



White Wreath Association Ltd® A.B.N. 50 117 603 442

Action Against Suicide

Web : www.whitewreath.com

Email : white.wreath@bigpond.com

Ph No 1300 766 177 Mobile: 0410 526 562

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Submission

Inquiry into Commonwealth Funding and Administration of Mental Health Services

- a. We welcome increased spending in mental health, however we believe it must go to the seriously mentally ill not the Worried well.
- b. (i, ii, iii, iv)We know from all those people who contact us the area where things are going wrong is front line assessment and ongoing assessment. In simple terms people are being left in the community too long until tragedies happen and discharged inappropriately whilst still very unwell.
There is no scientific evidence that counselling has any positive effect on serious mental illness so recent initiatives have not been targeted to those who most need help.
- c) The above comments apply here also.
- d) Severe mental illness is ignored. Early Intervention (a term constantly bandied about) should mean rapid admission to hospital particularly for people who are suicidal homicidal and seriously violent...very often all three at once.
- e) Mental Health training must be based on the real or genuine need. At the moment 75% of existing and new money goes to the worried well. Mental illness is a 1 chronic, 2 progressive, 3 neurological disorder affecting a) the structure, b) function, c) chemistry, d) and electricity of the brain.** Mental health staff are still being taught utter nonsense that mental illness is a complex bio-psycho-social illness.
Frontline and ongoing assessment is worse than at any time than in the last 250 years.
- f) There needs to be a nationwide suicide prevention strategy along the line of our guidelines and that would overcome many of the racial/cultural/ remote /rural issues of lack of access.
- If people copied suicide that all suicidal people would blow themselves up yet hanging has always been the most common form of suicide.

Silence on suicide is indefensible.

BELOW IS WHITE WREATH ASSOC LTD-Action Against Suicide
GUIDELINES

There is a desperate need for one standard approach to people who are suicidal throughout Australia and Internationally.

In our view and in the view of scientific research suicide is caused by neurological abnormalities. Mentally well people have an instinctive reflex to survive. A normal individual cannot turn off/override this reflex or what the Greeks referred to as Eros-life force. In an individual with a neurological condition commonly referred to as a mental illness this life force can become death force or what the Greeks referred to as Thanatos. Survival instincts are located in the Limbic System of the brain.

All current suicide prevention strategies fail because they do not acknowledge the neurological base of mental illness. Mental illness is a 1) Chronic, 2) Progressive, 3) Neurological Disorder affecting the, 4) Structure, 5) Function and 6) Chemistry of the Brain.

Assessment of mental illness should always cover these six points, currently it does not

1a. All patients should have a full physiological/neurologic examination, not just a "mental health assessment," "psycho-social assessment" and "risk assessment". For eg scars, burn marks and frequent cut/slash marks are noticed on the patient's skin and the patient say that they have never self harmed/attempted suicide it is tempting to say that they are hiding/lying-attention seeking, personality disorders etc. The truth may well be that the patient is in fact very ambivalent about their self-harming behaviour. At one interview they will admit that they will self-harm at another interview they will deny that they will self-harm.

1b. The fact that they can burn or cut themselves without pain is a feature of both localised reduction in pain sensation and disturbance of the limbic/serotonergic system of the central nervous system (i.e. the brain)

At present the tendency is for professionals to interpret signs of self-harm as willful attention seeking by manipulative antisocial personality disordered patients. Rejection by the mental health system leads to further suicide attempts and a high-completed suicide rate. The fact is any mental illness from anorexia to schizophrenia can involve self-harm/self destructive behaviour.

2. Self referral and or referral by relatives should be treated as an emergency- if the patient refuses admission then compulsory provisions of the Mental Health Act should be used.

3. Public safety is paramount when one talks of patient's safety this must automatically mean public safety.

The link of suicide with murder is almost without exception ignored by researchers and planners in relation to suicide policies and responses.

Professor Hughes in "Suicide and Violence Assessment in Psychiatry", Gen.Hospital psychiatry 1996 says, "It is estimated that 17% of Psychiatric emergency service patients are suicidal, 17% are Homicidal, and 5% are both suicidal and homicidal".

"Murder is one of the strongest predictors of suicide with a 30% suicide rate found amongst murderers in England." Source "serotonin, suicide and aggression; clinical studies" (Golden, Gilmore, Corrigan, Eketrom, Knight, Carbutt; Journal of Clinical Psychiatry 1991)

Recent high profile murders, murder suicide and at least one mass killing in Queensland were all preceded by one or more suicide attempts. In the worst killing the person was regarded as an "attention seeker".

4. Threats of suicide and self-harm including actual self-harm should be treated as if they were actual attempted suicides. In simple terms people are either suicidal or not suicidal. Personal judgments' about highly moderately, vaguely, possibly suicidal, should not be used/they are dangerously misleading.

5. Prisons have best practice suicide prevention. Key features are: -

a. If an individual or his family says they are suicidal he/she is treated as suicidal.

b. No one grandiose professional can make an arbitrary decision that a patient who was seriously suicidal one day is no longer suicidal the next.

c. High risk assessment teams made up of five people determine change in observation category. Each individual on the team must personally feel safe about the patient before there is a change in observation category. In simple terms no senior clinician can heavy other discipline/members to agree with him or her, as currently happens in the mental health system. We believe this is a good model to follow and would be happy to assist you and help to set up such a system. (This could put Qld up there with best practice suicide prevention)

6. All terms must be defined. For eg risk means, risk of suicide, murder and violence. Assessment means, a step-by-step process starting with a disciplined outward physical examination/observation before any verbal questions are asked. Again we are happy to take part in training professionals. This is a practical skill and needs to be taught on the job/workplace possibly with the assistance of a training video. If you are honest, assessment skills as they are currently taught in universities and places of training are appalling. In reality

many professionals miss obvious suicidal behaviours/clues. Accurate assessment is the rock on which the service rests. Safety, patient safety means public safety, therefore part of this issue is asking the family/loved ones, are they happy with the plan of action. Minimum periods of observation should be at least five days in the hospital for example, 48 hours cat. Red or constant observation for

example (refer also to high risk assessment teams mentioned earlier) suicide literally means: - self-murder.

7. In more than 80% of completed suicides and other mental health disasters someone close to the patient and or the patient themselves have tried, in good faith, to get help from professionals but been turned away.

This is both an attitude and training problem/issue.

Our concerns are reinforced by the real life experiences of our members and supporters and the recently released Sentinel Events Committee Report of the NSW Government.

8. History: - history taking/currently patients are asked only about their immediate family where as patients should be asked if there is a history of " Nervous breakdowns" (the term mental illness means raving lunatic to most people and they will simply deny it), early death suicide, self harm, drug and alcohol use to the point where it destroys family life/for at least 3 generations i.e. grandparents and further back if possible, family history, anywhere, is the one of the strongest indicators of both suicide and murder.

9. Suicide is special and specially prepared professionals should always be called in before patients are turned away/released.

10. Professionals must be accountable or nothing will change/many psychiatrists see suicide as a nuisance and a "red herring". To the best of our knowledge no Qld Psychiatrist has ever been held accountable for the death of a patient.

11. Mental Health Act/legislation must have provisions written in to ensure early admissions for suicidal patients (this was always the case for hundreds of years/such provisions only being removed as part of the de-institutionalisation/ anti Psychiatry policies of the last 20 years.

12. The hard scientific or factual evidence is that suicide, violence and murder are caused by morphological changes in the brain combined with low serotonin. Simply the structure, function and chemistry of the brain are not normal.

The newer Selective Serotonin re-uptake inhibitor drugs (S.S.R.I.s) are said to be safer in terms of it being harder to overdose on these drugs. However recent suggestions are that SSRIs (Zoloft, Prozac, Effexor, etc etc etc) may cause up to three to five times the rate of suicide in young people/particularly below 20 years of age. There are a number of lawsuits against drug

companies, and at least one recent murder in Australia was said in Court to have been caused by one of these drugs.

Depression is widely promoted as the major epidemic of the modern age and this in turn has led to a massive rise in the use of SSRIs, ".... In 1998 Doctors wrote 8.2 million anti-depressant prescriptions, compared to 5.1 million in 1990....", and the source "The new Abuse Excuse" by Claire Harvey, Monica Videnieks, Australian 25 May 2001.

There is no scientific evidence that serious mental illness is increasing, it occurs at the rate of 3% of the population everywhere regardless of drug use, child abuse, child rearing practices, stress, modern life pressures, youth of today, on and on ad nauseum. There is evidence that depression is the "In disease" and that prescribing of all psychotropic medication is increasing.

We recommend that anyone that is to be commenced on medication altering mood, feeling and thinking ability (Psychotropic medication) should be commenced on this medication in hospital.

The reality is that it is extremely difficult to get the right medication for the right patient.

Practically all of the newer anti-depressant and anti-psychotic medication takes 4-6 weeks to get to therapeutic levels. All psychotropic, psycho-active substances have serotonergic affects on the brain i.e. from alcohol and cigarettes to street drugs, from speed to Prozac. This combined with the fact that the scientific evidence is that there is a cause and effect relationship between low serotonin and suicide, murder and violence.

In our view this means that these drugs should be commenced in hospital where patients are under observation/protection/place of safety. It is also a clinical observation that in the first few days of commencing an anti-depressant the suicide rate dramatically increases.

13. Most of what we have said requires very little "New Money". If you are really serious about suicide then all of these areas must be covered i.e.

funding

professional/clinical practice

public safety

legislation

Yours Sincerely

Fanita Clark

CEO