White Wreath Association Ltd®
"Action against Suicide"

NEWSLETTER

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COMING EVENTS

White Wreath Day
Wear White to Work
29 May 2015

WHITE WREATH ASSOCIATION Ltd®
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Director's Report

White Wreath Association would not be able to continue without the support of it members and the general public in their generous financial contributions.

In spite of the tough economic conditions during the past year, your support has been unstinting.

We are more than grateful for your commitment and valued financial assistance as we edge closer to the aims, goals and endeavours of White Wreath.

The ultimate goal of the Association is the building of Safehavens, fully-staffed mental health facilities with ongoing programs and assessments to treat patients and assist families and carers.

As we work towards that objective, we continue to provide advocacy and support to the sufferers of mental illness and their families.

In raising awareness of the social impact mental health has on our society we are hopefully educating the public and reducing the stigma associated with mental health.

I would like to extend my sincere gratitude and appreciation to everyone who has been involved during the year in our fund-raising activities: White Wreath Day – In Remembrance of All Victims of Suicide – and Wear White at Work for those who could not attend the Service (both on 29 May); and Sock It to Suicide during the third full week in October.

Hopefully you and your friends and colleagues enjoyed yourselves and had fun with involvement in these two workplace activities.

Together we will make a difference.

I would like to thank everyone who has helped us during the year and wish all a Merry Christmas, a Happy and Prosperous New Year, and continued good health.

Fanita Clark
CEO

Peter Neame, Research Officer
White Wreath Association Ltd

The filial faith belief among the medical profession that every mental health patient can receive adequate treatment in community facilities is nothing but arrant nonsense.

Source: Brisbanetimes.com.au
Photo: Supporters of the Barrett Adolescent Centre gathered outside Parliament House to protest against its potential closure.

The closure of the 24-hour a day care State Government-run Barrett Adolescent Psychiatric Centre at Wacol in January, and the subsequent suicide of the centre's long term patients illustrates this.

The general public is well aware of the shortage of medium and long term beds and rundown condition of our mental health system.

Public awareness counts for nothing unless there is adequate provision of back-up mental health facilities. Nothing will be achieved but continued frustration.

The real need is accurate front-line assessment followed by time in hospital. Serious mental health illness affects three per cent of the population the world over, no matter what their upbringing.
One day it will be admitted that Care in the Community was a blunder. Blame will inevitably fall on the Government, not on the expert professionals who bulldozed it through.

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

Probably the best scientific defiition of a mental illness is a neurological illness that is chronic (long-term and serious), involves the structure, chemistry, electricity and function of the brain that progressively gets worse (generally) as one gets older.
As I said in my book, Suicide and Mental Health in Australia 1997, we should realise that you have to be sick to suicide.

Suicide should treated as a medical emergency, the same as it was 40 years ago. This would mean that all people with suicidal tendencies would be immediately admitted to hospital and subject to at least two week's assessment. Accurate front-line assessment is vital. The problem is the psychiatric profession and governments who do not want to provide medium and long-term hospital beds. Thus many seriously mentally ill people, who are suicidal, are misdiagnosed and refused treatment. It is recognised internationally that 96 per cent of people who are suicidal are seriously mentally ill.

That is people who suffer from serious mental illnesses, such as schizophrenia and manic depression (bipolar disorder).

Mental illness does not fly away once treated, but recurs again and again. Much of the current publicity about anxiety and depression and statements that, "one in five are mentally ill" and "one in two will suffer a mental illness" in their lifetime, are deliberately misleading.

These statements come from the mainstreaming/ care in the community movement over the past 40 years and are quite unhelpful to suicidal people. The statements are only an excuse to promote the sale of antidepressants and other expensive psychotropic medications. They are factually incorrect drivel.

Australia Media Release, Mental Health Report

One in five young Australians are likely to be experiencing mental illness, and less than 40 per cent are comfortable seeking professional help.

These are the findings of a report released in June by Mission Australia in partnership with the Black Dog Institute.

The Youth Mental Health Report found the rate of mental illness among young Australians aged 15-19 was much higher among females and Aboriginal and Torres Strait Islanders, while young people with a disability were also overrepresented.

Mission Australia CEO Catherine Yeomans said the findings highlight the increasing vulnerability of Australian youth, and the need for greater supports to help them on their journey into adulthood.

“The confronting findings in this report illustrate the significant challenges many of our young people are facing when it comes to psychological distress and mental health issues,” she said.

“This report makes it clear that Australian youth – particularly those facing significant disadvantage – need more support, not less.”

The report surveyed around 15,000 young people across the country aged 15-19 using the widely accepted measure of non-specific psychological distress known as the Kessler 6, which consists of a six item scale that asks about experiences of anxiety and depressive symptoms over a period of four weeks.

The report compared young people who were classified as having a probable mental illness and those who were not.

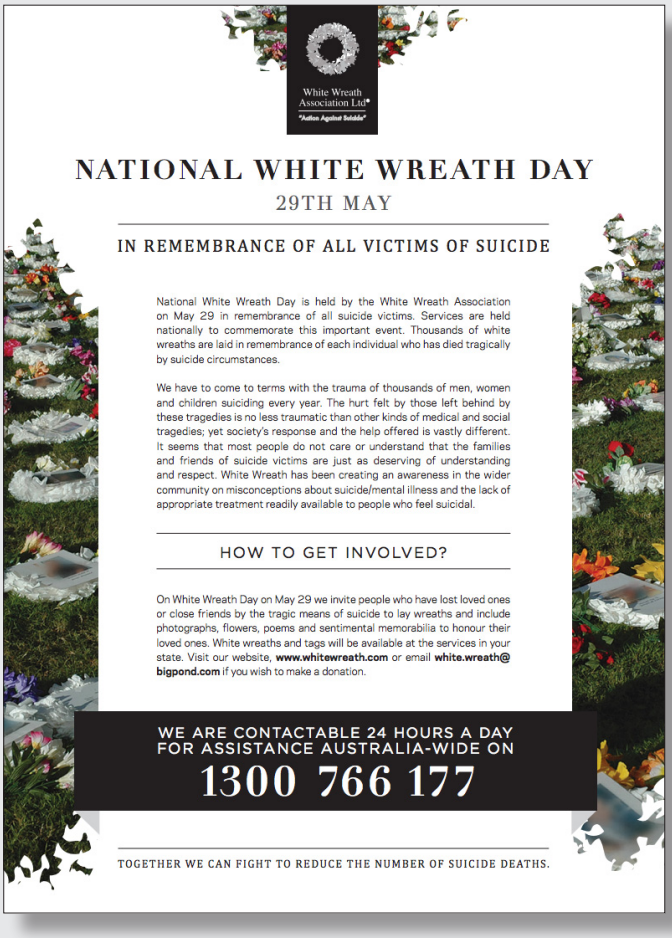
Key findings include:

- 21 per cent of young people surveyed were experiencing a probable mental illness
- Females were almost twice as likely as males to be experiencing mental illness – at 26 per cent compared to 14 per cent
- Aboriginal and Torres Strait Islander respondents were also more likely to be experiencing mental illness – at 32 per cent compared to 21 per cent for non-Aboriginal
- Over 60 per cent of young people with a mental illness were not comfortable seeking information, advice or support from community agencies, online counselling and/or telephone hotlines.
- Young people with mental illness were around five times more likely to express serious concerns about depression (57 per cent compared to 11.5 per cent) and suicide (35.3 per cent compared to 6.8 per cent).
- Young people experiencing mental distress were also more likely to be personally concerned about bullying/emotional abuse and family conflict, and were struggling with a higher number of concerns than young people who were not likely to be experiencing a mental health issue.

The Youth Mental Health Report provides a range of recommendations to address the issue:

- Targeting mental health in schools through awareness and early intervention programs
- Promoting peer education and support
- Reducing stigma that may prevent help-seeking behaviour in young people
- A whole of community focus on prevention and early intervention
- Use of online initiatives to improve access, appeal and affordability of mental health services
- Ensuring culturally appropriate service delivery, particularly for Aboriginal and Torres Strait Islander communities, as well as culturally and linguistically diverse communities
- Building a better understanding of mental health issues among families and those working with young people

Coming events



National White Wreath Day 29th May

Queensland (Main Service)

Official Ceremony 12:30 -1:30 p.m.
Display on view all day
Post Office Square (CBD)
270 Queen Street, Brisbane, Queensland

Contact
E: white.wreath@bigpond.com
Ph: 1300 766 177
M: 0410 526 562

Victoria

Civic Green (CBD)
Warrnambool, Victoria

Contact Lyn
E: stepmum108@gmail.com
M: 0417 169 073

Download and print this flyer at
www.whitewreath.com/WHITE_WREATH_DAY_FLYER.pdf

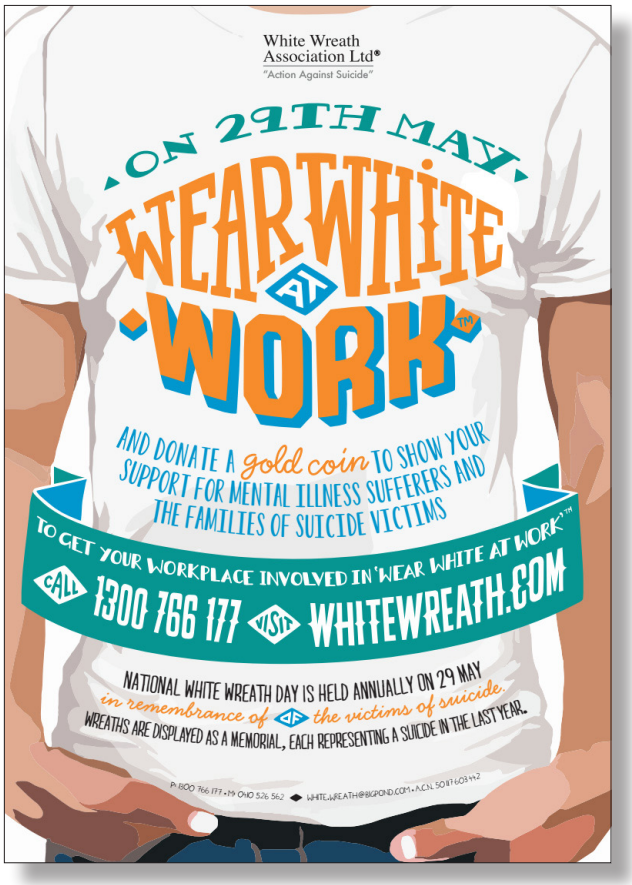
Wear White at Work 29th May

Get involved and assist us raise the much needed funds

Register your event online or contact us directly.

www.whitewreath.com
Phone: 1300 766 177
Mobile: 0410 526 562
white.wreath@bigpond.com

Download and print this flyer at
www.whitewreath.com/Wear_White_at_Work-A4_flyer.pdf



Student Assignment Assistance

One in five young Australians are likely to be experiencing mental illness, and less than 40 per cent are comfortable seeking professional help.

My name is Bonnie McCormick and I'm a third year student at Swinburne University, and as part of my minor I'm studying an introductory PR course. For an assignment, we are required to contact a NFP organisation of interest to us and to propose a hypothetical public relations plan pitch. As I'm currently studying to be a psychologist, mental health is of great interest to me and I found your organisation's approach to suicide prevention to be unique and highly pragmatic. I would love to be able to base a PR plan around the goals of your organisation, and to promote public awareness about mental health and the alarming statistics of suicide in Australia. I feel there is definitely a lack of education around the sheer magnitude of suicide and depression, as well as misconceptions regarding the vast demographics affected by these issues. As such, I was wondering if there is an appropriate person who would be willing to provide some feedback on a suggested PR plan in a couple weeks time. Thank you for your time and I hope to hear from you soon.

Dear Ms Clark,

Please find below a rough summary of the mock PR plan and a few related questions.
Thank you again for your time and assistance with my assignment.

Best Regards,
Bonnie McCormick

* * * * *

Goal
To increase public awareness of the magnitude and reality of suicide in Australia, the importance of pragmatic approaches, and to further community education through dispelling common myths and misconceptions about those affected by suicide.

Research and situational analysis
There is a substantial lack of community awareness and acknowledgment regarding the prevalence of suicide in Australia, as well as the vast demographics affected by it.

Misconceptions, myths and stigmas surrounding suicide are both vast and common, and can detrimentally impact efforts to reduce suicide rates and increase support and awareness. Research has found that:

Suicide numbers in Australia are some of the highest in the developed world, with recent statistics indicating a greater amount of deaths each year attributed to suicide than to motor vehicle accidents, yet there is very little community awareness of the magnitude of suicide in Australia.

Male suicides account for nearly 80% of recorded suicides. Even though suicide accounts for 22% of all deaths among young men between 15-24, this age group has the lowest suicide rate in comparison to other male age groups. Many are surprised to know that suicide rates are particularly high for both men and women over the age of 50, with women in the 50-54 year old age group and men above 85 having the highest rate per age group.

Target Publics
The general Queensland and national public. Particular focus on males of all age groups, and those over 50.

Mainstream media

Strategy
Suicide is an issue that affects a substantial amount of Australian's and their families every year. Misconceptions and lack of community awareness and education about suicide makes the issue less prevalent in our discourse and harder for those struggling to both understand and seek help for their problems. The strategy will therefor involve an information campaign highlighting statistics on the prevalence and demographics of those affected by suicide, and dispelling popular misconceptions to better inform the public, thereby encouraging community awareness and pragmatic approaches to seeking support.

Key Messages
Suicide in Australia can be seen as a silent and staggering epidemic, affecting all demographics and backgrounds.
Misconceptions hinder efforts to seek help and understanding.
Every life is precious and deserves adequate support

Tactics
1. Produce an educational booklet entitled "The facts about Australian Suicides" containing evidence based information, official statistics and the rates of suicide in Queensland, and of the demographics most affected by suicide. Information highlighting and dispelling common myths and misconceptions of suicide will be included, and the booklet can be easily distributed via the White Wreath website, through mental health facilities and areas attracting vast demographics such as community RSLs and shopping centres.

2. Outdoor and street advertising can be tailored to be both demographic and location specific, enabling an easy avenue to target certain publics. Publish concise and informative newspaper ads and posters contrasting the alarming statistics of suicide to other issues with greater social awareness such as skin cancer and motor vehicle accidents, and highlight the importance of pragmatic approaches such as the White Wreath Association's safe havens.

3. Distribute all communication materials via social media platforms (Facebook, Twitter, LinkedIn) and produce a dedicated and interactive website entitled 'The Facts about Australian Suicides', highlighting rates, demographics and the importance of awareness, informed education and pragmatic approaches to support.

Specific Objectives
1. To increase public awareness of the suicide rates and trends in Australia, as well as the vast demographics affected by it by at least 15 percent over the next twelve months.

2. Increase public education by actively dispelling common myths, stigmas and misconceptions surrounding suicide in Australia by at least 20 per cent over the next twelve months.

3. Raise awareness of the White Wreath organisation and the construction of safe havens as an essential and pragmatic approach to the staggering epidemic of suicide in Australia.

Q1) Do you feel that this campaign accurately reflects the goals and values of your organisation?

Q2) To what extent do you think your audience would agree and/or respond to such a campaign?

Q3) Are there ways in which you think the aims of your organisation can be better implemented into the campaign?

Q4) Are there any additional aims or messages you feel should be incorporated?

We Need You

Personal stories on mental health experiences and the affect on the person, their family and friends, are vital to making the public aware of the impact of our disastrous mental health system.

White Wreath seeks to publish as many personal stories as possible to hopefully increase community understanding and reduce stigma and discrimination.

We need stories and experiences of people dealing with the failures of our mental health system.

These stories are the most effective and powerful tool we can use in our fight to improve facilities and treatment for mental health. We also seek personal stories of people who through their own personal determination have achieved recovery.

The stories do not need to be professionally written. Tell of your experiences in your own words; write about what you know. Your message will be better understood by the reader. Sharing personal stories about living with a mental illness is important to inspiring others going through the same or similar circumstances.

All names and places mentioned in published stories will, if requested, remain anonymous.

Board Members

I am very pleased to announce the following elected Board Members and together we will serve you to the best of our ability.

Fanita Clark
Peter Neame
Mark Knipe
Ruth Avenell
Karen Smyth
Tina Knipe
Peter Clark

We sincerely thank Craig Gillespie during the time that he was with us for his wonderful work as our Accountant/Bookeeper. Replacing Craig but not a Board Member is Preeti Jain.

Membership Renewals

Please don't forget

Membership Renewals are due

on the 28 February 2014

World News

Call for inquiry after two Barrett Centre suicides

Australia - The family of an 18-year-old woman released after spending three years with 24 hour a day care at the Barrett Adolescent Centre at Wacol wants an urgent public inquiry into the reasons she committed suicide.

Source: Brisbanetimes.com.au
Photo: Mourners release purple balloons in memory of Talieha.

The two final patients to leave the former Barratt Adolescent Psychiatric Centre at Wacol when the state government closed it in January have since committed suicide.

Now the family of 18-year-old woman named Talieha wants a public inquiry into the state government's decision to close the Barrett Centre in January 2014 without providing a replacement adolescent mental health facility.

Talieha – an "arty, expressive wonderful girl" - tried to take her own life on April 1, before her life support was shut down on April 6.
Advertisement

She had turned 18 on February 6. She died two months after her 18th birthday. Talieha suffered depression, post-traumatic stress and she self-harmed.

At her funeral, family and friends released purple balloons.
A second former patient – a "funny-quieter" 18-year-old boy - from the final 10 at the Barrett Centre committed suicide at Wacol in June.

The issue of closing the Barrett Adolescent Centre without a replacement facility will be raised by Labor in the Queensland's Budget Estimates Hearings beginning today.
The state government rejects Labor's policy to build a replacement for the Barrett Centre.

A spokesman for Health Minister Lawrence Springborg insisted mental health clinicians tell them better mental health policy is to move young people to facilities closer to their families.

"It is just not our policy to build a replacement Barrett Centre because we think there are better mental care options," he said.
The spokesman - who was unaware of the suicides - said he would ask the department to investigate the type of care offered to the two young people after the Barrett Centre closed.

However Talieha's aunt, Melinda, said Queensland parents need an urgent investigation into why a teenager with a history of self-harm could go from "24/7" care at the Barrett Adolescent Centre to "independent living" at the Pine Rivers Community Care.

Melinda has written to Premier Campbell Newman and Health Minister Lawrence Springborg asking for an inquiry.

Melinda said the clinical director of the mental health facility at the Prince Charles Hospital told the family at a meeting on May 16 that the Pine River Community Care was "the best option out of a list of bad options."

Staff also told the family Taleiha should have been transitioned from the Barrett Centre to the Pine Rivers Community Care centre over six months, not over two short visits.

Continued on page 8

Call for inquiry after two Barrett Centre suicides

Continued from page 7

"We definitely want an inquiry, not only for our family and for Talieha, but for all the other kids in Queensland that have mental health problems," she said.

Melinda said the family was not completely happy with the care at the Barrett Centre, but said the 24/7 care had kept her alive.

"They kept her alive and she was there for three years," she said.
"So her mum wasn't really happy with her there, but at the end of the day they did keep her alive."

Melinda said Talieha was given just two short visits to the Pine River Community Care before they moved her from the Barrett Centre.

"They promised her she would have six weeks of 24/7 care – that's 24 hours a day care - and that lasted about two weeks," Melinda said.

"So she went from the Barrett Centre – which is like a hospital with 24-hour care with nurses on staff - to independent living.

"She was living by herself in a little unit within the Pine Rivers Community Care centre."

"So she spent three years in a hospital-type accommodation – I mean she was still a teenager at heart – she hadn't learnt all the everyday things you need to live by yourself."

Melinda said Talieha was a "selfie queen", who adored her younger cousins and loved drawing, dancing, music and videos.

"My kids are 8, 6 and 4. And she was the best big cousin they could ever have."

"Ninety per cent of her was this happy, vibrant, loving, very, very caring person.

"And that is why I am doing this. It will never ever bring her back but she would hate us if we did not fight for the rest of the kids with problems."

"She was absolutely gorgeous."
Former staff at the Barrett Centre are devastated to learn of the two suicides.

They insist the LNP made a mistake by not keeping the centre – inside the grounds of The Park adult mental health facility at Wacol - open until a replacement centre could be built.

"They did not just get moved," one staff member told Fairfax Media yesterday.

"They got dumped. That was the day they both got dumped."

"We never expected the first one to come and then the second one comes," the staff member said.

"And here's two kids, just turned 18 - who six months ago where in full-time care – who have found themselves trying to look after themselves with severe mental health issues."

The government spent the first 12 months of its time in office investigating alternative care for patients for the former Barrett Centre, before deciding to close it in January 2014.

* Fairfax Media has not published Talieha's surname at the request of her family.

http://www.brisbanetimes.com.au/queensland/call-for-inquiry-after-two-barrett-centre-suicides-20140714-zt7a0.html#ixzz37UHcunNr

World News

I Am Tired and Angry – personally speaking

USA - (August 5, 2014) I am angry and I am tired. In a four day span in Helena, two of our young citizens lost their lives due to the consequences of serious mental illnesses.

Source: Ttreatment Advocacy Center

One was a beloved son and father whose family will wonder every day for the rest of their lives what they could have done to prevent this tragedy. The other was a former neighbor who was a babysitter for our two sons many years ago.

Deaths like these remind me that psychiatric diseases are very treatable but not the way our system functions today.

Effective treatments can help improve functioning and allow some people with severe mental illness to begin the road to recovery and re-integrate with their families and communities. But we are still waiting for better antipsychotics that genuinely change the course of the illness and help people avoid some of the major side effects.

The way I see it, this won't happen because I live in a world that does not recognize serious mental illness as a legitimate disease and there is no push for better and more effective medicines for the most seriously ill.

I am angry that people in a psychiatric crisis cannot access respectful, thoughtful, compassionate and caring treatment. I am angry that our jails and prisons are overwhelmed with people suffering from serious mental illnesses. I am angry that there are more people in prison with mental illness because there are no inpatient beds when they become sick and very few treatment options.

I am angry at our elected officials, public health servants and mental health professionals who tell me that they understand the problem but don't do anything to improve the situation.

I am angry at families that do not recognize mental illness or advocate for their family members who are suffering.

I am angry at people who live with serious mental illnesses and - maybe because of shame and discrimination – don't try to access treatment.

Finally, I am tired of attending funerals for the children of families who have been lost due to serious mental illnesses.

Remember, the enemy is the illness.

Dr. Gary Mihelish
President of Nami Helena

http://www.treatmentadvocacycenter.org/about-us/our-blog/69-no-state/2601-i-am-tired-and-angry-personally-speaking

World News

Shortage of dedicated public hospital beds

Australia and New Zealand - The chronic shortage of dedicated public hospital beds in Australia and New Zealand for women with post-natal depression and their babies has been revealed in a recent discussion paper.

This shortage was disclosed in August by Queensland Mental Health Commissioner Dr Lesley van Schoubroeck in seeeking public input on a Commission discussion paper Perinatal and infant mental health service enhancement.

Queensland has the worst record of post-natal depression care with only one dedicated public hospital bed at the Prince Charles Hospital in Brisbane.

The State has 10 private beds at Belmont Private Hospital, while there are community perinatal and/or infant mental health services in only four of the 17 Hospital and Health Services, most of which are not recurrently funded.

In comparison, Victoria has an extensive network of community-based services for perinatal and infant mental health, supported by four public and four private Parent Infant Units (42 beds) for parents and families requiring inpatient treatment. Two new public units are planned for the near future.

Western Australia has community services and an eight-bed public Parent Infant unit, and will soon open another eight-bed unit.

South Australia has community services and a six-bed public unit.

New South Wales has an extensive program of community services and day programs for perinatal and infant mental health, and a 12-bed private inpatient unit.

Tasmania has community services and a six-bed unit which accommodates public and private patients.

ACT has community services. Mothers and babies can be admitted publically to Ward 2N at Calvary Hospital or privately to Hyson Green at Calvary Private Hospital.

New Zealand has community services and a six-bed public unit in Christchurch, with another six-bed public unit under construction in Auckland.

Dr van Schoubroeck said input was being sought on providing better support for families when they needed it most.
She said the Queensland Government had re-signed an agreement with the Commonwealth Government to participate in the National Perinatal Depression Initiative.

Debra Spink, a member of the Queensland Mental Health and Drug Advisory Council and co-founder of Peach Tree Perinatal Wellness, said more work was needed because figures showed suicide was the highest indirect cause of maternal death following the birth of an infant and one in six women would suffer from moderate to severe perinatal mental illness.

World News

If I Could Turn Back Time - personally speaking

USA - (August 15, 2014) I am a member of our community who lives with anxiety, sadness, fear, exhaustion, frustration, grief and society blames me for not doing enough for my son.

Source: Treatment Advocacy Center

When I drive my son to the hospital there is no one there to answer my questions or offer emotional support and when I come home, there is no consoling or casseroles waiting from friends. There will be no fundraisers to help with hospital bills.

I grieve and reminisce for the son I once raised by love and support the new child before me now. If my son had a heart attack, cancer or was in a car accident, my life would be different. My name is Nina McDaniel and I am the proud mother and advocate to my 32-year-old son, Michael, who has schizoaffective disorder.

Michael was a hard worker from a young age. Even though Michael was awkward and enjoyed being alone, he always showed a huge heart and always helped others in need. His smile warms your heart and his affection is contagious.

His downward spiral began in July 2007. He began wearing sunglasses all the time, even to bed. He also became paranoid over secret messages on the radio, helicopters flying overhead and thought his sister and her husband were part of a conspiracy.

We filed our first petition for commitment also in July 2007. This commitment resulted in only three days in the psychiatric unit. We filed another petition for commitment in August that resulted in five days of treatment in a psychiatric unit. That time he was rapidly losing weight by starving himself. Even though we were trying to save Michael's life, this began the endless cycling through the mental health system in order to attain help.

Things only got worse. In 2008, we rushed Michael to the emergency room after he tried to end his life by consuming a large amount of alcohol. The hospital just dismissed him as an alcoholic.

At one point we received a call from our daughter, who cried, "Michael swallowed a handful of my medicine, come quick!" We called the crisis unit, but nothing was done because Michael refused to voluntarily speak with them. Under the law, he still had the right to refuse treatment and remain psychotic.

After one terrifying episode that included verbal threats and a potential weapon, I was able to get Michael committed for 20 days. After the 20 days we decided as a family that we could not bring Michael home, he needed to remain in the mental health system. But that is not what happened. The hospital declined my request to have Michael placed in an intensive program. It ultimately became clear that if we did not take him home, the alternative would have been a homeless shelter and we were not going to leave him homeless.

My beautiful son deserves to receive help in his life and a chance for happiness. But instead, we feel like second class citizens, neglected by friends, neighbors and law makers who slash funding and block access to care.

Nina McDaniel
Mother of Michael

http://www.treatmentadvocacycenter.org/about-us/our-blog/69-no-state/2608-if-i-could-turn-back-time-personally-speaking-

World News

If I Could Turn Back Time, Part II - personally speaking

USA - My name is Nina McDaniel and I am the proud mother and advocate to my 32-year-old son, Michael, who has schizoaffective disorder.

Michael asked us to drive him to the hospital on his grandmother's birthday in 2010.

"I feel like I am a burden on society and I have no purpose in life, I want to kill myself," he told the emergency room. I received a phone call from the hospital 12-hours later that they had discharged him and he will be waiting for us on the curb outside.

We went home with Michael and 4 days later, he asked to be taken back to the hospital, getting there via ambulance and finally being admitted. The diagnosis was still chronic paranoid schizophrenia and he was hospitalized for only 7 days. Again and again the same cycle, the hospital has become the revolving door yielding no results toward insight or recovery. Just like other discharges, Michael stopped taking his medicine.

It was obvious that Michael was deteriorating at a rapid rate. Because of mental health laws and falling through the cracks, there was nothing that we could do to intervene. We watched this internal torture and endured the verbal abuse while praying to God to end all our pain. Michael stopped watching television, spent all of his time in the pool room or bathroom and talked to himself continuously.

Michael's enduring torture is just one symptom of this disease.

It is not a political issue, it is a humanitarian issue. Thousands are being lost every single day and families are falling apart due to the challenges of being a caregiver. Every tragedy that involves severe mental illness makes me wonder if anyone in Washington is listening.

I respectfully challenge members in government and advocacy groups to set aside their differences and take a UNITED stand for mental health.

Nina McDaniel
Mother of Michael

http://www.treatmentadvocacycenter.org/about-us/our-blog/69-no-state/2619-if-i-could-turn-back-time-part-ii-personally-speaking

World News

Man committed suicide six days after brother's unsuccessful plea for help

Peter Zovak's brother begged ACT Mental Health to get help for his severely depressed, hallucinating, despondent sibling six days before he eventually took his life.

But his desperate pleas for assistance, made less than a month after his brother was released by Canberra Hospital's mental health workers, fell on deaf ears.

"They said 'no, no, no, I don't think that's a mental health issue, tell him to see his GP'," his brother Ned Zovak told a coronial inquest on Wednesday.

"I said [to Peter], sorry mate I can't get you any help today.

"The look of devastation on his face will live with me forever."

Peter Zovak committed suicide less than a week later.

The Zovak case has raised questions of serious failings in the ACT mental health system, now being looked at by Chief Coroner Lorraine Walker.

Peter Zovak was already known to the mental health crisis assessment and treatment team, or CATT, by the time of his brother's call on December 12 last year.

A regular cannabis user, he began to experience worsening hallucinations and depression for the first time the month prior.
His brother, highly concerned at the deterioration, took him to the Canberra Hospital.

He was assessed twice and, after improvements, was discharged, with CATT workers responsible for reviewing his case.

Mental health staff had been told that Peter Zovak's condition was fluctuating and his mood subject to change in a matter of days.

A doctor at the hospital recommended two face-to-face visits with the man at his home to keep tabs on his condition.

Only one of those visits was ever conducted.

During that 15-minute visit, Peter Zovak told them from his driveway that he felt fine, and appeared to have improved and to be free from any risk of self-harm or suicide.

Instead of a second visit later that week, CATT staff called him the very next day, in which he again claimed to feel fine.
No effort was made to contact his family, including his brother, despite the fact he was the first to have raised the alarm with mental health services when he brought Peter Zovak to hospital the month prior.

Instead, they decided to cease contact with the client, later closing his file.

His brother, when he later called CATT in a state of desperation on December 12, would tell them he had not improved since his hospital visit three weeks earlier.

The CATT worker who took the call gave evidence to the inquest on Wednesday, claiming Ned Zovak had never pleaded for them to send help.

"In my view, that discussion never happened," he said.
He said he didn't recall Ned Zovak telling him his brother hadn't slept for a week, and claimed he agreed to send his sibling to a GP before CATT would become involved.

Silence on Suicide

Throughout history there has always been places of safety for the mentally ill – from monastery to hospital. It is only in the last forty years that we have believed we can do away with places of safety or mental hospitals.

The reasons for mental hospitals were:

- A place of safety or protection for the patient.
- Peace and quiet or a reduction in sensory stimulus (stress) which tended to agitate the patient.
- Return to a normal day/night, sleep/awake pattern (no sleep at all, sleep disturbance, or sleeping all day and up and agitated all night – "day/night reversal") – commonly occur in mental illness.
- Return to a healthy diet – not eating, over-eating or just very poor diet are common in serious mental illness.
- Return to a normal daily work/rest pattern.
- Basic level of physical health, diet, hygiene treatment of medical problems, all of which are neglected in mental illness.
- Protect suicidal patients from themselves.
- Protect society from dangerous patients.
- Establishment of a therapeutic community (such as White Wreath Association's proposals).

Nightly we are treated to television advertisements of the dying moments of car accident victims to discourage people from driving whilst tired, drunk or speeding – nothing is said about privacy or confidentiality. Yet when a person attempts or talks of suicide in a treatment setting, his family are often not told.

We are treated to every aspect from conception to birth, to surgical separation of Siamese twins, yet nothing is said about privacy and confidentiality, but when a suicidal-mentally ill patient is discharged into his parents or family's care they are often told nothing – on the grounds that it would breach the patient's right to confidentiality.

When a suicidal patient is refused care and subsequently suicides it is seldom publicised, yet heart disease, Aids, cancer, epilepsy, everything but suicide/mental illness gets masses of publicity and funding/awareness campaigns.

The deliberate official and media blind-spot on suicide/mental illness must be the greatest public hypocrisy of the late 20th century and early 21st century. Heart attack, serious injury, respiratory arrest etc – all life threatening conditions, are immediately admitted to hospital – suicide/mental illness is the only life-threatening condition where people are routinely turned away and this is something that has only happened in the last forty years.

Living with a Person Who Suffers Mental Illness

My life living with and trying to care for my partner suffering mental illness is very difficult.

I am from European background and like most families; my family is not supportive of me supporting my Australian partner. I am left alone most of the time to cope the best way I can, mainly because of cultural reasons. I was born in Australia but my parents came at a much later stage in life to Australia. Because of my European background certain issues of my existing life must be dealt only within the family and not broadcasted outside of direct family. Guilt and dirty linen must not be spoken about. They do not want anyone knowing that my partner has mental illness because of the shame.

Compassion and empathy from my family is non-existent except for one person, my Auntie. This saddens me as I wish up until now for support from my (mother, father, and sister) to help me cope as a carer for my partner or at least try to understand her illness and what I am going through as a carer.

I know this attitude is wrong and I can't cope with this alone. I need as a carer to talk to others, always trying to seek a solution to this devastation that has overcome my partner which I truly love. I want the best for her and myself so we both can regain a normal relationship. But I'm torn between family, traditions, beliefs and what my heart dictates to me.

As of European background I have contacted other European organisations for help and assistance only to be told, "To no avail"

I am at my tether end where I feel like chucking the towel in. However in my heart I strongly believe that being there for my partner I am making a difference, as difficult as it is. With the assistance of the White Wreath Association I feel there is a light at the end of the tunnel and I am truly grateful for their continued understanding and support. Not only for myself but also the work that they are doing in the community, educating the public on the seriousness of mental illness/suicide.

I hope my brief story is read by those of European background living in Australia who is in the same dilemma as I am.

Anonymous

A friend 4 me - my story

Kelly's Journal continued.

I remember telling her about the police dog. The only thing I remember her saying was "Man's best friend". I'm taken to the hospital. David phones and say he's coming. Louise phones to say she is coming. I tell Louise not to come because David is. After this night I loose Louise as a friend. She doesn't talk to me again. David turns up. I'm still off my face. I am laughing. David is so upset he leaves. He takes my phone with him to keep it safe. I'm not in a state to complain about that. He phones my Jo while I'm in hospital. I never find out what they talked about. I'm so sick after that.

I had never been so sick in my life. It was the worst sickness I could imagine. I can't walk. I'm on a drip. I can't stop vomiting and shitting. My hair start's to fall out; there are handfuls of it in my bed everywhere.

The next day Saturday Trudi comes to visit me. She is not happy with me. I tell her how upset I am about phoning Jo. She tells me not to worry about it. I remain on the drip for Easter. I'm disappointed when David does not turn up for Easter. He sends Melissa in with our kids; she has Easter eggs for me to give them.

I spend the week locked in mental health I meet a man while there, his name is Paul. He is having a party at his house for everyone when we get out. He gives me his address and phone number. I decide to go but I never do. When I get out of hospital I go straight to see David. He is still seeing Joanne but he tells me that she is just a friend. I'm happy I can tell he loves me and I can still win him. I'm staying at my dad's house when I get out of hospital.

Its Friday 10-4-2010 I wait at David's for him to come home from work. We have sex again and then he says he is going out for tea. I go back to my dad's. I don't know it at the time but he is taking Joanne out for tea. I find out a few weeks later and I find out months later that she had spent the night in his bed but its ok Joanne is just a friend. He thinks of her like a sister. She is good to talk to. He tells me this all the time. He says they only put up on Facebook that they are in a relationship because she was having trouble with another male and he leaves her alone now. I make it through the weekend. Well until Sunday afternoon at least.

Man committed suicide six days after brother's unsuccessful plea for help

Continued from page 7

That's despite Peter Zovak not having a regular GP, or even a Medicare card, according to his brother.

Under questioning by Zovak family barrister Wayne Sharwood, the worker agreed he may have now done things differently.

"Looking back now, I may have put the phone call as a follow-up phone call for the next day or day after," he said.

The worker claimed he was limited in his response because Peter Zovak did not want help from CATT.

That assumption was based on the client's attitude during the home visit and phone call the month prior, when he told staff he didn't need their help.

But Ned Zovak gave evidence that he told the CATT worker his brother liked CATT staff and favoured their help over the prospect of going back to the hospital, where he feared he would be locked up in padded cells.

"He just wanted to shove me off straight away to a GP," he told the inquest.

Counsel assisting Sarah McFarland, Mr Sharwood, and lawyers for the ACT government will now submit written submissions to the inquest.

Chief Coroner Walker told the inquest she may decide to issue notices of adverse findings.

Her findings will be handed down at a later date.

http://www.treatmentadvocacycenter.org/about-us/our-blog/69-no-state/2619-if-i-could-turn-back-time-part-ii-personally-speaking

Correspondence

My son has been an intense passionate person his entire life. But when tragedy struck in 2006 he turned for the dark side of himself.

He was 19 driving through the mountains with his best friend and his younger brother when he fell asleep and went I over a 60 ft ravine. Him and his friend were thrown from the truck but the young brother had his seat belt on and died. My son felt it should have been him. He consequently broke his back and suffered a serious head injury, which I believe is part of the current problems.

Then in 2009 he fell backwards from a 5-story balcony on purpose. He survived only because he did not struggle. He again broke his back. He now suffers intense back pain.

Now this Christmas his father, his best friend was found dead and he came home from Texas to his funeral. He then was driving back to Texas when he went through LA was robbed and shot twice. He is currently still in the hospital from this. He got shot in the leg and arm because he fought back and ran. Otherwise I believe he was meant to be killed.

All of his fathers' worldly possessions that he wanted to keep were stolen and his dad's dog he loved was put in the pound.

His car is impounded by police for evidence and won't be available for a few wks or until the investigation is complete. His best friend believes he has a death wish and I know he does. He speaks of wanting to die often. I need help before he does it. I'm at a loss as to what to do for him. I want him committed! But he's an adult and won't admit to medical personnel that he wants to die. He lost his best friend his dad and I did to. I don't have him now to be here with me to deal with our son. I am alone here trying to figure out what to do. Please help.

. . . . .

I read your statement Fanita and it rang home to me.

My son is 24, has major depression, and has attempted suicide once. I'm frightened of him as he has been violent including knocking over and breaking my wrist. But I also love him and feel powerless to help him or save him. I suspect that he will die before me.

I would not blame him as I think that suicide is perhaps a sane response to an insane and unbearable situation.

Thank you for fighting to the stigma of mental illness and suicide.

You can help

You can do your part to help White Wreath Association.

YOU CAN BE A VOLUNTEER

We need volunteers from any part of Australia.

YOU CAN GIVE IN KIND

- Petrol Gift Cards
- Stamps

OR DONATE BY SELECTING ANY OF THESE OPTIONS

1. Via credit card then follow the instructions.

2. Directly/Direct Transfer into any Westpac Bank
   Account Name:
   White Wreath Association Ltd
   BSB No 034-109 Account No 210509

3. Cheque/Money Order to:
   White Wreath Association Ltd
   PO Box 1078 Browns Plains QLD 4118

Donations are tax deductible.

Humour

I asked God for a bike, but I know God doesn't work that way. So I stole a bike and asked for forgiveness.

* * * * *

Why do people say "no offense" right before they're about to offend you?

Evening news is where they begin with "Good evening," and then proceed to tell you why it isn't.

* * * * *

The odds of going to the store for a loaf of bread and coming out with only a loaf of bread are three billion to one.