

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Young People with HIV or AIDS

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

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

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

*Table 1*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Reactions and Ramifications**

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

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

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

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

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

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

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

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

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

### **Responses to the Problem**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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