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

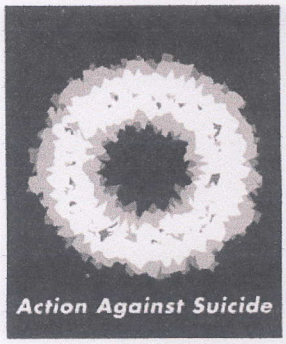
Action Against Suicide

HEAD OFFICE: PO Box 1078 Browns Plains QLD 4118

Web : www.whitewreath.com **Email :** white.wreath@bigpond.com

Ph No 1300 766 177 Mobile: 0410 526 562

NATIONAL WHITE WREATH DAY 29th MAY



19 September 2009

HEALTH INQUIRY INTO SUICIDE IN AUSTRALIA 2009

a) The personal, social and financial costs of suicide in Australia.

30 years ago anyone who was depressed and suicidal, anyone who mentioned that they were suicidal would have immediately been admitted to a "Place of Safety"/Asylum or hospital. The tragic death of many Australians illustrates how death seeking the "Modern Approach" of "Deinstitutionalisation/Care in the Community" recovery dogma model of "Care" is. Suicide was once recognised as a life threatening emergency. Thousands of people die needlessly in Australia because "Suicidal people are being cared for in the Community" Most that have completed suicide have had prior attempts and encounters with emergency services eg Police, Ambulance, Hospitals which this in itself places a financial burden on the Australian Government and also extends far beyond emergency services with assisting the victims and their families financially with monetary assistance. The White Wreath Assoc receives many cases over similar if not identical situations and the following is just an example.

- Police had three involvements with a young man and the hospital three presentations. The young man was aged 20 years with family history of mental illness. By definition he is in the highest risk group of suicide. He showed both suicidal and homicidal tendencies but still refused hospital admission.
- A woman's husband of 28 years who days before was refused hospital admission finally shot himself with a shot gun in the head a few feet away from her. The woman was splattered with brain matter. The room in their home that this tragedy occurred required cleaning and repairs and the woman herself was extremely traumatised and will be forever after witnessing such a horrific scene. This woman is unable to work and will require treatment for a very long time which will be funded from taxpayer funded services.
- A wife/mother that her 32year old husband who presented himself on three occasions to a public hospital and on three occasions refused admission only to take his life by hanging himself. He left behind a wife and four very young children aged 2,3,5 & 8 years. The husband was the sole financial provider.

These are only a few examples of the many cases the White Wreath Association receives and tragically this shows that people experiencing a major mental illness are a higher risk of suicide and self-harm than many other members of the community. This particularly applies during the days immediately after discharge from a psychiatric facility therefore in our opinion **no money whatsoever was saved by refusing hospital admission** as all the above will be supported long term by government financially one way or another. What you must also bear in mind is the loss of working hours by the direct family members while their loved ones are alive and who are there at all times for their loved ones trying to support and help them.

b) The accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides, (and the consequences of any under-reporting on understanding risk factors and providing services to those at risk)

We do not accept censorship of suicide information. Censorship of suicide information serves the self interest of the Psychiatric Profession, defensive Health Administrators and Government who closed all mental health beds. There use to be 300 per 100,000 medium and long term beds and now there are **NO** medium or long term beds in Australia. Suicide remains the only life threatening condition where people are routinely refused hospital admission. Censoring suicide information is the first step censoring all news. The media along with Government, Health Administrators, Health Professionals, Coroners and other public officials have been covering up the true rate of suicide and methods of suicide for over forty years. Suicide bombers are made public virtually every day….if methods of suicide encouraged others to suicide, why doesn't every suicidal person blow themselves up.

The media in concert with all the other three power "estates" have deliberately covered up the massive rise in suicide, murder suicide and mass killings since the wholesale closure of mental health beds, down from 300 per 100,000 to no medium and long term beds now. For eg over the last thirty years the young male suicide rate in Australia has risen 400%.

c) The appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcements and general health services in assisting people at risk of suicide.

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. 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. 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. 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.

d) The effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging help-seeking and enhancing public discussion of suicide.

To date apart from the White Wreath Association we have found no effective awareness programs.

If an individual or his family says they are suicidal he/she is treated as suicidal. No one grandiose professional can make an arbitrary decision that a patient who was seriously suicidal one day is no longer suicidal the next. 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.

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. 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 with constant observation. Suicide literally means: - self-murder. 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.

e) The efficacy of suicide prevention training and support for front line health and community workers providing services to people at risk.

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. Suicide is special and specially prepared professionals should

always be called in before patients are turned away/released. 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. 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. 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 lead 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 etc. 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.

f) The role of targeted programs and services that address the particular circumstances of high risk groups.

Recent high profile murders, murder suicide and at least one mass killing were all preceded by one or more suicide attempts. In the worst killing the person was regarded as an "attention seeker". 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. All emergency services must be re-trained and this includes Health Professionals, Health Administrators etc

g) The adequacy of the current program of research into suicide and suicide prevention, and the manner in which findings are disseminated to practitioners and incorporated into government policy.

As previously outlined family history is of the utmost importance and the White Wreath Assoc know of families that have lost all their children to suicide (4) in other families parents have lost three and two children. One of many questions the White Wreath Assoc asks to those that contact us has any "Body" contacted you regarding research and the reply has always been **NO** If research was truly serious then "Why" have these families not been contacted. We understand those involved are grieving and families must be treated with the utmost care however this can be achieved through our organisation for the betterment of research.

h) The effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress.

The White Wreath Assoc is **NOT** a Therapy/Therapeutic Group or a Phone Counseling Group (eg like Lifeline). What we are is a "Group" advocating changes that we know will benefit people affected by suicide/mental illness. We advocate early intervention (eg rapid admission into hospital) when individuals and loved ones detect a change, which indicate a person is at risk of suicide. Most of what we have said requires very little" New Money" and we would be happy to assist you with best practice in suicide prevention. The White Wreath Association has had a great deal of success in helping people to obtain information and support.

Yours Sincerely

Fanita Clark
CEO