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To: Committee, HAA (REPS)
Subject: Youth Suicide Discussion Paper

Supp. Submission No. 8.1
(Youth Suicide)
Date: 17/02/2011

HOUSE OF REPRESENTATIVES : COMMITTEE ON HEALTH AND AGEING

A response to the discussion paper on youth suicide
My initial submission was no.8

I have some concerns as to the conclusions which the committee has come to in regards to the directions future strategies should take. I am also however pleased to see the committee recognises that the poor quality of the data available to the government means that much policy has been directed by practitioners who are often either lacking in direct experience of the client group or are influenced by other interests.

1.1 Stating that 1 in 4 young male deaths and 1 in 5 young female deaths are suicides unfortunately obscures the fact that about 85% of suicides of Australians younger than 25 are men. The distortion of the date occurs because of the higher overall death rates for young males. Person reading 1.1 may think there is little difference in the rates and numbers of young male and female suicide deaths in Australia.
The decrease in the incidence of suicide in Australia over the past 10 years rather supports my observation that male suicide in this country has for over 100 years shown a strong correlation to male employment rates and we have recently witnessed a significant drop in unemployment.

1.2 The incidence of mental illness in a population reflects how it is defined. I would suggest committee members should look at 'The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder by Horwitz and Wakefield. As I mention in my submission a mental illness style intervention for young men who are not mentally ill can be very harmful. I am pleased to see the committee is aware of this (1.12).

1.27 Local government. Most local government organisations lack the trained staff or the knowledge to assist persons at risk or to direct service provision. Service provision through local government instrumentatilities would be worse than our current policy of referral to mental illness services.

1.29 Collaboration: Since the Action Plan of 1995 the first port of call for persons expressing the desire to self-harm has been mental health services. As a worker of many years experience I would state categorically that my experiences with mental health have not shown these organisations to be effective collaborators. In particular as I outline in my submission when a person at risk has been directed to mental health and does not exhibit symptoms of a profound mental illness or an immediate threat to self harm with a stated method., the person at risk will be sent away very often with no further referral or a referral to a service with a lengthy waiting list. This once again is worse than no intervention.

1.40 I am pleased the committee was able to hear from young people who had negative responses from services. These can be lethal. I recall trying to obtain help (from a community mental health team) for a young neighbour who was having a psychotic episode . Firstly I was told I had no right to assume he was ill. I explained my background and the symptoms I was observing. I was then asked if he was renting the property and if so I should contact the agent or the landlord and have him evicted. Problem solved! Fortunately I had the direct line number for Victoria's Chief psychiatrist Dr Ruth Vine and was able to take action.

1.44 Frontline services Please do not refer persons who are not mentally ill to mental health. See my submission as to why.
The highest rates of suicide occur amongst young men in the most disadvantaged communities. A data base like the one I completed shows this conclusively. Interestingly in rural communities high rates of young male suicide will occur in areas where young female suicide is almost unknown. So mental illness must only effect young rural men! No once again it is disadvantage ,lack of opportunity, inappropriate educational options and the lack of clinicians skilled at engaging men

Psychosis is not the predominant factor in suicide causation. The overrepresentation of mental health patients in suicide data has other causes some of which are the lack of long and medium term beds, the impact of inappropriate medication and poor case management eg the example I provide above.

Conclusion

Unlike most of the other submittees to this inquiry I have had a past and continuing involvement with the young people the committee is most interested, on a regular face to face basis.
The first suicidal young man I supported was back in 1986. I was interrupted in writing this by another somewhat older man at risk who needed to be seen now.
Prompt community based support by skilled practitioners who can engage men and if necessary assess and refer persons displaying symptoms of mental illness is the most practical strategy the committee could recommend.
Blanket referral to mental health with it's attendant pharmacotherapies has been and will continue to be a disaster.

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