THE PARLIAMENTARY JOINT STANDING COMMITTEE ON COMMUNITY DEVELOPMENT MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE ON 14 JUNE 2005.

INQUIRY INTO STRATEGIES FOR THE PREVENTION OF SUICIDE

Mr RAY KEMP, PROJECT MANAGER, INFORMATION AND EVALUATION UNIT, MENTAL HEALTH SERVICES WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Thorp) - Welcome, Ray. As you would be aware, we are currently looking at a reference on suicide in the State and this sort of information will be invaluable base information for us to work on. So if you could paint that picture for us that would be great.

Mr KEMP - Thank you for inviting me along today. I am the manager of the Mental Health Information and Evaluation Unit. My role is to provide a level statistical support and expertise to the Tasmanian Suicide Prevention Steering Committee, of which I am a member, as well as developing information for mental health on a broader range. Traditionally suicide is something that is covered in the mental health area. Even though I think you may have probably been aware of other presentations there is a broader, whole-of-government approach now being offered in this area, because it is not just specifically mental health. Today I want to give a brief presentation, which I delivered at the Suicide Prevention Forum recently in the south of the State, and discuss some of the information that is available also in this publication.

Firstly, all the statistics you will see today and the statistics we utilise are provided by the Coroner's Court. So we are reliant on the coroner making the determinations and therefore the information provided to us we record into a basic database system from which we provide updates and analysis and produce the publication. There are a number of limitations to that information. It is quite limited at the moment as to what information is collected and is available from the Coroner's Court. One of the areas that most people are particularly interested in which is causality of suicides, there is no information directly being collated and put together. It is a very complex area to try to work out the causes and, from what I understand, the coroner does not directly attribute causes. All he does is identify whether the person took their own life or the death is from other causes.

Mr BEST - We had some information from the coroner. He said they would make recommendations about things. I am not saying they would not say specifically what took the person's life although they would say that it might be something.

CHAIR - I see what you mean.

Mr KEMP - A lot of that information is currently not put into any information systems to be able to record that. At the moment it is really some fairly basic information about who they are, their age, place of death and the method of suicide. So there is a limited range of information that is currently available. Also we have limitations on how we can utilise this information. We do not go into small areas because we could then start to get into breaches of confidentiality - once you get down to small counts, people can be identified.

We tend to look at things very much in overview and try to analyse trends and so forth. We combine the information together and you will see some of that in the presentation today.

Mr MORRIS - Ray, what is the degree of certainty that these statistics are suicides? There must be a lot of cases where it is uncertain as to whether it was suicide or an accident; is that the case?

Mr KEMP - I do not think there is a high level of uncertainty. Our process is we are provided with deaths that are potential suicides which we use to record in our system and over a period of time as the coroner makes a determination - sometimes up to two to three years after the fact - we go through and actually clean out those. Eventually, over a period we end up with those who are purely determined as suicides by the coroner.

Mr MORRIS - Right.

Mr KEMP - In the last 1993-1994 information there may be some proportion of those that will be determined as not being suicide, but death by other means. We are looking in terms of probably four or five in a year that end up being determined as not being suicide. One of the purposes of this presentation is that there is a certain amount of urban mythology about suicide. Ask anyone on the street and they will say, 'Yes, one person a week jumps off the bridge'. Those sorts of things are part of the urban myth that has come about. There are reasons why that is and what I would like to do today is actually present some of the real statistics to show you where the issues probably are and help you focus in your deliberations instead of just having a very broad view and rushing off with some of the urban mythology because a lot of that is severely incorrect.

Mr WILKINSON - Because the bridge there has only been there about 30 or 40 years, hasn't it?

Mr KEMP - I do not have information for the period since the bridge has been there. With the information I get from the coroner, I only have the place-of-death basis since 1993. Towards the end of this presentation I will cover briefly the actual numbers and you will probably be surprised how low they are.

CHAIR - Ray needs to be gone by about 2 p.m. everybody, so please keep that in mind with our questions.

Mr KEMP - We will go to the first slide. This is looking at a general overall suicide rate between 1980 and 2003. We have more than 20 years data here, so we are looking basically at a trend and this is done as three year moving average. Because the counts are relatively small - and we are looking around 70 suicides per year in Tasmania - when

it comes to statistical analysis we start to get into problems about reliability of information when you deal with small numbers. So you produce a trend base analysis, combine this information together and produce three-year moving averages. This is done as a rate per 100 000. So it is a population rate. In fact our rate hovers around 15 per 100 000. One of the things that this graph particularly indicates is the rate between males and females. There is approximately a 4:1 ratio between males and females who complete suicide. At the presentations at that forum we had earlier this year, one of other researchers came up with some information about attempted suicides. In a lot of cases you will get the reverse situation - a 4:1 ratio of females to males with attempted suicide. So we are looking here at completed suicides and there is a much higher rate among men.

Ms HAY - For the years where there is a lower incidence rate, has that been attributed to any programs that were piloted that year?

Mr KEMP - No. We have not done any evaluations where we look at these things to try to find out what has had an appropriate effect, particularly the programs. They tend to be fragmented around the place, as you are probably aware and there is not an overall process. Perhaps some of the things have been focused in the other areas that we talk about - what has happened in suicide, how it has changed from what people perceive it to be. Some of the programs focus in the youth area and that is not now the major problem.

Mr WHITELEY - Did I miss something? Was there a reason we started at 1980 and not 1970? You do not have the data?

Mr KEMP - We do not have the database there. But this process has only been building for a while and in a lot of cases has only just started. The database was put together in the mid-1990s and then we went back to get information. The early information going back from the early 1990s comes from the Australian Bureau of Statistics information. This system was not set up the way it is operating now in Mental Health. We did not have a direct input into the process.

As I was saying, we are now looking at a graph, the same process of the three-year moving average over that period of time and we are looking at males in the 15 to 24 age group. In past processes this group has been the focus of suicide prevention programs because that was seen as the risk area, young males at risk. That was the case during the 1990s but, as you can see, it is dropping off. This led to some interesting speculation as to the process that was occurring, because the statistics of the total number of suicides was not going down. It was staying more or less static. In the last year we had a slightly higher number, but it is staying around that mid 70 to 80 region on an annual basis.

When we started to break this down into the next stage with the 25-to-39 age group, we began to see an increase, a considerable increase, over a period of time. We asked the question, 'Why is this so?' with limited information. It started to lead some discussions, particularly in suicide committee with a couple of a academic researchers there, with some ideas to start to look at. This has led to some further statistical results which I will show you in the next couple of slides. We have picked up quite an interesting process but it still needs further work to analyse it. It is still in an early stage. This is looking at the overall picture in 1978 to 2003, just a profile by age. Starting over that period you

can see the majority of the suicides are in this region from about 18 through to late 40s at the most and it

CHAIR - Is it still per 100 000 because you have t a lot more young people, haven't you?

Mr KEMP - This is not a rate, this is the total number of suicides on an annual basis.

CHAIR - Yes. It would change the shape of the curve though if you rated it, wouldn't it?

Mr KEMP - Yes. This is just to show the quantum over that period of time. Again, something like this tends to disguise more than it illuminates but it is a broad range statistically like the ones we produced in the report. What it led to was some discussions about what was happening with the age groups, why the change in age groups. Some of the discussion came up that there may be an age cohort that is prone to suicide, so we started to track this information.

This first slide looks at 1978 to 1982 and five-year age groups. What we have identified here at this period, this early cohort, which is a youth group and young persons between the ages of about 18 and 34. There was a peak there, which is, you might say, the traditional view of suicide. This is where most of the suicides were occurring.

The next graph shows the next five-year period with the same cohort -

CHAIR - Getting older.

Mr KEMP - getting older as they move through. But, as you saw from those statistics, the normal drop off with age and so forth does not start to occur.

CHAIR - I have sorted it, it is heavy metal music!

Mr KEMP - Again the next year, same group is going through. There is quite a generic social term to describe this group, they are called generation X. Culturally, this is where you get the complexity of the issues, what drives it, whether it is something that has come with that generation. This is the punk generation and so forth and some of their heroes like Kurt Cobain have been public suicides.

Mr WHITELEY - Might want to look at their parents.

Mr KEMP - Yes, and there is a certain amount of nihilism that came with that group and that culture, so it may have social aspects. This is only the overview. This is an opening for a lot of research.

CHAIR - Yes.

Mr KEMP - This is only what we are seeing in the broad statistics. Why is it occurring, I really cannot tell you that at the moment, we are still discussing ideas. A great subject for a phD.

CHAIR - Yes.

Mr KEMP - The next group, the five-year period and it is still there. We have started to pick up on this group, the 20 and 24s are quite high, but we are still getting this cohort moving through the population, up to the point of basically the latest statistics - up to 2002 - and you can still see that this cohort has moved through the population. This is why currently we are looking at an increase in suicides, particularly in the working-age male. It is a group that has moved through the population, so when it comes to sort of focusing on programs it makes it a lot more difficult. When we are working with youth, there are a lot of the projects working in the street community, schools and so forth, to get access to youth who may be at risk. What we are looking at here is a group that are a lot more difficult to access. Are middle-aged males going to turn up to forums or anything like that? Not necessarily. That is where there needs to be a review of some of the strategies - how do we deal with this cohort moving through the population?

CHAIR - I know that is pretty simple modelling, but by using that kind of modelling, if you start seeing signs you could almost try and predict where your programs have to be directed.

Mr KEMP - Yes. When we first did this analysis we thought, 'Well, here is something very interesting'. We put statistics together and forwarded this information to Martin Harris at the University of Tasmania, Rural Health area, who is a specialist in statistics, to find out if we had got something wrong. He came back only a month or so ago and he said that this phenomenon had now been recorded Australia-wide and in New Zealand. So it is not just a local phenomenon, or a Tasmanian phenomenon, this is something that is moving through the population.

CHAIR - Are those statistics both genders?

Mr KEMP - Yes. It is not broken down by gender but -

Mr WHITELEY - If it is consistent across the nation do we know whether or not it is consistent across the world? Is it a global -

Mr KEMP - The only other information we have seen at the moment is New Zealand, which has recorded the same phenomenon. That is another area.

Mr WHITELEY - They are on another planet!

Mr KEMP - This is another area to watch and move into: whether this is occurring in the United States, Europe and so forth. We do not know. Some international comparisons are also fraught. You get local problems and ways of dealing with suicide. For example, Japan has a different profile for suicide than some other developed countries. It has a cultural view of it.

It is an interesting phenomenon that this cohort is moving through the population that does appear to be at a higher suicide risk than some of the others.

You can see now that statistics for the youth area are relatively low in comparison to some of the other years; it is not a major focus.

This part of the presentation is trying to point out who is suiciding and what we know about that group. It appears that there is some cohort moving through the population in which there is a higher risk of suicide - or completed suicide.

The next part of the presentation is really to look at the method. How do people commit suicide? It is quite important that we start to look at some of these issues. There has been public focus on the method - the bridge and so forth; we need to do something about the bridge.

What the statistics tend to show is that even though the gun buy-back legislation came in it did not reduce the overall rate of suicides. All it has done is change the methods people use to suicide. So, focusing on a method does not solve the suicide problem because other methods are available.

This information is pre-1994 - it is 1978 to 1994. This is pre-gun-buy-back legislation and it shows that 44 per cent of the suicides were by gunshot and it is predominantly males who tend to suicide through gunshot. Carbon monoxide - gassing in cars - hanging, asphyxiation and poison were other methods used.

When the gun legislation came in the current period - 1995-2003 - gunshot dropped considerably to 20 per cent and I think current statistics show it has dropped even further.

CHAIR - But the gross number has not dropped?

Mr KEMP - No, it has not changed.

From what I understand the growth rate of suicide in Australia has not effectively changed since the turn of the last century.

Mr WHITELEY - That is per 100 000?

Mr KEMP - Per 100 000. It has stayed much the same for the whole of the last century.

Currently the gunshot rate is down to 11 per cent in 2004 so there has been a significant reduction in gunshot deaths, but hanging and asphyxiation by carbon monoxide poisoning are the two that have increased. So where this method is no longer readily available -

Mr WILKINSON - We won't say take up the slack, will we?

Mr WHITELEY - I thought it but I did not say it.

Mr BEST - Where you have 'other', does that include vehicles.

Mr KEMP - It includes the bridge - drowning, jumping and so forth - electrocutions, cutting wrists -

CHAIR - Single vehicle accidents?

Mr KEMP - It is very hard to determine with single vehicle accidents and the number is very small as far as accounts go. Not all single vehicle accidents go before the coroner. It has always been an issue.

Mr BEST - So 'other' could represent five or six a year of the 70 perhaps?

Mr KEMP - Possibly. It is very hard to determine that. We can only guess. There is no real information to look at the map and work out which area where -

Mr BEST - Obviously there are common methods here. I do not want to get too macabre but with poisoning, for example, does that mean using similar poisons or is it mainly prescribed tablets?

Mr KEMP - I do not have information on that.

Mr BEST - Carbon monoxide would be assumed to be in a vehicle?

Mr KEMP - That is a vehicle.

Mr BEST - It is pretty obvious.

Mr KEMP - Asphyxiation is ropes or plastic bags and so forth.

So when it comes to dealing with these things and trying to work out policies for reducing the suicide rates, it is best to focus on some idea of what the causes are -

Mr BEST - Absolutely.

Mr KEMP - rather than the method - not necessarily worrying about how many have jumped off the bridge because in fact that is mythology, it is a furphy.

Mr WILKINSON - Why have you got hanging and asphyxiation as the one item as opposed to the two?

Mr KEMP - That is basically the information we are provided from the coroner. They determine the method and so forth within a certain set of categories. They fit them in, so it is combined. You could actually go back to the coroner and actually break them down between hangings and asphyxiation.

Mr WILKINSON - Because they are totally different, aren't they?

Mr KEMP - They are different, yes. I am sure there are probably combinations of methods. Hanging is a form of asphyxiation unless it is a formal neck-breaking type. A lot of people who actually hang do asphyxiate so that is probably why it is difficult to determine and make those judgements.

This is another graph of principal causes in recent times and this is one of the ones that raised a fair bit of interest at the forum. We have broken it down a little bit further - overdose, carbon monoxide, hanging asphyxiation, drowning, gunshot, cutting and jumping. And this is where your single vehicle and so forth fits in.

On the question of people who attempt to jump off the bridge: as a result of the forum I made some inquiries about how many actually have jumped off the bridge. I went back and analysed the information from as far back as 1994, which is the date we began to get information on the place of death. I have not graphed that because it is too small a number. It is hard to determine exactly how many have jumped off the bridge but, of those that have been identified as jumping off the bridge, there were six people in a nine-year period. There were another seven potential suicides off the bridge - people whose bodies were actually found in the Derwent or on the shores of the Derwent and who may have jumped. So you have 13 people in a nine-year period who have actually potentially suicided off the bridge. That is from a total of about 600 or so. It is a very small proportion. This is one of the urban myths and I think this comes about because there is a large number of attempted suicides on the bridge.

People go out there in that sort of para-suicide way where they are calling for help. Especially in these days of mobile phones, people drive across the bridge, they see someone up there so they ring. The police arrive and escort them off the bridge and 2 000 people going to work will see someone being escorted off the bridge. I think that is why you get that urban mythology. I get it every time I mention that I have a role in this; people ask, 'How many jump off the bridge? I hear there is one a week'. That is the urban myth of Hobart, one a week. I have even heard that from people interstate - that one person jumps off the bridge every week.

In fact the figure for jumping does not just include the Tasman Bridge. We have had suicides off the Batman Bridge; we have even had a suicide off the Huon Bridge. That was a drowning.

Mr BEST - Can I just ask about the mix then? Does the rate vary, around the State? Does it vary much geographically or does it stay much the same?

Mr KEMP - It stays fairly much the same. The majority rate is in the south; the south has a slightly highly rate than the north. In this publication we produce figures for the regions and you can see in this example that in the southern region it is going up. On a slightly different scale that is the north and the north-west.

Ms HAY - What about rural or urban? Do you have that sort of breakdown?

Mr KEMP - We have not broken it down. We probably could break it down by a rural-urban split, but it has not been done.

Mr WHITELEY - Rural and gunshot would be interesting.

Mr KEMP - Yes. It is probably a higher proportion, but there are other areas that we could certainly explore and break down. Again, we are limited by the actual quantum of statistics to go to far or make too many assumptions because you end up making very broad assumptions with a lot of statistical errors in them.

Mr BEST - Is population a factor? Is that why you have more in the south than the north? A lot more people live in the northern part of the State, but it is more concentrated here.

Mr KEMP - There is a higher rate per population.

Mr BEST - There is a higher rate?

Mr KEMP - Yes.

Mr BEST - But you see no similarity or connection between the rate and the method of suicide?

Mr KEMP - I do not think so, no. With the bridge you are only looking at one, at the most two, completed suicides a year. There are other bridges and then there are other things to jump off besides bridges.

Mr BEST - Do you think that there could be something that could be extrapolated from the methodology? When you get to that stage, I suppose the view is that people have already made the decision. But then again, I suppose if it is an indication thing, where the methodology gives an indication -

Mr KEMP - Once people do make that decision -

Ms HAY - They find a method that sits best with them.

Mr KEMP - They find a method and there is strong evidence that a lot of people do not do it then. There are some impulse suicides but a number of people do tend to plan them and that is some of the indication of people making -

Mr BEST - Any idea of the average time frame, for example?

Mr KEMP - No. This is a whole area that needs a lot of research.

Mr BEST - Would there be any benefit of that, do you think, or not? I know you go on statistics that give us a picture and there are interesting things already with the ages groups and how that is drifting through. However, I suppose it is one of those things that until you start getting into it, you do not really know.

Mr KEMP - If we could get more information, whether through the Coroner' Court for the process or other processes, it would be certainly worthwhile. Information such as marital status would be quite interesting because, anecdotally, there is some evidence, especially with that middle-aged male group, that -

Mr WHITELEY - Estranged children would be a very interesting statistic.

Mr KEMP - Yes, those who watched *Four Corners* last night on the family benefit system and child support payment saw people having those sorts of issues and going into severe depression. That seems to have a strong correlation.

Mr MORRIS - The other thing that I would find very interesting would be the educational background and possibly whether there is a history of mental illness in individuals.

Mr KEMP - Yes. From what we understand, there are a lot of undiagnosed mental health issues with people who suicide. In the past we have identified from those who have a completed suicide those who have a known mental health issue background in that they are known to Mental Health Services, and it is generally around 10 to 15 per cent.

Mr MORRIS - Right.

Mr KEMP - That is the history of mental health issues. If you look at those who are in current treatment, the number is significantly small. Again, they make the publicity so if you get a suicide at the Royal Hobart Hospital or something, it does become quite -

Mr MORRIS - Well known.

Mr KEMP - well known. It becomes an issue and people feel that there are a lot of suicides happening in Mental Health or with Mental Health patients. A lot of mental illness is undiagnosed. We have identified some of those processes now with the reviews of Mental Health Services and Bridging the Gap. We are dealing with only a fairly small proportion of the population - we currently deal with about 1 per cent of the population as our client base, yet the prevalence analysis indicates 3 per cent of the population have a severe to chronic disorder. We are dealing with 1 per cent - approximately 6000 patients. We have, potentially, another 10 000 or so patients out there who are being treated, maybe by GPs or self-medicating, for a variety of different things. They are undiagnosed in a lot of cases and some are untreated. So that may lead to this. Mental Health is not a position to necessarily solve the problems and save the people. A broader approach is probably required, and that is more of a community-based approach, to start to identify programs.

There was a presentation at the forum which was quite interesting run by the CFMEU in the ACT where they came across a number of suicides in the building industry and have developed a program where people go out into the workplace and start to discuss these problems. They have barbecues to bring the issue up to educate their foremen, bosses and so forth to look for those early signs and also to pick up where these young people particularly are going awry with their finances and social conditions. Some form of early intervention is probably the best way to deal with those issues because it will identify those who are actually at risk.

From the earlier statistics showing that age group, how do we do that? How do we get out and provide help? Maybe it is in the workplaces. It is a broader thing. The ACT program was run through the union but not necessarily all unions have good coverage in the workplace, so it needs to be a broader scale of approach to be able to start to address this.

Mr BEST - That is pretty much what we are hearing. That is why I was wondering about a lot more research and whether there is much benefit in that. We are hearing that the broader networking is pretty much the catch-all. How does the randomisation aspect of this sit with the statistical aspect?

Mr KEMP - One of the issues of course is that suicide is still a relatively rare event in social terms.

Mr BEST - But more likely to happen in certain circumstances.

Mr KEMP - Yes, it is more likely to happen in certain circumstances and maybe there is a need to set up organisations or some support that does work with those. But, as I said, the issue is again that the target group will not seek help.

Mr BEST - That is what I was going to say.

Mr KEMP - I am a middle-aged man and I know that we do not go to doctors. There are all those social things that you have to deal with. How do you target something that actually assists these people in those circumstances? We really do not know enough about the full details. Sure, there is a lot more work required and a lot more potential for analysis. Unfortunately we have limited data to go back to. You really do need a long stream of data to start to look at this. Those are some of the things we are picking up.

Mr BEST - Those findings are quite fruitful in the sense of what you have done already.

Mr KEMP - We are starting to point out where some of the effort should be focused. In the past there have been a lot of youth-based programs out there. That may be an indication: perhaps one of the reasons the youth suicide rate has been reduced is that those programs exist. Some of those programs and that focus coincide with that change and those programs are ongoing so that may be a factor in reducing youth suicide. It is a very difficult thing to do and with this sort of information and small numbers you really cannot do much analysis. You start to run a statistical analysis and it becomes unusable data, so it needs to go on a broader scale.

Mr WHITELEY - This is probably a stupid question, but when people leave a workplace they often do an exit survey. It is a bit hard to do one of those with people who have killed themselves. However, has there been a concerted effort by anyone to do an exit survey with the next of kin? If somebody commits suicide, has anybody actually gone and sat down with the mother, the brother or whatever to try to build a picture of what occurred in that person's life over the last month or two? It goes to your question earlier, Brenton, about how long? What has been happening? Did they lose their job? Did their wife leave and take the kids? Did they have a restraining order on them? Have they gone bankrupt?

Mr KEMP - It would certainly be worthwhile to conduct that, but it would also be incredibly difficult.

Mr WHITELEY - Of course it would.

Mr KEMP - But I don't think you can go along to the family after a suicide and collect that information -

Mr WHITELEY - I know; we are not going to do it straight away. It is the sort of stuff that would have to be done later. I know it is a weird thing but I would think - and I have dealt with quite a few people in my past life - after a period of time people want to talk about it because they would not want it to happen to someone else in their street or to their other kids. I think they would be prepared to actually give of their story - there is

nothing like a story to get the facts. That is not taking anyway from what you have got. This is the raw data. What we probably need is the qualitative stuff.

Mr KEMP - Which does not exist at the moment. There is a national process of developing a national coroner's database and this is still in the development stage. I think they are starting to do that and for those sorts of processes you need to build your core information and then expand out to other areas. What you are talking about there is really a pretty full on research project.

Mr WHITELEY - It certainly is.

Mr KEMP - You would need highly skilled professionals to sensitively collect that information.

Mr WHITELEY - Not taking anything away from what you have done, but with respect I think that would be a very healthy research project.

DEPUTY CHAIR - Ray, how are you going getting through your presentation?

Mr KEMP - In fact I have completed the presentation, just as far as the slides go.

Mr WHITELEY - Is all this stuff in here? I came a bit late, is it all in here?

Mr KEMP - These are copies of the slides from the presentation, if you want to quickly look at those.

Mr WHITELEY - That would be terrific.

Mr KEMP - The rest of the information that we can publish is available in there. Some of the stuff is actually breaking that down a little bit further. There is limited information that we can analyse and limited information that we can publish as well.

DEPUTY CHAIR - Ray, can we continue to ask you questions or is there anything else you need to say to us?

Mr KEMP - No, I have finished my piece.

DEPUTY CHAIR - You made a suggestion there - and I might have misheard you - but you seemed to suggest that general practitioners were dealing with people who were suicidal?

Mr KEMP - No, I am saying that general practitioners tend to deal with probably a reasonable proportion of people who are suffering depression and there is a strong linkage between depression and suicide. In any form of mental illness there is a strong pre-condition. People with bipolar disorder and psychosis can also suicide, but there is a strong correlation from what we understand between depression and levels of suicide. Whether general practitioners are well qualified to pick that up is the question - although they may be providing medication.

DEPUTY CHAIR - That was really the thrust of my question.

Mr KEMP - A lot of general practitioners are not highly trained in mental health. And with the pressure on GPs to see people for very short periods, they may not be picking them up. It might be worthwhile to do something with the GPs - provide them with more information on how to identify potential suicides.

DEPUTY CHAIR - Sure, because for some people they could be the first point of contact, couldn't they? I have heard it said that men generally go and talk about not being able to sleep and feeling a bit off colour and that sort of thing. That can be an early signal.

Mr KEMP - Yes, they tend to be signals of clinical depression. I mean I am not a clinician, I am a stats man, so when you get into clinical areas I cannot really professionally advise you on that. But this is from things I have picked up from working in the mental health area for the last five or six years.

Mr MORRIS - What communication does the steering committee have with the coroner? Do you have a meeting with the coroner to talk about the type of information the coroner reports. Or do you just get the reports from the coroner as they see fit? How does that work?

Mr KEMP - A lot of the co-ordination is through the Suicide Prevention Steering Committee on which there is a representative from the Coroner's Office, along with me and people from different areas. We are dependent to a certain extent on the coroner making determinations. Our role has been to coordinate statistics, develop the database we use and maintain that. We provide a technical process. As far as collecting probably a greater range of information, the Coroner's Court would be the best one to talk to about what is recorded and what is asked when they go through their determinations.

Mr MORRIS - I gather the data you get from them is actually quite brief in terms of useful information for statistical purposes.

Mr KEMP - Yes.

Mr MORRIS - I wonder whether there is any value in asking the Coroner's Office, if it is not difficult for them, to give you a consistent but perhaps more complete set of information - even if it happened to be the person's educational background, for example, any simple set of data that might give you more useful information that was recorded for every person who was determined to have suicided.

Mr KEMP - I understand there are a couple of items that are not provided to us at the moment that look like being provided to the national database and I think it is something that they have only recently started to indicate. Information such as indigenous status and so forth is only just starting. Because there is a national process, they have been drawn into it and therefore they are required to collect more information. It is certainly something that has come up at the forum and today as well that we need to go back to the coroner's representative and start to discuss what additional information could potentially be provided for these analytical purposes.

If this coroners database actually develops what we do may be redundant. We may actually rely on that coroners database if we can access it and if it is maintained as an up-to-date process. That would give us then the potential to look at what happens in

other States, make those comparisons and look at Australia on a broader scale. In Tasmania, we have such a small count -

Mr MORRIS - That is right. It would be useful to have the bigger numbers to work with as well.

Mr KEMP - There is only a limited range of information that is currently being collected in this area, I understand, Australia-wide. It is a difficult area, especially when you start to get into the areas of causality. It is very complex to try to record that information.

Mr WHITELEY - I would imagine that some of the older people - not that they represent a large proportion - would be cases of voluntary euthanasia.

Mr MORRIS - You are certainly running into that area.

Mr WHITELEY - Not to say that that should not be a cause for concern but it is obviously not as much of a concern as the other.

Mr MORRIS - It is almost informed consent.

Mr WILKINSON - In that last slide on motor vehicle accidents, 'SL' stands for 'solids and liquids' poisoning, doesn't it? I am just trying to go through these.

Mr KEMP - You have got me on that.

Mr WILKINSON - And the EL is electrocution?

Mr KEMP - EL is electrocution.

Mr WILKINSON - SL would be 'solids and liquids', which is poisoning.

Mr KEMP - It is SI.

Mr WHITELEY - But the poison was a bigger representation on that other pie chart.

Mr KEMP - You have got me on that one what the SI actually stands for.

Mr WILKINSON - You have page 17 of the *Life is for Everyone* book.

Mr KEMP - It is a very small component. Off the top of my head I cannot remember what it is.

DEPUTY CHAIR - Because we are not surveying or not getting detail on why people are committing suicide, are we only travelling on suppositions?

Mr KEMP - Yes, without solid information. Even Australia wide there does not appear to be much - from indications from the forum we had a couple of speakers who were quite well known in the research area. Their indication was that there is very little data and this is an area for significant research effort. I think it is a case of committing funds and

so forth. That is how you get academics researching - provide grants and funding and so forth for them to do that.

DEPUTY CHAIR - It seems to be an interesting point because we say that men aged 25 to 44 are going through certain crises in their lives and there are certain things that occur but we have not got that substantiated, have we?

Mr KEMP - No.

DEPUTY CHAIR - We make assumptions.

Mr KEMP - That is only supposition based on what the statistics are showing us and looking at what could be causing it. There is a broad range of issues there and certainly it is a fertile ground for some significant research.

Mr BEST - This is purely hypothetical and probably almost a bit ridiculous, but say, for example, everyone in the whole of Tasmania above the age of 12 was asked to nominate someone close to them or someone they could rely on - it could be their doctor or it could be their sister or mother or friend - whom they could talk to or who could be there for them if they were vulnerable. Do you think that would help or not? Do you think that would make everyone think about it? What you are talking about is a very small percentage of people, but just hypothetically if everyone could and thought about it -

Ms RITCHIE - Register a buddy type of thing.

Mr BEST - I am not saying how you would do it, I do not know. Do you think in these cases it is because people have really made up their mind? Some would have tried to get help and feel they cannot cope any more, but there are others, perhaps, who do not know how to.

Mr KEMP - There is some potential in that but one of the issues with is raising the subject of suicide itself. That is why it has been treated warily, particularly in youth programs in schools. It has to be treated in a certain way because if you raise the issue you can actually -

Ms RITCHIE - Raise the profile.

Mr KEMP - you can raise the profile and -

Mr WHITELEY - Give an option.

Mr KEMP - give options to people who may not have considered them and they become suicidal. You have to be very careful. It is a sensitive area. There may be potential for more of a public campaign so that people would be aware. I would prefer you to raise these matters with people who are more clinically inclined and who are working in that area. They know more about treating mental illnesses and so forth.

Mr BEST - It is a very dangerous area in a sense, isn't it? Even whilst trying to do something about it, you know you still have to be cautious.

Mr KEMP - Yes.

Mr FINCH - It is like the way the media have to deal with it. They have to be very cautious about the way they report the incidents.

Mr KEMP - We hope they are. It is not always the case that the media are as sensitive as we would like them to be.

Mr BEST - Given all these things - you may not want to answer this - and looking at your presentation statistically, is it fair to say that we are reasonably successful in dealing with this?

Mr KEMP - I do not know if there is any evidence to say whether we have been successful or not.

Mr FINCH - Not if it has been going on since the turn of the century.

Mr BEST - You can joke about it, but it is the same. It has gone down, it has gone up. I am not saying you should be happy with that, but in a sense it has not gone completely up - it is always within this range, isn't it? And the population has increased.

Mr KEMP - The population has increased but if you look at that rate it still has not changed. It fluctuates around the same level for a period of time. So there is probably some assumption to be made because I do not know how long suicide prevention programs have been actively run. There may be an indication that they might not be that effective. I don't know.

Mr WHITELEY - Forty years ago they never talked about it.

Mr KEMP - That is right.

Mr WHITELEY - Someone had just died.

Mr KEMP - So it may not necessarily be that the programs they are running are that effective. It is hard to evaluate.

Ms HAY - It could be that there would be a rise in the number of suicides because of stress and pace of living and all the rest of it, but because the prevention programs are working they are keeping the numbers the same. You just don't know.

Mr KEMP -You don't know. It could be masking a considerable potential rise if they were not there. When you get into that area it is very difficult to come up with a picture. I am sure there are people world wide researching these sorts of issues and I do not think any one has really come up with an answer. There is a variety of opinions and a variety of different programs out there operating but how effective are they?

DEPUTY CHAIR - Is there one more gripping question people need to ask of Ray before we conclude?

Mr WILKINSON - I don't know whether it is gripping but it is a question.

Mr BEST - Magic wand!

Mr WILKINSON - The message I got from the conference that Kerry and I went to in Sydney was that there is not any easy answer. It is just a matter of doing something. Once you do something, then I suppose you are able to work from that. Do you think it is the same? There is no real foundation of knowns other than, yes, suicide is being committed, it is being committed in a number of different ways, but the causes are just a multitude of reasons.

Mr KEMP - Yes and the complexity of it is just so great. Someone described it recently - and I thought it was quite appropriate - as a miasma of misery. It is so complex. You can probably try to set in place programs that may be effective, but there is no program that will have an overall effect across the full range. You need to focus in areas where you probably perceive risk and so forth and move resources appropriately, but I do not think any one has the answers to it because it is so complex.

We have seen people from all walks of life suiciding, including the Rene Rivkins, and there is a variety of different reasons why. We had one today, who will be classified as a suicide, but it was a murder/suicide.

Mr WILKINSON - Is this the one at Brighton.

Mr KEMP - Yes.

Mr WILKINSON - Found him, did they?

Mr KEMP - Yes, they found his body at Brighton Army Camp. That case is a murder/suicide and you will probably make some pretty easy assumptions of why that one occurred.

DEPUTY CHAIR - Compared to that, you would think a 15-year old would have a pretty uncomplicated life.

Mr KEMP - Yes.

DEPUTY CHAIR - Ray, thanks very much for your information and for joining us here today. On behalf of all committee members, I thank you very much for helping us to get a picture.

Mr KEMP - I hope I clarified some of the -

DEPUTY CHAIR - Yes, the jumping off the bridge! That was one laid to rest.

Mr KEMP - The question was raised as to whether we should be publicising this. Should we be doing something to overturn that urban myth in Tasmania because it is so pervasive.

CHAIR - I do not know.

Mr KEMP - If you have members of Parliament now continually saying that is an urban myth, it is not true, it means that today there are 10 more people who did not know that previously. We recently had comments about putting anti-jump rails and so forth on the bridge. You are talking multimillion dollars for the construction and all you have done is -

Mr MORRIS - And which bridge anyway.

Mr KEMP - And is that really going to stop them? Will they find another method?

Mr WILKINSON - The facts show they will. Guns were taken away so they found another way.

Mr KEMP - And I think with the bridge in particular it is more a case of the para-suicide process of being seen, the cry for help and the last chance.

Mr MORRIS - In fact in some ways it might be a good location because it is relatively accessible for emergency services and the like. Perhaps we should put a phone up there with an emergency number.

Mr WHITELEY - Maybe we should actually publish the number of people who have been saved from self harm.

Mr KEMP - That is the difficult one: how many each year are rescued, stopped from suicide.

DEPUTY CHAIR - Again, thanks very much, Ray.

Mr KEMP - Thank you.

THE WITNESS WITHDREW.