13 September 2020

Committee Secretary
Senate Foreign Affairs, Defence and Trade Legislation Committee
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Committee Secretary

Submission:-

National Commissioner for Defence and Veteran Suicide Prevention Bill 2020 and the National Commissioner for Defence and Veteran Suicide Prevention (Consequential Amendments) Bill 2020

Please find our submission we wrote to Sir Peter Cosgrove in 2004. The issues are exactly the same and have not been addressed anywhere in Australian society. The scientific fact is that suicide is a neurological disorder which increases with age. Suicide is and always has been highest in the seventy-year age group and higher, even though this gets next to no publicity. " The severe psychiatric disorders including Schizophrenia, Bipolar Disorder, Severe Depression, Obsessive Compulsive Disorder, have been like other neurologically caused diseases such as Parkinson's and Alzheimer's, clearly proved to be diseases of the brain. Their proper treatment demands expertise in the brain physiology and pharmacology, rather than in human relationships. We have trained literally thousands of mental health professionals.....Psychiatrists, psychologists and psychiatric social workers....to provide counselling when what we really need are a few thousand professionals such as Neurologists, who are trained to treat diseases of the brain. (A Well Intentioned Disaster- The Fallout From Releasing the Mentally Ill from Institutions, Prof, E Fuller Torrey.)

THE FOLLOWING ARE OUR RECOMMENDATIONS: -

BY THE WHITE WREATH ASSOCIATION INC & PETER NEAME WHITE WREATH ASSOCIATION RESEARCH OFFICER AND BOOK AUTHOR

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 patients skin and the patients say they have never self harmed/attempted suicide it is tempting to say they are hiding/lying-attention seeking, personality disorders etc 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 an other 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 they limbic/serotonergic of the central nervous system (ie. the brain)

At present the tendency is for professionals to interpret signs of self-harm as wilful 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 researches 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 amounts murders 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 judgements 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 say 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 member s 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 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 practises, 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 practise
public safety
legislation

Kindest regards

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