Submission to the Senate Community Affairs Committee for the Senate Inquiry into Suicide from a Survivor

I am an independent Survivor. I am not affiliated with any organization or agency. The following is not an account of my personal story, however, some of the examples I have outlined in this submission are similar to my own experiences. I have chosen not to share the details of my personal story as I do not wish for it to become a matter of public record. Throughout my life I have known 12 people who have died by suicide, and I have known countless people who have attempted suicide. It is based on my knowledge of those peoples' experiences, combined with my own lived experience, that I make the following submission:

It is my belief that perhaps the biggest key to suicide prevention is in the acknowledgement of what a person has lived through in order to drive them to the point of choosing to end their own life. And perhaps the biggest hindrance to suicide prevention is the medicalization of suicide and the fact that it is all too often blamed on a 'chemical imbalance' in the person's brain. In everything I have read relating to suicide statistics, it is consistently reported that more than 90% of all deaths by suicide are associated with 'mental disorders' such as 'depression' and substance abuse. So why can't I find any mention anywhere in the suicide research and statistics about what *causes* 'depression' and substance abuse?

Instead of reporting that more than 90% of all suicides are associated with mental disorders; imagine if the findings read something like this:

Of all the deaths by suicide:

--% had been victims of war

--% had been victims of childhood sexual assault

--% had been victims of childhood physical assault

--% had been victims of bullying

--% had been given up for adoption

--% had been emotionally neglected as children

--% had been victims of racial discrimination

--% had been victims of homophobic discrimination

--% were war veterans

--% had been victims of, or been witness to, extreme acts of violence

--% had experienced the premature death of a loved one

--% had been in violent/abusive relationships

--% had partners that were unfaithful

--% were unemployed

--% were homeless

--% had served jail time

--% had experienced involuntary psychiatric treatment and/or detention . . . . . .

(This is meant to be an example only, and I have listed some of the things that are known to lead to increased risk of `mental illness' and/or substance abuse. I'm not suggesting these would be the only things that could possibly drive a person to suicide, and I would never intentionally discount or disregard anyone's circumstances or experiences)

If suicide statistics were reported like that and we had those numbers, then we would be able to clearly see where our support services are lacking, and also where they are harming instead of helping. Perhaps then communities would actually begin developing honest responses to trauma.

It is not necessarily the experience of the trauma itself, but the community's response to it, that can ultimately lead to a person's suicide. For example: a person who has been the victim of childhood sexual assault of an incestuous nature testifies in a court of law. The perpetrator is found guilty, but receives a sentence of only 12 months jail time, or worse, a good behaviour bond and/or a fine – **due to this country's appallingly lenient sentencing of sex offenders**. This person, already suffering the effects of the abuse then has to contend with being invalidated, discarded and disqualified by the law, especially when it is ruled that there is insufficient evidence for a conviction at all. This person is estranged from their family, as incest victims often are, and tries to seek help but is placed on a long waiting list for specialized sexual assault counselling – **due to lack of funding and resources**, with the knowledge that when they finally make it to the top of the list they are entitled to only a limited number of sessions – **due to lack of funding and resources**. This person, who is then reeling from the trauma of the initial abuse, combined with the trauma of a court case, combined with having to contend with an unjust outcome of that court case, is left completely alone and unsupported – **due to lack of funding and resources**. This person then begins to experience symptoms that could fit into any number of the 'diseases' listed in the DSM-IV-TR such as: sleep disturbance; increased feelings of anxiousness; fear of public places and social situations; distrust and fear of people; heightened state of awareness; disassociation; eating disorder; paranoia; distorted sense of reality; self harming; suicidal ideation; etc.

The person, then tries to access public Mental Health Services, but still has some level of self-awareness (otherwise known as 'insight'), and is therefore not considered 'serious' enough to require psychiatric attention – **a judgement call based on the fact that the person themselves initiated contact with the service, therefore knows they need help so still has 'insight'. Having awareness that they need help will be the reason the person doesn't receive any. This is due to lack of funding and resources**. This person is provided with a list of crisis support phone numbers, but after going through the difficult process of recognizing the need to phone someone, and then finding the courage to do so, the person then finds that each support line they try to ring is engaged, sometimes for hours on end. Or if they don't get an engaged signal, then they are prompted to leave a message with a name and contact number, with a recorded message telling them someone will phone them back as soon as possible, only to be left waiting for hours for a phone call that often never comes. – **Because there are so few people manning these crisis support phone lines due to lack of funding and resources. And in the case of phoning Psychiatric Triage for support, there is even less chance of that phone call being returned, because of the fact that there is only one worker who is expected to man the phones, do the assessments of the people who present to the Emergency Department, as well as be available for consultation with the psychiatric ward. This is due to lack of funding and resources.** These hours of waiting can be critical for a person clinging to the hope that someone is going to call, and with each moment that passes and the phone call doesn't come, their state of mind can rapidly deteriorate and move way beyond what could have essentially been resolved with some phone counselling, or with a home visit from the Crisis Assessment and Treatment Team. – **Though it would be would be highly unlikely that a Crisis Assessment and Treatment Team would conduct a home**

visit because by making the call themselves, they are showing they still have 'insight'. This is because each Area Mental Health Service has only one Crisis Assessment and Treatment Team due to lack of funding and resources. This person continues to experience any or all of those symptoms (that I listed above as fitting into the DSM-IV-TR), is still on the waiting list for counselling, and as a result of being left completely alone and unsupported, these symptoms can then escalate to (what is known as) an episode of psychosis; mania; major depression; etc, or even makes an attempt on their life. (It is extremely important to note, that what I am drawing attention to here, is the fact that at any time during this person's suffering, if adequate support systems were in place, then further suffering would have almost certainly been avoided. My meaning must not be misconstrued to suggest that I support the idea of earlier State Interventions). This person then comes to the attention of a Mental Health Service, either as the result of their suicide attempt, or as a result of a concerned citizen or member of the police force noticing 'disturbing behaviour' and is then subjected to traumatic involuntary detention and chemical and/or physical restraint, and quite possibly even shock treatment against their will. – **There are countless peoples' testimonies that involuntary psychiatric 'treatments' compound and in many ways re-enact their experiences of childhood traumas, however, Trauma Informed Models of Care have still not been implemented**. This person is then discharged from hospital on a Community Treatment Order, and lives under the constant threat and fear that their Order will be revoked and they will be put back in hospital against their will, if they do not comply with the Order. This is regardless of whether they feel the 'treatment' is helping or hindering their recovery – **due to the lack of a voluntary Mental Health System, and the lack of alternatives for treatment of 'mental illness'**. As a result of any or all of these experiences, this

person is unable to work, therefore loses their home, and is placed on a long waiting list for emergency accommodation – **due to lack of funding and resources**. This person is then homeless and forced to live on the streets. Finally, with no adequate help or support available, and not a shred of hope left, this person takes their own life. In the suicide statistics as they are currently reported, this person's suicide would be counted as one of the "more than 90%" that are attributed to a 'mental disorder' due to whatever psychiatric diagnosis they were labelled with whilst they were hospitalized – **it would not be included in this person's psychiatric file that they had a history of childhood sexual assault because, despite the fact that it is consistently estimated that as many as 8 in 10 people who come to the attention of Mental Health Services have a history of trauma, there is still no process in place for Mental Health Services to routinely screen for trauma**.

I realize that the scenario I have outlined may seem like an extreme example, but unfortunately these kinds of cases are far more common than most people are aware, and I know of many cases where the circumstances and experiences are far more extreme. That scenario I outlined could have begun with any traumatic experience and could have easily included a lot more systems failures. It could have included the person not being able to see the psychologist working in the school they attended as these psychologists are only at schools part time, and work many schools in their area. Therefore, more often than not, they will only have the capacity to work with students already identified as being in 'crisis' – **due to lack of funding and resources**. It could have included dealings with Human Services as a result of mandatory reporting when there is suspected abuse in the home – **which sounds great in theory but the victim, who is already in a situation of being abused by somebody who has power over**

them, is then further disempowered by the decision/question of disclosure being taken entirely out of their hands. Such reporting can have dire consequences for the victim. They are often subjected to further traumatizing experiences, such as: they can be violated with invasive physical examinations against their will, forced to testify in court, removed from their home and wind up in countless foster homes or be raised by the state. And due to lack of funding and resources there is not adequate follow up provided for those victims who have been removed from their homes. Or due to loyalty and confusion and a desire to protect their family, the victim will be unwilling to disclose the abuse and will deny everything. This is often a result of them not being educated from an early age about the difference between 'safe touching' and 'non-safe touching'. And not being educated about how crucial it is that they tell someone if any 'non-safe touching' occurs, because it is against the law for anyone, including their own parents, to touch them in a 'non-safe' way. In cases where there is insufficient physical evidence to prove the suspected abuse and the victim denies it, this will result in the victim remaining in an unsafe home. This can leave the victim feeling as though they are unable to disclose and report the abuse when and if they do feel empowered enough to do so, because they fear that they have already discredited themselves by denying it before. This can result in the victim remaining in their unsafe home for many years longer than what may have otherwise occurred. Or Human Services could have been involved where a person, being the sole carer of children loses custody after being made an involuntary psychiatric inpatient – **as there are no psychiatric hospitals with in-house round-the-clock child care facilities available. Consequently both parents and children are traumatized by separation, and single parents often lose custody of their children**. The person could then try to

fight for custody of their children, but never get their children back due to being seen as unfit because of the implications of their psychiatric diagnosis. Or due to them being forced to take heavily tranquilizing medication that renders them too drug affected to adequately care for their children. Or due them being unable to have their status of 'being a risk to self or others' lifted – **despite the fact that this country has no legal proceedings to formally prove this status, and it is based on opinion only**. The person could develop drug and alcohol dependency issues as a result of trying to manage their psychological/emotional/spiritual pain ('psychache') and then commit drug related crimes to support their habit and end up serving jail time – **which can obviously have all kinds of dire consequences, not the least of which, and perhaps one of the less obvious consequences, is that in the example of the person having a history of testifying to sexual assault in a court of law, they will often serve more time than what the perpetrator of their assault was sentenced with, giving the person a very clear message that their life is of no value, especially when their crime was that of theft of money or material objects**. Or due to their drug and alcohol dependency issues they could be passed to and fro between drug and alcohol support services and mental health services, resulting in not actually being treated by either – **because despite the overwhelming evidence for the need, there is still no adequate help available for people with 'dual diagnosis'**.

Again, I realize these examples may seem extreme, but it is all too common for people to experience any or all of these (and more) systems failures, and their community's failure to honestly respond to trauma. It is these experiences that will ultimately lead to a person's suicide, not the experience of the initial trauma, and not the fact that they had 'mental health issues' and/or 'substance abuse issues'. It is extremely remiss that these

people's stories are never told, heard or documented (except within in the confines of 'patient-to-patient sharing' in psychiatric acute units and day programme settings, 'client-to-client sharing' in detox centres, 'member-to-member sharing' in self-help support groups and Alcoholics Anonymous/Narcotics Anonymous programmes, and 'homeless person-to-homeless person sharing' out on the streets). These peoples' life experiences are not included in the suicide statistics. These peoples' suicides are instead captured and unfairly misrepresented in the more than 90% of suicides that are attributed to a 'chemical imbalance'.

The recent censorship of media coverage of suicide has led me to suspect and fear that, due to fear of being held accountable, officials don't want people to tell their stories because they don't want these (and more) systems failures being exposed and becoming public knowledge. There has been research done that proves the media can help reduce suicide rates when stories are reported carefully and responsibly, and as long as it is not glamorized or romanticized it in any way, and is in no way portrayed as an acceptable course of action. There are thoroughly researched, quite specific guidelines that have been drawn up, that clearly point out responsible media coverage of suicide, so why aren't the officials busily overseeing the reporting of suicide to ensure these guidelines are being adhered to, instead of still busily fighting to keep it hidden? Considering the fact that it's been proven that responsible media coverage can actually help to reduce the number of suicides, the reason given for this censorship – their fear of 'copy cat' suicides, doesn't quite hold up. Fear of accountability is pointless, because for the purpose of suicide prevention, the intent would be to raise awareness and to create avenues for change to occur, not to lay blame.

It is worth noting, that I can find statistics of increased risk of suicide when the research is based on the effects of trauma, but no acknowledgement of trauma in the suicide statistics. For example: I have found studies that report that people who have been victims of childhood sexual assault are 9 times more likely to suicide than people who have not. Victims of bullying; people who are unemployed; victims of war; war veterans; people who have served jail time; people who have lost a loved one to suicide; etc, are all higher risk groups and are considered more likely to suicide. While I do not doubt the importance of stand-alone research on the impact of trauma, it seems to me, that if it was also incorporated with the suicide statistics and research, then it's possible it could be contributing to suicide prevention.

The biggest gap in the research that I can see is the missing knowledge there is to be obtained from the people who have attempted suicide yet are still here to tell their stories. It is estimated that for each completed suicide there are at least 30 attempted suicides, therefore there is a mammoth wealth of knowledge that could be obtained from these people. From what I can tell there seems to be a significant shift, from what used to be considerably far and widespread thinking, that 'unsuccessful' suicide attempts are not 'real' suicide attempts, towards each suicide attempt being taken seriously. I have seen some small recent examples of organizations wanting to hear from people who have lived experience of 'suicidal distress', but unfortunately what I have seen has still had an unmistakable focus on the medicalization of suicide and people with 'mental health issues'.

There has been some acknowledgement emerging recently that the causes of suicide are more complex than previously known, but if the trend doesn't drastically shift away from the medicalization of suicide, and the focus on the relationship between 'mental illness' and suicide, this will result in increased forced psychiatric 'treatments' against people's will and an increase in the already alarmingly high number of people on Community Treatment Orders. When people are involuntarily detained and 'treated', and are put on Community Treatment Orders, they are subjected to such Human Rights abuses as the loss of the right to refuse treatment (informed consent), the loss of the right to bodily integrity, the loss of the right to freedom of movement, etc. Countless people's testimony of the trauma inflicted when they are treated against their will is consistently and deliberately ignored due to the tired 'it's for their own good' argument, despite the fact that the loss of their basic liberties more often than not results in a significantly diminished quality of life. This is not a helpful or humane way to 'treat' people, and the irony is that as a result of being subjected to involuntary hospitalizations and 'treatments', and Community Treatment Orders, many people actually become suicidal even though they may have never felt that way before. However, becoming suicidal is never acknowledged as being a result of their forced 'treatments', but instead it is blamed on their 'mental illness'.

It is known that people who are 'mentally ill' are at greatest risk of suicide during admissions to acute psychiatric inpatient units, and immediately following discharge. This research needs to be picked up and expanded on so that the reasons for this are fully understood, and to prevent this knowledge from translating into earlier State Interventions, more prolonged involuntary hospital admissions and more stringent requirements for people to be forced to comply with on Community Treatment Orders.

The medicalization of suicide is truly mind boggling when you consider that "more than 90% of all deaths by suicide are associated with mental disorders such as depression and substance abuse", while also considering and taking into account the overwhelming evidence of the remarkably high prevalence of childhood trauma in people who come to the attention of Mental Health Services and in people with substance abuse issues.

I have clearly pointed out that people are traumatized, and then re-traumatized, over and over, and that will ultimately lead to a person's suicide, due to a lack of funding and resources. We have the capacity, in this country, to create state-of-the-art facilities for responding to trauma. We have the capability, knowledge and expertise to educate communities about honest responses to trauma. However, the organizations/agencies with the *ability* to do so, do not have the *means* to do so, because they are so desperately underfunded. This country is wasting funds on Mental Health Awareness Campaigns, that are of little to no benefit, and in fact, many people who have a diagnosis of a 'mental illness' actually find such campaigns incredibly offensive. This country is wasting funds on the development of Mental Health Screening programmes that will ultimately result in more people being forcibly 'treated'. This country is wasting funds on the pointless research and debate about whether 'dual diagnosis' is the result of 'mental illness' fuelling 'drug and alcohol addiction' or 'drug and alcohol addiction' fuelling 'mental illness'. Clearly these funds need to be re-directed to the organizations, agencies and individuals who are the experts in minimizing the impact of trauma, and the who are experts in best practices that will maximize the victim's chances to recover from trauma and go on to lead full and healthy lives.

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