Parliament of the Commonwealth of Australia

House of Representatives

Standing Committee on Family and Community Affairs

ASPECTS OF YOUTH SUICIDE

SUMMARY REPORT OF A SEMINAR

May 1997

Australian Government Publishing Service

Canberra

CONTENTS

APPENDICES

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38th Parliament

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Secretariat

Mr Bjarne Nordin	Secretary
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Ms Kate DaDeppo	

RECOMMENDATIONS

- *Priority 1*

  That a National Advisory Council on Youth Suicide Prevention be established to provide strategic advice to the Minister and the Government on youth suicide prevention and related matters.

  Within six months of its establishment, the Council should produce a comprehensive three year work plan to be reviewed and updated annually. The Council should also report annually on progress in meeting the objectives in its work plan. Secretariat support is to be provided by the Department of Health and Family Services.

  The Council should be responsible for creating appropriate arrangements for consultation and cooperation between governments and the community at State and Territory as well as at Federal levels.

- *Priority 2*

  In conjunction with Priority 1, a Research Advisory Committee should be established to complement the work of the National Advisory Council on Youth Suicide Prevention. The Research Committee will be responsible for advising the National Health and Medical Research Council on the management of research projects and research grants and ensure consistency with national research priorities. The National Advisory Council on Youth Suicide Prevention will seek technical advice from the National Health and Medical Research Council, as required.

- *Priority 3*

  The following areas were identified at the seminar as warranting an immediate response. However, these would be subsumed by the activities of the National Advisory Council on Youth Suicide Prevention and the Research Advisory Committee.

  – **A depression awareness campaign to educate young people and their support networks on how to recognise depression and get help - including the use of internet resources;**

- **Standard procedures for hospitals to adopt when treating a young person presenting with attempted suicide / self-harm injuries;**

- **An immediate review of current funding and re-direction of some funds to more appropriate and better targeted programmes;**

- **Ensuring consistency in data collection at all levels of government.**

SUMMARY REPORT

Introduction

1. The House of Representatives Standing Committee on Family and Community Affairs has responsibility for monitoring the portfolio areas of health and family services, immigration and multicultural affairs, social security and veterans' and youth affairs. As part of this responsibility, Members of the Committee identified Australia's high rate of youth suicide as a problem to be highlighted by the Parliament and brought into focus by the Committee.

2. The *Aspects of Youth Suicide* seminar was convened on 28 February 1997, in order to gather information from a range of expert sources and to give Committee Members a comprehensive overview of the issues involved. The seminar also provided an invaluable opportunity for peak health and community groups, local organisations and youth workers, academics and professionals to exchange information about suicide prevention programmes throughout Australia.

3. The Federal Government's commitment to addressing the problem of youth suicide was demonstrated by the Prime Minister, the Hon. John Howard MP, who readily agreed to officially open the seminar. In his opening speech, the Prime Minister stressed the importance of a bipartisan approach to youth suicide prevention. He said:

> “1 do not pretend as leader of the Government that we have all the magical solutions, and 1 am not coming here to say that what has been tried in the past was completely wrong, and what we are going to try is completely right, it is not one of those issues. And 1 am sure that the Committee in its treatment of it, will understand that everybody, government and opposition members alike, approaches this with a positive sense, and a sense of commitment and goodwill." (Trans., p6)

4. The Prime Minister expressed a deeply felt personal interest in youth suicide and outlined the commitment of the Government to finding solutions. He stated that the outcome of the *Aspects of Youth Suicide* seminar and any recommendations would be closely monitored and read by him and his Government.

Research and current Government funding

5. The Committee recognises that extensive and comprehensive research on factors influencing youth suicide is currently being undertaken. However, this has emerged only recently. One problem highlighted during the course of the seminar was that youth suicide research needs to be co-ordinated at a national level. Of particular concern to the Committee is the inadequacy of detailed national data collection. This will be discussed further in the report.

6. The increasing amount of research into youth suicide is reflected by a growing recognition by all governments of the severity of the problem. Various governments at Federal and State level have funded youth suicide research and prevention programmes over the last two decades. Some of these have had success, others less so. In accordance with the Prime Minister's sentiments outlined in his speech to the seminar, the Committee would like to focus on how current and future funding is directed into the most effective forms of youth suicide research and prevention programmes.

7. Current funding for youth suicide prevention is detailed in the 1996/97 Budget under the *National Youth Suicide Strategy*. The Strategy provides $19 million over three years, to be spent in the following areas:

- $6 million for rural and regional youth counselling services - money has been granted to State and Territory governments to spend on these services;

- $6 million to Lifeline and Kids Helpline for telephone counselling services. These contracts are (at time of writing) being finalised;

- $3 million to provide programmes for parents. The detail of these programmes is still being developed by the Department of Health and Family Services;

- $2 million for education and training programmes for professionals such as General Practitioners, health workers, teachers, etc. The Hunter Institute for Mental Health has been contracted to encourage universities to teach youth suicide prevention strategies to relevant professions, and $1.5 million will be allocated to State and Territory governments to provide education and training; and

- $1 million for research specifically into childhood mental health and factors which lead to adolescent suicide and attempted suicide.

8. The $19 million *National Youth Suicide Strategy* is additional to a programme launched by the previous government, *Here for Life,* which provided $13 million in funding for programmes from 1995/96 to 1998/99. The *Here for Life* programme includes:

- the Youth Suicide Prevention Advisory Group which gives advice on the *Here for Life* programme as a whole, its direction and relevant demonstration projects in the programme ($0.5 million administration);

- $1.413. million to improve follow-up for young people presenting to hospitals and health services following self-harm;

- $1.35 million for support for GPs and health workers to identify, treat and refer young people at risk of suicide;

- $0.896 million to build communications networks to share existing initiatives and services; and

- $0.059 million to develop a media information kit to encourage responsible reporting on youth suicide issues.

9. *Here for Life* also includes a number of pilot suicide prevention projects for young people:

- who have attempted suicide and those with a mental illness who are at risk ($2.055 million);

- in rural areas ($1.227 million);

- of Aboriginal or Torres Strait Islander cultures ($1.058 million); or who

- are marginalised, homeless or seriously disaffected ($0.730 million).

Conduct of the seminar

10. In order to provide the Committee and other participants with a comprehensive range of information regarding youth suicide, the seminar chaired by Committee Chairman Peter Slipper, MP, was divided into two main sections. In the morning, four expert researchers in the field of youth suicide addressed the seminar. In the afternoon, representatives from a range of groups involved with youth suicide research and prevention initiatives contributed to the discussion. A programme of the day's events is at Appendix A.

11. The four main speakers at the seminar were:

- Dr James Harrison, Director, National Injury Surveillance Unit, Australian Institute of Health and Welfare. Dr Harrison outlined the demographic background to Australian youth suicide;

- Associate Professor Pierre Baume, Director, Australian Institute for Suicide Research and Prevention. Associate Professor Baume outlined the sociological factors that research has shown contribute to youth suicide;

- Professor Robert Kosky, Director, Department of Psychiatry, Adelaide Women's and Children's Hospital. Professor Kosky outlined the mental health factors involved in youth suicide; and

- Dr Meg Smith OAM, Chairman, Youth Suicide Prevention Advisory Group. Dr Smith outlined what support services are needed by young people in crisis and some problems encountered with existing services.

12. A list of all participants at the seminar is at Appendix B.

13. After listening to and considering all participants' contributions to the seminar, the Committee believes that the seminar achieved three main outcomes. These were:

- an identification of young people most at risk;

- recognition of the major factors influencing young suicidal people; and

- a better understanding of current service provision and delivery.

14. The information provided to the seminar on each of these three main areas will be outlined in the following sections of this report. A full transcript of the day's proceedings is available on request from the Committee Secretariat.

Young people at risk

15. Dr James Harrison gave a briefing on the demographics of young people in Australia who complete suicide, as well as those who attempt suicide. Dr Harrison pointed out that any statistics are unlikely to give a full picture of youth suicide in that some suicides may not be officially recorded as such, to protect the victim's family and friends from further trauma. At other times, a suicide is not recognised because of the nature of death, for example, a singlecar accident.

16. Also significant, especially to attempted suicide statistics, is the spectre of young people engaging in deliberately dangerous activities, while not (to others or to themselves) admitting to suicidal intentions. Examples of such activities include glue sniffing, goading police into high speed car chases, "train surfing", etc. Therefore it is important to remember, when looking at youth suicide statistics, that the problem is likely to be larger than officially documented.

17. Some of the main relevant statistics regarding youth suicide (ages 12-25) in Australia are as follows.

- In 1995, there were 350 young male suicides and 84 young female suicides. Members were shocked to hear that children as young as 12 had attempted suicide.

- The above numbers represented one quarter of all young male deaths and 17 per cent of all young female deaths.

- Rates of suicide per 100,000 head of population show that since the 1960s, the rate of young male suicide has almost trebled. The rate of young female suicide has doubled.

- For every completed suicide there are many attempts. Accurate figures on attempted suicide are almost impossible to obtain. However, hospital statistics show that for every death resulting from suicide, there are ten admissions to hospital for attempted suicide. Even this result underrepresents attempted suicides, as many are not admitted to hospital nor seek help.

- Suicide rates for Aboriginal people are even more sharply highlighted among young men than is the case for the general community.

- For young males in Australia between 1979 and 1995, there has been a fivefold increase in deaths arising from hanging.

- In comparison with capital cities, there is a markedly higher youth suicide rate in rural and remote areas. This-is particularly so in rural areas. There are also marked differences in the methods used to suicide - in rural and remote areas firearms are a much more prominent means of suicide than in urban areas, where self-poisoning is much higher. This of course means that in rural and remote areas, more suicide attempts are completed, due to the lethal nature of the means.

Australia's rate of suicide compared to that of other world countries is in the very high range. This figure may be misleading, however, as data is only available for Europe, North America, Australia and New Zealand and a few others. Over three quarters of the world is not reported on.

Young people with a history of mental illness, diagnosed or undiagnosed, have a higher risk of attempting suicide.

18. A full set of Dr Harrison's presentation graphs and tables is at Appendix C.

19. Young people who have previously attempted suicide are also at a very high risk of finally completing suicide. Research shows that 60 per cent of completed suicide cases had a recorded previous suicide attempt. The Jesuit Social Services have recently completed a survey of the Catholic hospital system and how hospitals respond to suicide attempts ~inc-luding a comparison with public hospitals). The survey found a very mixed result among hospitals, both in the Catholic and public systems. Some hospitals have minimal psychiatric or psychological care, discharging suicidal patients with no counselling or follow-up. Other hospitals have an established process for dealing with young suicidal people, including mental health assessments and appointments with youth workers.

20. This is clearly an area where a coordinated approach across all public and private hospitals would be of great benefit. An established procedure for identifying, assessing and counselling young people presenting to hospitals who have made a suicide attempt would have the potential to reduce the risk of further attempts greatly.

21. Sexuality is also a suicide risk factor for young people. Although there is little statistical data on whether young people who are confused or harassed over their sexuality are at greater risk of suicide, anecdotal evidence suggests that sexuality can be a strong influencing factor. Professor Kosky told the seminar that although statistics do not show an over-representation of homosexuals in completed suicides, clinical psychiatrists feel that in truth, they are over-represented. This is because many suicides linked to feelings of, or abuse because of, homosexuality may not be reported as such.

22. One invited representative pointed out that for all teenagers, including young gays and lesbians, there are four main support groups - their family, their peers, the church and school. For young homosexuals, these support groups may become alienating and/or hostile when homosexuality is revealed. Many young homosexual people fear alienation and rejection, placing them in a situation of depression, loneliness and despair, factors recognised as triggers for suicidal behaviour.

23. Given all of the above information, and Dr Harrison's more detailed graphs and tables, the Committee can conclude that young people completing suicide fall into several main categories. The young people at a higher risk of suicide are those who:

- live in rural and remote areas (particularly males);
- are of Aboriginal descent (particularly young men);
- suffer a mental illness;
- have access to lethal means;
- have previously attempted suicide; or
- are confused about or ostracised because of their sexuality.

24. This list is by no means exclusive and the Committee recognises that the problem of youth suicide will not be fully addressed by merely targeting these groups of young people. However, the demographics give a clearer picture about the greatest risk groups and indicate where a significant proportion of resources should be directed.

Major factors influencing young suicidal people

25. Until recent years, there has been little valid research on youth suicide, at an Australian or international level. While there is some divergence in the research literature as to whether suicide is mainly caused by mental illness or sociological factors, there is a growing subscription to the view that youth suicide is a deeply complex issue influenced by many factors, including mental health and wider sociological influences. The Committee recognises that any programmes or funding for youth suicide prevention must be underpinned by valid research demonstrating the causes of youth suicide, its prevalence amongst various groups and the best way of combating the problem.

26. A major part of building effective suicide prevention programmes is recognising the major factors that affect young suicidal people. This will always be a difficult task, as the factors are myriad and complex and not always obvious to those close to a suicidal young person. Professor Kosky described the mystery of suicide as "hidden and buried in the mind of the young person -beyond words in many cases". As with the demographic data outlined earlier,

the following research can, at best, be used to describe a significant number of suicidal young people. The Committee recognises, as was pointed out by participants at the seminar, that each young person at risk carries his or her own reasons for displaying suicidal behaviour. The factors influencing many young people at risk of suicide do not apply to all cases.

27. In the existing research literature, there is some question as to whether the major influencing factors for suicide are mental illness or sociological influences. The speakers at the *Aspects of Youth Suicide* seminar expressed a view, emerging in new research literature, that suicide is a result of these factors combining, to create a severe state of depression resulting in suicidal behaviour.

28. Professor Kosky described his research, in which all the young study subjects who displayed suicidal behaviour also exhibited the classically recognised symptoms of depression - sadness, tearfulness, irritability, poor sleep patterns, loss of interest in things in which they were previously interested, apathy, loss of appetite and sleeping in. However, he stressed that depression in itself is not an indicator of a person at risk of suicide. Professor Kosky's research further showed that when depression is set against a background of chronic family discord, the suicide risk increases dramatically. Professor Kosky describes a situation of family discord as one where there are long-term, intense arguments, bitter feelings because of divorce or break-up, lack of support emotionally for children/adolescents, or in some cases physical and/or sexual abuse.

29. Added to this complex of depression and family discord, other factors come to bear, according to Professor Kosky. This combination: depression, family discord and then a significant life event, can lead to suicidal behaviour in young people. The significant life event most often falls in the sociological sphere, described by Associate Professor Baume.

30. A/Professor Baume outlined the sociological influencers of suicide in two main categories - global and personal. At a global level, research has found that in countries with a high suicide rate, there are sociological factors such as:

- a high divorce rate;
- high youth unemployment;
- high female employment;
- extremely high alcohol consumption;

- a high number of unwanted pregnancies; and

- low church/religious participation.

31. It is important to note that these global factors are not necessarily the causes of suicidal behaviour. However, they are present in countries suffering a high youth suicide rate. The following factors are personal events in the life of a young person. While they may not appear severe to the outside world, in some young people these events may trigger suicidal thoughts and behaviour. This is especially so in the people mentioned above, suffering from depression and family discord. The personal factors include:

- loss - death of a family member or close friend;

- divorce in the family or other major family upheaval;

- break-up of a relationship with boy/girl friend;

- isolation - physical (for example, rural location) or emotional (few friends, low social skills);

- excessive use of alcohol or other drugs;

- confusion over sexuality or rejection because of sexuality; and

- contagion - school friends or other acquaintances committing suicide, heroes (rock bands, sporting figures) committing suicide, media reports of other suicides.

32. Linked to this final factor - contagion - is a concern held by researchers, health workers and youth counsellors that in our society suicide is becoming a more acceptable problem-solving option. Media reports on actual suicides, or television and film drama portraying characters with suicidal behaviour may trigger similar reactions in some adolescents. Clearly there is a need for young people to be educated in constructive and positive problem-solving techniques. This is discussed further in the report.

33. A/Professor Baurne outlined the large amount of suicide information available on the intemet, including methods of dying, how to write suicide notes and stories of other internet readers' suicides. There is also information on adolescent heroes such as Nirvana singer Kurt Cobain's suicide. A/Professor Baume also raised the possibility of using the internet as a suicide prevention tool and aiming to counteract the negative suicide infqn-nation currently available.

34. For many suicidal young people, the above mix of mental health and sociological/personal crisis factors combine to create a feeling of acute despair. It is important to note in this context that these factors are from the young person's point of view, not their family, friends, teachers or counsellors. The mix of factors which lead to young people being at high risk of suicide clearly point to some areas in which funding for counselling, education and support services could be well directed.

Service provision and delivery

35. The Committee recognises that many suicide prevention programmes, at a Federal and State level, have been devised and run over recent years. These include the *National Youth Suicide Strategy* and the *Here for Life* programmes outlined above. However, in discussion with the four main presenters at the seminar and other participants from health professions, youth services, peak bodies and federal agencies, it became clear that while some programmes are very effective, there remain gaps in existing service provision and delivery.

36. Dr Smith briefed the seminar on the nature of services needed by young people in crisis. Other participants at the seminar, many of whom work in youth counselling and support services, also gave detailed information about the range of services required.

37. A point which was greatly stressed was that young people in crisis need help that is user-ffiendly, easily available, and non-frightening or judgemental. Dr Smith pointed out that for any person, especially adolescents, a diagnosis of mental illness can be a frightening experience. These people need explanations of their problem, support through dealing with their illness and an assurance that the problem is treatable.

38. Most young people do not understand what depression is or how to cope when they experience it in a severe form. Dr Smith and other participants emphasised that depression awareness is a major key to preventing many youth suicides. Education about what depression is, how to recognise the symptoms, the treatments. available, including counselling or anti-depressive medication and where to get help, is vital for young people in crisis.

39. The Committee was told that the focus should be on depression awareness and help rather than suicide statistics and prevention. This approach avoids the dangers of contagion mentioned earlier. It also helps to erase the thought of suicide being a valid option for problem-solving. According to Dr Smith, depression awareness education must be targeted at the following groups:

- young people at risk- the groups mentioned in the previous sections;

- a recognition that peers are often the first contact for young people in distress - education on how to recognise depression in friends, and where more help is available;

- school teachers and other professionals - too often depression is shrugged off as teenage growing pains and normal feelings associated with adolescence; and

- parents of teenagers - how to recognise warning signs and approach a teenager about his or her depression, where to seek further help.

40. For some particular groups of young people, the need for support is even greater. These groups include young people in rural areas, where access to support avenues may be limited and existing health and welfare centres are likely to service a large cross-section of the community. Dr Smith identified young gay and lesbian people, who often lack role models, as a group needing specialised support networks. Young homeless people, who leave home for many complex reasons, also leave behind all of their support networks, including sympathetic family members, friends, school teachers and counsellors and neighbours. Research has also shown that many young homeless people have suffered physical or sexual abuse. This often leads to a distrust of adults and a wariness of support services staffed by adult counsellors.

41. The Committee was told that any kind of youth support service must be targeted appropriately, or young people simply will not access the service. This includes careful labelling of the service - young people often attach a stigma to titles such as "mental health service". Young people need access to young counsellors in a situation where they feel comfortable. Professional centres requiring appointments during school or work hours or where payment is required, will not meet the needs of many young people. Telephone lines such as Lifeline are also a valuable resource, as they can provide 24 hour assistance, providing immediate counselling to a young person in crisis.

42. Information for young people, their parents, school teachers and health professionals appears to be fragmented. While there are many good support, counselling and research programmes being run around the country, there is little coordination of services or information dissemination. This issue was raised by a number of participants at the seminar. Under the *Here for Life* Government programme, over $1 million has been allocated for improving communication networks amongst suicide prevention workers and coordinating information dissemination. However, anecdotal evidence presented to the

Committee by the four researchers and other participants, suggests that this strategy, as yet, has not been effective in bringing suicide prevention groups together.

43. Some participants, including representatives of Victoria Country Health Services, Suicide Prevention Australia, Lifeline Australia, the Australian Medical Association, the Australian Youth Policy & Action Coalition, youth workers, the Rose Foundation and Dr Brendan Nelson MP, advocated the establishment of a national office or clearinghouse for suicide information and programmes. This organisation would have responsibility for gathering, collating and disseminating information on suicide programmes and research throughout Australia. The organisation might also have a coordination role for development of national strategies.

44. The seminar presenters also outlined their belief that more research is needed into the issues surrounding youth suicide. The Committee supports the premise that government funding for suicide prevention programmes must be underpinned by valid research, and notes the $1 million allocated to childhood mental health research in the *National Youth Suicide Strategy*. Participants at the seminar advocated the establishment of a national suicide research body to coordinate and initiate new research on youth suicide.

45. Linked to the need for more research is the importance of evaluation. Several seminar participants emphasised the importance of evaluating the current suicide prevention programmes and research being undertaken in Australia. With limited funding for such an important social issue, it is important that resources are directed to research and programmes which work effectively.

46. The seminar enabled the Committee to gain a broad overview of the kind of suicide prevention programmes, information and research which are needed to recognise and assist in alleviating youth suicide. Of vital importance is that funding is directed to programmes which are well targeted, user-flriendly, research-based and monitored through evaluation. Equally, information dissemination is vital in order to identify effective programmes and ensure funding is directed to a ropriate services which provide a real benefit to the pp community.

Conclusions

47. The information provided to the Committee at the *Aspects of Youth Suicide* seminar, from the expert researchers and all other participants, has enabled the Committee to identify what it sees as the major issues for the Federal Government to address. It should be noted that many of these issues are not exclusively Federal issues, and there must be consultation, coordination and cooperation between Federal and State governments to provide effective prevention programmes.

48. There is clearly a need for education to help people recognise the symptoms of a person who may be contemplating suicide. The seminar was told that any education campaign should veer away from words and images such as "suicide prevention", and instead focus on depression awareness and problem solving skills. The signs of depression and its treatment must be part of any suicide prevention programme. In addition, removing the term "suicide" may assist in distancing it as an option for a young depressed person. Young people and their support network - friends, family, doctors, teachers and counsellors - need to be aware of the signs of depression and enable it to be treated as a socially acceptable illness.

49. Closely linked to the need for an education campaign on depression awareness is the need for young people in crisis, and their families, to know where to get help. The seminar included representatives from many community and health organisations conducting excellent counselling and suicide prevention programmes for young people. However, often the information on where to get help is not readily available in the community. Federal and State governments must look at ways to coordinate information on existing youth services and to get this information into the community as effectively as possible. This is an area where the professions that deal with suicidal young people - General Practitioners, hospitals, teachers, school counsellors and youth workers could be more effectively educated and utilised.

50. Throughout the seminar, the family was raised as a major influence on young people's lives. For many young suicidal people, depression combined with chronic family discord was stated to create overwhelming distress. The importance of family communication was emphasised as well as the need for extra support for families in crisis. This includes services such as teaching parents how to recognise depression in their children, telling them where to get help, supporting a family after a suicide attempt and providing appropriate counselling services following bereavement by suicide.

51. In light of the two suggestions for national suicide bodies, the Committee considers that the establishment of one peak national organisation could build on work already done in the youth suicide area. This organisation would have two main functions:

- to conduct a national stock-take of all suicide prevention programmes and services and disseminate this information as widely as possible, to enable local organisations to work together and to enable doctors, teachers, counsellors and young people to know where to go for help in depression awareness; and

- to integrate all suicide research in Australia, ensuring that research grants are used effectively to maximise information and knowledge of the problem and the best ways to work for prevention and to ensure consistency in data collection throughout Australia.

52. The Committee recognises that the existing Youth Suicide Prevention Advisory Group has helped to bring a focus to the problem, but does not consider that this group has sufficient direct input into policy making at a high enough level to achieve the results required. A new independent body could be established by using current administrative resources which would be provided and supported by the Department of Health and Family Services. Its membership would be determined personally by the Minister for Health and Family Services and it would report directly to the Minister and be chaired by an expert person with a high profile in the field.

53. The establishment of a National Advisory Council on Youth Suicide Prevention would constitute the Commonwealth Govermnent's principal body for dealing with youth suicide prevention. It would provide the Minister for Health and Family Services with independent and expert advice on the implementation of previous strategies, identify national needs, objectives and priorities and provide public information in order to increase community understanding of youth suicide.

54. Current funding for youth suicide prevention amounts to $32 million. From the evidence presented to it at the seminar, the Committee feels that although this amount is significant, much more needs to be done. This includes research, coordination, education, and counselling services - clearly a number of strategies demanding substantial amounts of funding.

55. The Committee advocates a review of Australia's current youth suicide prevention strategies and funding policies. At least, the possibility of reallocating some of the existing funds needs to be considered. While some of the

initiatives in the *National Youth Suicide Strategy* and the *Here for Life* programmes are well-placed and supported by research, others are not as successful. Moreover, a full evaluation of existing programmes has not yet been carried out. A comprehensive evaluation and possible re-direction of some of the existing resources will ensure that the current $32 million is spent on the most effective research and prevention programmes.

Recommendations

- *Priority 1*

  That a National Advisory Council on Youth Suicide Prevention be established to provide strategic advice to the Minister and the Government on youth suicide prevention and related matters.

  Within six months of its establishment, the Council should produce a comprehensive three year work plan to be reviewed and updated annually. The Council should also report annually on progress in meeting the objectives in its work plan. Secretariat support is to be provided by the Department of Health and Family Services.

  The Council should be **responsible** for **creating appropriate arrangements for consultation and cooperation between governments and the community at State and Territory as well as at Federal levels.**

- *Priority 2*

  In conjunction with Priority 1, a Research Advisory Committee should be established to complement the work of the National Advisory Council on Youth Suicide Prevention. The Research Committee will be responsible for advising the National Health and Medical Research Council on the management of research projects and research grants and ensure consistency with national research priorities. The National Advisory Council on Youth Suicide Prevention will seek technical advice from the National Health and Medical Research Council, as required.

- *Priority 3*

  The following areas were identified at the seminar as warranting an immediate response. However, these would be subsumed by the activities of the National Advisory Council on Youth Suicide Prevention and the Research Advisory Committee.

- **A depression awareness campaign to educate young people and their support networks on how to recognise depression and get help -including the use of internet resources;**

- **Standard procedures for hospitals to adopt when treating a young person presenting with attempted suicide / self-harm injuries;**

- **An immediate review of current funding and re-direction of some funds to more appropriate and better targeted programmes;**

- **Ensuring consistency in data collection at all levels of government.**

PETER SLIPPER MP
CHAIRMAN

14 May 1997

Appendix A

ASPECTS OF YOUTH SUICIDE

PROGRAM

Friday, 28 February 1997
Committee Room 2R3
Parliament House, Canberra

9:00amSpeakers and Invited Guests assemble in main foyer, Parliament House

9.20am	**Opening statement** by the Chairman, Mr Peter Slipper MP.	
9.30am	**Official opening** by the Prime Minister, the Hon John Howard MP.	
9.45am	Session 1	**Demographic background** Dr James Harrison, Director, National Injury Surveillance Unit, Australian Institute of Health and Welfare Presentation 20 minutes Questions by Committee Members 25 minutes
10.30am	Morning Tea	
10.45am	Session 2	**Social factors** Associate Professor Pierre Baume, Director, Australian Institute for Suicide Research and Prevention Presentation 20 minutes Questions by Committee Members 25 minutes
11.30am	Session 3	**Psychological/Psychiatric factors** Professor Robert Kosky, Director, Department of Psychiatry, Adelaide Women's and Children's Hospital Presentation 20 minutes Questions by Committee Members 25 minutes
12.15pm	Session 4	**Support services** Dr Meg Smith OAM, Chair, Youth Suicide Prevention Advisory Group Presentation 20 minutes Questions by Committee Members 25 minutes
1.00pm	Lunch	
2.00pm	**General discussion of issues by all participants**	
3.30pm	Afternoon Tea	
3.45pm	**Concluding session** and summing up	
5.00pm	Close	

Appendix B

SEMINAR PARTICIPANTS

Members and Senators

Senator the Hon. Amanda Vanstone	Minister for Employment, Education, Training and Youth Affairs
Senator the Hon. John Herron	Minister for Aboriginal and Torres Strait Islander Affairs
The Hon. Bob Halverson, MP	Speaker of the House of Representatives
Mr Kerry Bartlett, MP	
Mr Martin Ferguson, MP	
Ms Teresa Gambaro, MP	
Hon. Neil O'Keefe, MP	
Hon. Roger Price, MP	
Dr Andrew Southcott, MP	representing the Minister for Health and Family Services
Mr Warren Truss, MP	
Mr Barry Wakelin, MP	
Mr Paul Evans	representing Ms Trish Worth, MP
Senator Jeannie Ferris	
Senator Alan Eggleston	

Seminar Presenters

Dr James Harrison	Australian Institute of Health and Welfare
Associate Professor Pierre Baume	Australian Institute for Suicide Research and Prevention
Professor Robert Kosky	Adelaide Women's and Children's Hospital
Dr Meg Smith	Youth Suicide Prevention Advisory Group

Invited guests

Professor Michael Carr-Gregg	Centre for Adolescent Health
Mr Michael Chaaya	NSW Youth Advisory Council
Ms Kirsten Cross	Australian Medical Association
Reverend Bob Dunlop	Wesley Mission Youth Force
Dr Richard Eckersley	CSIRO
Mr Gordon Gregory	National Rural Health Alliance

Ms Heather Horntvedt	Parents and Friends of Lesbians and Gays
Mr Tony Humphrey	Suicide Prevention Australia
Ms Gail Kilby	The Rose Foundation
Mr Kilner Mason	The Mason Picture Company
Mr David Matthews	Pathways
Mr David McKie	NSW Department of School Education
Ms Coral McLean	Holy Family Education Centre
Father Peter Norden	Jesuit Social Services
Mr Julian Pocock	Australian Youth Policy & Action Coalition
Mr Phil Pringle	Christian City Church
Mr Neile Robinson	Sutherland Shire Council youth worker
Ms Diana Sands	Southern Highlands Bereavement Service
Mr Alan Staines	Suicide Prevention Australia
Mr Eric Tresize	National Summit on Suicide
Mr Bruce Turley	Lifeline Australia
Mr Derek Williams	Gay and Lesbian Teachers & Students' Association
Colonel Don Woodland	Salvation Army
Mr Ian Wright	Victoria Country Youth Services Inc.

APPENDIX C

GRAPHS AND STATISTICS FROM
DR JAMES HARRISON'S PRESENTATION

(are not available in PDF format, please contact the Secretariat if you wish to obtain copies)