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.