and prison officers or relevant medical services, intoxication by the Aboriginal inmate and an enormous level of despair and profound depression. Although this Inquiry will be examining suicides essentially from a non-custodial perspective, reference will be made in the Report to some of the findings of the Royal Commission into Aboriginal Deaths in Custody.

ABS data show that from 1981 to 1992 the number of male Aboriginal suicides in major rural areas of New South Wales was seven. Recorded suicide deaths among Aboriginal males in "other rural" areas for that same period totalled 17. The number of suicide deaths for Aboriginal women between 1981 and 1992 is recorded as one; for Aboriginal women in "other rural" areas the number of suicide deaths for this period was four. In actual numbers the most common method of suicide for both males and females appears to be within the category of "hanging, strangulation and suffocation". The rates of these suicides are unavailable, making it very difficult to compare these figures with suicide deaths for the non-Aboriginal population adequately.

Nevertheless indirect evidence suggests that there is an increasing incidence of suicide and suicide attempts among Aborigines, including in rural and remote regions (Baume, 1994:7). This has been clearly borne out in both submissions and oral testimony received by the Committee as well as in a number of studies (see for example, Hunter, 1988). The issue of Aboriginal suicides, especially among the rural population, will be discussed in further detail throughout the Report.

3.5 SUICIDE AMONG PEOPLE BORN OUTSIDE AUSTRALIA

Crowe (1994:5) observes that

> *the age standardised death rate from suicide for persons born overseas and Australian born persons is very similar and has shown little variability over the reference period [1982 to 1992].*

In relation to New South Wales specifically, Burnley (1994:302) notes that

> *mortality of the overseas-born and Australian-born did not differ significantly, in contrast to mortality from other causes, which is lower. However, this does not exclude the possibility that high suicide rates may exist for particular countries of birth. A more detailed analysis of suicide by country of birth is required, because of the large variations in cultures among the overseas-born.*

Data on levels of suicide among overseas born people living in rural communities are limited. Further, little information has been received by the Committee dealing with this issue. In relation to people from non-English speaking backgrounds (NESB) specifically, it has been suggested that because of the low number of NESBs in rural areas it may be difficult to obtain reliable rural figures (Personal Communication, 30 August, 1994).

3.6 CONCLUSION

As the following discussion has demonstrated, rates of completed suicide in New South Wales are of concern, most notably among young males. In recent times young rural males especially have become a significant at risk group and rates of suicide among this group in the smaller and more remote regions of the state have shown greater increases than those in urban centres. Although accurate data on attempted suicide are limited, the evidence received by the Committee indicates that females tend to make more attempts on their lives than males. Males, however, have higher rates of completed suicide. For rural males, firearms remain the most common method used to suicide but this has shown some decline among some groups over time while rates of suicide by hanging are increasing.

The following section will examine some of the factors associated with suicide and suicidal behaviour as provided both in evidence to the Committee and in documented research.

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.**

CHAPTER FIVE

STRATEGIES FOR THE PREVENTION OF SUICIDE IN RURAL NEW SOUTH WALES

As the causes of suicide are complex and interacting, the development of prevention strategies require thoughtful and detailed consideration and should be aimed at addressing a broad range of factors.

Because the Inquiry's Terms of Reference require the examination of suicide in rural areas only, the Committee is not in a position to extend beyond that brief. However, it is hoped that a number of the recommendations will be equally relevant to the issue of prevention of suicide for those living in urban areas and contribute to a model for those areas.

The Committee recognises that in many instances local responses are required to identify the issues and needs specific to a given community. It acknowledges also that such responses require support and coordination. The Committee recognises that in formulating its prevention recommendations for rural areas it is not always useful merely to transfer general or urban responses to suicide to the country.

The Committee notes that suicide is a relatively uncommon event. However, this should in no way diminish the significance and magnitude of the problem and the need to implement preventative initiatives. Suicide deaths in New South Wales now exceed deaths by motor vehicle accidents. It has been suggested that the ongoing and consistent prevention campaigns aimed at reducing road fatalities have significantly contributed to the decline in such deaths. The Committee proposes that similar priority be given to suicide prevention.

The Committee also recognises that in the context of suicide prevention it is necessary to evaluate and monitor the outcomes of any strategies and initiatives to ensure that they are effectively targeting those in need.

The Committee accepts that prevention may be considered from three approaches: primary, secondary and tertiary.

Pransky (1991:4) defines these terms in the following way:

> *Primary prevention is what happens for everyone, before there is any sign of a problem. Conditions are created that build a state of health and well-being - for everyone.*
>
> *Secondary prevention or early intervention happens at the earliest signs of a problem, or whenever a person or group can be identified 'at risk' of a problem.*
>
> *Tertiary prevention... bills itself as preventing people from getting into trouble again, or getting sick again ...[its purpose is] to rehabilitate, to reconstruct and to treat [and it targets] troubled people, diseased people and clients.*

It is proposed to deal with the issue of prevention strategies for rural suicides in the framework of these approaches. The Committee acknowledges that there can be overlap within these categories, particularly in relation to secondary and tertiary prevention. For the purposes of this Report tertiary prevention will specifically include tertiary services, that is specialist mental health services that assist people with a mental illness or who are at risk of suicide.

5.1 A COORDINATED APPROACH

This Inquiry has highlighted that the problem of suicide Australia-wide requires immediate attention and a coordinated response from government and community groups alike. Ongoing research, as well as the development of effective programs and initiatives are required to ensure that our high international suicide rating, especially among young people, is reduced.

As the Committee noted in Chapter Four, the National Health and Medical Research Council Suicide Prevention Working Party is currently working on initiatives and strategies to address suicide on a national level. Whilst the Committee acknowledges the importance of a national approach to suicide prevention as highlighted in Recommendations 4 and 5, it also considers that much can be done on a state level to assist in the reduction of actual and attempted suicide, and the minimisation of risk factors among certain groups. The Committee notes that a number of recent initiatives by the NSW Department of Health indicate a move in this direction, including the NSW Youth Health Plan (1994a) and the release of the Policy Guidelines on Suicidal Behaviour (1994b). These will be referred to further in this section.

The Committee also considers it important that suicide prevention be given a particular focus and be accorded a priority status within the Department of Health. Accordingly, for New South Wales, the Committee recommends that a senior position be created within the Mental Health Branch of the New South Wales Department of Health to examine issues relevant to suicide and suicide prevention. This senior officer, in consultation with a range of departmental, professional and community representatives, is to be responsible for a number of activities including:

- monitoring of suicide rates throughout the state;
- developing and implementing strategies and initiatives in the area of suicide prevention relevant to New South Wales;
- monitoring outcomes of those strategies and initiatives; and
- undertaking relevant research.

As well as the Area and District Health Services, the senior officer should also liaise with a range of Departments and organisations including, the Department of School Education, the Office of Youth Affairs, TAFE, the Police Service, the Department of Community Services, the Department of Courts Administration (Coroners), the Department of Corrective Services, the Department of Juvenile Justice, the Department of Agriculture as well as the Public Health, Community Health, Aboriginal Health and Rural Health Sections of the Department of Health. Liaison should also be undertaken with a range of relevant community and rural organisations and the proposed National Centre for Suicide Research (See Recommendation 5).

Given that suicide strategies need to be constantly monitored, the Committee considers that the position of senior officer be created for a period of two years initially and by way of a secondment from within the Health Department, and then evaluated after that period with a view to it being permanently established.

RECOMMENDATION 6

That a senior position be created within the Mental Health Branch of the New South Wales Health Department to deal with issues of suicide and suicide prevention and that appropriate resources be available to the designated officer to undertake his or her duties.

RECOMMENDATION 7

That the duties of the Senior Officer referred to in Recommendation 6 be:

- **to liaise and consult with a range of relevant departmental, professional, community and rural representatives on issues relevant to suicide prevention;**
- **to liaise and consult with the proposed National Centre for Suicide Research;**
- **to monitor suicide rates (including suicide attempts) throughout the state;**
- **to develop and implement strategies and initiatives for suicide prevention;**
- **to monitor the outcomes of suicide prevention strategies and initiatives;**
- **to act as State Coordinator for local and regionally-based Suicide Prevention Taskforces (see Recommendation 21); and**
- **to undertake relevant research.**

5.2 PRIMARY PREVENTION

As indicated above, primary prevention is aimed at creating conditions that build a state of health and well-being for everyone. A significant role of primary prevention is to address the broader social factors that may compromise the well-being of communities and groups. In recognising the significance of this role, the NHMRC (1993:179) notes that,

> *prevention... needs to be seen in the social context and the impact of social changes evaluated for potential positive and negative impacts on mental health.*

As much of the information received by the Committee has indicated, there are a variety of external factors which may compromise a person's mental health. As documented in Chapter Four, evidence has been received that suggests that these factors may also place vulnerable individuals at risk of suicide. For many people, vulnerability to mental and psychological distress may be heightened if they are

subject to adverse social and economic circumstances. Thus, as Raphael states (1994:16),

> *prevention policies in these social domains need to encompass broad enrichment programs addressing social adversity, social justice and equity. They must include, alongside these initiatives, focal programs for the marginalised and disadvantaged.*

Within the social domains relevant to both mental illness and suicide prevention, the Committee has heard and noted in Chapter Four, that issues such as family discord and breakdown, unemployment, social and economic disadvantage, violence, substance abuse, access to education, parenting skills and issues relating to gender, culture and sexuality, need to be considered.

In his examination of suicidal behaviour, specifically among adolescents, Davis (1992:101) recognises that a number of social problems require attention. He maintains that youth unemployment, which is intrinsically linked to prevailing economic circumstances, is a major concern. He also cites the issue of drug and alcohol abuse as necessitating action. Davis (1992) maintains that in terms of family life, we have to concede that marital breakdown is common and that many children have to negotiate this upheaval. As he (1992:102) notes,

> *at the same time much can be done to modify social and personal stresses in families, particularly those related to caring for a sick or handicapped member, financial strain, or poor organisational and living skills. It is important that vulnerable couples are made aware of, and have access to, marriage guidance and living skills programs, and that when separation occurs children are assisted through emotional upheaval generated by parental conflict and family break up.*

As this Report has demonstrated, many rural communities and families today are suffering considerable economic and social hardship brought about by the rural downturn and the devastating drought. Information given to the Committee suggests that many of the factors identified above are being experienced at a significant level among rural families. As the Committee has highlighted throughout the Report, evidence has been submitted indicating that many young people in the country believe that they will never find a job. For many individuals the situation appears hopeless, futile and without end. Specifically, the Committee has heard evidence of young people attempting suicide in increasingly high numbers in rural areas because of feelings of hopelessness, purposelessness and profound despondency (Evidence, 12 August, 1994).

This report has shown that many farming communities are also experiencing considerable stresses. The Committee has heard that much of this has been as a result of the rural downturn and the effects of long-term and crippling drought.

Clearly, many of these issues fall within the national domain. The Committee considers there to be a national need to address the rural crisis, to support and develop the rural economy and to develop policies, in consultation with the banks, to ensure that the needs and experiences of rural customers are given due consideration in periods of crisis. As a state-based Committee we can merely urge the Federal Government, albeit in the strongest possible terms, to recognise the rural community as a priority for economic, employment and business policy.

The Committee recognised in Chapter Four that drawing *definitive* conclusions about social factors and suicide can be complex. However, the Committee also noted, ongoing and specific research should be developed and supported that explores the complex relationship between these factors, mental health and suicide. Accordingly it has recommended that the Minister for Health urge the Australian Health Ministers' Council to support the development a National Centre for Suicide Research (See Recommendation 5).

Whilst the Committee anticipates that the proposed National Centre for Suicide Research undertake extensive research into issues relevant to suicide, it sees a role for the senior officer referred to in Recommendation 6 to monitor the effects of a range of factors that may impact upon suicide rates in New South Wales.

RECOMMENDATION 8

> **That the Senior Officer referred to in Recommendation 6 monitor the effects of the following factors on suicide rates in New South Wales: mental illness, unemployment, poverty, financial pressure and the rural crisis, isolation, family and/or relationship breakdown, violence, alcohol and substance abuse, drought, issues relating to sexuality, the media, loss, issues affecting Aboriginal people and any other relevant social factor and, in consultation with relevant Government and non-government groups and professionals, as well as the proposed National Centre for Suicide Research (Recommendation 5) develop appropriate strategies, the outcomes of which are to be routinely monitored.**

5.2.1 Community Awareness

Chapter Four of this Report examined the issue of the stigma associated with mental illness and suicide. The Committee considers that the issue of community

or public education is one of particular relevance to the overall issue of suicide prevention.

Whilst the Committee is concerned about the degree to which publicising suicide may lead to risk of 'copy cat' or cluster suicides, it agrees with the findings of Raphael's Report to the National Mental Health Research Council (1993:72) that there nevertheless needs to be

> *greater public awareness of risk factors for suicide, how to offer help and support, and the relationship of suicide to mental illness, which can be effectively treated. Clearly, education and understanding needs to be enhanced both in terms of increased sensitivity to support for those at risk.*

Fundamental to any educative strategy for the prevention of suicide is the need to break down the stigma of psychological and emotional distress and mental illness. It is important that these issues be viewed by the wider community not as failings, but as legitimate health concerns requiring attention and treatment, as well as understanding and compassion.

The Inquiry has found that young rural men, in particular, are a major risk cohort for suicide. However, many of these young men are raised in a culture which discourages them from disclosing feelings of depression, despair and hopelessness and demands the demonstration of sometimes excessive resilience. The Committee has also heard that farmers too, who have been identified as being a significant risk group for gun suicides (Burnley, 1994:21) are traditionally reluctant to reveal feelings of emotional pain, torment or psychological distress. However, the Committee acknowledges that this problem is one that is part of the entire Australian culture. As one submission to the Inquiry explained,

> *I sometimes think that the "macho" Australian image has much to answer for. The messages that males don't cry, are always strong (physically and emotionally) and can prove their maleness by drinking to excess and engaging in high risk activities provide no coping mechanisms for a man experiencing a loss and grief situation. I believe that it is important for males to learn that it is O.K. to cry and certainly no reflection on their maleness or a sign of weakness to admit to feelings that can be painful or devastating* (Submission 27).

The Human Rights and Equal Opportunity Commission's Inquiry into Human Rights and Mental Illness found that "the community has a poor understanding of mental health issues and generally lacks compassion for those affected by mental illness"

(1993). Accordingly, it recommended that there be a nationwide campaign to educate the general community about mental illness.

The Committee understands that, in an effort to break down the stigma associated with mental illness, the NSW Department of Health is developing information about mental illness for distribution in the community, through both the Area and District Health Services. The Committee strongly endorses this action.

The Committee notes that, under the National Mental Health Strategy, a national community education program is to be commenced in the near future, aimed at lifting community awareness of mental illness. The Committee has heard that $6.1 million will be spent over the next four years to realise that program and tenders for advertising agencies are in progress with the goal of commencing the strategy shortly (Evidence, 26 July, 1994). The NSW Health Department has advised the Committee that while not specifically addressing suicide, the program can be anticipated to create a positive environment for other educative tasks. The Department, as well as a witness before the Committee has indicated that if it succeeds in reducing the stigma and discrimination associated with mental illness, the program may also encourage people to talk about mental illness, to seek help or be referred for help earlier, thus impacting upon potential suicide (Submission 42).

The Committee commends the development of this strategy and strongly encourages its swift implementation. In relation to New South Wales in particular, the Committee urges the Minister for Health to ensure that rural communities are targeted as a priority for the national community education program.

In Section 5.5 of this Chapter, the Report will address the issue of strategies for the prevention of suicides among Aboriginal communities. The Committee has heard that like non-Aboriginal communities, Aboriginal communities need education in the identification of mental illness and encouragement to attend services for assistance. Of equal significance is the need for workers in relevant services, especially those workers with a non-Aboriginal background, to be trained in cultural awareness so that Aboriginal people feel comfortable about accessing the services. This issue will be specifically addressed in Section 5.5.

RECOMMENDATION 9

That the Minister for Health urge the Australian Health Ministers' Council to ensure that the interests and needs of rural people, including farmers, young people, people living in remote communities and Aboriginal people, are included as a priority in the proposed National Community Education Strategy on raising awareness of and reducing the stigma associated with mental disorders.

RECOMMENDATION 10

That the Minister for Health ensure that the New South Wales component of the National Community Education Program aimed at raising awareness of mental disorders targets rural communities as a priority, including farming communities, young people, people living in remote areas and, in consultation with Aboriginal organisations and Aboriginal communities, Aboriginal people of New South Wales. Issues relevant to suicidal risk behaviour, such as depression, should be addressed in that strategy, and information about relevant support services, as well as the encouragement to utilise those services, should be provided.

As mentioned above, the Committee is concerned about the degree to which publicity of a particular suicide may influence vulnerable individuals in their decision to suicide. It has been observed that this is a phenomenon found largely among young people and heightened risk has been noted following press reports of the suicide of a celebrity. In acknowledging the impact of the press on suicides among young people, Davies (1992:99) observes that

> *the media has a responsibility to carefully inform the community about mental illness and suicidal behaviour among youth.*

The Committee supports this observation and considers that mental health issues and suicidal behaviour among all age groups should be dealt with by the media in a non-sensational, unexaggerated way. It is imperative that any reporting or public education campaign indicate where help can be sought and *encourage* distressed and disturbed people to seek help.

RECOMMENDATION 11

That the Minister for Health, in consultation with the Australian Press Council, urge media organisations to continue to report any matters relating to suicide in a responsible and non-sensational manner.

5.2.2 Access to Methods

As the Committee has indicated earlier in this Report, the relationship between access to methods and suicide is an issue that generates much debate and concern. In Chapter Four the Committee outlined the various positions in relation to this debate. Much of the Committee's evidence has concentrated on the accessibility of firearms given that they are more readily available in rural areas, and they are frequently used in suicides, especially among young men. Whilst our evidence indicates that, overall, firearm suicides have in fact declined in recent times, they nevertheless remain the major method of suicide deaths among males in rural areas, and are particularly high among young males in the smaller and remote areas of the state.

Apart from firearms, anecdotal evidence has also suggested that a significant number of poisoning suicides in country areas are committed by use of fertilisers and other chemicals relevant to farming. Further, statistical evidence shows that suicide by hanging in rural areas has increased in recent years and therefore is another area of particular concern.

- **Firearms**

A number of witnesses gave evidence to the Committee about the suicide of their loved ones. Not only had most of these individuals suicided by use of firearms but many were under 25 years. In one instance the victim was 11 years old. All victims had ready access to a firearm. In spite of this, the Committee has received clear messages from many country and city community witnesses alike, that further restrictions on the accessibility of firearms in rural areas is highly problematic. At the same time, many of those witnesses, as well as a number of experts, have also acknowledged that some sort of control or other preventative strategy needs to be put in place to prevent firearm suicides.

According to Snowden and Harris (1992:82), "to reduce firearm suicide it is appropriate to consider other measures as well as tightening legislation". In this context the Committee notes the "culture" surrounding gun use: essentially male-oriented and associated with issues of power and machismo. It also notes that gun use is considered to be an accepted and acceptable part of rural culture and a necessary adjunct to agricultural industry.

The Committee acknowledges that firearms can serve legitimate purposes in farming environments such as vermin control, putting down sick or maimed animals and providing meat for the household. The Committee also notes that in the

current drought many farmers have been forced to dispose of animals more frequently. At the same time, the Committee has also heard that some rural households contain a large number of guns, many of which are rarely used. One witness indicated to the Committee that

> *a family in the country which has a legitimate use for a gun maybe needs one or two but has no reason for seven or eight or 15 guns. There is still scope to reduce the gun stockpile in the country, even if we acknowledge the use of guns in farming life* (Evidence, 28 July, 1994).

The Committee notes, however, that an individual only needs one gun to harm him or herself.

Much of the literature, especially that produced by health professionals, suggests that access to a firearm provides a crucial link in a chain of factors associated with a suicide. De Moore *et al.'s* recently published eight year study (1994) found most people who have shot themselves deliberately do so impulsively, are not psychotic and have ready access to firearms. The authors' findings suggest that, had the firearm been unavailable, the person may not have sought out an alternative method of self-harm.

Current laws in New South Wales require that any person wishing to own a firearm must obtain a licence. A number of options for the use of the firearm are provided on the licensing form. A licensee must nominate which option covers the purpose for which he or she wished to obtain a firearm. Among those options are hunting, recreational shooting and vermin control. However, the Committee heard that there is no subsequent requirement to prove that the purpose for which the firearm will ultimately be used is that which is nominated on a licence form (Evidence, 28 July, 1994). There is no requirement to register guns nor is there a limit on the number of guns a licensee may own. In order to obtain a firearm licence, an applicant must undertake a written test. There is no requirement for a practical test on firearm safety.

Among those who are unable to obtain a licence are people with a criminal record, those who are the subject of an apprehended violence order, those who have previously attempted suicide or caused self-inflicted injury or those who are of unsound mind. Moreover,

> *on the New South Wales firearm licence application form the applicant must detail any physical or mental disability and any referral for or treatment for alcoholism, drug dependence or a mental or nervous disorder within the last year. Police are also required to follow up applications with inquiries so as to ascertain*

the applicant's fitness to possess and use a firearm (NSW Cabinet Office, 1993:25).

A Discussion Paper prepared by the NSW Cabinet Office and the NSW Police Service examined the issue of mental illness and firearm misuse, an issue that was initially raised in the Report of the Parliamentary Joint Select Committee Upon Gun Law Reform. Most of the recommendations contained in the Report of the Joint Select Committee were incorporated into the Firearms Legislation (Amendment) Act 1992. Those recommendations relating to mental illness and firearms misuse were not implemented. It was considered that those recommendations required further examination and thus provided the subject for the joint Cabinet Office and Police Service Discussion Paper, entitled Mental Illness and Firearms Misuse.

Building on the recommendations of the Joint Select Committee Report, among the recommendations contained in the Discussion Paper were:

- that a voluntary reporting scheme be established so as to enable any person to report to police that a firearm licensee should not (in the opinion of the person reporting) continue to hold a firearms licence;

- that the Police Service take the necessary steps to acquaint medical practitioners, health care professionals and the public about the proposed voluntary reporting scheme, and that such steps include publication in major community languages; and

- that the proposed voluntary reporting scheme be modelled on the Roads and Traffic Authority's procedures for following up reports relating to driver's licences (NSW Cabinet Office, 1993:3).

The Committee commends these proposals and emphasises that a voluntary reporting scheme should be sensitive to the rights of the individual and also have regard to privacy issues.

At the same time however, the Committee is concerned that many at risk individuals who are not licensed gun owners may have access to firearms This may be the case, for instance, in families where a parent is the licensee and the children may nevertheless have access to the firearm.

Moreover, in light of de Moore *et al.'s* findings, people who present with self-inflicted gun shot wounds have often had limited contact with psychiatric services and so may be missed under a voluntary reporting scheme. De Moore *et al.* (1994:422) argue in relation to their study population that

> *many of the patients voiced suicidal concerns only in the days or weeks before the shooting, leaving little time to mobilise care. It is also possible that some patients, particularly in rural areas, may have had limited mental health services or may not have known how to access them.*

The Committee anticipates that its recommendations relating to the encouragement of people in rural areas to seek help in times of psychological and emotional crisis and those dealing with services may go some way to address this particular problem.

The Committee understands that the Government is soon to establish a Firearms Advisory Committee which will be made up of a wide range of community representatives. The function of the Committee will be to advise the Minister for Police and Emergency Services in relation to firearms.

It has been proposed that the tasks of the Firearms Advisory Committee include an examination of the Cabinet Office Discussion Paper on Mental Illness and Firearms Misuse.

The Committee endorses the establishment of a Firearms Advisory Committee. It also considers it appropriate for the Firearms Advisory Committee to examine the recommendations of the Discussion Paper on Mental Illness and Firearms Misuse. Further, the Committee was told that firearm suicide deaths are lower in Western Australia than in New South Wales. It therefore considers that the Firearms Advisory Committee should examine the Western Australian licensing system.

In relation to young people specifically, who may have ready access to guns, the Committee considers it essential that parents ensure firearms and ammunition are stored safely and securely. Moreover, it also considers that parents with guns must be thoroughly and regularly reminded of the dangers posed by firearms and their association with suicidal risk among young people. Parents should be strongly encouraged to attend safety awareness programs.

RECOMMENDATION 12

> **That the Minister for Police and Emergency Services convene, as a matter of urgency, the Firearms Advisory Committee to advise him on issues relevant to firearms.**

RECOMMENDATION 13

That the Minister for Police and Emergency Services ensure that representation on the Firearms Advisory Committee be broad based, including for example, representatives of sporting shooters, the farming community, the police service, proponents of gun control, experts in domestic violence, health professionals and victims groups.

RECOMMENDATION 14

That the Minister for Police and Emergency Services ensure that the tasks of the Firearms Advisory Committee include the following:

- **an examination of the recommendations of the Cabinet Office Discussion Paper on Mental Illness and Firearms Misuse;**
- **an examination of the need for full and proper training in safe firearm use before a person may obtain a firearm licence and the inclusion in that training program of a compulsory suicide awareness component;**
- **the development of a specific, accessible and ongoing community education program which examines the dangers of firearm misuse, and which targets as a priority, rural areas of New South Wales. Awareness of the possibility of suicide risk and firearm accessibility, especially among young people, should be emphasised in this education program;**
- **an examination of the effectiveness of Section 12 of the Firearms Act, 1989, (as amended by the Firearms Legislation (Amendment) Act, 1992) relating to the safe keeping of firearms and ammunition, especially in relation to rural areas; and**
- **an examination of the Western Australian firearm licensing system.**

The Committee has been told that because of the current drought, many farmers have been forced to dispose of their stock at increased rates. A submission to the Committee stated that this action is deeply distressing to, and demoralising for many farmers. The author observed that

> *it is no wonder then that a farmer is tempted to turn the gun on himself and suicide, as has happened in one particular case that I know of... Everyone is aware that rural suicide is on the increase.*

We believe that unless farmers are relieved of having to destroy their own animals, we could see more of them turning the gun on themselves.

Accordingly, it was suggested to the Committee that farmers should not have to personally destroy their stock but be able to call on assistance from the Department of Agriculture or the Army. The Committee strongly supports this proposal.

RECOMMENDATION 15

That the Minister for Agriculture and Fisheries develop, as a matter of urgency, an assistance scheme for farmers, to enable farmers to utilise the services of the Department of Agriculture when disposing of their stock.

5.2.3 Other Methods

As noted earlier, anecdotal evidence has been received by the Committee suggesting that some poisoning suicides in rural regions are committed by ingestion of fertilisers and other farming-related chemicals. Whilst the Committee recognises the importance of these chemicals for farming enterprises, it strongly encourages parents, in particular, to ensure that they are safely contained and not readily accessible.

The Committee's discussion in Chapter Four also highlighted the issue of packaging and accessibility of medication and its association with suicide. In his evidence Dr Michael Dudley referred to the packaging of antidepressants and the Committee has heard elsewhere of the possible lethal effects of medication such as paracetamol, erroneously considered harmless, in suicidal behaviour. The ease of accessing benzodiazepine drugs such as Serapax and Rohypnol, particularly among young people is also a matter that has been raised as a concern.

The Committee therefore urges the Minister for Health to raise with the Australian Health Ministers Council, as a means of suicide and attempted suicide prevention, the need to investigate the packaging and classification of, and the health warnings on, certain medications, including antidepressants, and the ease of gaining prescriptions of medications particularly benzodiazepines.

RECOMMENDATION 16

That the Minister for Health raise with the Australian Health Ministers' Council, as a means of suicide and attempted suicide prevention, the need to investigate the packaging and classification of, and the health warnings on, certain medications, including antidepressants, and the ease of gaining prescriptions of medications particularly benzodiazepines.

As data shows, suicide by hanging has increased as a method of suicide in rural areas in recent times. The Committee therefore considers it essential that the possible reasons for this phenomenon be investigated with a view to developing strategies to prevent its further increase.

RECOMMENDATION 17

That the proposed Senior Officer referred to in Recommendation 6, in collaboration with the proposed National Centre for Suicide Research (see Recommendation 5), investigate the causes for the increase in suicide deaths by hanging, especially in rural areas.

5.3 SECONDARY PREVENTION

Secondary prevention refers generally to the intervention strategies that are put in place at the earliest signs of a problem or whenever a person or group is identified as at risk.

The early identification of and intervention with those at risk of suicide is considered to be a major factor in suicide prevention. Of relevance in this context are the education and training of relevant professionals as well as community members to detect suicide risk factors and to respond appropriately in potential or actual crisis situations. Also of relevance in this context is the establishment of local community groups or regional task forces, that have as their major aim suicide prevention.

5.3.1 Education and Training of Professionals and Community Members

The above discussion has addressed the importance of community education as a step towards the prevention of suicides. In this section it is important to look at the significance of education and training for those who are likely to come into contact with distressed, depressed, profoundly stressed and mentally disordered and suicidal people in rural areas. Among this group of professionals are local

general practitioners, nurses, hospital staff, school teachers, police, members of the church and of course, community and family members. It has been suggested to the Committee that general practitioners in particular require specific training in the identification of at risk factors for suicide as they are the most likely to be first consulted for stress-related health problems and are able to refer a person to a mental health specialist.

The importance of education and training in suicide awareness and intervention has been highlighted to the Committee. It has been repeatedly stressed throughout the Inquiry that, for many people, professionals and community members alike, it was difficult to know what to look for as warning signs prior to a suicide, or what action to take. Moreover, the Committee notes that,

> *there is consistent evidence that the majority of young people communicate their distress and often their intent, as do older people, in the weeks before they suicide* (NHMRC, 1993:70)

The Committee has also heard that education and training are important to dispel many of the myths surrounding, and the negative attitudes towards, suicide. For instance, suicidal behaviour or attempts, particularly by young people, are often considered to be mere attention seeking actions, not warranting intervention. The Committee understands that these attitudes can be held by both professionals and lay people. According to a submission received by the Committee,

> *staff attitudes to suicide need extensive investigation and education. Staff who may be frontline... such as mental health and general nursing staff, resident medical officers, G.P.s, school counsellors etc, should have ongoing education in mental health and suicide awareness issues and be taught compassion and tolerance in this area.*

In recent times a number of organisations have developed comprehensive education and training programs aimed at raising the awareness of professionals and community members in relation to suicide risk factors, and offering guidance as to appropriate intervention, including the management of a suicidal crisis. Amongst those organisations brought to the Committee's attention during the course of the Inquiry were Rose Education Training and Consultancy, Youth Prevention Australia and the Murray Training Consultancy, based in Albury. The Committee notes that the North Coast Public Health Unit under the North Coast Gains in Injury Project is also undertaking suicide awareness training workshops for professionals such as school teachers, general practitioners and counsellors. This project, as well as the Rose Education Consultancy, also provides "train the trainer" workshops for those who wish to present suicide training awareness for others. Rose Education also

offers programs on how to assist survivors of suicide, including bereaved family and friends.

Evidence to the Committee concerning suicide awareness workshops indicate that they have strong support from rural communities. A submission from Appleby, King and Kay observe that

> *some rural communities have sought to train their personnel in community based caring and support services. Members of the police force, Ambulance Service, funeral directors, general practitioners, hospital staff, clergy and so on, have had the opportunity of attending workshops on suicide awareness education and prevention conducted by Rose Education and Training. Other communities have supported community education workshops for the general public.*

That submission also noted that many positive outcomes have emerged following suicide awareness workshops, including the establishment of community suicide prevention task forces, the establishment of survivor groups, an increased awareness of the needs in an area and the improved networking of agencies.

The Committee notes that in April 1994 the Minister for Education, Training and Youth Affairs commissioned Suicide Prevention Australia (formerly National Youth Foundation) to conduct youth suicide prevention workshops for New South Wales regional teachers, school counsellors, youth workers and health workers. Among the regional centres targeted for the workshops were Coffs Harbour, Bega, Leeton, Deniliquin, Balranald, Broken Hill, Bourke, Moree, Dubbo, Ballina, Tamworth, Parkes and Nowra. The major aims of the workshops were to raise awareness about issues leading to youth suicides and provide education and training in suicide prevention skills for youth and community workers, school counsellors, health workers and other community members.

The Committee commends all of these initiatives in the area of suicide awareness and prevention education and training. However, it is concerned that such programs are largely *ad hoc* and for many communities, merely one-off, particularly in those communities that have not established suicide prevention task forces or who have not participated in "train the trainer" workshops. Their effect in raising awareness therefore may only be short-term.

The Committee considers it essential that there be a coordinated approach to suicide awareness education and training that is both state-wide and on-going. This should be achieved through collaboration with relevant Government Departments and suicide awareness education and training organisations.

A document prepared by the NSW Health Department lists the topics which should be included in education and training programs for health and other relevant professionals, in particular. The Committee agrees with the issues that are identified and they are reproduced as follows:

- *importance of early identification*
- *identification of people who are at risk, eg those who have:*
    - *experienced loss, or series of losses (death, divorce, unemployment, disability)*
    - *gone through a change in lifestyle, routine, stress-levels, mood, sleep patterns*
    - *been talking about suicide (and) shown symptoms of depression (guilt, hopelessness, irritability, withdrawal from others)*
    - *exhibited helplessness (inability to think or act upon safe solutions to problems)*
    - *indicated actual verbal or written threats of suicide*
    - *the ability to carry out specific method of suicide plan (opportunity to access to means)*
- *the importance of taking a complete history in people at risk, including an inquiry into whether the person has contemplated or attempted suicide, and assessing the seriousness of intent*
- *dispelling the myth that asking about suicide will "plant" the idea with the person at risk*
- *effective interventions where a suicide attempt has been made*
- *the services available for referral and who is available locally for advice or information*
- *an understanding of the locally based action plan* (NSW Health Department, 1993a:5).

In relation to education for community members the Health Department document recognises that there needs to be an improved understanding of the precursors to suicide and possible prevention actions, as well as encouraging positive personal attitudes targeted to the following groups:

- *carers of people with mental illness*
- *schools and youth centres*
- *marginalised or isolated groups*
- *the general community* (NSW Health Department, 1993a:5).

The Committee further considers that in general terms the media also has a role in presenting both realistic images and positive examples of life today. This is especially important for young people whose impressions of the world as presented by the media can, as the Committee has been told, influence negative feelings, such as despondency and worthlessness (Evidence, 26 April, 1994).

The Committee recognises that under the New South Wales Youth Health Plan (1994) a strategy to educate health and other professionals and the general community about recognition of depression, suicide risk and the role of alcohol intoxication in impulsive suicidal behaviour has been proposed. The Committee commends this strategy and wishes to see the scope expanded to include all age groups.

RECOMMENDATION 18

That the Minister for Health, the Minister for Education, Training and Youth Affairs and the Minister for Community Services, in consultation and collaboration with relevant suicide awareness education and training organisations:

- **develop a state-wide, ongoing program of suicide awareness education and training for relevant professionals, including primary care providers, and community members, targeting rural areas of New South Wales; and**
- **develop appropriate strategies to encourage a wide range of professionals and community members throughout rural New South Wales to attend the programs.**

5.3.2 School-based Suicide Awareness and Prevention Programs

Evidence has been presented to the Committee concerning suicide awareness and prevention programs in schools. Testimony was given to the Committee regarding a program directed at rural young people aged between 15 and 17 years of age (King Evidence, 22 March 1994). That program, based in Wagga Wagga but undertaken also in schools in Narrandera, Bathurst, Orange and Cootamundra, aims to train school teachers to identify warning signs of suicide and to be confident in referring at risk students to counsellors. Its other aims are to use teaching as a means to change attitudes and improve knowledge about suicide among students, as well to "assist students to select appropriate resource persons that they could use for their themselves and for their friends" (King and Kay, 1994:1). An evaluation of the program in Wagga Wagga, undertaken by its designers, found that the program had achieved its aim of making teachers and students more aware of issues surrounding suicide, including a better understanding of risk factors.

The Committee has noted that professionals are divided about the effectiveness of school-based suicide awareness and prevention programs. In their American study Shaffer, *et al.* (1987) found that such programs may result in negative outcomes, such as fewer students seeking professional help. Among the findings of their evaluation of three programs in six different high schools were that

> *before exposure to a suicidal prevention program, most students held views and knowledge that would generally be considered sound. They knew many of the warning signs, took the view that mental health professionals are helpful and were aware that suicide threats should be taken seriously, that suicidal disclosures should be managed by consultation with responsible adults and that suicidal preoccupations were best shared. The program did not alter these views. The value of school-based screening programs was, however, demonstrated in the survey. Approximately 3% of the students identified themselves as being currently troubled or suicidal and wanting professional help... Relatively few students believed either before or after exposure to a program that suicide was a feature of mental illness. In view of the evidence that suicide is a feature of mental illness, programs that chose to ignore the psychiatric correlates of suicide are either operating in ignorance or are misrepresenting the facts* (Shaffer *et al.*, 1987:681).

Shaffer concluded that these findings do little to support the value of general education programs.

Raphael, for the National Mental Health and Research Council, notes that programs examining suicide in schools need to be carefully evaluated. She maintains that

> *it is clear students need support to deal with depression and grief but the risk of cluster suicides needs to be borne in mind and actively addressed, particularly with positive emphasis on the availability of care and the nature of effective treatments for depression and the value of social support* (1993:71).

Kosky and Goldney (1994:186) moreover, in their examination of suicide prevention strategies, argue that

> *continuing research is clearly needed to delineate what is and what is not effective in preventing suicide... There will always be proponents of one program as opposed to another in any area of treatment, and this is desirable. However, the proponents of any one approach to suicide prevention must retain a sense of perspective about their recommendations. For example, an uncritical enthusiasm for the promotion of suicide prevention schemes in schools should be tempered by the fact that there are no data to demonstrate that these are effective, and they may be counterproductive.*

In his evidence to the Committee, Dr Philip Hazell addressed the issue of the effectiveness of school-based suicide awareness programs. He argued (Evidence, 30 August, 1994) that whilst he thought such programs are a good idea he has

> *some reservations about their efficacy in reducing the suicide rate. The school-based programs have a place, provided they are presented as a global package rather than focusing only on suicide. They should really focus on wider mental health issues and they should also focus on ways in which people can overcome them and how they can seek assistance.*

The Committee clearly sees the need for teachers in schools to be equipped with knowledge to be able to identify students who may be depressed and at risk of suicide and know where to refer them appropriately. It further recognises there to be a need for students to be made aware of mental health issues, particularly depression and the importance of knowing where to seek help if they are feeling distressed. The Committee notes, in this regard, the significance of such components in the Personal Development, Health and Physical Education curriculum. This course "focuses on promoting positive interpersonal relationships between people and recognising individual rights and responsibilities" . Lambert (1994:84) states that,

> *the Personal Awareness strand of the Years 7-10 syllabus deals with effective communication and explores unacceptable ways of*

displaying emotions, eg violence, and socially acceptable and unacceptable ways of expressing needs. Management of stress and strategies for resolving conflict are also covered.

The Committee also understands that programs undertaken in certain schools, including primary schools, such as Peer Support and the "Buddy" program are significant in encouraging a nurturing and caring school environment, where young people are encouraged to "open up" and express their feelings.

It is the Committee's view that mental health is an issue that should be addressed through the school curriculum and would be best examined consistently through the Personal Development, Health and Physical Education course. This is in line with the proposals of the New South Wales Youth Health Plan. Among the issues to be canvassed under mental health would be understanding depression and other mental disorders such as eating disorders with a view to de-stigmatising them, identifying where help might be sought and encouraging students generally to disclose if they are feeling anxious, distressed, despondent and hopeless.

RECOMMENDATION 19

That the Minister for Education, Training and Youth Affairs, in collaboration with the Minister for Health, introduce a component into the Personal Development, Health and Physical Education strand of the Years 7 - 10 curriculum that addresses issues specifically relating to mental health. The topics to be canvassed in that course should include:

- **the identification of depression;**
- **the destigmatisation of mental disorders;**
- **the enhancement of coping skills;**
- **seeking out help; and**
- **drug and alcohol issues.**

In relation to addressing the issue of suicide specifically in schools, the Committee is concerned at this stage that wider, independent evaluations of specific programs need to be undertaken to determine their effectiveness for students across the state. Of particular concern is the possible copy-cat or contagion effect that may potentially arise especially, in the case of vulnerable individuals and where, for instance, it is undertaken in schools where a suicide has not occurred. Accordingly, the Committee proposes that both the Minister for Health and the

Minister for Education conduct a review and evaluation of the effectiveness of existing school-based prevention programs in New South Wales.

RECOMMENDATION 20

> **That the Minister for Health and the Minister for Education, Training and Youth Affairs conduct a review and evaluation of the effectiveness of suicide prevention programs that specifically target school students in New South Wales.**

5.3.3 Community Suicide Prevention Taskforces

Raphael (1993:72) notes that

> *empowerment and community development are important in prevention generally, for if vulnerable groups felt more control over their lives and futures, suicide may be less likely as an outcome. Community action in this regard is important, as, for instance, in the actions of a rural Victorian town where many youth suicides had occurred and a public action program was set up by the community.*

Throughout the Inquiry, the Committee has gathered a large amount of information concerning the establishment and operation of local suicide prevention taskforces. Many of these taskforces developed out of the great concern community members had with the level of suicide in their local communities.

Among community suicide prevention groups that have been directly drawn to the attention of the Committee are:

- the Young Community Caring Group;
- the Wagga Wagga Youth Suicide Prevention Taskforce;
- the Griffith Youth Suicide Prevention Taskforce;
- the Manning Suicide Prevention Taskforce;
- the Highlands Suicide Prevention Taskforce; and
- the Murray Suicide Prevention Committee.

The Committee has been very impressed with the commitment and initiative of members of these Taskforces and their capacity to involve a wide range of community representatives, such as health professionals (including general practitioners and mental health workers), school teachers, school counsellors, sexual assault counsellors, police, welfare workers, youth workers, representatives from business, representatives from the church, and survivors. Among the initiatives undertaken by the Taskforces have been the establishment of a crisis telephone line, assistance with the preparation of an "Anti Youth Suicide Video" screened as "commercials" on non-metropolitan television, instituting "train the trainer" programs for local workers and establishing suicide survivor support groups.

The Committee notes that an important feature of Taskforces is their interagency, as well as community focussed approach to suicide awareness and prevention. Given that rural areas are not all alike, such groups are also well placed to identify the specific needs and concerns of particular communities.

A submission to the Inquiry noted that the role of a Taskforce is:

- *to provide a coordinated community-based approach to suicide prevention*
- *to provide a focus for those groups, organisations and individuals who wish to be involved in suicide prevention*
- *to act as a resource centre where individuals, organisations and the media can obtain information*
- *to coordinate the development of:*
  - *information packages*
  - *workshop material*
  - *prevention programs*
  - *press releases*
- *to provide a forum for the discussion of issues relating to suicide prevention*
- *to act as an agent for change and evaluation*
- *to liaise with similar bodies and organisations* (Submission 27).

The Committee considers that Taskforces are important in empowering communities with knowledge of suicide issues and in encouraging responses to

suicide prevention that are based on the particular needs of local communities. They can also play a valuable role in breaking down the stigma associated with mental illness and suicide and generally provide an educative role. Taskforces are also important in their intersectoral approach to suicide prevention and the fostering of cooperation, liaison and information exchange between a range of departments and agencies.

However, the Committee recognises that the establishment of Taskforces is largely *ad hoc*. It has therefore been put to the Committee that taskforces would benefit from coordination at a State level. However in supporting this approach the Committee is concerned that such coordination should not compromise the local nature and identity of regional Taskforces.

The Committee considers that the Senior Officer proposed in Recommendation 6 should act as a State Coordinator for local Suicide Prevention Taskforces. In this role the Officer would undertake the following:

- facilitate the exchange of information, ideas and initiatives among local Taskforces;
- provide or coordinate relevant training as required;
- allocate funding grants for the realisation of Taskforce initiatives and monitor the effects of these initiatives; and
- act, where necessary, as a Taskforce representative to remote areas.

In making the following recommendations the Committee is in no way wishing to compromise the delivery of mental health and other relevant services to people in rural areas suffering mental disorder and distress and who may be suicidal.

RECOMMENDATION 21

That the Minister for Health encourage communities in the establishment of local Suicide Prevention Taskforces throughout the New South Wales Department of Health Districts, with particular emphasis on those rural areas where suicide rates are high. The Taskforces should be made up of a wide range of relevant professionals, including general practitioners, nurses, hospital personnel, teachers and school counsellors, as well as community, business and church representatives. Where there is an apparent need, Taskforces are to give particular emphasis to the identification of risk factors among young people.

RECOMMENDATION 22

That the aims and objectives of Suicide Prevention Taskforces be developed by local communities and may include the following:

- **acting as an information resource centre;**
- **offering education for suicide awareness;**
- **offering appropriate referral;**
- **liaising with other relevant organisations; and**
- **developing community initiatives for suicide prevention.**

RECOMMENDATION 23

That, as part of the role in developing and implementing suicide prevention strategies and initiatives, the Senior Officer referred to in Recommendation 6 act as coordinator for local Suicide Prevention Taskforces and:

- **facilitate the exchange of information, ideas and initiatives among local Taskforces;**
- **provide, or where necessary, assist in the provision of, relevant training as required;**
- **allocate funding grants for the realisation of Taskforce initiatives and monitor the outcomes of these initiatives;**
- **travel to rural areas to meet and discuss relevant issues with local Taskforces; and**
- **provide support for Suicide Prevention Taskforces throughout the state.**
- **act, where necessary, as a Taskforce representative to remote areas.**

5.3.4 Hospitals and Health Facilities

The Committee understands that many people who have attempted suicide present at hospitals or other health facilities. However, the Committee heard that not all hospitals and health facilities have had effective protocols or policy guidelines for the assessment and referral of people who present following an act of self-injury or suicide attempt.

The submission from the NSW Health Department reports that in 1993, a review of existing operational policies relating to suicide at service level revealed varying standards across the state. The submission notes (1994) that

> *while the requirements under such protocols cannot, given the vastly different conditions, be entirely uniform across the state, it was determined that a number of core service principles needed to be adopted and incorporated within local documents. Accordingly, a draft policy regarding the assessment process has been prepared and distributed to Areas/Districts for comment.*

The Committee understands that the guidelines have recently been incorporated into a circular, and are now Departmental policy.

The guidelines, set out in Policy Guidelines on Suicidal Behaviour (1994b) include information on a range of procedures depending on where a suicide attempter has been admitted. Also included are "Common Principles for all Assessments". These are that

> *Clear policy and procedures need to be available, in all settings, which include the following:*
>
> - *Information on how to assess suicidality, with focus on the variation in presentation across age and diagnostic groups*
> - *Identification of situations where there is a high risk of suicide*
> - *Identification of any acute precipitants which heighten suicide risk*
> - *Identification of current supports and current personal circumstances*

- *Elimination of an individual's ready access to the means of self harm*
- *Examination of both mental and physical state, especially where toxic substances may have been ingested*
- *Information on how to mange a person thought to be suicidal, including levels of observation and the appropriate manner to deal with the patient and their friends and relatives*
- *Consultation with an individual's family about their mental state*
- *Criteria for referral for more specialised assessment/treatment*
- *Explicit statement that all people who present be assessed, even if they have had multiple prior presentations*
- *Explicit statement of the need to delay discharge, following self poisoning or injury until an adequate mental state examination can be performed*
- *Information about the provisions of the Mental Health Act (1990) and when it is to be used*
- *Follow up procedures to support family and friends following an attempted suicide*
- *Follow up procedures to support family and friends in the event of a suicide*
- *Staff debriefing in the event of suicide by a patient*
- *Following a completed suicide detailed review and examination of the prior service delivery.*

Additional and specific guidelines for policies and procedures for people presenting with intentional self-inflicted injuries are provided for community based assessments, Accident and Emergency Unit Assessments, general hospital ward assessments and psychiatric inpatient assessment.

The Committee hopes that the utilisation of these guidelines by health facilities and hospitals will greatly enhance the intervention, assessment and treatment of those who attempt suicide, throughout all regions of New South Wales.

5.4 TERTIARY PREVENTION/SERVICES

As the earlier definition explained tertiary prevention refers to the prevention of people "getting sick again" and its purpose is to rehabilitate, reconstruct and treat. In relation to suicide prevention specifically, it can refer to ensuring that a person who has attempted suicide does not make any further attempts or that a person who may be at risk of suicide because of a mental illness is given appropriate care and treatment. Tertiary prevention or postvention also includes the development of appropriate strategies or programs for people who have lost a family member, friend, or in the case of young people, fellow student, to suicide.

5.4.1 Mental Health Services

The Committee understands that crucial to any suicide prevention strategy is the availability and accessibility of mental health and other relevant services. Such services are essential to ensure early intervention and the correct assessment and management of at risk and suicidal people throughout all regions of the state. Some witnesses have indicated that a lack of services in rural areas may in fact be contributory to the prevalence of suicide among certain people.

From its evidence, the Committee notes that the extent of mental illness in rural settings is at least similar to the level experienced by people in urban areas. However, the Committee has also heard that since rural people are less likely to attend relevant services for treatment, fearing for example, breach of confidentiality in rural towns, the level may in fact be underestimated. Moreover, because many rural towns, especially those that are small and remote lack mental health workers, much mental disorder and distress goes unnoticed (Submission 39).

The Human Rights and Equal Opportunity Report, Human Rights and Mental Illness highlighted the considerable difficulties in terms of service availability and accessibility faced by rural people and those living in isolated areas who suffer a mental illness or who experience psychological or emotional distress. Evidence

presented to that Inquiry observed that fundamental to this situation is that those who make decisions regarding mental health policies are city based administrators who

> *make adverse comparisons between city and rural hospitals, trying to make rural admissions conform to those of city hospitals. When services in the country do not get utilised to the required level because there is not the general population to sustain them and the population is decreasing, it is immediately questioned whether those services are needed and they are sometimes withdrawn* (HREOC, 1993:678).

Suicide issues fall largely within the domain of the mental health services of the Department of Health. However, public health, community health, Aboriginal health, migrant health and non-government agencies are also relevant to certain aspects of service delivery. The Directory of Mental Health Services in NSW (1993b), published by the NSW Health Department, outlines the range of services that exist throughout the State. Rural mental health services are contained within a number of health districts, including the South Eastern Districts, the South Western Districts, the North Coast Districts, the Central Western Districts, the Orana/Far West Districts and the New England Districts (NSW Department of Health, 1993b:33). Within those districts a number of rural centres deliver mental health services by way of community mental health services, managed by a clinical nurse specialist and some offer rehabilitation and accommodation services. Some rural areas also deliver crisis and extended hours services.

The Committee also notes that non-government organisations such as Lifeline, Creditline and Youthline can provide valuable telephone assistance for those in crisis.

Throughout the Inquiry the Committee spoke to a number of representatives from rural mental health services, all of whom demonstrated enormous commitment and dedication to their work. However, a number of them expressed concern about a range of issues relating to their large and often complex caseloads, the considerable distances that they have to travel to visit clients and problems of confidentiality for their clients given that mental health workers and mental health services are often easily identifiable in a community. A common concern often expressed by rural mental health workers was the difficulty in accessing psychiatric services or facilities for seriously at risk clients. This problem was particularly pronounced for people living in remote areas. It was further highlighted that for those people who require transfer to another location for psychiatric treatment, the move away from their community could be potentially dislocating and traumatising.

Other witnesses who gave evidence to this Inquiry, as well as many of the submissions received, emphasised the importance of having adequately staffed and

readily accessible rural mental health and other relevant services for people at risk of suicide. Much of the evidence indicated that 24 hour on-call crisis services for all rural areas were essential since many people contemplate suicide or engage in suicidal behaviour at times other that Monday to Friday, 9am-5pm.

A submission from Lifeline, Central West (Submission 30) for instance, observed that

> *in relation to relevant services, there are problems of isolation. There are insufficient people and they are mostly based in the larger towns or they only travel to the smaller towns once or twice a month. For the vast majority of people Lifeline is the only service available which is immediately accessible 24 hours a day.*

Moreover, the submission from the Catholic Social Justice Commission of the Archdiocese of Canberra and Goulburn commented that

> *the lack of medical, health and counselling services in rural areas of NSW is reaching crisis point in many communities. There is a lack of GP services in many rural areas and an absolute dearth of psychiatric services in the southern parts of NSW.*

In acknowledging the crucial role of specialist services for suicide prevention, a document prepared by the NSW Department of Health recognises that opportunities for intervention for suicide include service provision. That document states that

> *Each community should be able to offer:*
>
> - *counselling services in employment, unemployment and education settings*
> - *non-judgemental health services that are easily accessed*
> - *access to 24 hour information and a referral system for mental health issues*
> - *a health and welfare workforce trained in suicide prevention*
> - *support groups for people bereaved by suicide* (NSW Department of Health, 1993a:5).

The Committee notes that an Australia-wide review of mental health services for the seriously mentally ill was undertaken in 1992 by Schizophrenia Australia and coordinated by Dr John Hoult. The Review was included as part of the New South Wales Health Department's submission. **Overall, mental health services in rural New South Wales received positive ratings compared with other regions of Australia and New South Wales had 10 out of the first 11 rated services in Australia.**

The following is a brief summary of the findings of the study. It is important to recognise that the survey was undertaken when rural mental health services came within the responsibility of health regions, not districts as they are now currently known. However, for mental health services specifically, it is the Committee's understanding that the names of the regions and districts are largely the same.

The South-Western region of New South Wales, although rated at the bottom for the state of New South Wales, still outranked rural regions in Queensland, South Australia, Tasmania and Western Australia. However, the submission from the NSW Health Department recognised that following the review, "specialist services, such as rehabilitation services are probably underdeveloped" (Submission 43).

The rating for the rural health regions was divided into hospitals, community, rehabilitation and accommodation. The overall results of rural New South Wales can be summarised as follows:

South Eastern	50%
Orana and Far West	38%
Central Highlands	38%
North Coast	38%
Central West	34%
New England	32%
Hunter	28%
South-Western	22%

The highest score for all regions of Australia surveyed, both rural and urban, was 68% and the lowest was 6%.

The Review rated the South Eastern region of New South Wales as the best **rural** region in Australia for mental health services. However, in the submission to the Inquiry, from the NSW Health Department (Submission 42) it was noted that

> *compared to our standard of a good service, the South Eastern Region barely makes it to a pass mark. It is merely the fact that all other rural regions do not even reach this level that makes it look so good.*

Hospital services in the region were cited as a major factor reducing its score. The region rated highly in the area of community based services because it has a relatively high level of staffing, staff are distributed around the region to make them accessible and the region provides emergency services to its two largest towns (1992, cited in Submission 42).

The Orana and Far West region was commended in the Review for its efforts in seeking and obtaining its level of staffing and for the very good use to which it has put those resources. However, the review (1992:101, cited in Submission 42) stated that

> *Orana and Far West are not over-resourced in any conceivable way; you just have to consider the time it takes to visit their far-flung clientele to realise this. It is not like Fitzroy or Darlinghurst, where it takes only 5 minutes to drive to the patient... On top of that, there is a dearth of other support in outback Australia, so the job of case manager is that much more difficult; for example there is not a lot of psychiatric support. The region has used its resources well, and has come up with good innovations such as the Special Care Suites in Broken Hill and Dubbo, and a crisis service in Dubbo.*

The Review noted that the North Coast region has "some good programs, but staffing levels are on the low side by the standards of New South Wales and Victoria" (1992). Hospital services were deemed adequate in terms of accessibility and physical environment, with some good and bad features. Community staffing levels were considered high by the standard of rural Australia, "but since the standard is made so low by the 4 less populous states, it really means it is inadequate for the job" (1992:104, cited in Submission 42). The review acknowledged that the region "deserves credit for its efforts at accessibility, for its support of non-government organisations and for support of its innovative, if small, work programs" (1992:104, cited in Submission 42).

The Review of the Central West region noted that for community mental health staff especially, "case-loads are high, especially outside Orange and psychiatrists are a very scarce resource" (1992, cited in Submission 42). Overall the review noted that, compared to the rural regions of the less populous Australian states, the Central West region is "not too badly served" (1992, cited in Submission 42). According to the Review, a great deal of effort is made to service the smaller towns in order to go some way in overcoming the deficits in staffing (1992:121, cited in Submission 42).

The Review noted that the problem of accessibility is a major one for the New England region. It also observed that there is a shortage of medical staff in the hospitals in Tamworth. However, in relation to community services it found that

medical staff are dispersed well around the region so that accessibility is good (1992:135, cited in Submission 42). Rehabilitation services were deemed average for rural New South Wales, "which means quite inadequate for what is needed, but better than rural regions in other states" (1992, cited in Submission 42). Accommodation services in the region were considered below average for New South Wales (1992:135, cited in Submission 42).

The Review noted that the South-Western region does poorly for its hospital services and that community services have insufficient medical cover, consist of nurses only, and are thinner on the ground than anywhere else in New South Wales. Nevertheless, these professionals are spread throughout the region to improve access and there is an extended hours service. The Review stated that the South-West is hampered by lack of resources in all aspects and therefore receives a low ranking. However it also noted that "the state government policy of equity means that this region is at the top of the list for a new in-patient unit, additional community staffing and better housing" (1992:190, cited in Submission 42).

Evidence to the Committee from a senior Departmental officer indicated that

> *since that review and over time we have been addressing the issues that have been raised in that report* (Evidence, 26 July, 1994).

The Committee notes that the special mental health needs of people in rural areas have recently been considered by the New South Wales Government in its budgetary allocation of $169 million over the next four years for mental health services for the State and in its response to the Report of the Human Rights and Equal Opportunity Commission's Inquiry into the Human Rights of People with a Mental Illness. During 1994-1995 $7 million will be spent, among other areas, on services for people in rural and isolated areas.

As part of the overall budget package for new mental health services, rural regions have been earmarked specifically to receive:

- more child and adolescent mental health services;
- more Aboriginal liaison and mental health workers;
- increased after hour crisis services; and
- community rehabilitation.

The Health Minister (Press Release, 15 June 1994) has indicated that **new inpatient psychiatric units** will be built in NSW general hospitals at:

- Maitland;
- Grafton;
- Mudgee; and
- Shellharbour

Other community based facilities such as mental health centres will also be built around the state.

In its Response to the Report on Human Rights of People with a Mental Illness (1994), the NSW Government has targeted rural people as those with special needs. The response to the Report states that the Government has spent

> *$7.7 million in additional recurrent funds to upgrade mental health services throughout country regions such as the North Coast, New England, the Central West, the South West and the South Coast* (NSW Government, 1994:14).

Among the future goals outlined in the Government's response are to:

- expand existing, psychiatric units in general hospitals;
- provide supported accommodation facilities in the community;
- expand community-based services including
  - accommodation support,
  - extended hours/crisis services and
  - services for youth, older people and Aboriginal people in rural areas
- extend psychiatric services for older people in (among other areas) the Hunter and North Coast; and
- develop District women's health plans.

According to the Government's response, its plans and initiatives are designed to ensure that the disadvantage of people with mental illnesses having to travel vast distances for treatment does not continue.

The Committee supports the Government's budget plans and strategies for mental health services for New South Wales. The Committee anticipates that the funding and initiatives will significantly enhance the comparability of mental health services for people in rural areas with those in urban areas and overcome problems of

availability and accessibility. It considers however, that the mental health needs of people in rural areas should continue to be evaluated, including those groups that have difficulty in accessing or do not access these services, such as those in remote regions and farmers.

RECOMMENDATION 24

That the Minister for Health ensure that there be equity in the provision of mental health services across the state.

RECOMMENDATION 25

That the Minister for Health ensure that the goals and strategies for Rural Mental Health Services, outlined in the NSW Government response to the Human Rights and Equal Opportunity Commission Report into the Human Rights of People with Mental Illness and the mental health initiatives put forth in the specific budget package for Mental Health Services in New South Wales, especially those relating to people living in rural areas, are implemented as soon as possible and as a matter of priority.

RECOMMENDATION 26

That the Minister for Health, in collaboration with other relevant Ministers and non-government organisations, ensure that the mental health needs of people in all rural areas of New South Wales continue to be evaluated and addressed at least biennially. Special attention should be given to the needs of those in remote regions, young people and farmers.

(In evaluating and addressing the mental health needs of people in rural areas regard should be had to the following issues as proposed by the NSW Health Department, namely that each community in New South Wales should be able to offer:

- **counselling services in employment, unemployment and education settings;**
- **non-judgemental health services that are easily accessed;**
- **access to 24 hour information and a referral system for mental health issues;**

- **a health and welfare workforce trained in suicide prevention; and**
- **support groups for people bereaved by suicide.)**

5.4.2 Child and Adolescent Mental Health Services

The Committee understands that in rural areas children and young people suffering mental disorder or psychological and emotional distress, are generally attended to by community mental health teams or child and family teams working in conjunction with mental health services. Further, specialist psychiatric services for young people in rural areas are generally provided by visiting child and adolescent psychiatrists who tend to be located in metropolitan areas. When a young person requires acute hospitalisation, he or she may be placed in a unit with adults before being transferred to the city for more intensive assessment in a child and adolescent specialist service.

In its Response to the Human Rights and Equal Opportunity Commission Report into the Human Rights of People with a Mental Illness, the New South Wales Government (1994:12) acknowledged that

> *traditionally, mental health services for children and adolescents have been sparse and under-resourced.*

The Committee's investigations have confirmed this, particularly in relation to the experiences of rural New South Wales, and in spite of the fact that specialist services are necessary for young people who are mentally ill. Given that suicide among young people in Australia is one of the highest in the industrialised world and among young people in rural areas is of particular concern, the Committee considers the establishment of such services to be an urgent priority.

An expert witness told the Committee:

> *we need better tertiary services, and I mean by that child and adolescent psychiatry and residential units. We have got one residential unit that deals with psychiatric emergencies for adolescents in New South Wales... Child and adolescent psychiatry is also grossly under-represented in terms of medical services generally... and there is an increasing need for medical services, and I think justifiably so given the increasing rates of child and adolescent psychiatric disorders generally in the community* (Evidence, 10 February, 1994).

It has been submitted to the Committee that, given the increase over time in rural youth suicides, adolescent mental health services need to be acknowledged and financed in their own right. Moreover, many of the Committee's witnesses have indicated that there is an increased sense of hopelessness and despair among many country young people, which in many instances requires specialised intervention, therefore highlighting the need for child and adolescent mental health services in rural areas.

The suicide rate among young men in South Australia has fallen from 17.9 per 100,000 per population in 1988 to 3.7 per 100,000 per population in 1993. A recent article in Australian Doctor linked this apparent decrease in suicides in that state among 11-20 year olds with the establishment in 1988 of new hospital and community-based early intervention child and adolescent mental health services. In a newspaper interview (Adelaide Advertiser, 9 May, 1994), Professor Robert Kosky, Director of Child and Adolescent Mental Health, Adelaide's Women and Children's Hospital stated that,

> *identifying and treating depressive illnesses and early psychosis in young people had very important long-term benefits for both the patient and the community... A lot of the disability and problems resulting from mental illness are not caused by the illness itself but in the delay of appropriate treatment.*

The NSW Youth Health Plan (1994a), identifies a number of issues relevant to young people with psychological or emotional difficulties and to those with serious mental disorders. It also examines issues relating to the reduction of the suicide rate among young people. One of the objectives of the Plan is the need for health services to provide appropriate and timely assistance to these young people. In acknowledging the role of social factors in suicide risk, the Plan states (1994a:39) that,

> *providing services for this group in ways acceptable to young people will require ongoing collaboration between a range of service providers.*

Recently, the NSW Government, in its Response to the Human Rights and Equal Opportunity Commission Report into the Human Rights of People with a Mental Illness, specifically identified the special needs of children and adolescents with a mental illness. The Government has indicated that it will take the following measures to realise its goals for these services:

- provide $1.2 million a year to fund services for vulnerable families with young children and adolescents;

- expand specialised child and adolescent mental health services, particularly at Wagga Wagga, Albury, Dubbo, Mudgee, and in the Wentworth, Illawarra, Hunter, New England and North Coast regions;

- undertake research to improve cross-agency management and support for children of parents with mental illness or personality disorders;

- fund non-government organisations that assist children with mentally ill parents;

- co-ordinate child care for children with mentally ill parents; and

- develop a police youth strategy which specifically includes young people with a mental illness.

The Committee endorses these goals and is especially keen for those initiatives targeting rural areas to be implemented as soon as possible.

RECOMMENDATION 27

That the Minister for Health ensure that the goals and strategies for child and adolescent Mental Health Services, particularly those which are relevant to rural young people and outlined in the NSW Government response to the Human Rights and Equal Opportunity Commission Report into the Human Rights of People with Mental Illness, and the initiatives for child and adolescent mental health contained in the specific budget package for Mental Health Services are implemented as soon as possible and as a matter of priority.

(Among the goals to be implemented are that the NSW Health Department:

- **provide $1.2 million a year to fund services for vulnerable families with young children and adolescents;**

- **expand specialised child and adolescent mental health services in rural areas;**

- **undertake research to improve cross-agency management and support for children of parents with mental illness or personality disorders;**

- **fund non-government organisations that assist children with mentally ill parents;**

- **co-ordinate child care for children with mentally ill parents; and**

- **develop a police youth strategy which specifically includes young people with a mental illness).**

RECOMMENDATION 28

That the Minister for Health ensure that the mental health needs of young people in all rural areas throughout New South Wales, including those in remote regions, continue to be evaluated and addressed at least biennially. In meeting this recommendation consultation with those government and non-government organisations which specifically target young people should take place.

5.4.3 Psychiatrists

Evidence presented to the Committee has highlighted the problem that many rural and remote areas of New South Wales experience in attracting and maintaining psychiatrists and other mental health specialists. Evidence received has indicated that most psychiatrists servicing these areas are city-based and travel to centres to see clients for a few days per month. The Committee notes that in many instances this situation is more satisfactory than having no service at all or than requiring mentally ill people to travel to other centres to access assistance. However, problems can arise where a crisis situation occurs and there is no available psychiatrist.

Evidence presented to the Human Rights and Equal Opportunity Commission's Inquiry into Human Rights and Mental Illness from the Royal Australian and New Zealand College of Psychiatrists (1993:685) highlighted the problem by stating that

> *working in remote areas entails being professionally isolated, with greater demands placed on psychiatrists and lack of access to appropriate support services. Hence practising in remote areas is unattractive to psychiatrists and results in these areas being underserviced.*

Information provided to this Inquiry from the Royal Australian and New Zealand College of Psychiatrists and pertinent as at 15 May, 1994, indicates that of the 30 or so psychiatrists practising primarily in country areas of New South Wales, most are located in coastal regions or a few other major centres, such as Orange, Tamworth, Albury and Taree.

The Committee considers that access to psychiatrists in rural areas is crucial to the provision of adequate and appropriate mental health services to those regions. However, it also recognises that in reality, attracting psychiatrists to rural and remote regions and expecting them to stay indefinitely can be extremely difficult. A major reason for this is the isolation from professional networks.

The Committee notes that a number of regional health services utilise the services of city-based psychiatrists by way of "outreach services" for people in rural areas. The Committee considers that such services can provide a very valuable role in the delivery of specialist care to country regions and that such services should be supported and further developed. As Professor Brent Waters (Evidence, 26 April, 1994) observed,

> *I know [outreach services work] because we [at Prince of Wales Hospital] have been doing that for child psychiatry services for the southeast corner of New South Wales... We used to employ staff in Sydney and then we had a contract with them, whereby we sent people down to these country towns and we would do consultation and counselling with people. We would train local staff who they had recruited there but who did not have all the qualifications to be more skilled in dealing with particular sorts of young people and their families. We were available by telephone if there was a problem and we found that we had quite a dramatic impact on the level of services in those areas. We were sending, at the equivalent rate of about 150 days a year, people into areas like Bega, Merimbula and Cooma and relatively small towns, and some larger towns as well.*

The Committee notes that a strategy of the NSW Youth Health Plan is to enhance liaison psychiatry services to ensure mainstream health professionals are able to consult about mental health care of young people (1994a:40). It endorses this initiative.

RECOMMENDATION 29

That the Minister for Health:

- **in collaboration with the Royal Australian and New Zealand College of Psychiatrists, develop incentives to encourage psychiatrists to establish practices in rural areas of New South Wales;**

- **ensure that health services throughout New South Wales continue to develop outreach psychiatric services for people, including children and adolescents, living in rural and remote regions; and**

- **continue to enhance liaison psychiatry services to ensure mainstream health professionals in rural areas are able to consult about the mental health care of clients, including young people.**

■ Telemedicine conferencing

Information has been given to the Committee regarding the use of the telemedicine conference as a means of psychiatric assessment and consultation for people who are unable to access specialist mental health services. The Committee has heard that telemedicine conferences can be especially useful for people living in remote areas who have a serious psychiatric disorder. During the Inquiry the Committee had the opportunity to inspect the technology of telemedicine conferencing by way of a briefing from Professor Peter Yellowlees, of the South Australian Mental Health Service. Professor Yellowlees is a psychiatrist who undertakes many assessments of and consultations with clients in Broken Hill. According to Professor Yellowlees, clients are normally accompanied to the telemedicine conference by someone they know to minimise the impersonal nature of the technology and the potential for intimidation. Both parties can see and hear each other by way of a specialised television screen.

Professor Yellowlees indicated that **telemedicine conferences should be seen as an adjunct to visiting psychiatrists in rural and remote areas, not as an alternative. As acknowledged in the briefing, telemedicine conferences are appropriate for assessments but not for long-term psychotherapy.**

As well as their usefulness in assessing psychiatrically ill people in remote areas, telemedicine conferencing facilities can be effectively utilised for the teaching and training of relevant workers in these areas and assisting with staff support and supervision.

The Committee understands that the whole area of teleconferencing is rapidly growing and, in many respects, Australia leads the way in this technology. The Committee sees enormous potential for increased utilisation of telemedicine conferences in the area of psychiatric assessments of people in remote areas and in the training and education of relevant workers who service these areas. For the particular application of this technology, the Committee understands that the cost, after investing in the equipment, is the equivalent of two STD telephone calls,

where the conference is within Australia. For overseas link-ups it is the cost of two ISD telephone calls.

In the Report of the Human Rights and Equal Opportunity Tribunal into Human Rights and Mental Illness, it was recommended that

> *greater recognition should be given to the benefits of using telemedicine techniques to provide people in rural and remote areas with assessments and consultations involving input by city-based specialists. Governments should ensure that available technology can be more widely used* (Human Rights and Equal Opportunity Tribunal, 1993:937).

The Committee strongly concurs with this recommendation.

RECOMMENDATION 30

> **That the Minister for Health develop a network of telemedicine conference facilities to contribute to psychiatric and other specialist mental health services to people living in rural and remote areas who have a psychiatric disorder. The telemedicine facilities would be used for assessments and consultations for the psychiatrically ill and for training and education of relevant workers in rural and remote areas.**

5.4.4 Services for People Bereaved by Suicide

Throughout the Inquiry the Committee has heard that there are very few services available to people bereaved by suicide (suicide survivors) in rural areas - family members and friends alike. Members have been informed that, in many cases, these people themselves require specific attention and care after someone close to them has suicided. According to the National Health and Medical Research Council (1993:71),

> *those whose family members suicide are at high risk of pathological bereavements and potential suicide themselves.*

Evidence received by the Committee from bereaved parents, spouses, siblings and other relatives highlighted the enormous sense of despair, loss and grief following the suicide of a loved one. Many witnesses indicated that they thought they "couldn't go on" after the suicide and that they themselves contemplated suicide. A number of witnesses however indicated that counselling services for their needs were often unavailable or inaccessible. The Committee heard of one couple who

had to wait a number of days to see a counsellor after their son's suicide. The counsellor was also located in a town some distance away.

The Committee understands that, in some rural communities, Suicide Survivor Support Groups, including those such as Compassionate Friends, have been established to assist people through the grieving process. During its trips to country regions the Committee spoke with a number of people involved in such groups. All indicated that their experience with the support group had been extremely beneficial and considered that other such groups should be established throughout New South Wales. Moreover, the National Health and Medical Research Council (1993:71) recognised that suicide survivor self-help groups, along with counselling, provide valuable assistance to survivors.

RECOMMENDATION 31

That the Minister for Health ensure that bereavement counselling services are available, through the area and district mental health services, to family members and friends of those who have suicided. Such services are to be developed collaboratively with appropriate community organisations and the district health services.

RECOMMENDATION 32

That the Senior Officer referred to in Recommendation 6, along with local Suicide Prevention Taskforces (see Recommendation 21) encourage the establishment of suicide support groups in rural communities where there is an identifiable need.

- **Postvention School-based Programs**

Postvention refers to action taken after a person has suicided to prevent further suicides occurring as a result of the original event. During the Inquiry, the Committee heard evidence of specific school-based programs that occur when a student has suicided. In their study, Adolescent Suicide (1992), Martin, Kuller and Hazell examined the effects of the suicide of two students among adolescents attending the same school. The authors hypothesised that following the completed suicide of a peer, some adolescents will develop thoughts of suicide. They stated that

> *in itself this may not be a major clinical problem. However, adolescents with pre-existing depression, or a preoccupation with suicide, are vulnerable to developing a lowered threshold to deliberate self-harm. These adolescents may be at high risk for imitative (copycat) suicide* (Martin *et al.*, 1992:23).

A follow-up study by Martin (1992:27) found that

> *it appears from our previous work that young people with depression and suicidal thoughts seek out knowledge of deaths from suicide. By "seek out" the author means that they find out about, report that they are aware of, or remember, more deaths from suicide than others of the same age. One could speculate that they are looking to confirm the normality of suicide or suicidal thoughts in their peer group.... It is the author's belief that postvention after successful suicide of a peer offers an opportunity to identify then assist vulnerable and at risk teenagers.*

In his evidence before the Committee Dr Michael Dudley argued that as well as training school personnel to recognise depression and suicidal adolescents postvention programs

> *may be important after a suicide... It is something that I think generally needs to be adopted. There needs to be a critical events policy in schools about how to handle these kinds of events.*

Further evidence from Dr Philip Hazell observed that

> *one of the suicide prevention measures that I advocate is that every school in New South Wales knows what to do if there is a student death from suicide. I have calculated that, roughly speaking, each high school in New South Wales will experience a death suicide at least every five to ten years. It is not beyond the realms of probability in most schools that this will happen.*

The Committee notes that the Department of School Education has released a publication, Guidelines for the Management of Critical Incidents in Schools. The publication is essentially designed to assist principals in the development of local plans for the management of critical incidents. The guidelines provided are considered to be by no means exhaustive and the Department anticipates that each school will need to develop its own management plan which identifies the nature and range of critical incidents to which students and staff may be exposed (Department of School Education, 1993:1).

Included in the Guidelines (1993:7) is the acknowledgment that

> *emergency debriefing and trauma counselling for staff and students should be provided and included in the management plan... Principals and other key personnel need to be aware of:*
>
> - *the nature of trauma and how to minimise its effects;*
> - *the specific effects these incidents have on individuals;*
> - *self-management strategies that will facilitate recovery;*
> - *how best to provide support to those who have experienced trauma.*

Access to appropriately qualified debriefing and counselling personnel is part of the support needed.

Suicide is specifically examined in the document and a list of "danger signs" provided. The document (1993:22) states that

> *in the event of a suicide of any member of the school community the school's critical incidents management plan should be implemented.*

The Committee considers that it is important for schools, including those in rural areas to have in place a Critical Incidents Plan in the event of a student or staff member suiciding. It considers that such plans need to be developed by individual schools to reflect the specific needs and identity of the school and where appropriate, in consultation with and advice from relevant community organisations and professionals.

RECOMMENDATION 33

> **That the Minister for Education, Training and Youth Affairs urge principals of rural schools, in consultation with teachers, school counsellors and relevant community organisations, to develop Critical Incident Management Plans relating to suicide.**

5.5 STRATEGIES FOR ABORIGINAL PEOPLE

As the discussion in Chapter Four indicated, suicide and suicidal behaviour among Aboriginal communities in rural areas of New South Wales are a major concern. The fact that rates of suicide among this group appear low, demonstrates the underestimation of suicide in those communities, rather than an indication that the problem is a small one.

Suicide within Aboriginal communities is all the more compounded by the limited number of Aboriginal mental health workers and indeed, Aboriginal general health workers, who could serve a valuable role in both assisting Aboriginal people with mental disorders and educating non-Aboriginal health workers about relevant and interrelated cultural issues. It is further compounded by the limitations of mainstream mental health services which have traditionally failed to appreciate the special needs of Aboriginal people. In her address to the National Aboriginal Mental Health Conference (1994:6), Ms Pat Swan, Public Health Coordinator of the Aboriginal Medical Services, stated that

> *until now there has been next to no understanding of the problems and no acceptable services available to assist Aboriginal people in psychological distress. This contrasts to the wider Australian population where service provision in the mental health arena has seen vast improvements over the last thirty years. Mental health services have failed to meet the needs of Aboriginals who have used them. They have failed to cater to the needs of the many other people who could have used some help, but felt sure there was no point in trying.*

The Committee recognises that the problem of suicide and mental ill-health generally among Aboriginal communities is far-reaching and cannot be seen in isolation from factors relating to dispossession of land, decimation of culture, racism, lack of employment and education opportunities, poverty and deprivation. Moreover, according to the National Aboriginal Health Strategy Working Party's Report, A National Aboriginal Health Strategy (1989:ix),

> *health to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease.*

The Committee hopes that initiatives such as the recognition of Native Title, the goals of the Council for Reconciliation and the range of employment, education and

anti-discrimination programs, both at State and Federal levels may go some way to address these broader issues.

Specifically, the Committee's evidence shows that the mental health needs of the Aboriginal community require urgent attention, particularly for those in rural and remote areas. As the Royal Commission into Aboriginal Deaths in Custody (1991, Vol 4:224) observed,

> *not only are they disadvantaged by their socioeconomic status and cultural background, but proportionately more Aboriginal than non-Aboriginal people are disadvantaged by their geographic location, in the sense that many live in the rural or remote regions of Australia where mental health services are lacking.*

The Committee recognises, however, that any services targeting Aboriginal mental health must be responsive to the special needs of Aboriginal people and be culturally sensitive. Accordingly, adequately resourced and culturally appropriate programs need to be developed by and with Aborigines themselves (NHMRC, 1992:177 and NSW Aboriginal Mental Health Report). In this context it has been noted that

> *Aboriginal people do have mental health needs which require psychiatric expertise, yet the conventional psychiatric model does not offer an adequate socio-cultural perspective with which to deal with these needs... Ideally... services should operate in a 'within culture' framework. This means a service which is specifically attuned to the cultural imperatives of the community involved, rather than applying a 'cross-cultural perspective', which so often means, in practice, a dominant cultural perspective being applied more, or less sensitively to another culture ... Priority needs to be given to complementing the appropriate training of psychiatrists and other non-Aboriginal mental health professionals with the development of a cadre of AHWs [Aboriginal Health Workers] with appropriate mental health training* (Royal Commission into Aboriginal Deaths in Custody, 1991, Vol 4:249).

The Committee notes that the Government's recent response to the findings of the Human Rights and Equal Opportunity Commission Report into the Human Rights of People with Mental Illness has recognised that Aboriginal and Torres Strait Islanders with a mental illness, including those in rural areas, have special needs. Accordingly, in its response, it has indicated that it has made a commitment that by the end of the decade 1% of the global health budget will be spent on Aboriginal health needs.

Moreover, in the response to the Human Rights and Mental Illness report (1994) the Government has indicated that it will:

- expand services for Aborigines and Torres Strait Islanders by employing more Aboriginal hospital liaison workers and at least 20 extra Aboriginal mental health workers;

- develop liaison programs in key areas of the state, including Central Sydney, Penrith, the Blue Mountains, the Illawarra, the Hunter region, the North Coast, Bourke, Walgett, Wellington, Broken Hill, Wilcannia and Queanbeyan;

- offer mental health training to Aboriginal health workers in Queanbeyan, the Orana and Far West Region and the North Coast; and

- establish the Aboriginal Health Education and Applied Research Centre at Prince Henry Hospital - the first of its kind in Australia.

The Committee hopes that these initiatives will significantly improve availability and accessibility of mental health services for Aboriginal people throughout New South Wales and assist in the prevention of suicide.

The Committee highlighted earlier that Aboriginal communities, like non-Aboriginal communities, need education to identify mental illness and encouragement to attend at relevant services for help. Further the Committee recognised the need for workers in relevant services, specifically those workers with a non-Aboriginal background, to be trained in cultural awareness so that Aboriginal people feel comfortable about accessing the services. In this regard the Committee has heard that in some areas of New South Wales, Aboriginal Liaison Officers attached to regional health services are conducting such programs for non-Aboriginal hospital personnel. However, it was indicated in one rural centre that whilst such programs are mandatory they are scheduled during lunch hours, lessening the enthusiasm of some of the participants.

RECOMMENDATION 34

That the Minister for Health ensure that the goals and strategies for Aboriginal Mental Health Services, outlined in the NSW Government response to the Human Rights and Equal Opportunity Commission Report into the Human Rights of People with Mental Illness and the initiatives for Aboriginal mental health contained in the specific budget package for Mental Health Services are implemented as soon as possible and as a matter of priority.

(Among the goals to be implemented are that the NSW Health Department:

- dedicate 1% of the global health budget to Aboriginal health needs;
- expand services for Aboriginal and Torres Strait Islanders by employing more Aboriginal hospital liaison workers and at least 20 extra Aboriginal mental health workers, including rural areas of New South Wales;
- develop liaison programs in key areas of the state, including rural areas of New South Wales;
- offer mental health training to Aboriginal health workers throughout rural areas of New South Wales; and
- establish the Aboriginal Health Education and Applied Research Centre at Prince Henry Hospital).

RECOMMENDATION 35

That the Minister for Health ensure that the mental health needs of Aboriginal people, particularly those in all rural and remote areas of New South Wales, continue to be evaluated and addressed, at least biennially within a culturally appropriate framework.

RECOMMENDATION 36

That the Minister for Health, in consultation with relevant Aboriginal organisations and Aboriginal mental health workers, develop an education and training program for non-Aboriginal mental health workers, including those in rural New South Wales, to address Aboriginal cultural awareness and other relevant issues. Such a program should be mandatory and conducted at reasonable times for all Departmental non-Aboriginal mental health workers who are likely to come in contact with Aboriginal clients.

BIBLIOGRAPHY

Appleby, M., King, R. and Johnson, B. (1992). *Suicide Awareness Training Manual.* Narellan: Rose Education, Training & Consultancy.

Australian Bureau of Statistics. (1994a). *Suicides Australia*. Canberra: Australian Government Publishing Service.

Australian Bureau of Statistics. (1994b). *Australian Social Trends.* Canberra: Australian Government Publishing Service.

Australian Bureau of Statistics. (1994c). Suicide Deaths - New South Wales. (Unpublished data).

Baume, P. (1994). Developing a National Suicide Strategy for Australia, *in Public Health Significance of Suicide: Prevention Strategies. Proceedings of the National Conference on Public Health: Significance of Suicide*. 28 February - 1 March, 1994. Lakeside Hotel, Canberra.

Burnley, I. (1994). Differential and Spatial Aspects of Suicide Mortality in New South Wales and Sydney, 1980 to 1991. *Australian Journal of Public Health, 18*, 3, 293-304.

Cantor, C.H. and Coory, M. (1993). Is there a Rural Suicide Problem? *Australian Journal of Public Health, 17*, 4, 382-384.

Cantor, C. H. and Lewin, T. (1990). Firearms and Suicide in Australia. *Australian and New Zealand Journal of Psychiatry, 24,* 4, 500-509.

Clayer, J. R. and Czechowicz, A. S. (1991). Suicide by Aboriginal People in South Australia: comparison with suicide deaths in the total urban and rural populations. *Medical Journal of Australia, 154,* 683-685.

Cooper, S. (1992). *Farm Wars: The Battles Confronting Australian Farming.* Melbourne: Schwartz & Wilkinson.

Coorey, L. (1987). The Nature of Continued Domestic Violence in Country Areas. *Regional Journal of Social Issues, 21.*

Coultan, M. (1994). The Deadly Drought: at last we learn the truth. *The Sydney Morning Herald* (October 14), 1.

Crowe, P. (1994). Summary of Australian Bureau of Statistics Suicide Data, *in Public Health Significance of Suicide: Prevention Strategies. Proceedings of the National Conference on Public Health: Significance of Suicide*. 28 February - 1 March, 1994. Lakeside Hotel, Canberra.

Davis, A. (1992). Suicide Behaviour among Adolescents: its nature and prevention, in *Breaking Out: challenges in adolescent mental health in Australia* (Eds. Kosky, R., Eshkevari, H. S. and Kneebone, G.). Canberra: Australian Government Publishing Service.

de Moore, G., Plew, J.D., Bray, K. and Snars, J. (1994). Survivors of Self-inflicted Firearm Injury. *Medical Journal of Australia, 160*, 4, 421-425.

Dudley, M., Waters, B., Kelk, N. and Howard, J. (1992). Youth Suicide in New South Wales: urban-rural trends. *The Medical Journal of Australia, 156,* 2, 83-88.

Dudley, M., Waters, B. and Kelk, N. (1994). *Suicide Among Young Australians: Urban-rural Trends*. (Unpublished).

Guardian Weekly (1993). November 14.

Guardian Weekly (1994). March 27.

Hailstone, B. (1994). New Programs Cut South Australia's Toll of Youth Suicides. *The Adelaide Advertiser* (July 9), 8.

Haliburn, J.M. (1993). The Forgotten In-betweens: middle to late adolescents with psychiatric disorders. *Youth Studies Australia, 12*, 3, 44-48.

Hassan, R. (1992). Unlived Lives: trends in youth suicide, in *Preventing Youth Suicide: Australian Institute of Criminology Conference Proceedings*. (Ed. McKillop, S.). Canberra: Australian Institute of Criminology.

Human Rights and Equal Opportunity Commission. (1993). *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness, Vols 1 and 2.* Canberra: Australian Government Publishing Service.

Hunter, E.M. (1988). On Gordian Knots and Nooses: Aboriginal suicide in the Kimberley region. *Australian and New Zealand Journal of Psychiatry, 23*, 226-234.

Hunter, E.M. (1989). Changing Patterns of Aboriginal Mortality in the Kimberley Region of Western Australia, 1957-1986. *Aboriginal Health Information Bulletin, 11*, 27-32.

Kosky, R.J. and Goldney, R.D. (1994). Youth Suicide: a public health problem? *Australian and New Zealand Journal of Psychiatry, 28*, 186-187.

Lambert, J. (1993). The Role of Education in Preventing Violent Behaviour, in *Men and Women Against Violence. Proceedings of a One Day Seminar of the National Council of Women N. S. W. Inc.* 30 August 1993. Sydney.

Lawrence, G. and Williams, C. (1990). The Dynamics of Decline: implications for social welfare delivery in rural Australia, in *Rural Health and Welfare in Australia* (Eds. Cullen, T., Dunn, P. and Lawrence, G.). Wagga Wagga: Charles Sturt University.

Lester, D. and Abe, K. (1989). The Effect of Restricting Access to Lethal Methods for Suicide: a study of suicide by domestic gas in Japan. *Acta Psychiatr Scand, 80*, 180-182.

Maris, R.W. (1992). Suicide, in *Encyclopedia of Sociology* (Eds. Borgatta, E. and Borgatta, M.). New York: McMillian.

Martin, G. (1992). Postvention in a School. *Youth Studies Australia, 11,* 1, 24-27.

Mackay, H. (1993) Violence - a Cause and Effect of the Age of Anxiety, in *Men and Women Against Violence. Proceedings of a One Day Seminar of the National Council of Women N. S. W. Inc.* 30 August 1993. Sydney.

Martin, G., Kuller, N. and Hazell, P. (1992). The Effect on Adolescents of the Completed Suicide of Another Student. *Youth Studies Australia, 11,* 1, 21-23.

Morrell, S. (1994). Suicide in Rural and Urban New South Wales: 1970-1992. (Unpublished).

Morrell, S., Taylor, R., Quine, S. and Kerr, C. (1993). Suicide and Unemployment in Australia 1907-1990. *Social Science and Medicine, 36*, 749-756.

National Health Strategy. (1992). *Enough to Make You Sick: How Income and Environment Affect Health.* Research Paper No 1. Canberra: National Health Strategy.

National Health and Medical Research Council. (1994). *Outline of National Health and Medical Research Council's Draft National Strategy for the Prevention of Suicide.* Canberra: National Health and Medical Research Council.

New South Wales Bureau of Crime Statistics and Research. (1990). Suicide. *Crime and Justice Bulletin,* 8.

New South Wales Cabinet Office and New South Wales Police Service. (1993). *Discussion Paper: mental illness and firearms misuse.* Sydney: New South Wales Government.

New South Wales Department of School Education. (1993) *Guidelines for the Management of Critical Incidents in Schools.* Sydney: Department of School Education.

New South Wales Government. (1994). *Caring for People with Mental Illness: response to the Human Rights and Equal Opportunity Commission Report into the Human Rights of People with Mental Illness.* Sydney: New South Wales Government.

New South Wales Health Department. (1993a). Reducing Suicide in New South Wales. *Injury Issues, 10.* Sydney: New South Wales Health Department.

New South Wales Health Department. (1993b). *Directory of Mental Health Service in New South Wales.* Sydney: New South Wales Health Department.

New South Wales Health Department. (1994a). *New South Wales Youth Health Plan.* Sydney: New South Wales Health Department.

New South Wales Health Department. (1994b). *Policy Guidelines on Suicide Behaviour: key assessment criteria for New South Wales health areas and district staff.* Sydney: New South Wales Health Department.

Orr, W. (1992). *The Rural Crisis: helping others to cope.* Parkes: Parkes Community Health Centre.

Parliament of New South Wales. (1991). *Report of the Joint Select Committee on Gun Law Reform.* Sydney: Parliament of New South Wales.

Penley, K. (1993). *Ignore Them and They'll Go Away: Gay, Bisexual and Lesbian Young People and Suicide.* Adelaide: Second Story Youth Health Centre.

Phillips, R. (1994). *$169 Million Package for New Mental Health Services.* Media Release: Minister for Health. 15 June 1994.

Pransky, J. (1991). *Prevention: The Critical Need.* Springfield, Montana: The Burrell Foundation.

Raphael, B. (1993). *Scope for Prevention in Mental Health.* Canberra: National Health and Medical Research Council.

Raphael, B. (1994). The Suicide Experience, in *Public Health Significance of Suicide: Prevention Strategies. Proceedings of the National Conference on Public Health: Significance of Suicide*. 28 February - 1 March, 1994. Lakeside Hotel, Canberra.

Rolley, F. and Humphreys, J.S. (1993). Rural Welfare - the Human Face of Australia's Countryside, in *Prospects and Policies for Rural Australia* (Eds. Sorrensen, T. and Epps, R.). Melbourne: Longman Cheshire.

Royal Commission into Aboriginal Deaths in Custody. (1991a). *Royal Commission into Aboriginal Deaths in Custody: National Report, Volume 4.* Canberra: Australian Government Publishing Service.

Royal Commission into Aboriginal Deaths in Custody. (1991b). *Regional Reports of Inquiry in New South Wales, Victoria and Tasmania.* Canberra: Australian Government Publishing Service.

Shaffer, D., Garland, A., Gould, M., Fisher, P. and Trautman, P. (1988). Preventing Teenage Suicide: a critical review. *Journal of the American Academy of Child and Adolescent Psychiatry, 27*, 6, 675-687.

Salt, B. (1992). *Population Movements in Non-metropolitan Australia.* Canberra: Australian Government Publishing Service.

Snowdon, J. and Harris, L. (1992). Firearms Suicides in Australia. *Medical Journal of Australia, 156,* 2, 79-83.

Somerville, J. (1994). Suicidal Behaviour in Adolescent Females, in *Public Health Significance of Suicide: Prevention Strategies. Proceedings of the National Conference on Public Health: Significance of Suicide*. 28 February - 1 March, 1994. Lakeside Hotel, Canberra.

Sorensen, T. and Epps, R. (993). *Prospects and Policies for Rural Australia.* Melbourne: Longman Cheshire.

Standing Committee on Banking, Finance and Public Administration. (1992). *Checking the Changes: Review of Certain Recommendations of the Banking Inquiry Report.* Canberra: Australian Government Publishing Service.

Swan, P. and Raphael, B. (1994). Ourway, in *National Aboriginal Mental Health Conference.* 25-27 November 1993. University of Sydney.

Union of Farmers Incorporated. (1994). *Submission to the Senate Inquiry into the Rural Adjustment Scheme.* (Unpublished).

United Nations International Children's Emergency Fund. (1993). *The Progress of Nations.* New York: United Nations International Children's Emergency Fund.

United Nations International Children's Emergency Fund. (1994). *The Progress of Nations.* New York: United Nations International Children's Emergency Fund.

United States Department of Health and Human Services. (1989). *Report on the Secretary's Task Force on Youth Suicide.* Washington DC: United States Department of Health and Human Services.

Wahlquist, A. (1994). More Drought Farmers to Get Help. *The Sydney Morning Herald* (August 27), 11.

Walker, J. (1994). Banks Avoid Compulsory Mediation. *The Sydney Morning Herald* (October 15), 1.

Wallace, A. (1986). *Homocide: the social reality*. Sydney: New South Wales Bureau of Crime Statistics and Research.

Walmsley, D.J. (1993). The Policy Environment, in *Prospects and Policies for Rural Australia* (Eds. Sorrensen, T. and Epps, R.). Melbourne: Longman Cheshire.

Wilkinson, J. (1994). *Rural Assistance Schemes and Programs.* Sydney: NSW Parliamentary Library.

Yellowlees, P.M. and Kaushik, A.V. (1992). The Broken Hill Psychopathology Project. *Australian and New Zealand Journal of Psychiatry, 26,* 197-207.

Yellowlees, P.M. and Kaushik, A.V. (1994). An Examination of the Associations between Life Problems and Psychiatric Disorders in a Rural Patient Population. *Australian and New Zealand Journal of Psychiatry, 28,* 50-57.

Young Shire Council. (1993). *Annual Report.* Young: Young Shire Council.

Zubrick, S.R., Silburn, S. and Acres, J. (1994) Intersectoral Responses to Youth Suicide, in *Public Health Significance of Suicide: Prevention Strategies. Proceedings of the National Conference on Public Health: Significance of Suicide*. 28 February - 1 March, 1994. Lakeside Hotel, Canberra.

APPENDIX ONE

SUBMISSIONS

■ Andrews, R	
■ Ansens, M	Year 12 General Studies Student
■ Appleby, M	Director, Lifeline, Macarthur Region
■ Baird, R	
■ Balnaves, J	Chairperson, Catholic Social Justice Commission, Archdiocese of Canberra and Goulburn
■ Baxter, K	Social Work Adviser, Bathurst Base Hospital
■ Bird, S	Co-Manager, Exit Right Training
■ Booth, J	Clinical Nurse Consultant, Central Western Mental Health Services
■ Briggs, D	General Manager, North West Health Service
■ Browne, A	Griffith Youth Suicide Prevention Committee, Griffith Base Hospital
■ Byron, D	General Manager, Far West Health Service
■ Cullen, A	Executive Director, Australian Bankers' Association
■ Curley, J	Project Officer, Rural Health Support Education and Training
■ Dickerson, P	Director, Lifeline Central West
■ Doyle, J	Community Development/Outreach Worker, Highlands Community Centres, Bowral
■ Engelman, J	
■ Fairweather, R	General Manager, Castlereagh Health Service
■ Foley, R	Convenor, Education Sub Committee, Australian Funeral Directors' Association and Funeral and Bereavement Educators' Association
■ Giles, R	Secretary, The Association for Good Government
■ Gow, G	
■ Green, B	
■ Green, E	
■ Griffiths, J	Newcastle-Hunter Attention Deficit Disorder Support Group

■ Hill, S	Coroner, Wagga Wagga
■ Hills, C	
■ Hughes, R	
■ Jones, N	Co-Ordinator, Goulburn Family Support Service
■ Kay, R	Charles Sturt University, Wagga Wagga
■ Khoo, T	Director, Community Health Services, Macquarie Health Service
■ King, Dr R	School of Education, Charles Sturt University, Wagga Wagga
■ Kinsella, L	
■ Lohse, H	
■ Macpherson, L	Secretary, Family Association, Mental Health Support
■ Martin, J	
■ McAuley, J	
■ McGovern, T	Coroner, Parkes
■ Mooney, M (CBS)	Justice Secretary, Australian Conference of Leaders of Religious Institutes
■ Nixon, I	
■ Penley, K	Train the Trainer Project Officer, The Second Story, Youth Health Centre, Adelaide
■ Piercy, N	General Manager, Riverina Health Service
■ Pitty, W	
■ Podnieks, M	National Training Officer, Suicide Prevention Australia
■ Richardson, R	Executive Director, Australian Funeral Directors Association
■ Rose, D	Director, Office of Aboriginal Health, NSW Health Department
■ Russell, M	Murray Training Consultancy
■ Sims, K	Rural Counsellor, Macquarie Rural Advisory Service
■ Smith, E	Chairman, Associations of Relatives and Friends of the Mentally Ill, Young
■ Smith, R	President, Sporting Shooters Association of Australia (NSW)
■ Timson, P	Mental Health Team, Young District Hospital and Community Health Services

■ Trevillian, B	
■ Unger, I	Secretary, Churches Caring in Crisis Group, Parkes
■ Walls, J & S	
■ Wall, L	
■ Wansbrough,Rev A	Research & Liaison Person on Social Issues, Board for Social Responsibility, Uniting Church in Australia, NSW Synod
■ Waters, Prof B	Director, Psychiatric Services, St. Vincents Hospital
■ Weighton, A	Youth Options Co-Ordinator, Centacare
■ Wellesley, B	Co-Ordinator, Orana Community Health Services, Dubbo
■ Weston, A	General Manager, Murray Health Service
■ White, J	Chief Executive, NSW Farmers Association
■ White, K	General Manager, Lower North Coast Health Service
■ Wyn Owen, J	Director-General, NSW Health Department

APPENDIX TWO

WITNESSES AT HEARINGS

Dr Rick Alterator	General Practitioner, Cobar
Mr Robert Andrews	President, Lismore Branch Sporting Shooters Association
Mrs Margaret Appleby	Director, Lifeline, Macarthur Region
Hon Ian Armstrong MP, OBE	Deputy Premier, Minister for Public Works and Minister for Roads
Mr Tim Armstrong	Co-ordinator, Suicide Prevention Project, North Coast Public Health Unit
Ms Sandra Bailey	Chief Executive Officer, Aboriginal Health Resource Co-op Limited
Mr Frans Banens	Social Worker, Lismore Base Hospital
Mr Tony Baker	Coroner, Broken Hill
Associate Professor Pierre Baume	Chair, NHMRC Suicide Prevention Working Party and Dean, Faculty of Nursing and Health Sciences, Griffith University, Queensland
Associate Professor Ian Burnley	Department of Geography, University of NSW
Mr Tim Carr	Rural Counsellor, Cobar
Mr Ross Chalmers	Rural Counsellor, Parkes
Ms Leone Coolahan	Research Officer, Public Health Unit, South Eastern Region
Mr Desmond Cummings	Community Psychiatric Nurse, Mental Health Team, Young District Hospital and Community Health Services
Mrs Pat Daly	Churches Caring in Crisis Group - Ungarie

Dr Michael Dudley	Staff Psychiatrist, Avoca Centre, Royal South Sydney Hospital
Ms Mary Ewing	Rural Counsellor, Forbes
Mr Chris Foster	Crisis Counsellor & Psychologist, Cobar
Mr Greg Glass	New South Wales State Coroner
Ms Mavis Golds	Manager, Aboriginal Health, North Coast Public Health Unit,
Mrs Sue Gordon	Vice-President, Young Community Caring Group
Mr Des Graham	Nursing Unit Manager, Far West Mental Health Service
Mr Mark Harris	Manager, Macquarie Mental Health Services
Mr Neal Harris	Outreach Youth Counsellor, Dubbo Community Services and Information Neighbourhood Centre
Mr Graham Hay	Mental Health Worker, Macquarie Mental Health Service
Dr Phillip Hazell	Senior Lecturer in Psychiatry, University of Newcastle
Mr Mark Hemming	Clinical Nurse Consultant and Manager, Far West Mental Health Service
Ms Deborah Herron	Chairperson, Griffith Suicide Prevention Committee
Mr Sev Hill	Coroner, Wagga Wagga
Mr Graham Hitchick	Churches Caring in Crisis Group - Parkes
Mrs Faye Joyce	Director, Lifeline, Broken Hill
Mrs Gail Kelly	Representative, Western Action Movement

Dr Ray King	University Fellow, Charles Sturt University
Dr Nick Kowalenko	Director, Arndell School for Specific Purposes and Acting Head, Department of Child & Adolescent Psychiatry RNSH
Ms Barbara Lamrock	Community Mental Health Nurse, Forbes Mental Health Service
Ms Patricia Lelievre	Committee Member, Cobar Community & Rural Network Inc
Ms Sandy Lindeman	Adolescent and Family Counsellor, Dubbo Community Services and Information Neighbourhood Centre
Ms Kerry Luke-Browning	Publicity Officer, Young Community Caring Group
Mr H Lohse	Psychologist, Queanbeyan
Pastor Wayne Magee	National Co-ordinator, Suicide Prevention Australia
Ms Jan Mills	Co-ordinator, Farm Women's Focus Group, Injury Prevention, North Coast Public Health Unit
Ms Denise Montague	Co-ordinator, Suicide Prevention Project, North Coast Public Health Unit
Mr John Moore	President, St Vincent de Paul Association
Mr Stephen Morrell	Research Officer, Department of Public Health, University of Sydney
Mr John Noble	Department of School Education Representative, Suicide Prevention Project, North Coast Public Health Unit
Ms Catherine Nowlands	Acting Director, Forbes Community Health Service

Ms Wendy Orr	Social Worker, Parkes Community Health Centre
Mr Greg Packer	Aboriginal Liaison Officer, Riverina Health Service
Ms Rebecca Peters	Co-ordinator, Coalition for Gun Control
Ms Marija Podnieks	National Training Officer, Suicide Prevention Australia
Mr Mick Rowles	Clinical Nurse Specialist, Riverina Community Mental Health
Dr George Rubin	Chief Health Officer, NSW Department of Health
Mr Murray Russell	Murray Training and Consultancy, Albury
Mr Earl Ryan	Principal, Arndell School for Specific Purposes
Mr Terry Ryan	Policy Director and Acting Chief Executive Officer, NSW Farmers' Association
Ms Sonia Shay	Aboriginal Liaison Officer, Riverina Health Service
Mr Eric Smith	Chairman, Association of Relatives and Friends of the Mentally Ill, Young Branch
Mr Roy Smith	State President, Sporting Shooters Association of Australia (NSW) Inc
Mrs Margaret Soden	
Mr Tony Sutherland	Aboriginal Health Education Officer, Dubbo Public Health Unit
Mr Peter Timson	Clinical Nurse Consultant, Young Mental Health Team
Sister Morella Toscan	Churches Caring in Crisis Group - Ungarie

Mr Greg Tyrer	Psychologist, Department of Community Services, Dubbo
Mr Ian Unger	Churches Caring in Crisis Group - Parkes
Mr John Walker	Secretary, Young Community Caring Group
Mrs Helen Wall	
Ms Linda Wall	
Rev Ann Wansbrough	Research and Liaison Person on Social Issues, Board for Social Responsibility, Uniting Church in Australia (NSW Synod)
Professor Brent Waters	Director of Psychiatric Services, St Vincent's Hospital, Sydney
Mr Andrew Weightman	Youth Options Co-ordinator, Centacare, Wagga Wagga
Mr Warren Williams	Aboriginal Liaison Officer, Lismore Police Service
Dr Noel Wilton	Director, Mental Health, NSW Department of Health
Mr Peter Winecke	Churches Caring in Crisis Group - Ungarie

IN CAMERA

The Committee heard evidence in camera from 16 witnesses.

BRIEFING

Ms Jeanine McCrae	Executive Officer, Union of Farmers Inc.
Professor Peter Yellowlees	Chief Psychiatrist, South Australian Mental Health Services