

# UNLIVED LIVES: TRENDS IN YOUTH SUICIDE<sup>1</sup>

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## **The Nature and Magnitude of the Problem**

SUICIDE AMONG YOUNG AUSTRALIANS HAS BEEN GRADUALLY INCREASING over the past thirty years. One in six deaths of males and one in nine deaths of females aged fifteen to nineteen years in 1988 was caused by suicide. In 1966 the corresponding figure was only one in twenty for the age group 15 to 19 of age<sup>2</sup>. In 1988 there was one teenage suicide every forty-seven hours. An estimated 9,000 years of life are lost every year due to teenage suicides. In economic terms, adolescent suicides cost millions of dollars every year to the Australian economy. The loss, pain and grief suffered by the family and the community is even far greater and more profound than the economic loss.

The problem of youth suicide is not confined to Australia. It is now a global problem of increasing magnitude. It is shared by the rich and poor countries. The most advanced industrialised countries, however, have experienced a rapid increase in youth suicide. According to a study by an American sociologist, David Lester (1988), youth suicide has increased dramatically in many countries since 1970. His evidence presented in Table 1 below strongly supports this assertion and clearly shows that the magnitude of the problem has increased dramatically in the rich industrialised countries.

## **Youth Suicide Trends in Australia**

In Australia, the problem of youth suicide has gradually worsened since 1960. Whereas in the past suicide was positively correlated with age, that is, the risk of suicide increased with

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<sup>2</sup> These statistics have been computed by the author from the data provided by the Australian Bureau of Statistics in its publication, *Causes of Death*, Australia, various years.

age, the evidence presented in Figure 1 clearly shows that since 1964 suicide risk has significantly increased in two theatres of life—the very young and the very old. In the same period, there has been a relative and absolute decline in the suicide rate of people aged between 35 and 60. We thus have a curious situation in this respect. The suicide rate of the cohort which is now parenting the teenagers has experienced a remarkable decline over the past thirty years.

*Table 1*

**Suicide rates (per 100,000 per year) in 1970 and Changes by 1980  
for the Total Population and for those aged 15-24**

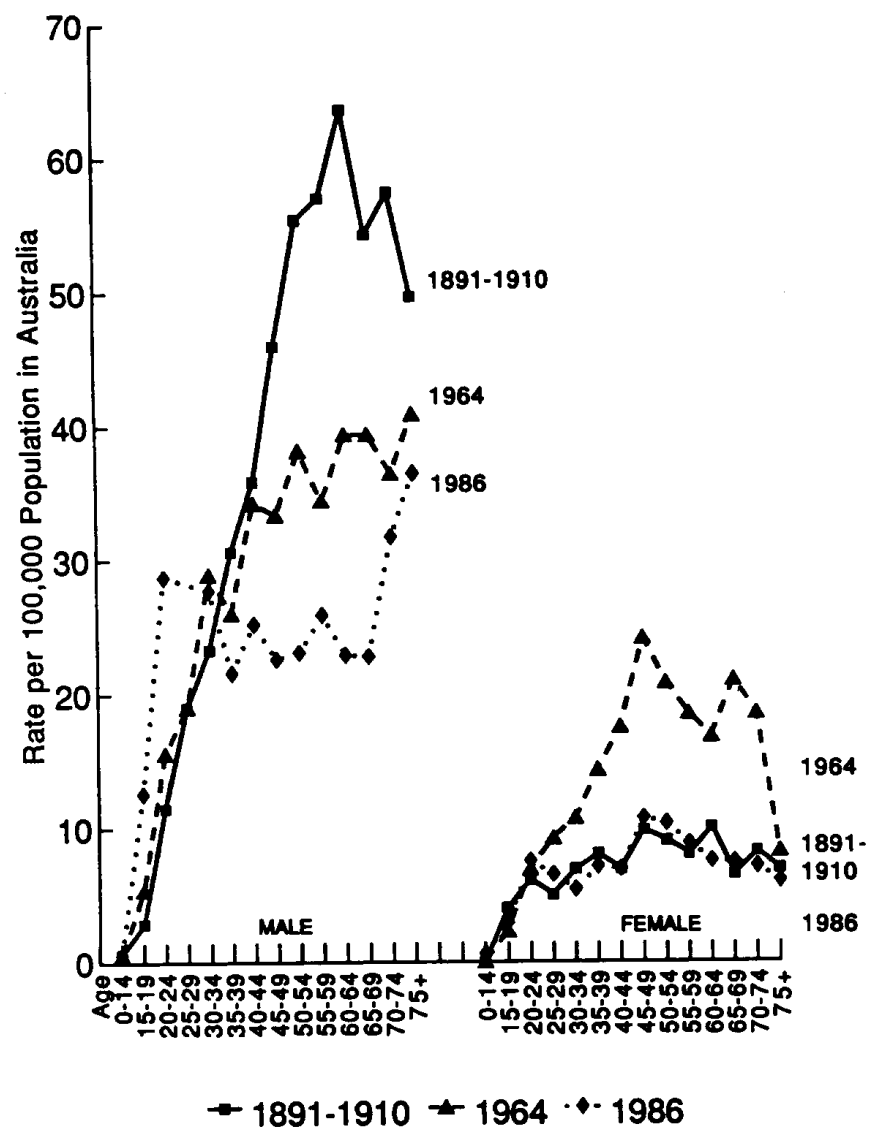
|                     | Total |                     | Youth |                     |
|---------------------|-------|---------------------|-------|---------------------|
|                     | 1970  | % Change<br>by 1980 | 1970  | % Change<br>by 1980 |
| Australia           | 12.4  | -11.2               | 8.6   | +30.2               |
| Austria             | 24.2  | +6.2                | 16.5  | +9.1                |
| Bulgaria            | 11.9  | +14.3               | 6.9   | +34.8               |
| Canada              | 11.3  | +23.9               | 10.2  | +50.0               |
| Chile               | 6.0   | -18.3               | 10.1  | -31.7               |
| Denmark             | 21.5  | +47.0               | 8.5   | +42.4               |
| Finland             | 21.3  | +20.7               | 14.7  | +60.5               |
| France              | 15.4  | +26.0               | 7.0   | +52.9               |
| Germany (West)      | 21.3  | -1.9                | 13.4  | -6.7                |
| Greece              | 3.2   | +3.1                | 1.5   | +20.0               |
| Guatemala           | 3.2   | -62.5               | 5.5   | -50.9               |
| Hong Kong           | 13.6  | -0.7                | 7.7   | +1.3                |
| Hungary             | 34.8  | +29.0               | 18.9  | +5.8                |
| Israel              | 5.8   | +3.4                | 3.7   | +64.9               |
| Italy               | 5.8   | +25.9               | 2.9   | +34.5               |
| Japan               | 15.2  | +15.8               | 13.0  | -3.8                |
| Netherlands         | 8.1   | +24.7               | 4.0   | +50.0               |
| New Zealand         | 9.6   | +12.5               | 8.0   | +73.7               |
| Norway              | 8.4   | +47.6               | 3.7   | +224.3              |
| Portugal            | 7.5   | -1.3                | 4.5   | +2.2                |
| Singapore           | 8.9   | +25.8               | 7.8   | +32.1               |
| Spain               | 4.2   | +4.8                | 1.4   | +92.9               |
| Sweden              | 22.3  | -13.0               | 13.3  | -13.5               |
| Switzerland         | 18.6  | +38.2               | 13.0  | +80.0               |
| Thailand            | 4.2   | +76.2               | 7.2   | +77.8               |
| UK: England & Wales | 8.0   | +10.0               | 6.0   | +6.7                |
| UK: Scotland        | 7.6   | +31.6               | 5.8   | +65.5               |
| USA                 | 11.5  | +2.6                | 8.8   | +39.8               |
| Venezuela           | 6.8   | -23.5               | 14.5  | -28.3               |

Source: Lester (1988).

The analysis of suicide trends presented in Table 2 reveals that among 15 to 19-year-old boys the suicide rate has increased from 7.3 per 100,000 population in 1968 to 17 per 100,000 population in 1988. The rate of 20 to 24-year-olds in the same period has increased from 15.3 to 32. The suicide rate among adolescent girls in the same period has increased from 2.4 to 4.7 per 100,000 population. However, the suicide rate of women between 20 and 24 years has remained relatively stable in the same period.

Figure 1

**Suicide Rate per 100,000 Population in Australia 1891-1986**



Source: Knibbs 1912; Australian Bureau of Statistics, *Causes of Death*.

Source: Knibbs 1912; Australian Bureau of Statistics, *Causes of Death*.

Why are young people in Australia who have everything to live for resorting increasingly to suicide? There are several reasons. Some of the increase in the youth suicide rate is due to the sophistication of data collection. Suicides are determined by coronial inquests. There is evidence which suggests that in recent years Australian coroners have categorised more unexpected deaths as suicide than before. In 1972, for example, 19.2 per cent of all unexpected deaths in Australia were classified as suicides. In 1981 the proportion had increased to 22 per cent. There has also been a tendency on the part of the coroners to categorise fewer female unexpected deaths as suicide. In 1970, 20 per cent of all unexpected female deaths were classified as suicide and 19 per cent of all male deaths were so classified. In 1981, 19 per cent of female and 23 per cent of male unexpected deaths were classified as suicide (Carr & Hassan 1987).

Table 2

**Suicide in Australia, 1965-1988:  
Average Yearly Rates per 100,000 Population at risk**

| Years<br>(inclusive) | Male           |                |                | Female         |                |                |
|----------------------|----------------|----------------|----------------|----------------|----------------|----------------|
|                      | 10-14<br>Years | 15-19<br>Years | 20-24<br>Years | 10-14<br>Years | 15-19<br>Years | 20-24<br>Years |
| 1968-1970            | 1.0            | 7.3            | 15.3           | 0.2            | 2.4            | 6.3            |
| 1971-1973            | 0.8            | 9.7            | 19.7           | 0.2            | 4.8            | 7.3            |
| 1974-1976            | 0.9            | 10.0           | 19.7           | 0.3            | 3.2            | 5.0            |
| 1977-1979            | 0.7            | 11.3           | 23.3           | 0.1            | 3.5            | 6.3            |
| 1980-1982            | 0.6            | 10.4           | 26.3           | 0.2            | 2.2            | 6.0            |
| 1983-1985            | 1.0            | 12.1           | 28.3           | 0.3            | 2.6            | 5.7            |
| 1986-1988            | 1.5            | 17.0           | 32.0           | 0.3            | 4.7            | 6.3            |

Source: Australian Bureau of Statistics, *Mortality Tables*.

This change in coronial classification was not uniformly applicable to all Australian states and territories. The New South Wales coroners in fact went against the national trend and classified fewer unexpected deaths in 1981 as suicide than in 1972. The Australian Capital Territory registered the most dramatic change and compared with 12.7 per cent of unexpected deaths in 1972 classified as suicide, 24.4 per cent of such deaths were classified as suicide in 1981. The Northern Territory coroners were least likely to classify an unexpected death as suicide (Carr & Hassan 1987).

These patterns if applied to adolescent suicides would suggest that at least some increase in the suicide rate is a statistical artefact. Due to increasing social differentiation and social structural changes young persons these days participate more visibly in the public domain and consequently it is more difficult for the family to conceal their suicide than it was twenty or thirty years ago. The author's research on coronial classification supports the recent observations of Robert Kosky that there has been a moderate trend among coroners to classify a verdict of suicide for young persons, but that there has also been a real rise in youth suicide (Kosky 1987). Whatever way we may view the problem the fact still remains that youth suicides were either historically higher but were hidden away as a result of

coronial classification practices or that they have been increasing gradually over the past three decades. From the author's work it seems that there has been a gradual increase in youth suicide. This then leads to the question which has previously been raised, why are young Australians killing themselves in increasing numbers? There are several sociological reasons which bear on the question and appear to have significantly influenced the increase in adolescent suicide. These are the high youth unemployment rate; changes in the Australian family; increasing drug use and abuse; increasing youth violence; mental health; and an increasing disjunction between 'theoretical freedom' and experiential autonomy.

### Unemployment Factor

The period of increasing youth suicide strongly corresponds to the high youth unemployment rate. Between 1970 and 1986, the unemployment rate increased about sixfold from 2.9 per cent to 18.1 per cent for 15 to 19-year-old males and from 3.6 to 19.5 per cent for 15 to 19-year-old females (see Table 3). The overall suicide rate for 15 to 19-year-olds in the same period increased by about 50 per cent. Among 20 to 24-year-olds, the unemployment rate increased by fourfold (from 2.3 in 1967 to 11.7 in 1987) and the suicide rate had increased by 86 per cent among men and remained unchanged among women.

Table 3

#### Unemployment Rate and Mean Duration of Unemployment Among 15-19 Year Olds, August 1970 to August 1986

| Year | Unemployment |        | Mean<br>Duration<br>of<br>Unemployment<br>(Weeks) |        |
|------|--------------|--------|---------------------------------------------------|--------|
|      | Male         | Female | Male                                              | Female |
| 1970 | 2.9          | 3.6    | 3.9                                               | 6.4    |
| 1972 | 5.6          | 5.9    | 6.5                                               | 1.5    |
| 1974 | 5.0          | 6.7    | 7.3                                               | 8.1    |
| 1976 | 12.7         | 15.8   | 19.5                                              | 17.6   |
| 1978 | 16.4         | 17.2   | 19.8                                              | 27.1   |
| 1980 | 14.7         | 18.8   | 24.9                                              | 28.1   |
| 1982 | 16.3         | 17.0   | 21.3                                              | 26.6   |
| 1984 | 22.1         | 19.7   | 28.6                                              | 29.2   |
| 1986 | 18.7         | 19.5   | 30.6                                              | 29.0   |

Source: Department of Social Security (1987).

The increase was primarily concentrated among the young men. The suicide rate for young women (15-24 years) in fact registered a slight decline in the same period. A significant feature of youth unemployment was that whereas the average unemployment period in 1970 for young males was 3.9 weeks, in 1986 it had increased to 30.6 weeks. The corresponding period for young women in the same period increased from 6.4 to 29 weeks. Unemployment in general and prolonged unemployment in particular is associated with low self-esteem and with emotional, economic and psychological insecurity. Because of the instrumental roles which are emphasised in male socialisation processes, low self-

esteem and continuous insecurity exposes them to a high degree of stress which requires skilled management. Those who cannot cope with it become more susceptible to self-destructive behaviour. A number of studies in Australia and overseas have confirmed the association between suicide and unemployment (Martina 1985; Hassan & Tan 1989).

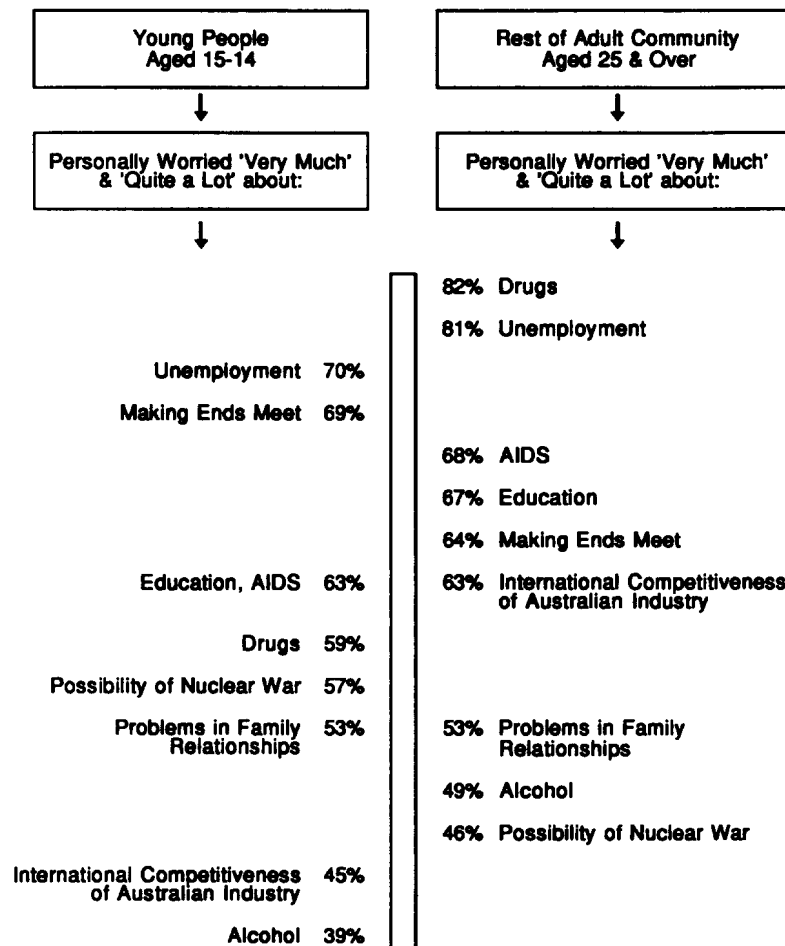
Unemployment appears to have different effects on men and women. Notwithstanding the high unemployment rates and increasing length in the period of unemployment between 1970 and 1986, the suicide rate of adolescent women did not increase to the degree as that of adolescent men. One possible explanation is the different socialisation patterns of women and men. Women are socialised into domestic roles which enable them to find meaningful activities in the domestic domain which reduces the sense of loss, loss of status, loss of self-esteem and loss of social contacts which is also experienced by unemployed men who are predominantly socialised into instrumental social roles. Other possible reasons may be that since most frequently men use violence of guns and women use self-poisoning to suicide, the chances of women surviving serious suicide attempts are now greater than men because of advances in intensive care medical technology and, also, it may still be possible for the family to 'conceal' female suicide more frequently than male suicide.

An interesting difference in the way young men and women cope with the insecurity of unemployment can be gauged from their marriage pattern. In 1978 only 0.4 per cent of all unemployed 14 to 19-year-old males were married. In 1986 the proportion had increased to 1.9 per cent. The percentage of 15 to 19-year-old married women who were unemployed in the same period declined from 5.8 to 4.4 per cent (Department of Social Security 1987). It would, therefore, appear that social insecurity compels men to seek security through early marriage which further compounds the problem by creating a greater degree of status conflict which according to Emile Durkheim (1951) and other researchers (Stack 1980) increases propensity to suicidal behaviour.

The increase in youth unemployment and the accompanying fear of economic deprivation appear to have had a significant impact on their consciousness. According to a 1988 national youth survey of young people aged 15 to 24, unemployment, poverty, education, AIDS, and drugs worried them most. In general, the result of the survey as reported in Figure 2 revealed a sense of pessimism about the future mostly created by their concerns about unemployment, substance abuse, possibility of a nuclear war and family problems. Although they shared these worries with the older Australians, the impact is likely to be much more consequential for the young, given their relative lack of economic and social independence.

Figure 2

**Community Issues and Concerns by Age, Australia 1988**



*This barometer shows the percentages of those under & over 25 indicating that they are 'very much' or 'quite a lot' worried about each issue in a structured question.*

**Source: Department of Employment, Education and Training (1988)**

Similar conclusions have been reported by several other recent studies suggesting that a large proportion of young people regard their future and that of the world with fear and trepidation. They see a world devastated by nuclear war and ravaged by pollution and environmental degradation, a dehumanised society in which technology is out of control and unemployment rampant. This pessimism about the future unfortunately is easily translated into a more personal despair, powerlessness and a sense of hopelessness which can contribute to mental illness, powerlessness, personal despair and a sense of hopelessness and other forms of problem behaviour among young people (Eckersley 1988).

Evidence from a study on causes of suicide which is now in progress provides some support for this statement. It shows that among young men the main 'causes' of suicide in descending order are: a sense of failure in life, unhappy love, mental illness, family and marital problems, substance abuse, and loneliness. For young females the main causes are:

unhappy love, sense of failure in life, family and marital problems and a sense of burden on others.

### **The Family Organisation**

There is now considerable reliable clinical evidence which points to a close link between suicidal behaviour and parent-child relationships. According to Hendin (1987) a leading American psychiatrist who has done some of the pioneering research in this area, the background of suicidal youngsters repeatedly involves parental figures who were frustrating, rejecting and unkind. The parents seem to want the child's presence, but without emotional involvement. They want him or her to fulfil parental expectations, though as parents they have given the child little support and incentive to do so. The young person may accept parental expectations in a mechanical manner without deriving much pleasure or satisfaction from fulfilling them. At the same time, they do not feel free to act in ways that would separate them from their parents. Adolescents in such circumstances may make few emotional demands but become instead withdrawn, depressed, quietly occupied with death and suicide (Hendin 1975; 1982; Dorpat et al. 1965).

If these clinically based findings are valid, then the changes in the Australian family and its organisation and structure may have significantly influenced the youth suicide rates in Australia. The size of the Australian family has declined by 15 per cent between 1976 and 1981 from 3.53 to 3.1 persons. Family type consisting of wife, husband and dependent children account for little over one-quarter of the Australian families (26.6 per cent in 1981). The fastest growing family type over the past twenty years was the single parent family. In 1981 there were a quarter of a million single parent families and their numbers are expected to grow in the future (Hugo 1986).

A substantial proportion of Australian children now spend part of their childhood living with one of their parents. In 1981, 13 per cent of children less than 15 years of age and 11 per cent of children aged 15 to 19 years lived in single parent households (Hugo 1986). As these figures only relate to one point in time, the actual number of children who have spent or will spend part of their childhood in a single-parent family situation is likely to be significantly higher.

There has been a simultaneous increase in couples living in de facto relationships, and in the divorce rate. In 1961, there were 2.8 divorces per 1,000 married women, in 1981 the rate was 12.7. These trends clearly suggest that the Australian family is undergoing a significant change in its organisation, composition and structure. These changes highlight the new emerging patterns of social organisation. How these changes affect the patterns of social behaviour is not yet totally clear, but as an indication of the implication of these changes for suicidal behaviour reference is made to a study which shows that, in the United States, a 1 per cent increase in divorce is associated with an 0.54 per cent increase in the suicide rate (Stack 1980).

A point which is often missed out in studies focussing on the relationship between the family and social behaviour is the socioeconomic attributes of the parents. In Australia, a dramatic change has occurred not only in social demography of the family but also in the qualitative attributes of the population involved in or likely to be involved in parenting. To illustrate this point it is worth focussing on the position of women. Women and men are now marrying later than before and there is now a longer gap between the time of marriage and the birth of the first child. In 1967, the median age of women at first marriage was 21.1 years and age at first birth was 23.7 years. In 1983, the corresponding figures were 22.7 years and 26.1 years. This is primarily due to the increasing educational attainment of men and women.

The data in Table 4 show young adolescents today are living with parents who are more educated than ever before. They are also living in families and households in which both parents are likely to be working more frequently than before. These qualitative changes in social, educational and economic status together with the fact that families now have fewer children than before, have created circumstances of more intensive emotional, economic and social investments in children. Parents under these circumstances generally expect more from their children in terms of academic achievements and success.

Table 4

**Educational Attainment of Men and Women born in 1915-24 and 1945-49  
Australia**

| Educational<br>Attainment                                | Men born in |         | Women born in |         |
|----------------------------------------------------------|-------------|---------|---------------|---------|
|                                                          | 1915-24     | 1945-49 | 1915-24       | 1945-49 |
| Degree                                                   | 5.3         | 8.9     | —             | 4.4     |
| Certificate/Diploma                                      | 10.7        | 15.7    | 14.7          | 26.3    |
| Trade Level                                              | 24.5        | 26.4    | 3.1           | 3.4     |
| Other                                                    | 3.0         | 4.6     | 1.9           | 3.4     |
| Total with Post-School Qualification                     | 43.5        | 56.7    | 20.5          | 37.5    |
| Without Post-School Qualification and<br>Left School at: |             |         |               |         |
| 17 and over                                              | 4.0         | 9.9     | 4.6           | 7.7     |
| 16                                                       | 6.2         | 9.3     | 8.9           | 13.3    |
| 15-14                                                    | 33.3        | 21.3    | 52.5          | 36.2    |
| 13 or under                                              | 13.1        | 2.9     | 13.5          | 5.2     |
| Total Without Post-School Qualification                  | 56.5        | 43.4    | 79.5          | 62.5    |
| Total                                                    | 100.0       | 100.0   | 100.0         | 100.0   |

Source: Australian Bureau of Statistics, *Social Indicators*, 1980, Adapted from Table 4.35.

A recent Australian study of educational attainment of young persons in their first few years of university has found that students whose father had a degree and whose mother is in a professional or semi-professional occupation, were more likely to succeed in university (Power et al. 1987). Those who may find it difficult to reach the academic expectations of their parents may experience a sense of failure and depression which under certain circumstances may have serious implications for their social-psychological well-being. Those who are unable to make the grade are also those who need more parental and social support. The clinical studies of suicidal young persons have found that they usually have a profound need to seek someone who can change their past frustrations of life. American psychiatrist Hendin has suggested that if at the heart of young suicide one invariably learns of profound difficulties in the parent-child relationship and if we are seeing unhappy families, absent parents and unwanted children increasing in numbers, a case can be made for the pessimistic prediction that the suicide rate among youth will continue to rise (Hendin 1987).

### **Suicide and other Forms of Violence**

The marked increase in suicide among the young has been accompanied by a rise in other serious problems such as homicide, drug abuse, alcohol abuse, delinquency and crime—all

of which are a barometer of social stress. Suicide methods over time have also become more violent. In 1966, 32 per cent of males and 6 per cent of females used guns and other violent methods to suicide. These figures had increased to 38 per cent and 13 per cent respectively in 1981. In a recent study of adolescent suicides in the United States it was found that there is a strong correlation between suicidal behaviour and the presence of guns in the home. The researchers suggest that, because guns were more often present in the homes of suicide completers, the rate of suicide by firearms may be proportional to the availability of this particular irreversible method of self-inflicted injury (Brent et al. 1988).

Table 5

**Arrest Rates for Serious Assault and Homicide  
for Persons 10-16 Years Old—Australia  
(Rate per 100,000 population)**

|      | Type of Crime   |        |          |        |
|------|-----------------|--------|----------|--------|
|      | Serious Assault |        | Homicide |        |
|      | Male            | Female | Male     | Female |
| 1964 | 21.3            | 0.8    | 1.2      | 0.14   |
| 1980 | 40.4            | 6.5    | 2.4      | 0.34   |
| 1985 | 61.5            | 8.9    | na       | na     |

They are also exposed to more violence through the print and electronic media. According to a recent American study, under certain conditions celebrity suicide stories influence violent, suicidal behaviour and increase imitative suicides (Stack 1987). For example, the suicide of Freddie Prinze who, at age 22, had risen from a humble Puerto Rican family to become the star of the popular television series 'Chico and the Man' was significantly associated with a rise in youth suicide in the United States. Studies have also revealed that, although fictional violence has no imitative effect on actual violence, the accounts of real violence is associated with real world aggression (Kessler & Stipp 1984; Messner 1986; Phillips 1974; Phillips & Bollen 1985).

Substance abuse is also a significant factor in youth suicide. In the United States, increase in youth suicides in the 1970s and 1980s closely parallel the increase in use and substance abuse among young persons and is now regarded by the American researchers as the single most common denominator of those at high risk. According to a major recent study of adolescent suicides, one-third of the suicide victims in the study were legally intoxicated at the time of their deaths. The high blood alcohol levels and suicide by firearms among adolescents are also highly correlated and, in these cases, suicide seems to occur hours rather than minutes after alcohol ingestion. Do suicide victims drink to lower their inhibitions and facilitate a planned suicide? Does the fatal impulse emerge spontaneously during a drinking bout? The role of alcohol intake and intoxication is now regarded as an important area of further research (Brent et al. 1988).

### **Suicide and Mental Health**

Mental health is a major factor in suicidal behaviour. It is particularly important in youth suicide. According to the South Australian Coroner's Court records in 1988-89, of the ninety-two persons aged 24 years and less who committed suicide in South Australia, eighty-six had a history of depression, acute anxiety and/or serious disturbance in

interpersonal life at the time of suicide. Given this extremely high incidence of depression among the young suicides, it is pertinent to ask whether or not they had access to psychiatric help. The case records in the Coroner's Court indicate that very few were receiving any psychiatric treatment at the time of suicide.

A general examination of the access of young people to psychiatric services in the public hospitals in South Australia, however, reveals that they had the lowest utilisation rate of psychiatric services in the public hospitals in South Australia in 1986. This is shown in Figures 3 and 4. Interestingly, when one compares the age-specific admission rates for psychiatric wards and the admission rate for attempted suicides, one finds that there is a statistically significant inverse correlation between the two rates. In 1986, at least in South Australia, the age group with the highest utilisation rate of public psychiatric services also tended to have lower admission rates for the attempted suicides. Although no causal inference can be drawn from this, this correlational analysis is plausible to suggest perhaps greater access to psychiatric treatment may have a salutary effect on the suicidal behaviour. We need more empirical research to assess the significance of this finding.

Figure 3

**Female pd & ec Rates per 100,000 in 1986**

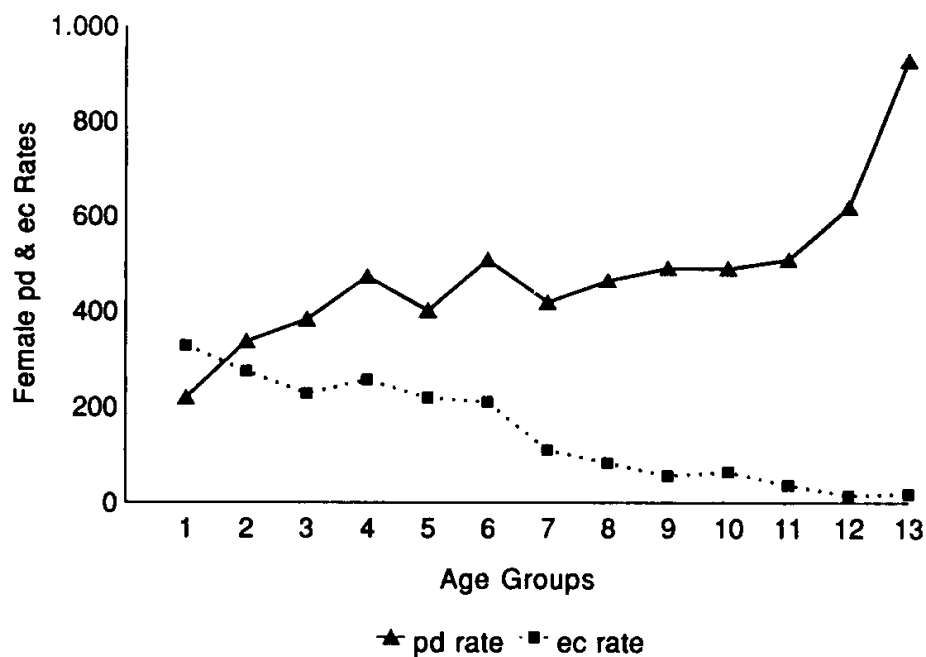
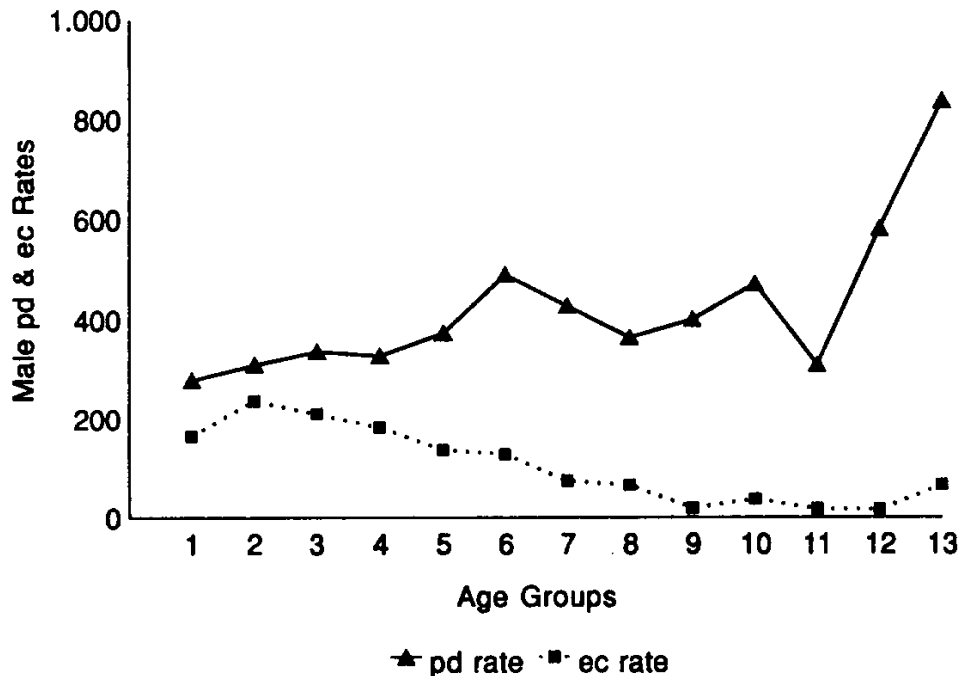


Figure 4

**Male pd & ec Rates per 100,000 in 1986**



pd = principal diagnosis and refers to ICD code 290-299 (psychosis/mental disorder)  
 ec = external cause refers to attempted suicide and ICD codes 950 to 959.

Source: South Australian Health Commission, Hospital Separation Tables 1986.

If access to psychiatric treatment reduces the incidence of suicidal behaviour then this can partly explain the dramatic decline in the suicide rate of people between 40 and 60 years of age who also have the highest utilisation rate of psychiatric services. A recent study of adolescent suicide strongly supports the need for psychiatric help. The study revealed that 22 per cent of adolescent suicide victims were suffering from a serious bipolar disorder (that is major depression and mania or hypomania) or a major affective disorder with a concomitant non-affective disorder (for example anxiety disorder, conduct disorder). They were also less likely than a control group of adolescent inpatients of a psychiatric unit to have had any contact with a mental health professional in their lifetimes (Brent et al. 1988).

However, irrespective of the casual link between the two the data reported in Figures 3 and 4 clearly reveal the need for improving the access to psychiatric services among the young people. This can be partly achieved by making them more aware of the available services and through encouragement by parents, teachers, employers and friends to use the psychiatric services to repair their mental health.

### **The Citizenship Rights for the Young and Experiential Autonomy**

The last major factor worthy of mention pertains to the disjunction between citizenship rights and experiential autonomy. In this paper citizenship rights is taken to mean the gradual extension of civil, economic, welfare and legal rights which are being gradually extended to

adolescents by the state. The extension of these rights does not automatically lead to the actual experience of them. The young have the formal rights but the autonomy to exercise them is mediated by parental and societal approval and in some instances such approval may not be granted either by parents and/or society. The absence of experiential autonomy on the one hand and the presence and promotion of civil rights on the other, may create a social disjunction which both creates as well as heightens the intergenerational conflict, one extreme consequence of which is suicide. Furthermore, changes in the Australian family such as a high divorce rate and increasing numbers of sole parents have also contributed to this conflict.

Conversely, it is plausible that the extension of legal, welfare and other rights to adolescents may have resulted in their exercising such rights which in turn have affected their suicide rates adversely. In other words, it may be that adolescents are experiencing their rights but are having difficulties in coping with the repercussions. (For example, one consequence of receiving unemployment benefits may be increasing numbers of adolescents living away from home in chronic poverty and isolation which then produces a new set of social and psychological pressures.) Taken together then, these factors may constitute one possible explanation why suicide among the young, and especially adolescents, has increased in recent years in Australia.

One further observation on the factors affecting youth suicide: Richard Easterlin, an American economic demographer has suggested that young persons born in a baby boom are adversely affected in their ability to fulfil their aspirations because, as young adults, they face different odds in competing with each other for scarce resources. Psychological stress among young adults, he suggests, will be comparatively high as will the divorce rate, suicide, crime and feelings of alienation. Poorer outlook for success may manifest itself less in economic insecurity than in a sense of the meaninglessness of life with few social constraints against suicide. Easterlin sees continued cyclical rises and falls in the rate of young suicides since the greater stress on a cohort results both in their having few children and in their having children with somewhat lower expectations and aspirations (Easterlin 1980).

## **Concluding Remarks**

In this paper the author has attempted to highlight some of the important sociological factors affecting recent trends in youth suicide. However, the domain of discourse in the study of suicidal behaviour is multidisciplinary which requires integration of data from psychiatry, psychology, biology and sociology in order to advance our understanding of the multifaceted problem and to evolve practical and effective strategies for suicide prevention.

In 1988, nine thousand years of life were lost through teenage suicides alone which cost the Australian economy millions of dollars a year. It is not beyond our collective abilities and capabilities to institute a suicide prevention program which can reduce this significant loss of unlived lives of young Australians by at least 20 per cent. To do so we need to recognise the magnitude of the problem and willingness to invest resources to develop suicide prevention programs and train people who can implement them. We need to integrate suicide prevention activities better into our existing programs which focus on a whole range of self-destructive or problem behaviours among our youth such as drug abuse, interpersonal violence, school drop-out, runaway and homeless youth. We need to inform and educate the public, the media, the entertainment industry and health services about our current knowledge in diagnosis, treatment and prevention of suicide among youth. Public education should not focus only on youth suicide but should also address the issue of removing the stigma associated with alcohol, drug abuse and mental health treatment in order to enable young persons facing these problems to seek treatment freely.

Parents, teachers, youth counsellors, juvenile and criminal justice personnel and clergy need to be educated how to identify suicidal tendencies among the youth in their care. Hospital emergency room personnel should be trained in suicide risk assessment as some accident injuries and also some drug abuse episodes may in fact represent suicide attempts. The suicide prevention program must be family, community and school based. Besides the public agencies, involvement of business and industry in the prevention program is crucial in providing and encouraging youth employment and counselling programs for the employees who may be at increased risk for suicide. Solutions to the youth suicide problem will require a variety of factors at all levels of society from Commonwealth, state and local government, to religious, business, educational, health care providers, community and family involvement.<sup>3</sup>

Studies of suicides among adolescents show that over 80 per cent of the suicide victims had talked about their suicidal state of mind with others within a week of their death. These communications are often made to close friends or family members (Brent et al. 1988). Suicidal acts have enormously different outcomes for various age groups. Among young persons between 15 to 24 years of age, only one in forty suicide attempts actually result in death. An estimated 15 to 27 per cent of attempters will probably never repeat their attempt, and this percentage is still higher among those who make suicide threats or communications. This means broadly based suicide prevention programs can be very effective in reducing loss of life through suicide. Just as elderly suicides are preoccupied with conflicts centring around the end of their lives, the young suicides seem determined not to allow their lives to begin. The community has a responsibility to create conditions which will allow at least some of our suicidal youth to begin their lives and to believe that their unlived lives are worth living.

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# **YOUTH SUICIDE IN NEW SOUTH WALES: URBAN-RURAL TRENDS 1964-88<sup>1</sup>**

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THE RISE NOTED IN AUSTRALIAN YOUTH SUICIDE OVER THE PAST TWENTY-FIVE years is part of a wider trend in numerous other Western countries (Kosky 1987). This paper reports an analysis of the official suicide statistics for young people aged 10 to 19 in New South Wales. It particularly considers firearm suicides and urban-rural trends.

Firearm suicide has received increasing attention in literature from the United States. Boyd and Moscicki (1986) noted that the firearm suicide rate for persons aged 10 to 24 years in the United States has increased from 2.3 to 5.5 per 100,000 in the years 1933 to 1982, whereas the increase in the non-firearm suicide rate for the same group over the same period was only from 2.5 to 3.3. The most dramatic rise in the firearm suicide rate has occurred since 1970, especially among males aged 15 to 24. Within this group, the rate of rise for suicides for 15 to 19-year-olds in this period was almost double that for persons aged 20 to 24 years (Schowalter 1990; Saltzman et al. 1988). In conjunction with this, Boyd and Moscicki (1986) note that in the 1960s and 1970s, there was a substantial increase in the number of civilian firearms in the United States. Firearms have therefore emerged in that country not just as a civil rights but also as a major public health issue.

Systematic published reports on urban-rural trends are rare. Thompson (1987) has noted, in a study of childhood and adolescent suicide in Manitoba, Canada, that native Indian males and rural Caucasian males suicided significantly more frequently and at younger ages than their urban counterparts. Ross and Davis (1986) have noted an exceedingly high rate of suicide and attempted suicide in a northern Canadian native community. An National Institute of Mental Health (NIMH) study of adolescents in rural Minnesota found that in one month, 30 out of every 1,000 had attempted suicide, compared with the national average of 2 per 1,000 (Rosenberg 1986, quoted in Forrest 1988).

## **Methodology**

Suicide figures for males and females aged 10 to 14 and 15 to 19 were obtained from the NSW Bureau of Statistics for the years 1964 to 1988. Methods of suicide were coded according to the International Classification of Diseases. Information was obtained about the subject's local residential area, and subjects were classified according to whether they usually lived in the Sydney statistical division (SD), the Wollongong or Newcastle statistical subdivisions (SSD), the rural balance of NSW (divided into rural cities, municipalities, and shires) and out of state. Five five-year periods have been used in many of the figures shown. This was particularly convenient since census years fell in the middle of these five-year periods, thus enabling suicide rates to be calculated using the population figures obtained in the census years.

Tables 1 to 4 give the definitions used in this analysis of official suicide statistics in New South Wales.

*Table 1*

**Sydney SD = Sydney Statistical Division**

Inner Sydney  
Eastern Suburbs  
St George-Sutherland  
Canterbury-Bankstown  
Fairfield-Liverpool  
Outer South Western Sydney  
Inner Western Sydney  
Central Western Sydney  
Outer Western Sydney  
Blacktown-Baulkham Hills  
Lower Northern Sydney  
Hornsby-Ku-Ring-Gai  
Manly-Warringah  
Gosford-Wyong

*Table 2*

**Newcastle SSD = Newcastle Statistical Subdivision**

It is part of Hunter SD (Statistical Division).  
It and includes:

Cessnock (C)  
Lake Macquarie (C)  
Maitland (C)  
Newcastle (C) Inner  
Newcastle (C)  
Remainder  
Port Stephens (S)

It excludes Hunter SD balance, which is  
defined as rural:

Dungog (S)  
Gloucester (S)  
Great Lakes (S)  
Merriwa (S)  
Murrurundi (S)  
Muswellbrook (S)  
Scone (S)  
Singleton (S)

**Wollongong SSD = Wollongong Statistical Subdivision**

Part of Illawarra SD (Statistical Division). It  
includes:

Kiama (M)  
Shellharbour (M)  
Wollongong (C)

It excludes Illawarra SD balance which is  
defined as rural:

Shoalhaven (C)  
Wingecarribee (S)

*Table 3*

**Rural NSW = NSW Minus Sydney SD, Newcastle SSD, Wollongong SSD**

**Rural Cities**

Shoalhaven  
Lismore  
Coffs Harbour  
Grafton  
Greater Taree  
Tamworth  
Armidale  
Dubbo  
Bathurst  
Orange  
Greater Lithgow  
Queanbeyan  
Goulburn  
Wagga Wagga  
Griffith  
Albury  
Broken Hill

(1986 youth population = 94,060)

**Rural Municipalities**

Casino  
Glen Innes  
Deniliquin  
Hastings

(1986 youth population = 10,230)

**Rural Shires**

Hunter SD balance (SSD)  
Illawarra SD balance (SSD)  
Richmond-Tweed (SD)  
Mid-North Coast (SD)  
Northern (SD)  
North Western (SD)  
Central West (SD)  
South-Eastern (SD)  
Murrumbidgee (SD)  
Murray (SD)  
Far West (SD)

Total of 111 shires  
(1986 youth population = 130,574)

*Table 4*

**Definition used for City/Municipality/Shire**

**City:**

25,000 Pop. or greater  
independent  
not suburb of any other municipality

OR 150000 Pop.  
distinct character or entity as a centre of  
population

(Local Government Act Part 2 Section 1003)

**Municipality:**

'administrative unit under the act'

(Section 1038)

**Shire:**

Extraneous to the major cities  
towns and villages encompassing rural tracts  
of land

(Section 1046)

**Results**

It is clear that suicides for youth have increased in NSW since 1964, both in absolute numbers and per 100,000. The overall rise in youth suicide has been from 2.8 per 100,000 in the 1966 quintade to 4.3 per 100,000 in the 1986 quintade, that is an increase of 1.5 deaths per 100,000 (see Figure 1). However, as we will see, this relatively small increase in overall suicide rate conceals vastly greater increases in certain subgroups of the NSW youth population.

There was only one recorded Aboriginal suicide in this group since 1981, when recording began. Aboriginal deaths are thought to be generally underestimated in NSW, there being a discrepancy between Bureau of Statistics and Health Department figures (Coleman, personal communication). Thus suicides are also probably underestimated.

*Suicides by age in years and sex*

Older youth are more likely to suicide. Considerable increases are seen in males from age 15, with the largest single increase being in the 17th year. In females, the rate increases less sharply, and plateaus in the 16th and 18th years (see Figure 2).

Figure 1

**Rate of Youth (10-19 Years) Suicide per 100,000  
1964-88**

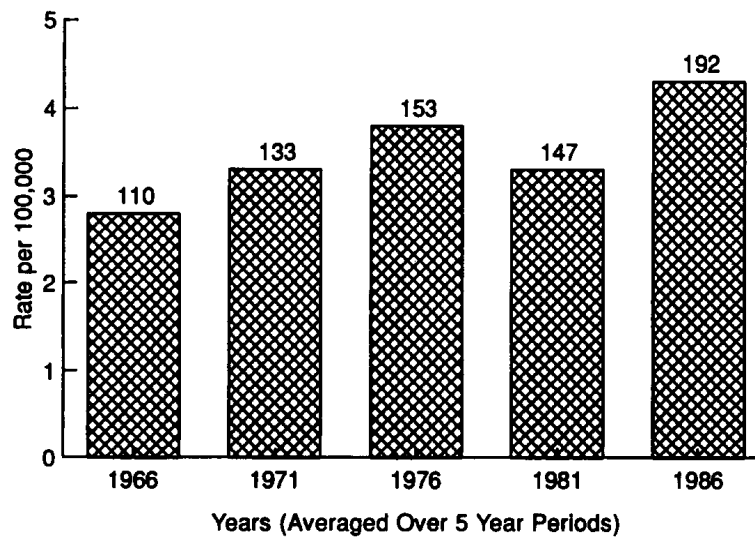
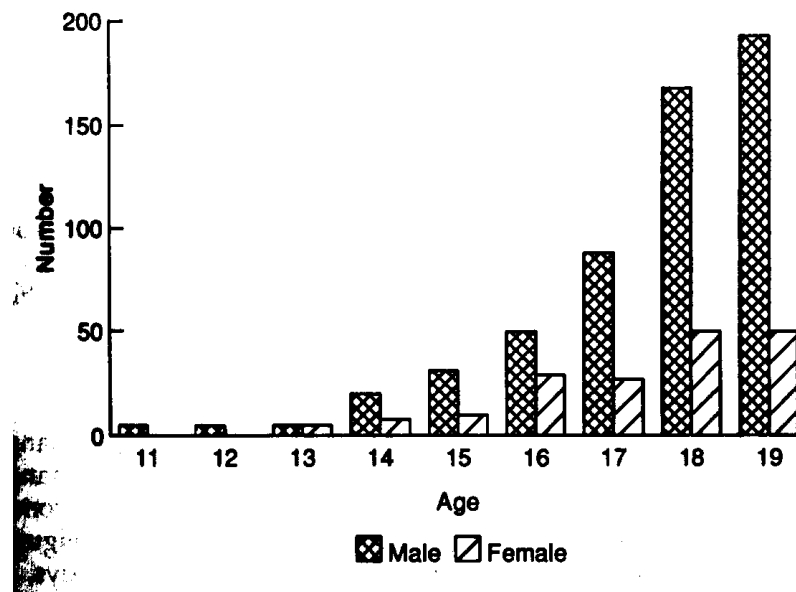


Figure 2

**Age of Male and Female Suicides  
NSW, 1964-88**

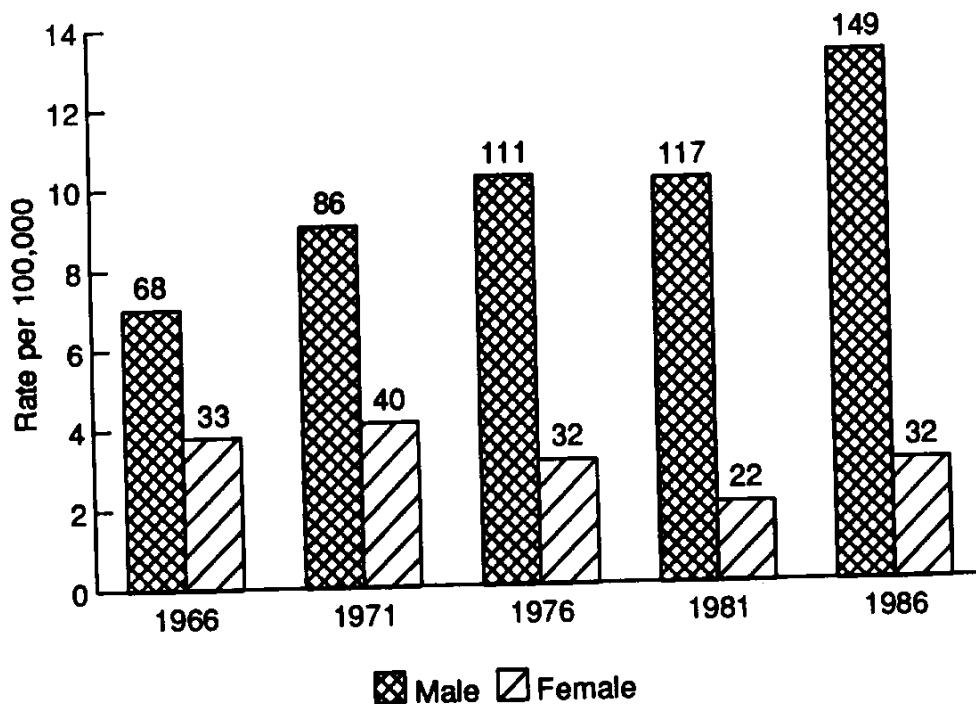


*Suicides for age groups, sex, and quintades*

The major contribution to the overall increase in youth suicide is a substantial increase in 15-19 year boys, among whom the rate per 100,000 has increased during every quintade since 1964. It has gone up from 7.0 per 100,000 in 1964-68, to 13.2 per 100,000 in 1984-88 (see Figure 3). The average annual rate for 15 to 19-year-old girls has not increased over the last 25 years (see Figure 3).

*Figure 3*

**Suicide Rate Males and Females (15-19 Years) per 100,000  
NSW, 1964-88**



The 10 to 14 year group constitutes only 6.1 per cent (45) of the total suicides (735) for the 25 years. The number of female suicides in this group is very small (11), and rates are not increasing. It is possible that boys of 10 to 14 years are increasing in the frequency of suicide, but only slightly (see Figure 4).

*Methods of suicide for sex and age*

The major method of suicide has been firearms, followed by poison, hanging, and industrial gas (see Figure 5). Boys use firearms, followed by hanging, poisoning, and industrial gas, while poisoning is easily the most common cause of suicide in girls, followed by firearms and hanging (see Figure 6). Poisoning is the only method in which girls' rates of suicide exceed boys.

Figure 4

**Suicide Rate Males and Females (10-14 Years) per 100,000  
NSW, 1964-88**

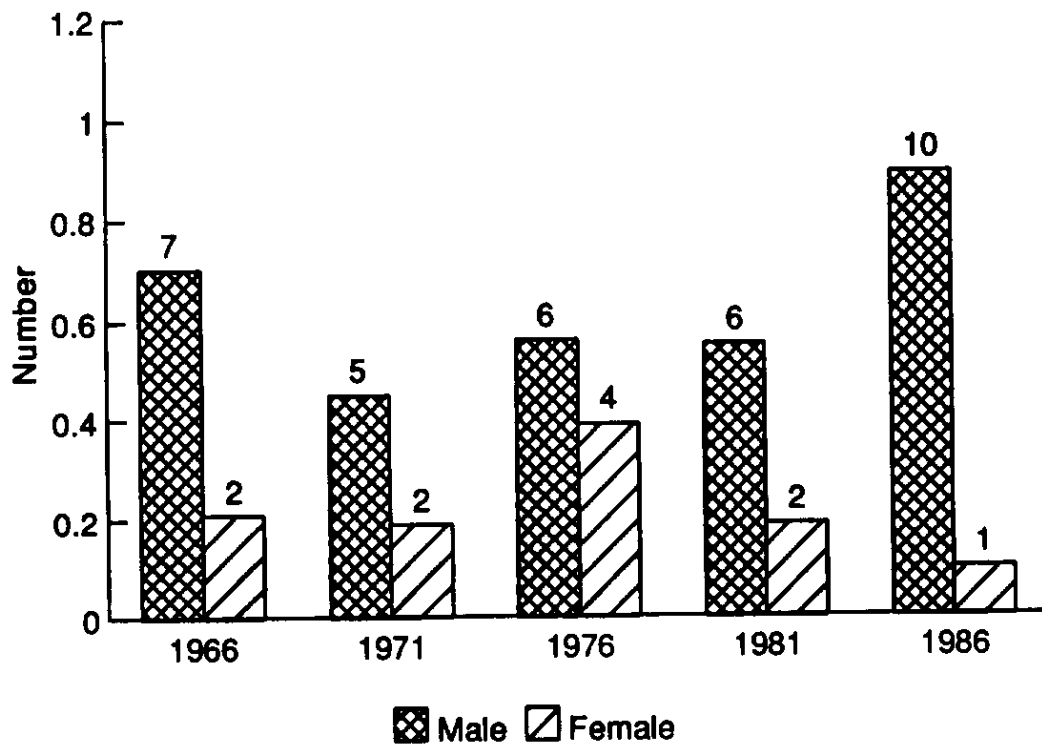


Figure 5

**Mode of Youth Suicide (10-19 Years)  
NSW, 1964-88**

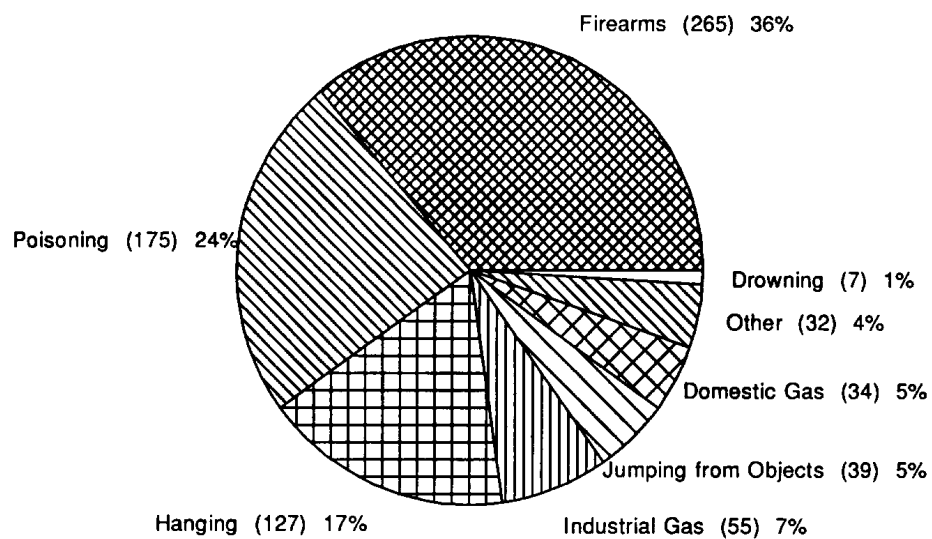
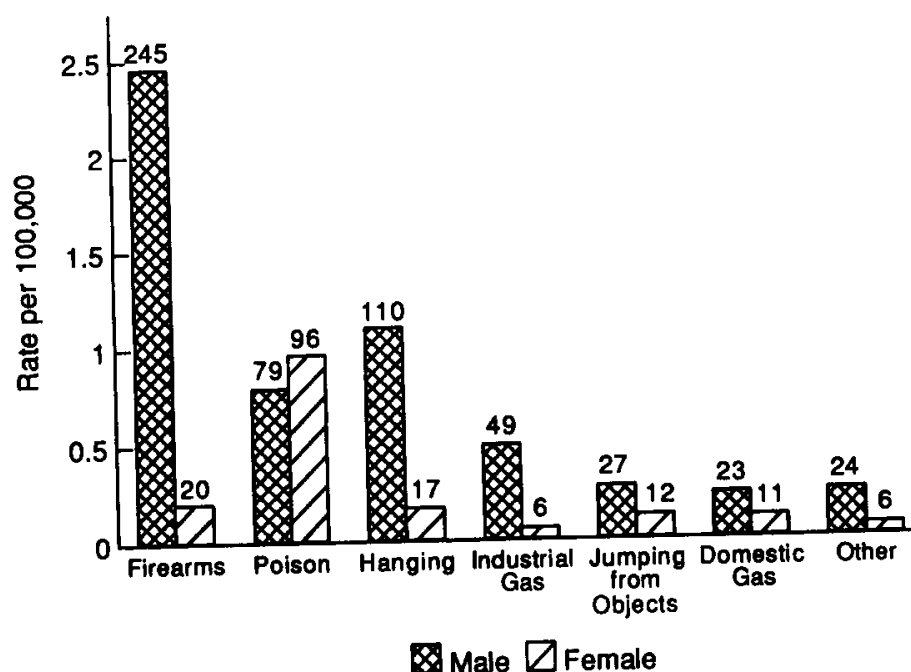


Figure 6

**Mode of Death by Sex per 100,000  
1964-88**



The major consistent change has been in 15 to 19-year-old boys' firearm suicide rates, which have risen from 3.4 to 5.6 per 100,000 (*see* Figure 7). There has also been a substantial consistent increase in boys' hanging suicides since 1976 (*see* Figure 8). Poisoning deaths in females have decreased substantially over the twenty-five year period (*see* Figure 9, Table 5).

#### *Urban-rural trends*

Overall, while most of the suicides (61.5 per cent) lived in the Sydney SD, 6.2 per cent lived in Newcastle and Wollongong, 28.6 per cent lived in rural areas, and 3.7 per cent lived out of state.

Over the twenty-five years in Sydney SD, there has been only a slight increase in the youth suicide rate, from 3.4 in 1966 to 3.8 in 1986. The numbers in the provincial cities of Newcastle and Wollongong are small, and their combined rates have stayed fairly stable overall. The youth suicide rates in rural NSW have increased consistently over the twenty-five years, from 1.6 in 1966 to 6.1 in 1986 (*see* Table 6).

Figure 7

**Firearm Suicides: Males and Females (15-19 Years) per 100,000  
NSW, 1964-88**

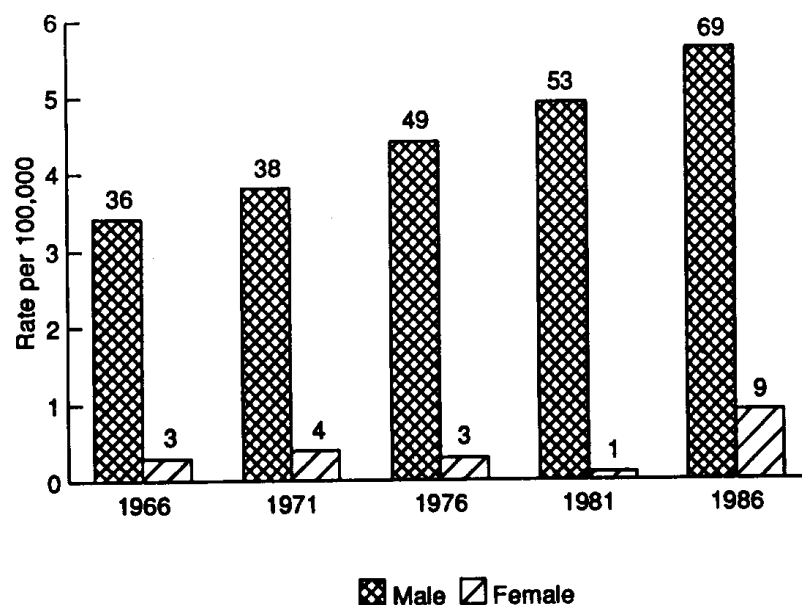


Figure 8

**Hanging Suicides: Male and Females (15-19 Years) per 100,000  
NSW, 1964-88**

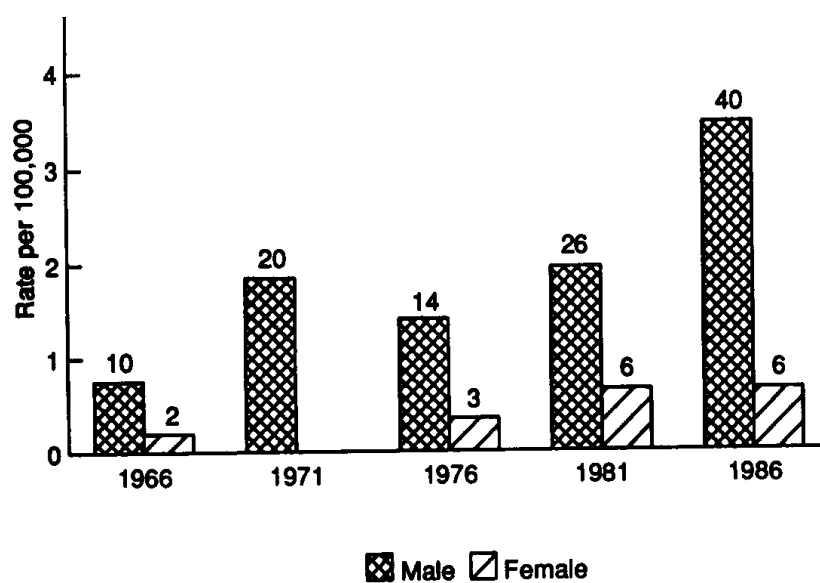


Figure 9

**Poisoning Suicides: Male and Female (15-19 Years) per 100,000  
NSW, 1964-88**

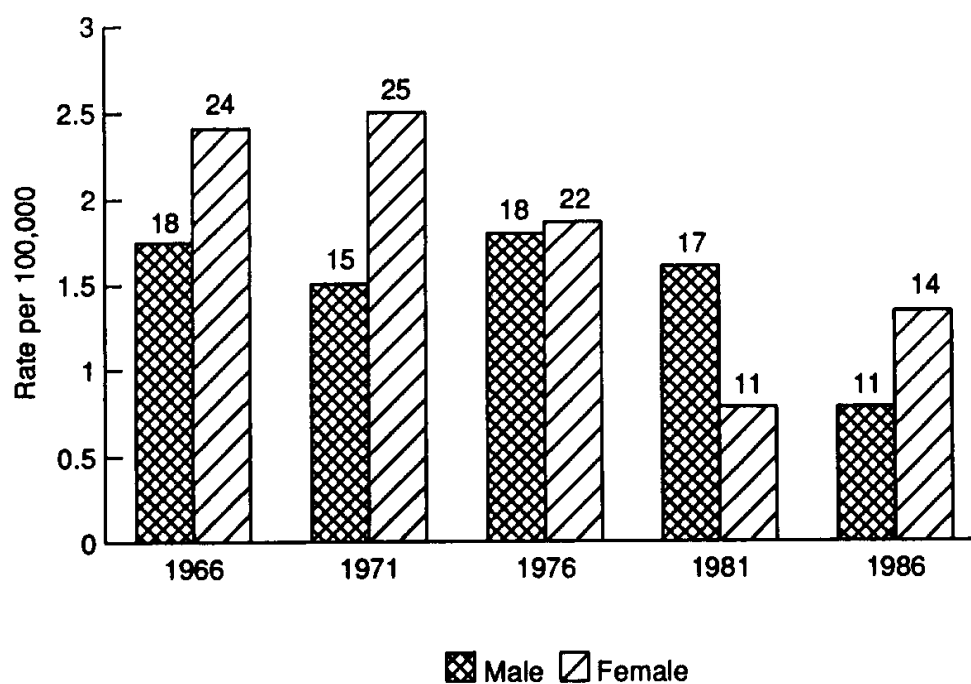


Table 5

**Poisoning Suicides for Males and Females (10-19 Years) in NSW, 1964-88**

| Years     | Number of Poisonings | Rate per 100,000 |
|-----------|----------------------|------------------|
| 1964-1968 | 42                   | 1.84             |
| 1969-1973 | 40                   | 1.62             |
| 1974-1978 | 40                   | 1.58             |
| 1979-1983 | 28                   | 1.05             |
| 1984-1988 | 25                   | 0.92             |

Table 6

**Total Suicides for Youth (10-19 Years) in NSW  
by Place of Residence, 1964-88**

| Years     | No. | Sydney       | No. | Rural        |
|-----------|-----|--------------|-----|--------------|
|           |     | Rate/100,000 |     | Rate/100,000 |
| 1964-1968 | 78  | 3.4          | 17  | 1.6          |
| 1969-1973 | 87  | 3.5          | 35  | 3.2          |
| 1974-1978 | 99  | 3.9          | 42  | 3.7          |
| 1979-1983 | 84  | 3.2          | 44  | 3.7          |
| 1984-1988 | 104 | 3.8          | 72  | 6.1          |

*Urban-rural sex differences*

Rural municipalities are few in number, and contribute few suicides. For purposes of this analysis, rural municipalities have been combined with rural shires.

The youth (10 to 19 years) population in rural cities has increased from 65,340 in 1966 to 94,060 in 1986, while rural shires/municipalities have slightly decreased from 142,371 to 140,804.

Of the rural suicides 35.9 per cent have occurred over the last five years (that is 20 per cent of the time), and this is largely a phenomenon of the older group (15 to 19-year-olds).

The rates per 100,000 for 15 to 19-year-old males in rural cities have more than doubled, from 5.1 in 1966 to 12.5 in 1986, whereas in rural shires/municipalities they have increased sixfold, from 3.5 in 1966 to 21.6 in 1986 (*see* Figure 10). The 15 to 19-year-old female rate in rural cities has fluctuated, whereas there is some suggestion that the female rate is climbing in the rural shires/municipalities (1.5 in 1964-68 to 4.9 in 1984-88), though the numbers are small (*see* Figure 11).

*Urban-rural differences in method*

Firearm youth suicides in rural areas have been steadily increasing for 15 to 19-year-old youth over the 25 years, while firearm youth suicides in the Sydney SD have remained fairly stable (*see* Figure 12). Moreover, the increase in rural firearm youth suicide rates is a male phenomenon, with female numbers (13) being too small to draw conclusions.

Firearm suicide rates in 15 to 19-year-old rural city males have increased from 3.8 (1964-68) to 6.6 (1984-88), whereas in the rural shires, the rates have gone up almost sevenfold from 2.3 to 15.2 per 100,000. Of rural shires, 75 per cent of 15 to 19-year-old male suicides have died in this way. Hangings have also increased over the 25 years both in rural cities and rural shires, though total numbers are too small to draw conclusions (total of 17 deaths).

Figure 10

**Suicide of Males and Females (15-19 Years)  
by Area of Residence per 100,000, 1964-88**

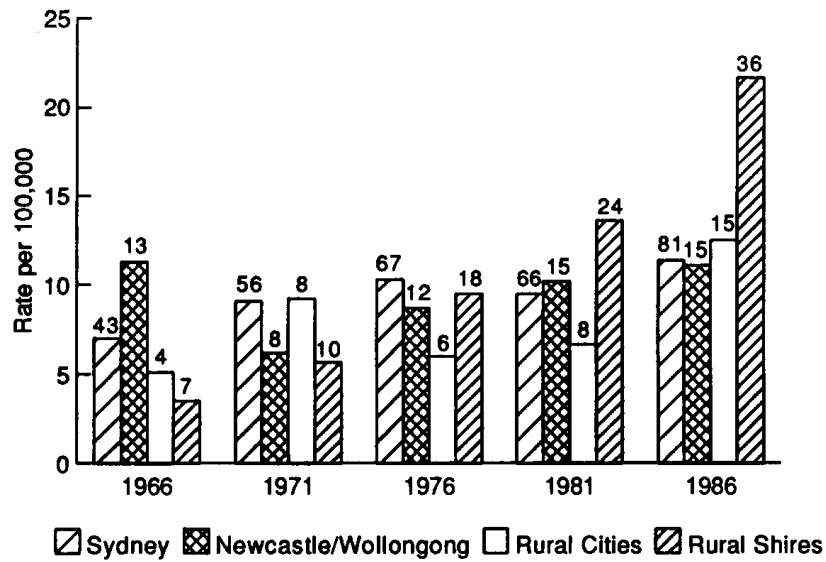


Figure 11

**Suicides of Females (15-19 Years) by Area of Residence  
per 100,000 for 1964-88**

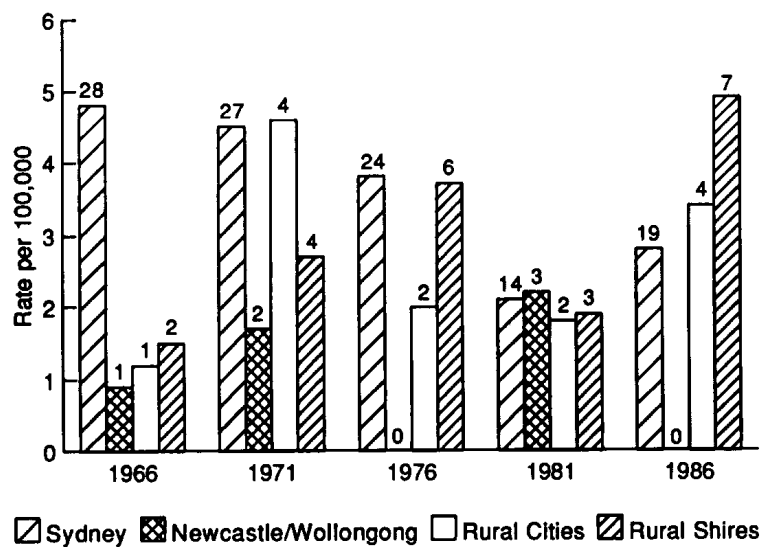
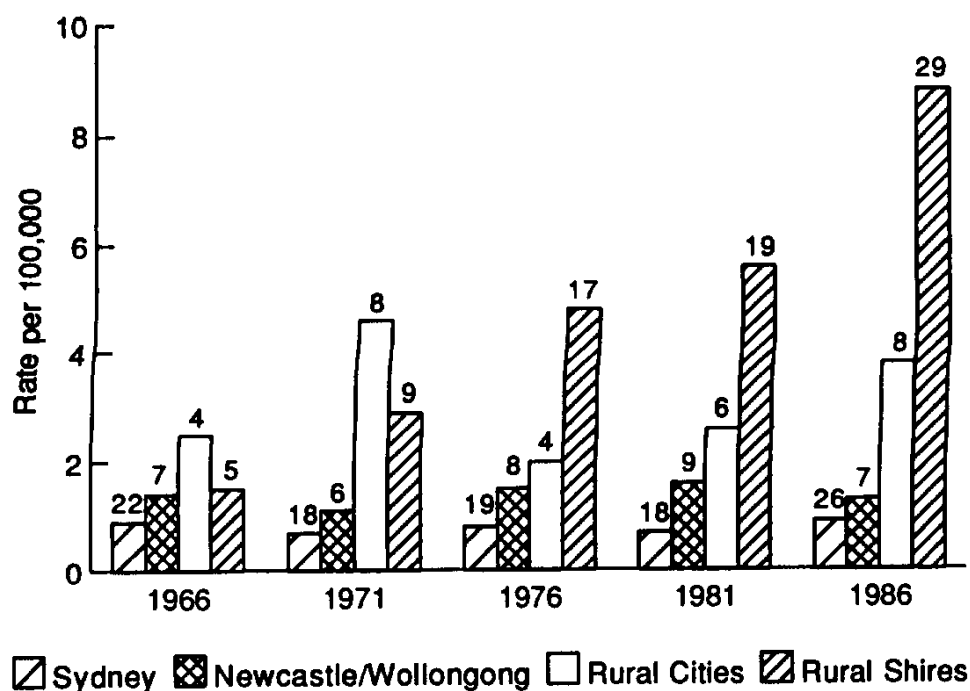


Figure 12

**Firearm Suicides (15-19 Years) by Area of Residence  
NSW, 1964-88**



## Discussion

It is clear that there has been a major increase in the rate of rural suicides in 15 to 19-year-old boys over the last quarter century, especially using firearms. The problem is predominantly found in rural shires and municipalities, and to a lesser extent in rural cities. We believe that a shift of this magnitude using such unambiguous methods as firearms and hanging, cannot be simply discounted as artefactual due to a shift in coroners' verdicts from 'undetermined' to 'suicide' in recent years (Kosky 1987), though this could be considered as a minor contributory factor.

There are a number of possible reasons for this being a peculiarly rural phenomenon, and particularly acute in what is known colloquially as 'the bush', that is the shires and municipalities. The first is that the Australian rural sector has suffered a major downturn economically over the last twenty-five years, with restriction of overseas markets, consolidation of properties and the collapse of small business. This is correspondingly reflected in unemployment and lower incomes, and poverty, malnutrition and substandard housing that afflicts many rural communities (Forrest 1988).

The second is that 'the bush' suffers 'the tyranny of distance' (Blainey 1983) and a corresponding lack of services and resources, including mental health resources.

A third more speculative but equally important reason is related to the changing perception of 'the bush' by those in rural and urban communities. 'The bush' is historically powerfully tied to Australian identity. It is often idealised as a setting where rustic folk work hard and maintain mental and physical health through self-sufficiency—an ethos which has spawned wilderness camps to rehabilitate drug addicts. As Australia has moved away from dependence on primary industry, the bush has assumed a less conspicuous role in shaping the national image. There has been a breakdown of close-knit rural communities and challenges to conservative value systems that have previously enabled endurance in the face of natural disasters and hardships.

The issue of values and beliefs in rural communities is likely to be important for several reasons. Firstly, it seems probable that there is a stark disparity in rural areas between traditional views about sex roles and male self-reliance (which perhaps is most enduring in these areas) and the reality of diminishing opportunities and rewards (for example high youth unemployment, people being forced off the land).

Secondly, it is also probable that the ideal of self-reliance and an individual moral attitude to human endeavour ('you're what you make of yourself') makes it easier for mental illness to be seen as a moral failing, and for wider structural and social problems to be seen as unimportant. In smaller communities, distress may be more conspicuous, and confidentiality more of a problem. These factors may make it more difficult for young men to seek help. There is a crucial relevance to suicide prevention programs at this point, which will be discussed below.

Thirdly, there may be more pressure for adolescents to leave home at an earlier age in 'the bush' than in an urban setting for economic reasons. This may also be a more critical event for a young person bound to a close-knit family/community of origin which is also depleted or in crisis, and which cannot act as a strong emotional 'launching pad'.

The reason for the increasing rate of firearm deaths relates to the availability of guns, especially in rural areas, where gun ownership is around three times higher than in urban areas (Marsden 1988). There is a strong link between firearm availability and firearm suicides, assaults and crime in urban and rural Australia, as there also is overseas (Wilson 1983, Marsden 1988). The case for gun control has been established beyond reasonable doubt on other data (Wilson 1983, Harding 1983). There is no uniformity in firearm licensing, prohibition and registration laws between the states, and a stockpile of unregistered weapons exists in NSW (Firearms Licensing Branch, NSW Police, personal communication). The national firearms inventory is rising at a rate that exceeds population growth (Walpole 1988; Anderson 1985), and is now high by international standards (Marsden 1988). It is a major factor working against effective gun control. We believe that our study lends further convincing data to support this conclusion.

There is also some suggestion that rates of alcohol abuse are higher in rural areas (Forrest 1988), in which case the likelihood of firearm death in the vulnerable may be compounded. Brent et al. (1987) in their study of deaths of 10 to 19-year-olds in Allegheny County, Pennsylvania, showed that firearms and alcohol are risk factors for suicide. Suicide victims who used firearms were about five times more likely to have been drinking than those who used other means. Moreover, they noted that the proportion of suicide victims that had detectable blood alcohol levels rose from 12.9 per cent in 1968-72 to 46.0 per cent in 1978-83. Hoberman and Garfinkel (1988) also reported that 28 per cent of 229 suicides had definitely, and 17 per cent probably, consumed alcohol unrelated to the cause of death within 12 hours of death. Alcohol may have a catalytic role in suicidal behaviour, especially with firearms. The Centers for Disease Control Surveillance Summaries have noted that prevention should include a decrease in alcohol use by, and firearms availability to teenagers (Saltzman et al. 1988).

We do not have reliable information about changing rates of alcohol abuse in rural settings, and lacking coronial information, cannot comment on the frequency of alcohol abuse in the subject's history or in association with the fatal shooting. These are vital issues for further study.

The question of whether these suicided rural adolescents are suffering major depressions is moot. It is the authors' opinion that the magnitude of the recent change is unlikely to be accounted for by a rise in the rate of the endogenous (biological) form of major depression, though it is likely that major depressions of other origins would contribute to the outcome in many of these adolescents. Many of the subjects could be expected to have depressive features in association with other diagnoses, for example, conduct problems (Shaffer et al. 1989) and a family history of chronic discord, mental illness and suicidal behaviour. However, we surmise that increasing rates of alcohol abuse, and increasing availability of a very lethal method (firearms) are making the most significant differences to the rates.

We do not have information at this stage about the social class of the suicided young people or their parents. Those owning guns are more likely to be younger men working in primary industry or blue-collar jobs (Marsden 1988). One might expect from what has been said that those who kill themselves may be part of transgenerational cycles of social disadvantage that they cannot see themselves as escaping. We have noted a drift to the rural city from 'the bush'; it is uncertain whether the least or most suicidal are moving.

A final crucial observation is the gap between suicide prevention programs and those they target. Rural shires and their young people are under-resourced in relation to all health—including mental health—needs, and suicide prevention programs may potentially fall into the trap of forgetting those who are least visible. Moreover, not only do they not have advocates but there is some suggestion from the preceding comments that they might reject such advocacy. It is possible that they would see such programs, as they would see help-seeking in general, as an alternative for the weak, and avoid or dismiss them.

## Conclusion

The most significant implications of these findings are the urgent need to assess, advocate, and plan for the mental health needs of rural adolescents, and to design and implement suicide prevention programs in 'the bush'. In view of the comments in this paper, the designers will have to anticipate and clarify potential stumbling blocks with their target audiences. The other urgent need is to take the need for gun control into the public arena again.

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# **TRENDS IN YOUTH SUICIDE IN TASMANIA: A COMPARISON BETWEEN YOUTH AND OTHER SUICIDE**

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IT HAS NOT YET BEEN DETERMINED THAT YOUNG COMPLETED SUICIDES represent a distinct entity, separable from other age groups. Nor has it been determined that the younger age group represents a homogeneous group (Maris 1985; Neiger & Hopkins 1985). However, comparisons between young suicide and older suicide groups show both distinct similarities and distinct differences.

An increasing risk of suicide is associated with increasing age (MacIntosh 1985), with the highest rates found among those aged 65 and over. Within the adolescent group, there is a steady increase in suicide rate from approximately 15 years of age. The risk of suicidal behaviour is significantly reduced below this age (Neiger et al. 1988). The seriousness of suicide among the older groups is largely ignored because of an increasing focus on the young. Adolescent suicide remains the age group with the lowest suicide rate (Osgood 1982). A survey of community attitudes showed that all age groups ascribed a higher risk to older people (Domino, Moore, Westlake & Gibson 1982).

Marked increases in male youth suicide rates have been reported along with a slight decline in female youth suicide rates (Moens, Haenen & Van de Voorde 1988). Completed suicide is traditionally associated with a higher incidence among males (McClure 1984; Dyck, Newman & Thompson 1988; Burvill 1980; Dorsch & Roder 1983; Paerregaard 1980; Frederick 1978). While surveys have found that adolescent males do predominate

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\* Presented by Commissioner Bill Horman, Tasmania Police, Hobart.

(Neiger et al. 1988; Joffe, Offord & Boyle 1988; Kotila & Lonnqvist 1989), other epidemiological studies have found significantly more females complete suicide in the adolescent group (Maris 1985).

The self-destructive behaviour of both the younger and older age groups may reflect suicidal careers that represent a progressive failure of attempts at adaptive behaviour. Despite this, it has been reported that the younger age groups are significantly more likely to have made multiple attempts prior to completing the act (Maris 1985).

The frequency of use of a particular method of suicide is related to the availability of that method. A significant decrease in the number of deaths from domestic gas poisoning occurred in England and Wales following the detoxification of domestic gas in 1963 (McClure 1984). The use of drugs is now the most common method in these countries. Although the patterns of suicide in England and Australia are very similar, one distinguishing factor is the large number of suicides by use of firearms in Australia (Snowdon 1979). The use of firearms is also disproportionately high in the United States (Frederick 1978). In contrast, death by firearms is exceedingly rare in Singapore where very strict gun control laws are in force (Kau & Tsoi 1985). A study in the United States comparing the severity of gun control measures in different states showed that the overall suicide rate is lower in those states with the most severely restrictive gun laws (Lester & Murrell 1982; Lester 1988).

It has been hypothesised that the higher suicide rate among the older age groups reflects the use of more lethal methods (MacIntosh 1985). However, while both the young and the older age groups use firearms as a means of suicide (Maris 1985), youth suicide is most associated with their use (Moens et al. 1988; Brent et al. 1988). A significant risk factor for young completed suicide has been reported to be the availability of firearms in the home (Brent et al. 1988).

There is no real difference in the likelihood in terms of suicide notes between the young and older groups. The age of the writer is not associated with either the length of the note or the number of notes left (Lester & Reeve 1982). While the desire to die is not communicated differently in the suicide notes of the two groups, the younger group communicate more inwardly directed aggression (Lester & Hummel 1980), are less concerned with feelings than actions and are more explicit about the forthcoming suicidal action (Lester et al. 1982).

Both young and older suicides are likely to be described as 'social misfits' and both groups are more likely to have experienced negative social interactions and social losses (Maris 1985). Dependent on the population studied, social isolation has been found to be significantly related to youth suicide (Moens et al. 1988) and older suicide (MacIntosh 1985).

An examination of interpersonal conflict and loss as a precipitating factor in completed suicide indicates that multiple personal loss, bereavement and serious family argument are significant risk factors in completed suicide in the older age group (Osgood 1987). However, an investigation of a youth suicide sample showed that 70 per cent had experienced interpersonal conflict immediately prior to death (Brent et al. 1988).

Family dysfunction appears to have a greater influence on the young (Joffe et al. 1988). Youth suicide has been associated with multiple problems in the family of origin (Maris 1985) and family relationships are characterised by a lack of support and instability (Neiger et al. 1988).

Older suicide has been associated with the occurrence of adverse life events. Recent widowhood and a major life move are significant predictors of suicidal behaviour (MacIntosh 1985; Osgood 1982). The status changes that occur during older age are also associated with the suicide act, for example, retirement, loss of job, lessening of independence and loss of income (MacIntosh 1985; Osgood 1982). However, both

groups have been found to be exposed to repeated stress and long standing problems prior to death and both groups have been found to perceive death as an escape from intolerable situations (Maris 1985). Adverse life events as precipitants of suicide in the young significantly more often reflect disciplinary crises or the anticipation of such (Diekstra 1985). While both groups are affected, it is possible that the young are more deeply affected by social stresses such as unemployment, marital breakdown and family disintegration. A survey of community attitudes revealed that a social stress is a more acceptable reason for suicidal behaviour for the younger group (Diekstra 1985).

Unemployment has been linked to increasing adolescent suicide in the United States (Seiden & Freitas 1980) and with young adult suicide in Australia (Meares, Kraihuhin & Benfield 1983). Younger suicides are less likely to have ever worked and have fewer financial resources (Maris 1985).

Physical illness as a reason for suicide is not significantly related to youth suicide. Older suicides are reported to have been in poorer physical condition and to have had poorer recuperative power (MacIntosh 1985; Osgood 1982).

In contrast, psychiatric illness has been associated with both young and older completed suicide (Joffe et al. 1988; Maris 1985) with depression being the most common diagnosis (Maris 1985; Brent, et al. 1988; Osgood 1982; Neiger et al. 1988). The depression in the young may differ from depression in the older group in terms of somatic symptoms with the younger group reporting very few (Osgood 1982). In addition, a diagnosis of depression in the young suicide group is more commonly associated with comorbidity of substance abuse (Brent et al. 1988). While one study reported that 72 per cent of the sample aged between 19 and 29 were known to psychiatric caregivers (Runeson 1989), a lack of previous mental health treatment has also been reported (Brent et al. 1988).

Young suicides are reported to have displayed a high level of risk taking and impulsivity prior to death. Their self-destructive behaviour is more likely to be based on anger and hostility. Linked to both these factors is the greater use of alcohol and drugs prior to death reported in the adolescent samples examined (Maris 1985).

Adolescent suicides are significantly more likely to have modelled the suicidal behaviour (Maris 1985; Phillips 1974; Phillips 1982; Phillips & Carstensen 1986; Phillips & Paight 1987). Consistent with a mechanism of contagion is a recent increase in time space clustering of adolescent suicide. Although the underlying reason for the clustering cannot be determined from this type of analysis, contagion is assumed to be mediated by three pathways: direct contact with the suicide; hearing of the event without direct contact; and indirect transmission via the media (Gould, Wallenstein & Kleinman 1990).

Although research has been conducted in an attempt to identify the similarities and differences between young and older completed suicides, many of the factors found to be significantly related to these groups may reflect age differences alone. That is, these differences would be found when comparing non-clinical or community groups so may not be considered pathogenic.

## Method

The suicide data were obtained from the coroner's inquest files held at the Tasmanian Archives Office and the Tasmanian Government Law Department. All files between 1968 and 1987 with a coroner's decision of suicide or an open verdict were analysed. A decision was made to evaluate the cases with an open verdict and to include those cases as suicide that met the following criteria:

- (a) the method by which death was caused was typical of those used by suicides, for example self-poisoning and hanging;
- (b) an expression of suicidal intent was made either verbally or by note, in the weeks and day preceding the attempt;
- (c) a history of suicidal behaviour;
- (d) the presence of potential precipitating factors such as mental or physical illness or a stressful life event; and
- (e) evidence of psychological/emotional distress in the days and weeks leading up to death.

A case was judged as suicide if either of criteria (a) or (b), and one other criterion was present. This decision was made in an attempt to achieve a more realistic description of suicide in Tasmania as a coroner's decision may be influenced by factors such as the age of the deceased or the presence of family members at the inquest (Kosky 1982; Farmer 1988; Platt, Backett & Kreitman 1988). Underreporting of suicide has been found to diminish with increasing age and is less common in recent years. The underreporting has been found to be greater in young female suicides, although this has not substantially altered suicide rates and trends (Moens et al. 1988).

Two raters were involved in the collection of the data. A test of inter-rater reliability showed agreement of a case as suicide at 97 per cent.

Six categories of method of suicide were determined. They included use of firearms, hanging, drowning, drugs, gas, and other methods. The category of 'other methods' included, for example, death by precipitation, self-immolation, cutting and stabbing, electrocution, asphyxia or the use of poisonous substances other than drugs. None of these methods were used with sufficient frequency to allow a separate category.

## Results

### *Total sample*

During the twenty-year period, 1968 to 1987, 1051 individuals suicided in Tasmania. This resulted in a mean yearly suicide rate of 12.85 per 100,000 in the Tasmanian population.

When considering the total sample, analysis showed no significant change in total suicide rate over the twenty years of this study. As expected, significantly more males than females suicided in Tasmania, the mean suicide rate for males being 19.29 and for females 6.47.

The mean suicide rate for individuals aged between 10 and 19 years was significantly lower than statistically expected at 4.53. The highest suicide rate, at 22.66, was found among individuals aged 40 to 49 years. This was significantly higher than statistically expected.

The lowest mean suicide rate for both males and females occurred in the 10 to 19 year age group. There was a steady increase in mean female suicide rate with age, peaking at age 40 to 49 years, and decreasing thereafter. Male suicide rate showed a sharp increase between the age groups 10 to 19 years and 20 to 29 years and remained high thereafter.

### *Comparisons between youth and adult suicide*

Comparisons were made between those suicides aged 19 and less and those aged 55 and over. Seventy individuals aged between 12 and 19, and 299 aged between 55 and 92 suicided in Tasmania in the period under investigation.

Significantly more adolescent males than expected completed the suicidal act. Males constituted 86 per cent of the adolescent sample against 70 per cent of the older sample.

There was no significant difference between the two groups in terms of a previous suicide attempt. Twenty-five per cent of the adolescent sample and 17 per cent of the older sample had previously attempted suicide. The communication prior to death of the intention to suicide did not differ between the two groups: 57 per cent of the adolescent sample and 51 per cent of the older sample. There was also no difference in the proportions of the two groups leaving a suicide note.

The younger group was significantly less likely to have had a recent visit to a general practitioner, was less likely to have been under medical supervision, was less likely to be in poor health and was less likely to have been admitted to a general hospital in the twelve months prior to death.

The younger group was significantly less likely to have had a recent psychiatric consultation, was less likely to have been under psychiatric supervision, and were less likely to have been admitted to a psychiatric hospital.

An examination was made of the individual's state of mind and behaviour in the days leading up to death. The information was extracted from the reports given at the inquest hearings. The younger groups were significantly more likely to have been displaying normal behaviour in the days before death; were significantly more likely to be angry, hostile or violent; and were more likely to be behaving impulsively or recklessly. The younger group was significantly less likely to be sad, tearful or depressed and were less likely to be confused or absentminded. The two groups did not differ in terms of anxiousness or distress, withdrawn or quiet behaviour, erratic or bizarre behaviour, changeable moods, the appearance of being calm or resigned, and sudden or unusual cheerfulness. An examination of the blood alcohol levels determined at post mortem revealed that the younger group were significantly more likely to be intoxicated at the time of death.

Reports from significant others and the content of suicide notes were used as a source of information to determine possible reasons for suicide. The younger group was significantly more likely to have suicided because of interpersonal conflict or loss and an adverse life event or avoidance. The younger group was also significantly more likely to have modelled the behaviour, although direct contact with another individual who had suicided did not differ between the two groups. The younger group was less likely to have suicided because of psychiatric illness, physical illness or social isolation.

An investigation of the method of suicide used by the two groups revealed that the younger group was significantly more likely to have used a firearm. Although the majority of the older group also used a firearm, the proportion in this group was not as high as for the younger group: 56 per cent of the adolescent group and 33 per cent of the older group. Examination of the trends over the twenty-year period showed an increasing use of firearms and a decreasing use of drugs for both age groups.

### **Discussion**

An examination of the literature combined with the results of this study suggest that adolescent suicides are not an homogeneous group. However, this is true of any other age group. Although some factors are highly associated with suicidal behaviour, a typical suicidal profile does not exist.

This study emphasises the point that adolescents comprise the group least at risk of suicidal behaviour. The relative invulnerability of the young in relation to completed suicide has been infrequently addressed and cannot be readily explained. A range of factors which correlate with suicidal behaviour and on which adolescent and older suicides differ may hold significance for this finding.

As reported in the majority of studies, this investigation found males predominate in the adolescent group. The claim that both age groups have similar suicidal careers is supported by this study. No differences were found between the two groups in terms of previous attempts or communication of the intention to suicide which may be shaping the behaviour.

The use of firearms was overwhelmingly the most common method of suicide in this adolescent group. If the availability hypothesis of suicide is accepted, the presence of firearms in the home must be accepted as a high risk factor, in light of the adolescent's impulsive and reckless behaviour. The absence of gun control laws poses an unacceptable risk to the community in light of these findings. The results of this paper provide a further indication of the urgent need for review of the accessibility of firearms in the general population.

As both the young and older groups most commonly used firearms as a method of suicide, the difference in rates between the two groups cannot be accounted for by the older group using more lethal methods as has been suggested (MacIntosh 1985). Other factors must be considered.

Despite the well reported social isolation of both young and older suicides, this study found that social isolation as a reason for suicide was more likely in the older group. However, this may be presenting a biased picture as the information was largely taken from reports of significant others, most commonly parents. It is possible that young people are assumed by parents to have many friends. In addition, the older sample may be more willing to admit to social isolation than the younger sample.

The multiple personal losses and conflict reported to be common in the older group are outweighed in this sample by the proportion of the younger group that were considered to be influenced by this factor in their decision to suicide. This may be due to higher levels of family dysfunction and greater family instability for the younger group (Joffe et al. 1988; Maris 1985; Neiger et al. 1988).

Although it has been hypothesised that the older group experience more adverse life events, it has also been suggested that the younger group are more deeply affected. This is supported by the fact that adverse life events and avoidance were more likely to be the reason for suicide in the younger group. This deep influence may reflect a lack of coping strategies needed to face and solve these types of situations.

There was no evidence of a high incidence of psychiatric disorder in the younger sample. Although depression has been found to be the most common diagnosis, the younger group were significantly less depressed in the days leading up to death. Although it was stated that mental illness was related to youth suicide and 72 per cent of one sample had had psychiatric contact, this study coincides with the report of significantly less mental health treatment for the younger group (Brent et al. 1988).

This study again provides evidence that modelling is an important factor in suicide of the young. The media should be encouraged to balance the tragedy of youth suicide with its frequency. Adolescent suicide rates are the lowest of any age group and are, therefore, the group who are coping most successfully.

Despite the limitations, a profile of an adolescent suicide in Tasmania is a male who is physically well and who has never had contact with mental health services. In the days leading up to death he is angry or hostile although this appears to be his normal behaviour. He behaves impulsively and recklessly and is drunk at the time of death. He suicides because of interpersonal conflict, most commonly with family, and because he faces an

adverse situation such as a disciplinary crisis. Death is achieved with the use of a firearm, a readily available means of suicide.

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# THE PREDICTION OF SUICIDE

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SUICIDE IS A DRAMATIC EVENT AND IT HAS A PROFOUND EFFECT UPON THOSE who have known the person who has committed suicide. It seems to be such a pointless waste of life and often, in retrospect, we can see measures which may have influenced the deceased. Inevitably we feel guilty about not having done just that little bit extra in trying to avert the suicide.

In this paper attention will be drawn both to the extent of suicide and suicidal ideation. The two will be drawn together and reference will be made to two studies which have tried to produce some understanding in our prediction of suicide.

## **Suicide and Suicidal Ideation**

Each year in Australia more than two thousand people, the population of a small country town, commit suicide. A virtually incalculable number have suicidal ideation. Indeed, some would say that the existential contemplation of the meaning of life is in essence an acknowledgment of one's potential for suicide and almost invariably the clinician is met with the comment that it is normal to have suicidal thoughts.

There have been a number of studies which have examined the prevalence of suicidal ideation in different populations and the figures have varied from as little as 5 per cent suicidal ideation in a sample of the general population of two United States cities (Vandivort & Locke 1979), to as many as 50 per cent of subjects in a general psychology subject pool during examinations, also in the United States (Bonner & Rich 1987). With such a diversity of figures one could question their value. To place this in perspective there follows some data from the assessment of suicidal ideation in a young South Australian adult population.

In a sample of 1,014 young men and women, with a mean age of 19.6 years, we found that as many as 17.5 per cent of women and 20.2 per cent of men, or as few as 3 per cent of women and 3.3 per cent of men reported some degree of suicidal ideation in the few weeks prior to testing (Goldney et al. 1989).

These figures require some explanation. We assessed suicidal ideation on the basis of using the General Health Questionnaire, a commonly used instrument which delineates psychological disturbance. In this instrument there are four questions related to suicidal ideation. These are: 'have you felt that life is not worth living', 'have you found yourself wishing you were dead and away from it all', 'have you thought of the possibility that you

might do away with yourself; and 'have you found the idea of taking your own life kept coming into your mind'.

If we simply used a positive response to any of those questions as indicating suicidal ideation, we arrived at the higher figures of 17.5 per cent of women and 20.2 per cent of men having suicidal ideation. We had some doubts about the reliability of those figures and decided to use what we termed a 'suicidal ideation score', which we derived from the General Health Questionnaire responses. Thus we used a Likert scaling of response to each question, with a cut-off score to provide a middle of the road figure of 11.7 per cent for men and 9.7 per cent for women as having significant suicidal ideation.

Now one can argue about the validity of this, but it seems that the most important factor to emerge is that whether we take the figure as 3 per cent or 10 per cent or 20 per cent, it represents a large number of people. For example, if we use the 10 per cent figure and extrapolate from our 19-year-old sample to the 15 to 24-year-old section of the Australian population, of whom there were 2.74 million in 1988, then this would mean that 274,000 Australians aged 15 to 24 years had suicidal ideation in 1988.

Now what does this mean? Can we take such figures seriously? How does this figure of 274,000 relate to the actual number of subjects who commit suicide each year, which of the ages 15 to 24 in 1988 was 448. Using these figures, it would suggest that one in 612 persons aged 15 to 24 years with suicidal ideation in 1988 went on to commit suicide.

To make this question just a little more difficult, it is of interest that we followed up those earlier subjects four years later and no less than 40 per cent of those who expressed suicidal ideation in 1984 denied ever having had any suicidal ideation in their lives when asked specifically in 1988 (Goldney et al. 1991).

There is a need to apologise for presenting such numbers and raising doubts about their pertinence at the outset of this paper. However, it is absolutely crucial to appreciate that there are many subjects with suicidal ideation, albeit fleeting; there are many subjects who subsequently deny ever having had suicidal ideation upon follow-up; and it is only a very small proportion of the overall suicidal subjects who actually commit suicide. In saying that it is only a 'small proportion', no attempt is being made to minimise the importance of those individual persons who commit suicide. However, if one is attempting to provide any hard data on the prediction of such events, one must maintain objectivity and resort to statistical methods to confirm or refute our clinical impressions.

## **Clinical Predictors of Suicide**

There have been many clinical studies which have emphasised the importance of various factors in leading to suicide. These factors are traditionally considered to be the expression of suicidal ideation; the presence of psychiatric illness, particularly depression and schizophrenia; alcohol and other drug dependence; increasing age; chronic physical illness; social isolation; the availability of the means of self-destruction; and increasing publicity about suicide.

## **Statistical Prediction of Suicide**

Although there have been many clinical studies, there have been very few statistical studies to actually test the power of the clinical predictors. Reference is made to two such studies. The first is an American study and the second was performed in Adelaide.

In an American study of 4,800 veterans admitted to psychiatric facilities in Houston, Pokorny (1983) identified 67 subsequent suicides, giving a suicide rate of 279 per 100,000 per year. A number of items were found to be significantly associated with suicide, including

the diagnoses of depression or schizophrenia; a history of suicide attempts or having been placed on suicide precautions; overt evidence of depression on the basis of the clinical examination; the complaint of insomnia and the presence of guilt feelings. In addition, there were forty-five other items, although their predictive value was not great.

Using a statistical method of calculating the power of individual predictors, and then using the twenty best predictors, it was possible to identify 35 of the 67 subjects who had suicided. This yielded a sensitivity of 55 per cent and a specificity of 74 per cent, figures which superficially appear encouraging. However, such a prediction of suicide was only made at the expense of 1,206 false positive identifications and led Pokorny to conclude that 'we do not possess any item of information or any combination of items that permit us to identify to a useful degree the particular persons who will commit suicide'.

The limitations which Pokorny referred to are further illustrated in examining our recent Australian data (Goldney et al. 1985; Goldney & Spence 1987). We identified 46 patients who had suicided after having had contact with a psychiatric hospital in Adelaide and compared these subjects with 46 controls who were selected on the basis of them being the next presenting patient of the same age and sex at the hospital after the patient who suicided had initially been assessed. We found a number of items which distinguished those who suicided. These items were the presence of a schizophrenic or depressive illness; a history of previous admissions; being unemployed; being drug dependent; having previously attempted suicide; having an involuntary admission; having alcohol or drug dependence in a first degree relative and being treated with major tranquilliser drugs and the injectable form of Fluphenazine (Modecate).

We examined the predictive ability of these ten items in two ways. We assigned an arbitrary score of 1 to each predictor and the sum of the scores for each patient was analysed for its sensitivity and specificity in predicting suicide. Using a cut-off point of 6 or more as indicating a higher risk, 24 of 37 suicides for whom complete data were available were correctly identified and there were five false predictions of suicide. This gave a sensitivity of 65 per cent and a specificity of 86 per cent. If we used a discriminate function analysis, that is a more sophisticated statistical weighting of the individual items, then a sensitivity of 83 per cent and a specificity of 67 per cent were obtained.

While these figures may appear acceptable, and in fact they are a little better than the Pokorny figures, it must be recalled that they are based on distinguishing those who suicided from an equal number of controls. This is the nub of the problem in the prediction of suicide. We can predict with some confidence if we know that, 37 of 74 subjects will inevitably commit suicide. But, the base rate of suicide is not 1 in 2. It is much less than this. As we have seen in our earlier example, it is 1 in 612 for subjects 15 to 24 years of age who have expressed suicidal ideation, and for the general population of 15 to 24-year-olds it is 1 in 6,120. This issue has been emphasised by Murphy (1983), a very respected researcher in the field of suicide prevention, who said that because of the low base rate of suicide one 'would need a test of unbelievable sensitivity and specificity to be of use'.

This point can be illustrated further by manipulating the base rates in the manner which is described by Pokorny in his American paper. If one uses a statistic that allows for a figure approaching 100 per cent to be a perfect prediction of an event, with 0 being a perfect prediction that the event will not occur and 50 per cent being a chance occurrence, then the Australian data with the suicide and control subjects combined, thereby giving a base rate of 1 in 2, allow the prediction of 79 per cent of the suicides. However, this predictive ability falls dramatically as the base rate decreases. Thus if the rate were 1 in 10, the prediction would fall to 62 per cent. For the rate of one in 100 patients committing suicide, the prediction using our predictors would fall to 50.7 per cent, a figure that could be arrived at by tossing a coin. When the true base rate for suicide of patients in our Australian study was used, namely 220 per 100,000 psychiatric admissions (a figure similar to the

Pokorny figure), the result is 49.7 per cent correctly predicted, again no different from that obtained by tossing a coin.

It is fair to note that these studies were not without their shortcomings. For example, age and sex, which are two factors said to be strongly associated with suicide, were not included in the analyses because of the case/control nature of the research designs. However, it is quite evident that our ability to devise instruments which predict suicide is very limited.

## Conclusions

It is important to emphasise that clinicians are well aware of subtle nuances of patient presentation that may herald suicidal behaviour. The task remains to quantify such phenomena in order to provide more accurate prediction. However, at the same time we must acknowledge our shortcomings. Indeed, if so-called experts in the field cannot reliably predict suicide, we must not place unrealistic expectations on those people in the community, such as nurses and custodial officers, who may at times have the onerous duty of care of subjects who may be suicidal.

Those who engage in the challenging field of suicide prevention frequently feel frustrated, impotent and guilty because such self-inflicted behaviour cannot be prevented. The studies reviewed place the problem in a statistical perspective, but should not be perceived with pessimism. Rather, they should be used to promote confidence in traditional clinical values, instead of anticipating that some check list will soon emerge to make our decision making easier.

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

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# **AN APPROACH TO THE ISSUE OF YOUTH SUICIDE AND ATTEMPTED SUICIDE IN WESTERN AUSTRALIA**

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THIS PAPER DESCRIBES THE PROCESS WHICH LED TO A RESPONSE TO THE problem of youth suicide and attempted suicide in Western Australia.

## **Background to the Youth Suicide Working Party Report**

Initially, discussions were held with Dr Kosky regarding the rising incidence of youth suicide in Australia. The idea of screening a high school population for potential suicide was mooted and the shortened version of the Beck Depression Inventory (Beck & Beck 1972) was recommended. The rationale was based on the evidence that depression is associated with suicidal ideation and suicide (Pfeffer et al. 1984). A pilot study was proposed, the method being to administer the inventory to Year 10 students in three Perth State high schools.

Permission to undertake the study had to be obtained from the Ministry of Education. This was denied on the grounds that the use of the Beck Depression Inventory would be inadvisable. It was felt that there could be emotional trauma to students and very strong community reaction to such questions as:

- I hate myself;
- I would kill myself if I had half the chance;
- I feel I am ugly or repulsive looking.

The justification for refusing the study is not based on fact. The Beck Depression Inventory has been used for many years without causing emotional trauma or a strong community reaction (Reynolds 1986, p. 127). However, the denial of its use did prevent the discovery that the Beck Depression Inventory lacks the sensitivity and specificity which is required to screen for a potentially suicidal young person.

An alternative approach was influenced by the recommendations emanating from the University of Louisville School of Medicine, Child Psychiatric Services (Sudak et al. 1984).

In particular, the following suggestions were instrumental in developing further strategies:

- The development of special training programs for mental health professionals, teachers and others who work with children and adolescents to increase their sensitivity and receptivity to suicidal messages.
- The development of a mental health awareness program in the school system, including universities, as part of the required curriculum to increase sensitivity and awareness of the signs and symptoms of the emotional problems of living, with specific emphasis on suicide. The role of friends and peers in the early recognition of suicidal behaviour and prevention of suicide cannot be over-emphasised.

Suzane Fabian had already been working towards implementing these recommendations in her contribution towards a two-day conference on youth suicide prevention organised through the Victorian Education Department. With the experience recorded in her book (Fabian 1986), there was an opportunity to use her expertise when she visited Perth for a National Association of Loss and Grief Conference.

Support for the proposal to organise a two-day conference in Perth was not forthcoming. The independent Western Australian Branch of the Australian Association of Adolescent Health was, however, able to organise a public meeting entitled 'Teenage Stress and the Risk of Self Harm—identifying the warning signs and where to seek help' (AAAH Public Seminar 1987).

In order to develop further the suggestions made by Suzane Fabian, the panel and the audience, a Youth Suicide Prevention Task Force was convened as a subcommittee of the Australian Association for Adolescent Health. Volunteers were sought from the Ministry of Education, Community Services, Police, Health and the non-government sector, including agencies representing youth.

Having collated a number of recommendations, they were sent to the then Premier Elect, Peter Dowding. It was recommended that developing strategies to combat youth suicide should be a priority. It was also stated that no one Minister could take responsibility for a problem, the causes of which are multifactorial, therefore requiring an interdepartmental response. Nevertheless, the issue was referred to the Minister for Community Services, Youth and the Family.

The Minister requested that the Youth Suicide Prevention Task Force should produce a position paper (Hart 1988). Meanwhile an article was published in the *West Australian* newspaper entitled, 'A dilemma in youth suicide'. This prompted the Minister for Health to request the Health Department of Western Australia to develop proposals to combat youth suicide.

The Royal Commission into Aboriginal Deaths in Custody was very much the focus of media attention. Responsible reporting of the issue was questioned. Evidence was given of the association between the media coverage of the suicide issue and the danger of precipitating further suicides (Phillips & Carstensen 1986). A meeting with the Police Department resulted in the development of a policy which specified that the only information that would be released would be that there had been a death in custody which would be investigated. From that date the media coverage of the Inquiry was less sensationalised.

An ABC Radio interview on the issue prompted a meeting to discuss the recommendations of the Youth Suicide Prevention Task Force and the Health Department proposals. Several weeks later, the Perth afternoon paper, the *Daily News*, carried the

front page headline, 'Torment of the Death Wish Kids'. The police were quoted as saying that Perth's suicide rate would reach epidemic proportions '... unless drastic action was taken'. A short time after this, the Youth Suicide Steering Committee was convened under the chairmanship of the Assistant Commissioner for Health.

## Discussion

The process by which the Youth Suicide Working Party was established has demonstrated some strategies which are given scant regard in the literature namely: politics, the media and teamwork.

### *Politics*

There is a suggestion made to paediatricians that they should 'urge State and Federal funding for service programs' (American Academy of Paediatrics 1989). The Report of the National Task Force on Suicide in Canada (Canada 1985) contains several recommendations which have political implications. The role of politics in ensuring there is a concerted effort in combating youth suicide cannot be underestimated and is more fully described in the *Australian Association for Adolescent Health National Newsletter* (Hart 1989). The demonstrated commitment and support from an empathetic state Minister has been a major factor behind Western Australia leading the way in tackling the issue of youth suicide.

### *The media*

The role of the media in raising public awareness about the issue, and thereby influencing the need to develop preventative strategies, has been demonstrated. Rather than the positive role media can play, greater attention has been paid in the literature to the dangers to young people of the exposure to media coverage of information about suicide (Phillips & Carstensen 1986).

It has also been claimed that: homicide rates rise after heavy championship fights, airline crashes rise after publicised murder/suicides and single driver vehicle fatalities rise after publicised suicides (Phillips 1974). In view of some cynicism of the credibility of such claims, Zubrick was asked to evaluate the article (Phillips & Carstensen 1986) which demonstrated that there is a clustering of teenage suicides after television news stories about suicide (Zubrick personal communication, 12 May 1988). There are, however, a host of critics and non-replications summarised in a chapter by Ronald Maris in a recent book, *Suicide: Understanding and Responding* (Jacobs 1989). He describes how there seems to have been an obsession with the influence of imitation in the sociological study of suicide rates. He felt this reflected the 'tenacity and publication success' of David Phillips rather than the degree to which imitation plays a part in the total dynamics of suicide.

Despite the critics of Phillips and subsequent studies which have demonstrated a reduction in teenage suicide following television newscasts about suicide (Kessler et al. 1988), a policy of erring on the side of caution seems prudent. This is reinforced by the experience in Western Australia of a peak incidence of youth suicide in 1988 at a time when there was significant media coverage of the Royal Commission of Inquiry into Aboriginal Deaths in Custody.

There is a fine line between on the one hand no publicity about teenage suicide with a resultant lack of awareness, and therefore lack of demand for preventative strategies; and on the other hand publicity which may lead to suggestibility. There is clearly a need for further research to determine where that fine line should be drawn.

### *Teamwork*

An essential ingredient in any enterprise which sets out to achieve a specific goal is that a team of people shares a vision for achieving that goal. When the collective interest is in working together on an emotive issue such as youth suicide, professional barriers and self-interest should be reduced. When pioneering a course of action, there is less vulnerability when the action is supported by a team approach. Also when team members represent government, non-government and community based agencies, there is the opportunity to amalgamate to become a more effective force for the benefit of the client.

The Youth Suicide Prevention Task Force and its parent body, the Australian Association for Adolescent Health, both consist of volunteers from various government and non-government agencies. The Youth Suicide Working Party, although convened under the auspices of the Health Department of Western Australia, had representatives from various government and non-government agencies.

A Community Interagency Suicide Prevention Program (CISPP) had been established in five urban centres in Alberta, Canada. The philosophy of the CISPP concept is that a service aimed at suicide prevention should not be isolated from other community helping services. The idea is that the problem of suicide should not be 'franchised' to one particular agency but that it is a total community responsibility. Each CISPP has a program coordinator to facilitate the following functions:

- to allow core agencies to develop specialised competence for each core function without isolating one service from others;
- to reduce confusion resulting from overlapping services, client sharing and referral shuttles;
- to provide multiple points of entry while ensuring that all clients will benefit from appropriate network resources;
- to provide crisis and chronic, short and long-term professional and volunteer, medical, psychological and social support services; and
- to provide an economical as well as 'politically' acceptable way of providing suicide prevention, intervention and 'postvention' services within a community.

Since the initiation of the CISPP concept, the suicide rate dropped from 25.1 to 12.4 per 100,000 in the five suburban centres where it operated, but rose 3 per cent across the whole province.

Having developed recommendations applicable to the Australian scene, it should be somewhat easier for other states to follow. The Report of the Youth Suicide Working Party to the Minister for Health should prove a useful foundation for the development of nationwide strategies.

The terms of reference of this report were:

- to identify the extent of the problem in Western Australia;
- to review the literature on youth suicide and possible interventions;
- to consider possible contributory factors to suicide by young people;
- to review the effectiveness of interventions elsewhere into youth suicide;
- to identify possible target groups for intervention; and
- to present recommendations for action in Western Australia appropriate to the problem.

A series of recommendations were developed from the terms of reference (Haywood et al. 1988) and from submissions from a number of individuals and agencies (see Appendix 1). Professor R.F.W. Diekstra has recently published a comprehensive strategy for the prevention of suicidal behaviour (Diekstra 1989b). It is encouraging to note the similarity between Diekstra's recommendations and those of the Youth Suicide Working Party.

## Progress Report

Following the completion of the Youth Suicide Working Party Report to the Minister for Health it was announced that funds had been allocated in order to implement the recommendations. Not long afterwards a state election was held and it was many months before any further action ensued.

Meanwhile, it was felt that some of the recommendations could be implemented immediately on a district level. An intersectoral group was convened in order to organise a day workshop for teachers, school nurses, guidance officers, police, school chaplains and representatives from a juvenile detention centre. A similar seminar was organised in a neighbouring district a short time later.

The group which organised the seminar has continued to meet and has established a plan to prevent the cluster effect within the district (Gostelow 1990). Talks and meetings have been held with school personnel to discuss the issue of youth suicide and the need to develop policies.

Some months after the completion of the Youth Suicide Working Party Report, a Steering Committee was established in order to implement the recommendations. The committee consists of representatives from the Health Department, Alcohol and Drug Authority, Aboriginal Health, Accident and Emergency Departments, Psychiatric Services, Department of Community Services, Police Department, Ministry of Education, Association of Independent Schools, Catholic Education and the Samaritan Befrienders.

Five Working Groups were established in order to oversee implementation of the recommendations. They include: liaison; service delivery; suicide and the law; research; and education. Some of the working groups enlisted the support of others in an advisory capacity.

The liaison group has been responsible for the coordination of activities designed to improve the management of young people who have attempted suicide. The Samaritans Befrienders have trained volunteers to help ensure that suicide attempters do attend follow-up outpatient appointments either at the hospital or local adolescent psychiatric clinics. In view of the delay in receiving an appointment, the volunteer can provide ongoing support in the meantime. To date several volunteers have been utilised and this service is proving valuable, but formal evaluation has yet to be performed.

Subsequent to the development of this scheme it has been discovered that a similar concept has been operational in Vancouver since 1972. The Suicide Attempt, Follow-up, Evaluation and Research (SAFER) program has as its objectives:

- to offer individual, family and marital counselling;
- to encourage alternative methods of coping with stress;
- to suggest further and professional help when indicated;
- to be available in times of recurring crisis; and
- to inform clients of other existing community resources.

When a suicidal person is admitted to hospital, the SAFER team is contacted and, with the agreement of the hospital staff, the team contacts the person to arrange follow-up visits whilst at the same time in or outpatient psychiatric treatment may be simultaneously involved.

In an evaluation of the program by Termansen and Bywater (1975), there was found to be an improvement in psychosocial functioning. Although the suicide rate did not change there was a 40 per cent drop in admissions for attempted suicide.

Unfortunately, the lack of acceptance of volunteers by some professionals has not made the implementation of this program easy. It seems that this is a problem not unique to Western Australia in that a similar conflict has been described in a critique use of volunteers (Hirsch 1982).

The professionals avoided the lay model of human warmth, understanding and kindness; the volunteers appeared insecure and defensive about not being professional. On the other hand, consumers rated more highly people who were warm, outgoing and who took time to listen (Wattie 1983). Mental health professionals were found to lack warmth, understanding and kindness but had better skills on general interviewing. They rated more highly than volunteers on being able to pick up important clues, to challenge evasiveness and to extract a coherent story. If volunteers and professionals could work together, the client could benefit from the attributes of both.

The liaison working group has a challenge to ensure that the management of suicidal young people is undertaken in a coordinated and cooperative manner. This is being facilitated by the production of an up-to-date list of resources. Also, provision of a twenty-four hours a day information service based at the Samaritan Befrienders assists with ensuring that a young person is referred to an appropriate agency. An 008 number has been established and there has been publicity to ensure rural youths are aware of the services.

### **Service Delivery**

As many young people tend to attempt suicide after hours, an after hours social work service was provided at the main teaching hospitals. This facilitated interviews with relatives who might not be available during the day following the attempt. Other agencies have reported an increase in referrals of young suicide attempters since the service began. It is believed that suicide attempters may not have been previously referred. Also, they may have discharged themselves from hospital in the absence of an immediate counselling service.

Evidence from a small study by Litt (Litt et al. 1983) found that only 33 per cent of first appointments of adolescent suicidal attempters were kept. As it is attempters who have a higher rate of attempt repetition and completion, it is important that strategies are employed to encourage attendance at follow-up appointments. A family history of psychiatric illness, especially with suicidal behaviour, puts the offspring at greater risk of suicide. There are implications, therefore, from a home visit study comparing teenagers who keep appointments with those who failed (Tautman et al. 1987). Those who failed were more likely to have a parent with an untreated, but significant psychiatric disturbance.

The provision of a twenty-four hour emergency psychiatric on-call service resulted in forty-one contacts over three months with fifteen call backs. Approximately half of the contacts related to self-destructive adolescents.

### *Suicide and the law*

This working group has ensured that Western Australia's strict gun laws are maintained and that an amnesty on unlicensed firearms should be publicised regularly.

In relation to the association between alcohol and the increased risk of suicide, measures to reduce the access by under age drinkers to alcohol are being explored. Also campaigns to encourage disposal of unused medications are operational.

Alternative practices to arresting youth have been implemented and the facilities for juvenile offenders are being reviewed; a course on at risk youth is being introduced to the Police Academy; and support has been given to the concept of a twenty-four hour advisory service to juveniles in custody.

## **Future Directions**

### *Identification of 'at risk' young people*

Diekstra (Diekstra 1989b) recommends that efforts are needed to increase awareness of the symptoms of depression and other warnings of suicide, as well as publicity given to organisations which can offer confidential and professional advice. Although the latter is being achieved in Western Australia, the former recommendation has not been included in the Youth Suicide Working Party Report. However, in response to community demand and concern, presentations have been made to various parent groups.

Kashani (Kashani et al. 1989) also recommends that there should be educational programs for parents focusing on the indicators of suicidal ideation in children. He bases his suggestion on the findings of his study of a community sample of 210 children. Of the children 6.6 per cent reported recurrent suicidal ideations. Only 14 per cent of the parents of these children were aware of their children's suicidal tendencies. He also discovered that the parents of the children who had suicidal ideation had a greater intensity of psychological distress.

This puts into question his own recommendation that there should be educational programs for parents, in that those who need them most, might be the least receptive. Another approach is to encourage troubled children and adolescents to seek help. This necessitates providing a service which is appropriate to their stage of development and to meet their needs. The criteria to be fulfilled in order to provide such a service are shown in the innovative pole of Table 1 (Jeanneret 1981).

Although there are some services which do provide a service appropriate to young people, they are not universally available. Also depressed and suicidal children and adolescents are unlikely to be motivated to seek assistance, however appropriate the setting. There is clearly a need therefore to devise a way in which to identify these 'at risk' young people.

The American Task Force on Youth Suicide Prevention has recommended that there should be the introduction of school based screening schemes (Rosenberg 1987). In David Shaffer's critical review of teenage suicide prevention strategies, he gives little credence to most interventions which are currently operational in the USA (Shaffer et al. 1988). He did indicate, however, that school based screening programs had demonstrated their value in a survey of approximately 1,000 students aged thirteen to eighteen. Three per cent identified themselves as being troubled or suicidal and wanted professional help.

Table 1

**Contrasts in Health Care Delivery**

| Dimensions         | Conventional Pole                                  | Innovative Pole                               |
|--------------------|----------------------------------------------------|-----------------------------------------------|
| 1. Ideology        | Conservative-pathology or growth orientated        | Radical, growth orientated                    |
| 2. Techniques      | Psychotherapy and formal treatment                 | Participation, counselling                    |
| 3. Staff           | Highly skilled professional<br>Involvement limited | Non professional<br>limited skill<br>involved |
| 4. Staff/patient   | Roles strictly defined                             | Roles sometimes vague                         |
| 5. Intake          | Defined groups                                     | Self selecting                                |
| 6. Location        | Therapists territory: conventional                 | Client's territory: unconventional            |
| 7. Access          | Formalised: fixed hours                            | Informal; flexible hours                      |
| 8. Confidentiality | May include parents                                | Anonymity                                     |

Source: Jeanneret 1981

Unfortunately, neither the USA Task Force on Youth Suicide Prevention nor David Shaffer specify which screening test is used or recommended. Reynolds describes a model for the screening and identification of depressed children and adolescents in school settings (Reynolds 1986). He acknowledges that not all depressed students are suicidal and vice versa (Sudak et al. 1984) but suggests that it is expeditious to include an assessment of suicidal ideation along with depression.

Identifying children and adolescents with depression provides the potential not only to intervene to prevent suicidal behaviour, but also to prevent other sequel. Jeffrey Dolgan, Chief of Psychology at the Children's Hospital, Denver Colorado, identifies a number of significant features associated with depression (Dolgan 1990):

- learning difficulty
- delinquent behaviour
- sexual promiscuity
- pregnancy
- substance abuse
- self harming behaviour

A significant proportion of depressed children become depressed adults, and depressed adults begat depressed children (Puig-Antich 1989). Even without the potential for suicide prevention, there is reason enough to increase the identification rate of depressed children and adolescents.

The Reynolds three-stage model for the screening and identification of depressed children and adolescents (Reynolds 1986) appears labour intensive. Also, as he points out himself, there is the concern that implementation of the screening model might not be acceptable to the school district. However, where the model had been used, there had been very positive acceptance.

Although not a screening test, a scale (see Appendix 2) has been devised to aid non-psychiatrists in the better recognition of anxiety and depression in general medical settings (Goldberg et al. 1988). The scales were derived by latent trait analysis from a standardised

psychiatric research interview. Only if there are positive answers to the first four questions do the remaining fourteen need to be asked. When assessed against the full sixty questions contained in the psychiatric assessment schedule, they had a specificity of 91 per cent and a sensitivity of 86 per cent. The scales have been administered by a community nurse in a high school to students attending her clinic.

The ease and speed of application of the scale made it readily acceptable to both staff and students. Although it is too early to provide an evaluation of the use of the scale in a school setting, the early indicators are that significant problems are being identified amongst students who attend the school health centre for whatever reason.

### *New approaches to intervention*

Having identified children and adolescents who may be 'at risk', the question arises as to what is the appropriate intervention to prevent unhealthy behaviour in the future. The answer to this question is beyond the brief of this paper, but has been and is currently being considered elsewhere.

In the literature there is in fact little emphasis on the role of peers in suicide prevention. There is a reference in David Shaffer's article (Shaffer et al. 1988) to peer counsellors but without evaluation of their effectiveness. Programs such as Youth in Search demonstrate the value of peer led groups. Anecdotal evidence (R. Barr, personal communication) suggests that young people will divulge more of their inner feelings to a room full of peers than they will to a professional.

The apparent success of the concept is likely to be related to the fact that the majority of the criteria of the 'Innovative Role' (see Table 1) are satisfied as well as the principles of intervention for young people's health (World Health Organization 1989—see Appendix 3).

Evaluative research of the program would, no doubt, provide useful information to influence the modus operandi of professionals who work with young people.

### *Primary prevention*

#### Preventing young people becoming 'at risk'

In his report on the social and psychological problems faced by young people in Australia, CSIRO principal issue analyst Richard Eckersley (1988) claims that:

... as a society we appear not to recognise the seriousness of the problems being experienced by young people. To the extent we do recognise the problems, we are applying remedies that will not work because they do not address the causes of the problems, causes that are deeply rooted in the fundamental changes occurring in Australian society.

The increase in suicides and attempted suicides amongst young people associated with an increase in depression is not a situation confined to Australia. It is a global phenomenon which some hypothesise is due to a complex form of gene-environment interaction or exposure to environmental risk factors (Klerman 1988). Perhaps in a vain attempt to medicalise the problem there have been suggestions that there could be viral agents, a 'suicidococcus' (Diekstra 1989) or some nutritional change to account for the increase in 'youthful melancholia'. Diekstra (1989b) has a more informed opinion from his international perspective on suicide and attempted suicide. A society which is subject to the following conditions is at a high risk for an increase in suicides over and above the rate that can be considered 'normal' for that society:

- economic instability or deprivation (unemployment);
- breakdown of traditional family group structure;

- interpersonal violence/increase in criminal behaviour;
- secularisation;
- increasing substance use/abuse.

These 'symptoms' are pathognomonic of Durkheim's (1897) anomie and, if in-roads are to be made into primary suicide prevention, 'these indicators of normlessness and social disintegration' have to be tackled. This is the challenge. It is the theme of the National Biennial Australian Association for Adolescent Health Conference, 'The Challenge of Change for Young Australians in the 90s'—to turn Alvin Toffler's *Future Shock* into Future Health!

## Conclusion

The message from young people in Western Australia has been heard and strategies demonstrated to ensure that a response was developed. The recommendations which emanated from that response were documented and the progress with their implementation described. Lessons learned in the process of developing and implementing the recommendations were discussed. Based on a literature review and experience, suggestions were made as to how 'at risk' young people may be identified and managed with an innovative approach. The final word rests with the challenge to make Australia a more favourable environment in which to nurture its young.

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Appendix 1  
**Recommendations**

*Recommendations regarding specific research needs*

- That funding be provided for a prospective study of a three month cohort of teenage suicide attempters attending hospital accident and emergency departments.
- That ongoing funding be provided for the appropriate collection of detailed information on suicides and attempted suicides in Western Australia.

*Recommendations on current service delivery*

- That access to consultation provided by the Child and Adolescent Psychiatric Services be made available on a twenty-four hour, on-call basis to hospital accident and emergency departments. Department for Community Services Crisis Care, and the Community Psychiatry Inner City Crisis Team, Samaritans and other community agencies.
- That a plan be developed for the provision of appropriate in-patient admission, assessment and treatment of acutely disturbed and suicidal adolescents and young adults.
- That Social Work Services at the major metropolitan hospitals be extended to provide a twenty-four hour, seven day a week on call service.
- That the social work services at the Parent Help Centre and Youth Health Services be expanded in order that they may cope with existing and future demand.
- That the Health Department convenes a group to develop guidelines to improve liaison and coordination of services between hospitals, government departments and relevant community agencies which provide treatment, education or social welfare services to suicidal youth after their discharge from hospital.
- That continuing education be made available to general practitioners to improve their recognition of depression in adolescents and young adults, and to facilitate their appropriate responses to suicidal symptoms and behaviour, and to make them aware of and encourage use of referral structures.
- The professional training of all professions having direct dealing with adolescents should have course components which facilitate an understanding of the developmental, health, social and emotional issues of adolescents.
- That guidelines and in-service education be developed as a matter of urgency in conjunction with the Ministry of Education to facilitate the early identification and referral of students who may be suicidal.
- That Department for Community Services staff receive in-service education on youth suicide, identifying at risk youth and resources available to them in the Health Department and non-government agencies.
- That continuing education be made available to Police in dealing with young people who may be suicidal.

- That the Health Department's current alcohol and drug public awareness campaign continue to target adolescents and young adults to bring about change in the community attitude towards alcohol and drugs.
- That a public education campaign is mounted on a continuing basis to educate the public regarding the need to dispose of unused medicines.
- That up-to-date resource information regarding available referral sources of youth for psychiatric, family and individual psychotherapy, social support services etc., be made available to general practitioners, hospitals and other health providers and agencies serving youth.
- That the Government's current policy to extend funding to family treatment and support services be supported.

*Recommendations on future service delivery*

- That coordinated assessment be made of future resource needs of accident and emergency services to cater adequately for the increased number of youth suicide attempts.
- The current Health Department plans for the Child and Adolescent Psychiatry Services to establish a new clinic in Fremantle should proceed as soon as possible.
- That the Ministry of Education be encouraged to make the Health Education K-10 Syllabus available to all West Australian schoolchildren.
- That the Office of the Family be asked to investigate development of ongoing parent education programs covering issues such as child development, the parents' self-esteem etc.
- That the recommendations already made by the Minister for Health for the establishment of an interdepartmental working party to consider alternative management arrangements necessary to support proposed changes to the *Policy Act* regarding the decriminalising of public drunkenness be pursued as a matter of urgency.
- That funding to support community recreational facilities for youth in underprivileged and country areas be extended.
- That legal restrictions on access to alcohol by youth be reviewed.
- That increased resources be made available for education programs about illegal drugs.
- That the relevant sections of this report dealing with the susceptibility of adolescents to television reports and program content on suicide be sent as a submission to the Australian Broadcasting Tribunal's Inquiry into Television Violence.

*Recommendations for containment of suicide clusters*

- That community response plans be developed for the containment of suicide clusters or for situations which might develop into suicide clusters.

- That this report be made available to the media with the specific request that journalists, program producers and others responsible for the report of suicide, consider carefully the evidence regarding the influence of the media on youth suicide.

## Appendix 2

### Anxiety Scale

*(Score one point for each 'Yes')*

- 1 Have you felt keyed up, on edge?
- 2 Have you been worrying a lot?
- 3 Have you been irritable?
- 4 Have you had difficulty relaxing?

*(If 'Yes' to two of the above, go on to ask:)*

- 5 Have you been sleeping poorly?
- 6 Have you had headaches or neck aches?
- 7 Have you had any of the following: trembling, tingling, dizzy spells, sweating, frequency, diarrhoea?
- 8 Have you been worried about your health?
- 9 Have you had difficulty falling asleep?

### Depression Scale

*(Score one point for each 'Yes')*

- 1 Have you had low energy?
- 2 Have you had loss of interests?
- 3 Have you lost confidence in yourself?
- 4 Have you felt hopeless?

*(If 'Yes' to ANY question, go on to ask:)*

- 5 Have you had difficulty concentrating?
- 6 Have you lost weight (due to poor appetite)?
- 7 Have you been waking early?
- 8 Have you felt slowed up?
- 9 Have you tended to feel worse in the mornings?

### Interpretation

Add anxiety score, add depression score. Patients with anxiety scores of five or depression scores of two have a 50 per cent chance of having a clinically important disturbance; above these scores the probability rises sharply.

### Appendix 3

#### **Principles of Intervention for Young People's Health**

Experience to date suggests a number of principles that appear to be effective in promoting the healthy development of young people:

- a prolonged supportive environment with graded steps toward autonomy enhancing self-esteem and promoting healthy life-styles;
- a positive interaction between young people and the key adults and peers in their lives;
- continual monitoring of the healthy development of young people within the sociocultural context;
- the development of programs based on a sound understanding of young people's beliefs and behaviour within any given culture;
- the use of people to implement programs who respect the young, have a sound knowledge of their needs, and are trained in communication skills;
- the use in programs of established principles of learning, behaviour, and development;
- the focusing of programs on groups of interrelated behaviour rather than single forms;
- the use of an intersectoral approach in programs in which key groups interacting with the young are optimally involved, including the school, the family, the health system, religious and community leaders, and community organisations;
- a close linkage of community-based programs with complementary school-based programs, with programs directed at those who have left or do not attend school, and the health care system;
- the involvement of young people themselves in the planning and implementation of programs, to the greatest extent possible.

Source: World Health Organization 1989.

# **COMPLETED SUICIDE IN WESTERN AUSTRALIAN YOUTH: A STUDY OF 96 CASES AGED 15- 24 YEARS**

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RECENT REPORTS OF CHANGES IN THE WORLDWIDE DEMOGRAPHY OF SUICIDE over the past few decades (Australian Bureau of Statistics 1985; US Centres for Disease Control 1986) have focused professional awareness and raised community concern about the apparent increase of suicide among youth. They have also highlighted the fact that, if effective preventive measures are to be developed, there is an urgent need to describe the characteristics of young people who take their own lives and to identify possible current causative influences.

While the overall rate of suicide in the Australian population has remained remarkably stable at about 11 per 100,000 over the past century, analysis of age specific rates show important trends over the past few decades (Burvill 1980; Goldney & Katsikitis 1983; Kosky 1987; Hayward et al. 1988). Increased suicide has been noted in both the very old (80 and over) and young persons (15-34) (Hassan & Carr 1989). For the over 80 age group the actual numbers involved are small. On the other hand, the increase among the

young represents a very significant trend, particularly for males. In the 25-year period 1972 to 1987, the age specific suicide rate among males aged 15 to 24 has steadily increased from 15.2 to 22 per 100,000 while the rate for females age 15 to 24 initially decreased from 6.5/100,000 in 1972 to 3.5/100,000 in 1982 and then increased to 5.75/100,000 in 1987 (Australian Bureau of Statistics 1989).

The changing demography of youth suicide in Australia reflects the worldwide increase in the mean rates for suicide in the 15 to 24 age group for countries contributing statistics to the World Health Organization (Barraclough 1988). Australian rates for males in this age group have shown a parallel increase to that recorded in the USA, with both countries having age specific rates of 21/100,000 in 1987. This is three times the corresponding rate in England and Wales which has remained fairly constant averaging 6/100,000. By contrast, the reported rate for male Japanese youth has steadily declined from 20/100,000 to 14.5/100,000 over the same period (World Health Organization 1989).

The absence of similar increases in older age groups suggests the possibility of relatively new factors that specifically influence adolescents and young adults and invites speculation as to causative influences which may have affected the present generation of youth. Kreitman (1976) has suggested that the increase in suicide among younger males is a relatively new phenomenon in developed countries which may be related to the emergence of the illicit drug culture among the young. Goldney and Burvill (1980) have suggested the possibility that it may be related to heavier alcohol consumption of younger males in recent years.

Shafii et al. (1985) found that 70 per cent of young suicides were substance abusers. Fowler et al. (1986) found that 53 per cent of 133 consecutive young suicides in San Diego had a principal diagnosis of substance abuse—particularly alcohol, marijuana and cocaine. This contrasts with a lifetime prevalence of 11 to 18 per cent in the general population aged 18 to 24 years (Robins et al. 1959) suggesting relative risk of suicide among drug abusers of between 5 and 9. The substance abuse was typically a chronic condition, present for 9 years.

Changes in the structure and circumstances of the family have also been linked with the recent apparent rise in youth suicide rates. There are several reports in the literature of the association between family conflict and suicidal behaviour in young people (Barter et al. 1968; Kosky 1983; Reynolds et al. 1988; Kosky et al. 1986 & 1990).

Shafii et al. (1985) reported significantly increased risk for suicide in adolescents who were exposed to past suicidal behaviour in parents, relatives and friends. They also reported a significant association with parental history of emotional problems. Deykin et al. (1986) have hypothesised that there may be an association between the increasing rates of suicidal behaviour among adolescents and the increasing rates of child abuse and neglect which have been reported over the past decades. They also have commented on the fact that the prevalence of known risk factors for child abuse and neglect, such as young and single parenthood, diminished social supports, poverty and unemployment has also increased over these decades.

Other environmental influences have been identified as having differential effect on youth as opposed to older sections of the population. Predicted rates of suicide have been shown to increase in the weeks immediately following nationally televised news broadcasts about suicide (Phillips & Carstensen 1986; Gould et al. 1988). Population pressure has been causally implicated in the rise in suicide rates in youth cohorts. Holinger (1987) reported a population cohort size effect. He found a positive correlation ( $r=0.34$ ) between the suicide rate for the 15 to 24-year-olds and the proportion of 15 to 24-year-olds in the US population over the years 1933-1987. This positive correlation was not found for other age groups in which the correlation was negative. Possible effects of such a population pressure might include the accentuated development of the adolescent 'sub-culture', increased

competition for available employment and educational placements and increased stress on the juvenile justice, educational and welfare systems.

There have been relatively few investigations of completed suicide among youth which have attempted to delineate factors associated with youth suicide in Western societies. Studies have been carried out in England and Wales (Shaffer 1974) and in Canada (Pettifor et al. 1983; and Garfinkel & Golombok 1983).

In the United States, Shafii et al. (1985) conducted a detailed 'psychological autopsy' (that is using all available information including medical and coronial records and interviewing the relatives and friends of the deceased) on 20 young people aged 19 and under; Poteet (1987), Thompson (1987) and Hoberman and Garfinkel (1988) have conducted retrospective descriptive studies based on information from coroners' and medical examiners' records with group sizes of  $n=87$ ,  $n=190$  and  $n=229$  respectively; Brent et al. (1988) compared 27 adolescent suicide victims with 56 suicidal inpatients.

With the exception of Pettifor et al. (1983) and Brent et al. (1988), all these investigations were descriptive studies employing no control or comparison groups; they vary in the extent to which their data collection methods were specified; most have relatively small subject numbers and they cover varying age ranges.

This present study aims to provide a population description of all officially recorded suicides by young persons aged 24 and less in Western Australia for a 36-month period from 1986 to 1988 and provide estimates of relative and attributable risk for associated factors.

## Methods

Case identification for this study was based upon coronial records and the data described reflect the coroners' ruling of suicide. All cases so identified for the 36-month period from January 1986 to December 1988 are included. Each recorded case of suicide was reviewed by one of the authors for case details and data were collected for the following domains: individual characteristics (age, sex, place of birth, current relationship/s), demographic details (place of residence, employment status), health history (health at time of suicide, past history) and details of suicide (time, method, place, blood alcohol level, evidence of substance abuse, precipitating circumstances).

Age-specific and age standardised mortality and hospitalisation rates were calculated using CHAMP (Epiwest Software, 1986). Age standardised rates were calculated by the direct method and were based on the age distribution of the Standard World Population so as to facilitate comparison of results from other Australian states and other countries. The most recent Australian Census was made during the survey period. In June 1986 there were 239,350 West Australians aged 15 to 24 years out of a total state population of 1,406,930.

## Results

### *Factors related to youth suicide in Western Australia*

During the 36-month period from 1986 to 1988 there were 96 officially recorded suicides among youth under the age of 25 years. In 1986 there were 25, in 1987 there were 28 and in 1988 the number increased sharply to 43. These numbers, when expressed as age standardised rates per 100,000 population, give rates of 10.4 and 11.7 for 1986 and 1987 respectively and 17.9 for 1988.

Of the 96 suicides of young people that occurred in the three-year period, 80 per cent were male and 20 per cent were female. They were all 14 years of age or older, with the highest frequency among 18 and 19-year-olds (see Figure 1). The mean age for males (20.3 years) was 1.3 years older than that of females (19.0 years).

The proportion of cases who were white of Caucasian ethnic origin was slightly lower than the proportion in the WA youth population (68 per cent of cases vs. 76 per cent of population). There was an over-representation of Aboriginals (7 per cent vs. 3.6 per cent).

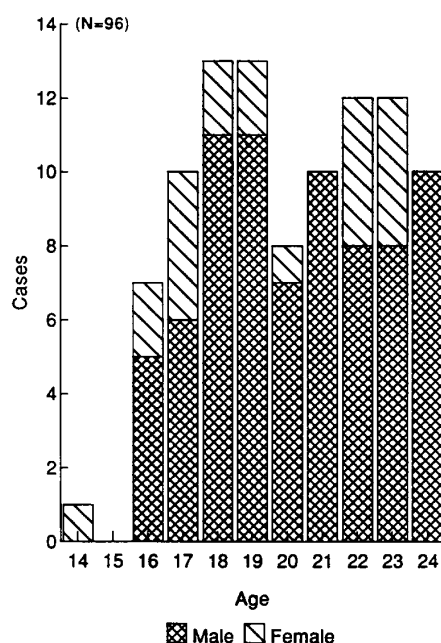
Migrant groups were generally not over-represented. The larger migrant groups from the United Kingdom and Europe had suicide rates comparable to their representation in the WA youth population (14.5 per cent vs. 14 per cent). However, while the actual numbers involved did not permit meaningful statistical comparison it did appear that some of the smaller migrant groups could be over-represented. These included those born in New Zealand (5 per cent vs 2.5 per cent), India and Malaysia (3 per cent vs. 1.5 per cent) and South Africa (2 per cent vs. 1 per cent).

Over two-thirds (69 per cent) of the suicides occurred in the Perth metropolitan area. This figure corresponds to the proportion of the overall youth population aged 15 to 25 living in metropolitan area of Perth (72 per cent). However, when the teenage group were considered separately it was found that non-metropolitan cases accounted for 41 per cent of the cases in the 15 to 19 years age group. This compares with 28 per cent of the 15 to 19-year-olds who live in the non-metropolitan areas of the state ( $X^2=3.6$ ,  $df=1$ ,  $p<.05$ ).

The highest rates occurred in the more remote and isolated areas of the state. The Kimberley and Great Southern Regions recorded age specific rates of 30 and 26.5 per 100,000 youth aged 15 to 24 years respectively. This is in contrast to the Perth metropolitan rate of 12.8 per 100,000.

Figure 1

### Age and Sex Distribution, Youth Suicide Western Australia, 1986-88



*Methods used in youth suicide*

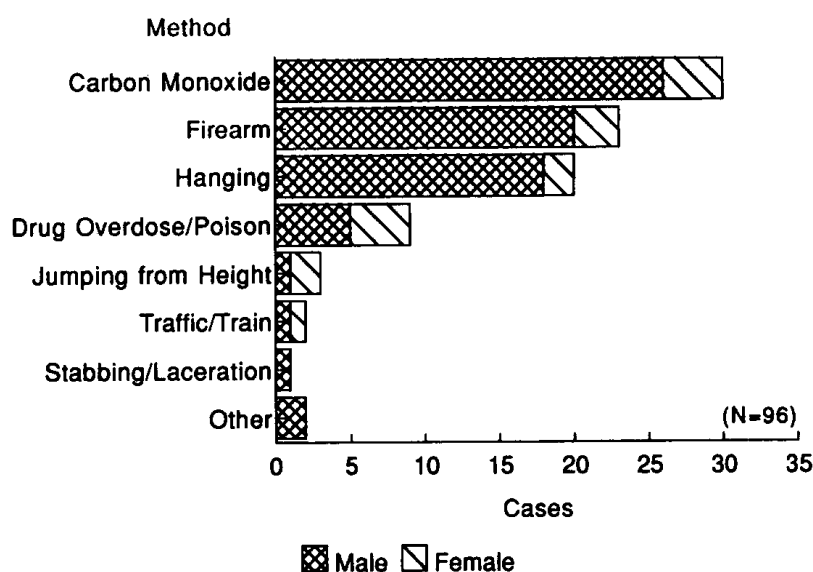
The methods of suicide used by males and females are shown in Figure 2. Over the three-year period studied the most commonly used method of suicide was carbon monoxide poisoning (32 per cent), followed by firearms (25 per cent), hanging (22 per cent), drug overdose (8 per cent) and jumping from a building or bridge (3 per cent). While hanging was equally represented in both metropolitan and country areas, other methods tended to reflect their availability, for example carbon monoxide, drug overdose and jumping from high places were more common in the city while the use of a firearm was twice as likely to occur in the country. Fifty-two per cent of the suicides committed the act in or around their home, 19 per cent went to a bush area, the remainder used a variety of other venues.

Of particular note was the fact that there was a substantial increase in the numbers of youth suicides by hanging in 1988 in comparison with previous years. In 1968 there was only one such death in this age group, in 1987 there were 5 and in 1988 there were 15. Comparison with aggregated ABS data (Australian Bureau of Statistics 1983) on method of suicide among youth in Western Australia over the period 1968-88 suggests that this represents a significant trend (see Figure 3).

During 1988 there was much media publicity given to a Royal Commission of Inquiry into Aboriginal deaths in custody. We were therefore interested in establishing how many of the youths who hanged themselves were Aboriginal and how many had done so in custody. Of the 13 people who died in custody in Western Australia during 1988, there were two whose cause of death was asphyxia due to hanging but none of these were in the age group 14 to 24 years. All but one of the 15 cases in this study who hanged themselves during 1988, were male and two were Aboriginal. Two-thirds (that is 10 cases) were resident in the metropolitan area of Perth. Two-thirds had recorded previous suicide attempts and one-third (5 cases) had multiple previous attempts which is double the corresponding rate of the overall study sample.

Figure 2

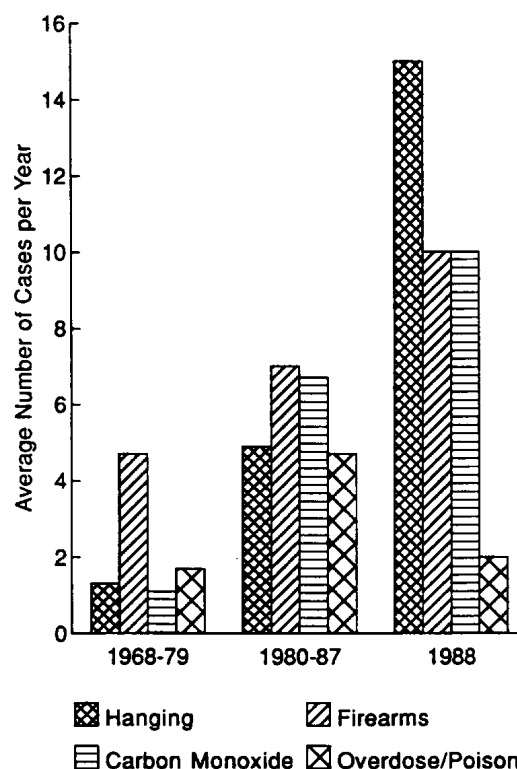
**Sex and Method of Suicide  
Youth aged 14-24 Years  
Western Australia, 1986-88**



As the date of death of these cases was not evenly distributed over the year, but tended to cluster around two particular months, the authors are currently examining whether these periods correspond with the number and prominence given to news reports regarding deaths in custody at that time.

Figure 3

**Trends in Method of Suicide  
Youth aged 10-25 Years  
Western Australia, 1968-88**



*Alcohol and other drugs at time of suicide*

At the time of death alcohol was detected in the blood of half of the cases. Of these three-quarters (that is 38 per cent of all cases) had blood alcohol levels over 0.05 mg/mL. Other drugs or substances were detected in 56 per cent of cases, with up to 4 drugs per case being recorded. Carbon monoxide was identified in 32 per cent of cases, minor tranquillisers in 5 per cent, antidepressants in 4 per cent, cannabis in 4 per cent, opiates in 3 per cent. Other drugs detected included anticonvulsants (1 per cent), Major tranquillisers (1 per cent), barbiturates (1 per cent), inhalants (1 per cent), and other chemicals and poisons (3 per cent).

The relationship between the drug detected and cause of death was also recorded. Apart from carbon monoxide which was present in lethal doses in 32 per cent of cases, antidepressants and anticonvulsants were found in lethal levels in all the cases where they were detected. In the cases where minor tranquillisers were detected, they formed part of a

lethal combination. Cannabis, opiates and 'other drugs' were only detected at levels said to be therapeutic or less.

#### *Drug abuse history and suicide*

One-third of the cases (31 per cent) were reported as having a history of drug abuse (including alcohol abuse). The drugs abused were alcohol (60 per cent), cannabis (27 per cent), opiates (3 per cent), and minor tranquillisers (3 per cent). (Note: more than one drug of abuse could be recorded for each person).

#### *Psychiatric history and psychological state*

Data were collected on the psychiatric history and psychological state of the suicide cases. It was found that 27 per cent of the 96 cases had sought professional help prior to the suicide. In most cases (73 per cent) this was a psychiatrist, in 20 per cent of cases it was a general practitioner and in one case it was a psychologist. However only 20 per cent of all the cases were receiving treatment at the time of suicide, and for 84 per cent of these, the treatment included medication, which was either antidepressants, minor tranquillisers, or a combination of the two.

Formal psychiatric diagnoses were available on most of the cases who were receiving treatment. These included schizophrenia (38 per cent), manic depression (6 per cent) other depressive disorders (17 per cent), anxiety disorder (6 per cent), personality disorder (22 per cent). In 71 per cent of the 96 suicides, family and friends told authorities that the person had been depressed for a period of more than two weeks prior to their suicide. Where a life stress event had preceded the suicide a record was made of the type of event. Figure 4 shows the distribution of these life-stress events for male and females. One half of the cases (49 per cent) had experienced relationship difficulties or a recent breakup of a relationship. Nineteen per cent (19 per cent) had recently lost their job. Sixteen per cent (16 per cent) were reported to have conflict with their families. Unemployment had been a factor for 13 per cent of cases and a similar proportion (13 per cent) were reported to be troubled by financial problems. Trouble with the law was reported in 12 per cent of cases; the death of a close family member or friend was reported as a significant stress for 9 per cent of cases; physical illness was reported as a stress for 7 per cent and a further 12 per cent were upset about their psychiatric illness.

Prior to the suicide, over one-third (36 per cent) of the decedants had told others of their intention to commit suicide and 33 per cent left a suicide note. One third of the cases (33 per cent) had made prior suicide attempts and half of these (16 cases) had made more than one attempt and one case had 10 prior attempts.

#### *Sex differences in youth suicide*

Females were more likely to be sober at the time of suicide than males. Sixty seven per cent (67 per cent) of the 18 female suicides had no alcohol at all, and 16 per cent had blood alcohol levels (BAL) of over 0.08 mg/mL. Forty-six per cent of the 77 males had no alcohol at all, the remaining male cases had BAL varying from 0.01 mg/mL to 0.18 mg/mL, 55 per cent of these had BAL of over 0.05 mg/mL.

Approximately one-third of both males (31 per cent) and females (33 per cent) were reported to have a history of drug or alcohol abuse. Only females abused minor tranquillisers and only males abused opiates; both sexes had histories of alcohol and cannabis abuse.

Males did not differ from females on the proportion of cases in which family and friends said that the person was depressed immediately prior to the suicide. Reports of depression

were present in nearly three-quarters of both males (70 per cent), and females (78 per cent).

A significant life-stress event in the period immediately prior to the suicide was identified for all but 14 per cent of males and 17 per cent of females (see Figure 4). Of the type of event identified, males and females only differed on report of relationship problems, which was an issue for 44 per cent of the females and 10 per cent of the males ( $X^2=4.7$ ,  $df=1$ ,  $p<.05$ ).

Females were more likely to have threatened to suicide prior to the act, with 33 per cent of females and 20 per cent of males making such a threat. They were also more likely to have made a previous attempt—55 per cent of females and 29 per cent of males having attempted in the past ( $X^2=4.67$ ,  $df=1$ ,  $p<.05$ ).

Females were more likely than males to have sought help from a professional prior to the suicide, 50 per cent of the females had sought help in contrast to only 22 per cent of 77 males ( $X^2=4.4$ ,  $df=1$ ,  $p<.05$ ). Females were also more likely to have had recorded histories of psychiatric treatment. Ten per cent (10 per cent) of males and 39 per cent of females had received such treatment ( $X^2=8.5$ ,  $df=1$ ,  $p<.01$ ).

Figure 4

**Precipitating Circumstances and Life-Stress Events, Youth Suicide  
Western Australia, 1986-88**



*Age specific characteristics*

Forty-six per cent of the cases were teenagers and 54 per cent were aged 20 to 24 years. These two age groups were compared on a range of demographic and clinical variables.

Both groups showed an essentially similar distribution of gender, ethnicity, and migrant status. The only demographic variable which differentiated between the younger and older groups, was metropolitan vs. country residence. There was an increased representation of younger cases in country areas and a corresponding increased representation of older cases in the city ( $X^2=3.5$ ,  $df=1$ ,  $p<0.1$ ).

Clinically, the younger group was more likely to have had conflict with their family ( $X^2=9.9$ ,  $df=1$ ,  $p<.005$ ), to be in trouble with the law ( $X^2=7.6$ ,  $df=1$ ,  $p=.01$ ), to have made suicide threats prior to their death ( $X^2=3.2$ ,  $df=1$ ,  $p=.1$ ) and had higher rates of adjustment and personality type difficulties as opposed to psychotic disorders such as schizophrenia.

They did not differ from the older cases with respect to the proportion of cases in their method of suicide, history of previous attempt and report of depression. They had both sought and received treatment at similar rates. A similar proportion of cases was reported to have a history of drug and/or alcohol abuse in both the younger and older groups. However, the older group were more likely to be intoxicated at the time of suicide, that is had blood alcohol levels (BAL) over .05 per cent at the time of their death ( $X^2=6.2$ ,  $df=1$ ,  $p<.05$ ).

As our initial choice of age grouping was made on the basis of statistical convenience, we considered that a more developmentally appropriate age-cut would be at the age when young people leave school. On repeating the analyses with those of school age, that is age 17 and less (19 per cent of cases) and those aged 18 to 24 years (81 per cent of cases), the only additional age specific differences to emerge were that females were more likely to be represented ( $X^2=5.9$ ,  $df=1$ ,  $p<.05$ ) and that there were no Aboriginal suicides in the school age group. The stresses of family conflict ( $X^2=17.4$ ,  $df=1$ ,  $p<.0001$ ) and trouble with the law ( $X^2=4.6$ ,  $df=1$ ,  $p<.05$ ) were again identified but were at more significant levels in the school age group.

### *Risk estimates*

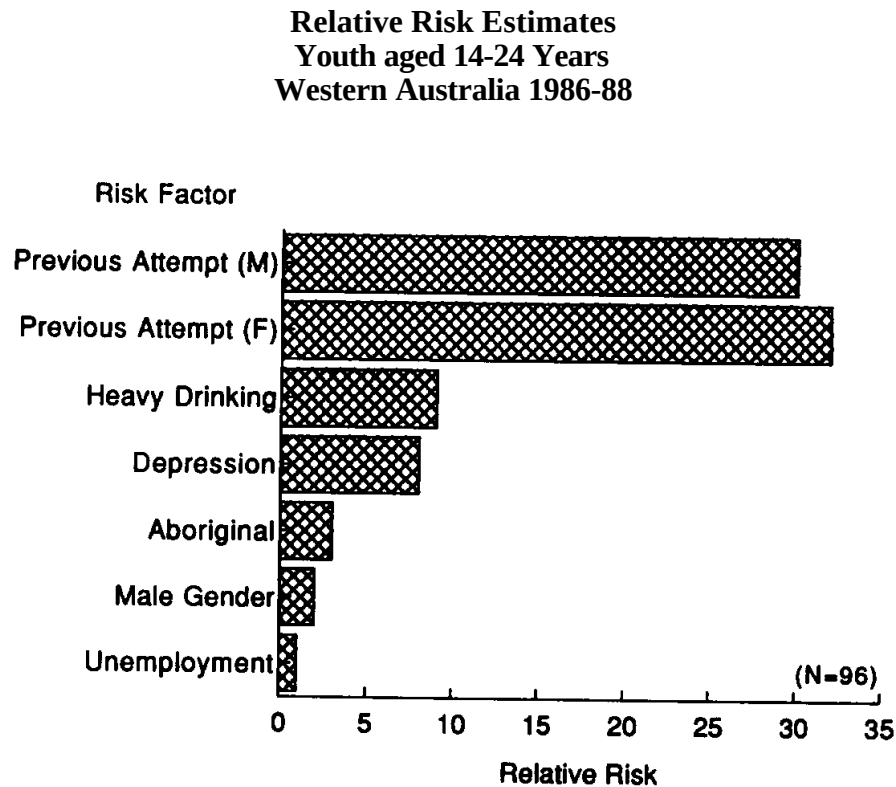
Relative and attributable risk estimates were derived by a comparison of the percentage of occurrence of specific individual characteristics in the suicidal population, to the best available estimate of the rate of each of those characteristics in the general Western Australian youth population (see Figures 5 and 6).

As there were no known prevalence data available on suicide attempt in the WA youth population, we used the Health Department of WA hospital discharge data to derive a conservative estimate of the cumulative total of youth in the 15 to 24 age group who had been admitted to hospital following a suicide attempt up to and including 1987. This suggested a lifetime prevalence of 0.94 per cent for males and 1.81 per cent for females of suicide attempt in this age group. Comparison with the percentage of study cases with prior suicide attempts revealed a relative risk (RR) of 30 for males and 30.9 for females. When adjusted for the population size of the affected group with known prior suicide attempts, this gave population attributable risks of (PAR) of 21.5 per cent for males and 35.1 per cent for females.

Estimation of the risks associated with depression was problematic for two reasons: firstly, information regarding the occurrence of depression among the 96 cases was only available from the retrospective reports of parents, friends and associates; secondly, the actual prevalence of depression in the WA youth population is unknown. The authors nevertheless chose to make their relative risk estimate using a prevalence figure of 9 per cent. This was chosen on the basis of rates of DSM-III type definition of depression of moderate diagnostic certainty reported elsewhere (Flemming et al. 1989). This also corresponded with the rate of significantly depressed affect reported in Reynolds and Robb's (1988) community survey of 600 Sydney adolescents. Using this figure the relative

risk associated with depression was estimated to be  $RR=7.8$  and the population attributable risk (PAR) to be 38 per cent.

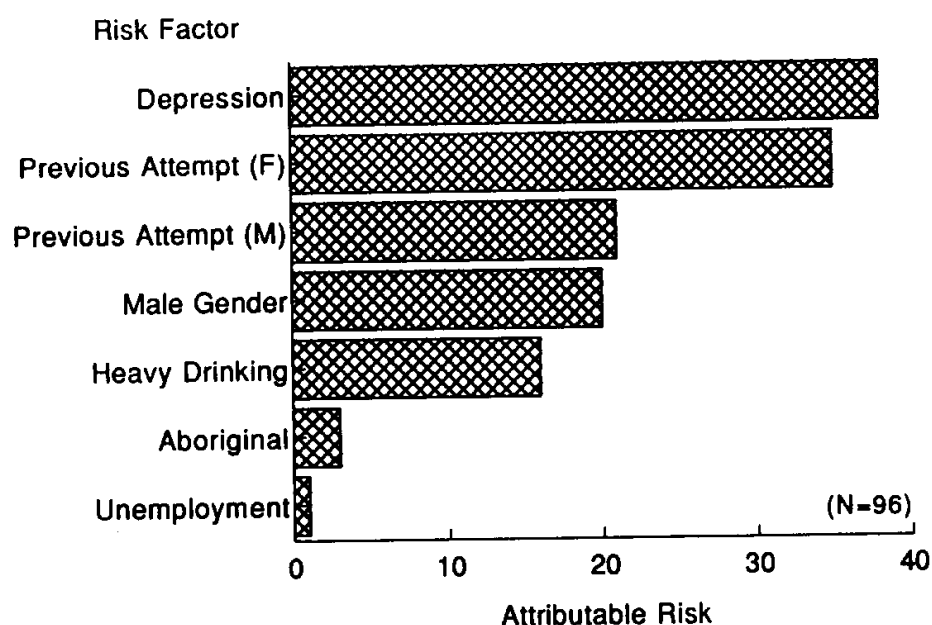
Figure 5



A history of heavy drinking was reported in 60 per cent of the decedants. This, when compared with recent community survey data (Australian Bureau of Statistics 1985) on the proportion of the WA youth population over the age of 18 years who are 'heavy drinkers', that is consume an average of six standard drinks (100 mL of alcohol) per day, yielded a relative risk for heavy drinking of  $RR=8.8$  and an attributable risk of  $PAR=17.1$  per cent. Other risk factors on which data were available, gave estimates for male gender ( $RR=1.5$ ,  $PAR=20.31$  per cent); Aboriginality ( $RR=1.9$ ,  $PAR=3.2$  per cent); and unemployment ( $RR=.76$ ,  $PAR=3.92$  per cent).

Figure 6

**Attributable Risk (PAR)  
Youth aged 14-24 Years  
Western Australia, 1986-88**



## Discussion

The goal in this study was to use coronial data to describe the clinical and demographic characteristics of a three-year sample of youth who suicided in Western Australia. An examination of gender and age specific characteristics was also of interest, to identify risk factors and to document possible contributory factors to the recent increase in the rate of suicide among Australian youth.

The conclusions which can be drawn from the findings are limited by the nature of the data which it was possible to code from records made for legal coronial purposes and the fact that tests of reliability were not undertaken. The problems inherent in psychological autopsy studies such as retrospectivity of data collection and the effects of the suicide on the informant and interviewer are well recognised. However, there is accumulating evidence from the few controlled studies undertaken elsewhere (Pettifor et al. 1983; Brent et al. 1988; Hoberman et al. 1988) to support the reliability and concurrent validity of data derived from such studies.

This study confirms the typical characteristics of youth suicides reported by recent North American studies. These include: male gender, particularly in the 18 to 19 age group; use of highly lethal methods; intoxication at time of suicide; past history of alcohol and drug abuse; recent depression and association with recent life-stress events such as the breakup

of important relationships and family conflict. In the majority of cases the suicide appeared to have been an impulsive action, made with little or no warning and was usually in response to some form of situational crisis.

Characteristics particular to Western Australia which might account for the recent increase in male rates are the over-representation of Aborigines; significantly higher rates (up to three times the metropolitan rate) in the more remote and isolated areas of the state; the over-representation of younger and school-age cases in country areas; recent increases in the proportion of suicides using highly lethal methods such as hanging and carbon monoxide; and the high proportion of cases with histories of drug and alcohol abuse.

The fact that over half of the males were intoxicated at the time of suicide would tend to support the views of Kreitman, 1976; Goldney & Burvill 1980, and Fowler et al. 1986 regarding the effect of drug use and increasing alcohol consumption among youth on the suicide rates in the younger age groups.

Of particular concern was the 54 per cent increase in youth suicide which occurred from 1987 to 1988. Almost half of this increase is accounted for by the number of young persons (15 cases) who used this method of suicide that year. We believe that the increase in the proportion of young people who took their lives during 1988 by hanging may have been affected by the media publicity given to the Royal Commission into Aboriginal Deaths in Custody which was prominent that year. Media reports during this time gave prominent emphasis to hanging as a method of suicide. Two-thirds of the fifteen cases who hanged themselves in 1988 had previously attempted suicide. By contrast only one-third of all ninety-six cases had prior attempts. This would suggest that these cases may have been particularly vulnerable to the imitative influence of such publicity. It also draws attention to the role of responsible media reporting in limiting such unintended effects.

The prevention of youth suicide is dependent on the ability to identify populations at high risk and offer interventions that modify these risks before suicide ensues. A recent review of youth suicide prevention studies (Shaffer et al. 1988) concluded that predicting who will commit suicide has frequently been dismissed as a futile enterprise in the general class of predicting rare events from common ones with all the problems of low specificity (high false positive rates). While they saw this as the principal failing of most prevention programs which adopt low-risk strategies, it may not apply to focused high-risk interventions, particularly as knowledge of specific risk factors improves.

Our identification of risk factors yielded figures which are similar to those reported previously on a smaller number of Western Australian teenagers (Silburn et al. 1988) and those reported on New York teenagers by Shaffer et al. 1988. History of previous suicide attempt was found to be the most readily identifiable risk factor with males having  $RR=30$  and  $PAR=21.5$  per cent and females having  $RR=31$  and  $PAR=35.1$  per cent. Heavy drinking ( $RR=7.8$ ,  $PAR=38$  per cent) and depression ( $RR=8.8$ ,  $PAR=17.1$  per cent) as the next highest risk factors have very much higher prevalence rates but present difficulties in identification, thus limiting their amenability in being targeted for preventive effort.

In conclusion, the authors believe that these findings lend support to preventive efforts aimed at enhancing the level of intervention and treatment given to identified high-risk groups. Such groups would include depressed young males presenting at hospital emergency departments with suicide attempts and students with significant depression identified in the school situation.

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# **YOUTH SUICIDE PREVENTION: A SCHOOL PERSONNEL TRAINING APPROACH**

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YOUTH SUICIDE IS RECOGNISED AS A GROWING HEALTH PROBLEM DESERVING OF attention and efforts to reduce its incidence and impact. Responsibility for acting in this regard has been considered to include a wide range of professionals and others who work or come into regular contact with teenagers. Amongst those seen as having an obvious role are the groups such as psychologists, social workers and medical personnel. However, youth workers, general practitioners, police officers and personnel working in schools are also perceived as having vital roles to play.

## **Youth Suicide and Schools**

School involvement with prevention of and intervention in adolescent depression and suicide has been a topic extensively discussed in the 1980s. While nobody is attributing the blame for a rising youth suicide rate on schools, questions are being asked about how schools can take a constructive and positive stance on the issue so as to assume a responsible and legitimate role in identification, intervention and prevention.

Frequent comments can be found in the literature outlining why schools have a part to play in assisting depressed and suicidal students. When referring to depressed adolescents Maag & Rutherford (1988) say:

School personnel can play a strategic role in early identification of depression. Children spend more time in school than in most other structured environments outside the home, and often have their most consistent and extensive contact with trained professionals in school. Schools represent an ideal milieu for assessing depression because students' behaviours, interpersonal relationships, and academic performance—all important indicators of mood and ability to cope—are subject to ongoing scrutiny.

School personnel are often in a position to be the first to notice developing depression (Maag & Rutherford 1988, p. 206).

Schools have become unavoidably and inextricably bound up with the issue of youth suicide. Although many schools prefer not to consider the issue of suicide and instead avoid the topic in the hope that it will never be a problem for them, this stance is no longer justifiable or acceptable.

## **Responsibility Regarding Suicide**

### *Practical efficiency reasons*

- School personnel are currently coming into contact with suicidal students in the course of their work (Gostelow 1990a). Suicide is thus a very real issue for schools and student services personnel particularly;
- school personnel are in a situation where the students they relate to have trust in them, look up to them as knowledgeable adults and are therefore likely to approach them or make them aware of suicidal intentions;
- prolonged contact with students over a period of time coupled with their knowledge of normal behaviour in young people, enables school personnel to be at the forefront in identifying students at risk of suicide;
- schools, by virtue of the regular and ongoing contact with students in a controlled environment, occupy a strategic and unique position to involve themselves in postvention (activities centred on counselling those staff and students suffering grief due to a loss through suicide).

### *Educational reasons*

- Depression, a major predictor of suicidal behaviour, is associated with reduced academic performance and learning problems. By addressing the depression, academic outcomes can be enhanced;
- suicide, while still being a 'delicate' and 'uncomfortable' topic for many, is a more acceptable topic for schools to include in the curriculum providing it is sensitively and appropriately handled. Teaching about suicide is defensible on a preventive level;
- crises such as suicidal behaviour in students (or staff) provide an ideal opportunity for schools to approach mental health issues like coping skills, problem solving and stress management. Schools and school personnel can model resolution of these issues for students in the way they deal with crises and involve students in their resolutions.

### *Social and moral reasons*

- Schools need to acknowledge that death of a student (or staff member) by suicide has a profound impact on the total school community—students, staff and parents. Schools need to be prepared for such eventualities as suicide and sudden death, and plan ahead to ensure they reduce the negative impact and

appropriately address all issues involved in helping those affected by death. By so doing they will also reduce the risk of suicide clusters occurring;

- schools have duty of care obligations. Professional responsibilities of school personnel go beyond simply teaching a specific subject area and include the general welfare of students in their care;
- the community now expects schools to assume a role in identifying and effectively dealing with suicidal students. Schools are expected to refer identified students on for help from the most appropriate agencies, but not to provide treatment themselves;
- schools and the Ministry of Education have an obligation to their staff to provide them with some training in the area. Given the fact that school personnel are in a position where they may face the warning signs of impending suicide and the effects of suicidal behaviour in the course of their work, they need training in how to recognise and deal with such students.

Schools are seen as being able to respond to the issue of suicide at three levels—prevention, intervention and postvention.

### **Prevention**

At the prevention level schools undertake activities designed to reduce the likelihood of suicidal behaviour amongst students. Such endeavours have been utilised extensively in the United States (Shaffer et al. 1988) and Canada (Alberta 1987). Preventive efforts have included:

- training staff to be able to identify, intervene with and refer students who need help;
- incorporating and/or coordinating educational programs which teach conflict resolution, decision making, stress management and other skills;
- including the issues of death, grief and suicide into school curricula;
- conducting parent awareness groups;
- liaison and developing links with community resource agencies;
- development of school policy and procedure documents on youth suicide.

### **Intervention**

Intervention level responses have involved school personnel identifying students at risk of suicide, taking appropriate action to assist and referring such students for professional help either within or outside of the school.

### **Postvention**

Postvention level responses are instigated in the event of a school experiencing a completed suicide or a number of suicide attempts. The aim of postvention is to recognise and deal with the needs of the school community—reduce anxiety, scapegoating and glorification and to reduce the likelihood of a contagion effect. At the same time efforts should enhance stability and a return to normal school routine. Naturally, postvention is often most efficient

and effective when it is conducted in an organised and considered manner. Thus many schools devise postvention procedures prior to crises occurring.

The phenomenon of suicide clustering in which awareness of one suicide creates an environment in which the probability of further suicides is increased has been described (Gould et al. 1989). It seems that one completed suicide provides the model for subsequent suicides by means of imitation or identification. It has also been argued that reporting of suicides may create a situation whereby suicide is seen as a normal and available means of solving life's problems.

The contagion process which leads to suicide clusters is something all schools need to be aware of and makes appropriate postvention efforts all the more important.

### **Roles of School Personnel**

The roles school personnel assume with regard to youth suicide vary between schools. However, the roles tend to be essentially based on professional position. The literature describes the tasks carried out by four main categories of personnel: administrators, teachers, school psychologists, counsellors and school nurses.

#### *Administrators*

Administrators hold a key role in regard to depressed and suicidal students. They have the power to decide if a school system will address the issues. Without their support and commitment, a systematic approach is virtually impossible, regardless of the enthusiasm of other staff. They typically lead postvention initiatives and model appropriate staff and student response behaviour in the aftermath of a suicide. Their role can also involve liaising with student services personnel, parent groups and community resources and they would usually be the media spokesperson in the event of a suicide. They are in a position to be able to oversee suicide prevention, intervention and postvention activities within the school. Resource deficiencies and school needs are something they are able to monitor and consider in conjunction with other staff. Details of administrator responsibilities have been provided by Franson (1988), Johnson & Maile (1987), McQuinn & O'Reilly (1989), Stevenson (1986), Thompson (1990) and Toepfer (1986).

#### *Teachers*

Teachers roles are described in the literature by Allen (1987), Bernhardt et al. (1988-89), Bogdaniak & Coronado (1987), Hunter (1988), Johnson (1985), Johnson & Maile (1987), McKenry et al. (1980), Osborne (1985), Pfeffer (1986), Powers (1979), Schuyler (1973), Smith (1976) and Strother (1986). Their role is considered to have four aspects:

- identifying students. Using a knowledge of warning signs they can identify students through classwork, classroom observation or playground observation;
- intervention with high risk students. Confronting students in a caring and open manner and initial action planning may be expected of teachers;
- referring students for professional assistance;
- classroom discussion or teaching on suicide is a required task of teachers in some situations.

#### *School psychologists and counsellors*

School psychologists and counsellors are key personnel for dealing with adolescent depression and suicide. Authors like Andreozzi (1988), Clarizio (1985), Fujimura et al.

(1985), Greuling & De Blassie (1980), Johnson & Maile (1987), Ray & Johnson (1983) and Reynolds (1986) detail how their role can include the following:

- consulting to and advising schools on suicide prevention, intervention or postvention in general;
- establishing, maintaining and monitoring the effectiveness of a system-wide program;
- working as a part of a response group or team of professionals in the school with the administration and other specialist staff;
- staff training and development;
- identifying of high risk students;
- intervening with and managing of high risk students;
- providing treatment for individual or small groups of students; and
- liaising with and referring students on to community resources.

### *School nurses*

School nurses have been described as having the capacity to perform a role similar to that of psychologists/counsellors. Valente & Saunders (1987) and Johnson & Maile (1987) consider nurses as people with a range of skills which help them in identification of students, consulting with schools, establishing and evaluating policy and procedure documents. They are less likely to have the counselling skills to engage suicidal students that psychologists and counsellors have. However, two features of their position enhance the role they can occupy.

First, they have an identified health function which makes it easier for students to approach them on the pretext of having a physical ailment. Secondly, they can make a physical assessment of a student who has just made an attempt so as to facilitate fast decision-making about treatment required.

In order for school personnel to perform the sorts of tasks outlined, they need input and training. This training will vary according to professional position, but is important to ensure people are able to perform what is required of them.

### **Western Australia**

The 1988 report on youth suicide prepared by the Youth Suicide Working Party for the Minister for Health listed a series of recommended changes in order to address the issue. Recommendation 3.3.8 relates to schools. It reads, 'that guidelines and inservice education be developed as a matter of urgency in conjunction with the Ministry of Education to facilitate the early identification and referral of students who may be suicidal' (1988, p. 24). Teachers, nurses and guidance officers (school psychologists) are all identified as those who have contact with, and may be the first to find out about, suicidal intent.

This recommendation has been followed up with the appointment of a Coordinator of Suicide Prevention in Education whose job it is to carry out training of key school personnel in the area of youth suicide.

The bridge between the recommendation and the work of the Coordinator was provided by some local research carried out by Gostelow (1990a). The study investigated secondary school professionals' understanding, perceptions and experience of adolescent depression and suicide. A sample consisting of 345 administrators, teachers, guidance officers and school nurses from across the state was used. The data provided a unique insight into their thoughts, actions, personal experience and desire for further training. In summary, the major findings showed that:

- most personnel reported contact with depressed and suicidal students in the past year;

- depression was considered to affect 10.4 to 20.1 per cent of students at any particular time. Between 1.7 per cent and 5.5 per cent of students were considered to have made a suicide attempt;
- a range of functionally effective beliefs about warning signs of depression and suicide were held. However, certain deficiencies and inconsistencies in knowledge were evident in all groups;
- personnel considered that they as individuals, their peers and other school personnel had roles to play in assisting depressed and suicidal students;
- guidance officers and nurses were perceived as the most important personnel in regard to developing competence in identifying students. They were also the people to whom referrals would be made;
- personnel considered a range of actions, like building trust, providing emotional support and referring students on for help, to be appropriate. However, inconsistencies within groups, confusion amongst individuals and uncertainties over role boundaries were evident;
- personnel rated their knowledge of proficiency levels in both depression and suicide as minimal;
- understanding in the areas had been acquired from incidental, informal and self-motivated means as distinct from formal or compulsory training;
- the vast majority of personnel expressed a need for inservice training in youth depression and suicide.

These findings provide a needs survey which indicated both direction and focus of training required and also baseline information against which training outcomes can be evaluated.

School personnel in different professional positions clearly see the issue of youth suicide as one which impacts on them; it is thus a real issue and one they feel under-prepared for. Acquiring more of an understanding is perceived as a need by the vast majority and they are willing to spend time obtaining this. Of note too, is the trust placed in guidance officers and nurses as people within the school system who have a lot to offer in regard to assisting suicidal students and supporting other staff by accepting referrals. Guidance officers and nurses also consider themselves to be the key people for dealing with suicidal students, defining a wide range of actions appropriate for themselves to take in their roles.

### **Training School Personnel: The Strategic Plan**

The position, Coordinator of Suicide Prevention in Education, was created at the end of January 1990. The appointment was made to address recommendation 3.3.8 of the Report to the Hon Keith Wilson, Minister for Health. Specifically it was intended that inservice training be developed and conducted by the Coordinator for school personnel in the area of youth suicide.

A decision was made that it would be most appropriate to devise a systematic training approach which facilitated dissemination of information and training input across the Ministry on a regulated and coordinated manner. Under this model, the training would be incorporated into the existing education district office structure with each district having its own clearly identified resource people to conduct training and raise awareness of youth suicide. In this way, two guidance officers per district (one of whom would preferably be the District Students Services Coordinator) would participate in workshop training aimed at enhancing their knowledge and proficiency levels.

They would then have the necessary expertise and materials required to train fellow guidance officers and ensure a level of competency in all guidance personnel. Once this

platform was established it would then be expected that these people would undertake staff training for all other levels of school personnel. The two initial workshop participants would maintain an ongoing consultancy and resource role for other guidance officers and all schools in the district. They would also train new guidance staff entering the district in the future. The model is shown in the Appendix to the Report.

A similar system was devised for training school nurses. Under this model, one school nurse per Health Department region would be involved in a two-day workshop training conducted by the Coordinator. It would be the task of these nurses to carry out further training of other school nursing personnel in their region. This model would ensure a nursing resource person was available to support nurses operating in schools and ensure training for new nurses starting in the system.

### **The Strategic Training Plan**

The strategic training plan involves the following steps:

#### *Development of a resource package for student services personnel*

This package needs to be comprehensive, locally relevant, provide a thorough background in the area and be practically useful. The content needs to be at a more sophisticated level and as such it will need to have sections on:

- facts and figures;
- myths and facts;
- warning signs, risk factors;
- models of cause;
- depression;
- intervention;
- postvention;
- prevention;
- legal considerations;
- training the school community;
- resource agencies;
- resource materials.

The package needs to be in a form which allows for easy use and updating as new information becomes available and to be sufficiently durable. A three-ring file would be most satisfactory.

This package will only be made available to guidance officers and nurses who undertake workshop training led by the Coordinator.

(Note: This document has just been completed and printing is underway. It is entitled *Youth Suicide Prevention: A Resource Package for Student Services Personnel* (Gostelow 1990b)).

#### *Development of a workshop*

This workshop will be specifically oriented around the Resource Package and the issue of youth suicide as it pertains to schools. It will be active and participatory, allowing participants to learn from each other and experiential exercises. The two-day format will provide a grounding in both knowledge and proficiency as well as suggestions on how to train others.

The workshop will be supplemented by video material. One of the tapes to be shown will be produced by the Coordinator and will show a discussion by a group of local experts on some of the more contentious youth suicide prevention issues.

*Training of key student services personnel from each Ministry of Education District and Health Department Region*

The two-day workshop will be used with a select group of two guidance officers per district and one nurse per region. Mixed groups will be used. While most training will take place in the city, there will also be a series of workshops in the country. A total of sixty guidance officers and eleven nurses will be trained. Each of them will receive a resource package and have access to the discussion group video for training others.

A small group of non-government guidance officers will also be trained. They will then be expected to use their expertise systematically with peers in Catholic and Independent schools.

*Training of other student services personnel*

This training will involve the key guidance officers and nurses conducting training for peers from their own profession. It will be done using the resource package and video. Formats will vary from district to district and may involve workshops, information sharing or discussion groups. This process will ensure a level of competence in all such personnel. The Coordinator will provide back-up and support at this stage.

*Development of a teacher training video*

A video for training school administrators and teachers will be developed. The video will include some factual information together with depictions of scenarios involving suicidal students and school staff. Role boundaries and referral procedures will also be outlined. It will be no more than thirty minutes long so that it fits neatly into staff meeting and professional development time allocations. The video will only be used by trained guidance officers as one facet of staff training endeavours and will not be used on a 'stand alone' basis. Access to the video will be controlled by the Coordinator.

*Training of other levels of school personnel*

This will be done within schools by the resident guidance officer, possibly in conjunction with the key district people. The nature of such input will vary according to situational and other variables. In most cases the teacher training video will be used as part of the input.

*Overseeing, supporting, monitoring and evaluating the training and information dissemination process*

This is an ongoing task essential to guaranteeing quality control and effective system-wide change. As this process takes place, modifications and improvements in the training procedure and resource package will be made.

Formal evaluation will include:

- pre and post testing of workshop participant knowledge and proficiency levels;
- surveying participants on how they have used their training in their work and in doing training of other staff;
- surveying participants regarding the Resource Package.

Informal evaluation will include:

- information gathered from other sources on every aspect of the process and Resource Package;
- observations made by the Coordinator.

### *Sharing the resource package with other departments and agencies*

Since much of the material in the package relates to youth suicide in general and how organisations can respond to the issue, it thus has applications in other settings. With adaptation, it could be made to fit the requirements for staff training and development in other government departments or non-government agencies. For this reason, a half-day seminar for appropriate people from a diverse range of settings (for example police, corrections, youth agencies, community services) will be conducted to raise their awareness of the package. Considerable interest has already been expressed in this idea.

Workshop training will be instigated for key people from these departments and agencies if there is sufficient interest. These people will receive a copy of the resource package.

### *Liaison and communication with the Youth Suicide Steering Committee*

The Suicide Prevention in Education project is one facet of a state-wide, integrated and coordinated approach to youth suicide prevention. As such, it is vital that progress updates be given to the committee and that the committee assess the effectiveness and direction of the Coordinator's work. This will happen at regular intervals.

## **Timeline**

The Suicide Prevention in Education project is such that a considerable amount of time and effort needs to be expended in the first few steps in order that the later steps operate effectively. If the resource package is of a high quality and extremely useful, it is likely to be used. If the workshop is informative and provides a good model for subsequent training by the participants, all parties will benefit. If the key guidance officers and nurses are well trained and enthusiastic about conducting further staff training, then they will follow through in their districts.

At the other end, it is vital that the Coordinator properly oversee, support, monitor and evaluate the training and information to personnel at all levels in the school system. Without this, the project may well lose direction and become piecemeal and uncoordinated, resulting in inconsistency across districts and school personnel missing out on training.

The Coordinator position should ultimately become obsolete and the system of spreading knowledge and proficiency self-sustaining. There will, however, have to be provision made for the task of updating the resource package as time passes and as new information in the area of youth suicide becomes available. In this way, it will remain a dynamic document fulfilling its purpose on an ongoing basis.

The timeline established is as follows:

|        |                                              |                       |
|--------|----------------------------------------------|-----------------------|
| Step 1 | Development of Resource Package              | Complete              |
| Step 2 | Development of Workshop and Discussion Video | June-July 1990        |
| Step 3 | Training of Key Personnel                    | August-September 1990 |

|        |                                                   |                         |
|--------|---------------------------------------------------|-------------------------|
| Step 4 | Training of other Student Services Personnel      | October 1990-June 1991  |
| Step 5 | Development of Teacher Training Video             | July-December 1990      |
| Step 6 | Training of Other School Personnel                | October 1990-June 1992  |
| Step 7 | Overseeing, Supporting, Monitoring and Evaluating | August 1990-June 1991   |
| Step 8 | Sharing Resource Package                          | November 1990-March '91 |
| Step 9 | Liaison and Communication with YSSC               | Ongoing                 |

### Summary

In recognition of the important role school personnel can play in identifying and dealing with youth suicide issues, a systematic approach is underway to train secondary staff in Western Australia. The approach involves a Coordinator developing a resource package and conducting workshop training for key student services people. These people will then be equipped to do subsequent training work with peers and regular staff. In this way, each school district will then have well-trained resource people and a systematic method by which awareness raising and appropriate level training can be carried out with teaching staff and other levels of school personnel.

The model holds great promise for enabling the identification of troubled students and referral of such students for appropriate assistance. The potential for preventing youth suicide is enormous.

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# **SWEPT UNDER THE CARPET: A COMMUNITY INITIATIVE TO YOUTH MENTAL HEALTH**

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THE PROBLEM IS TOO HARD, AND SOCIETY SWEEPS IT UNDER THE CARPET. However, mental ill`health is real for many young people as they grow up facing the social instability and difficult economic conditions of the early nineties.

Later on in life we like to think of adolescence as a carefree period in life, when we are not weighed down with adult responsibilities. We do not remember exactly how difficult the transition itself is from childhood to adulthood. We forget about how perplexing the process of sexual and emotional development can be, and how worrying it is, preparing to take an adult place in society and earn a living. In general, there is great reluctance to acknowledge the existence of serious mental health problems among many young people. Or, there is a pretence that the problems happen elsewhere and do not transcend social, economic and cultural boundaries.

New Zealand society's ability to acknowledge these problems has been hampered by the belief that New Zealand is a great place to bring up children. While, on the whole, it seems that New Zealand does provide young people with many opportunities, this belief is hindering our ability to recognise their mental health needs.

The reality is that many young people do have trouble in making the psycho-social adjustment of adolescence. Understandably, the very high rates of youth unemployment, the fear of joblessness, and the prevailing materialistic, worldly values that equate individual success with wealth, good looks, and power make many young people feel quite worthless and cast out by society. Fatalistic attitudes are found more and more among young people. The threat of nuclear annihilation, AIDS, and lack of economic prosperity make the future uncertain, and reduce inhibitions about high risk behaviour. Broken relationships, unhappy family backgrounds, confusion of cultural identity, or other influences can destabilise many young people. Then their anxieties can become overwhelming.

It was with this knowledge that the Youth Mental Health Project was initiated by the National Youth Council. The Council is the coordinating body of the voluntary youth sector in New Zealand and has a long history of bringing to the public's attention the issues facing young people. Through its contact with those working in the youth field, the Council saw

there was an urgent need in the area of mental health but very little specific youth-oriented work was being done. The main stimulus for the project was the steadily increasing rate of suicides and parasuicides amongst young people. Youth workers were regularly coming into contact with depressed young people who were considering suicide as a viable option to solving their problems.

A study by Antoniadis (1988) showed that the rate of actual suicide for young men between 15 and 19 has increased more than three times since the 1960s and has more than doubled for young women. The rate for males in the 20 to 24 age group has gone up by over 100 per cent in the same period, although the rate for females rose by only 10 per cent. In addition, data based on 1984 hospital admissions for self-inflicted injuries indicate that about 1 in every 600 people aged between 15 and 24 attempt to kill themselves every year.

The project began with the single straightforward (and some might say naive) goal of reducing the rate of youth suicide. However, it became obvious right from the start that the project would need to insist on a holistic idea of mental health that takes the physical, emotional, and spiritual dimensions of well-being into account. It was the belief of the project that a purely medical model was not appropriate for addressing the mental health needs of young people.

The primary prevention strategy of the project, therefore, was the promotion of mental healthiness and empowering young people with skills and knowledge to cope with the problems they faced. This decision was also heavily influenced by the work of Shaffer and his colleagues at Columbia University on the efficacy of youth suicide prevention programs (Shaffer 1988) which showed that school based education programs did not have an impact on the reduction of youth suicide.

The project had a duration of fourteen months. A steering group with representatives from mental health, health, education, and youth fields was established and funding obtained from the Child and Youth Development Trust. A small staff of four was employed, consisting of a coordinator, clerical assistant, journalist and cartoonist.

The main formal activities that the project undertook were in communications, production of resource materials, and training. Through its steering group and staff activities, the project also provided a valuable informal opportunity that would not otherwise have existed, for people working in youth mental health to report on what was going on nationwide, and discuss what should be done about it. It was this gathering together of knowledge and experience that provided most of the foundation for the conclusions and recommendations of the project. Almost no research has been done on youth mental health in New Zealand and there is a need for it in order to define the key areas for action.

## **What the Project Found**

In general, the public is unaware of and does not understand the mental health of young people. This lack of understanding also percolates into many areas of decision making. The youth mental health aspect is ignored and left out of many policies, programs, and services where it could easily be incorporated.

There is widespread misunderstanding of young people and of the way they think by the adult world. Few adults are adept at the youth culture yet the success of any program or service requires an understanding of how young people inter-relate, communicate and perceive the adult world. Unless factors such as the collective nature of young people, 'youthspeak', the power of image and fashion, and the desire to belong are understood then we will continue to miss the mark with the services and the resources we provide. One way to be sure that we are targeting our resources adequately is to consult with young people.

Young people are very direct and will not put up with adult compromises, which they take for duplicity. They switch off when they detect pretence of any kind. To be of any

use, it is essential that mental health programs and services are youth oriented and personnel are specially trained in working with young people. Adolescents prefer services staffed by younger people, whom they find less intimidating and easier to talk to.

In a recent series of consultations with young people about health conducted by the Office of Youth Affairs, the first thing young people asked for, in one way and another, was good basic information on health—how to look after themselves. They saw this as holistic, with good physical health leading from good emotional and mental health, and vice versa. They wanted straightforward information without lectures on matters like drugs, alcohol, contraception, stress and crisis management, peer pressure and sexuality. Information on these topics was expected from the education and public health systems, through various media: print, radio, television, video, and the classroom.

The second thing young people asked for was easier and cheaper access to medical and mental health care. The cost of services was a major deterrent to seeking help. The staff in the services was also a major influence on whether help was sought. If it was felt that the staff did not like young people or did not listen to them, then often they preferred not to go. The environment of the service was also important. Clinical settings were seen as alienating and often not welcoming, also if the access to the service was in a too public place there was the fear of being seen going in to the building. An example often cited was the positioning of the school counsellor's office in the administration block, often near the principal's office or in a place where there was much activity and everyone could see who was waiting to see the counsellor.

Finally young people were worried that their point of view was frequently misunderstood or ignored when decisions were made that affected them. This contributed to their sense of powerlessness. They wanted their voice to be heard.

Throughout the project, the most common problem was the lack of services and resources that were targeted at young people. In some areas, it is commonplace for young people to have to wait up to six weeks to see a counsellor—or pay fees they cannot afford. The high burnout rate among youth workers is a clear indication that the demands on them are increasing and they cannot cope.

Existing mental health services do not provide a range of solutions to meet differing needs. And they are not adequate to meet total demand, anyway. Staff are often not adequately trained to work with young people. In most professional training, little or no training is giving about the special skills required to working effectively with a young person. Youth is usually only covered in the human development module and often given scant attention.

The main options are psychiatric units or hospitals. The need is for youth oriented alternatives such as safe houses and youth refuges, therapy groups, daycare and more outpatient services.

Phoneline services have provided and continue to provide an important service. On two recent occasions when Television New Zealand screened documentaries—one on youth suicide, the other on safer sex—they provided a toll-free 'phone service. On both occasions, the phone service was inundated with calls from young people, especially from rural areas or areas where there are no 'phone services provided. Some young people who rang had never before talked to anyone about some major problems they had been experiencing for years. The provision of more toll-free services is seen as an important mental health service provision in isolated areas. Many young people are unable to ring services without having to explain to their parents what a certain toll call is for. The importance of confidentiality was seen as a paramount issue.

In the youth health consultations, preference was given to peer counselling as provided by Youthline but young people would still use adult services if nothing else was available. However personnel on existing adult oriented services require more training on how to work

with young people. The anonymity of phonenumber services was the major attraction as often young people felt very ashamed about their problems and did not want to talk with someone in person.

These are just a few of the issues that the project encountered in the fourteen months it operated. Because the lifespan and budget was limited, it was necessary for the project to focus on particular projects and to do these well, rather than try and tackle all the problems that required attention.

### **Communication and Liaison**

Mainly through radio, television and the press, the project worked to improve public understanding of good mental health for young people in the late 1980s, and the impact that social issues was having on their lives. This was achieved through appearances on talkback radio shows, issuing of press releases, giving interviews and speaking at conferences, community forums and other meetings.

The project also liaised with government departments. Although time consuming, this was important because a great deal could be achieved if youth mental health were taken into consideration as an integral part of policy. Many government officials were enthusiastic about the project and keen to cooperate. Liaison with government was also important in order that activities might carry on and develop after the project finished.

### **Production of Resources**

Good basic information was another one of the main things that young people asked for. The philosophy of the project was young people addressing the problems affecting young people. Our energy was to empower young people to cope with the pressures they faced. A young journalist and artist were employed to produce a publication called *under pressure*. This was a major tool in increasing understanding and coping skills among young people. The project produced *under pressure* as a booklet and a pamphlet. They are colourful and use a comic strip format, attractive to young people. They actually pick them up and read them.

The message of the pamphlet is simple. It encourages young people who are at risk to recognise what is happening to them and seek help. The booklet is more detailed. It aims at developing and strengthening the ability of individuals to cope with their difficulties such as lack of self-esteem, alienation, isolation, peer pressure, and sexuality.

The initial print run was 20,000 pamphlets and 10,000 booklets. By the end of the project, 115,000 pamphlets and 75,000 booklets had been printed and distributed. The booklet is now the responsibility of the Department of Health which is regularly having to reprint it to meet the still constant flow of orders. The demand shows the real hunger for resource materials. Youth workers and school counsellors commented that *under pressure* provided something for the first time that prompted young people to talk about their difficulties.

There is also the need for other resources using video, drama, creative writing and music to help facilitate mental health promotion. The Department of Health has just recently launched a new video and booklet on friendships called *Together as Friends* which builds on the messages of *under pressure*.

## Training

A major need identified by workers with young people was training in the areas of suicide detection, intervention and post crisis support. It is the frontline workers that often first come into contact or notice that a young person is in a crisis, yet few have had any form of training that will assist them to deal with crisis and ensure that the young person is assisted and supported through the crisis. The project provided training courses to youth workers, social workers, nurses and school counsellors throughout the country. All courses were well attended and evaluations indicated the desire for more courses to be offered. An area of particular concern was the lack of knowledge about the cluster suicide phenomenon and strategies to deal with it.

The area of training has been ongoing. Workshops, through the office of Youth Affairs, have been presented over the past two years. All main and provincial cities have been visited where two types of workshops have been presented. The first workshop is aimed at school counsellors and nurses, social workers and other professionals who work with young people. Topics covered in the workshop include Youth Culture, Attitudes to Suicide, Warning Signs, Ways to Help, Cluster Suicides and Postvention Strategies. Through small group work, use of videos and role plays and exercises, the participants are lead through a process which helps them understand the world of young people and gives them a stronger skill base to confidently assist someone who is suicidal.

The second workshop is for community based people who work with young people. Participants in this workshop include voluntary youth leaders, community youthworkers, crisis telephone volunteers, clergy, parent support group workers. The second workshop is similar to the first except the postvention strategies covered are more geared to a community setting as opposed to a school situation.

The next phase of training that is planned to be undertaken is training of general practitioners and health professionals in the use of an imminent suicide risk assessment manual which was developed at Columbia University. After this group, it is hoped that the training will be extended on the use of the manual to community people who work with young people.

Another concern has been the ability of many schools to cope with the aftermath of a suicide by one of its pupils. Experience has shown that many schools have not responded adequately to the tragedy of the suicide and staff have often responded in a state of panic. The way a school responds to a suicide can have a major bearing on keeping in check an outbreak of cluster suicides. This has been documented in writings by Poland (1989) and Pfeffer (1989).

This concern has been addressed by the provision of workshops for schools in developing a policy on death and dying and a crisis management strategy which can be implemented in the event of a suicide. The strategy can also be implemented in the event of a sudden death such as a motor vehicle accident or other serious crises within a school. For instance, some schools have used the strategy after a major fire to help the students deal with the loss.

The workshop has now been put into a booklet called *In A Time Of Crisis* (Taylor 1990), and has been distributed by the Office of Youth Affairs to all schools in New Zealand. It is based on strategies that have been developed in Canada and the United States and adapted to New Zealand needs taking into account different cultural perspectives to death and dying. It has now been used in several schools and is evaluated after it has been implemented. Counsellors in schools have eagerly welcomed the booklet and have asked for more workshops on implementing the recommended strategy.

It seems that the training workshops have given professionals the confidence to deal with a suicide situation. Because it is not a common situation and there is a taboo around

suicide, many professionals feel inadequate when a suicide situation arises and often lose confidence in their skills. The odds seem so much greater when dealing with a suicide. This loss of confidence can result in an awkwardness which the young client can interpret as uncomfortableness and may hinder a sharing of feelings and thoughts. The young person in crisis is often relying on the professional to be a stable force in an unstable time. While nothing can prepare a professional for a suicide situation, it is the author's belief that training enables the professional to think about their response to a suicide and the confidence to respond using the skills they already have as counsellors and those they learn in the workshop.

In conclusion, it is necessary to stress the urgent need for the mental health profession to address more seriously the whole area of youth mental health. To be serious about suicide prevention, is also to be serious about mental health promotion. Mental health needs of young people have been neglected for far too long. Action is required now. The provision of services must be looked at as well as the model which operates. Successful mental health promotion and treatment needs a much broader base than the medical model. Workers with young people and young people themselves can help mental health professionals to ensure that the service they provide is meeting the holistic needs of the client group. A partnership between mental health professionals and the community will ensure a better deal for young people.

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# POSTVENTION IN ADOLESCENT SUICIDE

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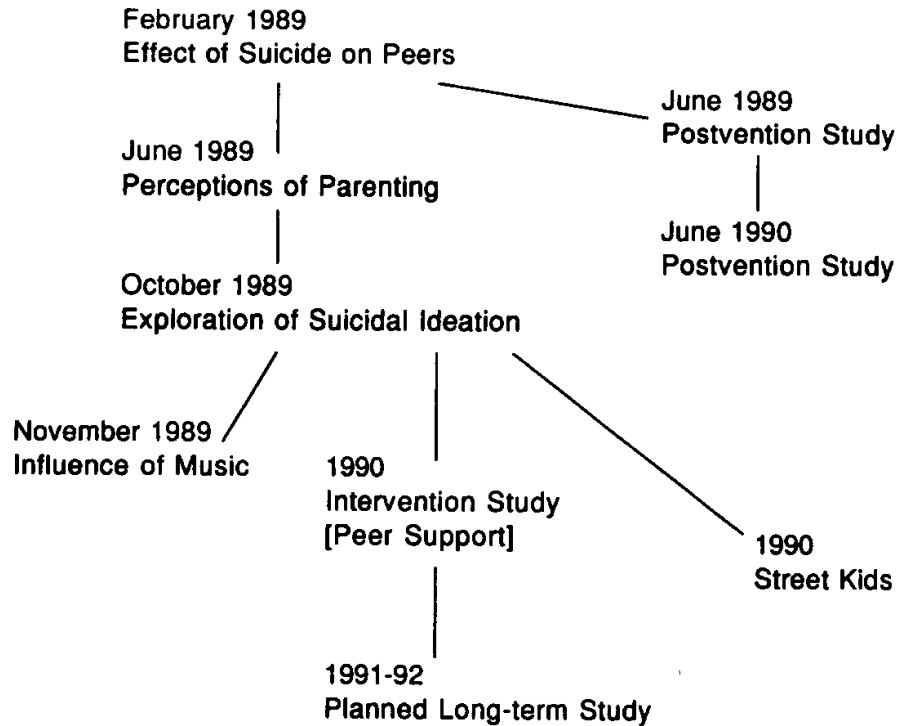
IN 1988, THREE DEATHS OCCURRED WITHIN EIGHT DAYS OF EACH OTHER, TWO students being from the same school. The first boy, a high achieving year 11 student who was 16 years old, took a lethal overdose of a mixture of medications. This followed what seemed to be recurrent depression and some family difficulties, neither offset by apparently good peer relationships and support. The death was followed by appropriate mourning and the funeral at the school, and a memorial service attended by family members, staff and students. The evening after the funeral one of the young pallbearers (18 years old), while attending a party, fell down a staircase and did not survive the consequent head trauma. Two days later, a year 8 boy who was thirteen, pulled the trigger of a loaded gun held to his head as his parents opened the door of his room. Again, the death was followed by a memorial service at the school.

The surviving family members of the two school students were referred separately to Southern Child and Adolescent Mental Health Services (CAMHS) in Adelaide for family grief work and support. The school counsellor, school chaplain and other senior staff were assisted with grieving students and staff over subsequent months by three senior professionals from our organisation and a number of close friends and classmates of the year 11 boy were offered several group sessions by an adolescent support team. Three months later, parents in the school were offered a session on Parenting the Teenager, a thinly disguised attempt to assist parents still suffering from the deaths and anxious about the possible effects on their own teenagers.

These events led not only to a broad network based clinical process within the community, but also to an ongoing series of research projects (see Figure 1) aimed ultimately at understanding all the factors which underpin adolescent suicide so that we may intervene to reduce the tragic and increasing loss, in particular, we became interested in completed suicide as a factor in subsequent suicide of others—that is contagion or the 'copycat' effect.

*Figure 1*

**Series of Research Projects**



**The First Study**

The literature on teenage suicide reports some evidence for a completed suicide having an influence on others leading to 'copycat' effects (or contagion) and 'clustering' (Motto 1970; Phillips 1977; Goldney 1989), whether this is a direct local effect or through reporting in the press. There is argument about such an effect and it is not clear how it may be mediated. However, the proximity in time of the deaths (at least two of which were probable suicide) led to the belief that there was a connection and, as a result, there were concerns about the effects of the suicides on other students in the school, particularly those close to the deceased. It was decided to investigate precisely what the effect of the deaths was on those remaining at school.

In early 1989, during the preliminary negotiations with the school, concerns were raised that a questionnaire about suicide might itself influence young people to attempt suicide, particularly those upset by what had occurred. A compromise resulted and it was agreed to investigate only students in year 10 (aged 13 to 17) that is, no student from either year in which deaths occurred. Interpretation of results to be presented should take into account the possible 'watering down' of any effects shown by the students not having had a day-to-day contact with the suicides prior to death. Students from the index school were compared with year 10 students from two other coeducational schools of similar demographic background.

The following hypotheses were tested:

- that knowledge of a completed suicide of a peer is associated with increased suicidal ideation among adolescents attending the same school;
- that knowledge of a completed suicide of a peer is associated with increased depression among adolescents attending the same school.

In addition, we sought to confirm previous reports that associations exist between depression, suicidal ideation and acts of deliberate self-harm in adolescents.

## Questionnaire

A composite self report questionnaire was prepared, including questions on behaviour and self-esteem, suicidal thoughts, deliberate self-harm, risk-taking behaviour, drug and alcohol use, and reported exposure to a variety of real and television events. The results from self report risk-taking and drug and alcohol use questionnaires are reported elsewhere (in preparation). The questionnaire included the Achenbach Youth Self Report (YSR)—it seems that numbers are appropriate sometimes, words, sometimes—which relates to the previous six months and contains a 'Depressed' subscale. This was used to provide a measure of depressive thoughts and affect. We used question 18 ('I deliberately try to hurt or kill myself') to provide information on what we have termed 'deliberate self-harm' and question 91 ('I have thoughts about suicide'), for information about suicidal ideation.

## Results

Questionnaires were returned by 357 individuals. Response rates of fully completed questionnaires were 92 per cent for the index school and 87.5 per cent for the controls. The mean age of the students was 14 years with a range of 13 to 17. There was no difference in mean age between schools. The ratio of males to females was M159:F 198 (M 44.5 per cent:F 55.5 per cent). There was no significant difference in the ratio between the index school and controls.

### *Reported exposure to suicide*

Overall, 263 students (74.9 per cent) reported that they had not been exposed to completed suicide in the past year, 75 (21.4 per cent) reporting having been exposed once or twice and 13 (3.7 per cent) reporting exposure more than twice. As expected, more students from the index school reported exposure to suicide than students from control schools. Of the index school students, 47.4 per cent reported exposure once or twice in the past year and 8.4 per cent reported more than two exposures. In contrast, 11.7 per cent of the control students reported exposure once or twice and 1.95 per cent reported more than two exposures. Within the control group, more students from the school geographically closer to the index school reported suicide than from the more distant school. There was no significant association between school attended and degree of reported exposure to suicide on television where only 110 claimed no exposure. One hundred and fifty-seven claimed exposure to one or two episodes and 85 claimed exposure more than twice.

Overall, more girls (30.3 per cent) claimed to have been exposed to completed suicide than boys (18.6 per cent), but the difference was smaller for the index school (F 66.0 per cent:M 48.7 per cent) even after excluding the students new to the school in the current

year. In contrast, with television suicide girls in the study overall claimed to have seen fewer episodes than boys (girls 35.8 per cent 'Never' as opposed to boys 25.8 per cent: girls 20.2 per cent 'more than two' as opposed to boys 28.9 per cent).

## Depression

Because the Youth Self Report 'depressed' subscales are constructed differently for males and females, data relating to depression is presented differently for boys and girls. The mean depressed subscale score for males was 11.32 with a range of 0-29.

Eight males (5.26 per cent) scored over the 2SD cutoff suggested by Achenbach for case identification and could be considered to be of clinical significance. Analysis of variance showed no significant difference between the means of index and control groups. For females, the mean depressed subscale score was 18.40 with a range of 0-50. Fourteen females scored over the 2SD cut off for case identification and could be considered to be of clinical significance. Analysis of variance suggested there was no significant difference between the means of index and control groups. Of particular note, there was no statistical evidence of higher levels of reported depression in the index school.

### *Depression and knowledge of a suicide*

Both for males and females, a significant difference in mean depressed subscale scores existed for those claiming exposure to completed suicide when compared with those claiming no exposure (see Table 1).

Table 1

#### **Depression and Suicide Exposure Mean Depression Subscale Scores**

| Sex     | No Suicide Exposure | N   | Claimed Suicide Exposure(s) | N  | F Test | p =   |
|---------|---------------------|-----|-----------------------------|----|--------|-------|
| Males   | 10.63 +/- 5.83      | 122 | 14.43 +/- 9.14              | 28 | 8.23   | <.005 |
| Females | 16.77 +/- 9.68      | 133 | 22.07 +/- 10.10             | 58 | 11.80  | <.001 |

In contrast, no difference in means existed for either males or females between those claiming exposure to television suicide versus those claiming no exposure.

When comparing index versus control groups, a positive association between reported exposure to suicide and higher depression score reached significance only in the control group (see Table 2).

Table 2

#### **Depression and Suicide Exposure Mean Depression Subscale Scores**

| Group   | Sex     | No Suicide Exposure | N   | Claimed Suicide Exposure(s) | N  | F Test | p =   |
|---------|---------|---------------------|-----|-----------------------------|----|--------|-------|
| Index   | Males   | 10.60 +/- 5.49      | 20  | 13.83 +/- 6.80              | 18 | 2.62   | .11   |
|         | Females | 17.55 +/- 8.88      | 20  | 19.67 +/- 9.71              | 33 | .63    | .43   |
| Control | Males   | 10.64 +/- 5.92      | 102 | 15.50 +/- 10.46             | 10 | 5.23   | .024  |
|         | Females | 16.63 +/- 9.85      | 113 | 25.24 +/- 9.90              | 25 | 15.62  | .0001 |

*Suicidal ideation*

Of students at the index school, 33.3 per cent claimed to have had suicidal thoughts at some time compared with 24.5 per cent for the controls. The difference did not reach statistical significance. The percentage of males claiming suicidal thoughts was lower overall but the difference did not reach statistical significance.

Overall, 12 of the boys claimed to think about suicide often as opposed to 15 of the girls. Of importance, 'frequent suicidal thought' as a question discriminated 8 out of 14 females defined as depressed (although the other 6 all claimed to have suicidal thoughts sometimes). Further, it discriminated 3 out of 8 males defined as depressed (of the other 5 only 2 admitted to having suicidal thoughts sometimes). Table 3 shows the mean depression subscale comparing 'no thoughts of suicide' with claimed 'thoughts of suicide'. Given that the YSR for girls aged 11 to 18 contains the question on suicidal thoughts as part of the depression subscale, the scores on this one question were removed from the subscale prior to analysis. Analysis of variance shows the difference in means to be statistically significant to both male and female groups to the .01 level (Scheffe).

*Suicidal thoughts and reported exposure to suicide*

A significant association existed between claimed exposure to completed suicide and reported suicidal thoughts for the group as a whole. Surprisingly the association was greater within the control group, results at the index school not reaching significance.

Table 3

**Depression and Suicide Thoughts  
Mean Depression Subscale Scores**

| Sex     | No Thoughts<br>of Suicide | N   | Claimed<br>Thoughts<br>of Suicide |    | F Test | p =   |
|---------|---------------------------|-----|-----------------------------------|----|--------|-------|
|         |                           |     |                                   | N  |        |       |
| Males   | 10.05 +/- 5.89            | 118 | 15.74 +/- 6.41                    | 34 | 23.62  | .0001 |
| Females | 14.80 +/- 8.25            | 133 | 26.40 +/- 9.43                    | 60 | 74.80  | .0001 |

*Deliberate self-harm*

Of the total population of students, 4.3 per cent claimed to deliberately hurt or try to kill themselves often and 11.7 per cent claimed to deliberately hurt or try to kill themselves sometimes. There was no sex difference (26 males and 30 females overall claimed to hurt or try to kill themselves at some time). There was no association between deliberate self-harm and being at the index school.

*Deliberate self-harm and reported exposure to suicide*

A strong association was found to exist between reported exposure to completed suicide and deliberate self-harm. Although more females reported deliberate self-harm and exposure to suicide more commonly than males, the association between these items was not significant for females.

A strong association between experience of suicide and claimed acts of deliberate self-harm existed at control schools but such a statistical association did not exist at the index school.

A strong association existed between claimed experience of suicide on television and deliberate self-harm. As with completed suicide, the association was stronger for males than females. The numbers were too small for between school comparison.

#### *Deliberate self-harm and suicidal ideation*

A strong association was found between claimed acts of deliberate self-harm and thoughts of suicide both for males and for females. A similar association was also found for the index group and controls.

#### *Deliberate self-harm and depression*

Table 4 shows the mean depression subscale scores comparing to deliberate self-harm with 'claimed deliberate self-harm'. As the question on deliberate self-harm is part of the depression subscale of the YSR for girls aged 11-18, responses to this question were removed from the subscale prior to analysis. Analysis of variance shows the difference in means to be statistically significant for both male and female groups to the .01 level (Scheffe).

Table 4

#### **Depression and Deliberate Self-Harm Mean Depression Subscale Scores**

| Sex     | No<br>deliberate<br>self-harm | N   | Claimed<br>deliberate<br>self-harm | N  | F Test | p =   |
|---------|-------------------------------|-----|------------------------------------|----|--------|-------|
| Males   | 10.31 +/- 5.87                | 127 | 16.48 +/- 6.86                     | 25 | 21.81  | .0001 |
| Females | 15.95 +/- 8.39                | 164 | 28.55 +/- 9.20                     | 29 | 54.02  | .0001 |

Positive responses ('Sometimes' and 'Often') to the question on deliberate self-harm for females correctly 'identified' 10 out of the 14 cases of depression missing four who denied such acts. A further 19 cases were 'identified' as false positives though six of those had scores in excess of 31.

Similarly for males, positive responses ('Sometimes' and 'Often') to the question on deliberate self-harm correctly identified four out of the eight cases of depression, missing four who denied such acts. A further 20 cases were identified false positives though eight of those had scores in excess of 17.

In summary, although more adolescents reported exposure to suicide at the index school, this was not associated with higher levels of depression or deliberate self-harm despite a slight increase in the number of those with thoughts about suicide, particularly among female students. Hypothesis 1 was sustained while Hypothesis 2 was not. Strong associations were shown to exist between depression, deliberate self-harm, suicidal ideation for the study and comparison groups taken as a whole, thus confirming the previous reports. In addition strong associations existed between these latter three and claimed exposure to suicide for the study and comparison groups taken as a whole, though this was not so at the index school. We believe that the evidence points to a group existing in each of the schools who report themselves as depressed and suicidal. This group could be called 'vulnerable' or

'at risk', and they appear to be more prone to awareness of a completed suicide than other students. We would further postulate that they are then placed at an increased risk for acting out suicidal impulses. We would postulate that what occurred at the index school was that this vulnerable group was supplemented by the large number of other students knowing about the deaths in their school. This additional group certainly then had thoughts about suicide, but levels of depression and acting out of impulses did not occur (or probably, more accurately, did not already exist) thus accounting for the lack of associations with suicidal ideation in results from the index school.

Despite the fact that we had studied year 10 students, it was clear that completed suicide had an impact in increasing the level of suicidal thoughts in other years within the school. The questionnaire appeared to be of value in discriminating those who in addition were part of what we have termed a vulnerable group.

## **The Second Study**

As the results of the first study became available, a completed suicide (a girl aged 16) occurred in another secondary school in Adelaide. Within days, the family had been referred to the author for grief work. As part of their search for understanding of why the suicide might have occurred, they offered the girl's personal diary, an audiotape made on the evening prior to her death, and several hundred scribbled notes passed between students in her class which had been hoarded. The search for understanding with this particular girl is the subject of other work (in preparation), but the postvention work will be presented here.

From the diary and the notes, a wide circle of named friends emerged. This list was discussed with the year 11 coordinator at the school and several other names of close friends or school mates were added. The parents of these 24 students were sent a letter requesting permission to meet with the students for assessment and some grief work. Nineteen students were then asked individually to attend the first session with the author, two Southern CAMHS staff and the year coordinator. At the end of this two-hour group session, the students were requested to complete the questionnaire used in the first study.

It was the combined opinion of the professionals that 10 students were struggling with their grief or for one reason or another might fit into the vulnerable group who might be influenced by the suicide. Scoring of the questionnaire confirmed 4 of those 10 students as being of serious concern. Further individual discussion with the adolescent or their parents showed that one of these students had attempted suicide by gassing on the day after her friend's death, one had a history of attempted suicide and several days subsequent to her friend's death attempted to suicide by overdose, and a third student had been part of a suicide pact with the deceased girl. The fourth student appears to have been severely depressed for some months, but this was most likely related to her having Turner's Syndrome which had left her physical development way behind her peers. Her depression had been exacerbated by the death of what was possibly only a rather distant friend. Parents of the four 'vulnerable' students were encouraged to seek expert counselling help for their adolescents. Parents of the six other students 'diagnosed' as struggling were informed (with the permission of the adolescent) of the results of the group session and questionnaire and told what signs might lead them to suspect the need for counselling. Parents of the other students were reassured that the grief process appeared to be going well.

Subsequently, a number of other students from the same school year identified themselves as struggling, and as having some resentment that they had been left out of the initial process. They were interviewed and completed the questionnaire. None were identified or confirmed as 'vulnerable'.

Teachers from the school who had taught the deceased girl also struggled with the grief process and the complexities of returning the school to a learning environment. A group

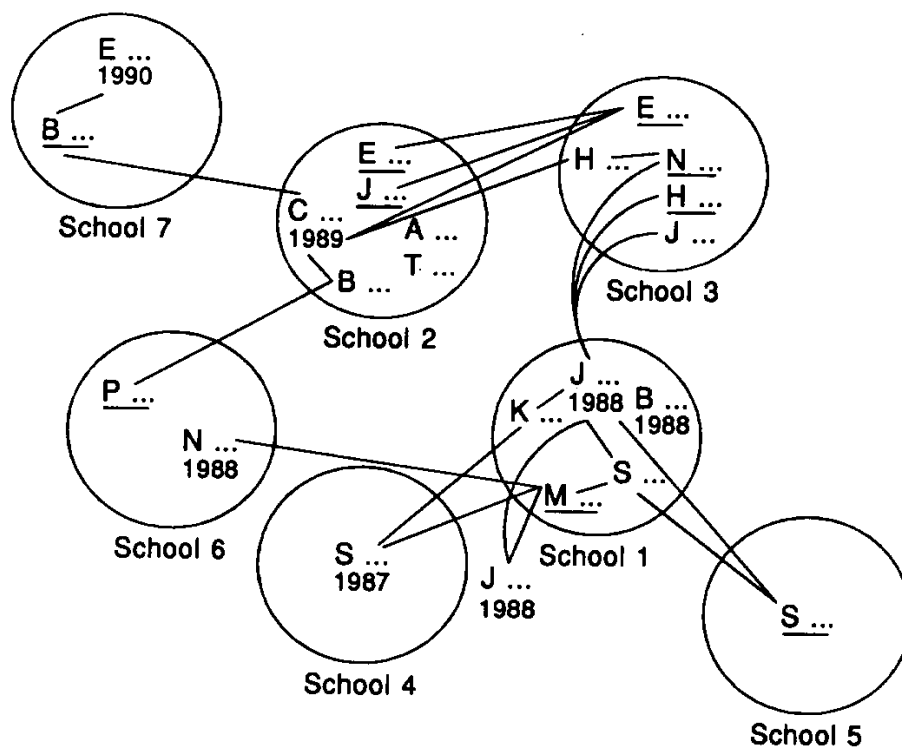
session with 32 teachers and 6 Southern CAMHS staff seemed to be of assistance in this and was followed by some months of monitoring the school environment with the principal and year coordinators. No further attempted or completed suicides have occurred in the school in the subsequent 15 months.

### Links

During the second clinical process and in the follow up to the first, it became clear that a number of students from both schools where suicides occurred had known one another either directly or through friends. A number of incidental clinical referrals have added students and other schools to the possible network connections. Figure 2 shows the minimum links which have come to light. The large circles represent different schools. Individual adolescents are represented by single initials (those underlined have been assessed and/or in personal therapy with the author). Dates represent the year of a completed suicide.

Figure 2

### Contagion in Adolescent Suicide



S ... from school 4 (who suicided in 1987) had a sister K ... who sat behind J ... in class at school 1. J ... (who suicided in 1988) had been friendly with N ... , H ... and J ... from school 3 (all from the same class). N ... attempted suicide after she was dropped by the other H ... at school 3. J ... (school 3) also attempted suicide about the same time. E ... (from school 3) was in the same class as the others and, due to unbearable teasing for her good academic performance, was moved to school 2.

These links are all tenuous. They do not take into account other factors in the lives of the students and there is little evidence that suicide was ever talked about seriously in the groups in which they mixed. M . . . (school 1) and S . . . (school 5), in their individual grief work over the loss of friends, both talked about suicide having been mentioned by several of their friends but, as it were, only in passing.

## Conclusions

The deaths from suicide of two students in one school led to an extensive process of grief work with families, friends of the deceased, other students, teachers and parents. Subsequently, the process was reviewed, and research was initiated to attempt to understand the effect of the suicides on the wider school community. It appeared that many students were given to think about suicide after a peer suicides, but only a small group also suffered from depression and/or had a history of deliberate self-harm (including attempts at suicide). The 'vulnerable' group existed in control schools as much as in the index school. We postulated that such a group would be at increased risk for attempted suicide following the death of a peer.

A further suicide in another school offered the opportunity to provide a better more comprehensive process of grief work, part of which was the attempt to define the 'vulnerable' group swiftly so that they could be offered personal help. The use of the group work format combined with a self report questionnaire seems to have been effective in this assessment.

An incidental finding as part of the continuing process was the series of links that exist between adolescents which may in part be influential in thinking about suicide.

Adolescent suicide is difficult to predict. A completed suicide offers the opportunity, however, to support the wide community of those who grieve the loss, and predict those who are vulnerable and at possible risk themselves for attempting or completing suicide.

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# SUICIDE PREVENTION AT ONE SCHOOL

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HAVING WRITTEN IN THIS AREA, THE AUTHOR WAS CONCERNED TO ENLIST THE empathy of like-minded colleagues, not to put off those who were not sympathetic to depressed kids, and to empower those with tentative interest to become involved at whatever level they felt comfortable.

## **Getting the Word out Among the Staff**

The pupil welfare coordinator was asked to help prepare a list of local agencies, emergency 'phone numbers, and contact addresses to be given to a particular year level at an assembly. This established a link, a recognition of her area of expertise and the precedent for working together.

When depressed or suicidal kids confessed their level of pain it was often to the librarian who knew of my interest in this area. Individual kids were sent to talk to me.

It turned out that many had counselling but had not mentioned their suicidal past to the counsellor. They felt comfortable to tell someone who would not under or over-react, and someone who specifically asked about this.

## **Getting the Word out to Kids**

At year level assemblies, students were given handouts of local 'phone numbers (pocket size) which they were asked to keep on their person at all times: 'Services For Teenagers—A Guide To Young People And Parents'. They were to show their parents, check wrong numbers and report the people who were not helpful. This gave valuable outreach numbers to all and did so without implied stigma.

## **Emotional Concerns at Puberty—Coping with Changes at Puberty**

There was concern that students be shown that the physical and hormonal changes they were experiencing were normal, that they affected their emotional state which in turn affected their family and friends. The assistance of the physical education teacher was enlisted to speak for five minutes on the physical body changes that teenagers experience,

that is the hormones, the organs, the pubic hair, the growth spurts, the sexual development and so on.

This was followed with a list of the emotional accompaniments to the body changes. By asking students to tick the ones they had experienced personally, the scenario was set up for later discussions in small groups. The fears and vacillations between the fading childhood and advancing adulthood were discussed. The effects on the teenager were explained as well as the effects on parents, brothers and sisters, and friends. Students then wrote down some of the changes they were noticing in themselves and their home life in the last year.

They were asked what they did to cope with so many changes. They were then split into groups of six to eight and with a teacher to help in the discussion and were asked to group their coping strategies in three columns:

|              |          |         |
|--------------|----------|---------|
| GOOD FOR YOU | HARMLESS | HARMFUL |
|--------------|----------|---------|

Small group discussions focussed on coping strategies that are not harmful.

This assembly was so popular that the health and human relations course has built it into their annual course (see Appendix 1).

This was followed with a sheet on self-help for depression (see Appendix 2). Once again, small groups, English classes, and consequent assemblies reinforced the idea that depression at adolescence was normal and part of everyday life. It had to be seen as part of daily coping.

### **Protective Behaviours**

At Year 9 assemblies, protective behaviours are discussed and students are asked to draw their hands and to list people at their fingertips who could be called in to help at times of need. By running these in the presence of colleagues, they are learning to do it too.

### **Niceness for Beginners**

As part of the building up of self-esteem, students are asked to say something nice to another student by writing it anonymously on a piece of paper addressing someone with whom they have not had contact. Students are also asked to say something nice about one of their mates. These are placed in a file and given to each person named. Everyone ends up with something nice to take away.

### **Bragging for Beginners**

At a year level assembly, students are asked to tell their partner what they do for their parents to help out, what they have done for friends, how they spend free time, money, their pet habits, proudest moments, something they have shared, something they have done for the environment, for nature, animals and so on. They are then asked to introduce their friend to another pair, telling them about the other person.

### **Self-Assessment**

Assemblies where students are to write self-assessments of their academic work, areas that need to improve, their general behaviour, punctuality and so on help maintain that

atmosphere of renewed monitoring and self-evaluation (see Appendices 3 and 4). These sheets are never collected but are part of the students' private belongings.

### **Goal Setting**

Assemblies helping with studying techniques, career discussions, what their rights and responsibilities will be when they turn 18 years old, all set the scene for growing responsibility and a sense of development. It is important for kids to see that things will change and they will be making important decisions that need preparation. It gives them something to look forward to.

At each assembly, five to eight awards are given out so that by the end of the year every student has received an award.

### **Working with Parents**

When talking to parents of depressed teenagers the author uses the checklist of warning signs and risk factors. By ticking the relevant factors, they are telling themselves how serious the threat is and through being taken seriously the situation is more likely to be tackled than shelved. If parents find it hard to broach topics with their withdrawn teenagers, a movie may be suggested from the video library on this topic for viewing and discussion, for example *Ordinary People*, *Surviving*, and *The Silence of the Heart*.

### **Conclusion**

The more normal it is to talk over problems rather than act them out, the more likely we are to resolve those problems. Therefore, the welfare and emotional stability of young people is inherently part of the role of those of us who come into daily contact with them. Suicide prevention is learning to live well and reaching out at times of need.

Young people need to know that they will get depressed at times, and it is OK to feel depressed when bad things happen and that there is a light at the end of the tunnel.

# Appendix 1

## Emotional Concerns at Puberty

1. Changes
2. Status . . . Suspended between childhood and adulthood—not here any more, not there yet.
- YOU
- Feelings & Fears
- Mood swings — very happy/laughing — very sad/crying
- Contradictory feelings — love/hate friends, parents, family members
- Intensity of feelings new — feel different — there must be something wrong with me?
- Sometimes revert to child, sometimes act like an adult
- Lost childhood identity. Not yet developed own identity — seek approval from friends . . .
- Lost old security and dependence: what's happening next?
- Questioning parents' values — looking for own set of values
- Anxiety — fear of things going wrong, failure

## Effects on Relationships

| <u>Parents/Adults</u>                                     | <u>Brothers/Sisters</u>                                             | <u>Friends</u>                                               |
|-----------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------|
| Tense, kids becoming unpredictable — turns to other kid/s | sibling rivalry why aren't you like Gary?                           | lots of ups & downs                                          |
| Love/hate contradictory feelings                          | fights/friendship — want separate room and privacy                  | break-ups—make-ups                                           |
| Worried about how to treat you. Too strict or too lenient | Too touchy or too pushy. Best keep out of their way (distant)       | Bragging, trying to impress, peer pressure, prove you belong |
| Treat you like a child/adult                              | Envy or disdain<br>Wish I could too . . .<br>I never did that . . . | Peer pressure to be grown up . . . or 'you're a baby'        |
| Not as close, don't talk intimately as often              | 'Copycat' or just like the others . . .                             |                                                              |
| Worried about what you may get up to                      | Worried about you                                                   | Don't know what to expect                                    |
| Fear of losing child's love                               | Regret loss of closeness                                            | Closer to friend                                             |
| Protective or Sink or Swim                                | Chance for revenge namecall                                         | Fear of 'catching it'                                        |
| Fear of upsetting child                                   | Resent 'special' rules                                              |                                                              |

## Appendix 2

### Self-Help for Depression and Stress

There are a few things you can do to offset depression which has not yet reached the form of a serious illness. Thinking about things or willing yourself to change them will not work, but keeping to as normal a routine as possible will help.

- **A sense of humour**—very important—it not only helps to reduce feelings of unhappiness but may put things back into perspective.
- **Activity**—any kind is important in that the pleasure of achievement can overcome any misery.
- **Work**—tackling and finishing almost any job is a great boost to morale and brings a unique sense of worthiness—which is almost a miraculous antidote to any depression. If you are up to it, try and force yourself to tackle a job you have been putting off—the resulting satisfaction is the best treatment you can get—from anyone.
- **Indulgence**—treating yourself can often lift the spirits, but bear in mind that overindulging in food or alcohol can lead to weight or dependency problems, and alcohol can deepen depression. Some people find being alone with a good book or a solitary walk or a bath is comforting.
- **Music**—found to be a mood elevator by most people.
- **Company**—being with other people can put your own problems in perspective and their good naturalness can often be catching.
- **Time and repentance**—many depressive feelings wear off in time or can be alleviated by making amends—if you feel you have inflicted hurt or damage.
- **Professional agencies**—(for example, material relief or social security) getting help with the nuts and bolts of life helps too, even if they are not the actual cause of your depression. Also, the activity is distracting; talking to people soothes, smoothing out wrinkles boosts self-esteem.

## Appendix 3

### Self-Evaluation

#### *Behaviour in general*

- Courtesy and consideration to classmates
- Courtesy and consideration to my teachers
- Completing set work
- Keeping my temper under stress
- Arriving on time to classes
- Arriving on time to school
- Being helpful to new students
- Not disobeying instructions, for example, eating in corridors, etc.
- Returning library book, paying fees, excursions, etc.
- Behaviour out of class, for example, playfighting, name calling, pushing in at the canteen, bullying, etc.

What I have to do in the future.

## Appendix 4

### Self-Evaluation

In class—concentration

Cooperating with others

In class—answering questions

My best subject—why?

In class—taking notes

My worst subject—why?

At home—revision/study

My work presentation

At home—extra reading

My behaviour in school

At home—research

My areas of strength

At home—catching up on missed work

My areas of weakness

What I can do to improve my performance.

# CLINICAL WORK WITH SUICIDAL YOUNG PEOPLE

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IN CLINICAL WORK WITH SUICIDAL YOUNG PEOPLE, I MAKE ONE ASSUMPTION that many people find difficult to tolerate, namely, that children may react to life's developmental struggles with the same anguish and 'unthinkable anxiety' (Winnicott 1962) as adults. Further, that the affective component of adult anguish (as distinct from its intellectual context) is, in fact, a derivative of this intense childhood state.

If we accept this assumption, it will offer us some common ground for creative communication. Such communication is especially difficult due to the controversies surrounding the subject of suicide in the young which tends to polarise opinions, while the rich variety of experiences at this Conference, from professionals involved in education, health, welfare, legislation and law enforcement, runs the risk of further diverging rather than converging views.

Defining who is a 'suicidal young person' is riddled with great difficulties. If only all suicidal young people were as articulate as Shakespeare's Hamlet. 'To be or not to be' is rarely uttered by the child or young adolescent to indicate their profound life and death struggles. Yet, to equate such absence of articulation with less intense or severe suffering is to erroneously trivialise children's capacities for and depths of despair.

I have adopted a developmental perspective (Rutter 1980) to the understanding and treatment (Holinger 1989) of suicidal young people meaning that all aspects of the young person's past are potentially relevant to the development of his or her suicidal condition. This includes family history, temperament, life events since birth, relationship patterns within and beyond the family and coping qualities summed up in creativity, vulnerability and resilience.

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## Conceptual, Clinical and Ethical Difficulties

Clinical work with a suicidal minor requires parental permission and consent for intervention. Occasionally (to be described), parents who are reluctant to give such consent become the focus of special confrontations. With older adolescents and young adults, parents participate less directly. In fact, issues of confidentiality may prevent the therapist from disclosing the privileged clinical information, paradoxically also bringing the therapist potential confrontation.

Based on my ten years of clinical experience with suicidal young people I have found that a number of clinical concepts and models are particularly useful. These are derived from psychoanalytic and psychodynamic views on death 'If you want to endure life, prepare yourself for death' (Freud 1914), (Laplanche 1976), of suicide as 'murder in the 180th degree' (Shneidman 1985), the notion of 'the expendable child' (Sabbath 1969), 'the suicide sequence' (Novick 1984), 'the matrix approach' to the spheres of vulnerability in the domains of psychiatric diagnosis, personality factors, psychosocial factors, family history and biological factors (Blumenthal & Kupfer 1986), 'familial and intra psychic splits' (Orbach 1989) and others detailed in Shneidman's (1985) epic contribution.

The empirical research literature also fortified my initial reluctance to accept the fact that children are capable of suicidal ideation, attempts and suicide (Shaffer 1974; Kosky 1982, 1983; Hawton et al. 1982; Hawton 1986; Rosenthal & Rosenthal 1984; Brooksbank 1985; Pfeffer 1986). This reluctance was based on the naive view that children are not capable of thinking about death (Orbach & Glaubman 1979), or to experience the depth of distress and desperation to lead them to suicide (Pfeffer et al. 1979; Pfeffer 1981, 1986, 1989).

The ideas and approaches of most experienced and intellectually and clinically sensitive teachers like Dr Murray Jackson, Mrs Sadie Gillespie, Dr Chris Dare, Professor Michael Rutter and Dr Eric Taylor are expressed in various aspects of this work.

Clinical confrontations with suicidal young people have raised many disturbing issues.

- Why think of self-injured children as suicidal rather than as 'accident prone' or inclined to more 'risk-taking' behaviour than the general population?
- Is suicidal behaviour an expression of self-destructive behaviour or an indication of the failure of a self-preservation system?
- If the definition of adult suicide behaviour depends on the notion of 'intent', given children's immature cognitive development and inability to think in terms of consequences of their action should such criterion be used with the young?
- If parents insisted that their child was essentially 'happy', how could the clinician override this view? When parental assessment and professional opinion differed, to what lengths did the professional's responsibility extend in determining the decision about a child's safety? And would raising the issue of suicide actually 'give ideas' to a non-suicidal young person?

These and other conceptual, clinical and ethical difficulties are familiar issues for clinicians working with suicidal young people. But there exists another level of difficulty. It arises in the course of longer term therapy work with suicidal people due to the unique clinical manifestations and psycho-dynamic aspects of the suicidal patient's core conflict—ambivalent struggles with **life itself**.

## Ambivalence, Splitting and Confusions

To state the obvious, the core issue for the suicidal young person is deciding 'to be or not to be'. The difficulties in clinical work with such young people are due to the psychological struggles which accompany this mental state.

The young person may not be able to articulate clearly his or her inner state. As one adolescent honestly declared when confronted with the severe disruptions of his past, 'I had not even thought of thinking about it before today'. What is happening in the mind of such an adolescent? The difficulty is that we do not know. However, very likely a process is occurring whereby a distance is introduced between the conscious appreciation of distress due to past events and the current anguish that is communicated through the suicidal behaviour. Clinical work in this situation involves appreciating two closely related psychological processes, ambivalence and splitting, which clinically manifest themselves as states of confusion.

Ambivalence can be defined as the 'simultaneous existence of contradictory tendencies, attitudes or feelings in the relationship to a single object—especially the coexistence of love and hate' (Laplanche & Pontalis 1983). The permutations of ambivalence observed in clinical practice are in part a result of the states of ambivalence being located in the will, the intellect or the affect, and its occurrence both in the normal states of mind (as in jealousy and mourning) as well as in pathological conditions (psychoses and obsessional neurosis). Similarly, the process of splitting—referring either to the splitting of the ego (Freud) or splitting of the object (Klein)—describes the existence of two psychical attitudes toward the one external reality.

The reason for mentioning these psychological processes is that they underlie a great deal of the confusion, ambiguity and uncertainties that characterise the clinical assessment and treatment of suicidal young people and their families. An awareness of the different states of confusion often helps to locate the developmental level of the patient in relation to other life struggles. These may include family conflicts, intimate relationship crisis or breakdowns, financial failures, frustrated ambitions, difficulties related to sexual identity, or threats to the sense of self-esteem.

These additional dimensions of the patient's mental landscape, initially often condensed, are revealed later in therapy as two distinct contributions to the suicidal behaviour. On the one hand are the pathogenic influences (directly causing the suicidal state), while on the other, the pathoplastic (giving the individual colouring to the expression of the basic struggle). Appreciating and interpreting the interplay of these factors becomes one of the great challenges of psychoanalytic psychotherapy. At other times, tolerating periods of not knowing, breakdown of understanding or pregnant silences between therapist and patient are experienced like sitting on a time-bomb. The major therapeutic difficulty during these times is to retain a sense of symmetry, avoiding distancing oneself from the patient's core conflicts, which may create an illusion of mastering the situation, while at the same time avoiding the over-identification with the crisis—stepping into the patient's shoes—that may create a helpless paralysis at the expense of therapeutic potency.

Finally, we need to remind ourselves of the coexistent psychological and psychiatric conditions that increase suicide risk:

- severe depression or psychosis especially where hallucinations or delusions containing themes of destructiveness, murder and suicide;
- altered states of consciousness associated with psycho-active drugs including alcohol;
- young people who have witnessed or survived a suicidal parent or sibling, or whose boyfriend, girlfriend or school friend has suicided;
- where a family history includes an unusual amount of violence and/or abuse (this includes sexual abuse, not necessarily associated with physical violence).

In summary, the clinical assessment of the suicidal young person relies on the appreciation of the clinical processes of ambivalence, splitting and confusion, the distinctions

between pathogenic and pathoplastic forces producing the suicidal state and the coexistence of a number of psychiatric conditions known to increase the suicide risk.

### **Phases of Clinical Work**

These are divided into the traditional areas of the referral, the assessment, the treatment and the ending.

#### *The referral*

In my experience, suicidal children never refer themselves and suicidal adolescents and young adults more commonly are referred by their parents, schoolteachers or counsellors or other mental health professionals (psychologists, therapists) and doctors.

For a child referral, it is important to note whether the parents initiated the referral, indicating that they have the capacity to notice, accept and act on their judgement about their child's distress. Commonly, the referral arises from a schoolteacher's suggestion who notices the distressed child and contacts the parents suggesting that they seek professional assessment.

Normally, adolescence is a time of emergence of independence and self-assertion (Freud 1958, Blos 1962). Not surprisingly, the acknowledgment and owning of serious problems 'goes against the grain' of these developmental requirements. Indeed, the usual mechanisms of problem solving at this stage involve denial ('nothing's wrong!'), displacement ('it's all the teacher's fault') or splitting ('everything's OK today, that overdose was yesterday'). Hence, we should expect as a matter of course **not** to elicit suicidal despair in suicidal adolescents easily. However, the professional is entitled to have an index of suspicion of suicide risk in certain presentations discussed above.

#### *The assessment interview*

The assessment interview with children and adolescents follows well-known sequences that include introductions, explanations regarding the purpose of the meeting, history taking both of the specific presenting problems and the developmental history of the patient and their family and relevant physical examination and investigations: all routine, except for one critical point. The clinician needs to maintain an **index of suspicion** regarding the possibility of suicidal ideation, intent or actual active plans.

The process of assessment is often accompanied by the confusions described before, increasing anxiety to a point of confrontation when the therapist realises that the young person has a life-threatening condition. This moment of realisation paves the way for a number of subsequent patterns of relating with the family. The patterns depend on the family's acceptance or denial of the formulation.

Essentially, the therapist needs to explain the nature of the suicide risk, the processes likely to occur with and without treatment, the immediate therapeutic recommendations and finally the therapist's availability. The overall aim of such communication is to empower the parents to retain their decision-making capacity—stretched to the limit at this stage—and support their taxed resources in the service of their 'at-risk' child. This communication between therapist and family contains elements of supportive understanding, education, and therapeutic planning. Beyond these ingredients, the therapist needs to be mindful of the legal and ethical issues that may arise if parents cannot appreciate the life-threatening nature of their child's condition. In the extreme, the therapist's responsibility in acting as the advocate for the child's welfare, may include overriding parental decision making. However, this should not be undertaken until and unless all other avenues have been exhausted. In such a

situation, the added responsibility would be to bring the matter to the courts (Truman & Van Eys 1984).

Even this early stage of the clinical encounter with suicidal young people may be associated with considerable stress and distress both for the family and the professional. As Crisp (1982) has commented 'to acknowledge distress in others we need to acknowledge our own distress and our failure'. As we all know, one risk in working with suicidal young people is their completed suicide. This may be experienced as a clinical or personal shortcoming in the therapist. The professional's response to both the 'distress' and the 'failure' of such work will be discussed in the clinical cases.

### *The treatment*

**Clinical Case:** A 19-year-old adolescent was referred by a colleague who was treating the boy's mother for depression.

I shall call this young man 'Greg'. He walked into my consulting room, greeting me with a warm smile and an almost giggling 'good-bye, how are things?' It seemed to me that this was more appropriate to a social meeting with an old mate, perhaps in a pub than a professional consultation. After a nervous beginning, he wished to smoke. I suggested that if he did, his attention might drift from the very issues he wished to think about, that were making him so nervous. He did not protest.

This young man had major worries. He wondered about his sanity, feeling that between the age of 6 and 15 he 'went mad'. Aged 17, two years ago, he left high school and began to drift, travelling around Australia, using a variety of drugs, drinking and holding only temporary jobs. At this stage of the interview, I started to ponder about whether he belonged to one of the special 'at-risk' groups mentioned before.

He went on and spoke about being 'paranoid' but was not very clear what this meant. He was obviously likeable, verbally fluent, and yet I felt increasingly uncomfortable as the interview progressed. Was he pretending to be a patient? Was he dreading going insane? I was confused by his confusing presentation so far. Yet he did impress me as a person in genuine distress, but distressed by what? The questions about his quest for sanity seemed unconvincing. Was there a deeper level of concern?

Later he described how his friends commented about him being 'like a house with the lights on but no-one at home' and elaborated that his family and friends felt him to be intelligent, kind and generous; that he had good looks but he felt himself to be 'garbage'. His fading facade and the discrepancies between how he was perceived by others and his own self-perception stirred questions about ambivalences and splitting the psychological mechanisms that allow for the coexistence of contradictory tendencies and attitudes.

At this point, let us shift the focus from the clinical relationship to the processes that were occurring in me in relation to the clinical material. A constant difficulty confronting the clinician is the selection of relevant material to respond to from the patient's material. Should one clarify the pathogenic or pathoplastic factors that are presented and link the suicide ideas or plans to personal difficulties? Would emphasising one or other theme alienate the delicately evolving rapport between the patient and therapist and thereby risk increasing the suicidal patient's resolve?

I began to wonder about my past experiences with similar troubled adolescents. Was this person struggling with normal adolescent tasks, the quest for an identity and independence and wishing understanding, support and acknowledgment? Was he troubled by his drug and alcohol addiction, or the feelings of madness that he was beginning to experience? I was increasingly concerned at realising that he entered with such a trivialised attitude, almost denying that this was a professional meeting. Or was he terrified, anticipating my opinion about his condition. Finally, the contradictions between his family's and friends' views and his own conflicting self-perceptions rang alarm bells in my mind. His

reference to feeling like garbage, did this mean he felt ready to be thrown out of the mainstream of life? Was he suicidal?

With this hypothesis emerging in my mind, I mobilised my courage and asked if he had in fact any suicidal ideas or plans.

Now to return to the clinical setting. 'Greg' was not at all surprised by this question. He became more serious. He explained that his suicide plans were the cause of his greatest conflict. Whether to overdose on heroin, or some other substance, or not to suicide. In any case, he felt that first he had to clear up his debts, money that he owed. He also wondered if he should leave a note or make a tape recording of his suicide and interestingly added 'of course not to do it at home or near friends, but to drive out into the country'. Maybe this was a concrete expression of his feeling like garbage and still retaining a wish to spare those close to him cleaning up the rubbish or was this a more malicious intent to become a missing person?

From this exchange, I understood that this adolescent was in fact hanging onto life by the thinnest of threads. His coping mechanisms were running out. He had travelled for nearly two years (defensive escape and denial), abused a variety of drugs (anaesthetising himself) and recently increased his social isolation (withdrawal). His defensive manoeuvres were no longer protecting him from himself. His belief was that, if he could talk with me, somehow (perhaps magically), I would remove his difficulties which I did not even fully understand.

I declared that he must be really desperate to know if anything would change his life before he does in fact kill himself. With this reconstruction of his unbearable state, his giggling facade now completely gone, he seemed to think for the first time before talking. He said words to the effect that he already had one foot in the grave. I continued to explain that 'this throwing out of yourself like garbage' was really his suicide plan and that perhaps he felt that it was a waste but that he had no other options. I offered to meet with him to see if there were alternatives which we could discover.

By providing this brief description of the clinical encounter with a suicidal adolescent, I wish to bring home the confusions, anxieties, ambiguities and uncertainties surrounding such clinical work.

Since therapy involves making accurate empathic contact with our patients, and the ubiquitous fear of death is an inherent part of therapeutic 'death work' (Pontalis 1981), as occurs in the therapy of suicidal patients, it follows that we as therapists, by remaining in contact with such material, expose ourselves to the vulnerabilities that accompany the helplessness of being witness to a potential murder scene, that is suicide (sui-of oneself, cidium-kill). 'No one kills himself who has never wanted to kill another or at least wished the death of another' (Stekel 1910).

Not surprisingly, such work makes great demands and comes at a personal and professional cost. Currently, my own rule is to restrict my work to two suicidal young people at any one time. This allows a safety margin should I need to cope with the impact of the aftermath of a completed suicide.

### *The ending*

As Goldney et al. (1987) note: 'it has become increasingly recognised in the last decade that attention should also be paid to those who survive the death by suicide of a relative or a close friend'. To this, I would add the surviving therapist and treating staff in the clinical setting.

This aspect of clinical work occurred in the aftermath of a teenage suicide in a hospital setting. Obviously, the focus of concern shifted from the adolescent to the surviving family and the hospital staff who remained in a state of shock. The detailed management has been discussed in a previous publication (Halasz 1988). The key factors are summarised here.

Surviving therapists and staff in a hospital setting need to be aware of the added vulnerabilities and risks for further suicide attempts in surviving patients. There is an urgent need to institute preventative measures to avoid the possibility of suicide clusters (Halasz 1987). The great danger for staff is that, during the phase of shock and disbelief in the suicide which is often accompanied by professional and personal questioning of decision making, roles and competence, professional boundaries and responsibilities often become blurred, authority in senior staff decision making is eroded and the risk of suicide clusters increases.

The surviving staff may reaffirm, in group and individual meetings, their unambiguous attitude aimed at preventing further suicides. The unambiguous directives, although value laden, minimise the risks of confusions and misunderstandings in the surviving patients, who may be tempted or inclined to idealise or glorify the suicidal act. Such repeated declarations attempt to prevent propagation of suicide clusters by suggestible young people, as occurs in hospital settings, through neutralising identifications with the suicide act.

## Summary

In approaching the subject of clinical work with suicidal young people, I have chosen to focus on three different phases of the clinical encounter. First, the assessment phase and the special stresses faced in allowing the realisation, both for the family and the therapist, that a child or adolescent has a life-threatening condition. Some management principles have been offered to facilitate this difficult and potentially confronting phase. Recommendations were made to invite a third party to arbitrate should a conflict of interest arise between the family's and therapist's perception of the risk to the young person's life.

Second, I have detailed some of the psychotherapeutic processes involved in the treatment of a suicidal adolescent. By detailing the patient's account of his difficulties, both in the past and as they related to his present life struggles, a picture emerges of a young person desperately weighing up his fate—to live or die. Such ambivalence directed at life itself imbues the therapeutic relationship with the unique stresses that characterise work with suicidal patients.

Third, by detailing the profound impact on surviving hospital staff of the adolescent suicide of a recently treated in-patient, certain management principles directed at reducing the risk for suicide clusters are highlighted. Whilst there are conflicting reports regarding the possible modelling effect of suicidal behaviour (Werther effect) (Phillips 1974; Walsh & Rosen 1985; Rosen & Walsh 1989; Modestin & Wurmle 1989), the clinical approach taken adopts the position that it is better to be safe than sorry. That is, all endeavours were taken to minimise the risk of copycat suicides, notwithstanding that there may be controversies in the research literature.

In conclusion, the emphasis of this paper has clearly been on the considerable stresses associated with the clinical work with suicidal young people. Lessons drawn from such experiences may have more general application in suicide education, prevention and research. I should like to finish on a positive note and add that beyond the stresses, there is also a sense of reward and achievement unparalleled in clinical work when one contributes to the survival of a suicidal young person.

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# **FAST CARS DON'T KILL ME: MARGINALISED YOUNG PEOPLE, HIV AND SUICIDE**

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THE LAST DECADE HAS SEEN MAJOR CHANGES IN THE WAY THAT OUR SOCIETY functions and survives (or does not survive). Although the recent changes in Europe threaten to overshadow all other movements within society, after a time those recent events will pale into insignificance compared to the changes brought about by the advent of the Human Immune-deficiency Virus (HIV) or AIDS.

Young people are immune neither to the changes going on in society nor to the effects of this virus even though, with regard to HIV, they may well believe they are (Hein unpub.). Moreover, the response they are able to make to the latter is vastly different to those mounted by others within the community. In fact, as has often been mentioned in the media and by the professionals involved in this field (Australian National Council on AIDS 1989), young people are particularly susceptible to the virus if, for no other reason, than that they are in a period of their lives that is marked by experimentation and flux. This is even more relevant when we begin to talk of young people who are isolated or marginalised within the community. They are vulnerable because of their age, and this is compounded because they invariably have to deal with the issue of independence long before they are capable of doing so. They are increasingly vulnerable because this premature experience of independence is a result of factors that militate against the successful completion of their transition from adolescence to adulthood.

The number of young people who have been infected with the virus is unknown. Estimations from overseas (Hein unpub.) and from here in Australia (Centre for Immunology 1990) are what we must rely on at this point. The information to hand indicates that the estimates are likely to be conservative. Thus, it is an area that requires careful research even though that task will inevitably be difficult to undertake.

On this occasion, one particular section of the youth population will be examined (that is the marginalised group of young people within society) to look at the role and effect that the virus has in their lives, how its very existence compounds other problems they may be forced to deal with and, finally, how they respond to this life-threatening force. Two sides of

the same coin will be examined. Firstly, young people in this group who place themselves within close proximity of the virus, and by virtue of that closeness push the limits of experimentation and play with life and death. The other side of the coin refers to that collection of young people who, having been contaminated with the virus, move into another phase of their lives. The issue of life and death is stark and overwhelming. For them, growing up and playing with that fragile entity called life within the context of HIV means the years become embroiled in an all-consuming whirlwind that never seems to slow down.

This paper is not a research document as such. It is simply a collection of observations and reflections based on a very small sample from an inner city environment. There is much more to learn. It is very much, unknown territory.

### **The Situation of Marginalised and Homeless Young People**

Before it is possible to understand clearly the connection between HIV and suicidal tendencies and action within this group, it is imperative to understand the context within which they move; to develop some picture of their behaviour and know the stresses and tensions which make up their daily existence and which lead to problems in their lives.

In 1989, two surveys were carried out involving marginalised young people who frequent the inner city areas of Sydney. The first survey, carried out in the early part of that year, was a simple analysis of eighty-three young people involved with the casework program of one inner city youth resource centre (Leary 1989). The second, a more comprehensive and complex study, was carried out with a not dissimilar group of young people (Howard & Kearney 1989). Both give a clear picture of the pain and isolation experienced by this group of adolescents.

In the first survey (Leary unpub. 1989), the average age was seventeen years and nine months. Well over half of the young people surveyed (59.1 per cent) self-referred with the most predominant reason for their initial contact with the centre being to find accommodation (65.1 per cent).

Most have experienced homelessness from an early age and have spent many years on the refuge merry-go-round. Howard and Kearney (unpub.) found that, by 11 years of age, 23.1 per cent of females and 34.8 per cent of males had run away from home at least once. Negative relationships and general unhappiness were cited as the main reasons for their leaving home. It is interesting to note that, even though they leave home, a large percentage (74.7 per cent) remain in contact with their family to some degree with a small number (32.3 per cent) maintaining regular low key contact with home (Leary 1989).

When the issue of family comes up in conversations with homeless young people, the reaction is always mixed. No matter what the level of abuse or neglect they have experienced, there is always a spark of desire and hope that pervades their thoughts of family. Ambivalence seems to be the identifying mark. The unsettling feelings that arise oscillate from a point of anger and frustration combined with an acute desire to punish, through to intense grief at the monumental loss and abandonment that this premature separation has brought about in their lives. The end result of all of this is that the feelings are unsettling and their experience of life is unsettled. That means stability is not often a well known or understood quantity in their lives.

The fact that housing is both difficult to find and maintain for these young people places enormous pressure on them with the resultant effect that any and all attempts at change and re-direction have limited influence in their lives. It is, therefore, not surprising that there are high levels of unemployment (78.3 per cent of the group surveyed by Leary) coexistent with equally high levels of homelessness or transience. In practice, this level of movement may extend to a point where not even refuge programs will house the young person concerned. In one case reported to the Human Rights Commission's Inquiry into Homeless Children

(Edwards & Leary 1988), one young person had been in thirty-nine placements within a twelve month period.

What is of importance to note among this group of young people is that there was a large number who possessed no form of income support whatsoever (30.1 per cent). This was in spite of the fact that they were often homeless and therefore without the financial support of family (Leary 1989). This is clearly an indication of the effects of isolation and homelessness on their level of confidence and their ability to negotiate other systems within society (such as the Department of Social Security). Questions must be asked with regard to the value and worth they place on their own lives.

Howard and Kearney (1989) found in their survey that a large number of the young people they questioned did not like themselves (72 per cent), saw little point in living (83.7 per cent), found life boring (89.1 per cent) and, at some stage during their lives, had attempted suicide (76.9 per cent of females and 59.0 per cent of males) by a variety of means.

In order to deal with the loss of family, the advent of homelessness, their inability to gain employment or income support, and their many thoughts of self-destruction, crime becomes an option because of all or some of the abovementioned factors. Many of the young people in the first survey (Leary 1989) had turned to crime at some point during their life resulting in their entry into the juvenile justice system (79.5 per cent). For many, that has meant, at some point, an experience of incarceration (56.6 per cent of total surveyed).

All of the young people surveyed had some involvement with drugs and alcohol. Frequent use of nicotine (88.0 per cent), cannabis (47.0 per cent) and alcohol (30.1 per cent) was evident within the group (Leary 1989). The use and abuse of drugs and alcohol are high on their agenda and it is easy to see why this is the case. It exists as a relief of the depression and the boredom, the lack of activity and stability. It kills the present and perhaps the future.

To analyse and interpret their behaviour and experience of life is a complex task. They have difficulty expressing their feelings and, when they are expressed, they possess an intensity that makes them fearful and cautious of divulging too much and so becoming too vulnerable. In summary then, how do they appear?

- They are homeless, more by necessity than by choice and usually from the age of 13 or 14 years.
- They are connected to families but for most that connection is tenuous and unsatisfying.
- They feel intensely the isolation, pain and anguish of having prematurely left a 'home' for the insecurity and danger of the 'street', even though this 'home' may not have held, nurtured or directed them in a manner, or with the clarity, they may have desired and needed.
- They lack an adequate education and the basic skills that would allow them to be competitive within a limited labour market.
- More importantly, they feel inadequate, anxious, attacked and under-developed from most if not all perspectives on their lives.
- They articulate in verbal and non-verbal terms, that this inadequacy or fragility is ever present, all-pervading and at times, all consuming of their energy and their strength.

- They therefore specialise in the development and maintenance of intricate walls and screens which serve to hide their lives, a task clearly focused on survival and the distancing of all who may come to know and understand the fragility of their lives.
- Consequently, they fear and shun closeness and intimacy. The only feasible option they recognise is an over-emphasis on independence and aloneness.
- Their conception of reality and of time is the 'now', there is no future; they wish to hide their past.
- They rarely plan in the real world. They desperately hold onto complex fantasies of how they want their lives to be.
- This 'dream world' of the future may be the only tolerable aspect of their lives. For that reason, hopelessness and helplessness range high in their emotional experience.
- Their innate desire is for a hasty and premature departure from a hostile and unwelcoming environment.
- The use of drugs and alcohol both alleviate the present pain and hasten an end about which they experience an intense ambivalence.
- Their anger, depression and sadness is at times both inwardly and outwardly destructive and offensive. The manifestation of this is delinquency and other self-destructive or antisocial behaviour.
- And yet they survive: for some reason, there is, in most cases, a spark of hope which flickers, attracts attention and invites involvement.

#### **HIV: the New Fast Car**

Adolescence is noted as a time of experimentation—a testing or stretching of the limits that are placed on the young person during this all important developmental phase. Presumed in all of this is the existence of a caring, supporting and containing force that allows the young person to experiment knowing there is some sort of safety net. As long as the young person concerned has enough structure and physical and emotional support, then some level of experimentation is both socially and developmentally normal, advisable and acceptable.

The major difficulty with experimentation within the context of HIV and AIDS is that, without the support here spoken of, this experimentation may well result in a markedly premature death due to contamination with the virus.

It is clear, from what has been said before, that family dysfunction and running behaviour produce this lack of structure. Within the young person, this is invariably translated into feelings of helplessness, hopelessness and, at times, utter despair. They lack that level of structure and support and, by this are at risk. They despair of their lives and, hence, often lose any degree of perspective or clarity that might have been achievable or expected at this point in their development. For some young people, this may be reframed into a level of despair that lessens their desire to carry on living. This is the serious problem that faces homeless young people today. They are marginalised and isolated by their life

experience and because of the virus with which we and they are faced, the problem is more acute than ever before.

It is clear from all that has been outlined that their grasp on physical and emotional stability, meaningful social support networks and life itself, is quite tenuous. This is not to deny their resilience. It is simply an acknowledgment that the loss of structural support within their lives is profound in its influence.

For a number of young people, stealing cars, driving at high speed—with the subsequent sub-conscious baiting of authority—is, at one and the same time, an expression of their needs—a call for help (Winnicott 1967) and a clearly articulated pushing of the limits. The emotional 'buzz' or rush of adrenalin that accompanies such experimentation fulfils a need for excitement, a release of tension, control, purpose and the distraction (Howard 1987) that is so necessary when so many other aspects of their life appear out of their control.

Invariably they are aware, at some level, of the limits they are pushing and the risk that goes with that movement. Attention to consequences, for either themselves or others, is not always that high on their agenda.

Part of the experimentation that goes with this group of marginalised young people is sexual experimentation. It is a dive into the murky waters of a desire for closeness and intimacy, belonging, exploration of bodies and the need to play in an adult world and manner.

Within the context of varying levels of self-awareness and a limited recognition of the need to be self- and other-protective, this experimentation is dangerous. Howard and Kearney (1989) found that, although knowledge of appropriate safe sexual practices was evident in both male (75.8 per cent) and female (61.5 per cent) respondents, the reported translation of that knowledge into regular safe sexual practices was limited (46.2 per cent of females and 50 per cent of males). Particularly in the case of young males, this may well have been overstated. Concern in this area is compounded because a large number (42.4 per cent) had never been tested for HIV and yet some (28.3 per cent) saw themselves as likely candidates for infection with the virus. Some evidence of the ramifications of their knowledge and practice base may be gained from the fact that 50.0 per cent of females reported having been pregnant at least once while 56.1 per cent of male respondents reported having caused at least one pregnancy.

The picture produced by all of this is quite alarming. They are unsupported, underskilled, unaware and sometimes self-destructive. They have many avenues by which they may push the limits and, in fact, push themselves to the precipice where life and death meet. Having the virus around within this context is not unlike handing them a loaded gun, a very fast car or an overdosed syringe. For some, their predicament is overwhelming, the possibilities for self-destruction enormous and the gamble with life and death extremely tempting to play with.

HIV is the new fast car; the vehicle that propels them to the limits of self-destruction and (in their ambivalence about their lives) only possibly, back again. It is the opportunity to test out their desire for a sense of power and their feelings of indestructibility. Because the effects of the virus are neither immediate nor clearly visible to them, in effect they do not exist. This is where the danger lies. The lack of immediacy in the area of HIV symptomatology produces in the young person a false sense of security and hence an absence of real threat. The attitude is invariably: no symptom, no problem; not me.

This is where the need for strong concerted efforts of a pro-active nature are simply imperative. Not to act is tantamount to leaving them to wallow in what they regard as their mess with their finger firmly fixed on the trigger of a gun they visualise as harmless.

## Young People with HIV or AIDS

For a practitioner, the area of young people and HIV is an extremely difficult one to talk about at the moment, particularly given the limited number of young people who are known to have been infected with the virus.

However, young people are becoming infected. It is a fact we cannot ignore. More importantly, it is a reality that must be dealt with in as pro-active a manner as possible. The most recent figures (July 1990), available from the National Centre in HIV Epidemiology and Clinical Research, indicate that there are 143 known HIV sero-positive cases in the 0 to 19 year bracket throughout Australia (Centre for Immunology 1990). Of that number, 110 arise from New South Wales alone. This is in stark contrast with the figures available during 1988 for the state of New South Wales. By May of that year, it is estimated there were approximately 44 young people who had sero-converted to HIV (Waters & Howard 1989). The leap from 44 to 110 is expected, alarming and indicative of the fact that, by no means, have we approached the plateau in terms of presentations.

Since 1985, our service has come in contact with thirteen young people aged 15 to 20 years who are HIV Ab+. Table 1 indicates the spread of new presentations each year over the last five years (Leary unpub. 1990).

*Table 1*

| Year | New Cases | Cumulative Total |
|------|-----------|------------------|
| 1985 | 01        | 01               |
| 1986 | -- (01)   | 01 [02]          |
| 1987 | --        | 01 [02]          |
| 1988 | 02 (01)   | 03 [05]          |
| 1989 | 04 (01)   | 07 [10]          |
| 1990 | 03        | 10 [13]          |

Three of the young people (indicated by the numbers in parentheses) established only initial contact and then moved on; two to another area of Sydney and the third to another state. Since 1988, we have noticed an increase in the number of infected persons presenting at the centre. In 1988, two new cases were noted at our service. In 1989, four new cases were noted. In the first six months of this year (1990), three new cases were noted (Leary 1990).

The first point that arises out of these raw figures is that of the increase in the incidence of HIV infection within the population of homeless young people within our service alone: a doubling of new presentations every year for the last three years. This is one service in a biased area. However, even taking this into account, this level of new presentations is alarming. What makes for even greater concern is that neither homelessness nor HIV are restricted to the inner city area of Sydney. Nor is the isolation, hopelessness or despair that invariably goes with both of those states. Again, it is these factors that markedly increase the possibility of infection simply because they radically influence the emotional, physical and behavioural predisposition of young people.

Only one of the young people who presented contracted the virus from a contaminated blood product. In every other case, transmission was by means of sexual contact—both homosexual and heterosexual—and through the sharing of contaminated needles. In most cases, it is difficult for the young person concerned and the professional involved to identify the mode of transmission of the virus clearly. This is because there may well be more than

one mode of 'at risk' behaviour; the young person may be engaging in unprotected sexual practices (either heterosexual, homosexual or both) as well as sharing needles.

The risk factor equation seems to present in this manner: the more separation and isolation from supportive structures that the young person experiences, the more helplessness and hopelessness becomes apparent in their lives. The greater the level of these and the longer the duration, the more likelihood there is of despair arising and overtaking them. Out of this comes confusion, a loss of control and involvement in a lifestyle characterised by risky behaviour taking a variety of forms. At this point, limits, safety and the future have minor influence over their behaviour.

Within this setting, contamination with HIV becomes very much a possibility, sometimes inevitable and, in selective situations, an event that is desired and even sought after by the young person.

### **Self-Infection, Self-Destruction**

An indication of the level of despair facing marginalised young people today may be gained from the fact that at least two of the thirteen young people known by our service to be HIV Ab+ have knowingly infected themselves with the virus by contact with another young person whom they knew to be contaminated (Leary 1990).

How is this form of behaviour to be understood? The simple answer is that it is not possible in any generic sense. Nor is it possible to know whether this will continue as a trend with regard to the way young people respond to their isolation and the presence of HIV. There are, however, some facets of this behaviour that are apparent at this early point in time.

The action of self-infection is clearly self-destructive, but because of the manner in which the effects of the virus gradually develop and the remoteness of the person's death, it is more than simply self-destructive. It is a cry for help gone wrong, an attempt to get others to change the way they behave; a desire to align oneself with another out of what feels like love; a search for purpose, place and attention by creating a role of sickness; a desire to punish others because they have not cared enough, said enough or done enough; an attempt at flight from a life and experience of relationships that appear 'out of control'.

On the basis of this, it is not unlike other attempts at suicide and perhaps completed ones: the thoughts are of self-destruction and, for some, the punishment of others. In part, this is clearly understood by the young person because it is a lived experience. The methodology is far less thoughtful, or calculated, a movement; it is certainly misguided and perhaps even a mistake.

The overwhelming wish for many marginalised young people is (not to die but) to be dead and so end the trauma of a life full of nothing. Like other experiences in their lives, this one is also marked by ambivalence: 'I want to die, but then again, I don't want to die'. Within the context of the adolescent thinking in the 'here and now', infection with HIV validates their need to communicate pain, punish self and the world, without the experience of pain or immanent death. In terms of the symptoms of HIV, there is no immediacy attached to infection: there is no immediate pain and no sudden death. This in effect clouds or masks the experience of infection and adds to the complexity of understanding and dealing with the young person.

So the young person is able to give out the existential cry for help that goes with suicidal action whilst retaining the need to vent the much present feelings of ambivalence so characteristic of their life.

Some young people do not just play with the gun, they use it. They do not just push the car to the limit, it becomes their vehicle of destruction. It seems that the same may be said for some young people with regard to HIV. It is there; so is their despair, confusion and

bitterness: so they use it. It is both their vehicle of communication (Allchin 1975) and yet the vehicle of their own destruction.

## **Reactions and Ramifications**

There are many reactions and ramifications for the young person having been infected with HIV, whether that infection has occurred by accident or as a result of a partial or deliberate move on their part. These results clearly affect the young person concerned as well as those with whom he or she associates. For the young person who sets out to achieve infection, there is the painful reality of an aftermath that must be dealt with in some manner.

With the more traditional attempt or completed suicide, there is either death or another chance within the presence of the scars that remain after the attempt. Here, the aftermath is the knowledge that the mess must simply continue for another eight or so years. The scars that remain are alive and actively destructive. Even though young people may decide, '... but I don't want to die no more', the reality they are faced with is an adult choice they were not capable of making but made all the same.

Whether infection is by accident or the pushing of risk to the edge, the problems here are profound. Their life goes on. They are still adolescent, but now with more pressure and tension than they could have considered possible: life with a death sentence. They still have their life history with its heightened levels of isolation and angst. And now there is even more reason to be angry; not just at others, but at themselves. The depression and confusion that occurs is profound, overwhelming and has the effect of scattering the many pieces of their life.

The loss of future is invariably accompanied by a loss or fear of loss with regard to family, friends, employment and other opportunities within society. This in itself compounds the already complex problems that must be dealt with. In an attempt at dealing with this potential or actual loss of support, running or an increase in the level of transience becomes a renewed option. As has already been mentioned, their experience has been one of continual movement after leaving home.

Yet again, there is good cause for them to keep moving: to avoid rejection and the reality of an impending death that lingers and invades. However, the fact that the running is, in part, there to avoid invasion is in itself a stimulation to further running because the need to escape is so acute and denial so strong, at least initially. Our limited experience is that the incidence of running is both increased and magnified by the advent of the virus in the life of the young person.

Another difficulty that arises is that the young person continues to be within that difficult period of transition in their life. Nothing has changed except the fact that this transition period is further complicated. So experimentation remains a significant part of their social experience. One of the risk factors that led to the incidence of the virus in their life in the first instance was that of serial monogamy, that is, the young person having a series of intimate sexual relationships. Within the context of sero-positivity, this is no longer merely a risk factor, it is potentially life-threatening.

Where this occurs, there exists the heightened potential for subcultural cross-infection. It is unpleasant to consider, but given the nature of their life experience and the fact that it is so negative in its orientation, the potential for some degree of subconscious or deliberate cross-infection is ever present.

The over-riding experience for young people in this group is that of increased levels of depression and confusion. Self-destructive behaviour, suicidal tendencies, and the desire to take others with you to the grave are all feelings and experiences that get acted out anew as a part of the aftermath of infection. Driving fast cars even faster, taking more drugs and a greater number of drugs at the same time are all parts of the scenario. The question that

remains is that of containing the problem. Here I refer, not just to the problem of suicidal behaviour but of the spread of HIV.

## Responses to the Problem

It is obvious that the end point of such a discussion must be that of seeking ways to prevent an increase in the level of self-destructive and suicidal behaviour among young people, as well as attempting to limit increases in the level of infection with HIV in the community. This must include attempts at limiting cross-infection among this age group and subculture as well as increases within other sectors of the community.

Clearly, the first aspect of this must be in the area of prevention. Reaction to the problem after it has occurred has proved less than satisfactory in some of the situations that we have faced.

In terms of responses, there is an inevitability with regard to some reaction from a legal perspective. In New South Wales, that response, as a measure of last resort, arises out of the *Public Health (Proclaimed Diseases) Amendment Act 1989* No. 206. There is clearly a need to have the possibility of restraining someone who, in a recalcitrant manner, fails to protect others or themselves from infection with HIV. However, this level of response is fraught with difficulties from legal and ethical perspectives not to mention the difficulties encountered from an implementation point of view. This paper is not the place to deal with those complex issues. Suffice to say that this should be the absolute last resort because in the short and long term, it is the least effective measure for either the person concerned or the rest of the community.

So other measures must be developed in order to support and protect all the parties concerned with this issue. In the context of this paper, consideration will be restricted to those young people who are, or may be, sero-positive to HIV.

It goes without saying that, of any predicament, this particular one requires of us a strongly coordinated, multifaceted, harm reduction and preventative approach with regard to intervention. In practice, doctors and youth services, residential programs and counselling services, community groups and educational facilities, police and other statutory authorities, all being able to work in a cooperative manner. This has been happening in some areas. More needs to be done.

Within New South Wales, health facilities have been developed that focus on the needs of young people who are at risk in this area. At present, those facilities are by and large restricted to the inner city areas. This may well be satisfactory for funding bodies and planners. However, HIV and suicide are not restricted to those areas.

One of the major dilemmas in the health area is that of providing services that encompass preventative work and harm reduction. Both approaches are necessary. Both are valid. Careful assessment has to be carried out on a case by case basis to know exactly what the mix of these approaches should be. Not to find an appropriate mix means that we run the risk of losing the person with whom we are trying to work.

With some young people, their tolerance to intervention is so low that to offer any more than simple harm reduction would be to threaten any rapport that may exist and hence scare them off. However, the trap for young and old players alike is that we must never negate the possibility of change. Harm reduction may well be the approach taken one day. That same young person may be ready and willing to consider other options the very next day. The importance of careful assessment cannot be overstated in this area.

What is implied in all of this is very clear. If the young person is going to feel able to cope and move through the drama and trauma of this transitional period of their life, whether they are sero-positive or not, is highly dependent upon the environment that the young person, supporting agencies and others can develop or redevelop.

What is the aim of assisting the young person at this point? For them, there has been an experience of environmental failure (Winnicott 1962). The culmination of this is the serious and excessive risk-taking behaviour which for some results in sero-positivity. The denial that results brings on running and further risk-taking behaviour that is often even more excessive in nature. If a facilitating environment can be developed that is 'good enough' (Winnicott 1963), and that means resilient enough, then the young person may be able to slow down gradually and face what is clearly a devastating situation which ultimately means being able to allow the depression to arise and be dealt with.

In practice then, this facilitating environment must consist of a variety of people and styles of intervention. For this to be established, it is essential for all those involved to remember that what we are aiming at, is not forcing change upon the young person but rather, inviting them to be involved in a process that is foreign, perhaps difficult but rewarding. It is simply the process of trying to engage them in the art of relating.

They have many needs when they are at this point in their lives. The most significant and, in fact, the hinge point of all the others is that of their need to relate with caring, understanding and resilient human beings. Engaging marginalised young people in these sorts of relationships is what will make all of the other support structures viable.

Contact with and support by family is absolutely crucial to their survival. Assisting both the young person and the family to regain and maintain some level of contact must remain on the agenda even if it appears impossible. Mediation or therapy might be useful but it must be seen within the context that limited contact, not restitution, may well be the goal.

Even if contact with family is possible, alternative accommodation is absolutely essential if change and stability are to occur for them. It is ironic, but one of the major weak links in this area is that of housing. Where is it possible to find adequate housing for young people who are potentially or in reality HIV infected? Most crisis youth services are willing to accommodate young people in this situation. However, if they remain in this form of housing, their problems end up being compounded by the nature of the service. You cannot stabilise a young person who is experiencing the ultimate in terms of personal tragedy, if the only option is that of crisis accommodation.

On several occasions in the last five years, we have endeavoured to increase their level of stability by increasing their independence. There have been few options in the medium to long-term area and so we have tried placing particular young people within housing department stock. This is a totally inadequate situation, because it fails to recognise their acute need for a style of support that is in part directive and yet non-intrusive. To place a young person on their own or with very limited support and structure is to ignore the fact that they need other people with whom they can relate, in order that they may re-engage with themselves and deal with the loss that is so evident in their lives.

An option that should be avoided with this age group is the establishment of AIDS specific accommodation. If you establish young people within this form of accommodation, you remove from their lives a degree of normality that is the quintessence of stability. Ghettos may be a quick fix solution. However, they often seem to breed increased levels of isolation and despair.

Housing for young people, regardless of their predicament, is a key factor in the provision of a facilitating environment which may help them bring about some change and an increase of stability in their lives. However, it must be linked with other support structures that assist young people not just to gain, but to maintain that stability and break the cycle of transience and despair which underlies their potential infection with HIV.

Without those added structures that are able to deal with the medical, social, employment, education and training areas, then the housing will become an isolated experience, the young person's stability will dissipate and homelessness will again be the

dominant issue. The inter-relationship between all of these aspects of a 'good enough' environment is essential.

Let me dispel a fear that may exist at this point; when such an approach has been taken, positive results have been achieved and the need to utilise extreme legal powers has not arisen. People have been protected and the risk factors to young people and others minimised.

Suicidal events are often thought about by young people within this group. There are clearly many young people who play with the possibility of self-destruction. There are an increasing number of young people who reach the point of completion. Undoubtedly, all of these young people reach this point as a result of the devastating critique they make of the world they have known to this point (Allchin 1975).

This is clearly the way it is with HIV. The virus is a major risk with regard to marginalised young people; the same way that fast cars and drugs have been for decades (Howard 1981). It is the belief of the author that the level of youth suicide and the incidence of HIV sero-positivity will rise in tandem. If the spread of both plagues is to be contained within our community, the time for action is now.

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# **ONE COMMUNITY, ONE GRIEF: ASPECTS OF ABORIGINAL DESTRUCTIVE AND SELF- DESTRUCTIVE BEHAVIOURS, THEIR 'PREVENTION' AND 'CAUSALITY'**

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THE MAIN AIM OF THIS PAPER IS TO CONSIDER SELECT EMPIRICAL INFORMATION  
on Aboriginal destructive behaviours in order to better understand those

behaviours in their wider social context, which is vital for a meaningful approach to suicide prevention.

The paper will focus on: Aboriginal destructive behaviour and its 'causality'; stressors operating in Aboriginal communities; and the impact of prison and police related interactions upon that community. The paper concludes with two local Aboriginal perspectives on suicide prevention.

### **Royal Commission into Aboriginal Deaths in Custody: Some Non-Aboriginal Comparisons**

Due to the broad terms of reference of the Royal Commission into Aboriginal Deaths in Custody, the 'gross over-representation' of Aborigines in Australian legal custody is receiving special attention by social scientists besides the gaggle of lawyers. In the South Australian Census of 1986, 2.1 per cent of all people in non-private dwellings were in prison, corrective and detention institutions. The corresponding figure for Aborigines in South Australia, was 18.8 per cent, a difference factor of nine times. This is the greatest degree of over-representation in Australia, as has been noted by Hunter (1989).

Quite aside from crime per se, other forces work in the outside community to bring into being those social circumstances, firstly, that attract police attention and secondly, if they lead to arrest, that create the potential of both an extraordinary incarceration rate, and of custody death (Biles et al. 1989). Biles' research for the Commission compared aspects of Aboriginal deaths with non-Aboriginal deaths, and showed that Aborigines comprised 20 per cent of custody deaths between 1980 and 1988, despite being less than 1.2 per cent of the population aged 15 years and over (Biles et al. 1989). In addition, almost the same proportion of non-Aboriginal deaths occurred in prison custody (67 per cent), as Aboriginal deaths occurred in police custody (62 per cent). Similar proportions overall, of Aboriginal and non-Aboriginal people were alone at the time of death (75 per cent and 81 per cent respectively), irrespective of custody type.

(Alleged) suicide (lethal self-injury) was the most common cause of death reported regardless of race (accounting for 46 per cent of all custody deaths—but 70 per cent of those who died under 30 years of age), followed by natural causes (accounting for a further 36 per cent).

A greater proportion of Aborigines died of natural causes compared with non-Aboriginal people (46 per cent compared with 33 per cent respectively). Furthermore, and contrary to Jones (1988), a greater proportion of non-Aboriginal deaths were reported as suicidal than Aboriginal deaths (49 per cent compared with 34 per cent)—a pattern that holds true regardless of place of death, that is prison or police custody.

Females, who represented 7 per cent of Aboriginal deaths in custody (compared with 4 per cent non-Aboriginal), comprised similar proportions of reported suicide custodial deaths as did males, which is in marked contrast to the general community pattern where the male suicide death rate is almost four times that of females. Of those seven Aboriginal women who died in custody, six died in the custody of police.

Observations which can be made from these data with regard to Aborigines in custody include the following:

- 'race' does appear to make a notable difference on a number of parameters;
- police custody deaths were more likely (2-in-3) for Aborigines compared with prison deaths;

- natural causes were more likely to be responsible for Aboriginal deaths, than for non-Aboriginal, and suicide was less likely, irrespective of prison or police custody at time of death;
- irrespective of race:
  - suicide was the most common cause of death;
  - it would appear that prisoners left alone are most 'at risk';
  - the information concerning remandees is particularly disturbing and calls for elaboration and further investigation.

Given that nearly one half of all prisoners who died allegedly chose to take their lives, custody is clearly highly stressful for all prisoners regardless of type of custody (police or prison). Police custody appears to be particularly 'risky' for Aboriginal prisoners but, as natural causes were responsible for so many deaths, health of the prisoners upon admittance is also a key factor, combined with that of their care while in custody.

This research highlights the gravity and scale of the difficulties large numbers of Aboriginal and non-Aboriginal inmates have in coping with the prison system. We can readily infer that many surviving prisoners fit this category.

We would suggest that in relation to suicide prevention amongst adolescents generally, it may be appropriate to emphasise general measures to reduce stress and promote coping mechanisms (Backett 1987).

## **Violence and Destructive Behaviour**

We will begin our consideration of stressors in non-custodial Aboriginal communities with an outline of recent cause of death data for South Australia. In 1988 in South Australia, Aboriginal death rates for all age groups continued to be much higher for both sexes than for the total population (Australian Bureau of Statistics 1988). Age-specific death rates for Aboriginals calculated by the Australian Bureau of Statistics (ABS) also enabled life-expectancies to be estimated, viz; for Aboriginal males this was between 50 and 55 years, and for females, between 65 and 70 years.

Of the 29 Aboriginals who died by 'Accidents, Poisonings and Violence', five were under 15 years and the remaining 14 were between 15 and 24 years of age. Similarly, 14 more deaths attributed to 'Other External Causes' took place in the age-group 15 to 24 years. Motor vehicle accidents claimed another six lives (all of them male).

It is obvious, therefore, that violence and destructive behaviour of various kinds play a significant role in the morbidity and mortality of the Aboriginal communities of this state. A survey of literature concerning other states together with anecdotal evidence continuing to emerge from a range of Aboriginal communities, confirms this impression.

The 'decline in traditional culture' together with, or resulting from, the 'impact of European cultures' are frequently described in anecdotal reports, novels, plays, and documentary features to have had a direct, if not sole, causal impact upon the aetiology of these tragic violent behavioural choices. In particular, the following are suggested: the loss of land and traditional authority structures, in particular the influence of elders; the forced extraction of Aboriginal babies and children from their families; the various factors that have contributed to poor health such as loss of opportunities for traditional lifestyle determination; the erosion of educational opportunities for generations; the lack of employment and hence the reliance on the state . . . Systematic studies to investigate these claims have, however, not been numerous, and many would question the quality of those that have taken place.

Wilson's (1985) study of Queensland Aboriginal reserves (conducted with anthropologists in 1980) combined court case evidence with an assessment of the

relationship between violence and social conditions. He concluded that there was a clear relation between types of reserve (in terms of origins, cultural expressions, presence of alcohol, and government control) and levels of social violence.

The 'high violence' communities were purported to be those where: traditional culture was less apparent; relatively high populations had a significant proportion of displaced residents from other areas; alcohol was legal; and community cohesion was lacking.

In these Queensland reserves, in addition to the homicide and violent assault, high levels of self-destructive behaviour led Wilson's team to claim the existence of a 'veritable epidemic of suicide and self-mutilation' combined with perceptions by Aborigines that the real cause lay in white administration and policy (Wilson 1985).

### **Rape and Child Sexual Abuse**

Rape and child sexual abuse amongst Aboriginal women was the focus of a recent urban-based survey conducted by Aborigines at the Adelaide Rape Crisis Centre (Carter 1987). Of the 59 respondents who had been raped, some felt that sexual abuse had precipitated suicidal ideation (7 per cent) and/or, alcohol-problems (61 per cent) and/or drug problems (35 per cent).

The report alleged that violent sexual abuse had remained taboo in Aboriginal communities and that change was essential. Sexual abuse was perceived by respondents to have had an important causal effect upon both substance abuse and suicidal thinking—while fear of the perceived likely reactions to public declaration of their experiences, apparently paralysed most victims into silence, thereby preventing either therapeutic or legal attention. This fear may also have led to tragic outcomes.

### **Other Suicidal Behaviour in a Remote Area**

The aetiology of suicidal behaviour was the focus of a study in the Kimberleys by Ernest Hunter. Over 4,000 coroner's files and/or death certificates were examined for the years 1957 to 1986 and, together with further community research, subsequent reports revealed a steady increase since the 1970s of Aboriginal deaths in early adult life due to motor accidents, other accidents, homicide and suicide (1988). The latter was reported to be increasing within the Kimberleys at an alarming rate. Most suicidal deaths (of which there were 14, 12 being male) were in a highly localised region, and for each a personal profile was compiled. All males used aggressive means (guns, knife, and nine used hanging) while the females used overdose and hanging respectively.

### **Causality**

Probing links between these fourteen suicides, local social circumstances, and some national social structural factors concerning Aborigines, Hunter (1988) suggests that Aboriginal males have become psychologically vulnerable to alcohol abuse as a result of the destruction of the Aboriginal sense of 'community'—described by reference to Durkheim's 'anomie' model. The recent ready availability of alcohol, he proposed, had enabled (not 'caused') this disenchanted and vulnerable population to indulge in self-destructive behaviour.

The authors feel that Hunter's theoretical approach is of special significance, surpassing the bounds of trans-cultural psychiatry, while declaring the need for a sociological analysis of Aboriginal suicide. He maintained that one cannot fully understand destructive behaviours,

without examining 'the consequences of social and political changes . . . of the last two decades', concentrating on the 'impact on constructions of the self and social integration'.

The 'causal' setting of Aboriginal destructive behaviours would appear to remain rooted in the past, yet it is clearly active in the contemporary economic and political milieu as well. Hunter proposed that, for Aborigines today, 'theoretical access to economic and political means, and thus to power, has never been greater'—while on the other hand, the dominant society does not provide sufficient resources to assist in building skills necessary to utilise that power—either at a personal/educational/psychological level, or at a material level—in order to establish the means to fulfil those ideals. A 'double-bind', therefore, would appear to be the key feature of the new political and social landscape inherited by Aboriginal people.

Tatz (1989) speculated on some of the social consequences of the colonisation of Australian Aborigines by indicating, for example, that even non-Aboriginals in our society who suffer poverty and/or other forms of discrimination have not had to withstand the sheer pace of social revolution in which 300 years of major change have been for some Aboriginal communities: 'telescoped into thirty years, sometimes twenty . . . or ten, or five', depending on the community. Such were, and to some degree remain, the pressures of the rate of change that Aboriginal people have had to withstand (Tatz 1989).

It could be argued that it is hardly surprising that widespread increases in suicidal and other destructive behaviours may have been 'triggered' in this most recent of historical epochs, when hope has been so intimately interwoven with confusion and frustration.

In tune with themes of the international literature, Hunter identified the particular 'at risk' group with regard to custody deaths in the Kimberleys as 'the young, adult male, confined in a lock-up, dying soon after arrest for a relatively minor offence, and being alone at the time of suicide' (Hunter 1988).

In the face of the 'dearth of information on Aboriginal suicide and deaths in custody', further interviews in the Kimberleys were held with 100 imprisoned Aboriginals which led Hunter to affirm that 'the lock-up collects a suicide vulnerable population', some of whom are juveniles.

Alcohol is frequently thought to 'cause' patterns of destructive behaviours amongst Aborigines, and whilst Hunter (1989) felt sure that 'symptoms of anxiety and depression . . . increase regularly with the quantity and frequency of alcohol consumption'. He also added that 'problem drinking' and suicide are best understood as 'surface expressions of issues at a profoundly deeper level of Aboriginal existence'.

They tend to intersect with only two government agencies—police and welfare. Censured for the expression of their powerlessness and exclusion—'unreliability, poor compliance, . . . manipulation', their 'failures' often are predicted and sometimes are welcomed. In short, they are treated as deviants, says this psychiatrist.

In response to the question 'Do general precedents exist in traditional Aboriginal culture for suicide?', one contemporary black perspective on 'Aboriginal problems' is unambiguous.

It is the Aboriginal contention that the current situation of their people is the product of European colonialism and racism, not of some theoretical prehistoric social, technological or psychological retardedness (Allen 1988).

Turning to earlier studies by medical personnel, suicidal behaviours were perceived by Cawte, as early as 1965, as 'emerging' for the first time; that is, they were not seen to be typical of tribal or traditional Australian Aboriginals. Rather, it was claimed that:

. . . depression, from being a rarity in traditional culture, is beginning to emerge more prominently in the transitional culture. With it comes suicide and attempted suicide, events uncharacteristic of tribal life . . . (1965).

Joseph Reser, a psychologist and Royal Commission researcher currently engaged in a study of Queensland Aboriginal suicides, provides a synopsis of the literature on Aboriginal suicide.

The medical and psychiatric literature has not been entirely clear . . . however, its existence has never been disputed . . . The reports from the 1960s and 1970s clearly suggest that the incidence of recorded suicide was low for some regions and some communities, [but that] it would be presumptive to conclude that this was a characteristic picture for Aboriginal communities generally, and erroneous to equate reported low incidence with nonexistence . . . there would appear to be considerable consensus among Australian ethnographers to the effect that there was no traditional precedent for suicide. Certainly suicide was not institutionalised in any obvious way, as in the case, for example, of many Papua New Guinea groups (Reser 1989, p. 45).

## Discussion

Increasing suicide amongst Aborigines would appear to be symptomatic of a general increase not just in self-destructive behaviours but in all forms of destructive, violent behaviours, substance abuses and unnatural deaths—at least amongst a significant minority of Aboriginal people confined neither to rural nor to urban Australian locations. As Tatz (1989) has demonstrated, such behaviour apparently continues to escalate despite the myriad of advances that have taken place in Aboriginal affairs in the last thirty years—from the advent of Aboriginal controlled health centres to political rights and the return of substantial tracts of land in most states—and Tatz and Hunter both suggest that these destructive behaviours are all symptoms of something deeper . . . something connected to the loss of hope for day-to-day living, and the loss of pride.

As has been stated, there would appear to be no general precedent in traditional Australian Aboriginal cultures for high levels of unstructured destructive behaviours of any kind—but to say that Aboriginal culture before European intervention was free of either emotional states such as depression (*see* for example, Morice 1978) or substantial violence would be to romanticise. Nevertheless, it would appear to be generally agreed even in the anthropological literature, that the 'new' violence that is being witnessed today in some areas is qualitatively and quantitatively different from earlier epochs. Hence, this recent phenomenon appears to bear little relation to genetic/cultural considerations *per se*. This does not mean however, that contemporary Aboriginal communities bear no responsibility for such behaviours, as the literature and numerous anecdotal reports together suggest the view that destructive forces seem to have gained their own considerable impetus and momentum within some Aboriginal communities, irrespective of the wider social 'origins' of those forces.

Returning to the most recent suicide data for South Australia—in each of 1988 and 1989, there were eight Aboriginal deaths recorded as suicides. In each of these years, four suicides were urban located, and four were rural. In 1988, six were male and two female; four were under the age of 20, (two of whom were rural living, one of whom was 15 years old, and two were urban). In the subsequent year, all were male, and just one (rural) suicide was under 21. From these data therefore, it would seem that no age-group, gender, nor Aboriginal region/community appears immune from suicide in South Australia, although the predominantly male pattern is sustained.

## Joint Study, Adelaide 1988-91

In 1986, following Aboriginal community concern over earlier suicides and suicide attempts in Adelaide, the Aboriginal Education Foundation (AEF), which is in regular contact with some 650 Aboriginal households in Adelaide for educational and family support purposes, initiated a joint study with the Department of Primary Health Care, Flinders University of South Australia. Two of three research instruments were designed cooperatively with the AEF and Aboriginal care-givers. They later became the focus of the research project, as housing tenancy was usually registered in their name, and also because they carry the day-to-day burden of their households.

Social and environmental matters are clearly of major importance to Aborigines. This is revealed succinctly in the definition of health given in the National Aboriginal Health Strategy Report (1989):

'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 and incapacity . . . life is health is life . . .

This was also borne out in the embryonic discussions with the Aboriginal care-givers. A 'new public health'—or social health, preventive approach to Aboriginal stress and destructive behaviours in their social setting therefore evolved, centred on the primary care-givers. It is these care-givers and their families therefore, that must support those 'youth' who would appear to be most likely to be potential suicide victims.

In-depth interviews with eighty-eight randomly chosen heads of household in state housing were conducted by Aborigines or persons well-experienced with and accepted by Aborigines. In an informal manner, major discussion points were probed on a range of social, cultural and highly sensitive, personal matters<sup>1</sup>.

The majority of households from which the sample was drawn (n=842) were those with whom the Aboriginal Education Foundation (AEF) had at some time previously contacted (estimated to be approximately one half of the Adelaide Aboriginal population), that is, those resident in Aboriginal Funded Unit housing. There is no list of all Aborigines normally resident in Adelaide.

On the parameters of age, geographic distribution, education level, duration of residency in Adelaide, and Aboriginal community origins and involvement, there is reason to believe that the randomisation process provided a representative group of Aboriginal care-givers (principally females), and their households. Seventy-two (82 per cent) were female adults, which reflected the matriarchal nature of these urban Aboriginal households. A smaller percentage of privately rented and/or purchased housing tenure was identified than is reflected in other published data.

The project is designed in three stages:

Stage I            Interviewing of random sample of Aboriginal household heads/care-givers.

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<sup>1</sup> These included: Anxiety; community ties; education and employment; family and relationships; finances and emergency aid; future hopes and fears; health problems; health services overview; household (cultural expression); housing; isolation; knowledge of parents; law; police and imprisonment; Aboriginal community outlook; personal mobility; prejudice and acceptance; problems and worries; self-abusive behaviour; aspirations and achievement; substance abuse; suicidal thinking; perceptions of treatment by government offices; violent and sexual abuse; 'visitors' to households.

Stage II            Interviewing of matched (as far as possible) non-Aboriginal supporting women. Dissemination of reports. Establishment of an Incident Register data base—with cooperation of Aboriginal organisations.

Stage III           Intervention/education on destructive behaviour: appropriate actions.

The random sample of eighty-eight adults that was interviewed in depth comprised mostly heads of households/care-givers (4-in-5, or 82 per cent), living in government rented housing, a very high proportion of whom were female (4-in-5, or 82 per cent).

The overall profile of the sample was the following:

Most had been in Adelaide over ten years, although many were born in non-urban locations. The average household size was four, and 1-in-4 had regular visitors who stayed more than a week.

More than 1-in-5 knew neither or only one parent. A significant percentage had suffered sexual (1-in-7, or 15 per cent) or other physical violence (51 per cent), often multiple assaults in childhood or as an adult.

Foster home or institutional experience was common; basic education was deficient due mostly to circumstances beyond their control, and there was clear evidence of attempts to improve their knowledge and skills. One-in-two had left school earlier than they now wished and a similar proportion had pursued some educational program since leaving school. High mobility was also common.

Many were experiencing substantial financial difficulty. One-in-four had sought emergency aid in the previous year and 2-in-3 (67 per cent) were in receipt of some pension or benefit (mainly supporting parents, or invalid pension, but also unemployment, aged or widow's pension).

Considerable isolation and loneliness was revealed. Almost 1-in-2 had no telephone (of 6 per cent for Adelaide as a whole); a similar proportion had no access to a motor vehicle. One-in-three had neither telephone nor vehicle. One-in-six had 'no close friend.'

One-in-three had no or weakening ties with 'outside' Aboriginal communities, and 1-in-2 used little traditional-oriented Aboriginal language/ways/customs or had little traditional culture-related discussion in their household: however, considerable caution is necessary in interpreting these data. Two-in-five had at least one current 'major health problem', and 1-in-5 claimed a present or past problem with alcohol. Twice this figure was reported in parents or caregivers and one half of the sample had at least one sibling and a past or present partner affected by alcohol.

Radford, et al. (1990) summarised that while most (9-in-10) claimed that they felt 'moderately or very well accepted' by society in general and all males could nominate at least one aspect of their lives in which they took pride, several females however, could see little hope for the future and day-to-day existence would appear to be a struggle for survival.

In relation to our earlier remarks concerning legal/judicial/penal effects upon this community, more than 2-in-5 in this sample (45 per cent, but 75 per cent of males and 39 per cent of females) expressed past 'trouble with the law'. Bearing in mind that 72 (82 per cent) of the 88 respondents in this study are female, and all but a few regarded themselves as 'heads of household', the results concerning imprisonment were as follows:

Eighteen (21 per cent) had been imprisoned at least overnight. Of these, 11 (61 per cent) were female. Therefore, 15 per cent of all females had been imprisoned. Of these 11, 10 were care-givers, of whom five were supporting women, and five were partnered. These 10 care-givers represented 17 per cent of the 58 female care-givers in the study.

Of those with custodial experience, eight (9 per cent) had been imprisoned two or more times, of whom three were female and five were male. One-in-two had been imprisoned for minor offences: almost the same proportion reported that their partners had

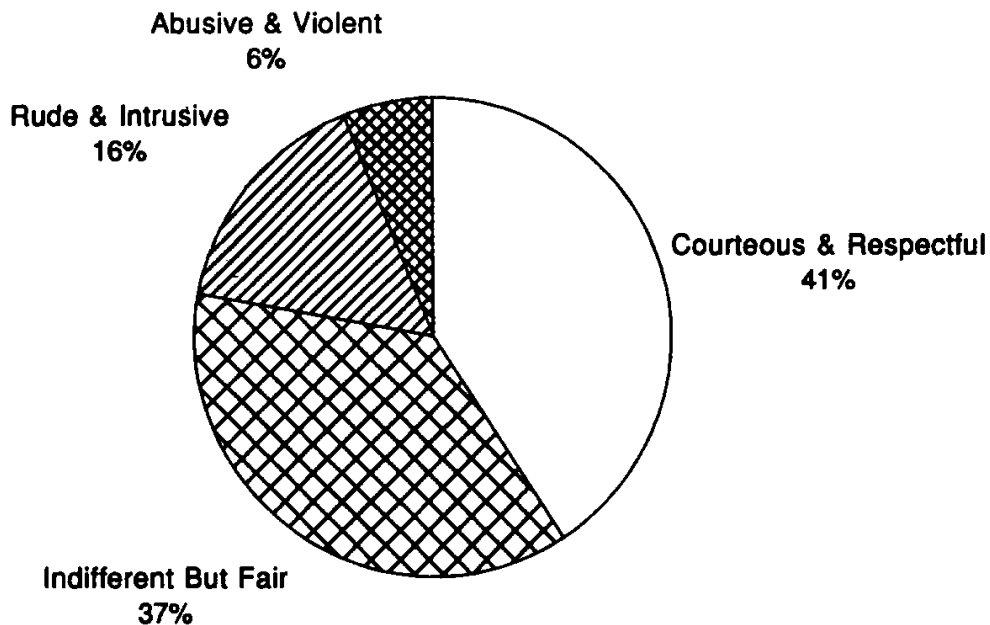
been imprisoned at least once. Nearly one half of the sample ranked 'gaol term' as one of the most stressful events (or likely to be so), which overall, was ranked as the fourth most stressful (past or likely) experience, following death, loss and health issues, and ahead of 'death of spouse or de facto'. Physical violence against self ranked next.

A very high level of experience of 'police contact' was reported. One-quarter of all respondents regarded 'frequency of contact with police' as one the most stressful matters of their lives. This ranked 14th (out of 34 items) and 'long-term unemployment' was 12th.

Most found their dealings with police were reasonable but 1-in-5 to 1-in-6 assessed police officers to be usually 'rude and intrusive', or, 'abusive and violent' in their dealings with them (see Figure 1). Similar perceptions were also apparent, in relation to 'usual' behaviour and attitudes of community welfare and social security staff. Two-in-three households had been visited by the police in the past two years with entry without a warrant being claimed in approximately one half. One-in-five had received alleged physical abuse by police.

*Figure 1*

**Perceptions of usual Police Attitudes and Behaviour  
(n=87)**



Thirty-five respondents (40 per cent) provided household reports of 'unreasonable police attention outside the home', 20 of which were personal experiences described to interviewers. This took two main forms: with alleged physical violence; and without physical violence (property ownership questions and assumptions). Cross-tabulations revealed these respondents were not particularly anti-police in comparison with those who did not report police 'attention'. In addition, 'persistent disturbance/unreasonable attention' outside the household was not associated with particular 'targeting' of respondents with legal histories. 'Unreasonable attention' was significantly associated both, with past experience of alleged physical abuse by police, (by a member of the respondent's household), and, with

the number of times police had called at the house. It would seem that respondents from frequently visited households are significantly more likely to also be subject to 'unreasonable attention' outside the home, usually, in the streets.

Generally speaking, the impact of law enforcement and judicial/penal interventions (together with social 'support' agencies) upon this Aboriginal community would appear to be considerable and a cause for particular and immediate concern; in particular, the impact of police attitudes and behaviour. Also, at least in Adelaide, fear of police apparently contributes to the prevention of help seeking, at least in abused females (Carter 1987), which could be related to this apparent concentration of police visits upon many (select) Aboriginal households, the members of which allege 'harassment'. In addition, we have already seen the (as yet unexplained) association between police custodial situations and unnatural Aboriginal deaths, including those resulting from 'head injuries'.

### *Suicidal behaviour*

One-in-three women reported past suicidal thoughts: one half of whom had had them during the past year and the same proportion reported past suicidal thoughts had developed more than once. One-in-five of the women interviewed (that is, heads of household, renting government housing) admitted a suicide attempt at least once (in half of these, more than once), usually by drug overdose or wrist-slashing. One-in-twenty identified at least one immediate family member who had taken their life, despite the fact that this was not specifically asked of respondents.

No evidence was found linking past suicide attempt with short duration of stay in the urban area, or with the number of children to care for.

### *Factors associated with suicide attempts*

The following factors were found to be associated with suicide attempts more frequently than could be expected by chance:

- employment instability of partner or care giver;
- lack of knowledge of at least one parent and foster home (but not institutional) experience by age 12;
- being in receipt of a pension or benefit;
- in receipt of past emergency aid;
- living in rented housing which was deemed unsatisfactory;
- personal mobility;
- lack of access to a private vehicle;
- frequent changes in employment;
- unemployment;
- a present major health problem in self or partner;
- drug abuse not including alcohol;
- number of police calls to the house;
- being bashed or sexually assaulted, a personal perception of non-acceptance by the rest of society, that minor violations of the law bring major distress; and
- frequent feelings of anger and that one did not have reasonable control of one's life.

Such associations in no way imply causality. Nevertheless, this constellation of factors pertaining to early life, present social circumstances, and personal emotional state and outlook combine to present a relatively cohesive picture both of historical oppression, and present day despair, pervading poverty and powerlessness which would appear to fit key aspects of the models of social crisis that have been proposed by Hunter (1989), Jacobssen

(1987), and Tatz (1989). Stage Three of the research (the non-Aboriginal supporting women comparison) will assist the authors to determine to what extent this is confined to the Aboriginal community, which will, in turn help to understand the 'class' as opposed to 'ethnic' dimension of self-destructive behaviour in Adelaide.

In summary, most Aboriginal heads of households and care givers in Adelaide can identify things in their lives in which they take pride and are able to form positive plans for the future. However, a significant minority of females were found who, as a result of the traumas of their past lives together with the level of stress induced by present economic, medical and other social conditions, have at least once (and often more frequently) contemplated or attempted suicide.

In a discussion of the similarity between these results and those reported in studies of American Indian suicidal behaviours, Hassan (1990) has concluded that:

One of the grim lessons social scientists have learned from the history of colonialism is that to destroy a society we do not need to kill all its members. The destruction can be achieved through the devaluation of society's social and cultural institutions through which social life is sustained and reproduced. This devaluation of social institutions produces anomie, hopelessness, despair and depression which condemn its members to a gradual and slow social death.

But this research has not been merely aimed to, as Tatz (1989) has said, reproduce 'more bad news'. As Aboriginal groups are participating not only in the design and execution of this study, but also in its interpretation of results, social, cultural, and political actions/interventions are being explored which combine professional and community-based preventive and ameliorative approaches.

**'Reflections Upon Urban Aboriginal Destructive Behaviour and its Prevention' by Muriel Van Der Byl and Maureen Neeson, community workers and members of the research team**

*Muriel Van Der Byl*

I am of Aboriginal descent—from the Ngarrindjeri Tribe situated on the Lower Murray region of South Australia. I have been employed by the AEF for the past eighteen years. Within our organisation we work as a team to achieve our aims and goals, which are, in outline, to support Aboriginal families in the following areas: education (all ages especially pre-schoolers); liaison in relation to housing, health, law, education and other social/welfare matters; nutritious meals in Aboriginal homes; emergency relief; country support (visits to Whyalla, Port Augusta, Quorn, Leigh Creek, Riverland); education of non-Aboriginal school students in Australian/Aboriginal history/culture and contemporary issues; and research such as the project of which this paper is a part.

In 1987, we had four suicides in a month in Adelaide. The families in the Aboriginal community were very distressed. They came to us and asked if we could do something to stop these tragedies. This is the first time I know of that the research has been asked for and done with Aboriginals. We were asked to find interventions and solutions to prevent destructive behaviour in despair.

In the old days the missions (reserves) were agents of social and structural change. European settlers' religion had far-reaching effects. Missionaries were ignorant of our languages and spirituality, underlying our well-established Aboriginal law, and what the land means to us. That is, our identity and pride. They regarded all Aboriginals as savages. Our ceremonies and initiations were regarded as worthless, savage barbarity. These well-meaning missionaries forced white man's society values upon us.

We got along in life by knowing how to live with nature and the land. We were taught the art of survival. Traditionally, the elders were the educators. That is one link which is missing today.

White man's society has oppressed us with the rape of our culture, and our land, but it has never been successful in breaking our spirit—up until now. Because of the drug scene, alcohol, and most of white man's diseases, which were entirely new to our Aboriginal society of the past. Forty-thousand years of a well established society has been destroyed in 200 years, and that is why we are now experiencing a wide social, and behavioural breakdown in Aboriginal families today. Our values have never been materialistic. Because of all of the breakdown in Aboriginal society today, we may not have a generation in the future. Many seem to be a part of a lost generation. The question of the deaths in custody is only touching the surface of a much bigger problem.

The research has shown some things about how these historical and current issues work in Aboriginal individuals of today, and how they are somehow related to suicide attempts and even suicides.

Traditionally, we do not think of land, housing, health, education, recreation, and so on, as separate or distinct things. Aboriginal people see everything as a whole, like a circle. Problems were solved by thrashing out issues over a long period of time. Now we are asked to do things 'yesterday', without time to think or to get together enough. It is like 'divide and rule' all the time, even if it is not intended to be.

Even in the cities, we need to work with an overall coordinated approach. This may give some hope back to our people, especially our young people. Too often the lack of continuity of staff and programs contributes to this fragmentation of our community and our goals.

We need to be able to implement our own policies, not other peoples'. . . to be given greater control so that we can make decisions that affect our people. In housing we need to be able to decide how to tackle the problems, and not just as advisers to 'white-fella' bureaucracies, but actually to say what is going to happen and how and when. It is the same for health. We can work with white-fellas; obviously, we have been doing so for years, but who has called the tune? Who has set things up without proper support for poorly trained individuals who then fail? Who is asking us to justify ourselves all the time? We have to be able to plan how to look after our people—to restore the sense of wholeness. Over the years Aboriginal people have always been asked to walk to white man's directives; what we are saying is that we all have to waltz together, but we must share in the composition of the music.

At a meeting not long ago, an Aboriginal youth worker told us that some of the Aboriginal kids who committed suicide by hanging had a knife in their hand or in their pocket—which may have been intended to be used to cut the rope, either by themselves (if they changed their minds) or by a rescuer . . . Maybe this sort of tragedy is really a cry for help, because no one takes them seriously. If one is to take something away from someone, they should have something to put in its place.

Our kids feel such hopelessness; their parents must take more responsibility in the well-being of their children, and, therefore, take a closer look at their own short-comings. We should listen more to what our kids are saying and their ideas. Parents and other people generally forget that. Whiteman's justice system has to learn to be more sensitive to Aboriginal cultural matters and to recognise how the history of our people has affected us—but it also has to learn how to deal with our kids consistently, so they know where they stand.

Culturally, we Nungas can never be united as one nation—without being assimilated. There is not 'one' Aboriginal people, except in a general sense . . . Each major tribal group has its own language and history and land: this makes it even more important that white

fellas learn to listen to each group as there are no easy answers. It is especially hard for Nungas in the cities who, though they may have lost much traditional culture, still have special ways of looking at the world, and at relationships, and the environment. It follows that any family support approach that aims at preventing suicide must work as part of the overall strategy of providing appropriate housing, health, education, and welfare that is understood and culturally accepted.

If the families are given hope, it will rub off on the kids. If they start to get hopeful, they will throw their drugs away and see how they can help each other to build our future again. They will see suicide as giving up and giving in. We have got to provide genuine positive alternatives to this destructive behaviour. Psychiatric treatment may help in the short term, but it is not the whole answer. We have got to set up networks of capable caring individuals (maybe those that have attempted suicide in the past and learnt from those experiences) to reach out to the ones that are isolated and despairing. This means that organisations like ours that are working with families need to be much better resourced to get on with their jobs properly, and with every part of our community—and now . . . before it is too late . . .

The government does not have all the answers, as I have already talked about how important parents are in all this, but the government has to help us bridge that 'deadly gap' that exists between the 'expectations' and the 'achievements'—as the psychiatrist from the Kimberleys, Ernest Hunter, and Colin Tatz have both said. These are not just words for academic ladder climbing. They are about lives, and about the future of our people in this (our) land.

*Maureen Neeson*

#### The prevention of youth suicide—an Aboriginal perspective

The focus of this outline of our work is the following:

- the family;
- parent support;
- the encouragement in the use of community networks;
- the teaching of new approaches and attitudes in parenting and family functioning

Any attempt at self-injury by one or more members of the family affects the entire family. Practical measures need to be presented to form a balance between the needs of the individual and of the family as a whole, and in such a way as to enhance constructive or coping behaviours for both.

Every destructive behaviour has a goal, which may or may not be conscious. The goal of self-destructive behaviour is to devalue oneself. Practical assistance needs to create better understanding of self, of the behaviour and its consequences, and has to be appropriate to the individual need and cultural context.

Recent history for Aboriginal people (particularly in cities or large towns) has rendered their present communities to be diverse in the degree of traditional or urban characteristics. Recommendations need to be sensitive to these differences.

Some generalisations can be proposed:

- The majority of the families that the AEF deals with are economically impoverished.
- The once defined family ties are now mostly fragmented and obscured.
- The difficulty in adapting to material based cultural values and goals.
- The tentative appropriation, even now, in the late 20th century, of an individual existential identity in life, as opposed to the collective identity and circular orientations of the Dreamtime way of perceiving life. Due to complex historical consequences of the destruction of Aboriginal social structures, many people appear to have significant difficulty in functioning in the Western dominant, individualist culture, and yet this is required of them in many circumstances.
- The lack of an effective basis to transfer traditional traits into current lifestyle to meet societal expectations.
- The persistence of a reluctance to use mainstream institutions and support agencies.

These elements often mitigate against individual and family functioning in a consistently constructive manner as well as forming obstacles towards youth working through their way between dependence in childhood and independent adulthood.

It is recommended that new approaches to family support be made more available to Aboriginal families to utilise as they feel able and appropriate.

*Practical suggestions: family support*

In the form of extra family assistance, for example:

- teaching—to groups at community houses (parenting program to be overseen by an elder of that community);
- 'hands-on' help in the family home (practical support and role modelling);
- to build on informal Aboriginal support networks with special reference to those families which are functioning effectively; and
- encouragement in the use of appropriate support agencies (for example, family support workers, Child and Adolescent Mental Health Services, and youth projects), and so on.

*Further suggestions*

- Assisting parents to cope in their environment (urban or non-urban).
- Reviewing of goals and values of parents and their children.
- Identification of specific types of support required for the family.

- Assisting parents to build up their own self-esteem, pride, and confidence. This would subsequently benefit the whole family.
- Allowing the parents to be honest about how they feel so that they do not feel the pressure of blame or inadequacy.
- Show parents how to create the elements for optimal family functioning—by demonstrating such skills or approaches as effective support, discipline, consistent positive reinforcement, empathy, nurturing, affirming, and patience.
- Facilitate the breakdown of antipathies towards seeking assistance for personal and family problems, from appropriate services.

This could be achieved by informing people about both the available agencies in the Aboriginal network, and other mainstream supports, which may be expressed by referring to such bodies as a supplement to the consultation of elders, which are becoming less available due to the considerably reduced life-expectancy of Aboriginal people. Such an approach may assist some people to transfer their terms of acceptable reference of learning from one form to another. As there is no Aboriginal psychiatrist or psychiatric nurse in Adelaide for instance, and psychiatric help may be appropriate, such assistance may be more acceptable if put to families in this manner.

### Acknowledgment

The joint study discussed in the latter part of this paper has been published as a monograph, *Taking Control*, and is available from the Department of Primary Health Care, Flinders University of South Australia. It would not have been carried out without the initiative, the 'framing of the problem', and the active involvement of the Nunga community of Adelaide. To them go the thanks of the Study Team for their ready cooperation.

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# SUICIDE: THE CORONER AS CATALYST

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SUICIDE IN OUR COMMUNITY HAS ALWAYS OCCURRED AND WILL CONTINUE TO occur. Although there is great change in our community's preparedness to speak openly about suicide the issue will never receive the attention it warrants until there is public understanding and acknowledgment that a problem even exists.

In general terms, suicide is the second largest class of death by external causes after motor vehicle collisions. Between the ages of 25 and 44 years, as many people have died by suicide as by motor vehicle collision and that age bracket comprises approximately 40 per cent of all suicides. The next largest group of suicides comprises the 15 to 25 age group nearly being 20 per cent of all suicides. The relative percentage is greater by reason of the latter age group comprising a nine-year age bracket, while the former group comprises a nineteen-year age bracket. Approximately 10 per cent of all coroner's cases in Victoria involve suicide.

Youth suicide is a most concerning area of suicide and its destruction of young life has implications for the long-term affairs of our community. The real question is whether our community even knows of the issue.

In a learned gathering of experience and expertise, one speaks with the converted, the specialist and the informed. In the context of expertise in the subject of suicide and, in particular, youth suicide, it is accepted that the coroner is not an expert. However, there is an area in which a modern coronial service can assist in a manner which has not previously occurred and which is not generally understood.

The qualification for coroner in Victoria is a law degree and, in the context of suicide, its issues and its specialty understanding, the coroner is not an expert. However, it is the coroner's statutory duty to administer the coronial service in a manner to enable appropriate investigation of death by suicide by harnessing the knowledge of experts for broad use and advantage of the general community.

In the coroner's investigation, the coroner is not a source of expert knowledge but is a catalyst by which the information and conclusions of that expert knowledge can be converted to broad community use and understanding.

## **Failure**

Coroners around Australia, and indeed throughout the world, have not really come to grips with suicide. One significant reason is the limitation imposed by considering only one case at a time independently of all other cases. A consideration in isolation of one set of facts has tended to result in coroners concluding substantially the factual mechanism of death, whether or not it is suspicious, whether or not the deceased's conduct resulted in his own death and whether or not the deceased intended to take his own life. This constitutes a legalistic approach to one case and provides legal conclusions for one case but does little else.

Another significant reason for the failure of coroners in dealing with suicide is a preoccupation with legal admissibility of evidence. This is seen clearly in British coroners whose concern in suicide is whether or not the deceased's intent to take his own life has been proved beyond reasonable doubt. In other words, the consideration is one of criminal law standard of proof.

In the face of the compelling public issues of suicide, the function of coroners in a manner just described is accepted as being a legal function which has some value. However, in the context of social function and in considering community learning, understanding and prevention, the coroner's traditional legalistic role does not adequately serve a modern community, does not deal with important community issues and has failed.

## **Fresh Approach**

It has been necessary to abandon the traditional British coroner and develop something different and of relevance to our modern society. In Victoria, this has been done and it is necessary to describe the changes in order to understand the modern coroner's function.

Prior to mid-1986, being the commencement of the Victorian Coroners Act 1985, a coroner in Victoria was substantially identical to a coroner in England. The strength of an English coroner is his ability to conduct an inquest in which, in theory, public issues and concerns can be dealt with and concluded in a public forum. The weakness of the English coroner is his function being limited to a court-based process of conducting a public hearing to the exclusion of broad involvement in an investigating process for which he is responsible.

On the other hand, the American Medical Examiner is an investigator for the purpose of determining medical cause of death. He is responsible for his investigation process but the investigation stops with the medical cause of death. The weakness of the American Medical Examiner is that he has no ability to deal publicly with public issues which may apply to cases he investigates.

The Victorian Coroner is a statutory hybrid of the British Coroner and the American Medical Examiner. He is an investigator with responsibility for his own investigation. He has a resource in the Victorian Institute of Forensic Pathology which provides the medico-scientific process akin to that of the medical examiner. He also has a public hearing process in which matters of learning, understanding and prevention are placed in the public domain.

The modern coroner's process is not limited by legal considerations of evidence. Instead, the Victorian Coroners Act provides that the coroner is not bound by the rules of evidence and can be informed in any manner which is reasonable.

The modern coroner's process is not limited to considering one case at a time. Rather, the Victorian Coroners Act enables the investigation and public hearing of many cases considered together. This enables consideration of broad issues and the obtaining of broad understanding with a view to securing the best prospect of meaningful prevention.

## Functions

The functions of the modern coroner are as follows.

- In circumstances of the coroner's absolute and exclusive control of the body of the deceased the coroner's first function is to enable registration of death and the lawful disposal of the body of the deceased.
- The coroner's second function is to investigate every aspect of death reported to him in order to conclude:
  - the deceased's identity;
  - all the circumstances surrounding the death;
  - the medical cause of death;
  - the particulars to enable registration of the death; and
  - the identity of any person who contributed to the cause of death.

In this investigation, the coroner relies not only on his own administration and understanding of the event being investigated but also on specialist investigators which may comprise police experts, scientists, forensic pathologists, aviation investigators, dangerous goods and industrial investigators and any and every other specialist who can assist in the coroner's investigation.

- The coroner's third function is to investigate every aspect of those fires which raise public issues in order to conclude:
  - the source and origin of the fire;
  - all the circumstances surrounding the fire; and
  - the identity of any person who contributed to the cause of fire.

In this investigation also, the coroner relies not only on his own administration and understanding of the event but also on specialist investigators which may include police experts, arson chemists, fire service investigators, explosives experts and any and every other specialist who can assist in the coroner's investigation.

- The fourth function which the coroner performs is to draw together the expert materials and conclusions so far as relevant to his investigation in order to analyse, learn and understand the event being investigated and with a view to seeing if there is anything which could be done to avoid the unnecessary repetition of tragedy.
- The fifth and perhaps most important function which the coroner performs is to inform the community and government publicly of the matters analysed, learned and understood and of how to avoid the unnecessary repetition of tragedy.

The coroner's work is not involved with civil or criminal liability. Rather, he is a civilian investigator obtaining fact and causation for the purpose of public analysis, public learning and public understanding. By this process, the coroner informs the community about its own affairs to enable the community to take whatever action is needed to prevent repeated injury to itself.

The coroner is a public messenger whose task is completed on delivery of the message. It is then up to the community itself to decide how or indeed whether it will act on the information provided.

In other words, the coroner is a social catalyst. He converts the expertise of specialists into public knowledge and public conclusion with a view to the community acting on the learning. In that process, the coroner is not consumed but simply contributes to the public process.

## **Structure**

The Victorian Coronial Service is a tiny organisation in which the full-time, twenty-four hour per day central administration of the state Coroner's Office comprises a total of thirty people. Around the state of Victoria, there are coroners and coroner's clerks constituted by magistrates and clerks of the Magistrate's Court and totalling some seventy people. The whole of the Victorian Coronial Service comprises approximately one hundred people.

The Coronial Service has a broad range of activity and responsibility. Its work and jurisdiction cuts across all areas of society in its general affairs. The coroner is able to perform his task only by relying on every outside individual, organisation, institution, government service and specialist function relevant to any investigation. Indeed, the coroner relies on the community as a whole.

Immediately, it is seen that the art of a viable Coronial Service is its ability:

- to harness many disparate forces to a concentrated point in the civilian affairs of society;
- to cause a process of reaction between the harnessed forces of specialist investigation and the community's affairs; and
- with a view to public analysis, learning, understanding and social change.

In every sense of the word, the Coronial Service is not a force in itself but rather is a catalyst by which many forces in the community expend their own energy in social change.

## **Process**

The coroner's process is now that of an investigator as opposed to his former sole task of hearing inquests. The coroner's investigation commences at the scene of event and may or may not involve an inquest. The inquest is both a process of public investigation and a statutory public forum for public information and public learning.

The purpose of the investigation is to find the surrounding circumstances, fact and causation with respect to death and to perform that task in a way that enables meaningful, informed and broad-based public comment, recommendation and report for the purpose of public learning, understanding and prevention.

## **Expertise**

It is apparent that the coroner's process is only as good as the information, expertise and knowledge provided it. Consideration must, therefore, be given to a mechanism whereby specialist knowledge may be obtained.

The Victorian State Coroner's Office has commenced a process whereby suicide could be considered by the Coronial Service in a manner that may be meaningful for modern times. Thereby ceasing the process of traditional case-by-case consideration, completion and then filing for nothing more than posterity of each suicide case considered by a coroner.

Instead, there is a compiling of all current suicide cases as they occur over a period of time. There is then a consideration of factors such as number of cases, age, gender,

method, attempts, prior indications and underlying factors—all of which may identify particular types of cases as a class, group or having similarities. There is then produced a crude working picture of current cases.

A panel of specialists has been formed under the organisation of the Victorian branch of the Royal Australian and New Zealand College of Psychiatrists. We have commenced to send a copy of every file to the panel for advice of what the materials mean to a specialist, what further information may be required, what can be learned and whether there is prospect of realistic prevention.

This is but a humble beginning of a Coronial Service conceding that it has previously failed and accepting that it needs guidance and direction to enable appropriate meaningful specialist information and understanding to be placed into the public arena.

It is apparent that there are many specialties and areas of expertise involved in suicide. There is clearly needed an involvement in the coroner's process of the range of specialists and expertise.

The mechanism of approach may commence, for example, with a group of fifty current coroner's cases which could generally be described as comprising a class of identifiable group of cases. The fifty files could be considered by, and advice obtained from, a range of experts. That consideration and advice may require more information but ultimately will provide interpretation, understanding and consideration for prevention.

Five of those cases may be worthy vehicles for public hearing as containing all the issues which need to be considered in detail in the public process. The remaining forty-five cases could be concluded without inquest and then produced as exhibits in the public hearing process in order to provide a broader basis to the facts in the hearing process and the issues to be considered.

As well as calling witnesses of fact in each of the five cases heard together in one continuous hearing, there would also be called as expert evidence a representation of the specialists which have previously considered the materials and advised. The expert evidence is the means by which the interpretation, understanding and questions of possible prevention are placed into the public arena.

Coroners' findings, comments and recommendations are made to cover the facts and the expert materials. These matters are recorded and produced in a public forum for the purpose of public information. The same materials are provided by way of report by Coroner to the Attorney-General by way of information to government.

## **Benefit**

One benefit from the type of process envisaged is that there can be made available to experts in the field the real primary source facts of suicide as and when they arise. It is clearly of great importance that any interpretation and understanding which may be derived from considering the current materials is disseminated, published and discussed by experts in the field as a matter of current knowledge and ordinary process of specialty.

No-one thinks that any issue of public concern can be remedied overnight. Everyone involved in the issue is interested to resolve the issue of concern in one way or another. The coroner has a role to play along with many other players. What is significant is that the coroner's role may be able to contribute something worthwhile to the process of public learning and understanding as a basis of community response. Without community response we will never properly tackle one of the most difficult areas of unnatural death.

## **Conclusion**

The ultimate benefit which may be derived from effective use of the coroner's process is the informing of a community and the converting of specialist knowledge and understanding to public learning, understanding and consideration of prevention. Until we can communicate the issue of suicide and its community consequences to the community as a whole and to those who organise its affairs, we will all continue to be restricted to discussion amongst ourselves. The first steps in the community responding to our concern with suicide as a significant issue of the community's affairs is the community sharing our awareness and concern.

# **ISSUES OF SUICIDE PREVENTION: 'YOU CANNOT COUNSEL THE DEAD'**

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SUICIDE PREVENTION ENDEAVOURS MAY BE DIVERSE. THIS PAPER DISCUSSES issues of primary and secondary prevention. Australia compared with other nations has an alarmingly high rate of young male suicide and, with this in mind, secondary preventative strategies that rely on impinging on the availability of culturally accepted relatively lethal methods of suicide are examined. Political pitfalls are highlighted before specific attention is given to suicide by drug overdose and firearms. Young Australian males have high rates of firearm suicide which coincide with findings from North America. It is suggested that tightening of firearm legislation might reduce overall suicide rates. It is noted that addressing social problems relevant to suicide is of undisputed importance but this should be combined with more direct practical measures to reduce death rates.

## **Issues of Prevention**

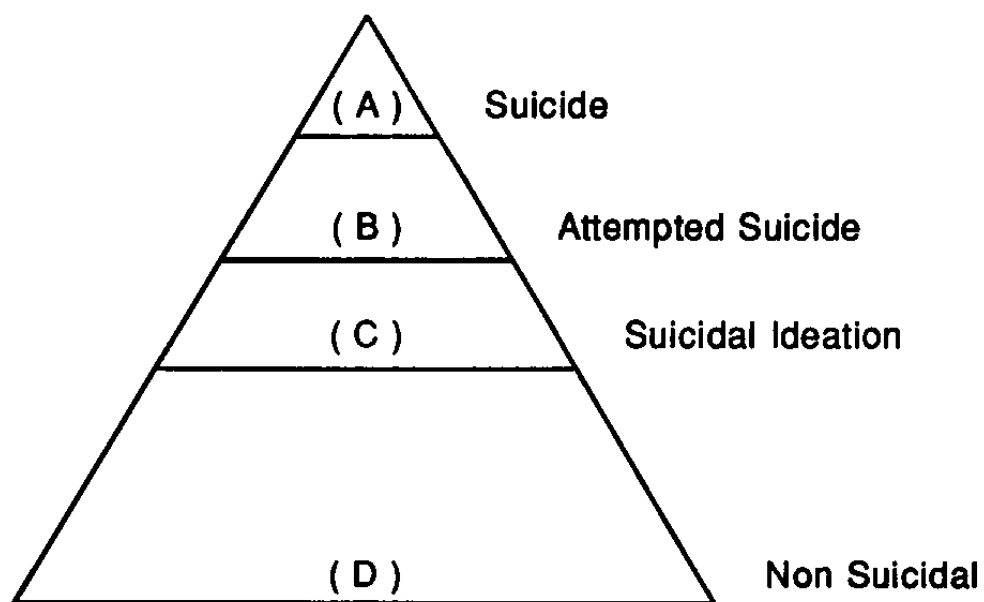
Primary prevention is the ideal of many areas of health care. It involves preventing individuals from developing the condition by modifying the risk to which the individual is exposed. The mental health field has a disappointing record in this area. All too often good ideas regarding primary prevention are later shown not to work. Secondary prevention has fared better—in this an individual may have reached a suicidal state but he is identified and assisted before significant harm develops. Put alternatively, primary prevention could prevent the initial occurrence of suicidal ideation or behaviour; secondary prevention could prevent non-lethal suicidal behaviour from progressing to death—either by removing the means for committing suicide or providing a therapeutic intervention (Shaffer 1990).

An illustrative, if imperfect, model of suicide prevention is shown in Figure 1. At the apex of this pyramid lie individuals who die by suicide. Beneath in order of descent lie attempted suicides; those with suicidal ideation and finally the remainder of the population who have no ideas regarding killing themselves. Let us suppose we wanted to design a strategy to prevent suicides—at what level might one intervene? The answer is at any level.

An intervention at the base of the pyramid might include educating a total population or generation, for example schoolchildren. They might be educated in stress management, coping with suicidal ideas or both. For this intervention to be effective, its effect must be resilient enough to permeate up the pyramid all the way to the apex—suicides. In other words, the education has to reach someone who, without it, would otherwise have belonged to the population at the top. Clearly, the intervention must touch many individuals who will not be at risk.

*Figure 1*

**Suicide Pyramid**



An alternative approach would be to intervene at the very peak: for example, by taking individuals who are in the process of dying by suicide and bring them back from the brink of death by effective medical resuscitation. Indeed, this is one of the few suicide prevention strategies that is likely to have substantially reduced suicide rates (Brown 1979). However, it would not solve needy psychological or social problems. Some of you may feel such interventions cheat by colluding with a wider social system that chooses to neglect the needy and produce a cheap fix to an embarrassing problem. There is some truth in this sentiment. However, the value of life must not be dismissed while pursuing causes in the name of social justice. Saving the life of someone who has just taken a potentially lethal overdose is every bit as important as resuscitating the victim of a motor vehicle accident. Anyone who has counselled families who have just lost loved ones by suicide will appreciate this.

Turning back to the pyramid, interventions may occur at any level between the two extremes. The medical system has conventionally provided services for attempted suicides and those with suicidal ideation. There is some wisdom in intervening at these levels in that it focuses efforts on high-risk groups. However, this pyramid is a misleading sham. It is not drawn to scale. For line (A) to be one inch or two-and-a-bit cm, line (B) should be over a

foot or 30 cm, line (C) considerably longer and line (D) should stretch for approximately 250 metres. When this is borne in mind, the huge potential costs in terms of resources become evident—and the realisation that these may never be delivered on a wide scale. Also, the possibility that an individual not at risk might be turned into a suicide becomes more apparent. Interventions strong enough to reach the apex may carry this risk when such large numbers of individuals not at risk are introduced to the concept of suicide.

### **International Data**

The major concern of this conference and worldwide must be the recent rise in suicides in males aged between 15 and 29 years. For most countries, young male suicides greatly outnumber female suicides—in Australia, this is so by 5:1 (Diekstra 1989). Of 19 countries surveyed by Diekstra (1989), Australia has the second highest rate for young male suicides (see Table 1). However, for the 30 to 59 age group it ranks only 12th and for the 60+ age group it ranks 13th (Diekstra 1989).

There are many perils in the interpretation of international data because of different data collection systems (Sainsbury & Jenkins 1982). Generally, national suicide data range from approximate to gross underestimations. But we can safely say that, while the world should be concerned regarding the young, Australia should be doubly concerned. Before leaving this table, notice also that, apart from having a high young male rate, the other unusual feature is that the rate is uniform across older groups. Inspection further of Diekstra's data reveals that there are three other countries that have both high youth rates and a relatively uniform distribution—Canada, the USA and New Zealand. What might this mean? We shall return to this later.

### **Methods of Suicide**

In a critical review of the impact of different interventions on suicide rates, Brown (1979) found little evidence to support suggestions that conventional services lower rates. He did suggest that it is highly likely that improved medical resuscitation of the self-poisoned has influenced suicide rates. In addition, he cited evidence regarding the detoxification of domestic gas in the UK. Domestic gas had accounted for 40 per cent—almost half of UK suicides—until the coal gas was phased out in the 1960s (Hassal & Trethowan 1972; Kreitman 1976). The following decade saw a sustained reduction in suicide rates by about 20 per cent. Note the elimination of a method accounting for 40 per cent of suicides achieved a 20 per cent reduction. This is consistent with the notion that approximately half switch to another mode of death while a half fail to kill themselves. There was some criticism of the UK findings as no reduction was demonstrated in The Netherlands following detoxification. This criticism is easily dismissed when it is realised that gassing accounted for only 7 per cent of suicides in The Netherlands prior to detoxification (Shaffer 1990). It would be very hard to demonstrate a significant fall with such numbers. Incidentally, Whitlock in Brisbane suggested that detoxification did achieve a reduction in mortality there. More importantly, he described a reduction in drug related fatalities following restrictions on the prescription of barbiturates—a highly lethal group of drugs (Whitlock 1975).

Table 1

**Male Suicide Rates per 100,000 1970 and 1985-86  
by country and age**

| Country         | 1970  |       |       | 1985-86 |       |       |
|-----------------|-------|-------|-------|---------|-------|-------|
|                 | 15-29 | 30-59 | 60+   | 15-29   | 30-59 | 60+   |
| Hungary         | 33.2  | 70.6  | 131.3 | 33.5    | 98.3  | 156.9 |
| Australia       | 15.3  | 29.1  | 33.2  | 26.1    | 22.3  | 28.6  |
| Canada          | 17.1  | 27.1  | 23.9  | 25.6    | 26.2  | 28.2  |
| Denmark         | 15.3  | 44.7  | 50.0  | 24.3    | 47.1  | 72.5  |
| Belgium         | 8.8   | 27.0  | 76.0  | 22.7    | 38.6  | 85.8  |
| France          | 11.3  | 32.2  | 68.5  | 22.7    | 41.5  | 93.7  |
| USA             | 16.2  | 25.4  | 39.3  | 22.6    | 23.6  | 43.4  |
| West Germany    | 22.8  | 39.5  | 67.7  | 19.7    | 32.3  | 59.2  |
| New Zealand     | 11.1  | 21.2  | 26.8  | 19.6    | 18.5  | 33.1  |
| Japan           | 16.5  | 20.8  | 70.2  | 18.4    | 40.3  | 64.7  |
| Czechoslovakia  | 32.5  | 52.3  | 87.9  | 18.1    | 43.4  | 79.7  |
| Ireland         | 2.8   | 5.0   | 4.2   | 15.9    | 15.9  | 16.1  |
| Scotland        | 6.7   | 14.9  | 20.8  | 15.8    | 23.4  | 21.1  |
| Bulgaria        | 9.8   | 16.2  | 82.5  | 14.0    | 22.8  | 102.5 |
| Singapore       | 10.4  | 21.3  | 98.4  | 12.7    | 18.1  | 99.4  |
| Venezuela       | 14.6  | 17.4  | 19.1  | 10.9    | 13.4  | 23.4  |
| England & Wales | 6.7   | 13.0  | 21.4  | 10.5    | 16.7  | 19.9  |
| Netherlands     | 6.0   | 14.1  | 35.1  | 10.0    | 17.7  | 37.7  |
| Mexico          | 3.1   | 3.4   | 5.8   | 4.3     | 4.1   | 9.6   |

Source: Diekstra 1989

In looking at the methods of suicide in Australia (*see* Table 2), it is clear that secondary prevention efforts could be focused on the four principal methods—firearms, hanging, motor vehicle exhaust gas and drug overdose.

Hanging may seem a daunting prospect to limit by decreasing availability. In part, it is, but if it is understood that many hangings occur in institutions—such as gaols and psychiatric units—opportunities for prevention become readily apparent (Dooley 1990; Hurley 1989). Improved monitoring and better design regarding potential anchor sites might prove effective (Jordan et al. 1987).

Non-domestic gas deaths are mainly motor vehicle exhaust gas deaths. Between 1961 and 1981, 10.6 per cent of suicides were by non-domestic gases. During this period, the proportion of deaths by this method climbed and continues to do so (Australian Bureau of Statistics 1983; 1988). Decreasing the carbon monoxide (CO) oxidising capacity of engines, designing slot shaped exhaust pipes (incompatible with hoses) and an automatic idling stopping device (dependent on time and ambient carbon monoxide concentration), have been suggested as preventative strategies (Lofling et al. 1989). The reduction of CO content in exhaust gas in the USA following the introduction of emission control standards in 1968 was associated with a significant although complex fall in overall suicide rates by this method (Lester 1989).

Table 2

**Methods of Suicide: Australia 1968-81**

|                                     | All ages<br>% | Under 25<br>Years |
|-------------------------------------|---------------|-------------------|
| Firearms and explosives             | 26.8          | 36.6              |
| Solid (drug) and liquid substances  | 33.2          | 21.0              |
| Hanging, strangulation, suffocation | 12.8          | 12.0              |
| Non-domestic gases and vapours      | 10.6          | 11.2              |
| Other/unspecified                   | 4.0           | 3.55              |
| Submersion (drowning)               | 4.0           | 1.4               |
| Gases in domestic use               | 3.4           | 2.9               |
| Jumping from high places            | 3.2           | 4.5               |
| Cutting and piercing instruments    | 2.0           | 0.5               |

The comparatively low rates of suicides by drowning is most likely a function of the high degree of proficiency of swimming in Australia—making such a method less attractive and more difficult.

Jumping from heights is a localised problem in cities with high bridges or cliffs. A recent study (Cantor & Hill 1990) in Brisbane compared subjects jumping from two adjacent bridges over the Brisbane River. The two bridge populations differed with regard to marital status, employment status, extent of previous psychiatric treatment, time since last contact with caregivers, place of residence and time of day (of jump). The highly significant differences of the two populations suggests that those prevented from jumping from one bridge by, for example a barrier, in the main would not jump from the other bridge.

That only 0.4 per cent of suicides were by domestic gas testifies to the likely impact of detoxification of gas in Australia. Between 1966 and 1971, the rate of this method fell from 7.9 per cent of all suicides to 2.3 per cent (Australian Bureau of Statistics 1983).

Self-cutting by young people is the second most common method of attempted suicide or parasuicide presenting to hospitals after drug overdoses. Yet it accounts for only 0.5 per cent of suicides. This belies the importance that reduction of suicide rates by reduction of the availability of a method requires that method to be relatively lethal. Availability and relative lethality are two essential ingredients. The full equation is that for any given method of suicide to be a major problem the method must be not only available and relatively lethal but must be culturally accepted. Self-incineration and ingestion of pesticides are common methods of suicide in the Third World but appear distasteful to western cultures—reflected in very low rates by these methods.

### **The Politics of Intervention**

For a major intervention to decrease the impact of a certain method of suicide, careful planning is necessary. Firstly, does the method constitute a significant problem? Secondly, is there the political and community goodwill to support such an intervention? For example, suicide proofing of prison cells might be politically well received—it is a relatively easy partial solution to an embarrassing problem. However, if the intervention was delivered clumsily, without appreciation of other issues, it might not be well-received by, for example, Aboriginal communities, who might be concerned that it might divert a government response from needy social issues. A third principle to consider is whether there is a powerful third party with a financial or other interest in opposing the intervention. It seems that caregivers

tend to be extremely naive with regard to this point. The Golden Gate Bridge in San Francisco has witnessed over one thousand suicides yet, after decades of campaigning for a barrier, there still is none—in possibly the most litigious culture in the world . . . Why? Will the motor vehicle industry rally to a call for exhaust modifications to reduce suicides? One would have to be joking. However, for other reasons, for example pollution, those interested in suicide prevention might then join this momentum.

### **Drug and Firearm Suicides in Australia**

Two other issues to be addressed are lethal drugs used for overdoses and secondly firearms. Note (see Table 3) that to a certain extent these methods are sex specific—overdoses female, firearms male.

An intervention regarding overdoses has a useful head start as it causes embarrassment to the medical profession, some of whom will be readily supportive of change and others, though more resistant, at least do not have a financial interest in blocking change. With firearms, the problem is severe and has some community concern from other sources, for example, those concerned about other forms of violence. However, it evokes considerable resistance from highly organised and heavily financially backed opposition groups. In addition, one in three households in Australia already possess firearms (Harding 1981) so change may be resisted.

Finally, firearms may be a symbol to some of power and masculinity so the threat of reduction of this may evoke unusually strong resistance.

*Table 3*

#### **Methods of Suicide, Australia, by sex 1968-81 for persons under 25 years**

|                                     | Male<br>% | Female<br>% |
|-------------------------------------|-----------|-------------|
| Firearms and explosives             | 44.3      | 11.1        |
| Solid (drug) and liquid substances  | 11.0      | 57.4        |
| Hanging, strangulation, suffocation | 13.4      | 7.1         |
| Non-domestic gases and vapours      | 12.7      | 5.3         |
| Jumping from high places            | 3.4       | 8.4         |
| Other/unspecified                   | 3.5       | 3.8         |
| Gases in domestic use               | 2.5       | 4.3         |
| Submersion (drowning)               | 1.2       | 2.0         |
| Cutting and piercing instruments    | 0.5       | 0.6         |

### **Overdoses**

Let us turn first to a survey of drug suicides in Brisbane (Cantor 1989) (see Table 4) covering the years 1979 to 1987. Note that psychotropic drugs accounted for 84 per cent of single substance deaths, emphasising the contribution of psychological disorders to suicide. The barbiturate group accounted for more than one-third of single substance deaths. Chloral hydrate, a rather unpleasant hypnotic that happens to be cheap, was by far the most common individual compound accounting for 13 per cent of single substance

deaths. Barbiturate deaths have declined since the late 1960s coinciding with the substitution of safer benzodiazepines, better prescribing practices for depressed patients and legislative restrictions on the prescription of barbiturates (Whitlock 1975). Nevertheless, continued pressure regarding barbiturates seems warranted.

Table 4

**Suicide by overdose: Brisbane 1979-87**  
**TCA = Tricyclic antidepressants**  
**NSAID = Nonsteroidal anti-inflammatory drugs**

| N   | Barbiturates | Chloral   | TCA<br>Hydrate | Benzo<br>Diazepines | Opiates    | Other    | Multiple |
|-----|--------------|-----------|----------------|---------------------|------------|----------|----------|
| 368 | 114 (41%)*   | 50 (18%)* | 37 (13%)*      | 12 (4%)*            | 21 (7.5%)* | 45 (14%) | 89       |

\* Percentage of single substance deaths—alcohol not counted

Before this survey was conducted, other persons in Queensland were concerned about chloral hydrate and combined efforts have resulted in state hospitals agreeing to limit its prescription to specialists only—a move that should result in a major decline in its use.

Antidepressants are the next group that warrants close consideration. It seems likely that, with better recognition of depressive illnesses, more antidepressant drugs will be (appropriately) prescribed. Tricyclics are the predominant antidepressant group worldwide, particularly so in Australia. New drugs are subject to much more rigorous screening before being allowed into this country than the established drugs were. Tricyclics are highly dangerous in overdose, the newer antidepressants are very much less so. However, some have rare but serious side effects. Already many researchers are suggesting that the risk of these newer antidepressants may be heavily outweighed by the risk of fatal overdose from the older tricyclics (Farmer & Pinder 1989; Henry 1989; Montgomery et al. 1989; Vuori et al. 1989; Retterstol 1989). To a large extent, Australia has slept on this issue. Hence, we have only one new antidepressant which the NHS benefits limit to use for depression accompanied by cardiovascular or bladder disease. Curiously, its overwhelmingly safer use in those likely to overdose is not an indication acceptable for NHS benefits.

## Firearms

For some time it has been recognised that firearms are frequently used for suicide by Australian males (Farmer & Rhode 1980; Snowdon 1979). The use of firearms in Australia is disproportionate to its overall rate—a comment that applies also to the USA. The firearm suicide rate in Australia has been found to be ten times that of the UK (Farmer & Rhode 1980).

As a result of growing concern about firearms in Australia, the author, in conjunction with Terry Lewin from Newcastle, undertook a detailed analysis of firearm suicides over the period 1961-85 using data from the Australian Bureau of Statistics (Cantor & Lewin 1990). Although the study focused largely on national data, a limited regional analysis was undertaken comparing Queensland with the rest of Australia. Queensland was singled out as, along with Tasmania, there were no legislative restrictions on rifles and shotguns (Fine 1985); also it had a comparatively high percentage of household gun ownership (see Table 5). Unlike Tasmania, Queenslanders were more likely to possess rifles as opposed to other

long arms—most firearm suicides in Australia involve rifles (Wilson 1983). Reasons for firearm ownership in Queensland were more dubious with it being the state most commonly to own firearms for self-protection or no specific reason.

A multiple regression based analysis of the data was undertaken. Suicide rates were examined with regard to age, sex, years and regions, with comparisons of firearm and non-firearm deaths.

The first finding to note was that a greater proportion of all suicides were committed by firearms by the under 20s than any other age group—for both sexes. It was also evident that a greater proportion of suicides in all age groups were committed in the 1980s compared with previous decades. Youth suicide rates in Australia have risen over the last two decades but youth firearm suicide rates have risen even more steeply.

*Table 5*

**Firearms availability and Australian suicide rates  
1975-77**

| State               | Guns per<br>1000 Persons | Percentage of<br>Gun-owning<br>Households | Suicide<br>Rate per<br>100,000 pa | Suicide by<br>firearms (%) |        |
|---------------------|--------------------------|-------------------------------------------|-----------------------------------|----------------------------|--------|
|                     |                          |                                           |                                   | Male                       | Female |
| NSW                 | 189                      | 25.4                                      | 10.74                             | 30.2                       | 7.7    |
| Vic.                | 145                      | 27.4                                      | 9.46                              | 34.9                       | 7.0    |
| Qld                 | 179                      | 28.9                                      | 12.97                             | 44.1                       | 6.7    |
| SA                  | 162                      | 26.5                                      | 11.35                             | 45.0                       | 13.0   |
| WA                  | 136                      | 19.5                                      | 9.91                              | 21.1                       | 1.2    |
| Tas.                | 211                      | 31.7                                      | 10.24                             | 44.4                       | 10.5   |
| NT                  | Not known                | Not known                                 | 11.00                             | 53.9                       | 42.9   |
| ACT                 | As NSW                   | As NSW                                    | 9.55                              | 28.2                       | —      |
| Australian<br>Total | 167                      | 26.3                                      | 11.15                             | 35.0                       | 7.6    |

Source: Richard Harding (1981)

American findings have been very similar with an increase in age adjusted rate of firearm suicide for the period 1953-78 of 4.9 to 7.1 per 100,000 (Boyd 1983). The Americans also found a similar disproportionate rise in young males (Boyd & Muscicki 1986). Canadian studies also emphasise high firearm suicide rates in younger people (Stenning & Moyer 1981; Tonkin 1984). Australia, USA, Canada and New Zealand are all new countries of pioneering backgrounds, with similar cultural attitudes to the physical aspects of masculinity and widespread availability of firearms (reservation is expressed regarding availability in New Zealand due to the author's lack of data). Could it be that this partly explains the similar age patterns mentioned before of suicide in those countries—that is, high young male rates with a relatively uniform distribution across all adult age groups?

The limited regional analysis (Cantor & Lewin 1990) supported the hypothesis that Queensland's loose firearm legislation, high household prevalence of rifles and different attitudes to firearm ownership was associated with a higher rate of firearm suicide. It must be conceded that other potential explanations for this regional difference have not been examined.

## Firearm Legislation

Would tightening firearm legislation, combined with education to change cultural attitudes to firearms, be effective at reducing suicide rates? Burvill (1980) suggested that the elimination of a lethal method was unlikely to achieve a sustained reduction of suicide. In the UK, the use of motor vehicle exhaust gas has risen between 1975 and 1980 and may, in part, be a substitution for domestic gas (McClure 1984). Detoxification of gas in the United Kingdom may have been effective, if inadvertently, at reducing suicide rates for more than a decade.

Research of the impact of firearm legislation on suicide is inconclusive. Gun lobby groups tend to present selected and biased data. It should be appreciated that findings regarding legislation and homicide are not of great relevance to suicide. In addition, most studies have been conducted in the USA where firearm ownership is more prevalent and where 'stricter' gun legislation usually refers to restriction on hand guns with little or no restriction on rifles (Westmeyer 1984). In Australia, handguns are already severely restricted (Fine 1985) with the current legislative reforms aimed at rifles and shot guns.

Bearing in mind reservations about applicability to Australia, some American findings will be mentioned. American States with stricter gun control laws in 1968 were found to have lower male suicide rates in 1969-71 and smaller increases in male suicide rates over a ten-year period (Lester & Murrell 1980). However, recently no change was found in the prevention of suicides involving guns following strengthening of hand gun laws in Maryland, South Carolina and Utah (Lester 1988). Nevertheless, a strong association between pistol prevalence and white male suicide rates was found in another study of nine US census divisions (Markush & Bartolucci 1985).

Canada's recent reforms may be most applicable to Australia. In 1977, comprehensive legislation was introduced (Scarff 1983). Firearms acquisition certificates became required for all weapons. Registration certificates, in addition, are now required for restricted weapons and some weapons are prohibited to individuals. Sentences for firearms offences were made more severe; prohibition orders for individuals deemed unsuitable for firearm ownership were introduced; seizure of weapons was made easier, safe handling and storage of firearms was promoted and, finally, businesses dealing in firearms were required to obtain a permit renewable annually. Following legislation, there has been a modest decline in the firearm suicides (Scarff 1983). The balance of evidence appears to support such legislative efforts.

## Conclusion

Suicide prevention should occur at multiple levels of the suicide pyramid, from education regarding coping skills through counselling services for the vulnerable, through issues addressed in this paper, right up to continued efforts with regard to medical resuscitation. All counsellors of those considering suicide should be urged routinely to inquire regarding possession of firearms and lethal tablets and to encourage their dismantling, safe storage or disposal. The bottom line is that you cannot counsel or provide any other helpful intervention to dead people.

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# **ADOLESCENTS IN CUSTODY: IMPLICATIONS FOR SUICIDE PREVENTION**

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RECENTLY WE PUBLISHED THE FINDINGS OF A STUDY OF THE MENTAL HEALTH of young people in custody in Adelaide (Kosky et al. 1990). The survey was not remarkable for its science, but it was unique in two respects. Firstly, we were able to use comparative data on measures of symptoms reported by normal schoolchildren in Adelaide and also by non-offending youngsters who had been referred for psychiatric help at the Children's Hospital, both groups being of similar age to those who we surveyed in the remand centre. Secondly, it was unusual for social or behavioural science researchers to have access to remanded youth. Mostly, studies have been limited to offenders who were referred for pre-sentence psychiatric or psychological reports, a relatively select few. It seems that this study is among the first psychiatric survey of youth in custody.

## **Young People in Custody in South Australia**

South Australia has a progressive record of trying to keep young people out of lockup. Many offenders are diverted into non-custodial programs, foster parent or other non-institutional settings to await trial. The population who is remanded in custody is rather small, but troublesome. The Department of Family and Community Services, which is responsible for the custodial care of these youngsters, was understandably concerned about their welfare. Anxiety has been heightened in the staff by concern about suicidal behaviour among the young people in their care and, especially, since the sittings of the Royal Commission into Aboriginal Deaths in Custody, staff at the Remand Centre were particularly conscious of their responsibilities for the welfare of the young people who are locked up. It is a measure of the progressive thinking, confidence in the staff and concern for the welfare of the children, especially on the part of the Chief Executive Officer of the Department of Family and Community Services, Sue Vardon, that we were given permission to work in the remand centre and to have access to the remandees. Nothing in our report should be

construed as being critical of the staff who, consistently, did their best for the young people in their care.

Our sample number was 82, and these were conservative admissions to the South Australia Remand Centre for Juveniles (SAYRAC) over a six-month period in 1989. Three only refused to cooperate and one was unable to complete the data gathering because of poor knowledge of English so the total final sample was 78. In the comparative samples, there were 240 schoolchildren and 82 psychiatric referrals. The average age of the samples was 15 years for the remandees and schoolchildren and 13 years for the psychiatric sample.

In each group, the adolescents were asked to fill out a standard questionnaire (the Youth Self Report, Achenbach & Edelbrock 1987) about how they were feeling in the previous month. Some of the questions and the number of each sample responding positively to them, are shown in Table 1 (for boys) and Table 2 (for girls). There were 115 of these questions altogether and Tables 1 and 2 show just those items which were particularly concerned with symptoms of depression, suicidal thoughts and substance use. Reference to these tables shows the level of symptomatology among Adelaide schoolchildren is relatively low overall, less than six per cent of this sample reported positive responses to the symptom check list.

*Table 1*

**Prevalence of 'very true' (or 'often true') Reported Symptoms in Males**

| Factor                | Community<br>(n=122)<br>% | Remand<br>(n=55)<br>% | Clinic<br>(n=53)<br>% |
|-----------------------|---------------------------|-----------------------|-----------------------|
| Trouble concentrating | 13.4                      | 34.5                  | 28.3                  |
| Trouble sitting still | 10.0                      | 36.4                  | 30.2                  |
| Cries                 | 0                         | 0                     | 15.1                  |
| Harms self            | 4.2                       | 12.7                  | 11.3                  |
| Feels unloved         | 5.0                       | 12.7                  | 15.1                  |
| Feels worthless       | 3.35                      | 3.6                   | 19.65                 |
| Accident prone        | 5.0                       | 18.2                  | 21.2                  |
| Nightmares            | 3.3                       | 7.3                   | 15.1                  |
| Not liked             | 3.3                       | 7.3                   | 11.3                  |
| Fearful/anxious       | 5.9                       | 12.7                  | 19.2                  |
| Suicidal thoughts     | 4.1                       | 12.7                  | 11.3                  |
| Trouble sleeping      | 5.9                       | 20.0                  | 15.1                  |
| Unhappy/sad/depressed | 2.5                       | 12.7                  | 9.4                   |
| Alcohol/drugs         | 1.75                      | 61.8                  | 7.5                   |
| Worries a lot         | 13.2                      | 20.0                  | 7.0                   |

This level is in keeping with (or slightly lower than) other surveys of general population of adolescents in Australia, New Zealand and the USA (Mitchell et al. 1988; Curry et al. 1988; Kosky & Silburn 1984). Especially interesting is that less than five per cent of these 15-year-olds reported alcohol or drug use (not tobacco). Only 21 per cent reported having suicidal thoughts.

By contrast, the remand group and the psychiatric referral group gave every indication of having a significant proportion of sick adolescents. High levels of positive response to the symptom list characterised both groups and, in general, there were three to four times more positive responses in these groups to each symptom than in the school group. With respect

to alcohol and drug use, over 60 per cent of the boys remanded and 48 per cent of the remanded girls reported positively.

*Table 2*

**Prevalence of 'very true' (or 'often true') Reported Symptoms in Females**

| Factor                | Community<br>(n=118)<br>% | Remand<br>(n=23)<br>% | Clinic<br>(n=29)<br>% |
|-----------------------|---------------------------|-----------------------|-----------------------|
| Trouble concentrating | 11.9                      | 26.1                  | 32.1                  |
| Trouble sitting still | 4.2                       | 21.7                  | 20.7                  |
| Cries                 | 6.8                       | 39.0                  | 34.5                  |
| Harms self            | 0.8                       | 17.4                  | 6.9                   |
| Feels unloved         | 1.7                       | 39.1                  | 10.3                  |
| Feels worthless       | 4.2                       | 13.0                  | 17.9                  |
| Accident prone        | 2.5                       | 21.7                  | 17.9                  |
| Nightmares            | 5.1                       | 17.4                  | 24.1                  |
| Not liked             | 2.6                       | 13.0                  | 13.8                  |
| Fearful/anxious       | 4.2                       | 17.4                  | 27.6                  |
| Suicidal thoughts     | 3.4                       | 21.7                  | 17.2                  |
| Trouble sleeping      | 5.9                       | 26.1                  | 24.1                  |
| Unhappy/sad/depressed | 6.9                       | 34.8                  | 17.2                  |
| Alcohol/drugs         | 0.9                       | 47.8                  | 6.9                   |
| Worries a lot         | 15.3                      | 52.2                  | 41.4                  |

When the symptoms were grouped into clusters, little difference was found between the remand and clinic groups on symptoms relating to depression, somatic (bodily) complaints, self-destructive symptoms or symptoms relating to delinquency (the mean score for the remand group was 19 and for the clinic group 14). In these clusters, the mean scores were (statistically) significantly greater than in the school group. Overall, the remand group showed a slightly stronger tendency to report more 'acting out' symptoms than the clinic group, but this was not great and, in any case, both groups had higher levels of emotional symptoms than in the school group.

The self-report questionnaire we used allows for a total score to be made for the samples. This score has, previously, been compared to a group of young people who were psychiatrically ill, so that a 'cut-off' score has been derived by the designers. The proportion of any sample who score above this cut-off score would be likely to be considered to belong to this group of psychiatrically ill young people. Overall, less than 10 per cent of the school population scored in this category. Forty per cent of the clinic sample were above the cut off point and this would be expected. However, what was surprising was that 40 per cent of the remand sample also scored in the category of the likely (psychiatrically-ill) cases!

Our survey thus shows that among young people on remand nearly half are likely to be in need of psychiatric assessment and care. However, this is not the only issue that was uncovered by our survey. We found significant social and educational deficiencies among this group.

Of the remand group, whose average age was 15 years (range 11-17 years), only 24 per cent were living at home. The rest were living with friends, intermittently with relatives or in children's homes or in 17 per cent of cases, were living on the streets. Despite their age, only 15 per cent were still at school. Most (79 per cent) had left school in year 8, the first

year of high school in South Australia. Not surprisingly 75 per cent were unemployed and, equally unsurprisingly, 60 per cent had been in custody previously. It is often thought that the young people remanded in custody represent the criminal element among adolescents—even the 'hardened criminal'. However, the main offences with which the young people in our sample had been charged were breaking and entry (20 per cent) and theft (20 per cent), and those behaviours could be seen in terms of their need to survive out of home.

Motor vehicle thefts accounted for only 15 per cent of charges. Assault or weapon charges also accounted for only 15 per cent of charges. Overall, our research team found these young people to be unhappy but cooperative. Many said they had never had the opportunity to mention how they felt to anyone previously.

## **Implications**

The adolescents in custody comprised a group of young people almost totally lacking in social or family support. They were, mostly, out of home, out of school and out of a job. Probably, many, because of their educational deficiencies and young age were unemployable. It seems hardly surprising that they should continue to offend and continue to be sent to custody, where they are adequately fed and where, however grim the environment may seem to us, it is clean and dry. Their life in SAYRAC is structured and is relatively worry-free, and the staff are kind and affectionate.

In the past, delinquency prevention strategies and the management of delinquents have been governed by social constructs of offending behaviour. It has been widely assumed that the social factors are paramount and that changes in the school or in the home environment provide ways to prevent delinquency. The other older method of delinquency prevention is the punishment model of custodial (prison) care but it is widely acknowledged that this does not prevent recidivism. For this reason, in South Australia, as few as possible adolescents are incarcerated (some other states seem to be going the other way and locking up more children).

### *Needs of adolescents in custody*

What emerges from our study is a profile of the needs of adolescents who find themselves in custody. Our findings suggest that current approaches to delinquents may be missing a vital point. We consider that many of the young people in custody are feeling unloved, unwanted, and worthless. Some, perhaps as many as a third of all adolescents in custody, may be suffering from depressive illnesses. Depressive illnesses are sometimes caused by psycho-social stresses (such as being unwanted or rejected or losing a loved one), but they can also be caused by biological factors. Among these are included genetic predispositions, physical (especially viral) illnesses, the effects of chemicals, or the long-term effects of minimal brain damage. Most commonly, depressive illnesses result from a combination of these factors.

Depressive illnesses are commonly confused with plain unhappiness or misery, and it is mistakenly thought that they can therefore be dealt with by gentle encouragement alone. However, depressive illnesses are characterised by persistent pervasive sadness and worry, not really responsive to this approach. There are sometimes suicidal thoughts, often poor sleep, poor concentration, irritability and feelings of worthlessness, helplessness and hopelessness. People suffering depressive illness are at high risk for suicide. Depressed people find it difficult to work, to concentrate, to learn or to relate to others and they may use alcohol or drugs to try to alleviate their chronic unhappiness. If a significant proportion of adolescents in custody have depressive illness, it is inappropriate for them not to get

psychiatric treatment, since the treatment of depressive illness is one of the most effective in modern medicine.

None of our study sample had a psychiatric assessment prior to or on admission. Therefore, apart from overlooking young people who may be in need of treatment, an added strain is placed on the staff who have to guess which youngsters among those in their care are most likely to attempt suicide.

Clearly, if we are to continue to lock up young people, we need to improve our ability to identify those who are mentally disturbed. We can do this by:

- Having a psychiatric assessment of all new admissions (but this would be quite impractical given current resources);
- training staff to be more sensitive to signs and symptoms. (This would be valuable but there is often a considerable turn-over of staff and individual variations in people's ability to recognise emotional signs);
- by allowing young people, on admission, to complete a short standard questionnaire (for example, the Youth Self Report on General Health questionnaire—shortened version). Those who generate a score above the 'cut-off' point could be referred to a medical practitioner who may make a psychiatric referral. In this way, many of those in need of treatment might be identified, although some could be missed.

A better model, though, would be one which did away with the need for custodial remand. In most cases in our study, the offences did not seem to warrant the custodial order—rather this was made because the young person lacked any social or family supports, or had failed to be stabilised in another institution. We feel that the current system is not adequately catering for the emotional needs of those young people and it is this aspect which has so far been neglected.

By comparison with the SAYRAC group, young people referred to psychiatric services are very rarely held in closed and barred units. Indeed, most states have adolescent inpatient units which are either in beautiful National Trust mansions (Rivendell in New South Wales and Hillview in Western Australia) or purpose built modern apartments (Victoria and Queensland). These places are comfortable and well furnished; they look and feel warm. They encourage the development of age-appropriate individual and social expressions. They are open and normalising. Friendly relationships are encouraged between the young people and the staff who are, nevertheless, aware of the need for kind yet consistent and firm limits on behaviour. Visiting and interaction with the community resources are encouraged. The needs of families in breakdown are considered and family therapy is usually a part of the management. Educational and vocational deficiencies are dealt with by special teaching staff. Social deficiencies are helped by enhancing individual responsibility, through modelling on staff and by encouragement and support. Such therapy has a long tradition in psychiatry. Despite usually having some of the most 'difficult' young people, such adolescent inpatient units can develop strong team and community spirit. In philosophy, style, tradition and practice they seem the antithesis of youth detention centres. In particular, their predominant focus on the emotional needs of the young people provides a major contrast to the youth detention system. Yet, our survey suggests that both systems may be dealing with young people in similar emotional difficulties.

Finally, there are some day centres which have been developed to deal with young people who have emotional, educational and social deficiencies. Originally developed in New York, these centres take the form of special schools with curricula which includes programs for special educational rehabilitation, development of vocational skills, social skills

groups, family therapy, individual psychotherapy and (where appropriate) medication. The young people live with their families, or in foster or other substitute care. Multi-discipline staff include special educational teachers, child psychiatrists, clinical psychologists and social workers. An example of this type of day centre is the New School in Western Australia which was established in 1982 associated with a Child and Adolescent Psychiatry Clinic in the northern suburbs of Perth.

## Conclusion

In summary, our survey of adolescents in custody focussed attention on their emotional needs. They reported levels of emotional and behavioural symptoms four times that of normal adolescents and similar to that reported by young people in psychiatric services in Adelaide. We consider that these young people are at risk for self-destructive behaviours and many may need psychiatric treatment. They also have striking social and educational deficits. Currently these needs are overlooked, which may be one reason for the high recidivism rates. The provision of a home, the treatment of depressive illnesses if present, remedial education, vocational rehabilitation and intensive programs for the development of age-appropriate social skills would seem to offer a better alternative for these difficult young people, than the 'punishment' model which currently dominates their lives.

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# TRAINING THE POLICE TO HANDLE SUICIDE

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POLICE ARE INCREASINGLY FINDING THEMSELVES INTERVENING IN SITUATIONS involving suicidal individuals. Moreover, a considerable amount of time and energy is devoted to investigating both attempted and successful suicides. Each year in South Australia approximately 200 people kill themselves. Probably ten times that number also attract police attention by flirting in some way with the notion of suicide. Police obviously cannot ignore these situations.

The majority of operational police officers, as a regular part of their duties, are being called upon to deal with a wide range of suicidal behaviour. A police officer may be sent to an incident shortly after an apparent suicide attempt and be required to restore order and confusion among distressed friends/relatives, talk calmly and patiently to an often uncooperative suicide attempter and make a sensible decision with inadequate information about what action should be taken. Alternatively, the more unfortunate police officer may need to relate to a disturbed individual in the process of trying to kill himself—this task is more delicate, with suicidal offenders at sieges who may have taken hostages and also appear homicidal. In addition, police are constantly required to assess the suicidal potential of prisoners. Another common task may be to conduct inquiries to determine if the cause of a sudden death was, in fact, suicide or something else. A large percentage of the people police deal with in the above situations are young adults and youths. However, the principles police act upon are not restricted by considerations of age.

It is important for police officers to appreciate the dynamics of suicidal behaviour. With education and understanding comes greater professional expertise in:

- talking to someone who has apparently attempted to commit suicide, for example, following a drug overdose;
- relating to someone who is in an immediate suicide threatening position, for example, preparing to jump from a window ledge;
- recognising early someone who may be a suicide risk, for example, a prisoner in the police cells; and
- conducting an inquiry into a death or disappearance which could be suicide.

## **Intervention Difficulties for Police**

Traditionally, the police role has been seen by the community and by police themselves as primarily concerned with law enforcement, that is, crime prevention, protection of life and property, investigation of offences and the apprehension of offenders. However, in recent years, the police have become more sensitive to a broad range of community social problems and the needs of victims of society, for example cases of domestic violence, child abuse, drug addiction and psychiatric disorders. An awareness of their community service role, as opposed to the law enforcement role, has created adjustment problems for some operational police officers.

Many police feel more comfortable dealing with law enforcement issues as these tend to be more predictable, can easily be related to set regulations and procedures and usually provide concrete results and, therefore, greater scope for job satisfaction.

A major difficulty in training police to intervene in community social problems is to develop the confidence of police officers to handle situations which many of them feel are well beyond their level of expertise and should perhaps be the concern of other helping professions. Through enforcing the law, police continually become embroiled in people's personal crises and emotional trauma. Who else in the community can the public turn to on a twenty-four hour basis and expect a response in a few minutes?

Some specific difficulties encountered by police intervening in incidents involving suicidal persons are as follows:

### *Difficult working conditions*

Many incidents with which police must cope involve difficult working conditions. It may be 2 am in the middle of winter by the roadside. The police officer may have to deal with excited bystanders, media looking for a story, frantic friends and an uncooperative suicidal individual. There may be other jobs banking up on the police radio network and confusion about what has occurred or might happen. The police officer has to gain control of the situation and, with the available information, make a calculated assessment about what is the best action to take.

### *Lack of knowledge*

Suicide, like many of the social problems which police must handle, requires a knowledge of very complex psychological behaviour. Situations with which police must cope would often tax the knowledge of psychiatrists, psychologists, social workers and welfare workers. It is often very difficult for police officers to predict what might happen or to know precisely what actions they should take when dealing with a suicidal individual.

### *Adopting patient flexible attitudes*

Police tend to be practical, action orientated, decisive and directive people. These qualities help them cope with offenders, conflict situations and law enforcement issues, utilising proven procedures and following legal requirements. Relating to suicidal individuals requires a more patient, gentle, reflective and flexible frame of reference. This involves a dramatic shift in the attitudes and behaviours of use in many other situations. Consequently, some police feel very unfamiliar and uncomfortable adopting patient, flexible attitudes when dealing with a distressed, suicidal person.

### *Lack of counselling skills*

Intervening with a suicidal individual, especially at a time of crisis, requires very sensitive interpersonal skills and a considerable amount of counselling expertise. Police are not counsellors, although often they must act as negotiators, mediators and arbitrators. Many police feel unsure of themselves in making decisions about what to say when relating to a distressed, suicidal person. Additional problems are created if a police officer's uncertainty is conveyed to the suicidal individual since rapport between the two of them is usually lost.

### *Lack of life experience*

Police officers gain considerable life experience in the course of performing their duties but this does not happen overnight. The majority of police officers engaged in uniform patrol duties are very young and only have several months general police training to guide them. They have to learn quickly and during that learning process find themselves required to deal regularly with difficult psychological crises, including the problems of suicidal youth. Young police officers are frequently the first responders to crisis situations. Society expects them to act with a great deal of wisdom and maturity to resolve the crises they encounter.

## **Police Recruit Training**

The South Australia Police Psychology Unit has among its responsibilities the task of training police cadets to cope with a range of crisis intervention situations police typically encounter. These include, for example, domestic violence, child abuse, sexual assaults, disasters, grief, drug addiction, psychiatric disorders, sieges, demonstrations and, of course, suicidal behaviour. The training philosophy adopted is designed to counter the operational difficulties police officers experience handling crisis situations. The recruit training package has been created to impart relevant knowledge of human behaviour, develop appropriate intervention attitudes, foster interpersonal skills and provide a frame of reference for operational experience in the real world.

The recruit training package relating to suicidal behaviour has been taught and continually modified since 1980. It is part of the Psychology (Crisis Behaviour) Module which is designed to acquaint police with their community service role as opposed to the law enforcement role. The suicidal behaviour training package is divided into three components.

### *Knowledge of suicide*

Police cadets receive theoretical knowledge from police psychologists using lecturettes, handouts, classroom discussions and case studies. No suitable films on suicide have been found. Topics covered include:

- The nature of suicidal behaviour: the ambivalent and emotional nature of suicidal behaviour is discussed together with factors which determine chances of survival.
- Myths about suicide: common myths are examined, for example, 'suicide happens without warning' and 'persons who attempt suicide are mentally ill', etc.
- Suicidal individuals: suicidal behaviour is presented as being on a continuum with distinctions being drawn between attention seeking individuals, not serious about dying, at one extreme, and determined suicide attempters at the other.

- Indications of suicidal risk: factors considered include reasons, behaviour, warning comments and emotional/physical state of suicidal persons.
- Preventing suicide attempts: basic principles about how to intervene with suicidal individuals are presented as a series of behavioural DOs and DON'Ts which may help a police officer relate effectively to a person threatening to kill himself or herself.
- Suicidal behaviour in custody: information is given regarding the profiles of suicidal prisoners, probable reasons for prisoners attempting suicide, risk assessment procedures and preventative measures to minimise the incidence of suicide attempts in custody.
- Relevant welfare services: those available within South Australia are reviewed.

The above knowledge requires half-a-day input. The human behaviour knowledge is supplemented with lectures from other police instructors regarding police procedures and coronial matters. Relevant procedural and legal knowledge provided throughout the Psychology (Crisis Behaviour) Module follows the input on human behaviour. This is quite deliberate. The idea is to get police cadets to initially think about human relations issues and to give these priority over regulations and legal issues. It is considered that this ordering of instruction helps develop more flexible attitudes than may occur if the initial emphasis is placed upon law enforcement issues.

### *Practical experience*

Following theoretical input on human behaviour, police procedures and legal matters, the training package concentrates on providing some practical experience of suicidal behaviour. The rationale applied is that theoretical knowledge alone is insufficient to develop attitude change in police cadets about the need for intervention when relating to suicidal individuals. Some experience of how suicidal behaviour affects people also tends to personalise the knowledge previously gained by cadets.

Providing practical experience of suicidal behaviour has proved difficult. Several approaches have been utilised including classroom discussions with individuals who have attempted suicide or with the relatives of persons who have killed themselves; visits to youth centres and psychiatric hospitals, which enable cadets to speak to depressed youths who show suicidal tendencies; and, visits to the Adelaide Mortuary, which confront cadets with the results of successful suicides. Subsequently, debriefs are conducted by police psychologists with police cadets to review their impressions, feelings and attitudes about the above experiences. These debriefs also allow the experience gained to be related to actual operational incidents.

### *Skills building*

Theoretical knowledge and practical experiences of suicidal behaviour are insufficient preparation for police duties. The process must also include the development of appropriate intervention skills. This is achieved by conducting a half-day of role plays about typical situations police encounter operationally.

Role plays are administered by members of the Police Psychology Unit who role play the part of suicidal individuals. Police cadets are paired off to act as police patrol crews. They are given a general scenario for each role play. The scenario includes the kinds of information a patrol crew would expect to receive via police radio when despatched to an

incident. It also includes the preliminary observations a patrol would make upon arrival at a scene. Police cadets are required to handle the situation as if the action was real. If the attitudes and behaviour of the cadets is conducive to resolving the role playing incident in a constructive way, the suicidal role player cooperates. However, if the actions of the cadets are inappropriate, the problems they encounter with the suicidal role player magnify. The role play is stopped when it is clear the situation is becoming controlled, stalemated or uncontrollable. Each role play is observed by other members of a cadet class.

On completion of a role play, the cadets, acting as a police patrol, explain what they were trying to do, what actions they feel were constructive and what they would do differently given another opportunity. The suicidal role player indicates what impact the patrol crew's behaviour has had upon him. Class members add additional relevant and constructive observations about the way the role play was handled. The police psychologist summarises the lessons learnt and relates them back to the guiding intervention principles provided earlier during the knowledge input stage of the training package.

Role plays provide a valuable method of integrating theoretical knowledge of suicidal behaviour and police operational procedures. They enable police cadets to experiment with techniques of intervention, increase their awareness of difficulties which may be encountered operationally and develop the confidence to handle real life situations constructively.

### **Some Other Initiatives**

In addition to the Police Recruit Training Program, some other initiatives have been introduced by the South Australia Police Department to help police officers recognise and cope with suicidal persons they may encounter in the performance of their duties. These initiatives are briefly commented upon below.

#### *Deaths in custody seminars*

Deaths in custody seminars were introduced into the South Australia Police Department in early 1989. These are one-day staff development programs for operational police officers. Their aim is to educate police in procedures designed to minimise the incidence of prisoner deaths occurring in police cells. Some of the deaths which have occurred were suicide. Also, on frequent occasions, police cell guards have acted promptly and prevented suicide attempts from being successful.

Part of the deaths in custody seminar is a segment entitled 'Suicidal behaviour in custody'. As with recruit training programs, police are given information regarding the profiles of suicidal prisoners. Also, probable reasons for prisoners attempting suicide are discussed, including the trauma of arrest and the influence of many prisoner's deprived backgrounds and unstable personalities. In addition, preventative measures to minimise suicide attempts are revised. In particular, police are taught to:

- treat the prisoner with dignity;
- create a climate for communication;
- make a careful risk assessment by: considering the prisoner's profile; reviewing the prisoner's background; observing the prisoner's behaviour; considering the prisoner's comments;
- ensure the prisoner is not isolated;
- monitor closely the high risk prisoner whilst in police custody.

Throughout the seminar, the care and welfare of prisoners is continually emphasised.

### *Prisoner screening form*

A prisoner screening form was introduced at the Adelaide Watch House in March 1988 and extended in June 1989 to all police stations where prisoners are detained. It is completed for all persons arrested, charged and lodged at a police station.

The form was designed in an endeavour to prevent persons suiciding whilst in custody. It requires the arresting officer, duty sergeant and all cell guards to note the physical and emotional condition of the prisoner. The intention is that the prisoner screening form should alert police on cell guard duty to high risk prisoners so that appropriate action can be taken.

### *Psychological debriefings*

The South Australia Police Department has a policy which requires police who have been subjected to emotionally traumatic situations to undertake a confidential psychological debriefing. Psychological debriefings have proven valuable in enabling police officers to ventilate their feelings and defuse their emotions regarding crisis situations they have encountered. Several police who have dealt with suicidal individuals have benefited from these debriefings. This has been especially important when police officers have intervened in incidents involving actual suicide attempts and in cases of deaths in custody. The debriefings and follow up counselling have enabled the police officers concerned to see these situations in a realistic perspective and, therefore, to return to operational duties with increased confidence and peace of mind.

## **Conclusion**

Police training programs have demonstrated their worth. Feedback from psychiatric hospitals indicates that patients for admission are being conveyed by police with more empathy and less distress than was the case prior to the introduction of police training to handle both suicidal persons and psychiatric disorders. Also, on several occasions during psychological debriefings it has become obvious that the police officer involved has capably utilised the guiding principles learnt during recruit training.

Improvements to the current training of police to handle suicide could be made by utilising additional teaching techniques such as films or videos, increasing the range of case studies discussed and devoting more time to role playing practice. Fortunately, police cadets receive some transference of relevant knowledge, appropriate attitude change and useful skills building practice from lessons learnt during training in related crisis intervention topics. This occurs throughout the Psychology (Crisis Behaviour) Module.

# **THE CRUSHING OF HOPE? YOUTH DEATH IN DETENTION CENTRES AND ADULT CUSTODY**

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Why am I here—life isn't worth living—I'm getting into trouble—I'm bored—I try hard to do something and I get knocked down for doing it—I try to live a happy life but it seems people are against me because I've been in trouble—I feel like nothing—when I have fun it's great then something happens to ruin it—it's not my fault for what I am—so I just don't understand life and why I was put here on earth—if I can't accomplish anything or do anything for other people or myself—maybe I should just die—then I wouldn't have any problems.

Phillip, 16

I wish I'd die soon, this world's . . . —I just want to die and be forgotten—I wish I had the button for the atomic bomb—I'd push it.

Boy, 15

There's nothing to live for—what have I got—my bike, the bag, some clothes and myself—WOW, that's life? If I absconded it'd be better to be chased than ignored—at least I won't be bored—something would be happening—life's boring—all the way through.

Boy, 14

I truthfully want to DIE.

. . . p.s. Because I am mixed up and confused and alone and can't take it anymore—I've . . . had this world.

p.p.s. Except I don't want Suzie to . . . up her life because of me so I'm sorry if I put all that on Suzie—she is free to do what she wants because I'm going to do what I truthfully want to do and that is DIE.

Girl 15, note left in file.

FOR MANY ADOLESCENTS, LIFE CAN BE RATHER DIFFICULT AND NOT FULL OF the promise they may have been led to believe. Some recognise this early, adapt by conforming, accept reality and make do as best they can within the confines. Others take on a social activism role and try to alter the situation by using already existing structures such as the law and public forums, or by direct challenge and confrontation; others drop out and create their own space; others resort to crime to get what they want either materially or emotionally; and still others drop into insanity, alter reality temporarily through drugs or permanently through suicide.

The majority of the young, however, will go through this 'phase'—adolescence—and be oblivious to the pressures eventually settling down 'to a place if not in the sun then at least in the consensus' (Hebdige 1979). Others are less fortunate. They are trying to find a way out, around or through their lives.

Some writers believe that drug or substance abuse among the young is related to adolescents being shut-out of meaningful participation in society, as well as to the pressures and stresses of living contingently for prolonged periods of time in an achievement-oriented society. Society has increasingly disenfranchised and, thereby, rendered them relatively impotent. 'Adolescence today is a parenthesis that many young people feel will never end. Adolescence is perceived as a "terminal illness" ' (Maris 1985). Whilst violence to others is an active 'solution' employed by some, suicide is the ultimate alternative or adaptation (Jacobs 1971), perhaps chosen after others have been found wanting or perceived as unavailable.

Whereas overall suicide is about the fifteenth major cause of death for Australians, it is now the second for the 15 to 19 age group (Australian Bureau of Statistics 1989). It follows motor vehicle accidents and is followed by other accidents (which include drowning, firearms accidents, poisoning, falls). However, as many authors note, the suicide figure is usually less than what it should really be for a variety of reasons, and many motor vehicle accidents and other accidents in fact are actual or disguised suicides.

It seems that an increasing number of the young feel so empty and powerless that they are seeking some form of oblivion, escape, tension release, recognition or validation of their existence through acts which are anti-social, violent, or self-destructive. If there is a feeling of no future, and therefore nothing left to lose, then it does not matter much what one does. Risk-taking behaviour becomes commonplace.

## **Depression in Adolescence**

The two concepts of masked depression and depressive equivalent behaviour were crucial in the proposition that children and adolescents are prone to depression, but that the overt manifestations can differ from that of adults (Burks & Harrison 1962; Glaser 1965; Kaufman & Heims 1958; Lopez-Ibor 1972, Spiegel 1967; Toolan, 1962). Kovacs & Beck (1977) rejected these ideas and felt 'that the term "masked" depression may be

misleading and unnecessary'. They suggested that the symptoms are merely 'presenting complaints' and 'are somatisations' or 'culturally accepted ways of construing or manifesting psychological discomfort'. Parker (1978) warned that the terms are 'vague, imprecise and variably used'.

There is now a considerable body of evidence for the existence of much depression in children and adolescents. It is unlikely that depression is behind all of the behaviours which were identified as masks of or equivalent to depression; the actual symptoms were mostly missed.

### **What of the Link Between Depression and Delinquency?**

Cormier (1966) linked depression and persistent criminality, a link proposed by other writers for sociopathy (Halleck, 1967; Melges & Bowlby 1969; Teitelbaum 1965; Vaillant 1975). Vaillant has suggested that we often bear anxiety for the sociopath and, if avenues for flight and manipulation are removed, the individual will decompensate and show the effect, including depression, present underneath. Teitelbaum (1965) suggested that the psychopathic life-style could serve as a defensive facade and that psychopaths 'develop an enormous investment in neutralising displeasure' with their life-style being fashioned along counter-depressive lines.

Delinquent acting-out in male and female adolescents was specifically examined by Chwast (1967) who found delinquent adolescents to be 'quite depressed' and that the degree of depression increased with age. He felt that some delinquents were defending against their depressive feelings by acting-out and, by so doing, were able to discharge some of the depressive underlay.

A study of 'Depression in an Adolescent Delinquent Population' by Chiles, Miller & Cox (1980) examined whether depression was readily observable in a sample of 120 male and female delinquents aged 13 to 15 admitted to a correctional facility, and what behaviours distinguished them from any non-depressed adolescents. Of the 120, 23 per cent met the criteria for a major depressive disorder.

The data raised the possibility of a relationship between father absence and/or mother presence in developing depression during adolescence.

Of note also was the tendency for the depressed group to self-medicate (mainly alcohol and marijuana) (60.7 per cent) as well as actively seeking 'exciting, dangerous, daring or illegal activities (35 per cent) in an attempt to relieve their feelings of dysphoria and boredom' (Chiles et al. 1980, p. 1182), and the presence of difficulties with schooling (attendance and behaviour problems).

Kashani, Henrichs, Reid & Heims (1982) found in a study of 120 male young offenders in a training school, that 18 per cent met the DSM-III criteria for major depressive disorder, one-third of whom also had depressed parents. They felt that parental depression may contribute to delinquent development.

### **What of the Link Between Depression, Delinquency and Suicide?**

Shafii (1986) found that 95 per cent of the adolescent suicide victims in his study had an associated psychiatric disorder by DSM-III criteria. A high percentage had an affective disorder: 76 per cent had major affective disorder or dysthymia as compared to 28 per cent in the control group. Other work by Shafii (Shafii, Carrigan, Whittinghill & Derrick 1985) suggested that 70 per cent of adolescents who end their lives by suicide had associated substance (mis)use, 70 per cent had a history of antisocial behaviours, 65 per

cent had 'inhibited' personality traits, with 50 per cent having made a previous suicide attempt.

At least a third of young people in a study by Shaffer, Gould & Trautman (1985) who ended their lives by suicide had an associated conduct disorder and one-quarter of the sample population were suffering from a depressive disorder. In addition, a high percentage of these youth (mis)used alcohol or drugs. A link between adolescent suicides (and attempts) and alcohol and other drug ingestion has been found in Australia (Hayward 1989; Hayward, Zubrick & Silburn 1988; Woodward 1989).

The comorbidity of antisocial and depressive symptoms appears a particularly lethal combination (Chiles et al. 1980; Frances & Blumenthal 1986; Shaffer et al. 1988; Shaffer et al. 1985), as does that between chronic substance (mis)use with affective symptoms and impulsive personality traits in young people (Blumenthal & Kupfer 1988).

Specific studies of females are far less numerous. However, Gibbs (1981) studied depression and suicidal behaviour in delinquent girls. She found 78 per cent of her sample of forty-eight girls reported depressive feelings and symptomatology. Nearly half of the subjects had made one or more suicide attempts. She postulated that the acting-out of the borderline and neurotic females in her sample may have been serving the function of defending against severe depression.

Four Sydney based research projects have supported the notion of a strong link between delinquency, depression and suicide for some.

Howard (1979; 1981) examined the link between helplessness, depression and delinquency in a group of 100 male young offenders of modal age seventeen years (range 15-18) resident in two units of a state training school. Group 1 (n=52) comprised first committals and Group 2 (n=48) comprised persistent offenders classified as anti-social personalities.

Each subject completed the Jesness Inventory (Jesness 1966), the Parental Bonding Instrument (Parker, Tupling & Brown 1979), the Costello-Comrey Depression Scale (Costello & Comrey 1967)—a measure of trait rather than overt depression, and an individual interview.

The results showed that the persistent offenders were significantly more depressed than the first committals and both groups were significantly more depressed than a general population on the trait depression measure (see Table 1).

*Table 1*

**Trait Depression Scores of Sample and General Population**

| Group                  | Mean<br>Depression<br>Score | S.D. |
|------------------------|-----------------------------|------|
| A General population   | 34.2                        | 13.4 |
| B Total sample         | 45.2                        | 19.8 |
| C First committals     | 40.4                        | 17.2 |
| D Persistent offenders | 50.3                        | 21.3 |

A with B  $t = 5.51$ ,  $df\ 99$ ,  $p < 0.001$

A with C  $t = 2.58$ ,  $df\ 51$ ,  $p\ 0.02 > p > 0.01$

A with D  $t = 5.20$   $df\ 47$ ,  $p < 0.001$

C with D  $t = 2.59$ ,  $df\ 98$ ,  $p < 0.01$

Source: Howard 1981.

It was also found that the persistent offenders, whilst being more 'depressed', felt significantly less care from their mothers than the first committals ( $t=2.02$ ,  $df\ 97$ ,  $p<0.05$ ), and if their parents separated this occurred at an earlier age ( $X^2=12.8$ ,  $df\ 3$ ,  $p<0.005$ )—usually prior to adolescence, with the father being the most frequent 'missing' parent.

The main variables which 'explained' the trait depression scores were a perceived lack of paternal care, and, to a lesser extent, maternal over-protection. The quality of parental care appeared more important than continuity, with those coming from families experienced as affectionlessly controlling (low care, high over-protection) having higher depression scores. The importance of the father in relation to trait depression and overall delinquent development was highlighted as was the importance of the mother in the development of anti-social sons. Howard's study also found a significant link between trait depression score and the use of 'hard' drugs ( $r=-0.22$ ,  $p<0.5$ ).

Parkins (1982) studied depression and other variables in two groups of male adolescents both of average age 14.5 years; forty-seven young delinquents resident in a training school, and forty-seven adolescents referred to a Department of Education clinic, none of whom had appeared in a children's court (see Tables 2 and 3). The study replicated Howard's (1979; 1981) findings for this new group.

Lamond (1982) also examined an adolescent delinquent group (64 consecutive admissions to a remand centre in Western Sydney—42 males, 22 females, average age 14.9 years) and compared them to a sample of 29 clinically depressed adolescents who were in and outpatients at an adolescent psychiatric unit (10 males, 19 females, average age 15.03 years).

Table 2

**Depression Subscales for Delinquent and Clinic Groups**

| Variables              | Delinquent Group<br>n=47 |      | Clinic Group<br>n=47 |      | F<br>1.42 | P     |
|------------------------|--------------------------|------|----------------------|------|-----------|-------|
|                        | mean                     | S.D. | mean                 | S.D. |           |       |
| Affective response     | 7.96                     | 1.45 | 6.66                 | 1.59 | 17.11     | <.001 |
| Social problems        | 8.08                     | 1.14 | 6.36                 | 1.67 | 31.50     | <.001 |
| Preoccupation sickness | 7.32                     | 1.66 | 5.87                 | 2.40 | 10.20     | <.001 |
| Self-esteem            | 7.08                     | 1.69 | 5.87                 | 1.92 | 10.84     | <.001 |
| Guilt                  | 8.30                     | 1.10 | 6.19                 | 1.47 | 53.41     | <.001 |
| Total depression       | 7.98                     | 0.97 | 6.25                 | 1.63 | 38.76     | <.001 |
| Pleasure               | 6.43                     | 1.78 | 6.51                 | 1.76 | 0.02      | m.s   |

Source: Parkins 1982.

Table 3

**Correlations for Depression and Parental Bonding**

|                         | Delinquent | Clinic | P                                  |
|-------------------------|------------|--------|------------------------------------|
| Maternal care           | .004       | -.092  | n.s.                               |
| Maternal overprotection | .264       | .418   | both significant<br>(0.05; 0.002)  |
| Maternal care           | -.373      | -.345  | both significant<br>(0.005; 0.009) |
| Maternal overprotection | .213       | .058   | n.s.                               |

Source: Parkins 1982.

Subjects were interviewed and then completed the Children's Depression Scale (Lang & Tisher 1978) and the Nowicki-Strickland Locus of Control Scale for Children (Nowicki & Strickland 1973).

Lamond found that there were no statistically significant differences between the CDS scores for the delinquents and the clinically depressed group; that is, the delinquents were as depressed as a group of adolescents diagnosed as depressed by psychiatrists (see Tables 4 and 5).

Consecutive male admission to a community-located treatment unit for adolescent young offenders for the period May 1977 to May 1987 were followed up by Howard (1987). Of the 750 admissions, 8 had committed suicide on or after the program (4 drug overdoses-1 in custody; 3 hanging-all in custody; 1 by throwing himself under a train). Another 10 had died violently, possibly disguised suicides in some cases (3 drug overdoses; 2 drunk; 1 stabbed; 1 punched). The rate for suicide was 1.07 per cent and for violent death 1.33 per cent; much higher than the 'normal' population.

Table 4

**Mean CDS Total Depression Scale scores by Group and Sex**

|         | Depressed     | Delinquent    | t<br>88     |
|---------|---------------|---------------|-------------|
| Males   | 152.20 (n 10) | 163.43 (n 42) | -1.193 n.s. |
| Females | 177.20 (n 19) | 161.86 (n 22) | 1.832 n.s.  |

Source: Lamond 1982.

Table 5

**Locus of Control scores by Group and Sex**

|         | Depressed    | Delinquent   | t<br>88 | P    |
|---------|--------------|--------------|---------|------|
| Males   | 20.00 (n 10) | 15.76 (n 42) | 2.507   | <.02 |
| Females | 18.47 (n 19) | 18.91 (n 22) | -0.292  | n.s. |

Source: Lamond 1982.

Table 6

**Death Rates per 100 of population**

|                                                                     | Suicide | Violent<br>Death                   | Total    |
|---------------------------------------------------------------------|---------|------------------------------------|----------|
| (a) 15-19 year old males—known to<br>Community Youth Centre 1977-87 |         |                                    |          |
| n                                                                   | 8 (750) | 10 (750)                           | 18 (750) |
| rate                                                                | 1.07    | 1.33                               | 2.4      |
|                                                                     | Suicide | Other<br>Accidents<br>(+ violence) | MVA      |
| (b) 15-24 year old males—Australia 1982                             |         |                                    |          |
| rate                                                                | .02     | .03                                | .07      |

Source: Howard 1987.

Table 7

**Community Youth Centre  
Deaths of clients who were or had been on the program 1977-87**

| <b>Suicide</b>       |                  |
|----------------------|------------------|
| Drugs                | 4 (1 in custody) |
| Hangings             | 3 (3 in custody) |
| Train                | 1                |
|                      | 8                |
| <b>Violent Death</b> |                  |
| Drugs                | 3                |
| Train                | 2 (+ drug)       |
| Shot                 | 2                |
| Run over             | 1 (+ alcohol)    |
| Stabbed              | 1                |
| Hit                  | 1                |
|                      | 10               |

Source: Howard 1987.

**Suicide in Custody**

Tuskan & Thase (1983) have stated 'the magnitude of the problem is great: suicide is the leading cause of death in most penal settings and a conservative estimate of the incidence of suicide in penal settings is three times greater than the national average' (p. 31). Flaherty (1983) reported a similar level for juveniles detained in adult prisons.

Whilst the incidence of suicide in custody significantly exceeds that recorded for the general population (Clark & Glaser 1984), it is acknowledged that conventional estimates of suicide incidence are conservative and the employment of official statistics, in vacuo, is an activity fraught with difficulties (Hatty & Walker 1986).

In an Australia-wide study of deaths in adult prisons, Hatty & Walker (1986) found that those particularly likely to commit suicide were:

- remandees with histories of self-inflicted injury or histories of previous suicide attempts;
- remandees charged with violent offences;
- for those convicted, after having been returned to prison for breach of parole or after an escape;
- young offenders with histories of convictions for property offences and who are single with no job, family or support; and
- that the period immediately following reception is most critical.

It has also been noted that suicide rates in NSW prisons are four to five times those found in English and Welsh prisons for 1989 (Baldry 1990; Seccombe 1990).

### Youth Deaths in Custody

Tables 8 and 9 show the number of deaths of young offenders in both youth detention and adult custodial settings (police cells and prisons). All state 'welfare' departments were contacted and gave information on deaths in their youth detention facilities for the ten years 1980 to 1989. New South Wales had the highest number, with two of the three suicides recorded occurring in the past two years.

It is obvious that young offenders appear to be 'safer' in youth rather than adult custodial settings when the number of cases of deaths of 15 to 19-year-olds in adult custody for the same ten-year period known to the Royal Commission into Aboriginal Deaths in Custody is forty-one; thirty of them suicides, mostly in New South Wales and mostly in the past three years.

Deaths in the age range of concern for 1990 to date in New South Wales indicate that this year may have more suicides than the previous (Baldry 1990).

*Table 8*

#### Deaths in Juvenile Detention/Custody Centres of Youths under 18 years of age, 1980-89

|       | Total | Aboriginal | Non<br>Aboriginal | Suicide |
|-------|-------|------------|-------------------|---------|
| NSW   | 4     | 1          | 3                 | 3       |
| Qld   | 0     | 0          | 0                 | 0       |
| Vic.  | 1     | 0          | 1                 | 1       |
| SA    | 1     | 1          | 0                 | 1       |
| WA    | 0     | 0          | 0                 | 0       |
| Tas.  | 0     | 0          | 0                 | 0       |
| NT    | 0     | 0          | 0                 | 0       |
| Total | 6     | 2          | 4                 | 5       |

Source: State Community Service/Welfare Departments

Table 9

**Deaths in Adult Custody (police cells or prisons)  
of youths aged 15-19 from 1980-89  
Known to the Royal Commission into Aboriginal  
Deaths in Custody**

| (A) | Age   | Number                          |
|-----|-------|---------------------------------|
|     | 17    | 7                               |
|     | 18    | 11                              |
|     | 19    | 23                              |
|     | Total | 41 (31 White,<br>10 Aboriginal) |

|     |                  |       |               |
|-----|------------------|-------|---------------|
| (B) | Suicide Findings |       |               |
|     | White            | 24/31 | 77.4 per cent |
|     | Aboriginal       | 6/10  | 60.0 per cent |
|     | Total            | 30/41 | 73.2 per cent |

| (C)   | Suicides in Adult Custody of Juveniles—State by year |      |     |    |      |    |       |
|-------|------------------------------------------------------|------|-----|----|------|----|-------|
|       | NSW                                                  | Vic. | Qld | SA | Tas. | WA | Total |
| 1980  | —                                                    | —    | —   | 1  | —    | —  | 1     |
| 1981  | 1                                                    | —    | —   | —  | —    | —  | 1     |
| 1982  | —                                                    | —    | —   | —  | —    | —  | —     |
| 1983  | 1                                                    | —    | —   | —  | —    | —  | 1     |
| 1984  | 1                                                    | 1    | 1   | —  | —    | 1  | 4     |
| 1985  | 1                                                    | —    | 1   | —  | —    | —  | 2     |
| 1986  | 1                                                    | —    | 1   | —  | —    | —  | 2     |
| 1987  | 3                                                    | 2    | 4   | 1  | 1    | —  | 11    |
| 1988  | 2                                                    | —    | 1   | —  | —    | —  | 3     |
| 1989  | 3                                                    | —    | 1   | 1  | —    | —  | 5     |
| Total | 13                                                   | 3    | 9   | 3  | 1    | 1  | 30    |

Source: Royal Commission into Aboriginal Deaths in Custody

Emerging from all of the above are the following conclusions, most of which raise issues for prevention, management and/or therapy.

- Depression does exist in delinquent adolescent populations often at levels higher than the 'normal population' and at levels often equal to adolescents diagnosed as clinically depressed.
- The depression can be evidenced either as a tendency to experience depressive affect, self-report of depression, or overt signs.
- The role of the mother seems particularly significant in persistent delinquent development, especially in the absence of the father, and if the mother is perceived as over-protective (affectionately constraining).

- The role of the father seems significant in overall delinquent development, and particularly significant in the genesis of adolescent depression with delinquency, especially a perceived lack of paternal care.
- A broken home per se is not of major significance, rather it is the quality of care.
- Feelings of being externally controlled and not having much impact on what happens is significantly related to depression.
- Depression in delinquent adolescents is related to an increase in the abuse of drugs (mainly heroin, 'speed' and pills).
- Depressed, delinquent adolescents tend to self-medicate with a variety of substances including alcohol, marijuana, pills and cough mixture, as well as heroin and other illicit substances.
- The combination of antisocial/delinquent and depressed symptoms, impulsivity and chronic substance use can be especially lethal.
- Adolescent young offenders have a higher rate of suicide and violent death than the 'average' adolescent.
- When placed in adult custodial settings, young offenders are at a greatly increased risk of suicide.

## Discussion

Ambiguity has tended to characterise the adult world's dealings with its youth; young offenders in particular. On one hand they are seen as victims: passive and powerless in the face of adult corruption which is seeking to exploit their gullibility, and the social system seems deaf to their ears. The response is that they need to be cared for, protected and helped. On the other hand is the victimiser: cruel, sinister, predatory, amoral and mostly male.

Likewise, there has been a tendency to romanticise troubled youth, especially on film and television, forgetting that many are not just likeable waifs or modern day junior Robin Hoods redistributing wealth in some form of neo-Marxist endeavour. Some are already dangerous and others become dangerous in the custody of the state.

Responses to young offenders have reflected this ambivalence. Understanding and treatment have competed with severe punishment and over time these responses have tended to fluctuate in significance along a continuum. During the seventies, treatment was to the fore with such an approach to be shattered by the impact of the 'nothing works' cry, a declining economy and consequent restriction of welfare budgets and the impact of conservative political ideologies with what some have seen as an increase in the ethos of vindictiveness (Pitts 1988). The reality is then that punishment can merely become a form of vengeance, especially if injury occurs to the punished and the prevention of crime does not eventuate.

The role of juvenile justice systems in the construction and maintenance of so-called 'dangerous, chronic or hopeless' young offenders bears great scrutiny. Such construction, deviancy amplification and the development of myths easily occurs in a climate of closed, rigid systems wherein inmates/detainees are hidden from the outside, labelled by politicians, the media and their guards as dangerous, untreatable and thugs. The fear of the community

is activated which may then lead to the justification for more punishment and security to protect the populous from such frightful characters.

Intensive analyses of the perspectives adopted by the correctional systems and the prisoners incarcerated within these systems are necessary if a broader understanding of death in custody is to be achieved (Hatty 1988). Profiling or focussing on the individual can deflect from analysis of other issues. Existing theories, which may conceptualise suicide as a failure to adjust, can tend to individualise the issue by positing psychological explanations of inmate deaths. However, this fails to take into account the degree of individual variation in the meaning of confinement, and does not address the question of institutional responsibility.

Hatty (1988) also argues that, in neglecting the contribution of institutional policies and procedures, the act of dying in custody is depoliticised. Research based on official records—with the objective of predicting the suicidal inmate and developing appropriate management strategies—decontextualises these deaths.

That penal policies are central to the occurrence of suicide was stressed by Burtch & Ericson (1979) who also claimed that coronial reports and the submissions of Boards of Inquiry are oriented more towards the exoneration of correctional personnel than toward the explanation of suicide or the development of appropriate strategies for intervention. A 'natural causes' finding can negate institutional responsibility and an official version of death tend to be constructed beginning with the version of events offered by those implicated.

Also true is that ideologies about crime and imprisonment influence the conduct of coronial inquiries, with particular qualities attributed to individuals who have died in custody. These qualities can be amplified within the coronial processes and assume explanatory power. As seems currently popular in NSW, the majority of inmates are portrayed as extremely violent individuals who require elevated levels of control within the institution, and those who have died in custody are often portrayed as psychologically inadequate; they are perceived as members of a high-risk group, and their deaths are interpreted as a failure to cope with the demands of prison. Thus, acts of negligence or brutality can be justified (Hatty 1988; Scraton & Chadwick 1986).

Attending to another contextual issue, Baldry (1990) has pointed out how two differing rates of suicide are correlated in NSW with two 'reform' periods of the past decade. She stated that:

... by 1980-81, the implementation of the Nagle Royal Commission recommendations was well advanced and in that environment there was only one suicide in the course of the year. By 1989-90, the present Government's reforms have become equally well entrenched with the difference that suicides are running at a record level.

A related factor is that state departments charged with containing and attempting to rehabilitate young offenders may choose to abdicate their responsibilities for whatever reasons (for example, no suitable buildings, the youth are 'too hard', 'they have become worse', 'they commit 'adult' crimes and should be in a adult system', or 'we have run out of options') and pass such youth to the adult correctional system. The blurring of boundaries between the two systems and the ease of entry from the juvenile to the adult must be scrutinised, especially given the increased risk for suicide of juveniles held in adult custody.

### **What can be Done?**

The obvious conclusion to the above findings on youth deaths in adult custodial settings is that young offenders where possible should be maintained in youth custody. Entry into the adult system should be extremely difficult to effect. Departments charged with the

responsibility for young offenders should accept that responsibility and develop appropriate humane regimes for the small number of very difficult to manage youth and which do not dictate the security level for the remaining majority of detainees.

Various attempts have been made to develop reliable, valid short and easily administered suicide screening scales for use in custodial settings. Arboleda-Florez & Holley (1988) have developed one such instrument in Canada and, in NSW, Coppel (1988) devised a scale for the prediction of suicide for the Department of Corrective Services. It is believed that such scales are not widely used, if at all at the present time. Whilst some of the scales are not significantly reliable or valid, and recognising that even if used suicides will still occur, efforts should be renewed to ensure that admitting staff are attuned to the issue of self-harm.

In relation to assessments by mental health professionals, it is a general concern that, once 'evidence' is gathered for the existence of a conduct or antisocial personality disorder, further exploration is often not undertaken; sometimes due to the behavioural characteristics of the client. Thus, for example, coexisting depression may be missed. It can be the case that the 'disorder' actually diagnosed can merely be a constellation of defensive behaviours/strategies/symptoms which may be an attempt to ward off the impact of unpleasant effect, or intrusions into areas which the client does not want to face and/or reveal to others.

Hatty & Walker (1986) have recommended that a crisis intervention service could be provided for all inmates. This service should function on the principles of crisis theory. Inmates in crisis should as far as practicable be granted additional access to significant others of their choice. The availability of the crisis intervention service to detainees/prisoners should be highlighted during admission/reception.

Staff training in the recognition of potential suicides, situations which may contribute to attempts, and their own and the system's role in creating environments which may promote or minimise risk should be an essential part of pre-employment and in-service courses. Training which emphasises control and techniques for the management of so called 'riots', at the expense of the areas mentioned above, may merely lead to staff constantly anticipating 'riots' and covertly or overtly contributing to dangerous outcomes. Untrained staff (a particular feature of some juvenile correctional systems) who may be scared and/or have little capacity to understand, relate to or listen to adolescents, can exacerbate or assist in the manufacturing of difficult situations. Fairly normal adolescent-adult interactions may become labelled as 'defiance' or 'insolence'.

Senior staff should be trained in a form of staff supervision which takes into account more than merely checking for completion of routine tasks. Sensitivity to the many manifestations of stress, and awareness of a staff member's capacity to relate to adolescents should be focal in such supervision. Additionally, for therapists/counsellors, the feelings aroused need careful recognition. Whilst support of colleagues and a support network outside work are essential, self-awareness is of paramount importance.

Young people in custody often complain about such things as: not being taken seriously, promised something and it not being done, being told lies, being treated sarcastically, being intimidated, being punished for petty things, being denied access to and contact with family and significant others as punishment. These staff behaviours often come to light after 'disturbances' or actual or attempted suicides. However, they are not often reported in the 'official' version of events. Adequate staff selection, training and supervision can help to eliminate these provocative practices.

Youth workers and correctional officers should also be provided with a welfare service which can adequately address any grievances articulated by the officers and psychological stresses inherent in the job (Hatty & Walker 1986).

Prison medical services need scrutiny. Most are responsible to two masters/mistresses: corrections and health. Most prison hospital environments are also staffed by the two departments which may have differing philosophies, ideologies and practices. From experience, it is not uncommon for some custodial, and even nursing/medical staff to have little if any understanding of mental disorders and to see most patients/inmates as 'con-artists', 'malingerers', or 'manipulators'.

Likewise 'case ownership' can cause difficulties, especially when security and mental health responses can be at odds. Furthermore, wildly contrasting diagnoses may be held with consequent differing treatment approaches employed by the range of staff who come into contact with the patient. Adequate case conferencing should occur with all views being aired, information shared and case plan consensus reached, rather than decisions being made by one person without proper consultation. A prison medical service can have the advantage of considerable expertise with the particular client group. It can equally have the disadvantage of becoming cynical and institutionalised.

Psychological autopsies should be conducted in the instance of inmate suicide (Hatty & Walker 1986), which also address social/contextual/ structural issues which seem to be involved.

For severely overtly depressed adolescents, there may be significant indications for psychotropic medication and/or hospitalisation. However, the use of medication is problematical with adolescents generally and more so with those who are delinquent and/or acting-out. Glaser (1978) has suggested that psychotropic medication may connote an attempt to force behavioural changes on an adolescent via thought and action control, and can be seen as further decreasing self-determination. He added:

The depressed youngster who feels unworthy of living or who seeks punishment has no reason to take medication that will counteract his desire to die or to be punished. The angry adolescent who feels right about settling disputes by violence does not want to be robbed of this power by tranquillising medication. For the drug-oriented adolescent, the use of psychoactive drugs means a conflict of messages: 'you don't want me to take mind altering substances which make us feel good, but you insist that I take your medicine, which also is supposed to affect my mind'. The paranoid individual fears to be poisoned . . . (p. 264)

Additionally, the delay in the therapeutic impact of medication, particularly antidepressants, may be further proof that nothing will help.

Likewise, psychotherapy itself can, and often is interpreted as an attempt by parents, courts and other agents of authority to 'control' and take over the mind of the adolescent. All of these issues must be considered and/or addressed early in the engagement phase of any therapeutic intervention.

With acting-out adolescents, the establishment of a therapeutic alliance or working relationship is a most difficult, frustrating, testing phase of therapy. To convert an actor and apparent non-feeler to a feeler and talker takes much time and patience. The therapist must survive this phase for both his or her own sake and that of the adolescent.

During the initial stage, the therapist should remain firm, consistent, assertive in setting limits rather than only act as a non-directive, reflective, passive adult. Thus the therapist should take the development of the working alliance slowly, attempt not to be annihilated by the depth of despair or high level of attack, taunt, or frustration which tests the adult to the limit, and remain honest and real—not just use therapeutic tricks or techniques.

Once limits are set and the depression has begun to surface a different, more 'traditional' approach is usually warranted, keeping in mind the issues of controls and so on that are concomitant in working with adolescents.

Arieti & Bemporad (1980) have suggested that depressed adolescents tend to isolate themselves from change and re-evaluation. They may have lost the ability to let experience from everyday life alter the unconscious or conscious cognitive beliefs learned in early childhood. Therapy should aim at allowing the adolescent to feel secure enough to open up to new experiences to 'form a new cognitive equilibrium based on more realistic data' (p. 356). Concrete rather than sophisticated interpretations aid this, as a message that there is no need to feel trapped in a certain pattern of living.

Whilst cognitive-behavioural approaches tend to be the most favoured form of therapy (see Beck, Rush, Shaw & Emery 1979), they can be enhanced by other work. For example, Rippere (1976) has noted how people make use of anti-depressive behaviours which have been acquired during socialisation. Socialisation includes the passing on of the accumulated knowledge ('the social stock of knowledge') designed to prepare all for coping with familiar problems—including 'low spirits'. Cohen & Taylor (1978) have referred to the 'escape attempts' which people utilise in their striving to cope with everyday life.

Parker & Brown (1979) found that young males tend to engage in more 'reckless' anti-depressive behaviour (or as they prefer 'behavioural adaptations') whereas females tend to more 'help seeking' and 'self-consoling' behaviour. They warn that attending only to behaviours which occur once the person is depressed may not be useful. What they suggest is looking at what people do when depressed or perceiving a potentially depressing situation is important and then strengthening or building on their repertoire, especially in the area of more functional anti-depressive behaviours or behavioural adaptations.

Of course, all of the above has to take into account the particular setting within which therapy/counselling is taking place, the extent of case 'ownership' which exists, and the influence on placement, program and management decisions available to the therapist/counsellor.

## Conclusion

Obviously, the above are rather 'ideal' suggestions and it is recognised that there are tremendous difficulties inherent in both the youth and the system. The problems experienced in attempting to work 'therapeutically' within custodial settings are many. However, this should not deter efforts at saving life and attempts to create humane custodial setting which do no further harm to the individuals they contain: staff and inmates.

The lack of goals, planning, and often any meaning in the lives of many young offenders was recognised by Lederer (1964) who put it this way:

the infinite expanse of future time is made meaningful only if we can see in it, at intervals, attainable goals. Without such markers and halfway houses the empty time-space is terrifying, and the delinquent deals with it by closing his eyes (Lederer 1964, pp. 58-9).

If there is no perceivable future, any point in maintaining a long-term effort is negated.

Whatever happens in treatment, no matter what the setting, there needs to be a focus on offering hope instead of despair, hopelessness and emptiness. Tooley (1978) suggested that the unhappiness, rootlessness and fear of things to come in developmentally dispossessed and depressed young people was related to a lack of an inner treasury that generates hopefulness. She saw it as a 'deficiency disease'—a lack of love for their lives and a lack of hope that they might feel differently in a year or two. Anti-social acting-out is a way of coping with the deficiency. Tooley suggests that 'rescuing, refurbishing, and re-labelling personality components that the adolescent patient has despairingly consigned to the trash' (Tooley 1978, p. 177) are necessary ingredients in working with these young

people; not as Baldry (1990) has warned by the creation of environments where hope is crushed.

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# CSV INITIATIVES IN RESPONSE TO RECOMMENDATIONS OF THE ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY

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MANY RECOMMENDATIONS OF THE INTERIM REPORT OF THE ROYAL COMMISSION into Aboriginal Deaths in Custody related generally to policies, practices and law about care and supervision of young people in prison and Youth Training Centres.

This paper outlines action Community Services Victoria (CSV) has taken in response to recommendations of the Royal Commission. CSV's responses are based upon our belief that the measures will prevent deaths by suicide.

The Royal Commission focused many of its interim recommendations on the management practices and suitability of cells used for detention. However, measures undertaken by CSV are not just targeted at our Youth Training Centres. Complementary initiatives targeted at community programs have been started. Strategically, community based initiatives promise substantial levels of prevention.

The initiatives of CSV are designed to prevent Aboriginal deaths, and particularly suicide, in custody. However, the initiatives may also prevent non-Aboriginal deaths in custody.

## **Statistical Context—Aboriginal and Non-Aboriginal Deaths in Custody**

Research was undertaken into both Aboriginal and non-Aboriginal deaths in custody by the Royal Commission. Findings of the research are important elements of the framework within which CSV initiatives have been undertaken because:

- the **relevance** of the CSV's actions can be judged;

- the **cost** of the actions can be weighted against **benefits**; and
- the **priority** of future initiatives may be calculated.

### **Proportion of Aboriginal and Non-Aboriginal Deaths in Custody**

It has been discovered that:

- In relation to their representation in the Australian population, Aboriginal people died in custody at a rate more than 20 times the rate of non-Aboriginal people.
- Aboriginals comprised 20 per cent of deaths in custody, but are less than 1.2 per cent of the Australian population aged 15 years and above.
- The number (proportion) of Aboriginal and non-Aboriginal deaths in custody is approximately equal to their relative proportions in police and prison.

A survey (Goldney & Reser 1989) found 29 per cent of persons in police custody were Aboriginals and that 32 per cent of deaths in police custody were of Aboriginals. Similarly, a prison census found Aboriginal people were 15 per cent of the prisoners and the proportion of Aboriginal deaths in custody was 13 per cent (Goldney & Reser 1989).

The 'alarming high Aboriginal death rate is explained almost entirely by the over-representation of Aboriginal people in custody' (Biles et al. 1989).

### **Aboriginal and Non-Aboriginal Suicides**

It may not surprise the community that the most common cause of death (46 per cent) in custody is by suicide. However, it would probably surprise many in the community to learn more non-Aboriginal deaths in custody (49 per cent) were reported as suicide compared with Aboriginal people (34 per cent) (Biles et al. 1989).

### **Number of Aboriginal and Non-Aboriginal Deaths in Police Cells and Prisons**

The Royal Commission found:

. . . those Aboriginals who die in custody are much more likely to die in police custody . . . 37 per cent (35/94) of Aboriginals died in prison custody while 63 per cent (59/94) of Aboriginals died in police custody.

In direct contrast to Aboriginal deaths, 67 per cent of non-Aboriginals died in prison while 33 per cent died in police custody (Biles et al. 1989). These facts support strategies to reduce use of police cells. Decriminalisation of public drunkenness and the alternative use of sobering up centres are obviously aimed at reducing use of police cells.

### **Deaths of Young People in Custody**

The Royal Commission highlighted teenage Aboriginal and non-Aboriginal deaths in custody.

- Tragically, over 10 per cent (that is, 11/103) of Aboriginal deaths in custody were teenagers at the time of death. (The Royal Commission, *Royal Commission Into Aboriginal Deaths in Custody, Interim Report*, 1988).
- 38 out of 462 deaths in custody were Aboriginal and non-Aboriginal young people up to 19 years of age (Biles et al. 1989).
- Proportions of deaths for Aboriginal and non-Aboriginal people is similar in all age groups except the 16 to 19 years age group. Seven per cent of all non-Aboriginal deaths occur in the 16 to 19 age group but 11 per cent of all Aboriginal deaths occur in the 16 to 19 age group.

These facts require special measures be taken for both Aboriginal and non-Aboriginal young people to prevent suicide.

### **Young Aboriginals in Victoria's Youth Training Centres (YTCs)**

Measures to prevent suicide in CSV's Youth Training Centres are partly in response to over-representation of young Aboriginals in its YTCs. Aboriginals, in comparison to non-Aboriginals, are significantly over-represented in Victoria's YTCs. At 30 June 1989, young Aboriginals represented 9 per cent of CSV's YTC population, yet only comprised 0.3 per cent of Victoria's population. The special vulnerability of young Aboriginals as evidenced by their over-representation requires special protective and preventive measures.

### **Suicides and Attempted Suicides in Youth Training Centres**

No Aboriginal and one non-Aboriginal death from suicide has occurred in Victoria's YTCs in the last fifteen years. One Aboriginal death occurred throughout Australia in institutions described by the Royal Commission as a Youth Training Centre in the nine-year period 1980-88 (*Royal Commission into Aboriginal Deaths in Custody, Interim Report*, 1988). These deaths by suicide in YTCs are numerically few but tragic. Custodial deaths are failures of our community to protect our young people.

A recent exploratory study discovered the number and type of reported attempts to commit suicide within CSV's YTCs (Keenan 1990). The study identified nineteen suicide attempts in a period of just over two years (January 1988 to March 1990). Methods of attempted suicide included attempts by hanging, cutting, poisoning, self-bashing and electrocution.

Factors which possibly contributed to the young person's suicide attempt included:

- poor personal emotional state;
- poor social adjustment;
- experience of recent loss; and
- previous identified suicide attempts.

The study highlights the need for staff to be careful and caring in supervising young people. Further, removal of hanging points from YTC cells must proceed urgently.

The Royal Commission investigated and reported on actual deaths in custody. However, attempted suicides are probably just as informative in pointing to changes required in practices and facilities to prevent suicide.

## **CSV Initiatives in Response to the Recommendations of the Royal Commission**

### *Modifications to CSV YTC Cells and Equipment*

The Royal Commission recommended:

Governments in all jurisdictions should ensure that all police cells are surveyed and that measures be taken, where necessary, to screen hanging points and to replace equipment or materials which are not suicide resistant (*Royal Commission into Aboriginal Deaths in Custody, Interim Report, 1988*).

In response, CSV requested the Ministry of Housing and Construction to carry out a survey of all cells in Turana, Winlaton, Langi Kal Kal and Malmsbury YTCs and also Baltara Reception Centre.

The McInnes Project Management Group was commissioned to undertake such a survey and to identify:

- potential hanging points;
- other possible suicide risks;
- minimum treatment for immediate implementation and more extensive treatment for subsequent implementation;
- the need for alarms and/or intercoms; and
- cost estimates.

Cells or bedrooms were surveyed and other areas (day areas, toilet and shower recess) were not assessed as high risk areas. Detainees are generally supervised and not locked in these other areas alone. The report stated major suicide risks in cells could result from ten causes listed below:

- hanging
- slashing
- fire
- electrocution
- drug overdose
- poisoning
- choking
- head banging
- solvent abuse (petrol, glue)
- asphyxiation (plastic bag). (McInnes unpub.)

The possibility of suicides from hanging, slashing, fire or electrocution could be reduced by modifications to cell design and construction. Suicide from drug overdose, poisoning, choking and head banging were assessed as being dependant upon adequacy of staff supervision and monitoring of what is taken into cells at night.

Each YTC was rated in terms of the relative risk of suicide posed by the cells and their equipment.

In response to the survey, CSV is undertaking the following modifications to its cells and cell equipment:

- removal of all horizontal bar grills from the insides of all cells or external bars where they could pose a risk;
- progressive removal of existing bedroom windows and frames and replacing them with specially made windows in high impact polycarbonate;
- installation of earth leakage circuit breakers to switchboards in sections;

- replacement of mattresses with fire retardant mattresses;
- fixing moveable steel beds to the floor;
- removal of steel 'hanging rails' from wardrobes and replacing them with light timber rails which will break under the weight of a small boy;
- installation of an effective smoke detection system;
- installation of an alarm/intercom system in isolation cells;
- installation of fire escape doors at particular Youth Training Centres.

The modifications to CSV cells are being undertaken progressively and will provide a safer environment for all youth.

The measures outlined above refer to existing YTC cells. In three years time (1993) rebuilding of Turana, Victoria's largest YTC, will be completed. Four units providing secure bedroom accommodation for fifteen trainees in each unit are now being constructed.

New cells at Turana will meet cell design requirements recommended by research completed on behalf of the Royal Commission (Reser 1989). The cells will include alarms and intercoms. Space in bedrooms to allow some flexibility in personal activities, privacy and some personal control of bedroom facilities will be provided. However, the cell design will ensure residents' safety and security.

In addition to cell design, the Royal Commission pointed out inadequacies in police and prison officers' training. The Royal Commission focused on staff training to perform duties involving safe management of persons in custody (*Royal Commission Into Aboriginal Deaths in Custody, Interim Report*, 1988).

### **Staff Training**

The new package of staff training in response to the recommendations of the Royal Commission is a key element to prevent suicide in our YTCs.

Implementing the training programs has required:

- creating training programs in both First Aid and Staff Instructions;
- adapting training programs used by other agencies in Safe Restraint, Prevention of Seriously Disruptive Incidents and Aboriginal History and Culture.

Consultation with key Aboriginal community and government agencies has been undertaken in development and conduct of programs.

Training is provided in four distinct areas:

*First Aid, resuscitation techniques and related health protection training:*

The *Interim Report* of the Royal Commission recommended (Recommendations 14, 28, 29) staff receive training in:

- first aid;
- resuscitation techniques, use of resuscitation equipment and refresher courses;
- recognition of symptoms of head injuries and major illnesses;

- identification of persons in distress/at risk of death through illness, injury of suicide. (*Royal Commission into Aboriginal Deaths in Custody, Interim Report*, 1988).

In response to these recommendations all institutional youth and child care staff receive training in a three-day first aid course. The course was developed by the Australian Red Cross Society in conjunction with CSV's Staff Development Branch. It equips staff to respond competently to life threatening situations and to prevent more effectively death by suicide.

#### *Safe restraint, self-defence techniques and prevention of 'seriously disruptive incidents'*

The Royal Commission recommended (Recommendations 30, 31) restraint methods such as 'choke holds' or 'head locks' must not be used. In addition, it recommended training in restraint techniques and use of restraint equipment (*Royal Commission into Aboriginal Deaths in Custody, Interim Report*, 1988).

CSV has now implemented a new training program directed at preventing 'seriously disruptive incidents'. The training is to develop positive staff/young person relationships and skills in identifying and responding positively to angry, depressed, violent or self-destructive behaviour. Techniques of self-defence, safe restraint and protection of other young people are undertaken.

Prevention of suicide is linked to this training by careful staff supervision and support of young trainees.

#### *Aboriginal history and culture*

The Royal Commission recommended staff training in '... understanding and appreciation of Aboriginal history, culture and social behaviour and ... abilities to effectively communicate and work with Aboriginal people'.

Reducing the alienation, isolation and vulnerability of young Aboriginals in YTCs is essential, and the staff training program in Aboriginal history and culture emphasises sensitivity and respect of Aboriginal culture.

#### *CSV instructions for safe management of Aboriginals admitted to CSV's YTCs*

Instructions for safe management of Aboriginals admitted to CSV's YTCs were issued prior to the Royal Commission's Interim Report. A substantial number of the Royal Commission recommendations were designed to establish safe management practices in police and prison cells.

CSV instructions have been amended to comply with the Royal Commission recommendations.

Features of the instruction include:

- non-admission if hospital treatment indicated;
- contacts with parents, Aboriginal Legal Services/alternative community representative and Aboriginal Youth Support Unit;
- intensive (15 minute) monitoring for the first 24 hours;
- detailed recording of behaviour/mood during intensive monitoring;
- placement in shared bedroom;
- limits on use of isolation;
- immediate medical attention for trainees not conscious or where doubt exists about their condition;
- medication practices;

- restraint practices;
- regional CSV staff contacts to begin/follow up case planning/management issues.

Staff are trained how to apply the instructions. Training in relation to the instructions includes material on prevention of youth suicide. Four elements of a suicide prevention program required by juvenile institutions as described by Rowan are included (Rowan 1989). These are:

- identification by trained intake worker of mental health and medical matters;
- training in signs of potential suicide;
- constant/intensive monitoring and use of shared accommodation;
- targeted referral of specific young people to Mental Health Specialist for assessment and treatment.

In addition, material from the Department of Family and Community Services NSW is used as a valuable staff training resource. Advice is given about:

- the frequency of adolescent suicide;
- 'myths' and 'facts' about suicidal behaviour; and
- critical warning behaviour of potentially suicidal young people.

### **CSV Instructions and Staff Obligation to Take Care**

The importance of the instructions to ensure safe management of young people in our YTCs is based on an obligation to protect persons in custody.

The need for state agencies to take measures to reduce custodial deaths has been considered by Temby (1989). Temby asserted that one of the keys to reducing Aboriginal deaths is to allow coroners to specify how particular staff have failed in performing their duties. State coroners are not able to identify whether a person was negligent and can only identify whether a person contributed to another person's death.

Clarification of staff responsibilities is also being reinforced by staff training to ensure a positive approach to implementing the instructions.

#### *Training YTC supervisors/managers*

CSV believes 'staff attitude' is a crucial factor in preventing youth suicides. Therefore, CSV has implemented specialised training for supervisors in our YTCs to support 'front line' staff. Supervisors receive training in the four subject areas described above but emphasis is given to their management responsibilities.

#### *Present and future staff training*

At present, CSV is training approximately 250 staff in all components of the training program outlined. In future, training will primarily occur as pre-employment training requirements of tertiary curriculum and mandatory components of CSV Induction courses.

#### *Additional medical equipment/nursing coverage*

In accordance with Royal Commission recommendations, additional medical equipment and nursing coverage has been provided in our YTCs. Additional funds have been used to provide:

- manual and automatic resuscitation equipment for all YTCs;
- an ambulance for a more remote YTC; and

- additional nursing coverage.

These measures complement existing YTC medical facilities and staffing.

### **General CSV Justice System Initiatives**

The *Interim Report* has stimulated CSV to take steps to prevent youth suicide by measures outside our YTC walls. Initiatives to reduce the number of young Aboriginals in our YTCs through diversion programs are being implemented.

#### *Statistical information—young Aboriginal offenders*

CSV is collecting statistics on the numbers of young Aboriginals on community based court orders and in YTCs. The statistics identify regions that feed the over-representation of young Aboriginals in our YTCs. New and additional measures of support will be considered to ensure reduced use of our YTCs. Targets will be established to stimulate more effective community support.

#### *Rural youth support program*

CSV's specialist rural youth support program, which commenced in July 1990, is a significant potential catalyst for change in support for Aboriginal young people. A primary role of the program is to reduce over-representation of Aboriginals in our YTCs.

#### *Community Justice Panels*

CSV is supporting development of Aboriginal Community Justice Panels (CJPs) throughout Victoria and particularly regions with significant Aboriginal populations. Community Justice Panels are composed of members of the local Aboriginal community willing to work as volunteers with criminal justice agencies (Attorney-General (courts), Police, Office of Corrections (Adult Corrections) and CSV).

Important ways in which the Community Justice Panels can work with CSV have been identified. In particular, involvement in pre-sentence court reports or other court advice, supervision of court orders and support for parolees (pre and post release) could reduce numbers of Aboriginals in YTCs.

CSV has provided training, developed regional instructions to link CSV with Community Justice Panels, program documents and promoted CJPs.

### **Conclusion**

CSV has initiated a range of measures in response to the Royal Commission into Aboriginal Deaths in Custody. Research undertaken on behalf of the Royal Commission revealed a larger proportion of young Aboriginals aged 16 to 19 years died in custody than non-Aboriginals of the same age. Ten per cent of Aboriginal deaths in custody were teenagers at the time of death. While a tragic and significant number of Aboriginal and non-Aboriginal deaths in custody do occur, few of the deaths occur in YTCs, though young Aboriginals are over-represented in them.

CSV's actions in implementing a range of initiatives seek to ensure we fulfil our duty of care. The special measures to prevent suicide respond to the special vulnerability of young Aboriginals. Young non-Aboriginals are also at risk and CSV measures also respond to their vulnerability.

CSV's approach to the prevention of youth suicide includes action to support Aboriginal communities. Through establishing community support and supporting the caring role of our staff, CSV initiatives offer the potential to prevent suicide by young people both in custody and while on court orders in the community.

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# **ENLISTMENT PROCEDURES AND INITIAL TRAINING PROGRAM: KAPOOKA ARMY BASE**

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THIS PAPER IS NOT A PRESENTATION OF RESEARCH FINDINGS, BUT IS INTENDED purely to outline the workings of the Army's Recruit Training Battalion.

Specifically, the aim is to outline the following aspects of the 1st Recruit Training Battalion (1 RTB):

- recruiting and selection procedures;
- recruit training;
- factors affecting recruit training;
- types of problems encountered;
- behavioural responses;
- resources available to deal with these responses; and
- preventative measures.

## **Recruit and Selection Procedures**

In order to be accepted for military training, applicants must first pass through a series of selection filters. They must first meet age and citizenship criteria. Applicants are then given a battery of aptitude tests, which differs slightly according to the nature of entry applied for. Generally these screen for general ability/logical reasoning and literacy, and highlight any obvious emotional instability.

After successfully completing this stage, a structured interview is conducted by a qualified Army psychologist to examine the applicant's family background, education, employment history, social relations, sports and interests, history of antisocial behaviour (if applicable) and motivation to enlist. An extensive medical examination is performed, and police and security checks are conducted.

After a second interview, an Army enlistment officer makes a decision regarding the individual's suitability on the basis of recommendations of others involved in the selection process and the applicant's presentation. In the case of officer and apprenticeship entry, the applicant must also appear before a selection board and be considered in competition with others.

Given that it is every citizen's right to bear arms in defence of his/her country and that enlistment is voluntary, it must be stressed that the Army employs a practice of negative selection. That is, an applicant is considered suitable unless there is evidence to suggest he/she would be placed at risk or place others at risk through military service. Whilst a psychologist may advise against enlisting an applicant due to personality or behavioural concerns, it is only the medical officer or enlistment officer who has the power to reject an applicant as having an unsuitable character.

Statistically speaking, a typical recruit on enlistment at 1 RTB is 18 years of age, male, has reached year 10 of education and enlists out of desire for a secure career.

## **Recruit Training**

The base 1 RTB is situated within the Kapooka Military Area, which is located 10 km west of Wagga Wagga, NSW. Training at 1 RTB is based on a thirteen-week program and is designed to inculcate the knowledge, skills and attitudes required by all soldiers of the Army, regardless of the trade or specialised area in which they may be subsequently employed.

### *Skills/subjects taught*

The skills and/or subjects taught during training include shooting, weapon handling, fieldcraft, physical fitness, drill, soldierly qualities, navigation, first aid, character guidance and development, development of self-discipline, and standards.

### *Lifestyle*

The training program is centred on the platoon group which consists of up to fifty recruits and six training staff. The recruits live in a barrack room, or dormitory, style of accommodation with four to a room, a platoon to each floor.

### *Daily routine*

The daily routine commences with reveille at 6 am, breakfast at 6.30 am and training at 7.20 am. The day is broken up into a series of forty-minute periods with a ten-minute break between periods and concludes with lights out at 10 pm. This constitutes a long day involving a lot of physical activity and mental concentration.

All of these activities occur in an environment of imposed discipline, constant supervision and continual assessment. Therefore, it is a closed and potentially stressful environment.

### *Assessment*

The recruits are under constant assessment of their performance and assimilation of the training they receive. Other aspects of assessment include what are regarded as soldierly qualities: attitude, energy, effort given into the activity, motivation, desire to learn and succeed, common sense, application, teamwork, a principal pillar in the framework of the military system, drive, maturity and perseverance to work through and stick to the task in hand, despite the fact that it may be hard and they are tired.

One result of this type of environment, training and assessment is the amount of stress and pressure that the recruits have placed on them and subsequently on the instructors. To some degree this is deliberate, and their ability to cope with it is also assessed as these factors together can mean the difference between life and death on the battlefield.

### **Factors Affecting Recruits' Performance**

A recruit's performance at 1 RTB is affected by a range of factors. Many of these are constant in that they are relatively similar for all recruits and relate to the training environment. Factors include the Army Training System which is a performance oriented approach to training and the instructional skills of those applying the system. The initial culture shock and feelings of isolation, together with the pressures and stress of the training environment also play a part in recruits' performance.

The degree to which these environmental factors affect recruits varies as a function of a recruit's pre-1 RTB environment, chance and individual differences. Given that chance is unpredictable and a person's background is predetermined and uncontrollable, individual difference is the only factor that staff can deal with directly and over which they can exert some influence.

### *Individual differences*

The influence of individual differences on recruits' performance can be examined in five broad areas.

First, a recruit with higher mental and physical capacity will have a better chance of succeeding at 1 RTB than one with lower level capabilities.

Second, in terms of Cattell's personality factors, a recruit who is 'extroverted' and 'stable' has a better training/adjustment prognosis than someone displaying unstable and introverted qualities. This is, however, a very simplistic model and in real terms open to subjective interpretation by training staff.

Third, the ability to socialise effectively with one's peers promotes adjustment to the training environment. This is to some degree influenced by the personality make-up of the platoon.

Fourth, a recruit's background, including such factors as age, education, previous employment, sporting interests and family background can influence his/her potential to adjust.

Finally, motivation is probably the main area of individual differences which affects performance and over which staff have the greatest influence. Essentially, an appropriately motivated recruit identifies with group needs, sees basic needs as being met, and responds positively to the use of feedback and reward for training staff.

### *Types of problems encountered*

All of these environmental and individual factors can combine to cause the following types of problems for recruits:

- medical problems (due to illness or injury);
- external (non-1 RTB) problems (such as family or finance related);
- training problems (due to poor fitness, coordination or assimilation);
- personality/behavioural problems (though less common, they are occasionally evidenced);
- adjustment problems (such as situational or separation anxiety); and
- attitude/motivation problems (particularly during the initial stage of training when a recruit is coming to terms with an alien environment).

### *Behavioural responses*

As a result of these actual or perceived difficulties, a recruit's frustration, anxiety and feelings of helplessness may trigger a range of responses. In some cases, an individual will choose to act out those feelings by becoming a discipline liability. Generally, however, it is recognised that this is an inappropriate and potentially punishable reaction, and usually recruits opt for a type of avoidance response. Avoidance may take the form of absence without leave, application for discharge, or physical complaints suggestive of somatoform disorders. Others withdraw to the point where there is a sharp decline in coping skills and subsequently training standard. In a very small minority of cases, a recruit will threaten suicide. Attempts by members of the Army are far lower than the general community and, of those, almost all can be considered merely attention-seeking gestures, predominantly in order to manipulate discharge.

### **Resources Available**

A number of resources are available to the recruits to help them overcome their problems and adapt their responses to achieve the desired result—to become a successful soldier. These resources include:

- Platoon Staff and Company Staff: These people, with whom recruits spend most of their time, provide the initial contact and counselling for the recruits. They also provide the initial assessment for referral to other support agencies.
- Medical Staff: These include Medical Officers (GPs) and specialist medical personnel usually civilians from Wagga, Canberra or Sydney.
- Psychology Staff: Psychologists from 17 Psychology Unit provide counselling and assessment for the recruits and advice to the training staff to assist in the management of the recruits.
- Psychiatric Staff: A civilian psychiatrist from Wagga is used when required, along with the facilities of Wagga Base Hospital. Recruits may be referred to the psychiatrist by a Medical Officer.
- Chaplains: Chaplains representing the Catholic, Anglican and Protestant denominations form part of the Regular Army staff at Kapooka. Other specialist religious support, such as Passover and Kosher meals for those of the Jewish faith, can also be provided.
- Community Services: The Army Community Services counsellors can also be called upon to provide assistance and support for the recruit, and his family,

where and when required. Together, these agencies provide a major, sustained and closely knit support system.

### **Preventative Measures**

A number of measures, or methods, to aid in the prevention, early detection and recovery of the problems and behavioural responses have been built into the training program and system of management for the recruits.

These measures, or methods, include:

- Staff Training: As part of the initial selection and introduction process for instructional staff at 1 RTB, training is given by psychologist and padre staff on the basic psychology of recruit problems, how to identify them, and counselling skills and techniques to supplement the formal military training all officers/NCOs already receive in leadership, management, interviewing and other command skills.
- Refresher Training: Refresher training is given progressively throughout the instructor's posting and includes counselling and other skills directed at assisting recruits to cope with all likely difficulties.
- Early Identification: This is the most important, and possibly the most difficult, factor to achieve. There is a reliance on the platoon staff to achieve this through initial interviews on the recruits' arrival and by close monitoring and association throughout their training.
- Stress Management: Stress management techniques, and coping skills can be taught in conjunction with the setting of short-term goals for both trainers and trainees. This enables more encouragement and the development of confidence and self-reliance.
- Compassionate/Emergency Leave: The use of this type of leave, in conjunction with other support agencies such as Army Community Services, can relieve, or even solve, many external pressures thus allowing the recruit to concentrate on his/her training.
- Discharge Option: An enlisted recruit is required to serve a minimum of four years on an Open Ended Enlistment (OEE) contract. The soldier is then required to give six months notice when requesting discharge from the Army. A recruit may, in the first three months of training, apply for a discharge. As the Discharge Authority the Commandant of 1 RTB may, unless serious compassionate circumstances exist, hold a recruit's application for discharge at own request for up to twenty-eight days. This is to allow counselling by training staff and/or other support agencies and also allow the recruit time to overcome the initial culture shock of his first few weeks in the Army. If at the end of this period the recruit still requests discharge, the application should be approved. This option provides an excellent safety valve as the recruit no longer feels trapped in his current circumstances.

## **Conclusion**

At 1 RTB, and in the Army as a whole, emphasis is placed on maximum retention of personnel through optimal man-management and leadership. The Army attempts to train as many recruits as possible to the standard where they can perform effectively as soldiers in operational units. It is reluctant to discharge potentially trainable soldiers without good cause. The Army's role is to train for war. Induction into a peacetime Army is a particularly stressful experience for all recruits, but reactions to this vary from soldier to soldier. The Army recognises and acknowledges this fact in the formulation of its training policies, by employing specially selected military trainers and specialist supporting staff and by continual development of effective man-management and leadership skills.

At 1 RTB, as in the entire Army, personal development, strength of character, self-reliance and enhancement of self-esteem are addressed as crucial to soldiering. In fostering these qualities, the Army is continuing its long tradition of producing young Australians who are physically, intellectually and spiritually prepared for the stresses of any contingency be it military or civil.

# EXERCISE ENIGMA

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THIS IS A CASE STUDY OF HOW THE RAAF, WITH THE ASSISTANCE OF MEMBERS of the NSW Police Force, recognised a problem and set about to provide solutions. It is, in itself, a story of trust and leadership by senior management in the RAAF.

The focus of the paper will be on an exercise known as 'Enigma'. While no 'hard' data is available to support such an affective subject, management and the training designers are heartened by the practical results gained so far.

## **Background to Enigma**

Early in 1988, a number of discussions were held between members of the RAAF based at Richmond in NSW and members of the NSW Police Force (based at the Police Citizen's Youth Centre at Camp Mackay), at Kurrajong. The members of the Police Force were invited to attend when the RAAF realised that their problem during working hours had the potential to be a problem for the local community after hours. The personnel involved in the discussions were also concerned at the number of RAAF members that had, or tried, to commit suicide.

The original plan to counter the problem involved the provision of activities such as gymnastics and other sporting pursuits. However, through discussions of the basic issues, the solutions were found to be in fields other than sporting ones.

The problems identified were not as militarily related as first expected, but were equally applicable to the community.

Eight interrelated causes for the behavioural problems of the young RAAF personnel were identified. They were:

- breakdown of the family unit;
- low self-esteem;

- a victim mentality;
- little regard for authority;
- little understanding of and regard for the rights of others;
- the need for instant gratification;
- financial debt; and
- material oriented management.

#### *Breakdown of the family unit*

The RAAF actively recruits young persons, relocating them to an area away from the support of their family and friends—thus removing their supportive networks. Moreover, the RAAF has no viable alternative to offer these persons in view of the location of the initial training units.

#### *Low self-esteem*

As with most large organisations, those whose performance is as expected are told as much. For those whose performance is below par, the message is very public. As often stated, 'the clothes make the man'—rank insignia included.

#### *Possession of a victim mentality*

It was noted that many of the young personnel had difficulty in handling criticism—quickly resorting to individual persecution rather than accepting it as constructive advice. However, the group also identified that, in many cases, the problem arose from the ineffective manner in which criticism was delivered.

#### *Little regard for authority*

Many of the young personnel joining the RAAF had little understanding of, or respect for those in authority. Taught at school to question authority and know their rights, many young personnel did not jump when told to. While there is no question as to the need for a ranked structure within the RAAF, those holding the authority need to be able to communicate their decisions.

#### *Little regard for the rights of others*

Many of the young personnel entering the RAAF are very 'I am' oriented, and while a degree of self-importance is promoted, the RAAF functions as a team to a common goal. Further, the self-importance was often without regard for the rights or comfort of others.

#### *Instant gratification*

We live in a take-away society where medicine, entertainment, food, good pay and education are almost expected to be readily available.

The RAAF can, therefore, be seen by some as an extension of this philosophy as a way of life that provides adventure and excitement. Encouraged by the media, and reinforced by the selective memories of families and friends, many aspiring recruits see the RAAF as a way of being trained while being provided with an adventurous life.

This is rarely the case in a peace-time air force, with those joining soon realising that for the majority, the life offers as much excitement and adventure as normally found with any nine to five job and the potential security of a twenty-year career.

According to members of the NSW Police Force, many of the young people joining the RAAF are a product of attitudes that tend to condition young adults to seek individual

pursuits, show little regard to the relationship between cause and effect and expect others to provide support, entertainment and an interest in life. Such expectations oppose the fundamental values of the RAAF where responsibility, initiative, mateship and support are the hallmarks of team effort.

Many of these young personnel show little self-confidence and have low self-respect and esteem and limited self-discipline. They are often loners and are easily bored—expecting excitement and entertainment to be provided. Feeling neglected by parents and society these individuals may react through poor productivity, vandalism and or violence.

#### *Financial debt*

Financial debt is another problem that may beset members of the RAAF—especially young single personnel. Paid an attractive salary, and employed by a stable and respected employer, these people become easy prey for the buy now but unable to pay later schemes. According to Sutchbury (1986), financial problems result in low morale, absenteeism, alcohol related problems, interpersonal friction, damage to equipment and poor attitudes.

Again, the problems can easily degenerate into an administrative one, with debt collection being undertaken through the RAAF, with disciplinary action and even discharge resulting from an inability to meet the requirements of the lending authority.

#### *Material-orientated management*

The RAAF is predominantly a technologically oriented member of the Profession of Arms. It has to be: aircraft must come first—their maintenance, flying and positioning relative to targets. Everything else is subservient to these objectives.

While the personnel oriented directorates, units and sections are diligent, supportive and responsive, the practicalities nonetheless determine the priorities of resource allocations, training and postings and the like.

When coupled with the political constraints decided by the lack of a perceived threat, the value of the tax payers' money must be maximised. Consequently, management of things (material) can assume a higher priority than the leadership of people. While leaders are often good managers, managers (of things) need not be good leaders.

Consequently, internal training and tertiary education sought by its personnel and/or sponsored by the RAAF has tended to concentrate on the development of management related skills. This thrust has been faithfully pursued in the training of its Senior Non Commissioned Officers (SNCOs). More recently, Officer, and to an extent SNCO training is more leadership oriented.

#### *The young single living-in member*

Already suffering from a possible lack of team spirit, the young single living-in member is often required to live on base. While sporting and other clubs operate at night and during the week-ends, many do not meet the needs of the younger personnel. Some clubs are, therefore, closing through a lack of patronage; with those remaining being run by older and/or married personnel. The Airmen's Mess, tending to centre on the provision of mainly alcoholic related activities, remains the major recreational facility on most bases.

The problem for these young personnel is heightened by the necessity to build Air Force bases away from the centres of populations and hence entertainment. Consequently, without means of safe and reliable transport, many young personnel are further 'confined' to base. Without appropriate leadership, motivation and support many develop and/or reinforce a habit of attending the bar—having either brought a societal habit to the RAAF, or adopting a new lifestyle in the absence of their old networks.

Should these individuals have access to a car, then the distances travelled to their entertainment, coupled with the possibility of alcohol adds another dimension to the problem. Many personnel, not wishing to become part of the bar set, become isolated within their rooms.

The RAAF employs social workers and psychologists to assist these and others of its members. The RAAF also employs chaplains within its own ranks to assist and provide guidance where necessary.

Generally, the assistance of these 'carers' aims to assist the individual overcome his or her problems by either 'using the system' or by putting the system right. The problem can therefore be viewed as a re-active management issue rather than one requiring pro-active leadership.

Suicide is the second major cause of death within the RAAF, with road trauma as the primary cause of death. One can only speculate at the number of hidden suicides within the figures for road trauma.

While no significant difference appears to exist between the death rates in the RAAF and that for the Australian population for suicide and road trauma (for an equivalent age span and rates for the populations), the death of one of our team is one too many—representing a tragic loss of life, as well as the loss of a valuable trained resource.

In 1897, when assessing the causes of suicide, Durkheim (1951) noted the influence the organisation has on the lives of the individual. Of particular importance was the degree of social cohesion in preventing suicide. In other words, people more connected to their social group were less likely to consider committing suicide. Further, groups that emphasised a strong community spirit also had lower suicide rates.

Later research has supported these important findings while highlighting the wide variety of physical and emotional problems triggered when moving to a new neighbourhood. In a case study spanning nine years and studying 7,000 people, Berkman & Syme (1979) found that single people with few close friends and relatives and without community participation died at a rate two to five times greater than those with social ties. Ornstein & Sobel (1989) link stress and suicide and other forms of death with people rating highly on stressful life events that involve personal changes to their supportive networks.

While the RAAF is a caring employer, relying on teamwork to achieve its goals, the Enigma development group considered it essential that the young RAAF personnel develop their self-confidence and esteem as well as their personal and professional supportive networks. Our senior management supported these views and thus the development of the program.

## **Other Training Design Issues**

Having identified the major problems, the next aim was to identify the target audience. This was not a difficult task: the 'coaches' being the target group, that is those personnel immediately responsible for the action of the 'players'. In our case the corporals—our first line of leadership and supervision—were the 'coaches'. Looked upon as the hardest rank in the RAAF, corporals could be 'one of the boys' one day, and, because of a promotion, become a supervisor the next, without any standardised or formal training.

Training for these 'coaches' would need to cover the basic skills required for leadership as well as including protective behaviours and networking skills. They would also need to be aware of the background from which many of their troops came. This would be an important process in breaking down the warrior mentality that often reveals itself in the form of '... that happened to me when I was young, I had to tough it out and it didn't do me any harm'. Communication skills would also have to be improved with practical experiences gained in briefing, monitoring and debriefing as well as counselling.

These corporals would have the challenge of establishing a makeshift replacement for the lost family. Further, the training had to be effective, cost efficient and practical with follow-up activities built into the program.

Moreover, for the development of the networks, the training had to be based around the experience of the superiors. In other words, a return to the basic philosophy of the elders passing on a way of life to the younger generation.

## **The Strategy**

A training program was established by No. 486 Squadron (a large maintenance Squadron) and No. 2 Aircraft Depot (another large maintenance organisation) and other Units within RAAF Richmond.

The leadership development component is known as Exercise Enigma, and is a unique leadership course within the RAAF, specialising in the development of personal qualities for the coaches, or first line leadership within the RAAF—the corporals.

## **Exercise Enigma**

Enigma specifically aims to develop the individual's self-worth and confidence while inculcating attitudes required for a task oriented workplace. To this end, Enigma follows the traditional philosophy of the elders (SNCOs) passing on a way of life to the younger generations. Specifically, the course is based on a symbiotic relationship between the spiritual, emotional, intellectual and physical domains. Enigma, therefore, develops the whole person.

Being a 'person oriented' course, Enigma is not designed as a quick fix. Enigma aims instead to produce individuals who are confident of their own abilities and strengths. Through discussions with and role modelling by the facilitators, the students develop values and attitudes that are consistent with the needs of the RAAF. That is, they develop a task orientation with recognition for the needs of the individual (and group). Enigma is therefore a blend of functional leadership and personal development, producing individuals who value responsibility and accept the relationship between cause and effect.

## **Why the Term Enigma?**

The term Enigma was chosen for two reasons. First, the reason or cause for the lack of concern and responsibility was an enigma to many senior personnel. Second, the term 'enigma' was used by the British in one of their more notable code-breaking activities. To this end, the use of the term similarly implies that each student has their own individual codes that must be cracked before their true potential can be realised.

## **The Logo**

The use of the butterfly as the logo symbolises the need for time and space if the individual is to attain a degree of potential—the development of the butterfly occurring over time and in a structured manner. The butterfly must also release itself from its protective chrysalis. If aided in its struggle, it usually dies. Humans too must learn for themselves—in an environment that provides protection appropriate to the objectives. After all, learning is something done by an individual. It is not something done to him or her.

Finally, the butterfly, known for its beauty and agility, usually develops from the much maligned caterpillar. The development of the individual similarly is often contradictory to expectations; one not knowing the leadership potential that may be unlocked through the caring yet confrontational environment of the exercises.

## **The Elders**

The philosophy of Enigma does not condone the use of 'leaders'. Being a personal development course, Enigma makes use of facilitators—specially selected staff from the workplace. All selected facilitators have the following functions:

- to pass on the required way of life expected by the RAAF;
- to act as role models to the students;
- to provide emotional stress and challenge in addition to those offered by the environment and exercise;
- to provide a supporting and caring safety net for students; and
- to be approachable enough to act as a member of the student networks of the student.

The wide-ranging demands placed upon the facilitators require special training for these senior SNCOs. However, because Enigma meets the needs of the workplace, this training not only aids the selected SNCOs in their role as facilitators, but also at work. The training also has direct application to their civilian life.

## **The Exercise**

The exercise consists of three phases: Theory, Application and Consolidation phases. All phases are structured and provide interrelated activities.

### *The theory phase*

One day is spent in the classroom involving role plays, simulation and discussion.

### *The application phase*

This three-day phase aims to develop the confidence, self-esteem and commonsense of participants in as short a time as possible. To this end, highly structured Fieldcraft and Adventurous Training activities are employed. Interactive debriefs and feedback are also an integral component of the phase.

### Protective behaviours

The protective behaviours component has a twofold aim. First, the creation of personal and professional networks, and second, to make each participant aware of the personal attributes required to make them an effective member of a network.

Protective behaviours also provides practice in giving constructive criticism. Time was also spent on the maintenance of self-esteem; both areas concentrating on communication

that reinforces the message that it is the behaviour rather than the individual that is unacceptable.

Trust exercises are also an integral component of the training.

### Fieldcraft training

The Fieldcraft activities consist of a confidence course, bush skills, team problem solving projects, counselling skills, navigation skills, knots and lashings, camp selection, use of equipment, abseiling and rock climbing.

### Adventurous training

The Adventure training component involves goal setting and an overnight trekking exercise. The routes selected provide challenge to the student leaders and their 'troops'. While at least one facilitator accompanies each team, their roles are limited to rostering the leadership and providing assistance in an emergency. The facilitators also lead interactive debriefs regarding the role of the leader.

The stressful experiences encountered by the students (supported by their network of mates), encourage the students to develop styles of leadership that prove successful in achieving a difficult task—with the team.

Experiences gained in both the Fieldcraft and Adventurous Training activities are vehicles used to highlight the processes used by the participants. Thus while the activities encountered are challenging and involve risk (thus illustrating the relationship between cause and effect) and the need for courage, time can be spent to ensure the process is highlighted, relating the behaviour (and results) to the workplace and home.

The aim of the interactive debriefs and other discussions is to transform fear into confidence, judgment to appreciation, pessimism to optimism and dependence to independence. The course further aims to produce independent, participating and assertive individuals—as evidenced by the voluntary selection of tasks and responsibilities by the students prior to their return to base.

This activity also contains a solo phase where participants are stripped of all luxuries and inserted into the bush on their own for up to eighteen hours. This activity allows the participants to reflect on their experiences gained on course as well as their role and as a leader and a member of society.

### Camp-fire discussions

While camp sites are chosen for their lack of comfort, camp-fire discussions are an essential component of the course. Trained to lead the discussion, the facilitators encourage the students to reflect on the successes, problems and challenges of the day while relating them to the workplace and home life. These discussions cement the symbiotic relationship between the spiritual, emotional, intellectual and physical aspects of the course. Peer support and bonding are also important aspects to the course with the aim of developing personal and professional networks.

### Formal Dining-In

While being a pleasant way to celebrate the completion of a strenuous and challenging exercise, the Dining-In provides the vehicle by which each student presents an account of him or herself as a result of the course and where and how the new skills will be used.

### *Consolidation phase*

Exercise Enigma was not designed as a quick fix. Instead, following the philosophy symbolised by its title and logo, a three-month consolidation program is provided to cement the relationships and skills. Topics included in this phase aim to develop supportive networks as well as improve communication skills, problem-solving abilities, goal setting and character development.

### **Does it Work?**

It seems that the exercise does work, supported by the following evidence.

First, the feedback from the students: the confidence they now have regarding their leadership skills, the assistance gained from having a network of friends—personally and professionally, and the responses gained from their troops.

Second, the responses from the troops about their leaders: positive feedback described their corporals with a willingness to work with and for them.

Third, the responses from section commanders: they were naturally impressed, for many of them were on the course as the facilitators (or elders). Those who were not on the course knew the quality of tutoring. Also nominations for courses are not difficult to gain—a real plus in the stressed environment of an operational level maintenance Squadron.

Fourth, the feedback from the 'elders': 'When do we do it again?'. It is evident that new corporals, finding, or being told of personal problems with troops will use their network (involving senior management)—through their section commander to ensure the problems are alleviated.

An interesting example of the success of this project is the case of the Commanding Officer (CO) returning the annual evaluation report on a young person, believing it to be in error. The improvement in morale and leadership ability following the exercise was significant enough for the CO to not believe it to be the same person. Naturally he was delighted to be told there was no error.

Then there was the case of corporals complaining of the lack of support from some of their SNCOs—so a course was specially designed for sergeants. This course had the same response and feedback.

Perhaps the most pleasing result is that the courses are continuing even though the personnel responsible for their introduction have been posted or left the RAAF.

### **Other Components of the Program**

Exercise Enigma was one of a number of initiatives introduced at RAAF Base Richmond to assist its young single living in personnel. Others included:

#### *Financial budgeting*

Financial budgeting and planning skills were taught by members of the Donanco School of Financial Management.

#### *Coffee shop*

The introduction of an alcohol free on base recreational environment in the form of a coffee shop which is not only for the younger personnel, but is also operated and run by them as well.

### *Upgrading of the Airmen's Club facilities*

Acting on the belief that the attitude of patrons generally matches the quality of their surroundings, the facilities of the club were upgraded through the purchase of new tables, chairs and carpet along with self-help painting and renovations. The idea appears to have worked, with the behaviour of personnel improving and the facility being used for non-alcoholic related functions.

### *Other related needs based activities*

The young personnel are encouraged to identify and organise those pursuits and activities which they feel are best suited to themselves and their peer group. Their SNCOs and other members of their network assist and encourage these endeavours. The activities chosen, while 'trend based' often support the development of attitudes required by the RAAF. The activities include bushwalking, motor sports and bowling: activities which reinforce, in a social way, the essence of the RAAF requirement for a team effort.

## **Conclusion**

The RAAF is a caring and responsive organisation, relying heavily upon teamwork to attain its goals. However, for young people separated from their families and friends and looking to the RAAF to provide adventure and excitement as well as a sense of purpose, disillusionment and isolation can easily occur.

With road trauma and suicide being the prime causes of death of RAAF personnel, senior management embraces any genuine attempt to further develop the personal qualities of its team. Exercise Enigma was one of the initiatives supported. Further initiatives involving adventurous training are actively being introduced for the development of RAAF personnel.

Exercise Enigma offers an experiential training that is based on the philosophy of the elders passing on the required way of life to the younger generation. Further, Enigma highlights the processes involved. That is, the bush is primarily used as a vehicle, the facilitators encouraging the students to identify the processes used to overcome obstacles and relate their experiences to the workplace and their role in society.

Exercise Enigma also aims to cement the symbiotic relationship between the physical, emotional, spiritual and intellectual domains of human endeavour and therefore develops the whole person.

It is too early to tell the effect of the training. However, if the short-term practical results are any indication, the program appears to be satisfying its objectives of raising self-esteem and confidence of the personnel as well as developing leadership qualities and personal and professional networks. By doing so, it aims to contribute to a reduction in the deaths of RAAF personnel through suicide and road trauma.

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# **A COMMUNITY BASED, MULTI-DISCIPLINARY APPROACH TO SUICIDE PREVENTION**

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THIS PAPER DISCUSSES THE DEVELOPMENT AND ACTIVITIES OF THE FIRST community-based suicide prevention group in Australia. Outlined in the paper are the history, objectives and the work undertaken to date of the Suicide Prevention Task Force. Also examined is the Task Force training package which is used to train health and welfare professionals in the area of suicide prevention.

## **Introducing the Region**

The Suicide Prevention Task Force was formed in November 1987. Its formation was the response of a number of workers who were working in Health and Welfare in the Campbelltown area, in the south-west of Sydney. These workers had attended a number of conferences and workshops about suicide and were frustrated that all efforts to deal with suicide appeared to be happening at an academic or university level or a policy level and very little was being done at the grass roots community level to make people aware of the issues of suicide, to prevent suicide and to work with survivors of suicide.

The Macarthur Region is about fifty kilometres south-west of the centre of Sydney. It is a distinct geographical entity which encompasses the three local government areas of Campbelltown, Camden and Wollondilly. Each of these local government areas is different and yet together they form an interesting pattern for workers. Campbelltown is the main population centre and this is where most agencies are based. However, as Camden and Wollondilly grow, services are being provided more and more in these two outer areas, with Wollondilly being the most rural of the three. Campbelltown itself is a mixture of public and private housing estates and, over the last ten years, the population has grown to about one hundred and thirty thousand, a third of whom are under 15 years-old.

Camden is mainly rural population, however, in the last twelve months there has been enormous growth and this is proving to be one of the fastest growing areas in this region. The Shire of Wollondilly is a mainly rural area with twelve small townships, each of which are also growing due to their proximity to Sydney.

Campbelltown is fortunate to have a number of service providers working in the area. The main government departments, both state and Commonwealth, have offices in Campbelltown as do the major non-government agencies. However, due to the enormous population increase, these agencies are always overworked with often long waiting lists for counselling services. The stresses of living in the Macarthur region are evident with the high youth population and very few recreation or entertainment facilities. There are high rates of vandalism, petty crime and family stress with a high proportion of young families and single parent families living in the area.

Workers in the area are constantly challenged with issues such as youth homelessness, domestic violence, child abuse and, more recently, suicide. It was from this perspective that a number of people who work in areas which focus on families and young people came together at the end of 1987 with the common purpose of addressing the issue of suicide in the Macarthur region.

### **Development of the Task Force**

The first meetings were somewhat chaotic. There were about twelve members, each of whom had a yearning to do something about suicide, without the knowledge of quite where to begin. There was an attempt to recruit to the Task Force a cross-section of professionals including ambulance drivers, police and doctors. However, representatives from these organisations, although expressing a keen interest, were unable to put the time and energy in to attending meetings.

In December 1988, an Association was incorporated to develop a Constitution with the following objectives:

- to decrease the incidence of suicide and attempted suicide in the Macarthur region amongst all age groups;
- to raise awareness and educate the general public and professionals working in Macarthur on the issue surrounding suicide;
- to provide training and a consultative service to those who requested such a service;
- to promote and encourage suicide prevention amongst people living in the Macarthur region;
- to collect statistical data to monitor the prevalence of suicide in the region;
- to acquire appropriate resources about suicide and related issues both from within Australia and from other international organisations;
- to encourage networking between local agencies who deal with suicide issues;
- to encourage active cooperation between government and non-government organisations regarding the issue of suicide prevention;
- to encourage and assist the formation of groups in other regions to address the issues surrounding suicide.

At this time, membership was considered seriously as it was felt it would be very easy to open membership to the general community, to become a mixture of professionals working in the field and others living in the community who perhaps were survivors or in some way touched by suicide. It was felt that this would not be viable and would be, in fact, untenable, so a decision was made that the Task Force itself would only be made up of professionals working in the field. It was acknowledged, however, that there may be a need for survivors in the community to meet, and it was felt that if this was an identified need in the future, a separate group would be considered, perhaps under the umbrella of the Task Force.

Members were drawn from a variety of health and welfare agencies, including state Departments of Family and Community Services, Education, Health; Federal Department of Employment, Education and Training; the local hospital; representatives from local government mainly working in the field of youth; and representatives from some of the major non-government agencies such as Marriage Guidance Council, Burnside, Lifeline and Centacare.

The group felt that the best place to begin was to become educated about suicide and to feel comfortable talking about the issue of death. A number of training meetings were arranged on a regular monthly basis, and each meeting was used to discuss issues relating to suicide, statistical data, overdoses, myths and facts, crisis counselling and so on. A local palliative care worker was contacted who was able to spend time with the group assisting people to work through their own death fantasies. This was found to be a really valuable experience and for many it opened the door to talking about an issue that even professionals find difficult to talk about: death. Through other organisations, the group was able to collect journal articles and books which were shared, read and discussed to enable an understanding of some of the concepts in this difficult material.

Others in Sydney who were working in the field of suicide were contacted and invited to share their knowledge and information about suicide.

### **Activities Suicide Prevention Brochure**

Very early the group became aware that there was very little information available for the general public in the area of suicide and suicide prevention, so a number of brochures were developed which would give relevant information about prevention of suicide and which would be available to the general public. Three brochures were developed: one targeting adolescents; one parents; and a general brochure. Each of these brochures provides information which can assist the general public to be aware of the issues of suicide. Every care was taken to ensure that these brochures were not sensational, that they had no jargon, and that they were clear and to the point. They also pointed out where help could be received.

The Macarthur Area Health Service and the Department of Employment, Education and Training assisted by providing some funding for artwork and the initial print run.

Response to these brochures has not been all positive. Prior to printing, the draft brochures were sent to some people working in the field of suicide who could give an opinion about whether the content was useful. The majority of the responses were positive. Some of these people felt that providing a brochure-style publication might encourage people to suicide. However, after some discussion with suicidologists in the United States, it is the belief of the group that this does not seem to be the case.

The launch of these brochures in February 1989 was a public affair held at the local shopping centre with assistance from 2JJJ. Following the launch of the brochures, there was quite a lot of interest not only by the local and Sydney media but also by the ABC through Radio National. The group's work with the media has also been quite extensive and it is felt that in breaking the taboo of suicide, there is no encouragement to those who are suicidal to attempt, but those who are suicidal are encouraged to seek help.

### **Employment of a Worker**

Enormous amounts of energy were needed to keep up with the demand put on the Task Force. Throughout 1989, the group applied to numerous Commonwealth and state government departments for funding for a worker to assist in the work. Unfortunately, no

funding was forthcoming, although some facets of the bureaucracy gave support to the submissions.

Late in 1989, the Myer Foundation made a grant for one-year's funding for a worker to coordinate some of the Task Force's activities.

The Suicide Prevention Worker has three main functions. The first, to coordinate and to assist in the training program so that more training can be provided to workers in the field. The second role is a networking role. Networking in its broadest context, which includes contact with others working in Australasia in the field of suicide prevention and suicidology, and overseas, and the collation of statistics so necessary in the development and continued work of prevention programs. Thirdly, the Suicide Prevention Worker will be involved in a number of groups for young people, as well as their families. In the first instance, a group is being developed for survivors in the Macarthur Region.

### **Training Others**

As expertise was developed in the field, requests were received to work with and train other professionals in the area of suicide. Over the last six months, a training package has been developed which is good grounding for other professionals who wish to work in the field. In the preparation of the training package, an attempt was made to condense the large amount of information available from overseas publications and others working in the field to provide succinct, factual information and literature sources for professionals who wished to expand their involvement in the area of suicidology, specifically in suicide prevention.

There were two main streams of thought about dealing with those who were suicidal. From the literature and discussion with suicidologists in the United States, these models of conceptualisation were, at times, at odds with each other. One model is the medical model which sees suicide as a psychiatric disease or sees suicide attempters as having a psychiatric disease. The other model, a more systemic analysis of suicide, sees suicide as something that could happen to anybody, given a number of stress factors occurring to them within a short, or protracted period of time. Following evaluation and discussion with suicidologists in the United States and within Australia, the Task Force chose the latter model and decided to work the training package around a more systemic analysis of suicide.

#### *Outline of the training package*

The aim of each day-long seminar—which has been presented to a range of health, welfare and legal professionals—is firstly to acquaint them with what suicide is; to discuss with them some of the myths surrounding suicide in today's society; to then look at what are considered to be the risk factors and warning signs for the person who may attempt suicide. The majority of the people that the Task Force trains are working with adolescents, therefore, some time is spent looking at adolescent suicide before moving on to the intervention phase—how to deal with it in a crisis mode and then how to deal with it in longer term counselling. Also, during training sessions participants are encouraged to continue researching about suicide and perhaps even to set up their own task forces. Therefore, an inclusive bibliography is provided, and those attending are encouraged to network and perhaps go back to their communities to set up an interest group which can focus on the issue of suicide and suicide prevention.

The definition used in the training package is one which comes from Shneidman (1985):

Currently in the western world suicide is a conscious act of self-induced annihilation best understood as a multi-dimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution.

The myths and facts session is an important part of the workshop. For many people, there are many myths about suicide and an attempt is made to debunk some of these myths to ensure that participants in the workshop are starting with a clear understanding of some of the myths and facts around suicide. Some of these myths are: those who talk about suicide do not attempt or commit it; all suicidal people are mentally ill; suicide only occurs in the adult population; talking about suicide encourages people to do it; suicide happens without warning. The risk factors and warning signs of suicide are discussed so that individuals will be aware of these when dealing with their client populations.

Some time is spent looking at adolescent suicide as it is the second highest killer of adolescents in Australia. Adolescent development and suicide is specifically discussed and then a video is shown called, 'I Don't Want You to Die', which was produced by a suicide prevention centre in America. The video uses role-play situations with adolescents to explore adolescents' perceptions of what suicide is, some of the antecedents to a suicidal situation, and some of the ways that an individual can actually intervene with a suicidal individual to avert the crisis, particularly when dealing with their peers.

The remainder of the training session is devoted to looking at counselling techniques for professionals involved in face-to-face client work. Issues such as level of lethality and degree of perturbation are explored in an attempt to train workers to assess both of these fundamental factors when dealing with suicidal individuals.

An important part of the role as a Task Force is to encourage networking and the development of other task forces in other areas. Resources are provided such as education backup and training for these groups in their initial phase of operation. It is easy for people to get enthused while attending a training session but that soon dissipates when they go back to their workplace so networking is encouraged at the seminar. Hopefully, it will continue to gather momentum.

### **Working with the Media**

The Task Force has been called upon on many occasions to provide information to the media about suicide, including radio and television interviews which largely looked at debunking some of the myths that the population has about suicide. At all times, work with the media ensures that reporting is accurate and non-sensational and sensitive to avoid 'copycat' suicides.

### **Some Issues Highlighted**

There have been several outcomes as a result of forming the Suicide Prevention Task Force. The first of these has been the overwhelming number of requests to provide training to both government and non-government organisations, both within the local area of Macarthur, within Sydney and, in fact, in large regional centres in NSW, for example, Newcastle, Taree, and Wollongong. Upon evaluating the training program, a consistent complaint by the attendants at our workshops and conferences has been the little training and the little provision for service that government has allocated to suicide and its prevention. This is a crucial issue, as the number of suicide attempts increases, especially amongst young people.

Secondly, and in some ways not a surprise to the members of the Task Force, workshop participants have talked about the lack of networking within the health, welfare and legal sectors. Often within one small geographical area a variety of services will not be aware of other services which exist within that geographical area. This has been an

important task, that of providing networking between agencies within areas, in order to minimise the effect of clients not being referred effectively.

Networking is also an effective way of workers supporting each other, to ensure that a quality service is given to each young person being seen. Professionals too are stressed, especially when working face to face with young people whose lives are stressful, and particularly if completed suicides or suicide attempts are a common occurrence. In areas where there is a paucity of workers, the opportunity for support and debriefing is vital.

Lastly, the several hundred participants to Task Force workshops and conferences have discussed the issue of looking at suicide and suicide prevention systemically from a community development perspective. Broadening participants' understanding of suicide has allowed them to look at many more options other than just maintaining and relying upon our psychiatric hospitals and psychiatrists and psychiatric workers as being the only help for the majority of suicide attempters and the surviving families. It has been the Task Force's experience, and certainly the experience mirrored by many of the workers throughout the areas in which seminars have been presented, that access to psychiatric hospitals has been minimal or nonexistent and certainly access to the scarce resources of psychiatrists and psychiatric nurses has been very difficult to obtain. By broadening the skill level of workers dealing with suicidal individuals, service delivery to those in need is more accessible. It should be emphasised that, when talking about suicidal individuals, the Task Force believes that the majority are not psychiatrically ill and do not have a diagnosable psychiatric condition. It is felt that, in providing prevention services, the group is reducing the burden in our already overtaxed psychiatric hospitals and community mental health services.

## **Conclusion**

It is now nearly three years since the Suicide Prevention Task Force first began. It began as a group of workers concerned about the issue of suicide in a small geographic area. The Task Force believes that it has made some impact, not only in prevention of suicide, but also in training of other workers how to deal with those affected by suicide. However, there is a lot of work yet to be done.

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# THE 'PROTECTIVE BEHAVIOURS' PROGRAM

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ONE WARNING SIGN IN INCIDENTS OF YOUTH SUICIDE IS A SENSE OF HOPELESSNESS and gradually deepening depression experienced by the young person. Too often, indications of this despair are only recognised with the luxury of hindsight.

The other side of this recognition is the degree of awareness the young person may have as to their increasingly vulnerable condition. It is sometimes apparent that the young person had attempted to communicate a sense of despair but, perhaps through an inability to articulate clearly, the seriousness of the message was missed. Likewise, others may have unintentionally ignored the plea or trivialised its importance.

No matter what the reason may have been, far too frequently, young people are unable to obtain assistance in a time of need. Guilt, fear, shame and powerlessness prevent them from disclosing their fears, feelings or actual experiences of abuse.

Whilst our education systems address many issues designed to prepare us for the workforce, in most states of Australia there is still a failure to impart skills and strategies for coping with the fears and threats abundant in our society. Identifying our feelings, differentiating between adventure and abuse, and knowing how to access those who can help us are issues generally ignored.

One program exists that does address these personal issues—the Protective Behaviours program. Exposed to the various components of this program, young people learn the skills to identify their vulnerabilities, whilst devising strategies to both protect themselves and get help if unable to cope alone.

## **The 'Protective Behaviours' Program**

Protective Behaviours is exciting, empowering and addresses all forms of abuse, both physical and psychological. It says there are practical, physical and psychological steps which can create safety and personal support for people. Protective Behaviours shows how an individual can empower her or himself even in the midst of a hostile or dangerous environment.

Protective Behaviours is based on two simple themes:

- we all have a right to feel safe all the time;

- there is nothing so awful we cannot talk with someone about it.

These themes are not so much taught as internalised, and, in this, the program differs from others. It is not a step-by-step teaching guide, but rather a conceptual framework for empowering the individual.

### Three Core Concepts of the Program

**Safety.** The young person is encouraged to identify situations when it is OK, even fun, to feel scared: for example, when riding a bike down a hill at break-neck speed or when riding on the roller-coaster. This concept is passed on to younger children by using their identification of early warning signs or, in other words, becoming aware of their bodily reactions to threatening situations. For instance, a child would be asked to describe the first way their body lets them know when they were not feeling safe. This sign might be that they can hear their heart beating loudly, their tummy feels strange or they go weak at the knees. Once the child has identified his or her own specific early warning sign, they will then be able to apply this feeling to an understanding of when they are in an unsafe or dangerous situation. The notion of **early warning signs**, then, is the second core concept.

The third is that of **networking**. The idea that victims themselves can have a part in preventing abuse, and that they can effectively get the help they need, is integral to the concept of networking. The young person is encouraged to identify others to whom he or she can turn for encouragement, assistance, action and other help when they are feeling unsafe. With younger children, a teacher would have them draw the outline of their hand, and in the diagram write the initials of grown ups to whom they could turn for help. The concept of networking is equally applicable to professionals involved in the area of violence or abuse. We all need to identify others to whom we can turn if abuse is disclosed to us. Wherever the Protective Behaviours Program is implemented, community awareness of reporting procedures and responsibilities will ensue.

### Five Strategies for Protective Behaviour

In order for these core concepts to be practised to the greatest effectiveness, Protective Behaviours uses five strategies. These are:

#### *Theme reinforcement*

Theme reinforcement—the two themes: we all have a right to feel safe all the time and nothing is so awful that we cannot talk about it with someone are repeated throughout the program, and ideally, afterwards by way of posters, stickers and so on. These themes can counteract other non-verbal, subtle, and not so subtle 'victim' messages.

#### *Network review*

After the young person has identified a personal network of trusted, helping adults to whom they can turn if they are not feeling safe, it is essential to review those selected regularly. This review ensures that the adult is available and that the young person still feels safe with that adult.

Throughout the program, some young people may become aware that something that has been happening to them for some time is in fact an abusive act. As statistics show that more than 80 per cent of abuse occurs from known adults, it is necessary to review the

network and allow the removal of any person with whom they have detected their early warning signs.

### *One step removed*

This strategy relates to the teaching process. All problems posed in course sessions are done so in the 'What could you do if . . .' or 'suppose . . .' or 'what if a friend told you . . .' form. By using the one step removed strategy in class, a victim of abuse can practise a very effective way of checking out attitudes and getting information. For instance, suppose a person who is being abused decides to take a first step in telling, he or she can do that by saying first, 'You know, I have a friend who's having trouble at home'. Judging by the response, the victim can then either reveal that the 'friend' is in fact him/herself or, if the concern is trivialised or discounted, the victim can move onto another person. One step removed also prevents the revictimisation that can occur by allowing someone to disclose abuse publically.

### *Persistence expectation*

This provides one of the major departures from other programs designed to arrest abuse. Most other programs, kits, colouring books and similar items teach the 'No, go, tell' sequence. That is, when faced with abuse, say 'No', then go and tell someone. Protective Behaviours takes this message one step further by recognising that many victims of abuse have gone and told someone and nothing was done.

It is not just enough that the young person is believed, though often just finding someone to believe the story is difficult in itself. The person selected by the young person to receive the disclosure must also take an action to make them feel safe. By using his or her early warning sign, the young person alone is the judge of when enough has been done to enable the early warning signs to go away. We must not reinforce victimisation by telling just one person, who may then do nothing about the situation, and leaving it at that. The persistence expectation is not just used for children and young persons, we need it for ourselves. Our own feeling that 'nothing can be done anyway' is an example of internalising the message that failure is inevitable, the problem insoluble. We, as adults, need to persist with creative stubbornness in our advocacy for non-victimisation.

### *Protective interrupting*

This is the process of stopping someone from self-disclosing in a context that would increase their victimisation. In teaching Protective Behaviours, it is not always possible to ensure that sufficient group confidentiality can be established to provide young people with enough protection from gossip. Gossip does not lead to effective intervention and merely serves to increase a person's jeopardy and our own feelings of powerlessness. Encouraging or even allowing a young person to tell too much in a group setting is irresponsible, as well as resulting in increasing the young person's feelings of hopelessness, vulnerability and despair. With protective interrupting, we are able to put situations into the one step removed mode and, if a young person should begin to disclose in front of the group, we can interrupt with something like 'You may not feel safe if you told us that. Right now I want you to pretend a friend told you that. Later on, after class today you should tell someone if this is happening at your house, or to someone you know'.

The protective behaviours manual (Flandreau-West 1989) describes various sessions, such as the 'lost key', 'verbal abuse', 'unwanted sexual touches', and 'physical abuse' sessions. Each session addresses one aspect of abuse and provides for the young person to brainstorm strategies based upon the two program themes.

These are then the basic components of the Protective Behaviours program. Each component is integral and essential in effectively equipping the individual to attain maximum protection.

One positive aspect of this program is its wide application. Protective Behaviours is being implemented in women's refuges by trained refuge workers. It is being given to mentally handicapped adults, to children in Youth Training Centres and it is being taught to elderly citizens to enable their use of the empowerment process.

In order to train someone to teach Protective Behaviours, all that is necessary is for the person to assimilate and internalise the themes of the program, and to practise their strategies. That person then interprets the program for their particular audience. The teacher becomes the instrument of the program and breaks it down into teachable chunks directly applicable to the audience they know.

Because Protective Behaviours is such a positive program, it offers one effective answer to those who feel that issues are too overwhelming to ever effect change. There are, of course, many other areas that need to be addressed, including the acknowledgment that young people can experience deep and real feelings, often to the extent of depression and despair, plus the need to train those most involved with youth to pick up the warning signals or tentative cries for help a vulnerable youngster might make. Protective Behaviours, however, can be seen as one important, powerful and empowering strategy towards improving an individual's ability to cope and survive.

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# **BIG SISTER/BIG BROTHER PROGRAM**

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THE BIG SISTER/BIG BROTHER PROGRAM STARTED IN THE UNITED STATES OF America in 1904. The original purpose was to stem the rising tide of juvenile delinquency and help children who came before the courts. Over the years the focus has moved toward prevention by providing support to the young person so that they can cope with a more complex society.

The program started in Australia in 1978 at the Sydney YWCA and was initiated at the Adelaide YWCA in 1980. There are also programs now in Darwin, Perth and the possibility of one in Albury-Wodonga. There is a program in operation in Victoria under the auspices of the Catholic Family Services. This Victorian program caters for 8 to 15-year-olds while the YWCA caters for 11 to 17-year-olds. In South Australia, similar programs were started in the country areas of Murray Bridge and Clare, in 1984 and 1989 respectively by the Department of Family and Community Services.

Part of the program funding in New South Wales and South Australia comes from the Department of Family and Community Services in each state. Western Australia fund their own worker and receive ancillary support from the Department of Sport and Recreation. Darwin has a recreation worker who incorporated the Big Sister concept into her position.

## **Purpose**

The purpose of the program is to provide one on one support to a young person who is going through difficulties during the transition from childhood to adulthood. The aim is to assist the young person develop their self-confidence, communication skills and their ability to cope with and overcome problems.

## **Structure**

The program is structured as follows. Volunteers between the ages of 18 and 45 are recruited and trained to be a friend and support, in other words, a Big Sister or Brother to a Little Sister or Brother. Volunteers come from all walks of life and experience, the majority

cite being supported through, or having survived problems when young as their motivation for being involved.

Training covers topics such as values and attitudes, stereotyping, communication skills, child protection, conflict resolution and adolescent development. There are support meetings with revision and guest speakers on relevant issues. Coordinators provide ongoing support and supervision and in Adelaide are on call for crisis support.

Like the volunteers, Little Sisters/Brothers come from a variety of backgrounds. Their reasons for participating in the program also vary: it ranges from being referred for support in developing social skills to being referred for support while an agency works with the family as a whole.

The program receives referrals from the Department of Family and Community Services, child and adolescent mental health services, Adelaide Children's Hospital, community organisations, school counsellors, parents and the young people themselves.

When an agency refers a client, the family is encouraged to make contact with the Big Sister/Brother Program. It is important that there is parental approval for the young person to be in the program because, if it is not forthcoming, it is setting up the volunteer and the young person to fail. The family is then interviewed and an assessment is made of the suitability of the program for the young person.

It is the young person who joins the program, not the family. It is made clear at the beginning that the volunteer is there as a friend for their child so interaction with the family is limited. This is important for establishing trust between the volunteer and the young person. It also protects the volunteer from being caught up in family dynamics.

When the Big Sister/Brother and Little Sister/Brother are matched, they spend approximately three to four hours a week together. The volunteer develops a relationship with the young person and they share experiences and problems as well as good times together. The time shared can be for pursuing a mutual interest, going out, just being together, usually a combination of all.

Sometimes the bond established between the Big Sister/Brother and Little Sister/Brother turns into a long-term personal friendship, while some matchings serve their purpose and the young person moves away from the program to lead their own lives. The former is pleasing but the latter is more so because the young person no longer needs us. We have achieved our goal.

# **SUICIDE: A CRISIS FOR THE WHOLE FAMILY; SHOULD SUICIDE SURVIVORS BE MANAGED DIFFERENTLY?**

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IN AUSTRALIA, OVER 2,000 PEOPLE WILL DIE FROM SUICIDE THIS YEAR ALONE. This figure is no doubt an underestimation of the reality. Whilst this is a tragedy in itself, the suicide survivors are far greater in number and could easily be estimated at over 10,000.

Indeed, it is known that over the last thirty years or so this country has seen a major increase in the number of suicides in those aged between 16 to 24. This shift represents a significant change in the profile of the surviving family (Baume 1988). It can, therefore, be assumed that in 1990 more parents will be burdened with this tragedy than was the case only a few years ago. Parents, however, are not the only ones who will feel the pain and guilt associated with the loss. Siblings, extended family members, as well as friends are also involved.

Whilst this paper is not about statistics, the numbers mentioned are an unhappy reminder of the tragedy Australia experiences each year and will continue to experience in the future. This paper focuses on the quality of life of survivors of suicide. It examines previous empirical reports and case studies and develops a framework for the management of those survivors.

The amount of research and literature on the subject of suicide is a testimony of a major effort by those interested in this field, to discover, give meaning to, predict and prevent self-destructive behaviours. It is apparent, however, that the focus has tended to be towards those who commit suicide rather than those who remain behind.

## Survivors of Suicide

Shneidman (1971) called those who remain behind, the survivors—and stressed that whilst suicide is one of the leading public health problems today, neither the prevention of suicide nor the management of those who attempt poses the major concern. Rather, it is the alleviation of the effects on the survivors whose lives are forever altered that should be considered.

When a suicide occurs, it is almost always the occasion of a crisis for survivors; children, spouse, parents, other relatives, friends, crisis counsellor, therapist, health professional or anyone closely associated with the person. The usual feelings associated with any serious loss are felt by most survivors of a suicide: sadness that the person ended life so tragically, and anger that the person is no longer a part of one's life.

The literature on this subject has been on the increase; whilst the majority of studies have discussed individual reactions to suicide, the impact of suicide on family system dynamics has been increasingly recognised as an essential factor mediating the crisis experienced by the bereaved individual (Calhoun, Selby & Selby 1982; Hajal 1977; Raphael 1983; Richman 1986). However, the few studies that have specifically examined the impact of suicide on family functioning have yielded conflicting results. Until recently, the majority of reports have suggested that the experience of a suicide survivor is an especially severe form of bereavement, and that the surviving family members are the most directly implicated in the aftermath of suicidal death.

These studies have indicated that consequences of suicidal death included many unique aspects, such as search for explanation, feeling of guilt, responsibility, shame, stigmatisation, and rejection, loss of social support, and self-destructive behaviour (Calhoun et al. 1982).

Barrett & Scott (1990) argue that many of these reports have been based, in part, on clinical observation, intellectual conjecture and theoretical speculation. Empirical attempts to compare suicide survivorship with other types of bereavement include studies by Sheskin & Wallace (1967); Cain (1972); Flesch (1977); Saunders (1981); Demi (1984).

Calhoun et al. (1982) and McNiel et al. (1988) have criticised the few existing empirical studies on a number of grounds. For example, authors have compared survivors of suicide with other populations in a post-hoc manner. The retrospective nature of the investigations, the lack of control groups, the use of specialised and non-standardised instruments, and the lack of operational definitions for the measured reactions and the limited size of samples have also been seen to be problematic in reducing the possibility of generalisation.

The survivors of suicide often experience much guilt and anxiety that may result from two main sources:

- the sense of responsibility that somehow one should have prevented the suicide. This is especially true when the survivors were very close to the person;
- the sense of relief that some survivors feel after a suicide. This happens when relationships were very strained or when the person attempted suicide many times and either could not or would not use available help (Hoff 1989).

A common tendency among survivors of suicide is to blame or scapegoat someone for the suicide. This reaction often arises from a survivor's sense of helplessness and guilt about not preventing the suicide. Deeply held beliefs about suicide also contribute to this response. Some survivors deny that the suicide ever took place. This seems to be the only way they can handle the crisis. Often, this takes the form of insisting that the death was an accident.

*For Example:*

A mother and father instructed their twelve-year-old daughter, who was a patient in the children's ward of a large public hospital, to tell the charge nurse that her older brother Tim had died in a car accident. The charge nurse of the ward happened to know that the family had been involved with the psychiatric unit of the hospital the previous year. At that time, the parents had insisted that Tim be discharged from the ward as soon as possible, even though he was highly suicidal and the psychiatrist in charge of the case had advised them against it. A week after his discharge Tim shot himself with his uncle's hunting rifle!

This case identifies clearly the denial which was taking place and the length to which the parents were going to hide what had actually happened.

*Reactions to suicide*

Barrett & Scott (1990) identified four types of reactions which suicide survivors experience.

- Grief reactions that are the normal result of losing a family member, including somatic symptoms, hopelessness, anger, guilt, loss of social support, and self-destructive behaviour which supports the Calhoun et al. study (1982).
- In addition, reactions that resulted from experiencing a death other than by natural causes and perceived as having been avoidable, including feeling stigmatised and shamed by the death, feeling abandoned by the spouse, and perceiving the death as preventable.
- A third type of reaction included grief reactions that resulted from the shock and pain of experiencing a sudden death, regardless of its cause, including searching for an acceptable explanation for the death.
- Finally, the fourth type of reaction seems to have resulted from additional trauma of dealing with the suicidal nature of the death, including feeling rejected by the deceased, feeling embarrassment over the mode of the death, wondering about the spouse's motivation for not living longer, feeling as if the deceased were somehow getting even with the survivor by dying, and concealing the mode of death by saying that it was something other than what it was.

This report supports studies by Cain (1972) and others that have documented many problems that can occur throughout survivors' lives if they do not have help at the time of the crisis of suicide.

Survivors consistently experience more grief reactions than other survivors, depression, serious personality disturbances, and obsession with suicide as the predestined fate for oneself, especially on the anniversary of the suicide or when the person reaches the same age (Hoff 1989).

Barrett & Scott (1990) highlight, however, that the course and quality of recovery from grief does not seem different from those of other survivors. They further argued that grief was not solely determined either by type of death experienced or by grief reactions occasioned by the death and that other factors besides the mode of death and concomitant grief reactions significantly influence both the course of bereavement and the quality of resolution.

The tragic effect of suicide is particularly striking in the case of young people after a parent's suicide. In studies of child survivors, some of the symptoms found were learning disabilities, sleep walking, delinquency, and arson (Cain & East 1972).

The findings of Barrett & Scott (1990) support a point of view expressed only by a few researchers: Shepherd & Barraclough (1974); Demi (1984); and McNeil et al. (1988). That is, that great differences did not exist between suicide survivors and other survivors. These writers are in agreement, however, with others who believe that suicide survivors undergo a major situational crisis and that the family functioning prior to the suicide should be studied further as this may affect the recovery rate of the suicide more so than the mode of death itself.

It is the opinion of the author that crisis counselling should, therefore, be available for all survivors of suicide.

### **'Postvention'**

Shneidman (1971) calls this 'postvention' an effort to reduce some of the possible harmful effects of suicide on the survivors. Making such support available, however, presents a special challenge.

Some people commit suicide while receiving therapy or counselling through a crisis centre, mental health agency or in private practice, or while receiving hospital care. In these cases, the counsellor, nurse or psychiatrist is in a natural strategic position to help survivors. Unfortunately, what often happens is that these professionals miss the opportunity for postvention because they may be struggling with the same feelings that beset the family (Baume 1988).

It is more effective to deal with the family immediately than wait for an impasse to develop, but if staff have not dealt with their own feelings, they may avoid approaching family survivors of suicide. A note of caution should, nevertheless, be made here in that survivors are not compelled to accept help, hence after making the decision to help, the counsellor has an even more daunting task.

The most useful preventive measure is for helpers to learn as much as they can about suicide and constructive ways of handling feelings one can have in working with self-destructive people. There will always be strong feelings following a suicide. However, a professional with a realistic concept of the limits of responsibility for another's suicide can help other survivors work through their feelings and reduce the scapegoating that often occurs.

In counselling in health care settings, health professionals should immediately seek consultation with others after a suicide occurs. Team debriefings are an important step in this process. They provide staff with an opportunity to air feelings and evaluate the total situation.

### *Debriefing*

Debriefing is a common way to structure reflection with groups and usually follows an experience. Simply to experience is not enough. Often helpers are so deeply involved in the experience itself that they are unable, or do not have the opportunity, to step back from it and reflect upon their actions in any critical way.

During the management of crises, debriefing provides an opportunity for staff to engage in reflection. Pearson & Smith (1985) have broadly structured it into three questions. What happened? How did you feel? What does this mean? It is essential that adequate time is given to staff for this reflection to be effective.

### *Journalling*

Another method of reflection which can be used in addition to debriefing is journalling. In the words of Holly (1984), keeping a journal is a humbling process. The person relies on his/her senses, impressions, and purposely records his/her experiences as vividly and creatively as they can. It is a learning process in which the writer is both student and teacher.

A journal is not just a description of impressions, it is impressions according to Holly (1984) plus descriptions of circumstances, others, the self, motives, thoughts and feelings. Taken further, it can be used as a tool for analysis and introspection. It is a chronicle of events as they happen, a dialogue with the facts and interpretations and perhaps most important, it is an awareness of the difference between facts and interpretations. A journal becomes a dialogue with oneself. Hence, to review journal entries is to return to events and their interpretation with the perspective of time. Time provides perspective and momentum and enables deeper levels of insight to take place.

In addition, self-examination and critical reflection after a suicide usually yield knowledge that can be applied on behalf of others (Hoff & Resing 1982; Hoff 1989).

### *Team meetings*

Team meetings also provide a forum to determine who is best able to make postvention contact with the family. If the helper who has worked most closely with the victim is too upset to deal with the family, another person should handle the matter, at least initially. In general hospitals or other health agencies where no-one has had training in basic suicide prevention and crisis counselling, outside consultation with a suicidologist or crisis counsellors should be obtained whenever possible.

### *Suicide survivors' grief groups*

Most suicides do not occur among people receiving help from a health or counselling agency. This is one reason why many survivors of suicide get so little help. In some communities, there are special bereavement counselling programs or self-help groups, such as widow-to-widow clubs, to help survivors of suicides. Ideally, every community should have an active out-reach program for suicide survivors as a basic part of comprehensive crisis services (Hoff & Miller 1987). Survivors are free to refuse an offer of support, but such support should be available.

A parent survivor, Adina Wroblewski (1982), has developed Suicide Survivors' Grief Groups since the suicide of her teenage daughter. Wroblewski's work is significant in two respects:

- following the suicide of her daughter, there were no peer support groups available to her and her husband;
- survivors of suicide do not necessarily need professional therapy as much as they need support from people who have experienced the same kind of loss.

This point has been illustrated by groups such as the Sudden Infant Death Syndrome Foundation and self-help groups for health and social problems, such as Alcoholics Anonymous and groups for mastectomy patients or for AIDS victims.

In the absence of these avenues of help, survivors of suicides can still be reached by police, clergy, and funeral directors, if such caretakers are sensitive to survivors' needs (Grollman 1977). These key people should take care not to increase guilt and denial, recognising how strong the suicide taboo and scapegoating tendency can be. The least one

can do is offer an understanding word and suggest where people might find an agency or person to help them through the crisis.

Techniques in helping survivors of suicide are essentially the same as those used in dealing with other situational crises. A survivor should be helped to:

- express feelings appropriate to the event;
- grasp the reality of the suicide;
- obtain and use the help necessary to work through the crisis (including sometimes his or her own suicide crisis);
- develop a forum for critical reflection;
- keep a journal.

### *Parent survivors*

When one deals with a parent survivor, certain variables affecting these survivors need to be kept in mind. A child's death leaves parents with feelings of guilt and powerlessness for their inability to have protected the child (Van Dongen 1988). Donnelly (1982) suggests that parents may never get over the pain of such a death, although time does help them to adjust. He further argues that the death of a child can also place extreme stress on a marriage and that, indeed in those families, separation and divorces are common.

A descriptive study by Hatton & Valente (1981), who conducted support groups for parents/survivors, found that the parents were overwhelmed with feelings of shame, guilt and self-doubt, confusion and isolation. Indeed, the research by Calhoun, Selby & Faulstick (1980) indicated that parents whose child committed suicide were rejected and blamed for the death by other adults. However useful, these studies did not have appropriate control groups and cannot, therefore, be used to generalise for all parent survivors.

Help for survivors of suicides has always been one of the goals of suicide prevention. Such work is important but difficult to carry out. Many people tend to cover up the reality of a suicide. The suicide taboo in modern times continues, despite a growing acceptance of the morality of suicide in certain instances (Battin & Mayo 1980; Hall & Cameron 1976).

### *The coroner's office*

One means of reaching a large number of survivors is through coroners' offices. It is there that every death is eventually reported and recorded. In Los Angeles County for example, all suicide deaths as well as equivocal deaths (those in which suicide is suspected but not certain) are followed up by staff from the Los Angeles Suicide Prevention Centre. Suicidologists then do a 'psychological autopsy' (Litman 1987). This is an intensive examination to determine whether the death was by suicide and, if it was, to define the probable causes of the suicide. Information for the psychological autopsy is obtained from survivors and from medical and/or psychiatric records.

Research is the primary purpose of the psychological autopsy; however, it is an excellent means of contacting the large number of survivors who are not in contact with a crisis centre, psychiatrist, or mental health agency (Sanborn & Sanborn 1976). Survivors are, of course, free to refuse participation in such postmortem examinations. Experience reveals, however, the majority of survivors do not refuse to be interviewed and welcome the opportunity to talk about the suicide. This is especially true if they are contacted within a few days of the suicide, when they are most troubled with their feelings. Many survivors use this occasion to obtain some help in answering their own questions and dealing with suicidal inclinations following a suicide. The 'official' interview situation is somehow a more acceptable circumstance for some people to open up about an otherwise taboo subject, and thus provides an ideal opportunity for the interviewer to suggest follow-up counselling

resources to the survivor. If weeks or months pass, survivors may resent the postmortem interview. By that time, they have had time to settle their feelings and questions on their own and in their own way, which may include denial and resentment. A delayed interview, however, may seem like unnecessary opening of an old wound.

## Conclusion

In conclusion, this paper has explored some of the aspects affecting suicide survivors and their postvention. In relation to the way parents may feel towards the loss of their child, data and studies that include control groups do not exist as yet to determine whether in fact these survivors go through the same type of grief as other suicide survivors. Further empirical evidence is therefore needed to make the case.

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# **THE ROLE OF THE 'BEREAVED THROUGH SUICIDE SUPPORT GROUP' IN THE CARE OF THE BEREAVED**

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'NOW, HERE, YOU SEE, IT TAKES ALL THE RUNNING YOU CAN DO TO KEEP IN THE same place. If you want to get somewhere else, you must run at least twice as fast as that,' said Red Queen to the exhausted Alice (Alice through the Looking Glass, Chapter 2). This is the feeling experienced by the majority of those who have been bereaved through suicide which precipitates their coming to the Bereaved Through Suicide Support Group (BTSSG). Bereaved people often describe grief as a bad dream from which they hope to wake. To experience the suicide of a friend or relative is one of the greatest hurts any person may endure. Grief following suicide is unique and so are the needs of the bereaved. It was to cater for these special needs that led two Adelaide bereavement educators: Harold Jones and Sister Veronia Honour to found BTSSG in April 1986. It is the work done in the group by these and others that will be presented here.

## **Composition of the Support Groups**

The group into which a new member enters is composed of ten to twenty members who all have had the common experience of being bereaved through suicide. This is regarded as a safe house where feelings are accepted and confidentiality maintained. Group work is done in the large group and small subgroups under the guidance of a counsellor and trained support workers. Here, members have the opportunity of learning from the experiences of others. Alongside the program of group work is an informal educational program covering topics such as the legal procedural matters of suicide, grief, health, stress management and coping strategies utilising resources from within the group and outside speakers.

Recreational activities are arranged with a view to fostering friendships and helping the bereaved to rebuild their lives.

There are various tiers of support for the group: the support workers are members who themselves have been bereaved through suicide, who have healed in their grief and who have been through a grief management training program. Guidance is provided by the Professional Advisory Council. This is composed of a psychiatrist, a bereavement educator, a funeral director, a coroner's officer and a general medical practitioner.

## **Phases of Grief**

Like Alice, the bereaved give the impression of being exhausted. They come to the group in desperation because they feel they are not coping with their grief and may regard themselves as failures. They come hoping to receive that support which they perceive to be lacking from their lives or of which they are running out. They often express their appreciation of the support they receive from the group. They also experience a sense of surprise and of relief: surprise that they are not the only ones to be experiencing such severe emotional turmoil and relief to find that these are quite normal experiences and that they are not going mad. To see that others have survived through their grief can be very uplifting for new members.

Following on these initial experiences is a period of understanding their own reactions, of creating order from the chaos, of learning to cope, and of coming to terms with the various issues involved in their loss. This brings about some experience of resolution of their grief which gives them a feeling of making progress.

From this follows a stage of healing: a time when self-esteem increases, new relationships are made and a new life is built. For many there follows, after a period of months or years, a phase of growth: a time of finding new meaning from their personal disaster and a time of creating a new dimension to their life.

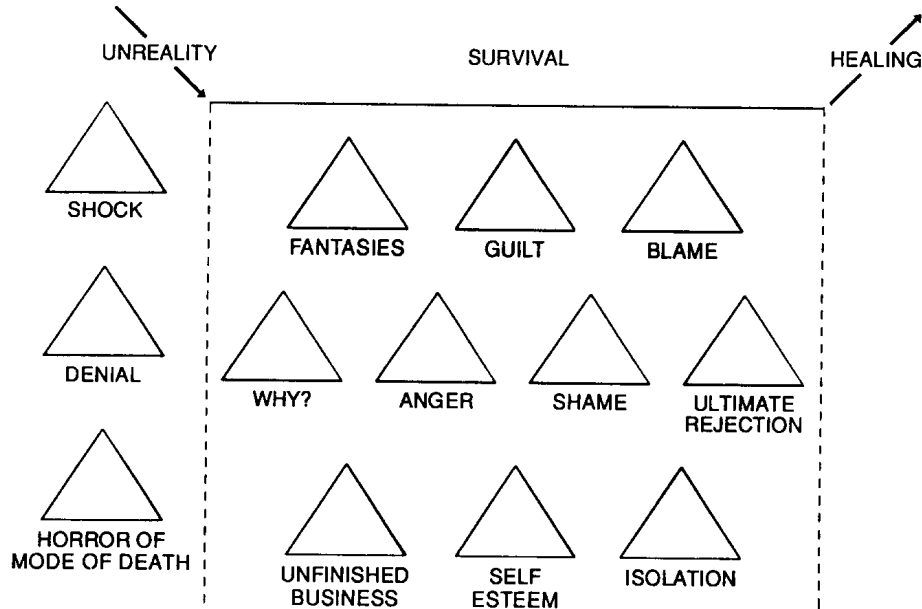
The work of the group is to permit the sharing of experiences and to guide and support through the normal oscillations of grief. Members are encouraged to express their feelings as they wish and they receive warmth and support back from the group members, which fosters cohesion of the group. Friendships may be made and maintained long after members have passed through the group.

Like dreams, every grief is different and yet suicide grief has a common story. This is the story of the emotional phases: some of the phases of suicide grief are unique in their nature and others are unique in their intensity. To the bereaved, these emotional phases are mountains. Like mountains, the ascent is steep and difficult and deceptive—one peak may hide another higher peak behind it. The mountain-climbing concept also helps the members to understand why they so frequently perceive themselves as not coping: they fail to take into account the affect of the steep incline of the mountain on their progress through grief. Only when viewed in 3-D can they comprehend what is happening to them.

The map of the mountains which are unique to suicide grief is shown in Figure 1. Figure 2 represents two groups of additions to the original diagram: the emotional phases of the survival stage and the healing stage which are common to all griefs. If the result is somewhat overwhelming for us, imagine how it may feel to the bereaved!

Figure 1

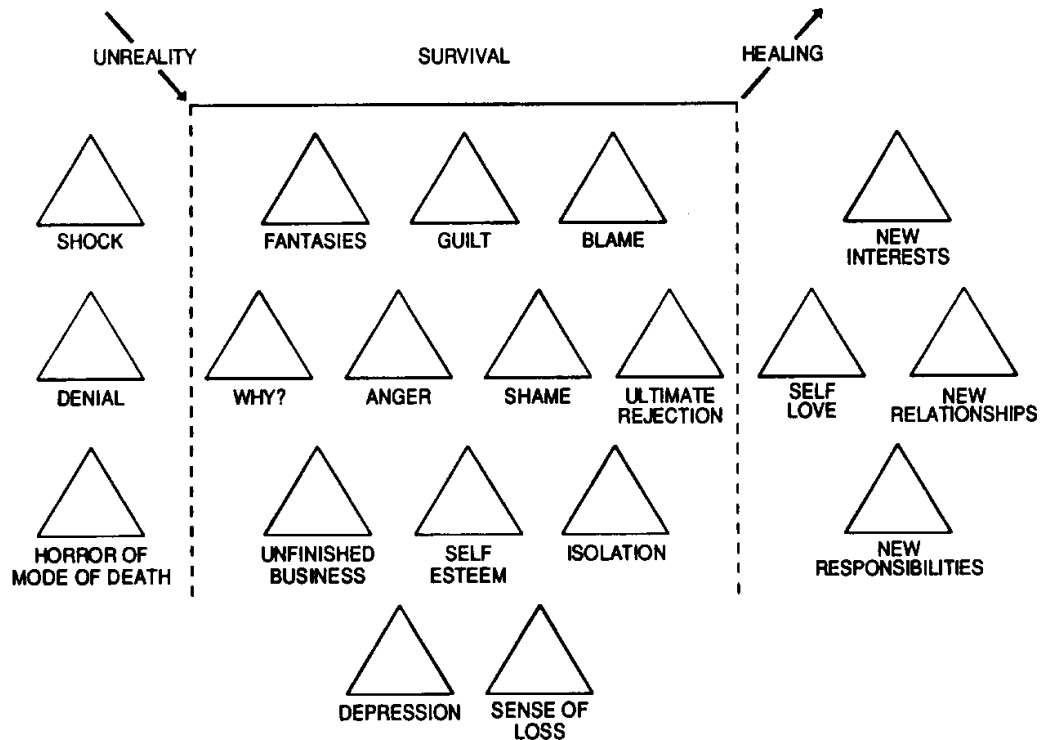
### The Mountains Unique in Suicide Grief



The process of resolution of grief is particularly difficult following suicide. Because of its nature, the grief is difficult to resolve. There are many of the risk factors of an abnormal grief reaction associated with suicide (Parkes 1985). In addition, the effects of support which are so important in helping a person work through their grief (Maddison & Walker 1967) by facilitating the expression of grief, of experiencing supportiveness and of maintaining self-esteem may be lacking. There are several reasons for this. The load of guilt and subsequent fall of self-esteem may be so great that the bereaved cut themselves off from the support of others. They may be frightened to ventilate their feelings at home for fear of hurting their family. Or it may be that their friends have moved through the healing of their own grief following the suicide and expect the family to have done so at the same rate. So, in effect, the bereaved has to pretend that all is well when all the time they are hurting desperately inside as the reality of the death sinks in. This commonly occurs between three and six months following bereavement. For them their grief is becoming worse, whereas others perceive that they should be over it. In desperation, many people contact the group around this time. By the time they join the group, this 'conspiracy of silence' described by Cain & Fast (1966) is often well established. If this is maintained for long, the bereaved is left carrying an enormous emotional load. As a result a pathological grief reaction and significant illness may result (Raphael 1975).

Figure 2

### Suicide Grief Map



One of the first aims of the support group is to break this conspiracy of silence by encouraging the verbalisation of feelings and rationalisation of emotions. In other words it encourages the process of grief work (Freud 1917).

Progress can be demonstrated by using the suicide grief map (Figure 2) at intervals. Members are encouraged to colour in each mountain to the height they perceive they have reached. Non progress over a period of a few months may be an indicator of the need for referral of the member for specialist help.

The group aims at aiding the resolution of some specific mountains. This will be illustrated by reference to selected examples.

#### Mountains

Guilt is one of the biggest mountains. This is the phase of the 'if only . . .'s. The parents of a teenager who suicides will feel guilty about not being able to prevent the suicide, about not identifying the suicidal behaviour before death, about their relationship with their child and about the upbringing of the child. They will feel a failure as a parent. Brothers and sisters have similar guilt and often regard themselves as unworthy siblings. Parents and siblings may feel guilt at being the survivors and yearn that they could replace their loved one in death. Most of the guilt will be imagined or be punitive self-blame or may be increased by blame laid on them by others. The task of rationalising their guilt will be more difficult if the suicide came on a background of family disruption. If the child has been causing disharmony at home, they may, in the heat of the moment, have fostered a death-wish for that child and when that was fulfilled be overcome with excessive guilt. If suicide followed on disharmony

or mental illness in the child, with repeated suicidal attempts, family members may experience guilt at the relief that the deed has finally been accomplished.

It often comes as a relief to family members to realise that all these types of guilt are common stories. Small group discussions help members to work through how much of their guilt is imagined or unrealistic. They may be helped by the results of suicide research: that nearly all of those who suicide are mentally ill (Robins et al. 1959) and that low levels of certain neurotransmitters have been implicated (Edmund & Asberg 1986). It seems that even the establishment of experienced crisis counselling centres seems to do little to reduce the suicide rate (Walk 1967). It seems that once someone has made up their mind to take their own life, there is very little that can be done to prevent them.

When the bereaved person is unable to see the body of the deceased, the mountains of denial (Brown & Stoudemire 1983) and fantasy are particularly prominent. It happens not infrequently that the body is not viewed by the bereaved because they may not wish to see the mutilation or is prevented by a well-meaning relative. Because of this, the reality of death cannot be established. An additional difficulty is that the bereaved has had no warning of the impending death and has not had the opportunity to pass through the preparatory anticipatory phase of grief. So there is difficulty in commencing the process of grief work. Fantasies regarding the extent of mutilation of the body also arise when the body is not viewed. These fantasies may cause revulsion, nightmares and preoccupation. The bereaved tell that it is easier to cope with the sight of the body or parts of the body (and funeral directors are very clever at making bodies presentable) than to cope with the imagined mutilations. If a member wishes, he or she can be referred to the coroner's office where the body may be kept. Support during the visit is offered by one of the trained support workers.

## **Why?**

This is a question which may never be answered. There is a personal mental postmortem examination of the life and death of the deceased. The coroner's officer may be of considerable help here. He is willing to discuss with the bereaved the implications in the police reports, the coroner's report and the suicide note.

## **Self-Esteem and Health**

By the time most bereaved join the group they are starting to rebuild their self-esteem. This plummets following suicide, sometimes to such an extent that the bereaved cut themselves off from their family, friends and offers of help even to the extent of isolating themselves within their home. There are several reasons for this fall, in addition to the normal fall experienced following any bereavement. Perceived guilt is usually the predominant factor. This is compounded with the blame put upon them from others regarding the death, shame because of the social stigma, rejection by the loved one who suicided and a sense of not coping through their own grief. Here the support group finds itself in a dilemma. If these reactions prevent the newly bereaved from seeking help, should the group be providing an outreach service? An attempt is made to meet these needs by providing a twenty-four hour telephone service and an individual counselling service.

Because the severe stress of grief may cause distress to the body and physical symptoms, a healthy lifestyle and stress management are encouraged. Issues such as diet, exercise and relaxation are discussed and include such topics as sleep and proper use or non-use of medications and alcohol. A common problem encountered is the belief that relations and enjoyment are prohibited following bereavement. If indulged in, these may

provoke guilt. People usually find that the forms of relaxation which they can undertake after bereavement are very different from those enjoyed beforehand. There is frequently difficulty in finding any form of relaxation which is acceptable. To give permission and to encourage enthusiasm for this, the group has compiled its own resource. They slowly come to realise that such activities as going to bed early with a good book, visiting a friend or taking themselves out to coffee are acceptable.

Identification of special problems which need referral elsewhere may occur, in which case the group would suggest appropriate referral—usually through that person's general practitioner. A common anxiety to many bereaved is which health problems are serious enough to take to their doctor. Because of the vulnerability of the bereaved to become sick, they are encouraged to make regular contact with their own general practitioner.

Many bereaved feel strong suicidal tendencies themselves, either wishing to join their loved one in death or feeling that life, following the bereavement, is not worth living. Shared group experiences are very helpful to those experiencing this and there is a certain normality in these feelings. However, the group seeks to identify and refer those at special risk.

## **Networks**

Strategies for self-support and mutual support are encouraged. Some of the main areas concentrated on are those areas of self-esteem, coping abilities and of personal growth. Programs of individual and group exercises are used to enhance these.

Socialisation of the group is an important part of recovery. Many previous friendships may have been judgmentally rejected on the performance of their support. New friendships need to be fostered and are not infrequently made between group members who maintain contact and support between meetings and even after members have passed through the group. A social program of recreational activities is organised to encourage members to rebuild their lives. This is particularly important at difficult times of year such as Christmas and Mothers' Day.

In addition to working with the bereaved, the Support Group works to foster and develop liaisons with other groups helping those bereaved through suicide. The links between the group and the coroner's office and the medical profession have already been mentioned. In addition the group works with funeral directors, school counsellors, psychologists, crisis organisations and church and pastoral care workers. Many of these professionals will have the task of helping the bereaved at the same time as wearing the cap of their own grief if the deceased was one of their own clients.

## **Conclusion**

One of the problems of working with those bereaved through suicide is the paucity of knowledge of grief following suicide both in the literature and in the community. In addition to encouraging and cooperating in research in this area, the group has also undertaken some educational projects. Last year, the group produced a video showing the experiences of those bereaved through suicide and staged its first public full-day seminar. The need for such was demonstrated by the attendance of 127 bereaved and professionals.

Unlike Alice, the bereaved cannot wake from their dream to the same Kitty and the same Great Arm Chair. For them the world is changed. The Bereaved Through Suicide Support Group is there to support them through their time of grief but also encourages the bereaved to pass through the group and on to a new life. Many members come through their grief with courage and fortitude and go on to add a fourth stage to that chart of grief—that fourth stage of growth. A deepening of personality, a new sense of caring for

others and a new meaning to life comes out of their grief. Or a new meaning may be found in religious beliefs. Some of our members who are from the caring professions have developed a deeper insight with their clients' problems which they might not otherwise have had and, as a result, have become more effective in their work. A number of artists amongst us have developed their art work in ways which had not previously seemed possible to them. It has been a great privilege to work with these people and to be able to learn from them. I thank them for sharing their stories with me and for entrusting me to present this paper.

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