White Wreath Association Ltd®
"Action against Suicide"

NEWSLETTER

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DIRECTOR'S REPORT

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Politicians, of all persuasions, are guilty of paying lip service when it comes to urgently needed changes to Australia's shambolic mental health system.

The recent Federal election campaign caused a hiatus in state governments' introduction of any meaningful mental health strategies.

Australia is in dire need of coordination of our mental health system, involving input from all arms of government – federal, state and council.

White Wreath supports the recent call by Suicide Prevention Australia for the federal government to set up a body within the Department of Health to secure cross-portfolio approaches to suicide prevention.

As good as this move would be, it does not go far enough.

The National Mental Health Commission held an extensive review of mental health programmes and services, handing down its findings last year to the Federal Government.

One of the commission's findings was: "Despite almost $10 billion in Commonwealth spending on mental health every year, there are no agreed or consistent national measures of whether this is leading to effective outcomes or whether people's lives are being improved as a result."

The response by then health minister Sussan Ley was a program of reforms to be rolled out over three years from this year until 2019.

These programs have been put on hold with the calling of the Federal

Follow us

election, the government going into caretaker mode..

It would have been obvious that the massive input by organisations and individuals into the Commission's inquiry would have provided ample evidence of the state of the mental health system.

But that was not good enough for the Australian Capital Territory Legislative Assembly, which decided in February this year to hold its own inquiry into youth suicide and self harm in the ACT.

I have lost count on the number of inquiries held over recent years by various governments into our mental health system.

Whenever mental health reform is mentioned to our politicians, their immediate reflexive action is to call for an inquiry.

What a waste of both time and money.

I would like to thank Lynny Mast, Warrnambool Victoria, for her tireless work in assisting White Wreath within her local area of Warrnambool Vic and Mount Isa Indigenous Men's Group (Ngukuthati Men's Shed) for organising the inaugural White Wreath Walk that was held on the 23 May and to all those that got involved with "Wear White At Work that coincided with White Wreath Day - In Remembrance of All Victims of Suicide both held on the 29 May yearly.

Fanita Clark
CEO

PETER NEAME, Research Officer, White Wreath Association Ltd

In keeping with the need to go back and restate why White Wreath Action Against Suicide was formed we need to look at the hard scientific evidence. Internationally in repeated studies it is recognised that between 93-96% of those who complete suicide were suffering from a diagnosed serious mental disorder that was currently undergoing treatment or had had recent treatment. For all intent and purposes only those suffering from serious mental illness commit suicide. Serious mental illnesses are Schizophrenia, manic-depression(bipolar disorder), psychotic depression and paranoid and delusional belief disorders.

Almost all of these illnesses one of the most profound symptoms is complete lack of understanding that they are ill ...a symptom from neurology called anosognosia. Thus the public campaigns in New Zealand and Australia to encourage those suffering from "anxiety and depression" to "seek help' are little short of nonsense.

The tragic reality is that if a person suffering from schizophrenia or manic depression seeks help they will be told that they have too much

insight and hospitalisation will only make things worse.

What is deliberately left out in the discussion about suicide is that in both New Zealand and Australia from the 1970s on all mental health...medium and long term beds were closed....32,000 in Australia and 10,000 in NZ. I pointed out more than 30yrs ago that for every one bed closed per hundred thousand population there where at least 7 more suicides and at least one more murder.

Trying to treat suicidal people "in the community" is hideously homicidal. If the community was the best place for seriously mentally people how did they get sick in the first place?

Suicide remains the only life threatening condition where people are routinely refused care. Of course in official reports it is not called "refusing care" it has the bureaucratic double speak word of "gate-keeping.

FEEDBACK

Hi
I'm madly trying to find out if there are any events held in Adelaide. I've just relocated from Brisbane and I'm struggling to find any events advertised over this way. Does your organization by any chance have contact with any organizations in South Australia that have an interest or focus on suicide prevention, remembrance, bereavement support, education etc that may run an event or that you could suggest /recommend I contact

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Hi I live in ….. and we have had a lot of suicides recently in February alone there were 5 deaths caused by suicide. I have started a men's group for indigenous me to talk about suicide. I came across White Wreath Assc. for information and it has been the most informative web site. I have suffered through suicide by my brother and nephew and 2 cousins. I would like to start a White Wreath group in ….. For me I want to be able to assist people to recognise triggers and invitations. And to offer myself and other people as supports, I also have been diagnosed with depression but I function with medication. I am a facilitator of young men's program funded by the Movember Foundation. In the past 2 meetings that we have had with the local indigenous men there has been over 50 participants. I have been trained by ASSIST suicide intervention and CORES suicide intervention both lacks any human - personal content. I have also attempted suicide in the past. I have seen so much grief by suicide that I would like to continue what I am doing in a professional capacity. When I developed a questionnaire and one of the questions was do you think there is stigma/shame attached to suicide it had a one hundred response of yes.

I sincerely thank you for your web page and will continue to do what I do in ….

I am sending you this email as a representative of a group of Tafe students, currently we are studying Suicide , the effects on families and we are gathering as much information as we are possibly able to. We have read a large content of the information available on your web site and have it to be most informative, which is why we have selected your organization to contact and ask if you would be so kind to assist us.
We would all appreciate sincerely if you would be able to send any brochures or information which is related to the White Wreath Organization to assist us in being further informed and being able to in turn bring further awareness of this very sensitive issue.
We have to date been able to find Lifeline and the Black Dog organization in Victoria related to this issue and I will be researching this further today.
If you are aware of any other contacts that address this issue in the North East of Victoria, we would be very grateful for any further information also.

With Kindest Regards

WORLD NEWS

AUSTRALIA

Call for national body to address suicide rates

A national office for suicide prevention should be established to end the piecemeal approach to suicide rates, says Suicide Prevention Australia (SPA).

Sue Murray, SPA's chief executive officer, says the incoming Australian Government should show national leadership and set up a body within the Department of Health to secure cross-portfolio approaches to suicide prevention.

“(the body) would coordinate data collection and give priority attention to this significant and complex social issue,” she said.

“Within a year of the election SPA wants to see legislation tabled for a National Suicide Prevention Act that requires government to provide evaluation reports to the Parliament at least every three years.

“The regional approach that allows for local solutions to be designed is positive and well supported by SPA members

“However, in the absence of national policy, the fragmented piecemeal lack-of-strategy that has persisted for years and contributed to the increase in suicides will continue."

“The call to make better use of technologies and to draw on the wisdom of those who have personal experience of suicide is also

strongly supported by SPA."

Ms Murray said the rates of suicide in Aboriginal and Torres Strait Islander communities must also be addressed immediately.

She said that with the rates 2.5 times higher than non-Indigenous Australians, it cannot be emphasised enough the urgency of releasing the funds to implement the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy."

She said a National Office for Suicide Prevention and accompanying legislation would demonstrate strong leadership and provide the needed attention to make significant improvements in the response to this complex social issue.

Source: SPA, 24 May 2016

AUSTRALIA

Second Victoria police suicide in a week puts spotlight on officers' mental health

Law enforcement agency says third suicide of the year of 'enormous concern' while review examines employees' wellbeing

Victoria police has confirmed a police officer took his own life on Wednesday night, making it the second suicide within the state's police force in one week.

In a statement, Victoria police said it was "extremely saddened to confirm that one of our members from the southern metropolitan region died last night following an apparent suicide". "He was off-duty at the time," the statement said.

"Our thoughts and deepest sympathies are with his family, friends and colleagues at this very difficult time."
Three Victoria police members have killed themselves so far this year.

"The death by suicide of a police member is always cause for enormous concern," Victoria police said.

"Looking after our people is one of our highest priorities. We know that anxiety, depression and post-traumatic stress can all be triggered by the stressful situations our people can find themselves in."

In October, the Victoria police chief commissioner, Graham Ashton, launched a review into the mental health and wellbeing of Victoria police employees. His announcement came two weeks after a senior constable took her own life while on duty at a Melbourne centre for victims of sexual assault.

The review will examine how Victoria police can support police officers during and after their career and make recommendations on how this support can be strengthened.

On Wednesday, Ashton told ABC radio that police stress and suicides were a “worsening situation” in Victoria.

“I’m seeing a lot more police suicides than I ever used to,” he told the ABC.

“This affects everyone differently and people absorb issues, absorb trauma and absorb things that they’re exposed to in different ways, and we have to understand that.”

The deaths follow the announcement on Monday by the Victorian police minister, Wade Noonan, that he would take three months’ leave from parliament due the toll of “constant exposure to details of unspeakable crimes and traumatic events”.

“It has been difficult to cope with the constant exposure to details of unspeakable crimes and traumatic events that are an everyday part of my role and accumulation of these experiences has taken an unexpected toll,” he said.

In December the National Coronial Information System released data on intentional self-harm rates among emergency services personnel, revealing 62 police service members took their own life across Australia between 2000 and 2012.

DENMARK

Denmark to declassify being transgender as mental disorder

COPENHAGEN (AFP) - Denmark will next year declassify "being transgender" as a mental illness, lawmakers from the Parliament health committee decided on Tuesday (May 31).

"It is completely inappropriate to call it a sickness," the committee's deputy chairman Flemming Moller Mortensen told AFP.

"There is a longstanding wish from the trans community in Denmark to have it removed" from the Health Ministry's clinical guidelines on illnesses, he added.

The move, which would come into force on Jan 1, is also intended to put pressure on the World Health Organisation (WHO), which has yet to remove transsexualism from its list of mental disorders.

Denmark has "no more patience" with the WHO, which will discuss the issue later this year, Mr Mortensen said.

Amnesty International hailed the Danish decision, saying it made Denmark "a role model for transgendered people's rights".

"Amnesty would also like to commend the government for its effort in the WHO, where it has worked to have the disease classification system changed," the group's Denmark chief Trine Christensen said in a statement.

Rights group LGBT Denmark also welcomed the move.

"To remove transgender from the section of mental disorders means removing an institutionalised stigmatisation of trans people," spokesman Linda Thor Pedersen said.

USA

The glamorization of mental illness

In December, Target celebrated the holiday season by launching a line of bad-on-purpose “tacky” Christmas sweaters, the perfect apparel for an irony-obsessed generation. One of these garments started a controversy, however; it bore the slogan “OCD: Obsessive Christmas Disorder,” which offended many of the millions of Americans struggling with mental illness. Were these people being too sensitive, too “politically correct?” Perhaps, though I doubt cancer patients would like to see a lame joke about their disease branded on shoddily-made supermarket apparel.

We’ve reached an interesting time in terms of the way the mentally ill are perceived in the wider society. Awareness of mental illness has never been greater, and people suffering from the effects of psychological disorders have never been more accepted. However, the widespread general knowledge about psychiatry has led to a strange and problematic trend: the glamorization and glorification of mental illness.

Modern police procedural shows often feature mentally ill characters, whose disorders somehow make them better detectives. In movies, mental illness is now usually portrayed as a fun quirk or a sexy personality trait that makes a character seem deep and truly in touch with the pain of living.

I’m beyond glad that the mentally ill are no longer portrayed as inhuman and dangerous. But making them seem preternaturally gifted or quirky and deep is almost as stupid and unrealistic. And it affects the way people talk and think about psychological disorders.

No one is ever just “sad” anymore. No normal person has a bad day – they’re “depressed.” And no one’s ever “neat.” If they like to keep a clean car, they’re “OCD,” even though they probably don’t know what OCD is and may have never met an OCD person in their life.

This epidemic of self-diagnosis doesn’t make any sense to me. I guess people think pretending to be neurotic is fashionable. The truth

is, anyone who has actually ever struggled with a mental illness wants to be defined by anything but their disease. They want to forget they have a problem, and just be a person.

I have generalized anxiety disorder, basically the most mild and easy to treat mental illness. It's the psychological equivalent of chronic back pain – annoying, but I don't let it affect my life in any way. So I don't have much place personally to complain about the way people glamorize disorder.

I wrote this column because many people in my family aren't as lucky. They have more serious and difficult problems. They live full lives in spite of their struggles, and they don't let a glitch in brain chemistry define them. I couldn't be more proud to be related to them. They're the ones who don't deserve to hear some jerk say he's depressed when he's trying to sound deep.

The media needs to make realistic mentally ill characters who sometimes struggle and sometimes succeed and sometimes fall on their ass, just like everyone else. And people need to stop self-diagnosing. If you think you have a problem, go see a psychiatrist or counselor, don't take it upon yourself to determine you have a certain disorder based on your own (probably incorrect) assumption about what it is.

Let's stop with everyone being fashionably neurotic. Pretending to be sick doesn't make you special.

Sam West is a junior majoring in economics. He is the Assistant Culture Editor of The Crimson White.

IRELAND

Opinion: Prisons now a dumping ground for mentally ill young men

We have amongst the lowest number of secure psychiatric beds per head of population in Europe

Despite having one of the highest levels of severe mental illness when compared with other advanced European nations, Ireland has fewer adult psychiatric beds than almost any other country in Europe.

New research looking at the number of beds across the EU shows we have even fewer secure (forensic) psychiatric beds compared with other countries.

Psychiatric bed numbers in Ireland have fallen drastically, and since 2011 beds have fallen to below 20 per 100,000 people, where the European average is still over 40 per 100,000.

The beds that remain are on wards open to the public and to other wards in the same hospital. It is often difficult to care safely for young people with disturbed and challenging behaviour due to acute delusions and hallucinations in such wards.

With the closing of the old-style asylums across Europe, many countries recognised that, even with the development of community mental health services, there would always remain a significant need for some inpatient beds. They are required so the most unwell and difficult to treat patients could receive the help they need in a stable and safe therapeutic environment.

Unfortunately we have failed to plan for the needs of such patients in this country, and the most unwell and difficult to treat patients increasingly find themselves either homeless or placed in prison rather than treated in hospital and supported in the community. Strangely, these well known facts are regarded as neither a failure of policy nor a cause for shame.

In 2016 the current 10-year plan, A Vision for Change will have run its course. It is timely to wonder what policy reforms will come next. A Vision for Change has led to considerable positive achievements. The experts who drafted the policy should be congratulated for the universal adoption of the ethos and language of recovery. However, while recovery is a commendable policy priority, it is not the same as cure, and it is increasingly obvious that people with severe, enduring and disabling mental illnesses have lost out in the recent changes that our mental health service has undergone.

Replaced asylums

People who have complex and difficult to treat problems are excluded from a “mental health” model that struggles to include the needs of those with severe, enduring and disabling mental illnesses.

Many of the acute inpatient psychiatric units which replaced asylums lack the short-term high observation units that could provide for the complex needs of such patients. Across the modern world, such patients are provided for in acute local psychiatric intensive care units.

Typically, in other European countries there are 10-15 beds serving every 250,000 people. This contrasts with Ireland, which has only 30 such beds in the entire country. Again, in other European countries the closure of the old asylums has been compensated for by opening high quality, therapeutically secure, forensic psychiatric hospital beds.

Ireland has not developed any such system and the number of forensic psychiatric beds at the Central Mental Hospital has stayed static at about two beds per 100,000 people.

In England and Wales, by contrast, asylum closures over the last 30 years have been associated with the development of a system of more secure forensic hospital beds so that there are now 7.5 secure forensic beds per 100,000 for the mentally ill.

Scotland, Northern Ireland, the Netherlands, Germany, Austria and many other modern mental health services provide between eight and 10 forensic secure beds per 100,000 population. Not surprisingly, Irish prisons have increasingly become the emergency department "trolleys" for young men with any form of psychotic mental illness. The great majority of young people remanded to Irish prisons, while actively unwell with diagnoses of severe and enduring mental illnesses, are charged with very minor offences. These patients have fallen through the net of a public mental health system which is not designed to meet their needs. Mental health legislation has reformed the rights of people detained for care and treatment, and further reform is needed. But reforms that exclude mentally incapable people from access to care, treatment and protection do them a disservice – it is already too difficult to intervene when a person with a severe mental illness is obviously relapsing and at risk of self-harm and neglect.

Violence is rare

Fortunately, Ireland is an inherently peaceful country where violence is rare and we are very tolerant of the mentally ill.

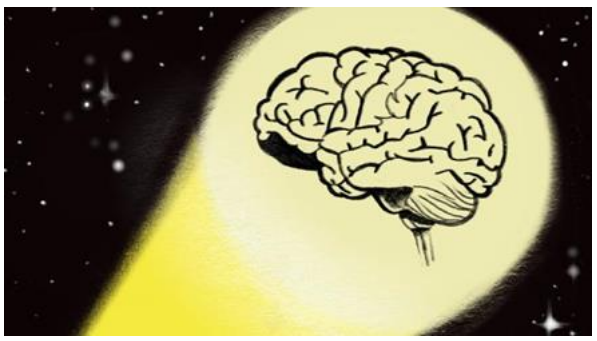
Tolerance, however, is not enough when young people with the most severe, enduring and disabling mental illnesses are ill-served by policies that fail to meet their needs. To be able to engage with community services, it is almost always necessary to first have the benefit of the acute treatment needed to restore the basics of mental health.

The next Vision for Change should help to direct resources towards services that are demonstrably effective in engaging and retaining severely mentally ill people to prevent homelessness and imprisonment. Should we fail to do this we are at risk of repeating the kind of discrimination and inhumane treatment which the closure of the asylums and the development of community mental health teams were designed to remedy. Harry Kennedy is clinical professor of forensic psychiatry at the Central Mental Hospital. He is writing in a private capacity.

Wed, May 18, 2016, 00:33

Harry Kennedy

AUSTRALIA



McGorry says mental health care becoming a field of broken dreams

Is it time to question the dogma that mental health care should be fully integrated and unprotected within mainstream healthcare?

At a recent mental health forum, I heard a story that crystallised the issue for me. A father described how his 17-year-old daughter — let's call her Lily — gradually had become withdrawn and taken to her bed. She became anxious and depressed.

She was taken to GPs, emergency departments and a range of other professionals and, though she had been functioning extremely well before becoming ill, was responded to negatively by health professionals, even given a label of personality disorder. Her parents were confused and overwhelmed and got no support.

Then Lily had a seizure. This was investigated and, after a lumbar puncture and brain scans, viral encephalitis was diagnosed. The fact she now had a "medical" (genuine) illness rather than a psychiatric one transformed not only her treatment but also the attitude of health professionals. She was now a "deserving" patient.

Mental health care, sitting as it does within general hospitals and traditional primary care, in many ways suffers from the same shabby treatment as Lily experienced.

Twenty-five years ago mental health care was deinstitutionalised, downsized and embedded in mainstream healthcare. The assumption we all made was that this would reduce stigma and lead to a fairer deal for people with mental illness.

No one has ever questioned or reviewed While the effects have not been as disastrous as in the US, this integration is becoming a field of broken dreams, with increasingly perverse effects. Suicide rates are rising and many survivors with mental illness are in jail, homeless or lead diminished and unproductive lives.

The good news is that this can be transformed if we are truly prepared to leave no stone unturned.

First, the assumption that mental illness is essentially the same as physical illness is too simplistic. This oversimplification is at the heart of the controversy around mental health. Yes, that most complex of all organs, the brain, is involved in all mental illnesses, but they cannot be reduced to a series of "brain diseases". We treat people, not just their brains. Only some people will be diagnosable with a clear-cut brain problem such as an infection like Lily.

The rest of us, usually with similar symptoms, have more complex vulnerabilities of a biological and environmental nature that combine to create patterns of distress, commonly blends of anxiety, depression or psychosis. The ideal therapeutic settings for understanding, diagnosing and treating these disturbances of the person are different from a frantic emergency department, a busy general practice or a hi-tech hospital complex. This has been denied or ignored by policymakers.

However, we have seen the value of these special cultures of care and flexible person-centred approaches in examples such as Headspace and early psychosis services, which have spread rapidly for exactly

this reason.

Another example is assertive community outreach, where people are engaged and treated on their terms in their own homes, with support being offered to families as well. Mental illness needs its own spaces and its own culture. Yet, even where they have been successfully built, they have been dismantled or are under threat.

The second side effect of the engulfment of mental health care within acute hospital systems is the loss of financial visibility and integrity of governance. When there were stand-alone mental hospitals the budget, however inadequate, was at least visible and safe. Within acute hospitals, always struggling for cash, mental health is at the bottom of the pecking order and money intended by government for mental health care is relentlessly diverted to other “squeaky wheels”.

Patients, families and directors of psychiatry are equally powerless in this. Physical illness always takes priority for hospital chief executives, just as new cancer drugs, however expensive, take priority over new psychiatric medications. This has led to an erosion of the scope and scale of the community mental health services that were supposed to justify the huge reduction in bed numbers that accompanied deinstitutionalisation.

The National Mental Health Commission recognised that the failure to provide community care in a proactive and timely way was causing an avalanche of the desperate to descend on emergency departments.

But more money to respond to this unmet need was off the table and this constrained and distorted its recommendations.

Furthermore, while the move to regionalise health planning to primary health networks has merit, cashing out highly visible and scientifically based programs to local health commissioners who also have responsibility for physical healthcare will lead to the same outcomes we have seen in the hospital system.

So what is the solution?

If people with mental illness are to get a fair deal and effective care based on the latest scientific evidence, the cultures of care must be redesigned and they must be more distinct, visible to the community and properly funded. We must recognise that mental health, while an essential part of the medical system, is different.

People should not be forced to fit in to the wrong facilities and approaches as unwelcome guests. The right spaces, attitudes and skills must be created and nurtured. Anyone who has been to a Headspace centre or early psychosis service knows what I mean. Not only do we need high visibility for the programs and facilities, we also need high visibility for governance and financial elements.

Mental health needs to separate its governance and its bank accounts from the hungry beast of general healthcare, where stigma dictates that it is still a low priority. As a nation, we must invest to reap the

benefits.

There is a jarring disconnect between the peak levels of awareness of mental health and the enormous gaps in care, which means that only 16 per cent of Australians with depression access even minimally adequate evidence-based care. No wonder the suicide rate is rising.

Patrick McGorry is professor of youth mental health and executive director of Orygen, the National Centre of Excellence in Youth Mental Health

USA

Study: Global Mental Illness Widespread, Undercounted

The number of people living with mental illness worldwide is underestimated by more than a third, according to researchers at Harvard University and University College London, who say mental illness accounts for 32 percent of all disability worldwide. Previously, mental illness was thought to be responsible for 21 percent of global disability.

Researchers say people with other health problems — such as heart disease, pain syndromes, neurological problems and HIV — often suffer from psychiatric disorders that go unrecognized by the medical profession.

Clinical depression often goes along with chronic illness but is rarely reported and treated, according to the authors, whose work is published in the journal The Lancet Psychiatry.

Cost of stigma

Those psychiatric disorders exact a high human cost, said Daniel Vigo, a psychiatrist and fellow at Harvard's School of Public Health in Boston.

“People with mental illness die before a heavy smoker, just to have a perspective on how serious this is," Vigo said.

Part of the problem, he said, is the stigma that accompanies mental illness. People with psychiatric disorders are more likely to avoid doctors and treatment than people who are physically ill.

He said the percentage of people who are being treated for mental disorders, about 8 percent of the U.S. population, is only the beginning.

Next steps

Vigo and his colleagues are calling for greater recognition of the problem by the global community, and for treatment for psychiatric conditions to be offered at the primary care level where many people with other health problems are seen.

"Mental health services need to evolve and not be considered a separate issue anymore," he said. "And there are a number of evidence-based interventions that are being piloted or applied on a much larger scale in both developed and developing countries that show the way this can be done."

Treatments that can be offered through primary care include medication and therapy, but recognizing a problem exists is the first step, according to Vigo.

In April, a mental health summit will take place in Washington in conjunction with the annual meeting of the World Bank.

Jessica Berman

February 05, 2016 6:01 PM

USA

John and Steve first taught me about suicide

By Chris Cobler

When I was an 18-year-old student at Washburn University, I met two guys who would become my dear friends throughout college and into my early 20s.

Steve and John were funny and smart, and we spent a lot of time playing softball, drinking beer and listening to music. Steve made a mix tape of his favorite Bruce Springsteen songs for me, and I've been a diehard Boss fan ever since. John remains to this day the funniest guy I've ever met; when several of us went to a comedy show once, we hung out with the comedian afterward, and that guy was taking notes about John's impersonations and one-liners.

They also shared a dark secret I learned later. They had become friends because they met at the Menninger Clinic after each had attempted suicide. I had never known anyone before who had attempted suicide, so I recall asking Steve what could possibly make him think this was what he should do.

He did his best to explain his feelings to me, but I can't say I really understood then or do now. What I do know is that we should try more to understand and support those who struggle with these mental health issues. Somehow, we need to get past the stigma associated with mental health and learn to talk about it in a healthy way.

As an editor, I've tried to help with this greater understanding in many different ways over many years, but it remains an elusive, emotional and challenging subject. In 2011, I was asked to attend a national conference on updating best media practices for reporting on suicide.

At the Advocate, we updated our policy to include these key elements based on what we heard from experts:

- We don't report the names of those who commit suicide unless the death occurs in some public way or venue.
- We don't go into detail about how the death occurred, listing only the basic cause such as a gunshot, hanging or overdose.
- We always publish information about how to get help with the brief item.
- We don't include this coverage with our police blotter, as we used to do, because that criminalizes the behavior and adds to the stigma.
- We avoid writing 'suicide" in the headline about a specific death and try to give these items low-key coverage on an inside newspaper page.

We followed this policy in print when we reported last week on the suicide of a 17-year-old in Victoria, but we stumbled when we posted the item to our social media platforms. On Facebook and Twitter, there is no equivalent to a small headline on an inside newspaper page. Every item that comes across your newsfeed is the equivalent to a front-page story.

I'll be recommending to our newspaper ethics board at our next meeting that we stop posting these items to social media. That won't stop our readers from doing so, of course, but I hope this will lower the intensity of the difficult conversations.

Some readers and even some at the newspaper think we should not report on so-called private suicides at all, and I am sure we'll be talking more about this argument. Our longtime stance has been that suicide is a public health issue that should be reported. Through consistent, sensitive and appropriate coverage, we hope to eventually lessen the stigma associated with mental health issues.

The mental health forum we organized in October with the Gulf Bend Center was another way we hope to make a difference. Reporter Jessica Priest continues to report on a multi-part series we intend to publish in the coming months on mental health. After the series appears, we plan to organize a second public forum.

Almost 40 years have passed since I first met John and Steve, yet our society's understanding of suicide seems to have advanced so little. Even I was surprised when I read in a Newsweek article, titled "The Suicide Epidemic," that self-harm had become the leading cause of death in developed countries for people ages 15-44, surpassing all cancers and heart disease.

Why don't we all know this statistic? Why aren't we all organizing efforts to help people get the treatment they need?

My old friend John tracked me down several years ago and called to catch up. I was pleased to learn he was happily married with kids. He sounded funny as ever and relaxed. He was one of the lucky ones who received the expert -- and expensive -- care he needed.

The Newsweek article concluded that "suicide is the rare killer that fails to inspire celebrity PSAs, 5K fun runs, and shiny new university centers for study and treatment." In Victoria, we still don't even have a support group for suicide survivors. We wrote several years ago about one woman's efforts to start one after the death of her father and her own attempts.

She reports receiving wonderful support from strangers after our article appeared, but, sadly, no sustained communitywide effort emerged. "I don't believe this town's opinion on suicide and mental health has changed much," she wrote me Saturday.

That doesn't mean we should stop trying, though. Amid the social media criticism of the Advocate for reporting on last week's suicide came the voice of David Boedeker, a Victoria resident who was only 13 when he tried in 2002 to do something about the rash of teen suicides then in our community. With the support of the Advocate and others, Boedeker arranged for Mike Miller, author of "Dare to Live," to speak in Victoria.

Boedeker went on to get a degree in psychology from Abilene Christian University and now investigates Adult Protective Services cases for the Department of Family and Protective Services. He reached out to say he appreciates the Advocate's efforts then and now to raise awareness about mental health.

"Over the years of becoming an adult, I've seen many people who have been a part of my life one way or another who have had friends who have committed suicide," Boedeker wrote, "and the Advocate can play a strong role in being a voice out there to help provide resources and also get people to talk about it."

AUSTRALIA

$1M for Indigenous suicide services

A $1 million Critical Response Project aims to ensure services available for Aboriginal and Torres Strait Islander families affected by suicides or attempted suicides are better coordinated and delivered in culturally appropriate ways.

Federal Minister for Indigenous Affairs, Senator Nigel Scullion said the program involved coordinators meeting with affected families to identify their needs and then making sure suitable services were delivered.

"One in three deaths across the country among Aboriginal and Torres Strait Islander people aged 15 to 35 is a suicide and the rates of suicide for First Australians is twice that of other Australians. This is an ongoing tragedy," he said.

"Although suicide services for First Australians do exist on the ground, they need to be better coordinated and driven by the needs of affected families.

“This initiative funds coordinators to work directly with the families to ensure this happens.

"The Critical Response Project helps to coordinate first-response services and ensure that essential support is provided to individuals, families and local communities dealing with suicide.

“It will also develop and trial new models of care to build resilience in communities as well as the roll-out of mental health first-aid training."

Senator Scullion said the initiative was initially focused on Western Australia where there was the greatest need. One in four Indigenous suicides across Australia occurs in WA.

The Critical Response Project will work closely with the Western Australia Mental Health Commission and operate alongside existing suicide response services.

It is important to note this initiative does not replace existing services that people at risk of self-harm should contact in the first instance.

Indigenous Mental Health Commissioner, Professor Pat Dudgeon, said the project would improve suicide critical response services in WA and arose from work undertaken by the Aboriginal and Torres Strait Islander Suicide Evaluation Prevention Project.

"There is a great need for governments, Commonwealth, state and local to be working with Aboriginal and Torres Strait Islander communities to offer a critical response to incidents such as suicide,” Prof Dudgeon said.

“There is a willingness for governments to deal with all of this and our project will help inform how we go about it."

The initiative will be coordinated by the University of Western Australia’s School of Indigenous Studies and trialled through to January 2017. People are able to contact the Critical Response Project by ringing 0455 252 678.

Source: Federal Government, 18 January 2016.

USA

Let’s get real about suicide prevention

By Kelvin Wade

May is Mental Health Awareness Month and if ever there was a time to be aware of the our mental health, it’s now.

The national suicide rate is at its highest in 30 years. The National Center for Health Statistics recently released a study that shows an overall increase of 24 percent in suicide between 1999 and 2014. That final year saw 42,000 Americans end their lives.

According to the Centers for Disease Control and Prevention, suicide

is the 10th leading cause of death. Homicide is 17th. So the fact remains that, for most Americans, you're more likely to take your own life than be murdered.

The results of this latest study has surprised many experts. There's been a rise across the board for the most part. The suicide rate by women ages 45-64 jumped by 63 percent while increasing 43 percent for men. Broken down by race, white women in that age group have seen their suicide rate jump 80 percent!

Some sociologists and suicidologists have speculated that economic forces such as recession, the cratering housing market, jobs lost to globalization and changing societal norms may help explain the distress that lead some to end their lives.

Divorce has increased and a prior study in 2013 did show that single middle-age men were much more likely to commit suicide than their married counterparts. We don't really know because mental health spending hasn't been a priority.

Our primary suicide prevention is aimed at the young and the elderly. But middle-age Americans, in the grips of despair, are killing themselves at an alarming rate. What are we doing about it?

Friday is the grim anniversary of my brother's suicide. And while that motivates me, I also think back to the many Bay Area Survivors of Suicide meetings I attended in libraries and churches in Fairfield and Vacaville in the 1990s. I'll never forget the anguished, bloodless faces of parents who'd lost children to suicide.

We have national conversations on issues that aren't nearly as pervasive as suicide. For example, 19 Americans were killed in this country last year by suspected radical Islamic terrorists. An investigation by The Washington Post found that black unarmed civilians killed by white police officers represented 4 percent of fatal police shootings. And according to Mass Shooting Tracker, last year 475 Americans were killed in mass shootings defined as a single incident that kills or wounds four or more people including the assailant.

All are tragic and worth attention.

But 115 Americans will kill themselves every day this year. There are nearly four times as many suicides as people murdered with firearms every year in this country. Where are our priorities?

This issue is worth our attention. Suicide hotlines work. Parents should talk openly and honestly about suicide with their children. It won't put the idea in their heads as many erroneously believe.

Medication to help those with clinical depression works. I know people who wouldn't be here today without those kinds of interventions.

The idea that suicidal people cannot be deterred or that if you help prevent a suicide that the person will find some other means is just not

born out by the facts. Intervention can work. There's no shame in needing help.

We debate and discuss many issues at the national level in this country and this needs to be one of them. As a country we should never again have a debate about health care without including mental health in the conversation.

A FRIEND 4 ME MY STORY

KELLY's JOURNAL CONTINUED

Today is my birthday. I never get a happy birthday from David or the kids. Instead I'm on the run. I drive around Newcastle all morning.

I'm trying to work out a way I can kill myself. I sneak home. I get my sleeping pills. I always have them just in case. I get away very quickly. I don't want anyone to find me. I know the amount I have won't kill me. I go to the shop and buy a hose. I know what to do. I need to find somewhere I can't be found. I drive around for hours. I can't find a safe place. It's the weekend and people are everywhere.

I'm a mess. I don't want to hide anymore. I phone Bronwyn. I arrange to meet her at the local pub. She talks me into going to the police. Trouble is the police have already traced my phone call.

They turn up at the pub. I'm arrested and taken to the police station. Bronwyn comes too. I'm finger printed and my photo is taken. I still have my black eyes but they are much better. They take me into a room and I tell my story. Bronwyn stays with me the whole time.

They then put me into a jail while they work my shit out. I'm locked in jail for 8 hours. The police tell me I have an AVO. I can't go anywhere near David. Bronwyn makes the police take me to hospital. She is worried about me. She is right. The police never looked in my car. When I get out of here I have plans. They send me to hospital. I have my phone back. I text Paul and tell him what I have done. My life with David was finished. I tell Paul that I'm ready to give myself to him. I ask do you still want me. He says yes. The hospital does not keep me. The nurse remembers me leaving with David last time I was there. She says we both looked so happy and can't believe what had happened. I have plans to kill myself once I get out. The hospital won't let me leave alone. I phone my sister to come and get me. It's after midnight. She ruins my plans. I stay at her house tonight.

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COMING EVENTS

SOCK IT TO SUICIDE

HUMOUR

Daddy did you know that girls are smarter than boys?
No, I didn't know that
There you go.

I've always thought my neighbours were quite nice people. But then they put a password on their Wi-Fi.

WISH LIST

Petrol Gift Cards, Stamps, Volunteers Aust/Wide

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DONATIONS TAX DEDUCTIBLE

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