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Suicide prevention initiatives

This issue is the last the Youth Suicide Prevention Bulletin to be published by the Australian Institute of Family Studies. The Bulletin was funded under the National Youth Suicide Prevention Strategy. We wish to thank all our contributors to these publications, and our readers for their interest and feedback.

The National Youth Suicide Prevention Strategy has now finished, and a framework for new suicide prevention initiatives, *Living Is For Everyone (LIFE): A framework for prevention of suicide and self-harm in Australia*, has been developed (see next page).

Aims of the LIFE framework are to:

- reduce deaths by suicide across all age groups in the Australian population, and reduce suicidal thinking, behaviour, and the injury and self-harm that results;
- enhance resilience and resourcefulness, respect and mental health in young people, families and communities;
- increase the support available to individuals, families and communities who have been affected by suicide or suicidal behaviours, and
- extend and enhance community and scientific understanding of suicide prevention.

Life
Living is For everyone

The Australian Institute of Family Studies is proud to have been involved in the Australian community's fight against the premature death of its young people by suicide.

Suicide rates for 1999 have recently been released by the Australian Bureau of Statistics in Causes of Death 3303.0. Rates for nearly all age groups are considerably lower than those for the previous ten years. While commentator, Dr Chris Cantor (page 3) suggests caution in interpreting the lower figures, it is indeed heartening to see them.

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of Family Studies



Commonwealth Department of
Health and Aged Care

COUNCIL HANDOVER

From NACYSP to NACSP

The Prime Minister, the Honourable Mr John Howard, addressed a joint gathering at Parliament House of Members of the former National Advisory Council on Youth Suicide Prevention (NACYSP), and the National Advisory Council on Suicide Prevention (NACSP) on 12 October 2000.

Mr Howard formally thanked Members of the former NACYSP for their work in developing the national strategy, and welcomed the new Members of the NACSP. The Prime Minister also announced Commonwealth funding of \$2.9 million for suicide prevention projects in the community, including an additional \$100,000 per year, ongoing funding for the youth counselling service Kids Help Line. In discussing his keen personal interest in the Suicide Prevention Strategy, the Prime Minister stressed the importance of the government, public services and community being able to work together in a cooperative way.

The final meeting of the NACYSP was held on 11 October 2000. The inaugural meeting of the new National Advisory Council on Suicide Prevention was held in Canberra following the Prime Minister's address on 12 October 2000.

Professor Ian Webster, AO, former Chair of the NACYSP and Chair of the new NACSP briefed Members on *LIFE (Living is for Everyone): A framework for prevention of suicide and self-harm in Australia*, that had been developed by the NACYSP. Professor Webster reviewed the many gains made under the National Youth Suicide Prevention Strategy during the life of the NACYSP, including the more than one thousand different projects now in existence in community settings, and discussed the need to develop links with related initiatives.

LIFE was released by the Honourable Dr Michael Wooldridge, MP, Minister for Health and Aged Care, on 6 October 2000. A copy of the *LIFE* Framework is available free of charge and consists of three companion documents in a slip case. These are available as a complete set only, and can be ordered by phoning 1800 066 247, faxing 1800 634 400 or via the Mental Health and Special Programs Branch Website: www.mentalhealth.gov.au



Final meeting of the NACYSP

Pictured (standing, from left): Mr D. Casey (Commonwealth), Professor I. Webster (Chair), Mr K. Davey, Dr B. Turley, Ms W. Quinn, Ms J. Davis-Lee, Professor G. Martin; (seated, from left): Ms P. Iker, Ms K. Scanlon, Ms M. Smith, Ms M. Briggs; (absent): Ms D. Podbury, Mr. H. Krebs, Ms Lipscombe, Ms M. Cuthbert, Professor R. Goldney, Ms J. Badcock.



PM greets new Advisory Council members

Pictured (from left): The Prime Minister, Honourable John Howard, MP, with some members of the new NACSP Mr Don Zoellner, Mr Michael Perrott, and Mr Wayne Koivu.

Drop in suicide rates for 1999

CHRIS CANTOR

As the accompanying Table shows, the 1999 suicide rates for males in the three age groups 15–24, 25–34 and 35–44 years, and females in the two age groups 15–24 and 35–44 years, were all well down on 1998 rates.

Random annual rate fluctuations are to be expected, and it is all too common for premature claims of rates being turned around one year for the reverse to be found the next. Procedural changes at the Australian Bureau of Statistics (ABS) can affect figures, causing such illusions. However, enquiry of ABS revealed that no procedural changes were introduced affecting 1999, so this possibility can be dismissed.

For 15–24 year old males, the last year to have a suicide rate lower than that which occurred in 1999 was 1986 – 13 years previously. Furthermore, the suicide rates of the age/sex groups most related to 15–24 year males – that is, 15–24 year females and 25–34 year males – also showed encouraging decreases.

The 15–24 year age range, particularly males, has been the priority of recent national concern and suicide prevention efforts. These figures raise the possibility that the “epidemic” may have turned, or be in the process of turning, either by national efforts or spontaneously.

It would be very premature to claim such a turnaround as fact, but figures for 2000 and beyond will be awaited with great interest. In the meantime, suicide prevention efforts must continue.

Dr Christopher Cantor is Adjunct Senior Lecturer in the Department of Social and Preventative Medicine, University of Queensland.

AGE-SPECIFIC DEATH RATES (a) : Suicide

	Years	Age Group (years)													
		15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+	All ages
M A L E S	1979	12.7	23.7	22.6	23.3	21.4	25.5	29	25.1	23.7	22.9	20.5	26.1	19.8	16.5
	1980	9.9	25.3	22.8	22.3	22	25.6	24.5	20.4	25.4	22.3	23.2	21.2	31.9	16.3
	1981	10.9	25.3	22.5	21.1	20.8	26.7	23.9	25.5	25.1	23.6	28	25	31.7	16.9
	1982	10.5	28	29.4	20.3	19.7	20.7	23.7	19.9	24.1	25.3	29.7	25.6	40.2	17.4
	1983	9.3	27.3	26.5	21.8	19.2	19.5	19.1	23.4	23.5	25.7	27.4	32	39.6	17
	1984	10.3	26.9	22.4	25.5	19.1	21.2	20	25.3	24.6	23.5	25.7	23.1	30.7	16.8
	1985	16.6	31.2	30.3	22.8	19.5	26	22.1	20.5	22.1	21.5	21.3	28.8	27.5	18.1
	1986	13.2	29.2	28.6	28	21.7	25.8	22.6	23.6	25.5	23.6	23.3	32	36.8	19.1
	1987	17.2	31.9	31	26.5	26.9	29.2	24.6	31.2	34.4	24.5	23.3	35.7	45.8	21.8
	1988	21	35.2	29.8	26.7	23.9	28.13	25.4	23.4	22.4	25.2	24.3	32.4	40	21
	1989	18.4	29.7	32.3	27.6	24.7	20	24.3	23.4	25.9	19.7	23.1	32.5	34.5	19.8
	1990	17.8	36.5	32.8	25.3	26.1	24.8	20.9	22.1	26.7	22.8	25.2	27.5	32.1	20.4
	1991	19	34.4	29.3	30.4	34.2	26.4	25.1	27.4	22.9	19.6	21.2	24.9	38.2	21.4
	1992	18.4	34.9	32.6	28.2	26.8	23	27.8	23.3	21.4	24.8	25.5	29.7	30.6	20.9
	1993	16.7	32	29.2	28.2	22.2	20.5	25.9	20.4	21.9	24	22.4	24.3	30.6	19.2
	1994	18.6	34.5	30	28.4	25	27.3	24.3	25.3	23.1	23.1	22.9	24.6	32.1	20.6
	1995	15.1	34.8	34.1	32.7	30.9	24.3	24.2	23.4	26.6	19.5	18.8	20.4	29.2	20.8
	1996	17.4	33.4	33.2	31.8	32.2	26.5	23.1	22.2	22.2	24.9	20.2	24.6	32.4	21.2
	1997	18.4	42.3	40.4	34.6	29.2	31.4	23.6	25.3	22.6	22.5	22.9	24.5	36.2	23.3
1998	17.2	35.9	42.6	39.4	36.6	29.5	25.5	24.9	19.7	20.3	26	17.1	25.6	23.1	
1999	14.2	30.5	36.6	33.4	29.8	28.6	24.8	24	21.9	19.6	19	26.6	30.5	21.2	
F E M A L E S	1979	3.6	7.9	7.9	6.9	8.6	9.8	11.2	14.2	11.8	13.2	9.8	12	4.8	6.6
	1980	2.3	6.6	7.3	6.4	9.5	10.1	9.7	8.7	9.7	5.5	7.4	6.5	9	5.5
	1981	2.4	6.4	5.9	5.8	8	9.1	11.7	11.1	10.8	6.8	8.7	7.5	6.3	5.5
	1982	1.7	4.7	9	5.1	8.2	8.5	11	14.2	9.9	12.4	8.6	12.4	7.6	6
	1983	1.9	4.8	6.8	6	7.3	6.7	8.8	10.3	10.7	10.5	8.9	8.3	8.1	5.4
	1984	2.4	6.3	6.3	6.8	7.1	6.2	12.4	8.6	8.8	7.6	6.9	5.9	5.6	5.2
	1985	3.6	6.2	6.1	3.2	7.1	4.9	9.8	7.5	8.6	8	7.2	8.1	9.5	5
	1986	3	7.8	6.7	5.8	7.7	7.3	11.2	10.3	8.9	7.6	7.6	7.6	6.2	5.6
	1987	6.2	5.8	6.4	5.7	7.4	7.7	8.5	8.7	10.1	7.3	9.8	9	7.4	5.7
	1988	3.8	5.2	6.2	8.2	7.9	7	8.3	8.2	7.2	10.3	7	7.8	10.1	5.6
	1989	1.9	5	6.9	6.8	5.4	8.1	6.1	8.2	8	8.9	10.5	8.3	7.3	5.2
	1990	5	3.9	5.9	8.1	5.3	6.5	7.1	6.5	6.7	5.7	7.7	8.1	8.4	5
	1991	3.2	9.4	8	6.7	6.8	8	8	7.5	11.2	8.9	5.7	7.8	8.1	5.9
	1992	4.8	6.5	6.1	8	6.6	7.8	6.1	6.8	7.6	6.6	6.8	7.2	8.3	5.4
	1993	3	5.1	5.6	5.5	7.7	4.2	7.5	6.5	5.1	5	5.6	6.3	6.5	4.4
	1994	2.7	5.6	6.3	5.7	7.9	6.7	6.4	6.6	6	6.7	3.9	5.7	7.1	4.8
	1995	4.7	7.8	7.1	6.8	7	8.1	7.8	8.6	7.8	5.3	6.5	4.3	5.9	5.5
	1996	4.2	4.4	6.9	6.5	8.9	6.6	7.8	7.6	5.2	5.3	4.2	7	4.8	5
	1997	5.2	8.9	8.1	7.8	8.6	8.4	7	9.5	7.6	6.6	7.1	6.7	7	6.2
1998	5.5	7.1	7.6	7.5	10.3	8.3	5.1	6.8	7	6.2	5.7	6.4	6.6	5.7	
1999	4.2	6.6	7.5	8.6	6.4	7.9	8.6	6.7	4.4	5.8	4.9	3.6	3.7	5.1	

(a) Rate per 100,000 persons.
Source: ABS Suicides 1921-1998 3309.0
Table updated with 1999 data by the ABS



Clockwork

Young people's health service

The Clockwork Youth Health Service commenced in August 1995, following discussions among the medical and youth services sectors in Geelong about young people and their health needs. Concern was expressed that young people were not using local health services while levels of youth suicide, substance abuse, and homelessness were rising (Success Works 1999).

General practitioners (GPs) provide 100 million consultations each year to 80 per cent of the Australian population and have broad skills in managing mental health, sexual health, drug and alcohol and family problems. They are in an ideal position to change worsening youth statistics such as suicide, alcohol and illicit drug abuse, child abuse and sexual health issues. However, a number of barriers deter them from being involved in adolescent health and Clockwork has a role in promoting strategies that improve youth access, education, integration, health promotion and research in general practice at a national level.

Access problems for young people

Many young people have difficulties with access to general practice, due to fears about confidentiality, cost and judgmental attitudes. In the Clockwork experience, many young people are also crisis-orientated, do not tolerate waiting, are often unassertive during consultations, but easily critical of GPs later. These issues and attitudes affect their help seeking behaviour.

In a needs assessment before the implementation of Clockwork, young people's attitudes to general practitioners

"Clockwork aims to promote the accessibility, relevance and quality of health care for young people, both by offering direct service provision of a range of holistic health care services and by impacting on community general practice and other mainstream health services throughout Australia, by distributing information on GP access, education, integration and health promotion."

LEANNE ROWE reports on a young people's health service run by general practitioners, youth workers, nurses and psychologists in the Courthouse Project in central Geelong, Victoria.

were surveyed. The following quotes are typical of comments from 80 young people:

They don't listen to what I say

They think I smell

You should see their body language if you tell them you are gay

They don't believe what I am saying

They make me feel uncomfortable

They think they know everything

We don't think about them because they are boring

I get the impression they can't wait to get out of there - they rush you

I hate those big words they use

They are people in white gowns with power to prescribe whatever drugs you're after

Difficulties for GPs

There are problems for general practitioners trying to provide a health service to disadvantaged young people.

Funding

Consultations with young people are time consuming and often require follow up phone calls and case meetings with other agencies. Medico-legal problems associated with issues such as suicide, drug addiction and child abuse are also time consuming. Not only are these items poorly covered by Medicare in general practice, but in the Clockwork experience, young people are often late, do not keep appointments or do not have a Medicare card. These issues result in poor remuneration for GPs working with young people.

In addition, it is often difficult for GPs to obtain support from short-term, State-funded programs that have a high turnover of staff and programs. Lack of funding and the short term nature of youth programs, deter GPs from networking with other services or from exploring adolescent issues in detail.

GPs are expected to know it all

The following list of suggested topics sent to Clockwork by a school, prior to a visit to Year 7 students demonstrates the expectation of the community for general practitioners to “know everything”:

eating disorders	youth suicide
depression	teenage pregnancy
contraception	self esteem
blended families	HIV/AIDS
TV violence	grief
alcohol and drugs	communication
panic disorders	steroids
bullying	homework
smoking	sexuality and STDS
cultsaromatherapy	

Medico-legal and ethical issues

General practitioners who work with young people are confronted with many difficult and ethical issues.

A 13-year-old may ask for emergency contraception, condoms or syringes.

A 15-year-old may request confidentiality for termination of pregnancy after consenting to sex with a 25 year old man.

A young person may admit to criminal activity that may endanger others in the community.

A 15-year-old may request antenatal screening tests because she is planning to get pregnant.

A 16-year-old abused, unemployed boy may ask: “Why shouldn’t I kill myself?”

Negative attitudes

“If a doctor tells me to do something I feel like doing the opposite.” Young people in focus groups at Clockwork have enlightened us with this message. Negative attitudes make youth health promotion more difficult.

Components of Clockwork program for GPs

Within the Clockwork program are a number of elements which support general practitioners.

Clockwork GP shared care project

General practitioners are supported to work at Clockwork with very disadvantaged young people, who do not normally seek health care. They undertake an orientation program, work with a multidisciplinary team and with other services, and bring this experience back to their own practices.

At Clockwork, GPs are helped to manage complex issues that are difficult to manage in isolation in private practice such as child abuse, homelessness, suicide, severe depression, sexual health issues and drug and alcohol abuse. Clockwork staff help GPs keep up-to-date with other youth services, and organise case discussions, secondary consultation, groups for young people, transport, assistance with referral and support to young people between GP visits.

Clockwork GP practice support

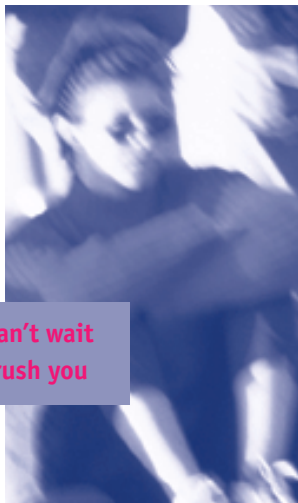
Clockwork has also developed major resources for general practitioners to use in their own practices, including:

- a brochure for young people, which details how to access General Practice;
- a folder on all Clockwork programs;
- a paper on the use of new Medicare item numbers in adolescent health;
- the manual: *Time for young people: about making general practice work for young people*;
- health promotional materials including posters developed by Clockwork and young people;
- a young people’s book on mental health, *Creating Girl X* (see elsewhere in this Bulletin); and
- the teenage health website www.clockhealth.com.au and associated health promotional materials.

Clockwork GP education

General practitioner education is provided by Clockwork in a number of ways:

- distribution of Clinical Practice Guidelines, Fact Sheets, kits of relevant journal articles and book lists;
- *Clockwork Newsletter* to GPs in the community;
- journal club and a program of GP self care by the Clockwork psychologists;
- development of policies and protocols on difficult areas such as suicide risk, sex offending, prescription drug abuse, sexual health and termination of pregnancy;
- a library of relevant books, that may be borrowed by GPs
- publication of articles in the *Australian Family Physician*;
- presentations to national conferences; and
- workshops for GPs and people working with young people, once a month, on topics such as engaging young people, illicit drug use, Cognitive Behavioural Therapy, sexually transmitted diseases, Koori Health, and endocrine disorders.



I get the impression they can't wait to get out of there – they rush you

GP special interest groups

A number of general practitioners have developed special interests in adolescent health. These GPs have developed resources and they assist other GPs with secondary consultation on issues such as anger management, learning disorders, teenage mothers, sexual health, eating disorders, gay and lesbian issues, and GP self care.

Clockwork network

A major role of Clockwork is to assist GPs work with other services. The GPs and staff at Clockwork participate in ongoing meetings with other relevant services, reference groups and Government and non Government bodies. The Clockwork service is collocated with other youth services and consultation with these services occurs on a daily basis.

Clockwork at a national level

Clockwork is involved in the development of the National Divisions Youth Alliance, which is run through the Australian Divisions of General Practice. This body helps to distribute information to GPs on youth health, as well as advocating for youth health nationally.

Clockwork service for young people

Clockwork provides a drop-in youth health service involving general practitioners, a community health nurse and a psychologist. The service seeks to provide a safe, secure, relaxed and confidential environment at all times. In providing longer consultation times (30 minutes to an hour) for young people of three to five times per week by a community health nurse and psychologist, it is hoped that the service will provide a broad focus on physical and mental health issues.

Many young people who are homeless, at risk of homelessness, living independently, or at risk of leaving school, may face major issues including depression, suicidal ideation, physical, sexual and emotional abuse problems and health checks are encouraged by the centre. Group sessions for young people on self-esteem and anger management, are provided to help prevent them from becoming part of the mental health system or juvenile justice system. Family therapy and mediation are also provided to prevent homelessness and help promote healthy relationships.

The majority of clients are aged twelve to eighteen years, with 76 per cent having mental health issues, 25 per cent express-

ing suicidal ideation, 90 per cent engaging in illicit drug use and other major issues including sexual health problems and child abuse. Fifty per cent of young people have left home and school. Seventy per cent of clients attend the service through word of mouth and from areas within an 80 kilometre radius.

There are currently ten general practitioners offering sessions on the Clockwork roster, but over the last four years, 30 GPs have worked at Clockwork. Clockwork also refers young people to more than 50 GPs in the community, who have identified themselves as youth-friendly and who offer bulk billing for long consultations.

Clockwork also runs the following additional programs:

- groups for young people at risk of leaving home or school, on anger management, grief and self esteem;
- art therapy;
- a group for young mothers experiencing postnatal depression and infant problems;
- preparation of health promotional materials including posters suitable for GP waiting rooms;
- an information session for parents in crisis, providing information and appropriate referral to family services;
- a school program for Year 9 students with a major focus on access to general practice in the community,
- community forums for parents and teachers on adolescent depression, for large audiences (over 200 people), and involving GPs as speakers or as panel members with other youth services; and
- adolescent health issues presented by Clockwork staff at curriculum days for teachers and to community groups, such Rotary Clubs.

Evaluation

The Success Works (1999) Evaluation of Clockwork identified positive outcomes for the young people using the service, for general practitioners and for the service system: "Clockwork is perceived as making a substantial contribution to improving the physical, psychological and social health of young people attending the service. It is also well regarded by GPs, enhancing their skills and expertise in adolescent health issues. The service is also valued as a resource for workers with young people in the broader community, particularly those in health and education." (Success Works 1999)

A manual entitled *Clockwork: Time for Young People* is available to communities interested in developing similar programs.

Reference

Success Works, Victoria (1999), "Evaluation of Clockwork Young People's Health Service" (rev edn), Department of Human Services, Barwon South West Region and GP Association, Geelong, Victoria.

Dr Leanne Rowe is Clinical Director of the Clockwork Young People's Health Service. The manual, *Clockwork: Time for Young People*, can be obtained by sending \$49.50 (including postage and GST) to Clockwork, PO Box 915, Geelong 3220.



Towards a sociocultural analysis of youth suicide

Researching the everyday narratives of urban and regional communities

SIMONE FULLAGAR

At the beginning of 2000, the Australian Research Council funded a three-year qualitative research project that was jointly proposed by the University of Sydney (Dr Glennys Howarth and Dr Gerard Sullivan) and Charles Sturt University (Dr Simone Fullagar). The project is unique in that it develops a sociocultural analysis of the ways in which urban (Sydney) and rural (Albury-Wodonga within the New South Wales/Victoria border region) communities understand, perceive and construct meaning around the issue of youth suicide. In this way it addresses a gap within current research on youth suicide that tends to draw upon the disciplines of epidemiology, psychology and psychiatry (see the Commonwealth Department of Health and Aged Care 1999 report).

While these approaches have provided invaluable knowledge about personal and social risk factors associated with suicide, there is still a lack of conceptual understanding about the cultural milieu that shapes the way young people think and act towards themselves, as well as how they are perceived by adults within their communities.

The study does not focus exclusively on those individuals who have been directly affected by suicide but instead explores the discursive processes that shape attitudes, values and beliefs about youth suicide. The everyday narratives of a diverse range of young people (aged 15–24), community members and service providers (family, teachers, sports coaches, police, youth/health workers), will be collected through in-depth interviewing. This process involves the use of open-ended questions and four case studies about different young people's experiences.

Some of the questions posed by the study include: how is youth suicide perceived within the community; what factors in young people's lives are seen to contribute to suicide; how is emotional distress managed; what is being done about suicide prevention within the community; and how else might suicide be prevented?

This will enable us to identify disparities between the way services, communities and young people conceptualise the reasons and risk factors related to suicide. It will also enable us to consider a range of different perspectives on the perceived effectiveness of local prevention initiatives and possible alternatives. An analysis of rural and urban differences is also central to understanding how everyday knowledge about youth suicide is produced within particular sociocultural contexts. The project aims to analyse the local knowledge of each community in relation to the wider cultural discourses about identity, sexuality and rural/urban life for young people. In particular, sexuality and identity have been largely overlooked in Australian policy and research until quite recently.

This research will provide an avenue through which young people's voices and concerns about suicide can be realised as an important source of knowledge for policy makers, service providers and communities. This is not to deny the complex processes that govern qualitative research and the researcher's own constructions of the issue.

The conceptual basis of the study draws upon post-structuralist sociology that is interested in thinking through the way that language mediates, or shapes, the complex relationship between the self and the social world (Foucault 1980). The significance of language in framing an individual's choice and behaviour is crucial to understanding the way in which suicide is constructed as an "option" in the process of "managing" oneself in times of distress. We approach the question of why someone suicides from a different angle by identifying *how* suicide comes to be constructed as a "meaningful" option for some young people. A post-structuralist approach does not assume to know the truth or reality of a young person's life, but rather explores the way in which individual actions are always constituted through social processes (Hallam, Howarth and Hockey 1999).

By analysing this discursive dimension of suicide we can develop a critical understanding of the wider moral economy that governs how young people are valued (or not), how a young person's emotional distress is responded to and what factors prevent young people from seeking help in times of crisis. In this sense, experiences of emotional distress are always inscribed with meanings that derive from the sociocultural context and not simply from "inside one's own head" (Kral 1998, Canetto and Lester 1998, Aldridge 1998).

If we consider the way that discourses shape how we think and act in the social world then we can see their political nature in terms of power and knowledge relations. Challenging and changing the discourses that govern the everyday lives of young people means effecting a transformation in the social sphere as we live it now.

This has important implications for thinking about policy, service provision and community responses. To give an example, a young person's suicide attempt may be talked about by adults in terms of "attention seeking behaviour", and hence not taken seriously. This discourse apports blame to the individual through jargon drawn from pop psychology, hence suicide is individualised as the young person's problem and he is also held responsible for "pulling his socks up" and getting on with things. There are cultural assumptions here about what it means for a young person to become an adult – assumptions about the individual's responsibility for control-

ling and managing private emotions in order to achieve an ideal way of being, that in neo-liberal societies figures as the rational, autonomous, self managing individual (Rose 1999).

A sociocultural perspective provides an important counterpoint to the dominant medical and psychological approaches to suicide, which do not fully explore the relation between the self and the social. Much research into the nature of youth suicide has been undertaken by psychiatrists and adolescent mental health researchers who have been concerned with the problem of mental health/illness and identifying individual pathology (Hassan 1995:155).

Yet, we don't really know how suicide is conceptualised by young people themselves – it may not be that a discourse of mental health figures in their understandings and if this is so, we need to consider the language and conceptual basis of suicide prevention programs and policies. Furthermore, discourses about suicide as primarily a mental health problem may well serve to frame a young person's emotional distress in terms of psychological problems, and so discount the sociocultural factors and the ways in which that distress is managed.

More recently, the significance of social factors which affect the lives and deaths of young people have been recognised through epidemiological research. For example, unemployment, geographic location, gender, homelessness, family difficulties, mental illness and previous suicide attempts (Setting the Evidenced-based Research Agenda for Australia 1999, Draft National Action Plan for Suicide Prevention 1998, Background on Youth Suicide in Australia 1997).

Sociologists have also contributed to the understanding of suicide as a social phenomenon. However, this research tends to use quantified measures, statistics and generalised causation theories (Hassan 1995). While this quantitative approach is useful in the evaluation of broad cultural trends and for examining the correlation between social factors and suicide, it does not allow for the exploration of the complex everyday meanings and social relationships governing the suicidal behaviour of individuals within their communities.

Hassan (1995:15) argues that to understand the motivated nature of suicide, one not only needs to explore the external social factors but also how these factors are internal to the suicidal individual. Often the term "social factors" confuses (1) the social causes, and (2) sociocultural conceptualisations, the former referring to the individual's social context, the latter emphasising the way in which such "factors" are discursively understood. Social factors such as unemployment or sexual orientation do not cause suicide in some determinate way. Rather, they are factors mediated by the sociocultural conceptualisations (or discourses) through which the individual experiences them.



The issue of sexuality and identity is not limited to gay or lesbian young people, but rather is a dimension of self that all young people negotiate through the customs, discourses and taboos of their culture.



By examining the everyday stories of different community members, we can start to see how young people may experience marginalisation in ways that might contribute to self-harming narratives.

These meanings transmitted in the form of everyday stories, media reports and narratives about oneself, shape the way young people construct their identity and whether or not they act in a self-violent manner in times of emotional distress (Billington, Hockey and Strawbridge 1998). By examining the everyday stories of different community members, we can start to see how young people may experience marginalisation in ways that might contribute to self-harming narratives.

For example, the study will explore the nature of beliefs produced through living with youth unemployment, a difficult home life or being gay in an urban/rural community. It will ask how these social situations are managed by young people and understood by different community members. What emotions are produced and what discourses regulate the way in which one expresses or represses these emotions? The study will also explore the nature of gender differences in attitudes towards youth suicide and take into account the higher rates of suicide attempts for young women that are not necessarily reflected in the suicide statistics (Cantor et al. 1999). We also ask how discourses about youth suicide are gendered and what might be the implications for responses to young women and men.

Within the transitional time of acquiring an adult identity, the question of sexuality arises as a significant experience that generates many conflicting issues for young people within their communities (Waite and Sullivan 1997). Sexuality involves the dimensions of self which include: gendered identity, self-image, sexual orientation, negotiating intense relationships and rejection/acceptance by oneself, family and community members (Sullivan 1990).

Research suggests that young gay/lesbian/bisexual people experience homophobia and marginalisation, both of which are associated with increased risk of suicide attempts (Nicholas and Howard 1998). In an American study, Remfedi (1994) found that one third of suicide attempts in his study occurred in the same year that the young person identified as gay or lesbian. The issue of sexuality and identity is not limited to gay or lesbian young people, but rather is a dimension of self that all young people negotiate through the customs, discourses and taboos of their culture. This research considers how suicide is related to a young person's emerging sexual identity; how they feel about themselves and how others perceive them within their own communities.

The issues raised above identify the significant connection between youth suicide and the process of identity formation, enacted in the roles and stories that constitute everyday life – in the domains of home, leisure and recreation, work or unemployment, study and the many other aspects of youth culture. From this perspective, suicide raises important conceptual and practical issues of how young people experience

and negotiate marginalisation – the power relations which govern the spatial organisation of everyday life and significant relationships.

For example, a young person's experience of alienating environments is significant in how they develop social networks and relate to themselves and within their community (Malone and Hasluck 1998). Leisure, cultural and social opportunities are vital in developing a young person's sense of belonging in relation to place, whether in an urban or regional context. Extending this conceptual approach we ask; what does boredom mean to young people and how does it impact upon young people's beliefs about themselves, their community and desired future?

This project conceptualises research as a discursive or knowledge practice in itself. That is, research is a means of transforming how we think about and hence devise programs and interventions that address the problem of youth suicide. This understanding also has implications for policy, in that policies are a means through which public discourse on suicide is circulated, and hence influences the thinking and actions of service providers.

For example, if we consider how suicide is talked about through the discourse of risk factors (these can be individual or population related), we can think about the implications for certain groups of young people. If being gay or lesbian is associated with increased risk of suicide, how might someone who is young, gay and feeling depressed or suicidal be treated by a health or welfare professional as "at risk" of suicide? Consider how the person's sexuality could become the focus of concern and how the young person's behaviour might be talked about in terms of "not coping" – in other words, the problem becomes individualised and the category of sexuality becomes reified (as a given truth connected to an inherent risk).

What is not acknowledged within this discourse are the homophobic attitudes and values that may indeed shape the young person's experience. If this relationship between the self and the social is not established in prevention discourses then there is a risk that emotional distress and suicidal thinking will be pathologised as a problem inherent in the individual's sexuality.

This example suggests the need for greater reflexivity about the language that is used to address suicide as everyday discourses have very real political effects on the lives of young people. The outcomes of this research will be made available to the participating communities and may be useful in generating alternative ways of conceptualising youth suicide, that may in turn directly assist in the evaluation of prevention strategies and health promotion programs.

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Leisure, cultural and social opportunities are vital in developing a young person's sense of belonging in relation to place, whether in an urban or regional context.



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Seasons for Growth

A national grief and loss education program

P. Clare Koch and Angela Magarry



The Sisters of St Joseph own and operate, through the MacKillop Foundation, the successful *Seasons for Growth* program. The Foundation is motivated by the inspiration of Mary MacKillop in whose idiom: “Never see a need without doing something about it” inspired the writing of the Seasons for Growth program. Dr Ann Graham is the author of Seasons for Growth.



Seasons for Growth is a national grief education program operating out of schools, welfare agencies and community based organisations for young people aged between 6–18 years. There is also a version for adults. The program has been funded under the National Mental Health Strategy and an evaluation of the program funded under the National Youth Suicide Prevention Strategy.

Program for young people

The core element of the program is the promotion of mental health, psychological competence and early intervention for young people from a significant “at risk” group of those who have experienced significant change due to death or family breakdown. The program has been in operation since 1996 and is now operating in over 2,000 schools throughout Australia.



Various pressures in society create a need for programs like *Seasons for Growth*. Although our society is relatively safe and without great tension, our value and belief systems are changing. Young people face both short-term and long-term adjustment following family break up, death or significant loss. Factors such as uncertainty about the future, changing expectations of families, and work which may require multiple relocations, have the capacity to affect the person both socially and academically. Without help, young people may continue to suffer, might not regain confidence, or a social network, or a sense that life is worth living. The alarming level of suicide in Australia suggests that young people are indeed in need of support to help them understand and manage their feelings of loss and grief.



Seasons for Growth provides a basis for enhancing resilience and community “interconnectedness” which are key activities in suicide prevention. It aims to develop skills in communication, decision-making and problem-solving. Using a wide range of creative learning activities, it explores important issues such as change, loss, feelings, coping and memories.

It is designed as a withdrawal program for small groups, rather than being incorporated in the general curriculum, and

is offered to students in need, not the whole body of students. It uses a process of peer communication and support facilitated by a “Companion”, who is usually not a professional counsellor but has a place in the relevant community. People involved in the program range from teachers, companions, gatekeepers (school principals and welfare agency managers), parents, carers, trainers, agencies and participants within the community.

Seasons for Growth is supported by a comprehensive range of materials, including Companion manuals and journals for various levels, a *Site Coordinator Manual* and *Trainer Manual*. It includes information and education for parents and the wider community. Regular support is provided via a newsletter and through the website: <http://www.goodgrief.aust.com>

Seasons for Growth adult program

A significant gap in services for adults was identified through local needs assessment and community-initiated requests for support. The *Seasons for Growth* Adult Program was developed to address this gap. The Adult Program is offered through three separate components, which allows participants to exit when they have sufficient information for their current needs. These components include: *Seasons for Growth* Parent/Carer Information Session; Understanding Change, Loss and Grief – An Introduction; and Exploring the Seasons for Grief.

Like the young people’s program, the Adult Program is offered in small groups and is facilitated by a trained Companion. As the overall aim is to maximise mental health and wellbeing among the adult population, there is a strong focus on mental health promotion in the program’s delivery.

The key beliefs that underpin the *Seasons for Growth* Adult Program are:

- loss and grief are normal and valuable parts of life; many different losses occur in one’s lifetime;
- adults, as well as younger people, need to have an opportunity to examine how loss and grief have impacted on their lives ;
- adults also need to be provided with the knowledge, skills and attitudes to understand and manage their grief experiences;
- the key to supporting others (for example, family members) through grief is to be “at home” with our own loss experiences;
- learning about loss and grief can, in itself, be quite liberating; and
- the sharing of stories allows us to connect with one another in ways that build understanding and decrease isolation.

There is a strong need for this type of program in our community to provide a system of support, strength, emotional and personal recognition, and opportunities for growth. It is a valuable model for support and education about change, grief and loss in community settings, and is viewed very positively by those involved. Participant feedback has pointed to the capacity for the adult program to provide for individuals at all ages.

Relevance to suicide prevention

Seasons for Growth is oriented towards the promotion of mental health, psychological competence and early intervention for young people and adults from a significant “at-risk” group, for example, people who have experienced significant change or specific loss due to death or family breakdown. The program is based on extensive research indicating the link between mental health, the development of life skills and the reduction of associated behavioural issues.

Although special reference is given to crisis intervention and grief counselling, the *Seasons for Growth* program does not provide counselling or therapy, but is an educative process that takes place in an atmosphere of like-to-like support. It helps young people talk about their feelings, puts them in contact with others who have experienced the same problems and provides some support during difficult times.

Through the inclusion of information and education for parents and the wider community, the program has the capacity to touch any aspect of the community and enable its members to address whatever issues are apparent in managing change and loss.

Those who enter the program are people who need it and can benefit from it; cost is no barrier, no-one is turned away; peer pressure is reduced through assurances of confidentiality and protection of information within the process. The external evaluation showed the program to be effective in being able to remove participants’ sense of isolation and allow them to express their feelings without being ashamed of them.

It is acknowledged that no one process can ever operate in isolation to reduce suicide as it is a complex phenomenon. Where *Seasons for Growth* has demonstrated a successful approach is in the provision of an early system of safety, opportunities for identification and referral, and lessening of vulnerability. The whole approach is to provide knowledge and the skills and attitudes that make a significant contribution to the emotional and mental wellbeing of young people and adults. The program in its current form also contributes to strategies against suicide through its post-vention approach. Where other professional services are available, the professional training of the *Seasons for Growth* personnel means that at-risk young people are appropriately referred on.

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Further Information

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Evaluation of Seasons for Growth

The following information has been extracted from the evaluation reports by consultants Denis Muller & Associates, in collaboration with Irving Saulwick & Associates.



The National Youth Suicide Prevention Strategy funded an external, independent evaluation of Seasons for Growth. Conducted in 1998–1999, it contained both qualitative and a quantitative elements. The qualitative component was based on in-depth interviews conducted at 15 sites where the program is offered. The sites included Catholic, independent and government primary and secondary schools. The quantitative component was based on a survey of 220 randomly selected sites across Australia, where the program had been operating for at least one year. Each site was sent one questionnaire for each respondent category, of which there were five: gatekeepers, companions, parents, primary school student participants, and secondary school student participants. Criteria selected for evaluation were reach, access, acceptability, efficacy, personnel, scope and resources.

Are the people reached by the program the ones it is designed to help?

Denis Muller & Associates, in collaboration with Irving Saulwick & Associates (1998) found that those who enter the program need it and can benefit from it.

“I thought it was excellent. I dealt with a lot of stuff that I’d tried to push away because I found myself always trying to help other people and hadn’t dealt with my own stuff.”
(Senior secondary girl)

Are the people for whom it is designed to help reached by the program?

However, the authors also found that many young people who need the program and could benefit from it but who are not included. There are three main reasons for this: needy children can be hard to identify; there is some resistance from parents; and young people feel the need not to be different from their peers.

Barriers to access included lack of resources to run more groups and a perceived lack of knowledge about the program among sections of the population who would likely benefit from it.

Is the program seen to be acceptable for its purposes by the young people in it, their parents, and management of the school or agency?

Participants completed the program with a more positive attitude than that with which they began, and it made them feel better about themselves. Nearly all companions believed their work was highly valued, and nearly all parents thought the program was a good idea. The program is regarded enthusiastically by the management of schools and agencies in which it is being offered.

Efficacy of the program

The evaluation aimed to determine whether participants, parents, companions and agency/school managers saw the program as making a positive difference to those who undertake it.

Parents, companions, school principals and agency managers believe without exception that the program is beneficial to participants.

Young people who have been through the program said that it was beneficial. Participants said that the program had: removed their sense of isolation; allowed them to express their feelings without being ashamed of them; let them see that other young people had troubles as bad as, if not worse than, their own; and helped them develop trust in others.

“I got it out of my system.” (Primary boy)

“It made me feel better.” (Primary boy)

As a result, many said they had been able to: seek support, when necessary, from the companion outside the formal processes of the program; form friendships and support networks with others in



the program; communicate better with their parents or siblings; understand that life moves on and that changes do happen; and cope better with their emotions.

Denis Muller & Associates, in collaboration with Irving Saulwick & Associates (1998) express the view that the program could be extended to cater for children who experience grief through losses other than death, divorce or separation. However, the majority of companions would prefer to see the program continue with its current focus. A parallel program for parents and carers of participants would be widely welcomed by parents, school principals and agency managers.

Personnel

The evaluation also asked the following questions: Are the selection, training, support and in-service provisions for personnel adequate? Are there enough people to do the job?

The majority of gatekeepers perceived the companions in their school or agency to personally well-suited to the work. Some companions and trainers found the training to be adequate. Some companions, even if experienced, were experiencing a sense of isolation. It was concluded that the program needs to develop a more comprehensive reconnecting, debriefing and peer review process for its companions.

Could Seasons be broadened into an intervention strategy for combating youth suicide?

Most companions and site coordinators thought that Seasons could and does contribute to reducing the incidence of youth suicide in that the program provides: an early system of safety; opportunities for identification and referral, and lessening of vulnerability.

Could its scope be broadened to reach young people with a wider range of problems?

The use of Seasons in wider social circumstances is more controversial. Adult respondents felt that consideration could be given to extending the scope of the program to other forms of loss affecting young people, but if it were extended in this way, it was felt that it should be run separately, and that companion training would need to be expanded considerably. A clear majority of companions (63 per cent) would prefer to see the program continue with its present focus.

Is the program adequately resourced to meet its current, and possible future, objectives?

The observations made about the other criteria have resource implications. There are budgetary constraints for some users of the program, particularly in providing

release time for teachers to companion a group of children. More resources are needed at the management level to support the continued implementation, consolidation and quality control of the program.

Conclusion

Evaluators concluded that *Seasons for Growth* met a critical need and was effective. It was recommended that the program with its high quality materials, continue to be delivered to additional sites, particularly to areas of need and that the program be revised to update it.

It was further recommended that the resourcing of the program in existing sites be examined with a view to providing a level of assistance such that every child who wishes to join the program can do so without cost to the family. It was also recommended that additional management resources are needed to effectively monitor and support the existing program, and to cope with anticipated strong demand for new sites and expansion in existing sites.



**"I thought it was excellent. I dealt with a lot of stuff that I'd tried to push away because I found myself always trying to help other people and hadn't dealt with my own stuff."
(Senior secondary girl)**

It was recommended that consideration be given to extending the scope of the current program to other forms of loss affecting young people and to developing a parallel program for the parents and carers of young participants.

In response to the recommendations arising from the evaluation, the MacKillop Foundation has received funding from the Commonwealth Government for national infrastructure support and marketing. This funding has contributed towards the appointment of a national coordinator to assist in strengthening support systems and widening the communication processes with sites. The funding will also contribute towards the revision of the program, its printing and marketing phases. This financial assistance forms is related to the approach being taken by the Commonwealth Government to promote partnerships and create a national infrastructure framework for government and non-government agencies in the area of early intervention in mental health.

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Youth resilience in foreign lands

The rise in suicide among young people, especially young men, has been a growing and alarming international trend. Deaths from suicide now exceed those from motor vehicle accidents, and suicide is currently the leading cause of death in young people in Australia (Baume 1996).

Although the overall rate of suicide in Australia has remained constant for 100 years, the rate of suicide for young men has tripled since 1960 (Victorian Government 1997). According to the Victorian Suicide Prevention Task Force (Victorian Government 1997), most young people successfully negotiate the transition from adolescence to become well-adjusted adults. However, the Task Force noted a decline in the wellbeing of young people in the last 30–40 years, as indicated by the following:

- major depressive illness is becoming more widespread among the young in western societies;
- self-inflicted injuries have risen substantially, especially among young women aged 15–29 years;
- illicit drug use and alcohol use are more prevalent among the young, particularly young men, and contribute to the increase in depression;
- excessive dieting and eating disorders, such as anorexia nervosa, have increased among teenage women; and
- employment opportunities for young people have reduced significantly, with those under 30 years of age representing just under half of all unemployed people.

In response to findings indicating mental health difficulties among young people, concerted action has been taken to address this issue at both national and state levels. Advisory Bodies have been formed to oversee policy development, funding and resource allocation and development of targeted suicide prevention initiatives (Mitchell 2000). In terms of suicide among non-English-speaking background (NESB) young people, “little research has been done in this area” (Cantor, Neulinger, Roth and Spinks 2000).

Likewise, while some suicide prevention initiatives have focused on NESB young people, there appears to be a significant under-resourcing of initiatives targeting this population. For instance, in the first National Stocktake of Youth Suicide Prevention initiatives, it was found that only 1.6 per cent of all projects focused on the NESB population (Mitchell 1999). However, the ABS Census (ABS 1996) indicated that NESB young people represented 15.9 per cent of the population of young people aged 15–24 years.

At a national level, analysis of suicide deaths indicates that 25 per cent of suicides are among the immigrant population, with 60 per cent being from NESB (Cantor et al. 2000; Hassan 1995;



Kyrios 1994). At a New South Wales state level, nearly 27 per cent of suicide deaths are among the immigrant population, with 57 per cent being from NESB (McDonald and Steel 1997). However, significant gaps in the available evidence on immigrant suicide limit informed discussion and action in the area of suicide prevention for NESB young people (Dusevic and Baume 2000).

Immigrant suicide deaths data

Most research on immigrant suicide in Australia occurred during the 1960s and 1970s (Burvill, McCall, Stenhouse and Reid 1973a; Whitlock 1971). However, the pattern of immigration and suicide has changed dramatically since then. Whereas earlier immigrants came from the United Kingdom and Western Europe, during the last two decades there has been a greater influx of Asian immigrants.

In response to the absence of data, McDonald and Steel (1997) examined suicide deaths and attempts data in New South Wales in order to obtain a quantitative profile on NESB suicide.

McDonald and Steel (1997) reported that in general the NESB population in New South Wales had a similar or lower rate of suicide risk than the state average. However, after the age of 65, the immigrant population had a significantly higher rate.

Overall, McDonald and Steel (1997) found that overseas-born NESB young people in the 15–24 age range had lower rates of suicide than the state average, the Australian born and those born in English-speaking countries.

In terms of gender effects, they found that NESB males aged 15–24 had a lower rate of suicide than the average rate for males in that age range. Females, on the other hand, had similar rates to the average female rate in that age range. NESB males had a higher suicide rate than NESB females.

Figure 1 and Table 1 depict McDonald and Steel’s (1997) findings on age-specific suicide rates by people of non-English-speaking backgrounds. However, the nature of coroners’ data means that suicide data on second generation (and beyond) immigrants is not included in the statistics on NESB immigrant populations. Deaths data is only collected on “country of birth”, meaning that there is no data on suicide among the Australian-born children of immigrants (Kyrios 1994). Consequently, current suicide data does not provide an accurate picture of suicide among NESB young people beyond the first generation of overseas born.

In terms of examining differences among specific non-English-speaking communities, small sample sizes preclude a detailed exploration of this issue. However, it may be reasonable to assume that “some immigrant groups of young people have higher suicide rates than the Australian-born and others lower, as has been found for all ages” (Cantor et al. 2000: 78).

To compensate for small sample sizes, an analysis of cultural differences was undertaken by McDonald and Steel (1997) by grouping the data into regions, with the results depicted in Table 1. Young people from the Middle East, Northeast Asia, Southern Europe and Southeast Asia had lower suicide rates than the state average and the Australian born population. However, young people from Western Europe and Eastern Europe had suicide rates that were higher than the state average and that of the Australian-born population.

Immigrant suicide attempts data

Figure 2 depicts the age-specific rates of attempted suicide resulting in hospitalisation documented by McDonald and Steel (1997). In terms of attempted suicide among young people aged 15–24, NESB females had lower rates than the average female rate in that age range. NESB males had the lowest rates overall, in comparison to the average male and female rates in that age range. NESB females had a much higher rate than NESB males.

However, suicide attempts data needs to be interpreted cautiously given the various methodological limitations (McDonald and Steel 1997). Those attending a hospital following a suicide attempt are only a relatively small proportion of those attempting suicide. It has been estimated in New South Wales that approximately 20–50 per cent of people who attempt suicide receive hospital treatment as a result of the attempt (Sayer, Stewart and Chipps 1996). Whether there are ethnic differences in the proportion of all suicide attempts receiving hospital treatment is unknown. There is also evidence documenting the under-use of health services, particularly mental health, by NESB populations (McDonald and Steel 1997; Minas 1991; Minas, Lambert, Kostov and Boranga 1996). These factors make any analysis of immigrant suicide attempts data difficult (McDonald and Steel 1997) and difficulties are compounded by deficiencies in the collection of ethnicity data by service providers (McDonald and Steel 1997; Trauer 1995).

Figure 1. Age-specific rates of suicide by NESB New South Wales residents (1979–1992)

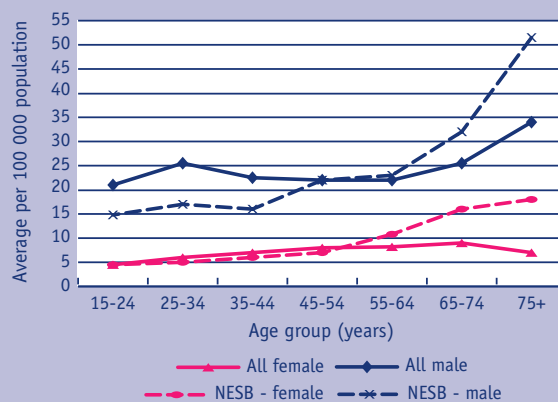


Figure 2. Age-specific rates of attempted suicide resulting in hospitalisation (1988/89–1993/94)

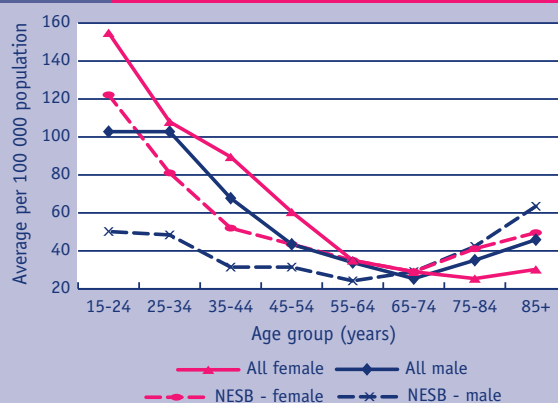


Table 1. Mean age-specific rates of suicide per 100 000 in NSW by region of birth (1979 to 1992) and in selected countries of birth¹

Place of birth	Age group (years)			Ratio of rates for 75+ years to 15-24 years
	15-24	65-74	75+	
Rates in NSW				
ALL	12.79	16.53	17.27	1.35
Australia	12.98	15.56	14.95	1.15
English-speaking countries	15.66	14.43	18.73	1.20
Non-English-speaking countries	9.42	24.13	32.44	3.44
Southern Europe	7.69	25.13	23.30	3.03
Western Europe	19.58	22.77	40.28	2.06
Eastern Europe	24.64	44.83	60.30	2.45
Middle East incl. Egypt	5.87	15.64	33.76	5.75
Southeast Asia	8.65	9.06	9.84	1.14
Northeast Asia	6.80	23.47	37.42	5.51
Rates in Country of Origin				
New Zealand	19.28	13.68	26.81	1.39
England/ Wales ²	5.77	11.54	11.35	1.97
Scotland	9.36	10.76	10.79	1.15
Italy	3.26	17.67	24.50	7.51
Greece	3.74	6.86	11.25	3.00
Former Yugoslavia	8.96	41.28	62.30	6.95
Former Democratic Rep. of Germany	10.32	47.17	94.80	9.18
Austria	16.21	36.23	54.49	3.36
Former Czechoslovakia	8.50	33.60	53.36	6.27
Hungary	17.52	81.86	110.66	6.31
Poland	10.57	16.63	15.71	1.49
Hong Kong	5.91	34.11	52.05	8.81

¹All rates in country of origin are for 1987 except for Austria (1988), Former Dem. Rep. of Germany (1989), Greece (1986) and Malta (1988)

²England and Wales combined because data is aggregated in WHO published figures

Source: WHO World Statistics Annual

Given that prior suicide attempts are one of the best predictors of suicide (Diekstra 1993; Gunnell and Frankel 1994), limitations in immigrant suicide attempts data poses a number of challenges. First, current information on immigrant suicide attempts may not give a complete picture of the extent of the problem. Second, the absence of accurate data poses a challenge to the development of initiatives targeting NESB young people at risk.

Identification of modifiable risk and protective factors

The available data on suicide behaviour among young people from non-English-speaking backgrounds imposes serious limitations on the identification of the risk and protective factors that may be operating. Yet the identification of such factors is crucial to the development of targeted suicide prevention initiatives (Beautrais 2000; Patton and Burns 2000).

McDonald and Steel's (1997) data on immigrant suicide behaviour indicates lower suicide rates among overseas-born young people in comparison to the average rate for that age group. The protective factors contributing to these lower rates are unknown, with research needed to explore these factors to allow their incorporation into mainstream suicide prevention initiatives targeting young people. Analysis of cultural differences, however, indicates a diversity, with some groups of overseas-born NESB young people having higher than average rates (McDonald and Steel 1997). The risk factors, which may be operating in these sub-groups, are unknown. The finding of diversity in rates also cautions against assumptions of homogeneity among NESB young people and highlights the need for tailored approaches.

Incidence and prevalence of mental health problems

In terms of risk factors operating among the general population, researchers have documented the strong relationship between mental illness and suicide (Baume et al. 1998; Beautrais 1998; Goldney 1991; Mason 1990; Pirkis and Burgess 1998; Tiller, Krupinski, Burrows, Mackenzie, Hallenstein and Johnstone 1997).

There have been serious limitations in data exploring mental disorders in the immigrant population. The recent National Survey of Mental Health and Well Being (Andrew, Hall, Teeson and Henderson 1999), reported that NESB participants had lower rates of mental health problems than the general population. However, participants with language difficulties were excluded from the study limiting its generalisability. Similar methodological issues limit the findings of studies exploring psychopathology among NESB young people (for example, Klimidis, Stuart, Minas and Ata 1994). Consequently, the absence of incidence and prevalence data further limits the identification of NESB young people at heightened risk for suicide.

Other risk factors that have been identified as playing a potential role in suicide among young people have not been explored in the context of those from non-English-speaking backgrounds. These include risk factors such as: alcohol and substance abuse, parental psychopathology, family history of suicidal behaviour, social disadvantage, personality factors, sexual orientation, unemployment, homelessness, custody and incarceration, physical illness and disability and other negative life events (Patton and Burns 2000; Beautrais 2000).

In recognition of the unique challenges facing immigrant suicide prevention, the New South Wales Transcultural Mental Health Centre (TMHC) and the New South Wales Health Department, Centre for Mental Health, jointly funded a project to address the needs of NESB communities under the New South Wales Suicide Prevention Strategy. The aim of the project was to develop a suicide prevention program for NESB communities in New South Wales. The project adopted a "whole of life" approach.

In acknowledgement of the gaps in available evidence, the Project adopted four main evidence gathering strategies to inform the development of a suicide prevention program for NESB communities in New South Wales. These will not be presented in detail here, as they have been extensively outlined in the Project Report (Dusevic and Baume 2000).

The four main evidence-gathering strategies were:

- Review of the international literature on immigrant suicide and suicide prevention.
- Review of quantitative data on New South Wales NESB suicide deaths and attempts.
- Review of NSW, National and International suicide prevention initiatives targeting this population.
- Analysis of quantitative and qualitative information obtained from keystakeholders through: survey, questionnaire, focus group consultations and workshop consultations.

In examining available evidence, some of the areas reviewed by the Project included: modifiable risk and protective factors; evidence for the effectiveness of suicide prevention initiatives targeting this population; current initiatives focused on NESB populations and the implications of these findings for the development of suicide prevention initiatives targeting NESB immigrant populations.

In terms of the evidence developed by the Project, the following data was obtained:

- Key stakeholder survey: baseline measures of initiatives in policies, education packages and suicide prevention initiatives targeting NESB communities in New South Wales.
- Key stakeholder questionnaire: baseline measures of knowledge, attitudes and experiences among key stakeholders regarding NESB suicide and suicide prevention issues.
- Key stakeholder consultations: information regarding how the problem of suicide in NESB communities is perceived and possible actions that could be used to prevent it.

On the basis of the findings, the Transcultural Mental Health Centre formulated its strategic directions in the suicide prevention area. In recognition of a "whole of community" approach required for effective suicide prevention, future initiatives will be developed in collaboration with young people from non-English-speaking backgrounds, as well as other key stakeholders such as local, state and federal government, non-government and community organisations. It is only by addressing the needs of culturally and linguistically diverse communities, that we can move towards equitable and effective suicide prevention.

Dissemination of the Project's findings will be guided by an information dissemination plan, including presentations at the upcoming *Diversity in Health: Sharing Global Perspectives 2001 Conference* occurring at the Sydney Convention and Exhibition Centre, Darling Harbour, Sydney on 28–30 May 2001.

For further information on the Project, contact Ms Neda Dusevic, NESB Suicide Prevention Project Manager, NSW TMHC. Phone: (02) 9840 3800.

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New course in prevention studies

The Australian Institute for Suicide Research and Prevention is offering a Graduate Certificate in Suicide Prevention Studies (subject to University approval) which will commence in semester 1, 2001.

This course is specifically designed for people working in human service occupations who seek to acquire the basic knowledge and skills necessary to work with suicidal people. It will provide students with a scientific analysis of the phenomenon of suicide along with the practical expertise required to identify, assess and intervene in suicidal behaviour. In particular, students will be encouraged to develop an awareness of the dimensions of evidence-based practices in contemporary suicide prevention.

The Graduate Certificate in Suicide Prevention Studies is a part-time 40 Credit Point course offered through Griffith University's Mt Gravatt Campus, Brisbane. The course will be taught over five full weekend sessions and completion of the course is expected to take one year.

For further information or application packages, contact the Postgraduate Student Service Centre. Phone: (07) 3875 5958. Fax: (07) 3875 5838. E-mail: psscmsg@mailbox.gu.edu.au

Awareness and use of the Kids Help Line service

Wendy Reid



This article presents the results of an independent evaluation of the Kids Help Line telephone counselling service – its reach, service response and service accessibility. It provides information on young people’s awareness of, expectations of, access to, and experience in the use of the service. It also reports on the impact of two promotional campaigns designed to increase awareness of Kids Help Line.

Kids Help Line is a telephone counselling service providing young people with 24-hour access to trained counsellors. It is a service to build, support and enhance resiliency and coping in young people across a range of issues. Under the National Youth Suicide Prevention Strategy, Kids Help Line was funded by the Commonwealth Government to provide an improved service to young people and to make them more aware of the service.

Methods

Kids Help Line is an Australia-wide service. The major methodological challenge was to obtain and analyse information reflecting the breadth and diversity of actual and potential service users, while at the same time examining more closely a number of quite specific questions and issues.

The evaluation has made use of very broad data, drawing on total service contact and response data over several years, and selectively sampling specific groups for quantitative and qualitative study.

The sampling of specific groups was undertaken with a view to ensuring both integrity of data and adequate coverage of potential service users. Selective samples included callers from regional Western Australia and the Australian Capital Territory including Queanbeyan and Cooma, the entire student population of a large and culturally diverse Brisbane high school, and groups of young people identified as being at high risk because of a history of mental illness or homelessness.

Awareness

The awareness and knowledge young people had of services provided by Kids Help Line was evaluated by means of a survey of 1644 high school students in Brisbane. Ninety-four per cent of the students had heard of Kids Help Line, most as a result of

exposure to advertising. More than 80 per cent of the young people were aware that the service was free, anonymous and that it operated 24 hours a day, seven days a week.

The young people had a clear knowledge of the kinds of services provided with 86 per cent stating that Kids Help Line would respond to a young person who needed help because of suicidal thoughts.

Three quarters of the sample said that they would consider calling Kids Help Line if they had a problem. Males were less aware and knowledgeable than females. Young people of Asian background, both male and female, were less aware and knowledgeable than other Australians. Overall, the level of awareness of Kids Help Line, including awareness of its role in suicide prevention, was very high, and most young people were prepared to use the service if they needed help.

Expectations

The high school survey was also used to determine expectations of young people concerning the Kids Help Line service. As well, a series of focus groups involving both high-risk and lower-risk young people was run.

Young people had a clear expectation that Kids Help Line would provide assistance to callers experiencing suicidal ideation. Kids Help Line was rated as equal to friends and markedly higher than school counsellors or health professionals as a potential source of support for young people experiencing thoughts of self-harm.

Young people in focus groups expected counsellors taking calls from suicidal young people to listen, clarify problems, persuade callers not to suicide, assist with problem solving, and provide an objective perspective. They did not expect counsellors to make referrals except in very limited circumstances.

Access

Access to Kids Help Line was evaluated through analysis of “calls attempted” and “calls answered” data over a two-year period both before and after new equipment had been installed and increased counsellors became available (as a result of Commonwealth funding under the National Youth Suicide Prevention Strategy). Service users were also asked about any difficulties they experienced reaching the service.

There was an increase of 24 per cent in the number of young people connected to counsellors during the 12-month period following the introduction of new equipment and the appointment of additional counselling staff when compared with the preceding twelve months.

However, there was little change in the proportion of calls answered (46–48 per cent). The reason for the static rate of



call–response was that there was an approximately 18 per cent increase in total number of calls in the 12-month period following funding, compared with the previous 12-month period and some increase in average call duration.

Results from the callback survey suggested that approximately one third of callers had got through to a counsellor immediately, while two thirds had waited in a queue for an average of eight minutes. A total of 12 per cent hung up and called back before getting through.

Satisfaction with counselling

Satisfaction with Kids Help Line was evaluated through a callback survey during which young people who had received counselling were independently interviewed at the end of the counselling session to find out about their experience of the service provided by the telephone counsellor. Respondents to the High School survey who stated that they had used the service were also asked to provide information about their experience.

The callback survey revealed that young people who had just used the service believed that they were taken seriously by their counsellor, were given sufficient time to explore their problem, felt better at the end of the call, and would recommend the service to a friend.

Overall, callers were very satisfied and reported positive and helpful experiences. Of the 50 respondents from the High School survey who reported having called Kids Help Line, the large majority reported that they felt listened to, and around two thirds reported that they had felt understood and that the experience had been helpful.

Impact of advertising

The impact of advertising and promotion was evaluated by analysing service-use data from two regional areas before and after local television campaigns and through a metropolitan survey of bus users and non-bus users in relation to two promotional posters located inside buses.

There were marked differences between regions with respect to impact of advertising. The greatest impact was in regional Western Australia (Kimberley, Pilbara, Wheat Belt and Goldfields), which experienced an increased call rate of nearly 50 per cent for the 12-month period following a television advertising campaign. Much of the increase was associated with requests for information rather than counselling; there was no increase in suicide calls. By contrast, after the same television campaign, there was little change in the rate of total calls from ACT/Queanbeyan/Cooma. In metropolitan Brisbane, during a bus advertising campaign, bus-users had a marginally higher level of awareness of the Kids Help Line service than did non-users. While statistically significant, the relationship between bus use and awareness was trivial. The use of buses to promote Kids Help Line appeared to have little impact on service awareness, probably because awareness was already near saturation level.

Evaluation recommendations

Evaluators, Dr Robert King and Professor Barry Nurcombe from the Department of Psychiatry, University of Queensland, and Professor Len Bickman, Centre for Mental Health Policy and Research, Vanderbilt University, USA, made the following recommendations.

The current level of promotion is sufficient to develop and maintain a high profile for, and accurate knowledge of, Kids Help Line. This level of promotional activity should be maintained to ensure that each age cohort knows about the service.

Future special advertising campaigns should target high-risk groups and regions or demographic groups with low usage or where there are few alternative sources of help for young people. Campaigns such as the Bus campaign lack impact because they provide a general message to a non-specific and saturated market. While there is need to maintain service awareness in major centers, a greater proportion of the advertising budget should be allocated to targeted advertising. Specific groups that could be usefully targeted include young people in more remote parts of regional Australia, adolescent boys and young people, both male and female, of Asian ethnic origin.

The High School survey in either its present form or a modified form should be undertaken in a range of schools in metropolitan and regional Australia to obtain a more complete picture of adolescents' awareness and knowledge of Kids Help Line. It would be of particular value to target areas with substantial indigenous populations. The administration of these surveys will facilitate better-targeted promotional activity.

Despite increased staffing and improved facilities, service access remains a significant problem. Approximately half the callers hang up before speaking with a counsellor and many of these (including high-risk people) may not call back. In order to address this problem, further counselling staff should be employed. In the absence of additional promotional activity, service usage should plateau with the result that further increases in rostered hours of counselling will enable higher rates of call response. Secondly, calls should be managed more expeditiously with a view to reducing average length of calls thereby increasing throughput for each counsellor. It was recommended that call-management be addressed through a specifically funded controlled trial, evaluating both the capacity of training to increase throughput and the impact of increased throughput on the counselling experience of young people.

It is likely that the high level of consumer satisfaction with the service reflects Kids Help Line's current service culture; particularly its child centred practice philosophy and the training and supervision of counsellors. The Kids Help Line service culture and its associated professional practices should be retained and enhanced.

Reference

King, R., Nurcombe, B. & Bickman, L. (2000), Kids Help Line Suicide Intervention Strategy Evaluation: Report 1: Awareness and Utilisation of Kids Help Line under the National Youth Suicide Prevention Strategy.

For further information about the service, see the Kids Help Line website: www.kidshelp.com.au/ Crisis line number: 1800 55 1800.

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The role of social cohesiveness in promoting optimum child development

GRAHAM VIMPANI



An understanding of the genetic and biological underpinnings of child development, while necessary, is an insufficient framework for understanding the complexity of human development. Whilst the concept of the mother–infant relationship stressed by Bowlby (1969; 1980) and Ainsworth (1978) and others (Blehar et al. 1978) is important, Bronfenbrenner’s (1979) seminal work drawing attention to the broader ecology of child development and the impact of the many different social systems that interface with the developing child is a significant advance.

The importance of this perspective within the health care professions has again been highlighted as a result of McKeown’s (1976; 1988) and Fogel’s (1994) historical analyses of the impact of the industrial revolution on health, and more recent work examining the links between socio-economic inequality

and health. McKeown, former professor of Social Medicine at the University of Birmingham, claimed that improved living conditions and nutrition had been the main cause of improved health in Britain following the Industrial Revolution rather than advances in health care; Nobel Laureate Fogel set out to disprove his hypothesis and became even more convinced of the central role of better nutrition in improved mortality throughout Europe.

The “new morbidity”

Recent concern about the impact of the massive social changes experienced in the last half century on patterns of child health and wellbeing was described as the “new morbidity” (Haggerty et al. 1975) by an eminent American pediatrician Robert Haggerty (who had undertaken a seminal study of child health status in Rochester NY in the early 1970s).

The new morbidity was reflected in new trends in the epidemiology of developmental, behavioural and learning disorders in children and young people (Garbarino 1993; Garbarino and Kostelny 1997; Osofsky 1997). These trends included self-harming behaviour in young people, which in turn widened the focus of attention beyond the family unit to the broader social environments that impinge on children and young persons – including the support and reinforcement provided to parents, children and young people by neighbourhoods, schools, friends, peers and mentors at a geographical level. It also considered the impact on the health and wellbeing of children and families of macrosystem features such as social values and public policy in general. This work mirrors broader movements within the field of public health that is reflected in documents on the broader contextual framework of health produced under the auspices of the World Health Organisation, such as the Ottawa charter (1986) and the Jakarta declaration (1997).

Social isolation

In today's mobile societies, many nuclear families are isolated not only from members of their extended family but from their neighbours. Social isolation contributes to a sense of disempowerment and alienation. Because of housing difficulties, poorer families are often amongst the most mobile, compounding the adversity experienced by their children. This breakdown in social cohesiveness constitutes a significant disruption of the pattern that has existed for most of human history, where the village clan of 50–100 people, in which women had a significant community role, and which was communitarian in its social order, had been traditionally responsible for the task of childrearing (Boserup 1981). Such structures acknowledge the fact that most primate species are social animals and flounder without social support networks, and therefore tend to form groups that can provide this support, particularly for rearing their young (Bly 1996).

Socially toxic environments

There is mounting concern that the increasing recognition of child maltreatment in all its forms, the growth in disruptive behaviour problems in children and young people, the deteriorating developmental achievements of children from many minority groups (especially those living in inner cities) and rising youth suicide rates are the modern day equivalent of the miner's canary – a barometer of what Garbarino (1995) has coined a “socially toxic” and certainly less civil environment (World Health Organisation 1986).

This environment is marked by a breakdown in the effective functioning of many families, contributed to in part by the declining role of adult males in family life through both physical and emotional absence (Bly 1996). Another factor is the pervasive “famine of parental time”, and an erosion of mutually supportive social relationships (in part a consequence of high social mobility and a decline in trust). Other factors include growth in domestic and community violence (World Health Organisation 1997), demands for rights that are uncoupled from responsibilities (witness some elements of the recent debate on IVF for single and lesbian parents), and growth in various kinds of addictive behaviours.

Social wellbeing

These contemporary concerns give further weight to the argument that human wellbeing cannot be judged solely by improved economic wellbeing (as reflected in continuing growth of the GDP throughout most of this period). Other

measures of social wellbeing, such as the Index of Social Health (Miringoff 1996) or the Genuine Progress Indicator (GPI, Cobb et al. 1995) tell a less optimistic story that resonates more closely with community opinion (Eckersley 1998). Moreover, there is ample evidence that economic growth has been unevenly distributed in many industrialised societies with increasing socioeconomic inequality. There is also evidence that at least on some measures of health status, states with wider income gaps between rich and poor fare less well than those where the gaps are narrower (Wilkinson 1996).

Social capital

One concept that has emerged within this debate that has potential value as an explanatory variable for some features of the “new morbidity” and which may also give guidance about some possible ways to address the contemporary dilemma is that of *social capital*. Kawachi et al. (1997); Kennedy et al. (1996); Kaplan et al. (1996); and Wilkinson (1994) have all argued that these widening gaps have led to declining levels of social cohesion and trust, what they term a “disinvestment in social capital”. This concept has growing appeal in at least some countries (Cox 1995) and international organisations, such as the World Bank (1993), in part because in a public marketplace of ideas dominated by economic concepts, it resonates with opinion leaders and those who hold the key to the public purse.

What is particularly helpful is the analogy that can be drawn with government expenditure on other forms of capital – human (the level of education and training of individuals in a community), physical (infrastructure) – namely, that outlays to promote its growth can be considered an investment, rather than a cost. In Australia, for example, both the left (Latham 1998) and right (Smith 1998) of politics have grasped the concept, albeit with different emphases, since it first received wide exposure in the Eva Cox's 1995 Boyer Lectures (Latham 1998). While the conservatives have emphasised the importance of strengthening communities to support families as an alternative to government intervention, the left sees it as a way of challenging unhealthy aspects of economic rationalism and ensuring that social considerations have a key place in policy making whose goals include building a caring civil society that rests on the legitimacy of state intervention (Baum 1998).

Social cohesion

Social cohesion is a central element of social capital that includes “those features of social organisation, such as trust, reciprocity, norms and networks that can improve the efficiency of society by facilitating coordinated actions” (Putnam 1993). High levels of social capital contributes to a willingness to take risks in a social context based on a sense of confidence that others will respond as expected and act in mutually supportive or non-harmful ways (Fukuyama 1995), and the active and willing engagement of citizens within a participative community (Onyx and Bullen 1997). It is the very fabric of a civil society.

There is a growing body of evidence that social cohesion has considerable relevance to child health, development and behaviour. However, there are fewer studies that have analysed the relationship between the broader concept of social capital and health outcomes, and some of those that purport to do so have used definitions of social capital that could be justifiably challenged. For example, Sameroff and Seifer (1983) clearly demonstrated a link between cumulative environmental risk and cognitive development, and Coleman (1988) and Smith et al. (1992) examined the impact of several dimensions of social capital on high school completion rates.

Factors associated with low-cohesive neighbourhoods

Other work has shown that communities with less dense social networks and lower rates of social engagement experience higher rates of child maltreatment and other forms of criminal behaviour. For example Vinson, Baldry and Hargreaves (1996) found that the one outstanding difference between two adjoining economically depressed neighbourhoods with contrasting rates of child abuse was in the structure of the networks in the two areas with a relative lack of connection between the more immediate (familial) and more distant parts of the social networks in the area with the higher rate of abuse.

These are findings similar to those found in other settings previously by Salinger et al. (1983) and Garbarino and Sherman (1980) in an analysis of similarly contrasting area samples found that mothers in the higher risk neighbourhood tended to assume more exclusive and direct responsibility for child care, less frequently used children in the neighbourhood as playmates for their own children, engaged in fewer neighbourhood exchanges, made less use of neighbourhood resources and rated their neighbourhood more poorly as a place to live.

Korbin and Coulton (1995) found that poor families tended to function better in neighbourhoods characterised by markers of greater social capital – community investment, trust and organisational affiliation. Weatherburn and Lind (1998) found that child neglect was a strong predictor of juvenile crime and, drawing on the work of Belsky (1993), concluded that several of its antecedents, poverty and unemployment, were less likely to lead to child maltreatment in families that had strong social supports.

Recent analyses from the National Longitudinal Survey of Children and Youth in Canada (NLSCY) (Voyer 1999) have shown that lower socio-economic status levels lead to lower levels of social support, and poorer children are likely to have social support networks that are relatively impoverished in intellectual and cultural activities – features that are associated with poorer school attainment (Ryan and Adams 1999).

Boyle and Lipman (1999) found that neighbourhood level characteristics, in particular the proportion of one-parent families in a neighbourhood, had an impact on the prevalence of child behaviour problems over and above the impact of this feature within families; interestingly neighbourhood poverty had no additional influence beyond its individual effects within families.

Kohen, Hertzman and Brooks-Gunn (1999) found that lower cognitive scores were more common in children living in neighbourhoods characterised by a high proportion of single female-headed families; only 10 per cent of children living in neighbourhoods with 0–5 per cent single female-headed families had low cognitive competence scores compared to 22 per cent in those with the largest percentage of single female-headed households. They also found that children living in the least cohesive neighbourhoods (as measured by support provided by neighbours and perceived sense of community) were least likely to be ready for school – 27 per cent of the former obtained low cognitive competence scores compared to only 13 per cent in neighbourhoods rated high on cohesiveness. They were also more likely to obtain lower behavioural competence scores (19 per cent compared with 12 per cent).

Social capital and outcomes

Recent work has also attempted to examine a range of health and developmental outcomes against more global measures of social capital. Runyan et al. (1998) developed what they termed a social capital index comprising five separate indica-

tors – whether or not there were two parents in the home, social support of the maternal caregiver, fewer than two children in the family, neighbourhood support, and regular church attendance (as a proxy for social group membership). They examined the correlation between individual indicator measures and the global social capital index scores and whether high-risk children in a preschool sample were “doing well” or “not doing well” on the Batelle Developmental Inventory Screening test and the Achenbach Child Behavior checklist. They found a strong link between the individual indicators and, most convincingly, the global index and these developmental outcomes.

The index used in this study could be criticised from various perspectives (Vimpani 2000). For example, regular church attendance as a proxy for social group involvement may not be generalisable to other societies; the presence of two parents at home is not immediately obvious as an indicator of social capital, nor is the presence of more than two children in the home. However, it represents an important start in developing a measure of social capital that extends beyond measurement of its isolated components.

Social capital and resilience

It is also clear that some of the features known to be associated with resilience in disadvantaged children and young people are closely related to elements of social capital. For example, optimism is unlikely in the absence of trust between individuals, support from an extra-familial mentor is unlikely without a level of proactivity within neighbourhoods.

Participation in organised groups also distinguished resilient individuals from others. In the NLSCY, Jenkins and Keating (1999) found that ten-year-olds in multiple risk situations with good connections to people other than parents (teachers, friends and siblings) had much lower levels of behavioural difficulties than those with poor relationships. Interestingly, these supports were more influential in this age group than in younger (six-year-old) children; older children also benefited from multiple external supports, whereas six-year-olds only needed one.

Measurement of social capital

Some recent work in Australia is providing some useful guidance in the development of valid and reliable instruments to measure the various dimensions of social capital, including social cohesiveness. For example, Onyx and Bullen (1997) have developed and field tested a 36-item questionnaire that examines the various dimensions of social capital, elements of which are shortly to be used in a randomly selected cross-sectional survey of Australian children. The Australian federal government has also recently funded a consensus building approach to the development of an agreed set of core indicators of social and family functioning that can be used in surveys of child health and wellbeing (Zubrick 1999).

Social support interventions

There is clear evidence that interventions aimed at improving social support for families, such as that provided by extended home visiting by nurses (Olds et al. 1997) or paraprofessionals (Johnson et al. 1993), are effective in reducing maternal depression – itself an important determinant of child health status (Cox et al. 1991), child abuse, maternal self-esteem, and employment prospects and criminality in parents and children (Olds et al. 1998).

Whether they do this by improving parenting skills, in particular by strengthening attunement between mothers and their infants, or the support provided by the visitor, or by the way in which visiting enhances the growth of social networks – particularly if home visiting is combined with group activities for parents, as in the NewPin program developed in London (Tracy and Whittaker 1990) – or a combination of all of these, is not as yet clear. For despite Weiss's (1997) notion that "home visiting is the lynchpin that connects the axis of the family to the wheel of community services", none of the published evaluations of extended home visiting have examined in any formal way the impact these programs have on the strength and reciprocity of social networks, despite the availability of promising instruments (Tracy and Whittaker 1990).

... governments and others concerned about social wellbeing might contribute to enhancing social cohesiveness and contributing to a more civil society.

Initiatives

These intervention studies give some signposts to the ways in which governments and others concerned about social wellbeing might contribute to enhancing social cohesiveness and contributing to a more civil society.

Participation between residents and government agencies in building neighbourhoods that provide greater and more coordinated levels of social support to families with young children is clearly one direction (Mulroy 1997), and it is this notion that in part underlies the "full-purpose" schools movement in the United States (Dryfoos 1994). Schools involved in this movement attempt to diversify their purposes to promote a broader range of activities in support of their neighbourhood and the more successful have become a base for community development activities.

A combination of universally available family-centred and group-focused activities that encourage volunteer participation, as achieved throughout New Zealand by the Plunket society of visiting child health nurses and volunteers, and in some parts of Britain by NewPin, offers promise. Family support, preschool education and effective parent training, allied with situational prevention that modifies opportunities for crime, are known ways of preventing crime and enhancing neighbourhood safety (Farrington 1994; Karoly et al. 1998).

Indeed, it has been argued that along with poverty reduction and the development of healthy public policy, parenting is the most important public health issue facing many western societies. Thus, improved support of families with children would be one of the most effective ways whereby governments could intervene to improve social cohesiveness (Acheson 1998). The current Commonwealth Government's Stronger Families and Communities Strategy, along with other initiatives in Australia – like Families First in NSW and Parent CARE in Queensland – are steps in the right direction.

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MENTAL HEALTH OUTCOMES

Two documents released

Two documents, *Action Plan 2000* and *Monograph 2000*, developed as a joint Commonwealth, State and Territory initiative, were released in November 2000. They represent an important step to improve the mental health outcomes of the Australian population. They provide the policy and conceptual framework for promotion, prevention and early intervention for mental health – key themes of the *Second National Mental Health Plan*.

Together, the documents provide the foundation for a progressive implementation of activities for promotion, prevention and early intervention for mental health across Australia.

With this in mind, these documents have been developed for the widest possible audience – all those people who may come into contact with people at risk of developing a mental health problem or mental disorder, and all those who are generally interested in the broad concept of mental health.

- The *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health* (Action Plan 2000) presents a major and exciting new direction for improving the mental health outcomes of the Australian population. Incorporating the best scientific evidence available, it contains strategies to promote mental health, to reduce mental health problems and disorders, and to intervene as early as possible to minimise the impact of these problems in our community. Importantly, it recognises the potential for contributions from all groups in the community and provides opportunities for a nationally coordinated approach.
- The companion document to Action Plan 2000, called *Promotion, Prevention and Early Intervention for Mental Health: A Monograph*, sets out the theoretical basis and conceptual framework and discusses in more detail a number of important issues relevant to the implementation.

Ongoing feedback on the Action Plan and the Monograph is welcomed from individuals and organisations with an interest in promotion, prevention and early intervention for mental health. You are invited to contribute your feedback in the following ways:

- Complete the feedback form included at the back of each document.
- Lodge your feedback through the website at <http://auseinet.flinders.edu.au>
- Take part in a discussion forum in your state/territory. These will take place during mid-2001.

To order: visit www.mentalhealth.gov.au, or phone 1800 066 247; or (08) 8357 5788.

REVIEW

Creating Girl X

Creating Girl X is a beautifully illustrated diary of an imaginary Year 12 student, who works through her friends' issues of depression, grief, drugs, smoking, sexuality, war, racism and school pressures, but with hope for the future.

Creating Girl X combines the ideas, poetry and art of more than 50 young people living in Geelong, Victoria. Girl X represents the voices of the young people and she reassures them that it is okay to express despair, connect with friends and seek help.

Girl X describes depression: "I was drained of strength, incapable of emotion, dead emotionally, and plagued by a constant fear of being alone. What is the point? You live, accomplish nothing and then die. Everywhere I go, I look into people's eyes and search for something that is not there."

She equates sex with exploitation: "I'm tired of watching everyone else falling in and out of relationships - intoxicated sex and empty promises. I made a stupid mistake at a party, I want sex to mean something, unlike many of my friends who feeling already spoiled and let other people use their bodies. You watch sex on TV, hear it on the phone, read it in all the mags, get sent it by Email. It's not special anymore."

She talks about the pressure to be dangerously skinny: "There are glorified teenage expectations of what to wear, how to be an individual and fit in, and who to like. All everyone wants is to find the one person in the world, who understands them perfectly and will accept them for who they are – their soul mate."

She understands why young people take drugs: "Without this emotion or in fact any emotion, the world would be stricken and run by a wave of mechanical emptiness, intoxicated by a never-ending supply of illicit substances. A world such as this often serves as an escape from reality which is ridden with unhappiness and sorrow."

But Girl X also rethinks the problems and works through a creative message of hope.

Leanne Rowe, Clinical Director of Clockwork, says that the process of consultation with local young people was an important as the final book, and this process needs to be replicated in other communities.

Creating Girl X can be obtained by sending \$24.80 (including postage and GST) to Clockwork, PO Box 915, Geelong 3220.



LITERATURE HIGHLIGHTS

The following selections from recent additions to the Australian Institute of Family Studies library collection may be borrowed via the interlibrary loan system. Please contact your own library to arrange loans. Thanks are due to the Institute's *Australian Family & Society Abstracts* database for the Australian entries.

ABORIGINAL CHILD REMOVAL

The stolen generation: psychological effects of the systemic removal of Indigenous children from their families and culture, by B. Stevens & V. Bushell, *Ethos*, no. 178, Jun 2000, pp. 17-19.

In 1997 the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families: Bringing Them Home documented the circumstances and effects of 150 years of systemic removal of Indigenous children from their families and community and into missions, white adoptive families and foster homes. This article discusses the psychological effects of this removal of children from their families and culture. Risk factors such as substance abuse, criminal behaviour, suicide, abuse and domestic violence are identified and a case study is presented of an Aboriginal man who spent his childhood in institutional care.

ABORIGINAL FAMILIES

Evaluating Aboriginal empowerment programs: the case of Family WellBeing, by K. Tsey & A. Every, *Australian & New Zealand Journal of Public Health*, vol. 24, no. 5, Oct 2000, pp. 509-514.

Relative powerlessness has long been recognised as a major factor shaping Aboriginal health. This article evaluates the effectiveness of a Family WellBeing empowerment course. It was found that participation in the program resulted in high levels of personal empowerment. The course enhanced participants' sense of self worth, resilience, ability to reflect on causes of problems and problem solving ability. Participants felt that they were able to bring about modest, but significant, improvements in their general sense of well being. There was no evidence, however, of organisational and community empowerment. The effectiveness of this program shows the importance of resourcing Aboriginal people to develop their own programs that address trauma and other issues. The study highlights the following lessons for the use of empowerment interventions to improve health conditions, particularly among socially disadvantaged groups: a need to adopt an ecological approach that simultaneously addresses empowerment in multiple settings; a need to ensure that such programs reach a critical mass of the target group; and for policy makers and practitioners to take a longer term approach to empowerment interventions. (Journal abstract, edited)

CHILD SEXUAL ABUSE

History of physical and/or sexual abuse and current suicidality in college women, by R. Thakkar, P. Gutierrez & C. Kuczen, *Child Abuse & Neglect*, vol. 24, no. 10, Oct 2000, pp. 1345-1354.

This study examines the relationship between a history of physical and/or sexual abuse and current suicidality in college-age women. The study also looks at the relationship between abuse status and attitudes about life and death.

BEREAVEMENT

Predictors and correlates of bereavement in suicide support group participants, by J. Callahan, *Suicide & Life-threatening Behavior*, vol. 30, no. 2, Summer 2000, pp. 104-124.

This study examined the associations between demographic factors, circumstances surrounding the suicide, and overall levels of grief (using the Grief Experience Questionnaire) for a sample of survivors of suicide. All were participants in suicide support groups. It was found that the most significant predictor of high levels of distress was seeing the body at the scene of the death. Support from family and friends proved to be the strongest protective factor. Results suggest that a model that combines posttraumatic reactions and grief would be the most appropriate way of helping the survivors deal with the aftermath of suicide.

BULLYING

Persistence of bullying from childhood to adolescence - a longitudinal 8-year follow-up study, by A. Sourander, L. Helstela & H. Helenius, *Child Abuse & Neglect*, vol. 24, no. 7, Jul 2000, pp. 873-881.

The objective of this study was to examine the factors associated with bullying and victimization from age 8 to 16. It was found that if bullying and victimization were still happening at age 16 it was associated with a wide range of psychological problems at both age 8 and age 16. It is suggested that preventive measures should be targeted at those children who are characterized by both psychological disturbance and bullying.

CHOOSING LIFE

Why young people do not kill themselves: the Reasons for Living Inventory for Adolescents, by P. Gutierrez, A. Osman & B. Kopper, *Journal of Clinical Child Psychology*, vol. 29, no. 2, Jun 2000, pp. 177-187.

A group of 206 (101 boys and 105 girls) adolescent psychiatric inpatients completed the Reasons for Living Inventory for Adolescents (RFL-A), Minnesota Multiphasic Personality Inventory for Adolescents and a packet of self-report measures. Additional information, including diagnosis and suicide status, were obtained from the patient's medical records. It was determined that the RFL-A is

a valid and reliable measure of adolescent suicide risk potential and that it possesses better predictive power than the Beck Hopelessness Scale. The clinical and research utility of the RFL-A is discussed.

COMMUNITY DEVELOPMENT

Building communities that strengthen families: elements of effective approaches, by D. Scott, Seminar paper presented at the Australian Institute of Family Studies seminar series, 16 November 2000, Online only <http://aifs.org.au/institute/seminars/scott.html>

The author of this paper states the belief that we now have the conceptual and empirical components of a strong foundation for developing programs aimed at family strengthening and community building. She outlines these components, gives examples of what she sees as promising programs, and then draws the common ingredients from these programs and identifies some of the challenges such programs face in 'going to scale'.

Building healthy individuals, families, and communities : creating lasting connections, by D. Collins & T. Noe, New York, London, Kluwer Academic/Plenum, c2000, xiii, 112 p., ill., 24 cm.

This book addresses the problem of substance abuse prevention. It describes a program called "Creating Lasting Family Connections" which was designed as a community-based program focussing on increasing community, family and individual protective factors which could reduce substance abuse among at-risk 12-14 year-olds. The book draws upon the large body of knowledge which is available today about how to reach and influence youth and help families build resiliency.

Communities that care: a prevention approach to build the resilience of young people in our communities: report of the study visit of Communities that Care initiatives in the US and UK, by G. Fiske, Melbourne, Vic, Youth and Family Services Division, Department of Human Services, 2000, 58p and Online (390K) <http://hnb.dhs.vic.gov.au/4A2567300007C6E7/BCView/69515FC53AD8FD954A2568DB0011285C?OpenDocument>

Communities That Care (CTC) is a local community-based prevention strategy that aims to bring together community leaders and agencies to work on preventing social problems including drug abuse, juvenile delinquency and crime, depression and homelessness. The strategy is based on more than 10 years of research into the social factors which exist in the community that place young people at increased risk of developing problem behaviours during their adolescence. It is being applied successfully in more than 400 communities in the United States and is being trialled in the United Kingdom. The report gives the reader an overview of the context for the Communities That Care development, current overseas policy and program implementations of Communities That Care by government and other agencies, and the evaluation of the Communities That Care effectiveness by funding and other bodies.

These selections from recent additions to the Australian Institute of Family Studies library collection may be borrowed via the interlibrary loan system. Please contact your own library to arrange loans.

Communities That Care prevention strategies : a research guide to what works, Developmental Research and Programs, Inc., Seattle, WA , Developmental Research and Programs, Inc., c2000 xviii, 171 p., 28 p.

The Communities That Care program uses research-based tools to help promote the positive development of children and youth and aims to reduce at-risk behaviors in young people.

CONFLICT

The effects of parental conflict on later child development, by K. Schmidtgall, A. King & J. Zarski, *Journal of Divorce & Remarriage*, vol. 32, nos. 1/2, 2000, pp. 149-157.

This study examines the relationship between family conflict and depression in female adult children of divorced parents. A significant relationship was found between parental conflict and depression in the adult female children of the marriage.

CROSS CULTURAL DIFFERENCES

Ethnicity, gender, self-esteem, and coping styles: a comparison of Australian and South-East Asian secondary students, by L. Neill & M. Proeve, *Australian Psychologist*, vol. 35, no. 3, Nov 2000, pp. 216-220.

South-East Asian secondary students studying in Australia experience the transitional experiences of adolescence and of studying in a foreign country. An understanding of differences in coping styles between Australian and South-East Asian secondary students may be important for providing appropriate support for South-East Asian students studying in Australia. The association of ethnicity, gender, and self-esteem with the use of different coping styles was investigated in 63 South-East Asian and 63 Australian students in two Australian secondary colleges, using the Adolescent Coping Scale (Frydenberg & Lewis, 1993a). South-East Asian students reported greater use of the reference to others coping style than Australian students. Students with low levels of self-esteem reported using nonproductive coping to a greater extent than students with moderate and high levels of self-esteem. There were no gender differences in the use of coping styles, or interactions between ethnicity, gender, and self-esteem. An implication of the study is that South-East Asian students should be supported in using the coping style of reference to others. (Journal abstract)

Suicide among adolescents and young adults: a cross-national comparison of 34 countries, by G. Johnson., E. Krug & L. Potter, *Suicide & Life-threatening Behaviour*, vol. 30, no. 1, Spring 2000, pp. 74-82.

This survey of suicides among 15-24-year-olds in 34 of the wealthiest nations demonstrated that 15,555 youths killed themselves in a 1-year study period. Thirty-four percent of these suicides were firearm-related. There was an association found between divorce rates and youth suicide rates. For a smaller sample of countries, an association was found between firearm availability and firearm-related suicide rates among youths.

DOMESTIC VIOLENCE

Psychiatric disorders in adolescents exposed to domestic violence and physical abuse, by D. Pelcovitz, S. Kaplan & R. DeRosa, *American Journal of Orthopsychiatry*, vol. 70, no. 3, Jul 2000, pp. 360-369.

This study examines the relationship between physical abuse and psychiatric diagnoses in two groups of physically abused adolescents. It was found that adolescents who were physically abused, and lived in homes where they were exposed to domestic violence, were at greater risk for a variety of psychiatric disorders than physically abused adolescents who were not exposed to domestic violence. The first group were particularly vulnerable to anxiety and depression.

DRUG ABUSE

Drugs in perspective: get real, by W. Rosevear, *Social Alternatives*, vol. 19, no. 3, Jul 2000, pp. 8-12.

In his role as a doctor working in alcohol and drug recovery and prisoner health, the author raises concerns about the National Tough on Drugs Strategy, arguing that it is making the situation worse not better. Issues discussed include: death from drug overdoses; drug related crime; imprisonment rates for drug offenders; drug use in prison; stigmatising drug use; suicide risk; illegal versus illegal drugs; Swiss Heroin Trials; Naltrexone; and legalising all drugs. Recommendations which focus on the legalisation, regulation and the taxing of all drugs are presented.

EVALUATION

Valuing young lives: evaluation of the National Youth Suicide Prevention Strategy, by P. Mitchell, Melbourne, Vic, Australian Institute of Family Studies, 194p, tables, figures, illus.

The National Youth Suicide Prevention Strategy was an initiative of the Commonwealth government to provide a coordinated approach to youth suicide prevention throughout Australia, and was administered through the Mental Health Branch of the Department of Health and Aged Care. This summative evaluation of the Strategy was conducted independently by the Australian Institute of Family Studies (AIFS). Two frameworks to guide the design and methodology of the evaluation were used: The Public Health Approach, and Program Theory or Program Logic. Issues discussed include: the scope of youth suicide; rise of youth suicide in Australia; attempted suicide and deliberate self harm; history and development of the Strategy; Finland's suicide prevention initiative; developments in Australia; policy and program context in areas such as mental health, health and welfare of children and adolescents, homelessness, and Aboriginal and Torres Strait

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Islander well being; description of the Strategy; Strategy approaches and activities; AIFS evaluation of the Strategy; major achievements and good practice findings; and key areas of work relevant to youth suicide prevention and implications for future policy and planning.

FAMILY SUPPORT SERVICES

Family interventions in first episode psychosis, by M. Ovens, In, M. Bashir & D. Bennett, eds. *Deeper dimensions: culture, youth and mental health*, Parramatta, NSW, Transcultural Mental Health Centre, 2000, pp. 130-145.

The Early Psychosis Outreach Community Health (EPOCH) Program is described in this chapter which makes particular reference to family interventions, and is based on the experiences of the family therapist working in EPOCH and other similar programs. A summary is provided of the implementation of a Family Forum and a multiple Family Group Series, including an evaluation of both. Experiences, successes and challenges of working with parents from non-English speaking background (NESB) are discussed. The author's attempts at overall family intervention evaluation are outlined. It is concluded that both individual and group interventions with parents of first episode clients are effective at decreasing stress and increasing knowledge and coping.

A preventative services program model for preserving and supporting families over time, by P. McCartt Hess., B. McGowan & M. Botsko, Michael, *Child Welfare*, vol. 79, no. 3, May-Jun 2000, pp. 227-265.

This article reports on selected findings from a three-year study of a sample of families served by the Center for Family Life's preventative services program. The study examined the nature and results of the services the families received.

Toward building a typology for the evaluation of services in family support programs, by V. Manalo & W. Meezan, *Child Welfare*, vol. 79, no. 4, Jul-Aug 2000, pp. 405-429.

This article briefly reviews the development, philosophy and practice principles of family support programs. Typologies currently in use to classify these programs are examined. The difficulties these classifications pose for program evaluators are discussed. A new typology is introduced and the potential for this typology for the evaluation of family support services is discussed.

HEALTH PROMOTION

What do adolescents need for health development? Implications for youth policy, by J. Roth & J. Brooks-Gunn, *Social Policy Report*, vol. 14, no. 1, 2000, pp. 3-19.

This article examines how youth develop in healthy ways and how we can facilitate this process. Three questions are raised and answered: 1) What is needed to help adolescents to develop successfully?; 2) How do the settings in which adolescents live, study, and play enhance (and, in cases, impede) their wellbeing?; 3) How can we use what we know about the worlds of adolescents for the development of successful youth programs?

I N T E R N E T

The relationship of internet use to depression and social isolation among adolescents, by C. Sanders, T. Field & M. Diego, *Adolescence*, vol. 35, no. 138, Summer 2000, 237-142.

This study investigates whether there is a link between the level of internet use with depression and social isolation among adolescents. The study found that low internet users reported better relationships with their mothers and friends than high internet users.

M A S S M E D I A

An exercise in improving suicide reporting in the media, by K. Michel., C. Frey & K. Wyss, *Crisis: The Journal of Crisis Intervention & Suicide Prevention*, vol. 221, no. 2, 2000, pp. 71-79.

This study was conducted to help develop a set of guidelines for media reporting on suicide in the Swiss print media. In the first instance quantitative and qualitative aspects of suicide reporting were monitored for 8 months. The results of this survey were presented to the media in 3 ways: at a national press conference; written guidelines for suicide reporting were sent out to all newspaper editors; and the results of the survey and the guidelines were discussed in a personal meeting with the Editor-in-Chief of the main tabloid. A second, identical survey was then conducted. Frequency, form and content of the newspaper reports before and after the press conference were compared. It was found that while the number of articles had increased over the 3 years between the first and second survey, the quality of reporting had clearly improved. It was noted that the personal contact with the editor of the tabloid seemed to be the most effective means of intervention.

M E A N S & M E T H O D S

Death by hanging: implications for prevention of an important method of youth suicide, by R. Kosky & P. Dundas, *Australian & New Zealand Journal of Psychiatry*, vol. 34, no. 5, Oct 2000, pp. 836-841.

This study aimed to identify factors associated with deaths by hanging among young people in Queensland. All cases of death by hanging among young people during 1995 and 1996 in Queensland were recorded as suicides. Most were males and a quarter were indigenous persons. Half of the deaths occurred in regional or rural areas, with unemployment, the experience of personal loss, psychiatric illness and alcohol use as possible precipitating agents. Early warning signs were the onset of uncharacteristic behaviours and threats of suicide. The private nature of hanging means that there are rarely opportunities to prevent it in the period immediately before the fatal event. To prevent hanging as a means of suicide, it is necessary to understand more about the difficulties experienced by some young men who are living in rural areas and more information about the cultural problems experienced by indigenous young people. Young people in the justice system may need personal support, and it is necessary to determine if young people, especially those living in rural areas, have adequate access to the professional expertise needed to diagnose and treat mental disorders. (Journal abstract, edited)

Firearm-related deaths in Australia 1998, by J. Mouzos, Canberra, ACT, Australian Institute of Criminology, 2000, 6p, tables, figures and Online (60K) <http://www.aic.gov.au/publications/tandi/ti161.pdf>

This paper provides a statistical overview of deaths whose underlying cause was reported as being a firearm related death during 1998. It is the first in a series of reports to be produced annually examining firearm related deaths in Australia nationally, and also by state and territory. This report includes statistics on firearm deaths as a whole, as well as statistics on suicides, homicides, fatal accidents, deaths as a result of legal intervention, and also deaths where the injury was undetermined as to whether it was accidentally or purposely inflicted. Information presented includes type of firearm used, gender variation, age variation, marital and employment status, and country of birth.

M E N T A L D E P R E S S I O N

Child-reported depression and anxiety in preadolescence: I. associations with parent- and teacher-reported problems, by J. Mesman & H. Koot, *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 39, no. 11, Nov 2000, pp. 1371-1378.

The aim of this study is to investigate which parent- and teacher-reported broad behavioral syndromes and which of a range of specific behaviors signal the presence of child-perceived depression and anxiety in children. The study found that teachers are more likely than parents to notice internalizing problems. Teachers are also more likely to notice related problems such as social and academic problems in children reporting depression or anxiety. These findings, as well as the fact that referral of children is generally based on parental concern, may account for the low rate of referral of children with internalizing problems.

Child-reported depression and anxiety in preadolescence: II. preschool predictors, by J. Mesman & H. Koot, *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 39, no. 11, Nov 2000, pp. 1379-1386.

The aim of this study is to examine whether or not parent- and teacher-reported behaviors in preschool aged children can predict child-reported depression and anxiety at age 10 to 11 years. It was found that teachers, but not parents, can provide valuable information in regard to preschool signals of preadolescent depression. Signals that may predict later depression include early social and academic problems. However, no predictive signals for anxiety were noted.

Parent-child bonding and family functioning in depressed children and children at risk and low risk for future depression, by D. Stein, D. Williamson & B. Birmaher, *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 39, no. 11, Nov 2000, pp. 1387-1395.

The aim of this study is to evaluate parent-child bonding and family functioning in depressed children, children at high risk for depression and a low-risk control group. The study found that maternal depression, especially in families with a depressed child, has a negative effect on parent-child bonding and family functioning.

Suicidal ideation in adolescent psychiatric inpatients as associated with depression and attachment relationships, by J. DiFilippo & J. Overholser, *Journal of Clinical Child Psychology*, vol. 29, no. 2, Jun 2000, pp. 155-166.

Fifty-nine adolescent psychiatric inpatients (25 male, 34 female) completed self-report measures of suicidal ideation, depressive symptoms, and attachment to mothers, fathers and peers. After adjusting for depressive symptoms, attachment variables failed to contribute additional variance in suicidal ideation. Self-reported depressive symptomatology remained the strongest predictor of suicidal ideation. In conclusion the findings seem to indicate that prevention and treatment efforts should focus on mother-adolescent attachment and peer attachment (particularly in girls) to reduce risk for depression and suicidal ideation.

Treating adolescent depression: a review of intervention approaches, by C. Finn, *International Journal of Adolescence & Youth*, vol. 8, no. 4, 2000, pp. 253-269.

This article examines the nature of depression in adolescents, as distinct from depression in children. It reviews the various intervention approaches which have been used to treat adolescent depression. These interventions include: pharmacotherapy; cognitive-behavioural therapy; psychodynamic therapy; family therapy; and interpersonal therapy. Other considerations that may influence treatment such as comorbidity, gender and cultural issues are discussed.

M E N T A L H E A L T H

Families, mental illness, and suicide, by R. Kosky, *Suicide & Life-threatening Behavior*, vol. 30, no. 1, Spring 2000, pp. 1-7.

The author argues there are intrinsic problems with research into suicide because there is no general agreement about the meaning of the key words “family”, “mental illness”, and “suicide”. Yet the way in which they are interpreted in the context of this research influences the formation of theories, the interpretation of results, and the development of suicide prevention strategies.

Parental background, social disadvantage, public “care” and psychological problems in adolescence and adulthood, by A. Buchanan, J. Brinke & E. Flouri, *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 39, no. 11, Nov 2000, pp. 1415-1423.

This study found that family context (severe social disadvantage or being placed in out-of-home care) is more strongly associated with psychological problems in adolescence than family structure. It also found that being raised in a single parent family and being placed in care predicted adult psychological distress in men, but not in women.

M I G R A N T S

Immigrant and refugee young people: challenges in mental health, by M. Bashir, In, M. Bashir & D. Bennett, eds. *Deeper dimensions: culture, youth and mental health*, Parramatta, NSW, Transcultural Mental Health Centre, 2000, pp. 64-74.

Important influences on the mental health of young immigrants and refugees are identified in this chapter which discusses other common stressors impacting on young immigrants, including family expectations, sex roles, identity problems and racism. The link between migration and psychiatric disorder is made with an analysis of cross cultural research on young immigrants and refugees, raising issues of: substance use; acculturation; self esteem; poverty and behavioral and mental health problems; loss; depression; and coping behaviour. Recommendations are made for prevention and early intervention.

Suicidal behaviour in young migrant women, by A. Fry, In, M. Bashir & D. Bennett, eds. *Deeper dimensions: culture, youth and mental health*, Parramatta, NSW, Transcultural Mental Health Centre, 2000, pp. 146-163.

Intra cultural and cross cultural factors are examined in this chapter which describes the Blacktown Youth Suicide Prevention Project (BYSPP) in which 80 young people who presented to emergency departments with deliberate self harm and varying degrees of suicidal intention were studied. Young female migrants were over represented in the study. Issues discussed include: migration and stress in young people; mental illness in migrants; defining and reporting suicide and attempted suicide; suicide and migrants; precipitating factors for 12 young migrants; and clinical practice issues.

Young people, culture, migration and mental health: a review of the literature, by K. Bevan, In, M. Bashir & D. Bennett, eds. *Deeper dimensions: culture, youth and mental health*, Parramatta, NSW, Transcultural Mental Health Centre, 2000, pp. 1-63.

A review of the literature dealing with young people and mental health is provided in this chapter. The first section aims to give a broad overview of mental health issues affecting all young people in Australia, addressing topics of: life stage transitions from childhood to young adulthood; psychiatric morbidity; youth suicide; environment, lifestyle and other vulnerabilities; risk taking and risk behaviours; and protective factors and resilience. The second section provides an analysis of the literature on mental health and young people of non English speaking background (NESB), discussing issues of: culture and life transitions; the process of migration and settlement; psychiatric morbidity; attitudes to mental health and mental illness; family dynamics and family conflict; acculturation and acculturation stress; identity development; and experience in the broader community. The third section discusses young people’s experience of being a refugee, tackling issues of: the refugee experience and mental health problems and disorders; the refugee experience and the family: impact on development and functioning; and vulnerable groups of young refugees.

P A R E N T C H I L D R E L A T I O N S H I P

The relationship between parenting style and children’s adjustment: the parents’ perspective, by D. Daufmann., E. Gesten & R. Santa Lucia, *Journal of Child & Family Studies*, vol. 9, no. 2, Jun 2000, pp. 231-245.

This article discusses the relationship between authoritative and authoritarian parenting styles and the socio-emotional adjustment in primary school children as reported by the parents. Findings showed that authoritative parenting was positively associated with healthy adjustment, whilst authoritarian parenting showed a non-significant impact on child adjustment.

Parental monitoring: a reinterpretation, by H. Stattin & M. Kerr, *Child Development*, vol. 71, no. 4, Jul-Aug 2000, pp. 1072-1085.

This study questions whether monitoring their children's movements is the best way for parents to know what their children are up to. The authors suggest that disclosure from the child is a more reliable source of knowledge. The authors conclude that a new prescription for parental behavior must rest on an understanding of the factors that determine and encourage child disclosure.

P R O F E S S I O N A L P E R S O N N E L

Client suicidal behaviour: impact, interventions, and implications for psychologists, by L. Trimble., K. Jackson & D. Harvey, *Australian Psychologist*, vol. 35, no. 3, Nov 2000, pp. 227-232, tables.

Members of the Australian Psychological Society's Colleges of Clinical and Counselling Psychologists were surveyed to ascertain the incidence and impact on them of client suicidal behaviour. Also sought were their opinions about preferred interventions in managing high-risk clients, and coping strategies in the event of a client suicide. Four hundred and thirty-seven responded, a return rate of 29%. Just over half (n=244) were members of the College of Clinical Psychology, 187 were members of the College of Counselling Psychologists and 5 were members of both colleges. More than one third (n=170) had experienced one or more completed client suicide, 332 had experienced attempted suicide, 377 noted threats or suicidal gestures, and 396 suicide ideation. Clinical psychologists rated hospitalisation, referral to a GP or psychiatrist, and restricting access to means of suicide as more effective interventions than counselling psychologists, who rated verbal 'no suicide' contracts as the more effective intervention. Psychologists who had experienced a client suicide ranked recognising that they were not responsible, talking with their colleagues, an increased acceptance of suicide as a possible outcome, and talking with their supervisors as the most helpful strategies following the event. Less than half could recall any aspect of pre-registration training in dealing with suicidal clients, although most had undertaken some professional development since. The authors conclude that further research is needed to determine the effective intervention strategies for working with suicidal clients. (Journal abstract)

Q U A L I T Y O F L I F E

The four qualities of life: ordering concepts and measures of the good life, by R. Veenhoven, *Journal of Happiness Studies: An Interdisciplinary Forum on Subjective Well-Being*, vol. 1, no. 1, 2000, pp. 1-39.

This article examines the meanings of the terms 'quality of life', 'well-being' and 'happiness'. It explores the four qualities of life: 1) livability of the environment; 2) life-ability of the individual; 3) external utility of life; and 4) inner appreciation of life. It also asks if the quality of life can be measured and concludes that the most inclusive measure is how long and how happily people live.

Creating places where resilience thrives, Bloomington, IN, National Educational Service, 1999 72 p., ill., 28 cm.

This issue contains the following articles: Beyond individual resilience by David Osher [et al]...(pp.2-3); I was wrong about group homes by Eric Edmonson (pp.5-6); Lost boys: why our sons turn to violence and how we can save them by James Garbarino (pp.7-10); Easier said than done: shifting from a risk to a resiliency paradigm by Sybil Wolin (pp.11-14); If you build it, they will come: a nontraditional approach for systems change by Ken Reavis [et al]...(pp.15-17); Building resilient families and communities: an interview with Karl Dennis by Kimberly T. Kendziora (pp.18-21); Exercises in a resilient system of care, cultural competency, and the wraparound process by Vera O. Pina & John VanDenBerg (pp.22-30); Tapping into resiliency: the kaleidoscope approach by Nick Dwyer (pp.31-33); Developing relationships that build resiliency: including peers in the wraparound process by Vernessa Gipson, Lillian Ortiz-Self & Deirdre Cobb-Roberts (pp.34-37); Growing resilience: creating opportunities for resilience to thrive by David Osher [et al]...(pp.38-45); "It's so great to have an adult friend": a teacher-student mentorship program for at-risk youth by Julia Ellis, Jan Small-McGinley & Lucy De Fabrizio (pp.46-50); Coming out resilient: strategies to help gay and lesbian adolescents by Tania DuBeau & David E. Emenheiser (pp.51-54); Answering a traditional call with a community response by Roslyn Holliday Moore & Araminta Rivera (pp.55-59); IDEA: parental protections under the law by Sherry Kolbe (pp.60-62); Meeting the needs of children and youth with challenging behaviors by Lyndal M. Bullock & Ann Fitzsimons-Lovett (pp.63-68); The Sacred Child project: a new definition of "formal" services by Jon Eagle [et al]...(pp.69-72).

Kids of survival : real-life lessons in resilience, Bloomington, IN, National Educational Service, 1997 64 p., ill., 28 cm.

This issue contains the following articles: Betting on me by Alan Meredith Blankstein & Lyndal M. Bullock (pp.2-4); Thinking on good things by Franklin T. Hysten (pp.5-7); The "bad dude" story and keys to my survival by Warren Rhodes & Elva Edwards (pp.8-13); Overcoming four myths that prevent fostering resilience by Sylvia Rockwell (pp.14-17); Tara's death: a lesson in love, grief and resilience by Thomas Reilly & Eleanor Guetzloe (pp.18-23); Experiencing professional renewal through nurturing young survivors by Linda Bell (pp.24-26); Finding meaning in a socially toxic environment by James Garbarino (pp.27-30); How to be a turnaround teacher by Bonnie Benard (pp.31-35); I am, I have, I can: what families worldwide taught us about resilience by Edith Grotberg (pp.36-39); From risk to resiliency: a history of the research by Tim Duffey (pp.40-43); Using academic strategies to build resilience by Theodore Pikes, Brenda Burrell & Connie Holliday (pp.44-47); Building resilience with the self-control

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curriculum by Martin Henley (pp.48-51); Meeting the needs of children and youth with challenging behaviors by Lyndal M. Bullock & Ann Fitzsimons-Lovett (pp.52-60); Shaping a brighter future by uncovering “survivor’s pride” by Sybil Wolin & Steven J. Wolin (pp.61-64).

Patterns of children’s coping with life stress: implications for clinicians, by D. Donaldson, M. Prinstein & M. Danovsky, *American Journal of Orthopsychiatry*, vol. 70, no. 3, Jul 2000, pp. 351-359.

Boys and girls, aged 9-17 years, completed a coping checklist which listed four types of stressors: school; parents/family; siblings; peer/interpersonal. Similar patterns of coping strategies were found across the various stressors. However, it was found that the older adolescents used a broader range of strategies. The implications of this for clinical practice are discussed.

Psychological foundations of stress and coping: a developmental perspective, by D.T. Kenny, In, D.T. Kenny ... [et al.], eds. *Stress and health: research and clinical applications*, Sydney, NSW, Harwood Academic Publishers, 2000, pp. 73-104.

How does coping change over the course of development? Is coping in childhood continuous with adult coping or are there qualitative differences? How does development affect coping? What are the critical precursors of coping in children, and how does coping affect development? The author of this chapter addresses these questions, drawing on a range of theories in the developmental psychology and stress literature. Discussion includes the relationships between parental internal working models, attachment, and coping; the relationships between attachment quality, immune function, and health; and the relationships between quality of attachment and learned helplessness/resourcefulness.

A re-examination of risk and resilience during adolescence: incorporating culture and diversity, by E. Arrington & M. Wilson, *Journal of Child & Family Studies*, vol. 9, no. 2, Jun 2000, pp. 221-230.

This article considers the concepts of risk and resilience in the developmental contexts of youth from different cultural backgrounds - African, Asian, Latino and Native American. The authors promote a conceptual model of risk and resilience as a multidimensional phenomenon. The relevance of culture and diversity in a developmental perspective is discussed.

Resilience, *Child Development*, vol. 71, no. 3, May-Jun 2000, Special Section.

This special section on resilience contains the following articles: The construct of resilience: a critical evaluation and guidelines for future work by Suniya S. Luthar, Dante Cicchetti & Bronwyn Becker (pp.543-562); The odds of resilience by Alexander von Eye & Christof Schuster (pp.563-566); Some thoughts about resilience versus positive development, main effects versus interactions and the value of resilience by Mark W. Roosa (pp.567-569); Are there implications for prevention research from studies of resilience? by JoAnn L. Robinson (pp.570-572); Research on resilience: response to commentaries by Suniya S. Luthar, Dante Cicchetti & Bronwyn Becker (pp.573-575).

Resilience in child refugees: an historical study, by G. Palmer, *Australian Journal of Early Childhood*, vol. 25, no. 3, Sept 2000, pp. 39-45.

Research on unaccompanied refugee and evacuee children who came to Australia in the late 1930s and early ‘40s sheds light on parenting and caregiving practices which may support children in times of unexpected stress and trauma, and which may help protect them against the lifelong disabling effects such experiences can have. This lifespan retrospective study revealed that, while many children experienced short-term psychosomatic responses to the stress and trauma of separation, war, and persecution, there was a vast difference in effects over the longer term. Factors which may have contributed to this disparity are explored in this paper. (Journal abstract)

When you’re feeling all alone ... make the connection, by C. Teng, *Healthsharing Women*, vol. 11, no. 2, Nov 2000, pp. 12-15.

In many instances, people are able to make plans for the future. However, when this is not the case, and when there is no opportunity to plan, individuals still have to cope. This short article is about the practice of counselling for those moments when life’s challenges are too big to cope with alone. The article is presented in two parts: firstly a brief outline of counselling; and secondly, a practical application based on the author’s experience in counselling women faced with unplanned pregnancies.

R I S K F A C T O R S

The cost of being perfect: perfectionism and suicide ideation in university students, by T. Hamilton & R. Schweitzer, *Australian & New Zealand Journal of Psychiatry*, vol. 34, no. 5, Oct 2000, pp. 829-835.

The aim of this study was to evaluate the relationship between perfectionism and suicide ideation in tertiary students. The authors found that the presence of suicide ideation was associated with higher scores on questionnaires dealing with perfectionism and on general health. There were significant differences between participants with high levels of perfectionism and participants with moderate to low levels of perfectionism on a measure of suicide ideation. Neither gender nor age were associated with differences in the scores, with results indicating that high levels of perfectionism may indicate a vulnerability to suicide ideation. It was concluded that perfectionism is a valued attribute in high achieving populations. The question needs to be asked, however, at what cost? Findings indicate that high levels of perfectionism may be associated with an increased vulnerability to suicide ideation. The authors suggest that further research is needed to gain a better understanding of the complex interrelationship between personality and temperament, environmental factors and self destructive behaviour. (Journal abstract, edited)

‘High risk’ adolescents five years on: the subsequent suicide and homicide of former ‘Looked-after’ and ‘Exclusion Unit’ adolescents, (11-15), by C. Pritchard & E. King, *International Journal of Adolescence & Youth*, vol. 8, no. 2/3, 2000, pp. 139-148.

Adolescents aged 11-15 years, who either spend time in ‘Exclusion Units’ and are ‘Looked-After’ by the Local Authority are at high risk for a range of psychosocial pathologies. This study analysed

police records and a Suicide Register of 6-year cohorts of former 'Looked-After' 'Excluded-from-School' adolescents. Some surprising findings were revealed in relation to subsequent suicide and homicide rates as these adolescents approached adulthood (15-25 years). Interestingly there were no female suicides or murderers in either group. There were also no suicides amongst the male 'Looked-After' group. However, there were two suicides and two further homicides amongst the male 'Exclusion-Unit' group. The 'Exclusion Unit' suicide and homicide rates, when compared to the respective rates for the general population, were found to be 17 and 163 times higher. This interim study emphasises the particular vulnerability of former 'Exclusion-Unit' youth. These youth have no statutory right to support or supervision after leaving school, unlike the former 'Looked-After' youth. Further analysis of this data and a reconsideration of post discharge 'Exclusion Unit' policy is needed.

Morbidity of Vietnam veterans: a study of the health of Australia's Vietnam veteran community: suicide in Vietnam veterans' children (supplementary report 1), Australian Institute of Health and Welfare, Canberra, ACT, Australian Institute of Health and Welfare, 2000, 14p tables, figures and Online (68K) <http://www.aihw.gov.au/publications/health/mvv-svvc/mvv-svvc.pdf>

In the Department of Veteran Affairs 1998 publication *Morbidity of Vietnam Veterans: A Study of the Health of Australia's Vietnam Veteran Community*, it was reported that children of Vietnam veterans had a substantially higher rate of suicide than that experienced by the general Australian community. In 1999, the Australian Institute of Health and Welfare Validation Study confirmed this finding and recommended that suicide in veterans' children be investigated and the results drawn to the attention of the Vietnam Veterans Counselling Service. This report is in response to the recommendation, and provides an analysis of the suicides of Vietnam veterans' children by a range of demographic characteristics captured on death certificates. The report covers patterns of suicide over time, as well as the distribution by sex, age at death, birth cohort, suicide method and geographic distribution.

Parameters of suicidal crises vary as a function of previous suicide attempts in youth inpatients, by T. Joiner Jr., M.D. Rudd & K. Wagner, *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 39, no. 7, Jul 2000, pp. 876-880.

Suicidal crises demand an enormous amount of clinical attention, yet little empirical research has been conducted on the parameters of suicidal crises in general, and in children and adolescents in particular. The authors developed predictions, based on conceptual work on the unique characteristics of multiple suicide attempters, regarding the intensity and duration of suicidal crises in youths presenting to inpatient psychiatry units. The study also draws on work on the effect of previous suicidal and depressive experience on later functioning. It was hypothesized that multiple attempt status would relate significantly to intensity of suicidal crises and would relate more strongly to intensity than to duration of crises.

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Findings conformed to prediction: multiple attempters experienced more intense but not more long-lasting crises; the relation between multiple attempt status and crisis intensity exceeded that between multiple attempt status and crisis duration. In conclusion the implications of these findings for suicide risk and clinical assessment and management are discussed.

Peer functioning, family dysfunction and psychological symptoms in a risk factor model for adolescent inpatients' suicidal ideation severity, by M. Prinstein., J. Boergers & A. Spirito, *Journal of Clinical Child Psychology*, vol. 29, no. 3, Sep 2000, pp. 392-405.

This study examined models of suicidal ideation severity among adolescents who had been hospitalized because of concerns of suicidality. The study measured suicidal ideation, psychosocial risk factors of peer and family functioning and psychological symptoms of generalized anxiety, depression, conduct problems and substance abuse. The results demonstrated relations between suicidal ideation and several areas of adolescent peer functioning. Divergent processes for peer and family predictors of suicidal ideation were also found.

Predictors of adolescent suicide attempts: a nationally representative longitudinal study of Norwegian adolescents, by L. Wichstrom, *Journal of Child & Adolescent Psychiatry*, vol. 39, no. 5, May 2000, pp. 603-610.

The objective of this research was to investigate the risk and protective factors for previous and future suicide attempts among adolescents. A longitudinal study followed a representative sample of high school students (N = 9,679) in grades 7 through 12 (aged 12-20 years) from 1992 to 1994. The students were tested for: psychiatric symptoms (depressed mood, eating problems, conduct problems); substance use; self-worth; pubertal timing; social network; and social integration. The study found that 8.2% of the participants had attempted suicide at same time and 2.7% reported an attempt during the 2-year study period. Logistic regression analysis showed that future attempts were predicted by: previous attempt; female gender; young age; perceived early pubertal development (stronger among girls); suicidal ideation; alcohol intoxication; not living with both parents; and poor self-worth.

The relationship between posttraumatic stress symptomatology and suicidal behavior in school-based adolescents, by J. Mazza, *Suicide & Life-threatening Behavior*, vol. 30, no. 2, Summer 2000, pp. 91-103.

This study investigated the relationship between posttraumatic stress disorder (PTSD) symptomatology and suicidal behavior. It was specifically interested in suicidal ideation and suicide attempt history. The study controlled for depression and gender in 106 adolescents in an urban high school. Participants completed a range of self-report measures. The data was analysed using a hierarchical multiple regression design to account for the relationship between PTSD symptomatology and depression. The results showed that after controlling for depression and gender, PTSD symptomatology was significantly related to suicidal ideation and showed a trend toward suicide attempt history. These findings show that PTSD symptomatology has a unique relationship to adolescent suicidal behavior that cannot be explained by depression or gender. The implications of these results for future research are discussed.

Risk behavior in a community sample of children and adolescents, by A. Flisher., R. Kramer & C. Hoven, *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 39, no. 7, Jul 2000, pp. 881-887.

This study sought to investigate whether there is covariation between risk behaviors, including suicidality in a community probability sample of children and adolescents; and to investigate whether risk behavior is associated with selected potential correlates. A sample of 9- to 17-year-old youths and their caretakers were interviewed in the Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) Study. The risk behaviors measured were: marijuana smoking; alcohol use; sexual intercourse; fighting; cigarette smoking; and suicidal ideation/ attempts. Significant relationships between all pairs of risk behaviors were found. The study concluded that clinicians should be alerted to the possibility of risk behaviors, especially in children and adolescents engaging in other risk behaviors and those with inadequate resources, stressors, functional impairment, or psychopathology.

Young suicide attempters: a comparison between a clinical and an epidemiological sample, by B. Greholt., O. Ekeberg & T. Haldorsen, *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 39, no. 7, Jul 2000, pp. 868-875.

This study compared the risk factors for self-harm in 2 groups: hospitalized adolescents who had attempted suicide and adolescents reporting suicide attempts in a community survey. Hospitalized suicide attempters aged 13 to 19 years in a region of Norway were assessed and interviewed. Risk factors were identified by comparisons with a general population sample who participated in a questionnaire study. In this population sample, a separate analysis of risk factors for reporting deliberate self-harm was performed. Low self-worth, low socioeconomic status, and little support from parents or peers characterized hospitalized suicidal adolescents compared with those who were not hospitalized. The risk factors were more powerful for hospitalized than for nonhospitalized adolescents. It was concluded that prevention efforts should target the same factors for both groups. This would need to be implemented at a population level for nonhospitalized adolescents and at an individual level for hospitalized adolescents, with a focus on depression, low self-esteem, and family communication.

RURAL COMMUNITIES

A primary mental health-care model for rural Australia: outcomes for doctors and the community, by H. Malcolm, *Australian Journal of Rural Health*, vol. 8, no. 3, Jun 2000, pp. 167-172.

To address the high rate of depression and suicide in rural Australia requires a multifaceted approach to educate the community, improve the skills of health workers and provide user-friendly patient counselling. The present paper describes a model that covers each of these aspects and details the outcomes with respect to the doctors and the community. Improved awareness in the community of mental illness and the availability of treatment, decreasing the stigma of such a diagnosis, and increasing the skills and reducing the isolation of doctors in rural areas who treat mental illness were all positive benefits from this cost-effective way of providing mental health care in a primary setting. The adoption of this model in all primary core settings is advocated. (Journal abstract)

Rural mental health: neither romanticism nor despair, by J. Wainer & J. Chesters, *Australian Journal of Rural Health*, vol. 8, no. 3, Jun 2000, pp. 141-147.

This paper explores the relationship between rural places and mental health. It begins with a definition of mental health and an outline of the data that have led to the current concern with promoting positive mental health. The authors then consider aspects of rural life and place that contribute to positive mental health or increase the likelihood of mental health problems. Issues identified include environment, place, gender identity, violence and dispossession and the influence of the effects of structural changes in rural communities. The paper concludes with a discussion of some of the determinants of resilience in rural places, including social connectedness, valuing diversity and economic participation. (Journal abstract)

Youth mental health promotion in the Hunter region, by T. Waring ... [et al.], *Australian & New Zealand Journal of Psychiatry*, vol. 34, no. 4, Aug 2000, pp. 579-585.

This article describes the work of the Hunter Institute of Mental Health, with special emphasis on its role in mental health promotion and prevention with adolescents. The Ottawa Charter for Health Promotion is used as a framework to describe the varied functions of this organisation. A number of youth mental health promotion programs are given as examples of the Institute's work. Results of preliminary evaluation of the Youth Suicide Prevention - National University Curriculum Project are provided. It was found that the Hunter Institute of Mental Health, a self funding unit of the Hunter Area Health Service, provides innovative health promotion programs as part of its role as a provider of mental health education and training. The model may be particularly applicable to mental health services in regional Australia. (Journal abstract, edited)

RURAL URBAN DIFFERENCES

Youth suicide trends in Australian metropolitan and non-metropolitan areas, 1988-1997, by D. Wilkinson & D. Gunnell, *Australian & New Zealand Journal of Psychiatry*, vol. 34, no. 5, Oct 2000, pp. 822-828.

Suicide is an important cause of death in Australia, with young Australians experiencing particularly high rates of suicide. The purpose of this study was to examine trends in suicide among 15 - 34 year olds living in Australian metropolitan and non metropolitan areas between 1988 and 1997. The authors also examined differences in age within this group, gender and method of committing suicide. They concluded that non metropolitan males aged between 15 and 24, have disproportionately higher rates of suicide than their metropolitan counterparts. The most common method of committing suicide in non metropolitan areas is hanging, replacing the use of firearms from ten years ago. Although legislation may reduce method specific suicide, the potential for method substitution means that the overall rates may not fall.

SCHOOL ROLE

MindMatters, a whole-school approach promoting mental health and wellbeing, by J. Wyn ... [et al.], *Australian & New Zealand Journal of Psychiatry*, vol. 34, no. 4, Aug 2000, pp. 594-601.

This article discusses the MindMatters project, an innovative, national mental health promotion program which provides a framework for mental health promotion in Australian schools. Its objectives are to facilitate exemplary practice in the promotion of whole-school approaches to mental health promotion; develop mental health education resources, curriculum and professional development programs which are appropriate to a wide range of schools, students and learning areas, trial guidelines on mental health and suicide prevention and to encourage the development of partnerships between schools, parents and community support agencies to promote the mental well being of young people. The program provides a framework for mental health promotion in widely differing school settings. The teacher professional development dimension of the program is central to enhancing the role of schools in broad population mental health promotion. The authors found that promoting the mental health and well being of all young people is a vital part of the core business of teachers by creating a supportive school environment that is conducive to learning. Teachers need to be comfortable and confident in promoting and teaching for mental health. Specific, targeted interventions, provided within a whole-school framework, address the needs of the minority of students who require additional support. (Journal abstract, edited)

The School Focused Youth Service - addressing the needs of 'at risk' young people, including those at risk of suicide, by M. Seiffert, *Health Education Australia*, Winter, 2000, pp. 26-28.

The School Focused Youth Service is a state-wide service in Victoria, begun in late 1998 as a recommendation from the Suicide Prevention: Victorian Task Force Report (July 1997). Its aim is to develop a more integrated response to the needs of 'at risk' 10-18 year olds who are displaying behaviours that require support and intervention. Some of these behaviours are known to make these young people more vulnerable to suicide. To effectively support these young people, youth and family services in the schools and in the community need to work more in partnership. The role of the School Focused Youth Service is to strengthen that partnership and to assist in developing strategies for a more collaborative approach to the welfare of young people. (Journal abstract)

S O C I O L O G Y O F S U I C I D E

Suicide: a 15-year review of the sociological literature part 1: cultural and economic factors, by S. Stack, *Suicide & Life-threatening Behavior*, vol. 30, no. 2, Summer 2000, pp. 145-162.

This article reviewed cultural and economic patterns from 130 sociological works on suicide from 1981 to 1995. The traditional Durkheimian perspective on suicide was often questioned by research on the impact of: the mass media; alcohol; class; modernization; religion; and politics. Major theoretical developments included the application of differential identification theory to Phillips's model of copycat suicide, the application of criminology's opportunity theory to suicide, and new explanations for the link between alcohol and the social suicide rate. The major new suicide trend of the divergence in the male and female suicide rates, after half a century of convergence, are reviewed. Patterns of continued stability in suicide research findings in areas such as racial differences and economic strain were noted.

Suicide: a 15-year review of the sociological literature part II: modernization and social integration perspectives, by S. Stack, *Suicide & Life-threatening Behavior*, vol. 30, no. 2, Summer 2000, pp. 163-176.

This article reviews the findings of 84 sociological studies published over a 15-year period. These studies were concerned with tests of the modernization and/or social integration perspectives on suicide. Some of the research on modernization, religious integration, and political integration questioned or reformulated the traditional Durkheimian perspective. A major new theoretical development, Pescosolido's religious networks perspective, gained some empirical support in the 15-year period. It was found that the strongest support for social integration theory came from research on marital integration. The research on migration, a force which leads to the lowering of social integration, continued to find a positive link to suicide.

S T R E N G T H E N I N G F A M I L I E S

Family diversity and family policy : strengthening families for America's children, by E. Sparks & L. McCubbin, Boston, Mass., London, Kluwer Academic, c1999. xx, 168p., 24 cm.

"Family Diversity and Family Policy describes the dimensions of diversity which characterize the contemporary American family and discusses the implications for public policy and associated intervention programs linked to this diversity. The authors contend that if the programs and policies available to support families are to be maximally useful, they need to reflect the diversity of the families they intend to help."—BOOK JACKET

Programs for the promotion of family wellness and the prevention of child maltreatment: a meta-analytic review, by J. MacLeod & G. Nelson, *Child Abuse & Neglect*, vol. 24, no. 9, Sep 2000, pp. 1127-1149.

Fifty-six programs which were designed to promote family wellness and prevent child maltreatment were reviewed. Meta-analysis, using a 3-step model testing procedure was employed. The findings indicate that child maltreatment can be prevented and family wellness can be promoted.

Strengthening family resilience, New York, Guilford Press, c1998. xiv, 338 p., 24 cm.

Based on the conviction that all families have the potential for repair and growth, this book offers a fresh alternative to clinicians' prevalent focus on family dysfunction. Drawing upon extensive clinical and research experience, Froma Walsh presents an innovative framework for therapeutic and preventive work with couples and families who are distressed, vulnerable, or at risk. Filled with suggestions for strength-promoting, collaborative interventions that can help family relationships rebound from the worst of times, the book provides important clinical insights for professionals and students in a range of mental health and human service settings. This

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volume is a useful guide for family therapists and counselors, psychologists, social workers, and other social service and health care professionals. Its coverage of both theoretical and practical concerns also makes it an invaluable text for advanced undergraduate and graduate-level courses.

S U I C I D E P R E V E N T I O N

Collaborating to prevent suicide: a clinical-research perspective, by D. Jobes, *Suicide & Life-threatening Behavior*, vol. 30, no. 1, Spring 2000, pp. 8-17.

It is argued that the presence or absence of certain key relationships paradoxically can be both suicide causing and suicide preventive. When suicidality is involved, there are a number of issues that can interfere with effective clinical practice. Fortunately for clinical practitioners, a new paradigm has begun to emerge in contemporary clinical suicidology which objectifies suicidality and emphasizes the phenomenology of suicidal states. This approach is creating new and better ways to effectively assess and treat suicidal conditions.

Exploring the potential for primary prevention: evaluation of the Befrienders International Reaching Young Europe pilot program in Denmark, by B. Mishara & M. Ystgaard, *Crisis: The Journal of Crisis Intervention & Suicide Prevention*, vol. 21, no. 1, 2000, pp. 4-7.

It is acknowledged by most national suicide prevention strategies that it is important to develop primary prevention activities in order to reduce the incidence of suicidal behavior. However, it is a lamentable fact that few prevention programs have been subjected to even the most rudimentary evaluations. This article describes the evaluation of a primary prevention program which has been developed and implemented by Befrienders International.

LifeForce suicide prevention program 1999/2000, Sydney South, NSW, Wesley Mission, 2000, 46p.

LifeForce is a suicide prevention program, implementing a strategy to significantly reduce, and eventually eliminate suicide in Australia, by equipping strategic persons to identify and help each suicidal person during their time of suicidal crisis, and refer the person to an appropriate qualified resource. The program focuses on critical intervention and prevention strategies. This publication provides an overview of the principles of LifeForce, what the organisation aims to achieve and the programs that have been undertaken. At the time of publication, LifeForce had trained over 1400 gatekeepers, through seminars and workshops conducted in over 60 communities in New South Wales, Victoria and Queensland, predominantly in country areas.

A model for analyzing suicide prevention, by M. Upanne, *Crisis: The Journal of Crisis Intervention & Suicide Prevention*, vol. 221, no. 2, 2000, pp. 80-89.

This study monitored the evolution of psychologists' conceptions of suicide prevention over a 9-year period. It was part of the National Suicide Prevention Project in Finland. The study was designed as a retrospective self-assessment in which the participants compared their earlier descriptions of suicide prevention with their current views. Any changes in conceptions were analyzed and interpreted

using both a theoretical model for analyzing suicide prevention and the explanations given by the subjects themselves. The model proved to be a useful framework for revealing the essential features of suicide prevention. The study found that changes in the participants' conceptions had shifted toward emphasizing a curative approach and the significance of individual risk factors. Protective factors remained part of the prevention paradigm. The psychologists' sense of the difficulties of suicide prevention was enhanced by their practical working experiences. Their feeling of powerlessness was also highlighted in the practical setting.

Preventing suicide : a resource for general physicians, World Health Organization. Dept. of Mental Health. Mental and Behavioural, Geneva, WHO, 2000 18 p., 21 cm.

This booklet is written primarily for general practitioners. Its aim is to provide an outline of the main disorders and other factors associated with suicide. It also provides valuable information for the general practitioner on ways of identifying and managing suicidal patients.

Preventing suicide : a resource for prison officers, World Health Organization. Dept. of Mental Health. Mental and Behavioural, Geneva, WHO, 2000 19 p., 21 cm.

This booklet is aimed at prison administrators and officers. It is designed to be used as an aid in developing mental health and suicide prevention programs. It also aims to help maintain the safety in custody of suicidal inmates. General background information on suicide is included.

Preventing suicide : a resource for teachers and other school staff, World Health Organization. Dept. of Mental Health. Mental and Behavioural, Geneva, WHO, 2000 24 p., 21 cm.

This booklet has been written primarily for teachers and other school staff. However, information has been included which may be of use to others interested in establishing or running suicide prevention programs. It examines the various aspects of suicidal behaviour in adolescence, the main protective and risk factors and ways to identify 'at-risk' individuals. Information on how to help students and staff when suicide occurs in the school community is provided.

Preventing suicide : how to start a survivor's group, World Health Organization. Dept. of Mental Health. Mental and Behavioural, Geneva, WHO, 2000 41 p., 21 cm.

This booklet describes the way self-help groups work. It presents evidence which strongly suggests that they are a powerful tool for people to help themselves and others. The process of setting up and running a self help group, specifically for survivors of suicide, is explained in detail.

Taking responsibility for suicide, by D. Edwards, *Access: The National Issues Journal for People with a Disability*, vol. 2, no. 2, Apr - May 2000, pp. 15-17.

Social factors leading to suicide are identified in this article which discusses the reality of suicide and suicide risk in Australia. Some of the primary principles of suicide risk reduction are outlined, highlighting coping skills and protective resources. It is suggested that workplaces need to consider harm minimisation as part of their human resources strategy.

COMPILED BY BELINDA SNIDER

If you wish forthcoming conferences, workshops or seminars to be listed in the Youth Suicide Prevention Bulletin, and in the Institute's Internet pages, please send details to Belinda Snider, Australian Institute of Family Studies, 300 Queen Street, Melbourne 3000 Victoria, Australia. Phone: (03) 9214 7864. Fax: (03) 9214 7839. Email: belinda@aifs.org.au

GOOD HEALTH – GOOD COUNTRY

4–7 March 2001
Canberra, ACT

The 6th National Rural Health Conference, "Good Health – Good Country", aims to inform the rural and remote health agenda. For the first time it incorporates Infront–Outback – the Health Scientific Conference, enhancing the position of the National Rural Health Conference as the preeminent rural and remote health event in Australia. The overall theme, Good Health – Good Country: from conception to completion, reflects the connections between health status and many aspects of life in this country, and it also speaks of the importance of getting it right at each stage of the human life cycle. The conference will pick up a range of current strategies and developments that are important. It will help participants to see and feel the relationship between their local work and national, state and regional developments. There are seven concurrent sessions. Delegates will have the choice of attending one of six streams – two Infront–Outback streams, three general streams, and one arts stream.

Further information: The 6th National Rural Health Conference, PO Box 280, Deakin West ACT 2600. Fax: (02) 6285 4670. Email: conference@ruralhealth.org.au. Web: <http://www.ruralhealth.org.au>

YOUTH DEVELOPMENT

22–23 March 2001
Adelaide, SA

The National Youth Development Conference will provide an opportunity for the diversity of contributors to youth development to meet with colleagues, explore good practice and promote further strategic advances in youth development across Australia.

Further information: Email: ausyouth@saugov.sa.gov.au. Web: <http://www.ausyouth.on.net/conference.html>

MENTAL HEALTH

28–31 March 2001
Brisbane, Qld

The 4th National Conference of the Australian Infant, Child, Adolescent and Family Mental Health Association will be an opportunity for delegates to discuss mental health issues for children, young people, families and their communities. As part of the conference theme, Building Bridges: Promoting Mental Health for Families and Communities, the program will feature keynote presentations, papers, posters and workshops showcasing collaborative initiatives across different agencies / sectors that facilitate positive mental health outcomes for children, young people and families.

Further information: 4th National Conference Infant Child and Adolescent Mental Health, Secretariat, PO Box 1280, Milton Qld 4064. Phone: (07) 3858 5563. Fax: (07) 3858 5510. Email: mha2001@im.com.au. Web: <http://www.aicafmha.net.au>

FAMILY CARE

29–31 March 2001
Sydney, NSW

The Tresillian Family Care Centres Conference 2001 aims to provide a practical and varied program for professionals who work with families and their young children. The program reflects some of the innovative and complex knowledge and skills that are necessary to promote and maintain the health of Australian families. A mixture of child health and family mental health issues will be discussed by several leading clinicians in Australia.

Further information: Conference Secretariat, Tresillian Family Care Centres, McKenzie Street, Belmore NSW 2192. Tel: (02) 9787 0869. Fax: (02) 9787 0880.

DRUGS AND YOUNG PEOPLE

4–6 April 2001
Melbourne, Vic

The theme of the 2nd International Conference on Drugs and Young People is "Exploring the bigger picture".

Further information: Email: events@adf.org.au. Web: <http://www.adf.org.au/>

COUNTRY CHILDREN'S SERVICES

6–8th April 2001
Sydney, NSW

The annual conference of the Country Children's Services Association of NSW Inc – Children's Services in the Balance: Finding Ways Forward – aims to explore ways that services can balance the needs of children, families and communities by: developing an understanding of the interrelationships between early childhood professionals and managers in service provision; examining and developing strategies to address increased responsibilities of volunteers as managers; exploring strategies to implement proposed curriculum framework; and providing opportunities for discussion and debate regarding changes to children's services regulations.

Further information: Country Children's Services Association of NSW Inc, PO Box 118, Katoomba NSW 2780. Fax: (02) 4782 4425. Email: conference@ccsa-nsw.asn.au

SUICIDE PREVENTION

7–9th April 2001
Sydney, NSW

The 8th National Conference of Suicide Prevention Australia – "Suicide Prevention 2001: A Human Odyssey" – will include pre-conference workshops providing practical advice and skills; a Young Peoples' Forum; Indigenous Forum; Bereaved through Suicide Forum; Mental Health Consumer Forum; a Research Symposium; and a special showcase for resources, materials, videos, programs and research posters. A "Walk for Life" is also planned to promote mental health as a key underpinning to suicide prevention.

Further information: Conference Secretariat, PO Box K998, NSW 2000. Phone: (02) 9211 1788. Fax: (02) 9211 0392. Email: conference@suicidepreventionaust.org. Web: <http://www.suicidepreventionaust.org>

DRUG AND ALCOHOL PROGRAMS

10–12th April 2001

Gold Coast, Qld

The philosophy of the Best Practices in Drug and Alcohol Programs conference is based on the principle that good health is a basic right of all humanity. Communities throughout Australia are developing intricate programs to combat drug and alcohol abuse that are designed to meet the needs of their own individual communities. The conference will focus on the practical work and issues that concern drug and alcohol program providers throughout Australia, and also on partnerships between government providers, community invitees and individuals with a commitment to the future development of drug and alcohol programs.

FORTHCOMING CONFERENCE

The 4th National Conference on Infant, Child and Adolescent Mental Health will be held in Brisbane, from the 28–31 March 2001.

The conference program includes papers from consumers, carers and professionals on mental health issues for children and young people. And there will be a youth forum where young people will have a chance to hear from other young people about mental health issues affecting them and what they are doing about it.

The conference will provide an excellent opportunity to meet up with other people who are interested in mental health issues. Reduced fees will be available for consumers, and other avenues of financial support for consumers are being investigated.

We are looking for:

- young people to be involved in the forum, the planning stages and as conference delegates;
- workers who can volunteer their time for the forum or as support people for consumers attending the conference;
- agencies who can help in offering services, support, resources to the forum and the conference;
- young people and workers to take an active part in the consumer sub-committee at the planning stages of the conference;
- people to disseminate information far and wide about the conference and the forum; and
- funding for the forum.

To register, or to obtain more information, contact Michael Chinn: Email clarus@tpg.com.au, or visit the Australian Infant Child Adolescent and Family Mental Health Association web site at <http://www.aicafmha.net.au/>

Further information: Conference Secretariat, Australia/Australasian Conferencing Services, 16 Olden Court, Hydeaway Bay, Qld 4800. Phone: (07) 4945 7122. Fax (07) 4945 7224. Email: icsa@bigpond.com.au

FORENSIC MENTAL HEALTH

19–21 April 2001

Vancouver, BC Canada

This conference will found the new International Association of Forensic Mental Health Services (IAFMHS). Registration fee for the conference will include membership in the Association until January 2002, and a copy of the first issue of the Association's Journal of Forensic Mental Health, that will begin publication in 2002.

Further information: Derek Eaves, M.D., BC Institute Against Family Violence, Suite 551, 409 Granville Street, Vancouver BC V6C 1T2. Phone: 604-669-7055. Fax: 604-669-7054. Email: info@iafmhs.org. Web: <http://www.iafmhs.org>

DIVERSITY IN HEALTH

28–30 May 2001

Sydney, NSW

"Diversity in Health – Sharing Global Perspectives" is a landmark conference on multicultural health and wellbeing incorporates the Australian Transcultural Mental Health Network 2nd National Conference, the 3rd Australian Multicultural Health Conference, and the NSW Transcultural Mental Health Centre 6th Conference. This will be a priority conference for everyone concerned with the wellbeing of multicultural Australia. One of the key topic areas is Child and Adolescent Health and Wellbeing.

Further information: Diversity in Health Conference Secretariat, PO Box 265, Annandale NSW 2038. Phone: (02) 9518 9580. Fax: (02) 9518 9581. Email: diversity@pharmaevents.com.au. Web: <http://www.tmhc.nsw.gov.au/diversity.htm>

CHILDREN AND YOUNG PEOPLE

9–16 June 2001

Sicily, Italy

The conference, "Children and Young People in a Changing World: A Holistic Approach", is organised by the International Union of Anthropological and Ethnological Sciences, the Italian Ministries of Social Affairs and Education, and Children's Forum 21 (New York, Italy, Greece). It aims to provide a unique opportunity for young people, along with an interdisciplinary group of academics, policy analysts, members of non-government organisations, lawyers, judges and other professionals, to discuss at length the old and new challenges facing children and adolescents and their caregivers, and what we can individually or collectively do about them.

Further information: Dr. Cristina Szanton Blanc. Email: csblanc@igc.org.

LEARNING CULTURE

20–21 June 2001

Melbourne, Vic

The Victorian Community Services and Health Industry Training Awards 2001 celebrate the emerging learning culture in the industry. These awards recognise those in the industry who are setting the pace, and focus on five key areas: industry achievement in creating a learning culture; life long learning; student achievement; innovation in training delivery and assessment; and best practice in professional development in a registered training organisation. This

conference offers the opportunity for the presentation of a number of papers based on the theme of “Partnerships for Empowerment”.

Further information: Liz Wright, Event Coordinator, PO Box 1300, Carlton Vic 3053. Email: register@intraining.org.au. Web: <http://www.intraining.org.au>

HEALTH OUTCOMES

27–28 June 2001

Canberra, ACT

“Health outcomes evaluation” and “evidence based health care” are phrases now well entrenched in the mainstream rhetoric of health policy development. They are used to justify and explain health funding allocation. But what do they mean to the practitioner? How can the health outcomes approach be used at the level of service delivery – in the doctor’s surgery, the acute care ward, the allied health clinic – to improve health care for clients? This 7th annual International Health Outcomes Conference will cover: developments in the National Health Priority Areas; health consumer experiences; the integration of the health outcomes approach in general practice and primary care; health outcomes measurement in indigenous communities; aged care; hospital quality; and health promotion.

Further information: Jan Sansoni or Lorna Tilley, Australian Health Outcomes Collaboration. Phone: (+61) 02 6205 0869 or (+61) 02 6291 7271. Fax: (+61) 02 6205 2037. Email: jan.sansoni@act.gov.au or jansan@atrx.net.au. Web: <http://www.health.act.gov.au/epidem/ahoc.html>.

CHILD AND FAMILY POLICY

28–30 June 2001

Dunedin, New Zealand

The Children’s Issues Centre from the University of Otago is sponsoring the Fourth Child and Family Policy Conference. The theme is “Children and young people – their environments”, and topics covered will include: natural and outdoor environments; participation and involvement; contexts and neighbourhoods; play and recreation areas; planning – local and central government; social and economic environments; virtual environments; learning and therapeutic environments; and safe and unsafe environments.

Further information : Children and Young People: Their Environments, Children’s Issues Centre, University of Otago, PO Box 56, Dunedin, New Zealand. Tel: +64 3 479 5038. Fax: +64 3 479 5039. Email: cic@otago.ac.nz

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Building Capacity for Life Promotion: Technical Report Volume 1 describes the Strategy’s system level activities which aimed to build capacity and assist the adop-

tion of evidence-based practice in all service systems relevant to youth suicide prevention.

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