White Wreath Association Ltd®

"Action against Suicide"

NEWSLETTER

ABN 50 117 603 442

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DIRE

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Two articles in this edition of the White Wreath newsletter highlight the complexity of problems facing Australia's mental health/ suicide programs.

The first is a $400,000 research grant to find new ways the help protect people at the risk of suicide and find interventions to prevent suicide.

The second is a Federal Budget grant to the overloaded Headspace program, which the CEO admits is facing major challenges.

An example is seven to eight week delay in accessing the free service in Launceston, northern Tasmania.

White Wreath has continually urged Federal and State Governments for a national body to establish a body with the power to oversee an evidence-based coordination of mental health programs between the states.

Fanita Clark
CEO

PETER NEAME, Research Officer, White Wreath Association Ltd

All animals and living things that are able to move will be aware of, and move away from obvious danger. When we are near another living

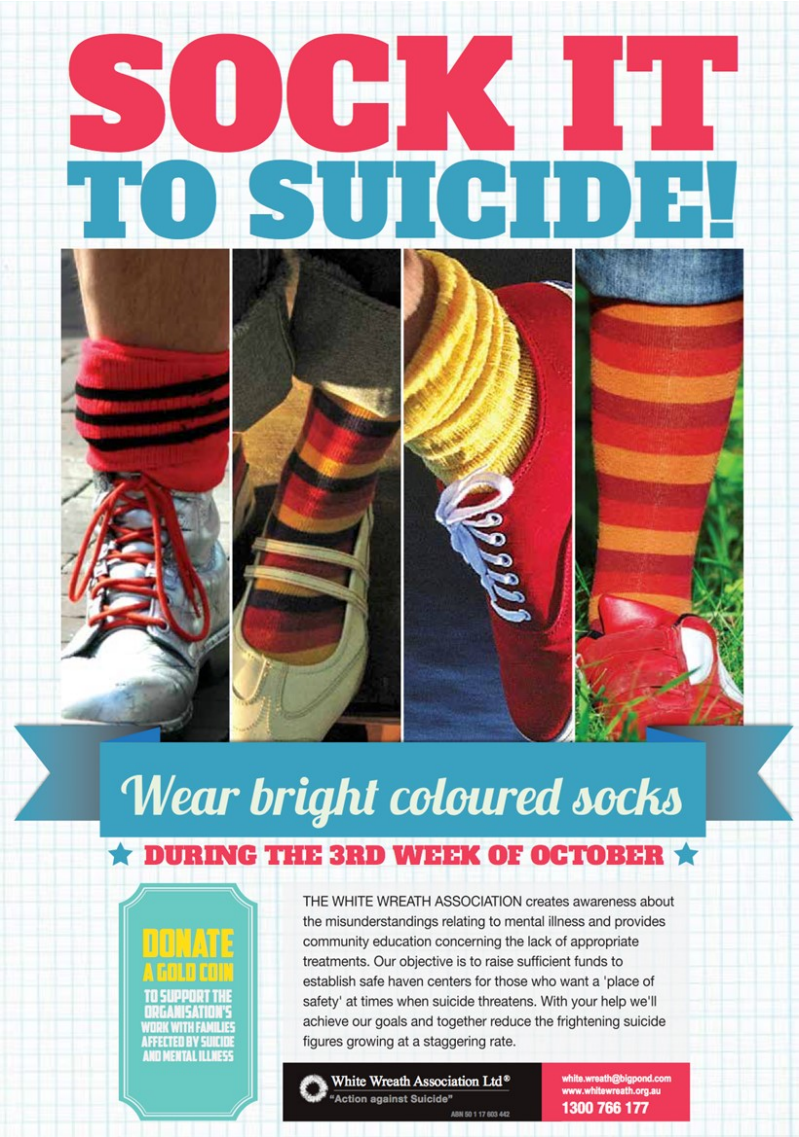
thing, even another person, we need to be aware of the potential risk to ourselves before we get too close.

Closeness, geographical closeness or proximity is a key factor in:

1. Avoiding and being injured or killed by another predator; and
2. Planning to kill another animal/human being.

In other words, killers will move close to their victim/target already be living there.

COMING EVENTS



PLEASE GET YOUR SCHOOL, WORKPLACE, SOCIAL CLUB ETC INVOLVED AND TOGETHER LETS “SOCK IT TO SUICIDE”

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AGM

IMPORTANT NOTICE

ANNUAL GENERAL MEETING
OF BOARD MEMBERS
WHITE WREATH ASSOCIATION LTD

Monday 2 September 2019 - 7PM

15 LEITCHS ROAD SOUTH
ALBANY CREEK QLD 4036
(FOOD SUPPLIED B.Y.0)

WORLD NEWS

AUSTRALIA

Research to help prevent suicides

“The Commonwealth Government is investing $400,000 in four innovation research grants to find new ways to protect people at risk of suicide and interventions to prevent suicide,” said Health Minister Greg Hunt.

“Funding will be provided through the Government’s $12 million National Suicide Prevention Research Fund (NSPRF), for projects which support bold ideas to prevent suicide in Australia,” he said.

“Suicide is a national tragedy and around 3000 Australians take their lives each year.

One life lost to suicide is one too many.

“The NSPRF is a world-first. It is designed to provide sustainable financial support for Australian suicide prevention researchers to develop new knowledge and approaches to suicide prevention.

“The four research projects will receive up to $100,000 to contribute to the evidence-base in suicide prevention and ultimately reduce the number of people lost to suicide each year.

The four successful research projects are:

Dr Mark Larsen, University of New South Wales: behavioural patterns at suicide hot spots.

Dr Miriam Posselt, University of South Australia: suicide prevention tools for asylum seekers and refugees.

Professor Frances Kay-Lambkin, University of Newcastle: alcohol, depression and social isolation in older Australians.

Dr Wei Du, Australian National University: hospital-to-community supports to prevent people attempting suicide again.

Mr Hunt said the NSPRF was managed by Suicide Prevention Australia with a research advisory committee of leading experts from the lived experience community and the research, government and clinical service delivery sectors.

Since its inception in 2017, the NSPRF has invested $2.93 million in suicide research projects.

He said the Government was committed to investing in mental health services for all Australians, and a key pillar of our long-term National Health Plan.

He said the Government was prioritising better mental health for all Australians with a record $4.9 billion expected to be spent on mental health this year alone.

He said the strong economic management ensured the continued record investment of funding into vital health initiatives including mental health, life-saving medicines, Medicare and hospitals.

Date: June 17, 2019.

AUSTRALIA

Headspace gains $37m Federal Budget funding headspace, the national Youth Mental Health Foundation, has been granted Federal Government's $375 million in the Federal Budget to address the mental health needs of young Australians.

CEO of headspace, Jason Trethowan, said this funding will grow and strengthen the headspace platform to reduce wait times for young people and improve service integration.

"With young people seeking help at an unprecedented rate and rising levels of complexity and acuity, it is increasingly evident that headspace is experiencing major challenges in meeting the growing demand for services," he said.

The Government announced new investments including:

$111.3m to increase the number of headspace sites to 115 to 145 across Australia by 2021. There will be 10 new headspace centres and

20 new satellite services including satellites in Sarina and the Whitsunday;

$152m to help headspace centres experiencing high levels of demand to improve their services and reduce wait times so that young people can get more rapid support in times of need.

The new investments will cost $263.3m from 2018-19 to 2024-2025.

In addition, and as previously announced, the Government will also invest in:

$2m for a Young Ambassadors Program; and

$110m to support the continuation of the headspace Youth Early Psychosis Program at 14 headspace centres to support young people at the early stages of severe mental illness.

“The funding in this year’s Federal Budget will help headspace centres to meet the growing demands of young people through increased clinical workforce capacity, infrastructure improvements in existing headspace centres, and enhanced online supports to young people,” he said.

WORLD NEWS

Electroconvulsive Therapy Devices Market to Witness Growth Acceleration During 2016 – 2024

Electroconvulsive Therapy (ECT) is treatment considered most safe and effective for certain psychiatric disorders. ECT is the most common treatment performed for severe or major type of depression. Though mechanism of action for this treatment is not fully known. It is said to be effecting central nervous system components such as hormones, neurotransmitters, neurotropic factors and neuropeptides. The process of generalize seizure is required for both the beneficial and adverse effect of ECT. Many studies have shown reduction of glucose metabolism in anterior and posterior part of brain in study of before and after procedure of ECT.

Though this treatment is said to be effective for many psychiatric disorder there are significant controversies related to this procedure. Some study have concluded ECT procedure just marginally more effective that other placebo procedures. This procedure is viewed harmful by general population and mental health professionals. Despite of all the controversies ECT is used by US and is endorsed by the American Psychiatric Association. Professional associations of

Canada, Netherlands, Germany, Austria, Denmark and India have professional guidelines to use ECT.

ECT is performed on only selective patients with high degree of symptoms of severity and functional physical or mental disorders. It is also given to the patient who require treatment response urgently e.g. patients with suicidal behavior. It is also considered in the patients with treatment resistant cases of bipolar disorder. It is also used for the cases of acute schizophrenia. This treatment is considered for the cases of schizophrenia patients who show minimal or no response to the antipsychotic medications. ECT is also recommended for the treatment of obsessive-compulsive disorder (OCD), catatonia, depression associated with Parkinson diseases, pain and acute confusion psychosis.

The increasing cases of mental illness due to brain injuries, Bacterial infections causing mental disorders and increasing long term use of substance abuse linked to depression and anxiety is expected to increase the usage of ECT device. Changing life style and increasing exposure to harmful toxins is expected to attribute to the increasing usage of the device. The prevalence rate of schizophrenia was approximately 1.1% for the 18 years and above population in 2010. As per the report of National Alliance on Mental Illness, 1 out of 5 adults in the US experience mental illness.

Growing incidence of mental disorders and demand for treatment options for severe mental illness are the factors driving the growth of global electroconvulsive therapy devices market. Advancements in technology and development for study of brain is believed to play the crucial role in the growth of global electroconvulsive therapy devices market over the forecast period.

The global market for electroconvulsive therapy devices is segmented on basis of product type, end user and geography:

Based on Product type, global electroconvulsive therapy devices market has been segmented as follow:

- Unilateral
- Bilateral

Based on end user, global electroconvulsive therapy therapeutics market has been segmented as follow:

- Hospitals
- Specialty Clinics
- Mental Hospitals
- Others

Increasing smoking rate, tobacco consumption and incidence of bacterial infection causing mental instability are the factors primarily

responsible for growing cases of mental disorders. The increasing aging population is resulting in increasing geriatric patients receiving ECT. ECT device of two types: bilateral ECT, in which electrodes are placed in either side of your head. This type if device effect the entire brain. Unilateral ECT one electrode is placed on top of the brain and another electrode is placed in the right side of the brain. In some hospital, ECT is performed with ultra-brief pulses which last for half a millisecond pulse compared to the standard pulses. Shorter pulses are expected to help prevent memory loss after the procedure.

Based on the end user, the global electroconvulsive therapy device market has been segmented into hospitals, specialty clinics, mental hospitals and others. Mental Hospital end user segment is anticipated to contribute the maximum share among end users.

Based on the regional presence, global electroconvulsive therapy device market is segmented into five key regions viz. North America, Latin America, Europe, Asia-Pacific, and the Middle East & Africa. North America will continue to dominate the global electroconvulsive therapy device market for due to high prevalence of mental disorders. Europe is expected to hold second largest market share in global electroconvulsive therapy device market.

Some of the major players operating in the global electroconvulsive therapy device market are Somatic, Mecta and Ectron Ltd and others. In US, only two companies i.e. Somatic and Mecta manufactures ECT device.

June 14, 2019

WORLD NEWS

COLUMBIA

For every two soldiers killed in combat, one commits suicide: Colombia opposition leader

In a blistering attack on the allegedly inhumane treatment of Colombia's soldiers, opposition Senator Gustavo Petro revealed that for every two soldiers killed in combat, one commits suicide.

Petro last week showed his fellow senators videos allegedly from 2017 showing how soldiers were submitted to torture and other forms of inhumane treatment as part as their training.

The leading opposition senator bitterly argued that brutal training methods traumatize soldiers and bitterly concluded that "suicide is more efficient to kill soldiers than the FARC," the group that spent decades combating the military until a peace deal in 2016.

According to General Nicacio Martínez, between 2004 and 2019, 3,388 members of the Army died in combat or as a result of the conflict. In a similar period, from 2000 to 2016, 1,155 members committed suicide. That means that for every two killed in combat, one commits suicide in the Army. Suicide has been more effective than the FARC in killing soldiers in Colombia.

Senator Gustavo Petro

Sergeant Gladys Triana confirmed Petro's concerns before a Senate Commission, claiming that the psychological and physical abuse of soldiers is constant.

According to Triana, her cousins "had to endure beatings,… [and] psychological abuse that is hard to overcome."

"Colombia has a good National Army. We cannot allow this to obscure the doctrine and essence of the army," the sergeant added.

In his rebuttal, Defense minister Guillermo Botero claimed that the homicide rate within the army has lowered from 93 cases in 2005 to 46 in 2018, similar to a rate of 20 for every 100,000 soldiers.

"It is worth to stress that last year we achieved a 50% decrease compared with the previous figure," Botero said.

Nevertheless, the army homicide rate within the army is almost four times as high a among Colombians in general, according to 2017 statistics of the medical examiner's office.

Petro surrendered the evidence he had received of abuse to the minister and asked him to revise protocols.

AUSTRALIA

The Royal Commission into Victoria's mental health system is making progress.

We've recently finished a round of community consultations across the state where we heard from more than 1,600 people and we're currently taking submissions online.

Our **June newsletter** is attached with more details.

You can also read our latest media release here: **https://rcvmhs.vic.gov.au/news**

If you would like some posters (attached) to display in your community or workplace, please email **contact@rcvmhs.vic.gov.au** or call **1800 00 11 34**

AUSTRALIA

Travel insurers refusing to cover mental illness 'widespread', investigation finds

By national consumer affairs reporter Amy Bainbridge and the Specialist Reporting Team's Loretta Florance

Hundreds of thousands of Australians are still being sold travel insurance policies that will not cover them for mental illness, years after a landmark case against QBE was meant to turn things around.

Four years ago, Ella Ingram was awarded compensation because her insurer, QBE, decided not to cover her for a bout of depression that forced her to cancel an overseas school trip

She took them on and won, and the case got the attention of the Victorian Equal Opportunity and Human Rights Commission (VEOHR), which launched an investigation into travel insurance companies.

"It should've been and it could've been a watershed moment for other insurers to look at their policies to try to determine whether they did have the basis to discriminate against people on mental health conditions," commissioner Kristen Hilton said.

"But it wasn't."

The commission investigated three travel insurance companies — Allianz, Suncorp and World Nomads (now nib Travel) — and the data the companies relied on to support blanket exclusions for mental health conditions.

Mental health exclusions mean the policy holder cannot make a claim if their trip is affected by mental illness of any kind, pre-existing or new.

The exclusion treats everything from mild anxiety to a psychotic episode exactly the same.

The investigation found in a period of eight months, between July 2017 and April 2018, the three companies sold 365,000 policies containing exclusions, and denied hundreds of people's claims on the basis on mental illness.

"In terms of unlawful discrimination, we found that it was widespread and far-reaching," Ms Hilton said.

"We have recommended that insurers contact all of the claimants that might have been affected by these discriminatory policies."

Such blanket exclusions are only lawful if the insurers can justify them with statistical data, which shows the group is too high-risk.

"In all the insurance that we looked at, we found that the data was either inadequate to justify the policy, it was out of date, or in some cases the data simply didn't exist," Ms Hilton said.

Cheaper to fly home

After Ms Ingram won her case against QBE, she booked a flight to Europe and started to look for travel insurance that would cover her.

But, despite some insurers removing blanket exclusions, she still could not find an affordable option.

"We came up with this plan that if I was overseas and I started to slip and become unwell again mentally, I could make an assessment right then and there and think I should probably go home now," she said.

"The cost of the flight home was going to be less than the premium to pay for an existing mental health condition."

She said she found the lack of progress that pushed the commission to look into the issue disappointing.

"I don't want to sound pessimistic, but I don't think there has been too much change and … that's been disappointing," Ms Ingram said.

"I don't want to sound pessimistic, but I don't think there has been too much change and … that's been disappointing," Ms Ingram said.

"In my position where I've gone through this court case, I've gone through the whole debacle of it all, it's disconcerting to see that it's still happening, it's still an issue and there's still policies out there that are discriminating against people."

But there is some room for hope.

The three companies that participated in the investigation, which represent more than a third of industry, all agreed to change their policies and scrap blanket exclusions.

"The insurers that we worked with, were good to work with … there was a recognition that perhaps the industry had not moved in the way that community understanding and medical understanding of mental health conditions had," Ms Hilton said.

Insurers 'stuck in the stone age'

But consumers essentially rely on the companies' goodwill because the commissioner is powerless to hold them to their legal obligations not to discriminate.

"That's probably one of the issues; as a regulator in this space, we would like to have stronger powers, we would like to take more robust action," Ms Hilton said.

"We've certainly submitted the report to the insurance regulators in the insurance industry and pointed out what the deficiencies in the current system are and we've encouraged better regulations."

But she is taking heart that insurers are recognising they have fallen behind community standards when it comes to mental health.

And the commission is not completely taking the companies at their word that the eight recommendations resulting from the investigation will be taken up, and things will improve for consumers.

"All insurers that were party to the investigation have agreed to change their policies, or have already changed their policies in relation to blanket exclusions," Ms Hilton said.

"A number of them have also agreed to implement all of our recommendations,".

"We've also said that we'll go back in six months' time and look at what development and progress have been made and report on that."

For Ms Ingram, that change is long overdue.

"People in Australia are going to get diagnosed with mental health conditions. I just feel like the general population of Australia is starting to move forward in talking about mental health conditions and I feel like insurers are stuck in the stone age," she said.

The ABC contacted Allianz, Suncorp and nib Travel, but all declined to comment before the public release of the investigation.

The Insurance Council of Australia (ICA) said it had been working alongside its members to improve mental health-related coverage and outcomes for customers.

"The ICA and members cooperated openly with VEOHRC during its inquiry, but have not seen the final report," the ICA's Campbell Fuller said.

"Travel insurers responsible for most of the market had either removed exemptions or were intending to do so before this inquiry was instigated in 2017.

"This trend has continued and soon insurers with more than 80 per cent share of the travel insurance market will have removed blanket exclusions for mental health conditions, with cover also widely available for first-instance episodes of mental health conditions.

"Many insurers cover pre-existing mental health conditions on an individually underwritten basis similar to coverage available for pre-existing medical conditions."

CANADA

Suicide policies in Canada and beyond: What's working and what needs to change

JOANNE LAUCIUS Updated: April 18, 2019

Between 70 and 80 people take their own lives in Ottawa every year.

Dr. Simon Hatcher, a psychiatrist and researcher in clinical epidemiology at The Ottawa Hospital Research Institute, said he believes it's possible to reduce that number by 20 per cent within five years.

"It's been done before. It's not rocket science," he says, pointing to the example of the Nuremberg model, a protocol first used in Germany which has now spread all over Europe and beyond. "I'm sure it can be reduced. We can do better."

Suicide is considered a public health issue. But Ottawa Public Health has not set a target for reducing suicide in the city. Even the issue of setting targets is controversial.

"I'm not sure setting a target will help. What will help is setting a collaborative approach," said Ben Leikin, supervisor of Ottawa Public Health's mental health team and co-chair of Suicide Prevention Ottawa, which recently merged with the Ottawa Suicide Prevention Coalition.

It's also important to consider whether a reduction in the number of suicide deaths and attempts would continue over time. There are some environmental factors, such as natural disasters or large-scale layoffs for example, that can't be controlled and have an effect on the suicide rate, says Leikin

Leikin said while he applauds those who have set a target for suicide reduction, Ottawa has not.

"Any evidence that exists out there, we're open to it. Let's not reinvent the wheel."

There have been a number of strategies touted to prevent suicide. Here are a few of them.

Zero Suicide

What is it? This "continuous improvement model," first implemented in health-care systems in the U.S., works on the idea that people who have contact with the health-care system can be prevented from taking their own lives. There are three main pillars: a direct approach to suicidal behaviours, continual improvement of the quality and safety of care processes and an organizational commitment to the aspirational goal of zero suicides.

Among the measures: removing the lethal means of suicide; training a competent and caring workforce; using screening to determine who is at risk of suicide; ensuring all patients at risk are closely followed; treating suicidal ideation independent of the patient's diagnosis and transitioning patients with "warm hand-offs and supportive contact."

Does it work? The Henry Ford Health System, a non-profit health-care provider in the Detroit area that includes eight hospitals, 48 medical centres and 13 walk-in clinics, has often been named as an example of good outcomes. Henry Ford, which calls the protocol “perfect depression care,” introduced it in 2001. In a study published in 2007, Henry Ford reported a 75 per cent reduction in the suicide rate. There were actually zero suicides in the Henry Ford system for an 18-month stretch between 2009-2010.

The model has moved into Europe and Canada. The first Zero Suicide campaign in Canada was unveiled in May 2016 at the St. Joseph’s Healthcare Foundation in London, Ont.

The model is not without controversy in the mental health community. Hatcher says there is one major problem with translating the zero suicide model: three-quarters of people who die by suicide have no contact with mental health services in the year leading to their death.

“There’s a lot of rhetoric about it, but not a lot of evidence,” he says. “It irritated a lot of clinicians by calling it Zero Suicide. It’s like going into intensive care and saying, ‘There will be zero deaths.’ As a psychiatrist, I am responsible for getting (my patients) the best treatment possible. The implication here is that we are responsible for a death by suicide.”

Zero Suicide works for hospitals and health-care networks, not for regions and jurisdictions, said Leikin.

There is also debate over whether zero is an attainable goal. Zero Suicide calls it an “aspirational challenge and practical framework for system-wide transformation.”

“I think we should shoot for Zero Suicide. But it will never happen. There will always be people with unbearable angst. Our task is to work toward it,” says psychologist Dr. Antoon Leenaars, the former president of the Canadian Association for Suicide Prevention.

The Nuremberg model

What is it? The Nuremberg Alliance Against Depression was initiated in 2001 as a community-based model project in the German city of Nuremberg, which has about 500,000 residents.

How does it work? Called a “multi-level intervention,” it’s a four-level approach that engages partners from parents to police officers to family physicians.

First level: General practitioners and pediatricians are invited to educational workshops on how to recognize and treat depression in the primary care setting.

Second level: An awareness campaign for the general public is aimed at improving knowledge and reducing stigma. Campaigns have included posters, advertising spots in movie theatres, brochures, public events and websites. Local organizers are also urged to develop a relationship with the media to prompt discussion, and to set guidelines on coverage to prevent copycat suicides.

Third level: Patients in high risk groups — such as teens in crisis — are given “emergency cards” guaranteeing direct access to professional help. Local self-help groups are provided with expert advice and partnerships are created with patient associations.

Fourth level: Workshops are held with groups such as health-care professionals, counsellors, clergy and police officers. There are also information sessions for parents, teachers and youth workers and prevention programs in schools.

The program also tracks data on “core indicators” such as number of suicides, number of suicide attempts, public opinion, attitudes, knowledge and media coverage of suicides.

Does it work? A lot of other jurisdictions have adopted it. After suicidal behaviour was reduced by 20 per cent in Nuremberg, 18 partners in 17 European countries established the European Alliance Against Depression in 2004. There are now about 100 regional networks in the alliance.

The Mental Health Commission of Canada’s Roots of Hope suicide prevention program, which has been adopted by communities in Labrador, Newfoundland and New Brunswick, has some parallels, but the European Alliance has stricter protocols.

A national strategy

What is it? More than 20 countries have a national strategy for suicide prevention. Canada has a federal framework, but not a strategy, and that needs to change, argues the Centre for Suicide Prevention, a branch of the Canadian Mental Health Association. The Canadian Association for Suicide Prevention has also been calling for a national strategy for more than 20 years and released a blueprint in 2004 and an update in 2009.

Canada is the only G8 country without a national suicide prevention strategy and one of the few industrialized countries that doesn’t have one, according to the Centre for Suicide Prevention. The U.S., Australia, Japan, Scotland, England and Finland all have working national policies in place.

The centre says research shows that a strategy must address suicide directly and have its own prevention strategy, outside the broad umbrella of mental health, “otherwise there is a danger that the prevention message will be diluted, ignored, or lost altogether.”

The strategy also can't be the responsibility of a single government department, but must be addressed by all government departments and sectors affected, including the community, workplace, schools, families, the criminal justice system and education.

Does it work? Finland was one of the first countries to introduce a national strategy in the 1980s, and the suicide rate there dropped by nine per cent over 10 years, according to the Centre for Suicide Prevention. Scotland introduced a strategy in 2002 and saw an 18 per cent reduction in suicides by 2012.

Jackie Doyle-Price was named the United Kingdom's first Suicide Prevention Minister in October 2018. Her role oversees a strategy that includes a focus on how social media and technology, such as predictive analytics and artificial intelligence, can help identify suicide risk.

England's strategy was introduced in 2012. In a progress report published in January, Doyle-Price said the suicide rate in England was at its lowest in seven years. "However, these rates can change over time," she noted.

Achieving a low rate and maintaining it over time is an eternal problem in suicide prevention. In the U.S., which has a national strategy, the suicide rate increased 24 per cent between 1999 and 2014, from 10.5 to 13 suicides for every 100,000 people.

NDP MP Charlie Angus introduced a parliamentary motion for a national suicide prevention "action plan" earlier this year.

"We need to put language to this that says this is an epidemic, that it's causing devastation," says Angus.

It also has to be a made-in-Canada plan that recognizes the realities of vulnerable groups in Canadian society, such as Indigenous Peoples, and the relationship between the provinces and federal government when it comes to health policy, he says.

Among other measures, the motion, M-174, calls for a national public health monitoring program, national standards of training for those who work with vulnerable populations and an annual report to Parliament, which would include data on progress for the previous year. "If we're not diminishing the numbers of deaths, then the plan is not working," said Angus.

The motion is up for second debate on May 2. If it passes, Angus said Canada would be obligated to put a number of steps in place, including identifying groups at elevated risk and introducing strategies that would prevent suicide among these groups within 18 months.

“I was shocked at the level of suicide among middle-aged men,” said Angus. “When a large industrial plant goes down, we need to have a plan to raise awareness (about suicide).”

Understanding the biology of suicide

What is it? Scientists are delving into the complicated interplay between genetics and environment and the role each plays in suicide risk.

For example, molecular biologist Zachary Kaminsky’s research hit the news in 2014 after he and colleagues at Johns Hopkins University in Baltimore discovered a chemical alteration in a gene called SKA2 linked to stress reduction. The finding suggested that doctors could identify suicide risk and even prevent suicide through a blood or saliva test.

But it’s complicated, said Kaminsky, who is now the DIFD Mach-Gaensslen Chair in Suicide Prevention Research at The Royal’s Institute of Mental Health Research.

Kaminsky did a study of about 925 soldiers deployed to Afghanistan. A blood test identified a variant of SKA2, correctly identifying five soldiers who had elevated scores for suicidal ideation.

But the tests also found a high number of false positives — these soldiers tested positive, but they did not have suicidal thoughts. That brings up the question of identifying people who are not at risk. There’s also the problem of identifying those who are at risk, but not being able to do anything to help them.

“We have to understand if we will cause a problem that we have no solution for,” said Kaminsky.

Does it work? Researchers are learning more and more about the interplay for genetics and the environment. But it’s not as simple as administering a once-in-a-lifetime blood test to everyone to determine whether or not an individual is genetically vulnerable to suicidal thoughts. First of all, genes may be switched on or off by traumatic or stressful events. Biological systems are adaptive to experiences.

“It’s not just genes. It’s context,” said Kaminsky.

At the same time, vulnerability to suicide risk is believed to be determined by a complex interplay of genetic factors. “Is there one gene that does it all? If I said that, I would get ripped apart,” he said. “In term of coming up with a magic bullet that works for everyone, it becomes very challenging.”

But he also has a lot of hope. At some point, a negative test result may conclude that someone is not at risk of suicide, for example.

“The more research we do, the more we understand about the biological systems that will lead to more treatment targets,” said Kaminsky.

“Treatments target systems we believe to be dysregulated with the hope of bringing them back in line. The more we know, the more we will be able to do this correctly.”

He uses an analogy: A car owner notices the coolant is low, so he adds more. Then it runs low again, so he adds more. Adding more solved the problem for a time, but not the underlying problem. The mechanic figures out that the problem is the water pump. “Once fixed, no more symptoms and no more treating the symptoms because the treatment was better.”

There are also promising new drug treatments for helping people in crisis. In March, the FDA approved a new depression treatment in the form of ketamine, which has been used as a painkiller, anesthetic and recreational drug, delivered as a nasal spray. A study of depressed patients at imminent risk of suicide in emergency rooms at 11 centres in the U.S. found the treatment resulted in significantly rapid improvement in depressive symptoms — including some measures of suicidal ideation.

EGYPT

The Hidden Truth about Suicide in Egypt

By Omnia Essawy November 22, 2018

Suicide is a very tragic and sensitive topic to discuss. This is one of the main reasons why people try their hardest not to talk about it. However when the tragedy of someone ending their own lives strikes, it is not okay to keep denying it anymore.

This is what happened recently when the tragic news of a young psychiatrist committing suicide in Damanhour started spreading. The story as told through different sources of media is that Dr. Ibrahim Ahmed Nasra, a resident of the psychology and neurology department in Damanhour’s Educational Institute took his own life by throwing himself from the 9th floor.

Following the news of his suicide, some screenshots of posts Ibrahim had posted on his personal Facebook account started circulating on social media. The posts mainly expressed the severe depression Ibrahim was struggling with for quite some time.

Among the screenshots was a picture of the very last post Ibrahim published on his account saying; “Grant me the strength to go…”

Surprisingly though, it was later reported that the coroner ruled Ibrahim's death as an accident, not suicide.

This sparks an even more threatening issue that is rooted in our Egyptian society. It is the way we choose to bury our heads in the sand and hide the truth about suicide. Whether he jumped or slipped, the undeniable truth is that he was clearly struggling when he was alive.

Maybe he did slip, maybe he wanted to jump but hesitated at the last second, or maybe he actually did jump. The reality is that we can never know for sure because Ibrahim is gone and so are all those who struggled through their lives till they just chose to end it. Yet, we only seem to care about sugarcoating the ugly truths so we can keep living in denial.

This is not new and Ibrahim is not the first nor will he be the last to suffer silently then leave our world struggling. According to the World Health Organization, suicide is the second leading cause of death among 15-29-year-olds worldwide. Egypt "officially" ranks as number 143 in the world in suicide rates which calculates for 4 suicide cases in every 100,000 people. And these are just the official records.

However, because of traditional values and the stigma put on suicide in Muslim countries, there is significant underreporting of suicide. So much so that there is NO formal statistical documentation of suicide in Egypt. What is even more saddening and dangerous is the fact that if a suicidal person actually tried to get help, they won't be able to because Egypt currently does not have a suicide hotline!

Denying the existence of a problem will not make it go away. Calling it something else will not soften its blow. But facing it head-on and trying to find a solution for it might eventually do. As a psychologist, Ibrahim knew more about the human mind and mental health than the average person. However he still severely struggled with his own. It is too late for him, now, but we can use his example to open our eyes and try to make a change. Don't wait till it's too late for you or someone else, act NOW! If you are struggling, ask for help! You need it, you deserve it and there is no shame in asking for it

AUSTRALIA

Australia's rising suicide rate sparks calls for national target to reduce deaths

Lifeline urges Scott Morrison's government to follow Scotland's lead

Australia's suicide rate is now at 12.6 deaths per 100,000 people. This is equal to 2015 as the highest recorded rate in the past 10 years.

The counselling service Lifeline has urged the Morrison government to set a national target to achieve a 25% suicide reduction over five years.

The chairman of Lifeline, John Brogden, said the statistics were an outrage.

“Behind every number released today is a person who is cared for and loved, with family and friends left devastated by their loss,” Brogden said.

He urged Australia to follow Scotland’s lead. In 2002, the Scottish government set a target to reduce suicide by 20% in 10 years. It achieved a reduction of 17% by 2016 and the number of suicides in Scotland in 2015 was the lowest it has been since 1974.

The health minister, Greg Hunt, announced on Wednesday the government had allocated $36m to suicide prevention projects.

“One life lost to suicide is one too many,” he said.

The Men’s Shed program is also getting a $400,000 boost to help encourage men to speak up about their feelings and seek assistance.

Lifeline received close to 1 million calls from Australians last year and each day, on average, helped 115 people make a 24-hour safety plan.

Suicide is the 10th ranked leading cause of death for males but does not appear in the top 20 leading causes of death for females.

Last year there were 165 suicides of Aboriginal and Torres Strait Islander people, which was a slight increase on the 162 the year before.

INDIA

19 students commit suicide within a week since Telangana intermediate results were announced

Ashish Pandey
Hyderabad
April 25, 2019
UPDATED: April 25, 2019 13:55 I

At least 19 students committed suicide in a span of one week since Telangana Intermediate Examination results were announced on April 18. Chief Minister K Chandrasekhar Rao (KCR) reviewed the situation and ordered the concerned authorities to do a free-of-cost re-evaluation of students' papers.

At least 19 students killed themselves in a span of one week since Telangana Intermediate Examination results were announced on April 18.

Following the reported suicides and protests by the parents, the Telangana government has swung into action with Chief Minister K Chandrasekhar Rao (KCR) reviewing the situation with Minister of Education G Jagdishwar Reddy. The chief minister also ordered the concerned authorities to do a free-of-cost re-evaluation of students' papers.

Parents claim that something went wrong in the correction process as the job of processing the results was given to a software company. They alleged that the group led to the failure of 3 lakh students.

A total of 9.5 lakh students appeared for the intermediate first-year and second-year examinations in March this year.

Parents and students claimed that those students who passed with distinction in most papers have been awarded single digit marks against expectations, declaring them a 'File'. Parents and students allege negligence in the matter.

Meanwhile, on Wednesday, amid protests by students' parents and student organisations, Chief Minister KCR held a review meeting at Pragathi Bhawan which was attended by Minister of education G Jagadeesh Reddy, Educational Secretary B Janardhan Reddy, Secretary Board of Intermediate Education A Ashok and Chief Advisor to the Government Rajeev Sharma.

FRANCE

Wave of police suicides in France sparks alarm

The number of police suicides in France this year has risen to 25, after two officers were confirmed dead over the weekend after apparently taking their own lives.

“[We] have learned with alarm, sadness, but also great anger that yet another two officers have killed themselves,” the French police union, ALTERNATIVE Police CFDT, said in a statement on Sunday, April 7.

Few details have emerged so far about the victims. The first was identified as a 37-year-old woman who worked the night shift for a police station in the northwestern Paris suburb of Conflans-Sainte-Honorine, according to Le Parisien newspaper. After failing to report for duty on Saturday evening, her colleagues launched a search. They tracked her phone near to her home in the town of Guainville, where she was found dead in her car from a self-inflicted gun wound.

The second was a 49-year-old named simply as Christophe, who was an officer at a local police station in the southeastern town of Alès. Christophe’s body was discovered on Sunday, a week after he went missing, regional newspaper Midi Libre reported.

The Information and Communication Service of the National Police (SICoP) confirmed to FRANCE 24 on Monday that two officers were reported dead over the weekend, but specified they remained “suspected” suicides until further notice.

A police suicide every four days

If proven true, that would mean there has been an average of one police suicide every four days since January. The statistic is high in comparison with previous years, and has worried ALTERNATIVE Police CFDT and other unions.

Over the last decade, there have been an average of 44 law enforcement suicides a year in France, according to official data. That figure spiked in 2014, when at least 55 officers took their own lives. Just four months into 2019, there have already been nearly half that many deaths.

There is no clear underlying cause for the high rate of police suicides. A 2010 study by the National Health Institute for Medical Research

(INSERM) found that a number of factors could lead to depression, including occupational hazards, family problems, health issues, addiction and financial strain.

Yet police unions have argued that the relentless pressures of the job are largely to blame.

“Even though there are multiple factors behind the reason for acting – between personal problems and complicated professional situations – there is undeniably a real strain on police who are confronted daily by social deprivation, hierarchical stress and successive operations without the possibility for regular rest,” the ALTERNATIVE Police CFDT statement said.

In an effort to tackle the issue, former interior minister Gérard Collomb launched a police suicide prevention programme in May 2018 that promised to provide greater support to at-risk officers.

The government’s efforts, however, have come under fierce criticism for failing to reduce the suicide rate.

“(We) have noticed, that beyond words, the concrete actions taken are not bold enough to stem the scourge of suicides,” the ALTERNATIVE Police CFDT statement said.

In March, the Committee for Workplace Health and Safety (CHSCT) also sounded the alarm over the situation.

“Operational overwork, professional exhaustion, injuries in the line of duty, psychosocial issues, suicides and attempted suicides! To use a medical term, the national police is in critical condition,” it said in a statement.

The police suicide rate in France is 36 percent higher than that for the general population, according to a 2018 senate report. On average, there are an estimated 14 suicides per 100,000 residents in the country each year.

USA

Film and TV miss the mark in portraying mental health conditions

A new study from the USC Annenberg Inclusion Initiative finds popular media underrepresents and misrepresents characters with mental health conditions.

BY USC Annenberg staff
JUNE 4, 2019

A new USC report reveals that mental health conditions are rare in film and TV: Few characters across popular film and TV series exhibit

mental health conditions, and those who do are routinely dehumanized.

The report, “Mental Health Conditions in Film & TV: Portrayals that Dehumanize and Trivialize Characters,” is the first from Associate Professor Stacy L. Smith of the USC Annenberg School for Communication and Journalism and its Annenberg Inclusion Initiative to investigate the topic.

The study examined 100 top-grossing films and 50 popular TV series to understand the prevalence and context of mental health conditions in entertainment. Using a purposefully broad definition, the prevalence of mood disorders, anxiety, PTSD, addiction, suicide, autism spectrum disorders, and other conditions was evaluated. Additionally, the elements surrounding those depictions were investigated to understand whether mental health conditions are dehumanized, stigmatized or trivialized in popular media.

Fewer than 2% of all film characters and roughly 7% of TV characters experience mental health conditions on screen. In contrast, close to 20% of the U.S. population experiences some form of mental health condition or illness per year. The majority of portrayals also feature straight, white, adult males.

“The prevalence of mental health conditions among the audience far outpaces the characters they see on screen,” Smith said. “This presents a distorted view of the world for those who live and thrive with mental health conditions but never see their stories represented in popular media.”

Also missing: LGBT characters with mental health conditions

One group that is virtually absent from media portrayals of mental health conditions is the LGBT community. There were no LGBT film characters with a mental health condition across the 100 top films of 2016 and only eight TV characters across 50 popular shows in 2016-2017.

To supplement the movie findings, an additional 100 films from 2017 were evaluated. Only one LGBT character was portrayed with a mental health condition. The lack of LGBT characters shown in this capacity is striking, as the National Association of Mental Illness indicates that mental health conditions are nearly three times more likely to occur among members of the LGBTQ community.

The report was conducted in partnership with the American Foundation for Suicide Prevention and funded by The David and Lura Lovell Foundation.

JAPAN

Suicide now leading cause of death among children aged 10 to 14 in Japan

Suicide has become the leading cause of death among children aged 10 to 14 in Japan for the first time in the postwar period, an analysis of government demographic data has shown.

While the total number of people across the country who kill themselves has declined remarkably in recent years, statistics released by the health ministry for 2017 showed that 100 children in that particular age group took their own lives, accounting for 22.9 percent of all deaths in their generation.

Cancer came second for the age bracket, at 22.7 percent, followed by accidents at 11.7 percent.

Among Japanese nationals, the overall number of suicides peaked in 2003 at more than 32,000 before declining to 20,465 in 2017. However, the number of suicides per 100,000 people among those aged 10 to 19 remains flat.

Among those between 15 and 39, meanwhile, suicide has been the dominant cause of death since 2012. About half of those who killed themselves were in their 20s.

Individual factors prompting children aged 10 to 14 to kill themselves have not been sufficiently clarified, according to the white paper from the Health, Labor and Welfare Ministry on preventing suicide and other documents.

Many of those involved in cases of suicide had not previously attempted to kill themselves, making it harder for people around them to recognize the signs, the documents said.

A recent trend in Japan in which suicides by children surge just after holidays, such as the spring and summer vacations, has become a major social issue.

Junko Sakanaka, a school counselor and member of a government panel tasked with the prevention of suicide, has said it is a “serious situation” for suicide to be the leading cause of death among those aged 10 to 14.

“To prevent children from taking their own lives, we need to grasp the more detailed, actual conditions. Now, we adults are being questioned on the extent to which we can recognize (children’s) distress signals, which are hard to perceive,” she said.

In July 2017, the government adopted a suicide prevention plan, which included a focus on measures to prevent youth suicides.

It has strengthened counseling online, while schools are also giving lectures to students on how to seek help when they have concerns.

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 hear 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.

FEEDBACK

I recently lost my husband to suicide 8 weeks ago. I am looking for a support group that doesn't require me to drive a far distance. Do you offer this kind of support? Thanks

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Having made a number of failed suicide attempts I've now decided next week is the time to do it when my daughter is away. I screwed up badly last weekend I know it will hurt her initially but in the long run it will stop me messing up her life like I did with my youngest son I don't

want to be talked out of it I just want you to let her know I love her and my sons

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What can I do to help this fantastic organisation? I have been touched by my friends suicide and support a family member who is affected by mental health issues including attempts as well as a close friend with severe depression. I have been very disappointed with the public health system and there respond to people in my community and family with mental health issues.

I've suffered mental health problems for many years. Had argument with partner and can't cope anymore

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Good afternoon, I’m a student enrolled in a Diploma of Mental Health course at TAFE. I’m wondering if you offer any voluntary/placement positions as I would like to gain hands on experience. Looking forward to hearing from you. Kind regards,

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Hello My name is …….. Firstly, I apologise for the shocking spelling, grammar etc that will be contained in this email. I am truly beside myself at this moment so I'm not thinking clearly due to my extreme distress let alone able to compose an email. I am severely mentally unwell and I have been desperately trying to get some help for myself for several years now to absolutely no avail. I cannot go on existing like this indefinitely. I have complex ptsd, BPD, severe depression, anxiety, agoraphobia, an intense fear of human beings, and a very long history of severe trauma. I had a psychologist who I was seeing for 3 years until some months ago. I begged that psychologist on countless occasions to get me some more help as I was not coping with every day life and she repeatedly said "bear with me". Three years went past and she did nothing, so I finally had to fire her and demanded that she now get me some help. At that point she then finally found a mental health service. I explained to the mental health services the exact support that I needed when I first met with them. I told them that I needed help setting up direct debit systems to pay my utility bills, as I am usually too mentally unwell to pay them, so the service gets cut off. I have the money to pay my bills, it's just a matter of my poor mental health. I was living without any electricity for over a year, as I couldn't purely due to my mental health pay the bill and as I had no one to help me, it got cut off. Similar things happen to me regularly and it's very distressing and extremely difficult to live with. This assistance with setting up direct debits has now been refused. I also told the service that I need to see a female GP as I have some medical concerns and because I struggle to leave the house and I have an intense fear of people (particularly strangers) I need someone to take me. They said all they can do is provide me with a list of details of local female GPs and nothing more. I also explained to the service that my car is dying

and I desperately need to get if fixed and serviced but I cannot be around a strange man on my own so someone needs to come with me as support. This is now refused. All the service is now going to do for me is to help me apply for NDIS and nothing more and this service also ends in June of this year so then I'll have literally absolutely nothing yet again. NDIS takes several months to be reviewed and it's also notoriously difficult to be approved on grounds of mental health, so I'm left in a dire situation. I've also had no working people phone for several months now, which I also requested help with from the service but was refused and I was told that I should go to a neighbour in an emergency, even though I've explained that I cannot interact with people as I'm terrified of them. I've spoken to my GP a he said that there's no other service available to help me and that due to my severe bank ground in trauma and abuse that I need to accept that I'll never be happy or normal and that I need to deal with it. The worker I was assigned also told me that she can refuse me service and does not need to give me a reason why. That's really unethical and distressing. She also said that her job is not to treat me like a baby and that I need toe learn to do things for myself assume is not my personal babysitter. My ex psychologist wrote a long report explaining my trauma to background, diagnoses and why I can't function normally and need help but been overlooked. On one hand my worker has said to me many times that she's not a therapist or medical person yet at the same time when my psychologist emails why I mentally cannot so certain things my worker over ruses these facts. The worker also clearly doesn't personally like me and made no secrets about that which made me feel very unsafe and uncomfortable around her so now I've been left even more terrified of people and reaching out. My old psychologist was very focused on the issue of money and said that she relies on my 10 sessions a year as she has "to put food on the table" and she also used to tell me how terrible her own personal existence was and it only added to my distress. She also betrayed me in the end by calling the police, as I was not coping, even though we had a agreement together that she would not the police again as this really triggers me and I also live in a small unit block so all of the neighbours become involved in my affairs I suffer even more for it. I don't have any family or friends at all and I can not maintain a relationship with anyone as I have been betrayed, abused and traumatised far too much in the past - including even from professionals. The only relative I have is a sibling who is severely disabled and lives in full time care and I am a huge part of her life trying to support for her in many ways while I can't even care for myself. She is not being cared for properly - the staff don't even give her medication regularly as well as countless other issues and I am now far too mentally exhausted to keep fighting the battle for her, so she's also suffering too but there's no one to help us. I also asked my worker to help support me with the complaint about my sisters care, as it's a very serious matter which I mentally can't take only own, and my worker of course refused and told me to contact a another organisation which I did, but that organisation didn't even bother to reply to me. I've phone and emailed all sorts mental health

organisations and services over the years and I've gotten nowhere and I am definitely rapidly deterioration and I have ZERO support. I am now so mentally unwell and terrified of human being that isn't leave my house or speak to a soul for several weeks at a time and I am increasingly struggling with her whelming internal rage and sorrow. I've no psychologist or anyone to w en talk to. I've called ……. a few times and they've told me that my situation is beyond their scope so they cannot help me. I have a very long history of seeing psychiatrists, being hospitalised etc, but I have learnt over the decades the hard way that when you have a severe mental illness and on top of that you have no family, friends or anyone to help you, people are very predatorily and will 9/10 times use it as an opportunity to get something for themselves and not give a darn about the patient. Then no one believes the patient as we're deemed 'mental" and so it goes on. I have literally nowhere else to turn to. Please help as cannot survive like this much longer and I've rub bone out of ideas at this point. I have an intense fear talking to strangers on the phone so if anyone does contact me can it please be via email. I've genuinely desperately wanted to kill myself since I was 12 years old but I'm trapped here as I have a disabled sibling who needs me as she has no one else in the world, but ideally I'd love for more than anything fir all of this to just end and I die. Thank you.

Hi I am currently suffering with some mental health issues due to domestic violence I was in 9 years ago, just wondering if you can point me in the right direction on who to talk to. Thank you

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HUMOUR

A child asked his father, "How were people born?" So his father said, "Adam and Eve made babies, then their babies became adults and made babies, and so on." The child then went to his mother, asked her the same question and she told him, "We were monkeys then we evolved to become like we are now." The child ran back to his father and said, "You lied to me!" His father replied, "No, your mom was talking about her side of the family."

A proud and confident genius makes a bet with an idiot. The genius says, "Hey idiot, every question I ask you that you don't know the answer, you have to give me $5. And if you ask me a question and I can't answer yours I will give you $5,000." The idiot says, "Okay." The genius then asks, "How many continents are there in the world?" The idiot doesn't know and hands over the $5. The idiot says, "Now me ask: what animal stands with two legs but sleeps with three?" The genius tries and searches very hard for the answer but gives up and

hands over the $5000. The genius says, "Dang it, I lost. By the way, what was the answer to your question?" The idiot hands over $5.

Source **https://www.rd.com/jokes/**

DOIG WEBSITE TECHNOLOGY

Steve has volunteered his time with White Wreath for a number of years and has developed a wonderful Website for us that he has also maintained over the years. White Wreath receives much congratulatory comments regarding our Website and below is information if you wish to contact Steve personally.

Do you know anyone who might be thinking they need help with their existing website or need a new website built (efficiently and effectively)? Please forward my details to them.I can help with any of the following:

- Making a website mobile phone/tablet friendly.
- Adding features or functionality to websites: image galleries, contact forms, forums, image carousels, calls to action, Facebook feeds & more
- Converting a static website to an editable website where the website owner can edit his/her own web pages, upload images and PDF documents, publish a blog & more.
- Performing SEO (search engine optimisation) tweaks to websites to increase website rankings.
- Upgrading old out of date website software to the latest website software version: e.g. Wordpress, Joomla, Drupal, Magento.
- Maintaining your website software at the most up to date version to avoid security vulnerabilities.
- Increasing the speed of awebsite to ensure website visitors do not leave because they were kept waiting too long for a slow website to finish loading.

Happy to help anyone with website needs, and would appreciate any referrals you can make.

Sincerely,
Steve Doig

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TWITTER: https://www.twitter.com/doigwebtech

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WISH LIST

Petrol Gift Cards, Stamps, Volunteers Aust/Wide

OR YOU MAY LIKE TO DONATE

DONATIONS TAX DEDUCTIBLE

1.Via our credit card facility posted on our Website www.whitewreath.com then follow the instruction.

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

The Views and opinions in our Newsletter are not necessarily the views and opinions of the White Wreath Assoc

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