White Wreath Association Inc. ABN : 66 592 492 997

Action Against Suicide

HEAD OFFICE: PO Box 1078 Browns Plains BC QLD 4118

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

Ph: 07 3219 7279 Fax 07 3219 8148 Mobile: 0410 526 562

NATIONAL WHITE WREATH DAY 29th MAY

26 April 2005

Committee Secretary
Senate Select Committee on Mental Health
Department of the Senate
Parliament House
CANBERRA ACT 2600
Australia

Dear Secretary

White Wreath - Action Against Suicide was formed by Fanita Clark who lost her newly diagnosed schizophrenic son to suicide in 1999. She knows first hand how hard it is to "access" mental health care.

We hear the same pattern of refusal to admit and assess early when a family, loved ones, and even the patients themselves seek help. We know of countless tragedies where people have tried five or more mental health facilities only to be refused admission and to go on to suicide, and in some tragic circumstance kill their entire family.

The following submission has been prepared for White Wreath by Peter Neame. Peter Neame is a Mental Health nurse, Forensic nurse and general nurse of 34 years; author of four books including "Suicide and Mental Health in Australia and New Zealand" 1997 and "Profile of the Mass Killer Amok, Murder, Madness and Badness" 2003. Peter is White Wreath Assoc Inc Research and Publicity Officer.

RECOMMENDATIONS IN ORDER OF PRIORITY

White Wreath has cut back the number of recommendations to only those that are essential to both save lives and improve mental health immediately. So much has been said about mental health locally, nationally and internationally. There have been literally thousands of enquiries and tens of thousands of preventable deaths, but the objective evidence is that mental health care for the 3% of the population who are seriously mentally ill is worse than at any time in 250 years – any time in Australia's history.

1. All suicidal people, that is people who say they are suicidal, whose friends, relatives and carers say they are suicidal or those who indulge in acts that are self-harming, attempted suicide or self destruction be immediately admitted, compulsorily if necessary, to hospital for a period of no less than three months. Explanation:- This one provision would save at least 3,000 lives per year.

2. That Psychiatry become a branch of Neurology – Mental Health Assessment should be neurologically grounded. Verbal assessments lead to thousands of deaths per year. Assessments are worse than at any time in the last 250 years.

3. Any professional who refuses a patient care and that patient subsequently suicides, commits murder or serious offence must be named and charged with murder, manslaughter, arson etc., whatever the subsequent disaster.

4. That mental health professionals be given immediate training in the neurology of mental illness.

5. That all professionals be trained in how to assess people for suicide, murder and violence.

6. That all people no matter where they present i.e. at Court for anti social behavior and violence, at Family Services for "dysfunctional behavior" at the Family Court and especially all those who are subject to Domestic Violence Orders be assessed for suicide, murder and violence.

7. That only Mental Health Nurses and Psychiatrists with a minimum of 5000 hours direct patient contact with the mentally ill be responsible for training Mental Health Professionals and for the care and management of mentally ill people.

8. A return to a three year on the job Mental Health Nurse Training Program with separate registration.

Feminist studies and social engineering witchcraft and sorcery have replaced a minimum standard of clinical hours experience so much so that the training in Mental Health of both doctors and nurses is the worst in the world.

Note: We have not mentioned the need for more beds, money or more resources and manpower because if individual professionals get frontline assessment right then these services will automatically follow the increased demand. At present resources have been taken from the Mental Health Services to bolster the doubling of the prison population and the massive increase in throughput of the Court system. Lawyers, judges and prisons get money that should be spent on the Mental Health System.

INTRODUCTION

There have been countless enquiries into the prison system and the mental health system.
More often than not these enquiries have been subverted or hijacked by the perceived need to "push prison reform" or "push reform of the mental health system". Reform meaning closure of beds.

With the wholesale closure of Mental Hospitals more seriously mentally ill people are "cared for" in the prison system than anywhere else.

There are no medium and long term mental health beds, down from 32000 in 1960 with a population of 10.1 million to nil now with a population of 20 million. If there were any beds mental health professions would not fill them for they have been trained only to treat the worried well and those with self limiting/stress/relationship crises. It takes 5 – 10 years for a seriously mentally ill person to get appropriate care. 75 – 80% of the chronically mentally ill get refused or "gate keeped" from care because "there are no beds". Conversely if the mentally ill person commits a serious crime a bed suddenly becomes available in the prison system.

Dorothea Dix campaigned for 40 y ears to get the mentally ill out of jails and into hospitals from 1841 – 1880. Now 125 years later they are back in jail if they do not kill themselves in the meantime.

In 1939 Penrose advances the thesis that a relatively stable number of persons are confined in any industrial society. Using prison and mental hospital census date from 18 European countries, Penrose found an inverse relationship between prison and mental hospital populations. He theorized that if one of these forms of confinement were reduced, the other would increase. According to this theory, where prison populations are extensive, mental hospital populations will be small and vice versa. Thus if there is room in prison and a shortage of hospital beds, many mentally ill who come to the attention of law enforcement might well be directed to the criminal justice system. Another corollary of this theory is that if civil commitment is reduced, involvement with the criminal courts will increase. Source (***Persons with severe mental illness in Jails and Prisons: A Review***, Psychiatric Services April 1998")

What is the point? Society "the system" still spends the same amount on the mentally ill but they have to offend and go through the Courts to prison. Money from the mental health system has gone into lawyers' and judges' pockets and onto the prison system. The price for society is also a massive rise in suicide, murder-suicide, mass killing, arson, violence and sex offending. Interestingly Governments were quite pragmatic about creating beds in the 1880's. Prisons, for example, "Hokititia Goal" were simply renamed Seaview Lunatic Asylum.

Sixty-eight percent of the prison population is mentally ill. Therefore all development about prisons and mental health should occur together.

MENTAL ILLNESS

"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". Prof. E Fuller –Torrey.

What this means is that mental illness is a neurological disorder or brain disease affecting:

1. Structure
2. Function
3. Chemistry of the brain

Schizophrenia remains the main reason for people with mental illness attending general practitioner clinics but depression gets all the publicity. Schizophrenia is the main cause of suicide but depression gets all the publicity. Why?!!!

Serious mental illness affects 3% of the population the world over no matter what the upbringing practices are, use of drugs, stress, prejudice against gays etc etc ad nauseum. This one fact tells you in an epidemiological sense that mental illness is not caused by external social factors. Health professions are taught that suicide-mental illness is a "complex bio-psycho-social illness". This is only really a pseudo-sophisticated interpretation of the totally discredited Flower-Power anti science, anti psychiatric view that the mentally ill are the "sensitive victims of a sick society".

99.9% of mental illness happens at conception.

0.1% may be caused by disease, toxin, or injury to the brain.

Serious mental illness affects 600,000 Australians of which one third cope well with little or no intervention, one third require treatment for life and one third require hospitalisation and treatment for life.

The constant repetition of the "one in five will suffer a mental illness" is just the extension of the nonsense that the mentally ill are the sensitive victims of a sick society who can of course be cured by "caring in the community", empathy, therapeutic alliances, counseling, phone counseling, rebirthing, getting in touch with our inner, outer and sexual self.

Why one in five?!! This is four million people in Australia a massive target population for the sale of antidepressants and other expensive psychotropic medication. Also a target population for the other "social therapies" for which there is not a scrap of scientific evidence. When you say one in five you are implying everyone can be mentally illness. This is factually incorrect nonsense.

The end result is that 75-80% of the seriously mentally get no treatment whatsoever. The government on advice by Psychiatrists and Social Planners made conscious deliberate move away from treating serious mental illness – an illness that is a progressive neurological disorder that tends to get worse over time – an illness that is not positive and trendy, to the worried well.

By pretending mental illness is everything but a severe progressive neurological illness t hat is 100% caused by biological factors we have made society a much more dangerous and miserable place. Almost all the 200,000 homeless people in Australia are mentally ill, 68% of the prison population is mentally ill and although total crime has decreased violent crime has increased.

Yorkshire Post – Monday September 19th, 1994
The self-evident folly of Care in the Community

One day it will be admitted that Care in the Community was a blunder; but by then it will be too late to undo the damage. Blame will inevitably fall on the Government and not on the expert professions who bulldozed it through 20 years ago.

Not only does the policy not work; it could never conceivably have worked. Commonsense tells us that, if you take 100 patients from a long-stay "mental" hospital where they are under proper supervision, with all facilities on site, there will chaos if you scatter them throughout the community.

Complaints about under funding are useful political ammunition for Labour and union demagogues but they are irrelevant. No amount of funding could guarantee regular supervision of every individual by trained staffs. The notion is absurdity, as a labour government would very soon discover. Parents and relatives of patients in long-stay hospitals have always been united in condemning the wholesale closure of these institutions.

Against almost impossible odds, they are still campaigning for hospitals to be kept open.

One Yorkshire relative wrote to Sir Keith (now Lord) Joseph to express concern. He replied: Alas I was one of those who launched the plan to move people from old institutions into community care. I left the Department before it became clear that provision in community was lagging badly and there would still be a need to have refuges for those who couldn't cope.

"The White Paper which I fathered was over-optimistic about the provision of community care facilities." Lord Joseph is one of those rare birds a politician who admits he was wrong.

Relatives support groups have tried unsuccessfully to discover the fate of former hospital patients who have been "released". Even the Chief inspector of Prisons has had difficulty in finding out how many have ended up in jail."

The only evidence comes from regular news reports of murders, accidents, suicides and other tragedies. (An epileptic patient, who had spent 40 years in a West Yorkshire hospital, was found drowned alone in a bath after being "relocated".)

There is no proper coordination between hospitals, prisons, psychiatrists, GPs, nurses, social workers and housing departments. It is not their fault. They are stuck with an impossible task and, until someone admits it is impossible to guarantee Care in the Community, the chaos will continue."

Professionals blame government for problems in mental health but it is professionals who refuse people care at the front line and discharge unwell people inappropriately.

The Burdekin Report and the National Mental Health Plans have made the situation worse.

The reality is that "Modern Mental Care" and mental health planning is the direct cause of all our current problems in mental health.

MENTAL HEALTH ACTS, LAWS, LEGISLATION

If the Senate Select Committee on Mental Health is serious you will quickly realize that changes that will save lies, reduce misery, homelessness and suffering – must happen at the front line – at the point of first contact whether it be family/social services, family court, general practice clinic, police, prison, criminal court, counseling services. Where ever a mentally ill person first turns up.

Simply changing laws – bits of paper like National Mental Health Plans changes nothing. However, important mental health legislation changes must be:-

a) Legislated right of access for voluntary patients

b) Legislated right of admission as first line of treatment for anyone who is suicidal, claims to be suicidal or said by the friends and loved ones to be suicidal. When I first started 34 years ago – suicide meant automatic admission – now the suicide rate in young men is 400% higher.

If patients can get treatment early on in their illness then they can be prevented from becoming or graduating to a forensic patient, committing suicide, or just general deterioration in their mental state.

Health Care generally depends on three levels of prevention i.e.

1. Primary or first level prevention:- i.e. eliminating the illness altogether. Nothing whatsoever has to date been shown to prevent or reduce the level of mental illness therefore prevention in mental illness must start at the next two levels.

2. Secondary Prevention:- Intervening as early as possible where the illness has been diagnosed/suspected for example intervening early in families where there is a pattern of

3. mental illness, drug abuse, early offending, suicide, arson, homicide or indeed anything that may be associated with mental illness.

4. Tertiary prevention:- At this level or prevention the illness is well established and treatment/management is aimed at preventing the worst outcomes, for example long term institutionalization, loss of job, social contact, family, homelessness, side-effects of medication, imprisonment.

By definition any mental health act that does not incorporate a legislated right to early intervention and focuses entirely on compulsory/committed patients is by definition an unsafe and deficient act. Unfortunately many mental health acts throughout the world have been reformed in this way. The presumption of these reforms is that voluntary patients can access care when they need it. This idea/dogma primarily from the 'antipsychiatry movement' which has been adopted as main stream psychiatric practice (the common result of which is that when people try to access care they are almost always turned away). The idea/dogma that patients can and will voluntarily seek help ignores the fact that serious mental illness affects the very thought processes of mind. In the very early stages of a serious mental illness patients may recognize that they need help, but once the illness takes hold patients, commonly will not accept they are ill and in need of treatment. This is in stark contrast to a physical illness where the more discomfort/sickness one feels the more one is likely to seek help and be cooperative and thankful for that help.

In practical every day life what does this mean?.....Quite simply it means that patients have to be very ill to get services and this means by definition that there will be a subsequent rise in suicide, murder, murder-suicide mass killing, arson, crime, sex offending, violent offences, homelessness, drug and alcohol problems and the straight physical disorders associated with all of these things such as Hepatitis C and Tuberculosis.

Unfortunately changes to legislation are usually not to direct future practices as much as to put in p lace legal framework for what is already happening. Thus mental health disasters will only be prevented when professionals change their practice back to early intervention and when governments spend serious money on serious mental illness rather that on the worried well-which of course are where the votes are, if there are any votes in mental illness.

DRUGS AND OTHER "EXTERNAL CAUSES"

There should b e 70,000 mental health beds – that is medium and long term beds nationwide. There are no medium and long term beds – mental illness is now more common and visible to everyone therefore there is a rise in single issue causes – quick fix – moral crusade – election campaigning.

Indeed if the select committee merely uses the inquiry to "beat the government around the head" you have lost the point completely.

Drug crusades do not alter the drug problem or mental illness. There is no scientific evidence that drugs cause mental illness even tough drug induced psychosis is an accepted diagnosis.

Psychiatric diagnosis is not scientific and relies solely on an emotive-subjective interpretation of the outward presenting symptoms – there is no objective test for mental disorders – no scientific test. Repeated studies in Scotland, England, U.S.A. and Europe have shown that patients with similar social and verbal skills as the psychiatrists get favourable diagnosis where those from lesser backgrounds do not.

Professionals, politicians and others use drugs to say that people cause their illness by abuse of drugs and are therefore responsible for their own illness – part of the ancient moral prejudice against the mentally ill.

HOW OUR BRAINS FEND OFF MADNESS

28 August 2004 "New Scientist" – Rachel Nowak, Melbourne

Cannabis like substance produced by the brain may dampen delusional or psychotic experiences rather than trigger them.

Heavy cannabis use has been linked to psychosis in the past, leading researches to look for a connection between the natural cannabinoid system and schizophrenia. Sure enough, when Markus Leweke of the University of Cologne, Germany, and Andrea Giuffrida, and Danielle Piomelli of the University of California, Irvine, looked at levels of the natural cannabis-like substance anandamide, they were higher in people with schizophrenia then in healthy controls.

The team measured levels of anandamide in the cerebrospinal fluid (CSF) of 47 people suffering their first bout of schizophrenia, but who had not yet taken any drugs for it, and 26 people who had symptoms of psychosis and have a high risk of schizophrenia. Compared with 84 healthy volunteers, levels were six times as high in people with symptoms of psychosis and eight times as high in those with schizophrenia.

This is a massive increase in anandamide levels,'Leweke told the National Cannabis and Mental Illness Conference in Melbourne, Australia, last week. And that is just in the CSF. Levels could be a hundred times higher in the synapses, where nerve signaling is taking place, he says.

But were the high anaddamide levels triggering the psychotic symptoms or a response to them? Leweke, and his colleagues found, to their surprise, that the more severe people's schizophrenia was the lower their anandamide levels.

The team's theory is that rather than triggering psychosis, the substance is released in response to psychotic symptoms to help control them. People with the worst symptoms might be unable to produce sufficient anadamide to prevent them.

At some point in their lives, between 5 and 30 per cent of healthy people have had symptoms such s delusions or hallucinations, which can be triggered by something as simple as sleep deprivation. 'All of us are potentially psychotic," says David Castle of the University of Melbourne. So for the body to have a system that prevents these experiences getting out of hand makes sense, he says.

The new findings suggest antipsychotic drugs could be developed that target the anandamide system, but it will not be simple. The active ingredient in cannabis THC binds to anandamide receptors. But people with schizophrenia who use cannabis actually have more servere and frequent psychotic episodes than those who do not. This may be because THC makes anadamide receptors less sensitive.

Leweke's team also found anandamide levels lowest in people with schizophrenia who used cannabis more frequently, suggesting it may disrupt the system in other ways too.

Up to 60 per cent of people with schizophrenia use cannabis. A study by Castle, also reported at the Melbourne meeting, has found that people use the drug to get rid of unpleasant emotions associated with the disease such as anxiety and depression."

All people who have a drug addiction to the point where it destroys their lives have an underlying mental illness – mental illness is the cause not the other way around.

MANY MENTALLY ILL LACK CARE

Adapted from an article by Carol Nader in "The Age" 25 February 2004

Many mentally ill people who also have significant drug problems are being denied access to the mental health system because they're considered too difficult to treat, experts say.

And patients who are admitted to psychiatric clinics in hospital are easily gaining access to illicit drugs.

General practitioner Michael Aufgang, who specializes in treating drug addiction, said many advanced psychiatric patients also had a drug problem, but 'the most needy are left without treatment'.

'Sometimes the role of the emergency department is to be a caring and supportive environment for these people, and we need to accept that, rather than say they don't belong here,' he said.

Melbourne University professor Patrick McGorry said there was resistance to liking psychiatric and drug counseling services. Because resources were so stretched, 'if they can see a way not to get involved in a case, they'll do it'.

One woman, who did not wish to be named, talked about her son who died from a heroin overdose a year ago. She said her son, who was 27 when he died and was a heroin addict from the age 14, developed a mental dysfunction after trying to get off a methadone 'cold turkey' program. He spent several months in a psychiatric ward, but she said the hospital did not treat his drug problem.

'It's almost like you go to hospital with hospital with cancer and a broken arm, and they treat your broken arm but not your cancer,' she said. 'That's what happened. They don't liaise with the drug counselors, and its killing kids.'

Opposition health spokesman David Davis said there was a need for integrated services that dealt with the complex needs of patients, rather that 'a series of services that treat in a fragmented way the different problems of the one patient'.

"Unfortunately the morphological deficits that underlie the chemical imbalance often remain unchecked. In many instances, pharmacologic treatment must be sustained indefinitely, with the added burden, in many cases, of increasing dosage due to decreasing efficiency of the drug/receptor interaction". "Awakening the Sleeping Giant" Those readers who have viewed the film "Awakenings" would have seen this same effect after initial 'miraculous cure' Dopamine, steadily lost its effectiveness – a common experience with patients who are seriously mentally ill and regarded as 'treatment resistant'.

"Drugs that produce hallucinogenic effects in humans, such as lysergic cid diethylamide (LSD), mescaline, and dimethoxymethyl amphetamine (DOM), demonstrate high affinity for 5-HT" and 5 H'c receptors". (Behavioural Studies of Serotonin Receptor Agonists as Antidepressant Drugs).

"In addition, it has been shown that morphine, amphetamine, cocaine, and nicotine self administration, as well as intracranial self stimulation, are all decreased following 5-HT uptake inhibition" 'S.S.R.I.'s Effects on Motivated and Consummatory Behaviours'.

SCHIZOPHRENIA AND DRUG ABUSE

(From headlines, the Newsletter of the Neuroscience Institute of Schizophrenia and Allied Disorders Sept 2001)

"For many families coping with non-compliance, it will come as no surprise that many schizophrenia patients abuse drugs. Even excluding their very high levels of tobacco smoking, around half of all patients appear to use whatever mind-altering substances are available to them. The most common drugs, in descending order of usage-frequency are alcohol, cannabis, amphetamines, opiates such as heroin, and hallucinogens. The reported effects include increased rates of relapse and hospitalization; worsening of psychotic symptoms; increased aggressive behaviour, and increased period of homelessness.

This tendency to drug abuse is no much higher than found in healthy people of equivalent age groups that it warrants being recognized as a symptom of the illness. And when drug abuse is added to the other problems of non-compliance, it adds yet another burden of distress upon families and carers."

The modern approach is to admit that there is an association of mental illness with violence but to 'blame' this violence on drugs. The most violent mass killers are sometimes 'obsessively clean living'.

Drug use is a symptom – not a cause of mental illness – the greater the alcohol or drug abuse the greater the underlying mental illness. In the gold rush days of California, Australia, New Zealand, and South Africa, Opium Dens and Whore Houses were open 24 hours per day – if you had the money you could buy any mind altering substance or any 'depraved sexual act' anytime of day, any day of the week including Sunday.

One can read about 'decaying morality', 'disaffected/displaced youth', drugs, and debauchery from the earliest recorded history. Drugs do not 'cause mental illness'. Truckloads of moralizing diarrhea have not contributed to understand mental illness or the "drug problem".

PRISONS THE NEW MENTAL HOSPITALS

Prison care for the mentally ill is better than no care at all because prisons provide services that were once provided by mental hospitals, asylums or true places of safety.

For a person whose life is one of chaos, disorganized severely mentally ill, constant poverty, homelessness and re-offending – sometimes the very day they are released from prison – prison is a far better, safer environment where they will get, often for the first time since they left home, dental care, medical care and mental health services.

I would echo Prof. John Gunn's comments here "The vast majority of prison staff are caring and relate well to their charges" Pg 335 British Journal of Psychiatry, 2000, "Future Directions for Treatment in Forensic Psychiatry".

In 1998 there were 49 suicides in custody – in the community there were 2700 yet massive publicity was given only to the prison suicides – the misleading assumption being that prison's cause suicide. The reality is that prisons have become the "New Mental Hospitals" and prevent thousands of suicides per year. Prisons have best practice suicide prevention.

In the community most young people who show early warning signs of mental illness: self destructive/self harm behaviour, withdrawn, aggressive behaviour, petty offences, excessive use of drugs and alcohol as well as actually saying they will suicide to the point where parent/loved ones try to get them help – will be turned away (with tragic consequences) by outpatients Departments and mental health facilities. See the two cases enclosed – a murder and suicide at the end of this submission.

The reality is that in a climate where there are no medium and long term beds and where mental Health Professionals are taught it is "bad practice", "anti-therapeutic", likely to cause institutionalization", "a treatment of last resort". (All dogma from the anti psychiatry – de-institutionalisation movement), early imprisonment even mandatory sentencing <u>actually saves lives.</u>

<u>The idea that Prisons are "brutalizing" places is largely nonsense.</u>

The intellectual arguments about "criminalizing the Mentally Ill" and conversely "medicalising Criminal behaviour" (the idea that criminals are not criminals but victims of illness, stress, child abuse, bad parents etc.) have probably been with us since the beginning of civilization. So has the fanciful idea that some magical potion, snake oil solution, "positive environment" exists in the community that will magically cure mental illness/criminal behaviour. Community has always been the cheapest option – societies do not spend such large sums of money unless there is no choice.

A most recent case covered by the Australian is an excellent example of how Mental Health Services get it so wrong and why beds are so important. In this case the police's action to arrest and jail the young 17 year old is probably the only action that will save his life. The Mental Health System was "caring for" him in the community.

Suicidal teenager to face charges – Australian 15 April 2005

A teenager who threw himself in front of a moving car in what his lawyer described as a "sad cry for help" has been charged with damaging the vehicle's windscreen.

The 17 year old Aboriginal boy was in detention last night after appearing briefly in Perth Children's Court with a visible scar on his neck.

He cut his throat with a piece of broken bottle early last November and just weeks later in the goldfields town of Boulder he allegedly threw himself in front of a Subaru sedan as drove through a roundabout, landing on the bonnet on the passenger's side and cracking the windscreen.

He allegedly told the driver he was trying to kill himself then ran away.

Magistrate Sue Gordon, chair of the Prime Minister's National Indigenous Council, expressed concern for the boy's mental state. His lawyer, Peter Collins, said his mental health had worsened since he was placed in detention a month ago for an unrelated breach of bail and other offences

He has been known to police for about five years and recently pleaded guilty to four charges, including assaulting a police officer. But mental health advocates described the latest charge against him as callous and disappointing.

Associate Professor Ted Wilkes, who this week helped to launch a report into indigenous youth that found almost one in four was at high risk of mental illness, said he was flabbergasted that police would consider such a charge.

"It's cruel for any human being in crisis to be treated like that," he said. "With indigenous youth, we need tolerance and compassion to break the poverty cycle and all that comes with it."

Professor Sven Silburn, chair of the state's Ministerial Council for Suicide Prevention, said he would ask Police Commissioner Karl O'Callaghan for more information about the circumstances.

"What this is going to do for Kalgoorlie's reputation and for race relations in that town cannot be good," h e said.

Commissioner O'Callaghan is on leave and a spokesman refused to comment on the damage charge.

Mr Collins told the court police in the goldfields city of Kalgoorlie charged the then 16 year old as part of a "no tolerance" policy to antisocial behaviour.

Mr Collins told Ms Gordon that Kalgoorlie police had refused to drop the charge, despite discussions with Perth prosecutors, who believed it was not in the public interest to proceed.

Ms Gordon will today consider a bail application for the youth provided a relative can commit to supervising him and ensuring he gets psychological treatment.----------

Suicide is not a romantic "cry for help" it is the result of a serious mental illness and maybe the first warning sign of serious mental illness.

Martin Bryant's father committed suicide. The young Jeff Weise, 15 years old, who shot 10 people before committing suicide in a school massacre at Red Lake, Minnesota, USA on March 24, 2005, father also committed suicide. Both had exhibited weird anti social behaviour for years before the massacre including direct threats. In Bryant's case there were many suicide by-car attempts one which left him seriously injured and his partner dead. Bryant's first mental health referral was at age 4 years and he is Australia's best example of "Community Care" or "Care in the Community".

Alcohol and Drug Services will not alter the prison rate because the underlying reason why people become addicted is mental illness, not as Drug and Alcohol Treatment Specialists would have you believe – the other way around. It has been known for centuries that people with mental illness use alcohol and drugs as self-medication. All of us have access to drugs and alcohol. Less than 3% become addicted. Recent research shows that over 90% of people who have a drug and alcohol problem have underlying mental illness. Countries that ban drugs and alcohol have exactly the same rate of mental illness.

As part of the De-institutionalisation anti psychiatry movement drug and alcohol services become a "Specialty" a totally artificial creation.

So what happens now to the 90% of people with a dual diagnosis i.e. mental illness plus drug additction, they turn up to drug treatment facilities and they are told that they have a mental illness therefore they should "access" Mental Health Services. If they can find a mental health service they are told that they have a drug problem therefore they should "access" drug treatment services. The end result is that they get no treatment. However it should be recognized that probably 90% of Forensic patients will not comply with treatment and even if they do – compliance does not mean an end to violence and re-offending something deliberately ignored when people talk of "community alternatives".

What am I saying here? Quite clearly the individuals who are seriously mentally ill and now outnumber the old fashioned "honest Crim " who made crime his occupation/business, are very ill and need institutional care. 60% New Zealand, 68% UK and 63% USA of the prison population are said to be mentally ill on the basis of recently conducted research.

Dual diagnosis that is having a mental illness plus a drug/alcohol problem or a mental illness and an intellectual handicap or as more likely the case with intellectually handicapped people - all three. Dual diagnosis or multiple diagnoses is again a "mutagenic child" of the de-institutionalisation – anti psychiatry movement. For example, an individual who is charged with a number of offences from willful damage to assault and has a diagnosis of:

- Schizophrenia
- Anti-social Personality
- Borderline Intelligence
- Substance Abuse

(Very common scenario)
Which diagnosis are we treating today???? Here is a real life, very common results in order of most likely occurrence:

At the Mental Health Service we are short of beds as we almost always are and there is also not-to-put-too-fine-a-point on it the added incentive of getting rid of a "difficult patient".

Day 1. Clinician

"Well this man has a personality disorder, therefore he is not mentally ill and therefore, we can send him back to prison".
Plan – back to prison.

Day 2. (Same shortage of beds and anti psychiatry ideology)

"This man has a drug treatment problem more appropriately handled by drug treatment services in the community or prison".
Plan – back to prison.

Day 3.

"This man is intellectually impaired more appropriately treated "in the community" but since he is facing charges he can "access" facilities in prison".
Plan – discharge back to prison.

Day 4. Schizophrenia

"This man is now stabilised on h is medication".
Plan – discharge back to prison.

When I started training as a psychiatric nurse in 1971 we had Primary and Secondary Diagnoses – the primary diagnosis is where treatment was concentrated. **In the above example Schizophrenia has caused all of the other diagnoses including the alleged borderline or diminished intelligence**.

The truth is, despite State and Federal Ten Year Mental Health Plans, full of grandiose generalizations there is no effective State or Federal Mental Health System. Health care depends on:

I. early intervention
II. access
III. availability of services

Nothing has ever been discovered that prevents mental illness – it occurs at the same rate everywhere. So early intervention depends on medium and long-tem beds. Remember that closure of Psychiatric Hospitals was followed by the closure of Social Welfare Homes, Youth Detention Centres, Centres specifically designed for the Intellectually Handicapped. Intellectual Handicap by itself does not lead to institutional care unless very severe. Most intellectually handicapped people who were in mental hospitals and now jails were there because of mental illness and /or drug abuse. The rate of mental illness in intellectually disabled people is 50% higher than of the general population. **Indeed all recent research points to something also noted centuries ago, that mental illness, criminal behaviour, suicide, intellectual disability, drug and alcohol abuse, personality etc is genetic in origin.**

So with the closure of all other institutions prisons have become the last repository for all those who are at risk to themselves or others or who just cannot cope.

"Overall prison populations in Australia have increased from 12,113 in 1987 to 19,082 in 1997". ("Some jails face the challenge from ageing inmates". Source – Courier Mail, Monday May 31, 1999)

During the same period mental hospital populations decreased from 10,163 to 4,000, a decrease of around 6,000 beds – a very similar figure to the increase, 6,969 of prisoner population.

MENTAL HEALTH PROFESSIONALS

It is the action of the individual clinician (doctor, nurse, social worker, psychologist, counselor etc) from the first point of contact that determines whether a mentally ill person dies or lives. Too many die.

Policies, legislation, documents are just bits of paper and <u>real agenda</u> of the current system recommended by the Burdekin Report and all federal and State plans since is "Gate keeping or refusing the seriously mentally ill care and transferring what resources there are to the worried well who have self limiting conditions not requiring any treatment at all.

Professional training has been subverted with social engineering concepts of "feminism", "freedom", "self direction", "least restrictive practices", "patient's rights" and privacy laws. It is now a patients right to kill himself and his family.

A 13 year old boy had been telling a school counselor about his suicidal desires for nearly a year when he finally hung himself at age 14 years. His mother only found out that he had been suicidal after his death – the counselor refused to tell t he family on the grounds of privacy/confidentiality.

Health professionals refuse to tell parents about their child's illness "on privacy grounds" even though the parent will subsequently be given the impossible task of caring for their seriously mentally ill loved one. All part of a self-fulfilling cycle of nonsense that ends in death. When a person has a heart attack or serious life threatening accident do we go through this pseudo-sophisticated hand wringing nonsense – no! And that is the real prejudice on mental illness – not taking it seriously or substituting inquiries, planning documents, national and states' mental health plans for action, paralysis by analysis.

Many perhaps as much as 99% of mental health professionals unaware that mental illness, serious mental illness occurs at the same rate everywhere 3%. 80% of known scientifically proven – factual cause of schizophrenia is genetic.

Professionals are still being taught that mental illness/suicide is caused by child abuse, upbringing, stress, prejudice against gays – social causes or social causation. Thus when a parent demands that their child get appropriate care they are often accused of abusing their child and suicidal people are subjected to hours upon hours of grilling about child abuse.

Children are told to leave home as part of modern psychiatric care – leading to homelessness, abuse on the streets, even murder and suicide.

PSYCHIATIC DIAGNOSIS, PREJUDICE AND LABELLING

There are many labels which professionals who talk about "reducing stigma", "prejudice" and "labeling" use to refuse care. These are commonly – "No evidence of mental illness" (almost always a total lie), "Mainly behavioural" (always a misdiagnosis) – there is no such diagnosis as behavioural – neurological disorders commonly lead to deterioration in behaviour. "P.D." (i.e. personality disorder, therefore untreatable, therefore a criminal justice problem, therefore not our problem). A.S..P.D. – Anti social personality disorder (same explanation for P.D.). Attention seekers – people who self harm (Deliberate self harm D.S.H., self mutilation), cutting off a limb, penis, breast, ear, or gouging out their own eyes to sticking pins and objects into themselves and burning and slicing their skin superficially are labeled "Attention seekers". In war time and in torture chambers of old superficial burns, cuts and mutilations were known as the most painful because this is where the body has most of the nerve endings sensitive to pain.

If you self mutilate it means you are oblivious to pain and have low skin conductivity, an outward extension of the serious neurological problems in the brain but professionals are not taught to assess people in this factual objective way.

The "bread and butter" of the mental health system the very reason for the existence of "A Mental Health System" are the chronically mentally ill – those who need treatment and sometimes hospitalization for life. If the same patients turn up to the same services or outpatients department day after day, year after year with the same complaints or worsening complaints then it is very easy for that service to find reasons to reject the patient - especially if the service is based on "Recovery" and "Rehabilitation" and refuse to recognize that some people remain seriously ill for life.

In mental health the way to hell is paved with good intentions. Edward Shorter in "History of Psychiatry – From the Era of the Asylum to the Age of Prozac" 1997 describes de-institutionalisation as "one of the greatest social debacles of all time".

Suicide is the only life threatening condition where people are routinely refused admission. In what other life threatening condition would a person be refused care. There is none this is the real prejudice in mental health – not taking it seriously. Campaigns about prejudice, deinstitutionalization, labeling are a deliberate smoke screen for total neglect and complete rejection of those most in need of care. In other words the "Inverse Care Law" applies. The more seriously mentally ill an individual is the less care they get, conversely the healthier you are the more care you get.

Schizophrenia or earlier 'dementia praecox' is the 'bread and butter' of the mental health system. It is the most debilitating illness requiring the most use of resources worldwide. It used to be said in a time before the memory of almost all 'modern psychiatrist' and those working in the mental health field, **"if you get the treatment of Schizophrenia right, almost everything else in the mental health field will improve".** This is because Schizophrenia has everything from mood swings to catatonia, from complete starvation to homicidal violence, from complaints of pains in the bladder, bowel, heart, to pains in the head, from suicidal depression to grandiose mania.

However, as a direct result of monetarism, the de-institutionalisation movement/psychiatric survivors movement, government planners and psychiatrist made a conscious deliberate move away from the chronically mentally ill who have their illness for life and never cured, to the worried well – those suffering from 'stress disorders' and mild depression. This suited completely the doctrinaire treasury 'whiz kids' straight out of university who believed the best form of government spending is no government spending and the Psychiatric Profession who could go from $80,000 - $200,000 / year treating the chronically mentally ill to a million dollars plus a year, treating the worried well who would come right even if they were wrongly treated. Ministers of Health could claim that they had saved millions whilst the transfer of costs to the prison system could be championed as the Government 'getting tough on crime', a socially acceptable vote winner at the expense of the chronically, mentally ill.

To both achieve this aim and 'cover their tracks' both government and the Psychiatric Profession needed to 'up-grade' psychiatric diagnosis or in reality 'cook the books'.

Starting from the late 1960's to mid 1970's:-

- Drug and Alcohol services were de-institutionalised and removed from Mental Health Services, hence the total chaos in this area.
- Intellectually disabled services were de-institutionalised and removed from Mental Health Services.
- Many dangerous and violent Schizophrenic, depressive, manic and manic-depressive patients were re-categorised or re-diagnosed as Personality Disorder.

Personality disorder is short for Personality disordered therefore not our problem – a criminal justice matter etc.

As a result many seriously mentally ill patients were dumped in inadequate accommodation in the community, on the streets, prison;, or in other facilities not capable of coping with the myriad of problems presented by a person suffering from Schizophrenia.

DANGEROUSNESS AND POLICE SHOOTINGS

An acutely mentally ill patient confronted by police, by definition finds it hard if not impossible to communicate and hard if not impossible to understand. They have a neurological disorder which impairs thought formation, hearing, understanding,, perceiving. Talk therapy does not care or help mental illness and unfortunately Police are the front line mental health practitioners. They receive their preparation to handle acutely dangerous people from the very same people who routinely turn mentally ill people away from care. Therefore almost all people shot by the police are mentally ill.

The hard or scientific evidence is that medication and / or reduction I n symptoms does not make a dangerous person safe.

"Even though they may receive neuroleptic treatment, many patients suffering from schizophrenia, schizo-affective and paranoid disorders as well as other psychoses remain violent." Jari Tiihonen, **International Psychiatry** Today vol 3 no.4 1993.

"In short managing the risk of the offending behaviour can only rarely be reduced to simply controlling active symptoms of the illness." Pg 16 ***Review of Queensland Forensic Mental Health Services,*** P Mullen and Chettleburg Feb 2002, referred to hereafter as the Mullen Report.

I refer you to telegraph.co.uk "When will they ever learn?" 20/3/05. In this case a social worker, psychiatrist and a judge all said the killer was safe. Immediately following release from hospital he killed his mate, cut off his arms and fried his brains in butter before eating them. Then the heroes responsible for his care moved him out of high secure care into medium secure and he promptly killed another patient. He had already killed a young woman and the "system" encouraged him to kill two more. The report pointed out that this hideous nonsense has been going on for 15 years in England, as it has in Australia and New Zealand.

Psychiatrist and their organisations are the most irresponsible link in the chain and judges, when they make orders that an individual be assessed and treated in the community, instead of a place of safety are directly to blame also.

This downplaying of dangerousness has led directly to another Inquiry into Mental Health in Australia and a crisis in t he prison system in Western Australia.

A man who had tried suicide in 2004 in NSW was cared for in the community and killed entire family. Four lives lost where only one person was presenting as a risk, a 400% increase in mortality. No other illness has such a high mortality rate.

There is no accountability of psychiatrists, judges, lawyers, psychologist, social workers and sadly even some nurses who let dangerous people out to suicide, murder, murder-suicide, mass kill, rape and commit repeated arsons. The professionals blame "The system" ipso facto the government. No government or opposition member takes any part in the assessment treatment and management of the mentally ill. **Blaming the system is the greatest escape route of all.** Unless professionals and their associations are held directly accountable then there will be no improvement whatsoever.

Madness and Badness almost all dangerous people whether assessed as mad or bad have problems with the limbic – serotonergic system specifically the amygdale or emotional brain. They are lethal killing machines or re-offending machines because they have no concern for consequences, for themselves,

for their victims, or for society's norms, values and laws. The only management form that is safe is security and containment.

In secure setting almost all killers, rapists, violent offender's arsonists, and sex offenders appear model patients / prisoners. This is because the rules of the hospital / prison form as external code/conscience that they are unlikely to ever have. This explains in a factual neurological way why apparently model patients / prisoners ***the best behaved, most loved, empathized with, high performing*** on every test and tick sheet go on killing or re-offending sprees the moment they are released. It is impossible to overstate how dangerous these predatory killing machines are.

Why does the "system" or truthfully individual professionals get it so wrong so often. They base their assessments on verbal questioning, tick sheets, IQ tests and their personal emotional subjective feelings. Commonsense is extinct in psychiatrists, social workers and psychologists and this group of professionals express **open disdain for the public interest, public safety, and public opinion.** The jury system has survived a long time because the historical lesson is that "Experts should be on tap not on top". Members of the public have on average much more commonsense than any judge, lawyer or psychiatrist.

Assessments should be based on:-

- The presence or absence of neurological symptoms.
- Total history from the day an individual is born, not just a potted history aimed solely at "Recovery" and "Rehabilitation" of the individual killer/perpetrator. Real events such as violent acts are not included in reports or downplayed with sophisticated language. E.g. a young man who stabbed his mother to death, stabbing her 98 times becomes "An intelligent young man who has committed an index offence". "Centre for the criminally insane" becomes Forensic services then High Secure Care. ***Attempted murder of a nurse becomes "Violence in the context of the 'repressive atmosphere' of a locked facility".*** These are not mere euphemisms or political correctness. Such downplaying of dangerousness leads to murder of innocent members of the public.