Senate Inquiry into Suicide 2009

Submission of SOS Survivors of Suicide Bereavement Support Assoc Inc.
(www.sosbsa.org.au)

1. As a suicide bereavement support group we obviously only hear of where possible preventative measures have broken down, that is, if they were instigated at all. Could these deaths have all been prevented if mechanisms been in place early enough and the person suffering been receptive to them? Of course these are the things we'll never know of our loved ones. We can only look back and dream of what might have been had we known more, had others known more, had our loved ones known more, that "someone" had ,or hadn't, done "something" and that we all had been receptive to what might have been.

2. What is so dominant in the above paragraph? "If only we had known"! We, in essence, were ignorant of what our loved ones were experiencing and if we did have some idea, eg the person had been in the mental health system for some time with suicidal behaviour, how to respond at that time of greatest need. Is it our "fault"? No, for if one knows no better one cannot do any better and yet for years and years we grapple with debilitating self blame and regret. Could we even have done better? Perhaps, perhaps not, but we hope so because this is why we desperately seek and support preventative measures which will work – who would wish to visit our grief onto any other family or community!!

3. Our group offers support for those bereaved through regular support group meetings, newsletters and a website, social outings and a 24/7 telephone support line. We also receive calls from those who are suicidal or trying to find help for someone who is suicidal.

4. Many of the suicidal callers are from regional and country areas where accessing services are difficult and not just because of "physical" inaccessibility. They often report being afraid that others in their small communities may "find out" eg "My boss is the doctor and everyone says I'm strong and reliable", "My friends might see me if I go to the doctors." In smaller communities, possibly even more so than larger ones, reputations, good or bad, can be jealously guarded and mental illness carries an enormous stigma.

5. While one may say they should not be afraid to seek help through their communities, the reality is that there are some things an individual wants to keep private and until we achieve a more "Mediterranean" Australia then this is what we have to work with. This does not mean we should not work with these communities themselves. A community which better understands mental health and truly rejects those things which are risk factors will eventually, hopefully, become more compassionate towards the emotionally/mentally wounded in their midst.

6. Many callers have expressed enormous relief that they can receive 6 free professional counselling sessions through providers such as the Suicide Callback Line. This allows them the anonymity they so desperately seek. Perhaps we should have a **dedicated national 24/7 suicide crisis and follow up** professional counselling phone support system which has the word Suicide in its title as the Callback line has. There is also the benefits of web counselling.

7. We also receive a number of calls from partners and parents of people with suicidal behaviour Their issues

a. Where to go for help
b. How to care for someone suicidal as they have already visited the Emergency Department and were sent away 3-6 hours later, just with the information that

their loved one “needs help”.

c. How to talk to their loved one about their suicidal thoughts/behaviour.

Having a suicidal loved one is a terrifying experience (also for the sufferer) and can throw families into extreme panic. Perhaps in larger emergency centres, if professional counsellors cannot be made available, having trained volunteers on call to comfort and provide information for the “support” persons would be an option or staff at least providing literature/dvds on care matters would help.

8. Inpatient/just released suicide prevention.

The British National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness 2006 “*Avoidable Deaths*” is probably quite similar to the Australian situation and discusses some of the problems and offers possible solutions. We should look at these.

The authors write these tragic words:

“In fact, unlike suicide in the community where supervision is less immediate, all in-patient suicides could be seen as preventable.

It is time to change the widespread view that individual deaths are inevitable- such a view is bound to discourage staff from taking steps to improve safety. It may be a reaction to the criticism of services and individuals that can happen when serious incidents occur. Therefore, if mental health staff are to give up the culture of inevitability, it is up to commentators outside clinical practice to give up the culture of blame.”(p6)

We forget sometimes that whether we are patient, passerby or provider, we all value respect, appreciation, care and understanding.

9. Suicide is an international problem and it is our belief that all countries should diligently inspect promising research and programs from other countries which may be applicable, or have elements of applicability, to their own cultural situations (or even changing aspects of the culture). There is no point in, or time for, reinventing wheels.

10. We also believe that there should be a more rapid dissemination of promising research to the coalface.

11. Some of our members are also medical/paramedical staff. We hear from them, especially those in ER, of the frustration of dealing with self harming and suicidal people and those who are mentally ill but not suicidal. It is evident that staff education is sorely needed and that staffing levels must be improved, even that the system used for dealing with these patients through ER be changed. There is no doubt this Inquiry will also be made aware of the many other areas deficient in service provision.

12. Some members are shattered that “Privacy Issues” prevented them from helping their loved ones “If only his doctor had told us that he had been thinking of suicide”. There appears to be an enormous amount of confusion as to how “Privacy Laws” can appropriately be utilized in certain cases. There also appears to be some reluctance by medical/mental health providers in utilizing a patient’s support system to help them provide a circle of care even though this is recommended in providing good mental health care. We recognise that patient autonomy is important but some of the stories we hear indicate that the “patient” and his/her doctor needed **our** help.

13. Sometimes, of course, a loved one doesn’t accept that he/she is ill, or like Andrew Robb (MP) initially, do not realize that they have an illness. It is hard to support someone like this.

It is even harder when the support people do not know there is a mental illness either. Courses like Mental Health First Aid should be as common as swimming lessons. The vast majority of people with mental illness do not suicide but mental illness is a factor in many suicides though what specifically “causes” suicide is still unknown.

14. We applaud the concept of “Standby” and hope that as they become more available and better recognised they will earn the trust of those family members who may be more vulnerable and yet who may be less likely to reach out for help after a loved one’s suicide. Research (1) also shows that contact groups like ours are very beneficial in helping “survivors” reconstruct their world. We offer models of hope, survival and acceptance.

15. Though improving, there is still a great amount of stigma attached to mental illness, suicide and being related to someone who has suicided. We must look at campaigns which have been reasonably successful in communicating the truth in their messages eg the human rights movement, the gay movement.
We must also work with those great communicators of our age, the advertising industry and web designers, in how to “package” destigmatising mental illness messages.

Courtenay Harding (2) states, “Many mentally ill people have the capacity to lead productive lives in full citizenship. We should have the courage to provide that opportunity for them.” Indeed.

16. Our men, in particular, bear the brunt of this scourge of suicide but it should also be remembered that twice as many women attempt. We need to know how to reach each one before they become a statistic.

17a. How do we reach the almost unreachable? In particular, those whose brains have been damaged by the co morbidity of addictions. Obviously, its best before it happens, which can only happen with an extremely perceptive, responsible and responsive community. That’s a big call-does this mean we should flood the community with academics and experts dispensing paternal advice?– no, just building cohesive communities who are aware, empowered and care eg “Headspace”
17b. Many studies have found that a significant majority of those who suicide have visited their doctors fairly recently. Research has to be done into what silent messages may have been sent and family and friends –everyone- have to be taught how to recognise the, sometimes blatant, messages which are being sent (see # 13).

18. Tragically, childhood sexual abuse is sometimes mentioned by our callers. Sometimes it is intrafamily and not infrequently outside but the child was too afraid to tell anyone. Sometimes we are the first they have told-to quote Senator Fielding,
“Those feelings are pretty raw. You keep silent about it because it is not something you want to share, that, as a young kid you were sexually abused, or abused in any way.”

There just has to be zero tolerance of these life destroying acts. Children and teens are still having their childhoods stolen today, even as you read this.

19. Other callers are overwhelmed by the complexity of their personal relationships especially marriage/ intimate partner failures. This area has to be addressed more adequately and to prevent intergenerational dysfunction and destruction. Research should not only look at the breakup and its after math in suicide cases but at what were the elements which caused the breakup in the first place.

20. We also lose many of our “highly functional” people, eg medical practitioners, police. We must research what additional environmental/ personal factors may be influential and work to mediate these.

21. Farmers suicides have received much press. Farmers occupy a unique micro culture where mice plagues, droughts, wild dogs, self sufficiency, fuel prices and dirt have a significance way beyond the comprehension of most people who are not “off the land”. To provide prevention effectively to any micro culture we must be aware of, and have empathy for (even if we are puzzled by), the things that a micro culture values and judges itself by.

22a. During this inquiry, we will hear much of “risk factors”, “protective factors”, “building resilience” and where to aim “messages”. One only has to reflect on the two Parliamentary Apologies issued this year and remember how much damage was done to the children. How long has the damage lasted? A lifetime. So whom should we work with? It is the whole of society’s responsibility to ensure our most vulnerable are cared for, not just children but including adults at their most vulnerable (from suicidal society leaders to the suicidal, addicted, mentally ill street wanderers and the lonely, debilitated elderly).
22b.Not that we must assume its all due to childhood causes. In truth we do not know where on life’s journey the suicide factor kicks in but for some it appears to have been a long term plan and for others an immediate response. Most people wounded in childhood are able to absorb their childhood traumas and live life as best they can. What wounding (biological/psychological/ environmental/spiritual) too in adulthood promotes suicide as the only option?

23. Is there a biological aspect to suicidal behaviour? Probably - after all, every human individual is a complex biochemical factory. Only now are we starting to get empirical evidence of differences however.

24. Psychological autopsies. This is a tool used to try to determine the deceased’ s history and state of mind to discover what may have caused him/her to suicide. It often involves interviewing family/friends.
The value of these done just after the suicide, i.e. in the first few years only, may be limited as we have found in our support groups that there is often little knowledge or understanding of signs and symptoms of mental illness or that a particular comment/action may have indicated a mental illness eg depression or particular activator. It may not be until years later, after much reading/reflection that the survivor may be able to judge better the events of the time and the issues leading to it. They may have also gathered additional information from others over this time. Such studies then may have to be conducted over a long period of time and preferably by the same person/s to allow a disclosing relationship to be developed.

25. This Inquiry does not stand alone and should not be viewed alone. It is the latest in a long list of Parliamentary Inquiries where suicide is a continuing theme in the submissions received (not necessarily reflected in the final reports). It is there in many of the health/mental health/stolen generation/forgotten generation Inquiries. The recently concluded Men’s Health Inquiry received many submissions which detailed considerable concern over Australia’s suicide rate.

26a.The honourable Senators during this Inquiry will undoubtedly become familiar with the many theories about suicide. Note the common theme of a lack of “belonging” (of us, but not one of us- an experience which may be perceived and/or actual) and learn of the excellent work being conducted by our academic institutions into mental illnesses and suicide research (see# 10), but for a layperson’s lived experience of depression, suicidal behaviour and the experience of family members Graeme Cowan’s books “I am Back from the Brink” and “I am Back from the Brink, Too” are valuable resources.
26b.To really understand the unending questions that hack at the heart of someone bereaved through suicide and to understand the problems unique to them, we recommend visiting the following reputable web forums: http://forum.forsuicidesurvivors.com/ and www.suicidegrief.com

These honest and raw postings are the experiences, thoughts and emotions many bereaved struggle with every day. Much of the "secondary wounding" occurs because our society is afraid of grief interactions and have unrealistic expectations of "recovery". Suicide grief is particularly difficult for others to comprehend and also still carries a stigma. We applaud the Salvation Army for their online suicide bereavement training program http://salvos.org.au/suicideprevention/index.php?show,livinghope,overview though additional funding may be required to make it more accessible.

27. To summarise

Stigma- distorted or untruthful negative views by a society of a particular subject/group which causes discrimination of those affected. To change a stigma, one must change the views and actions of the society from whence it came.
Mental illnesses- are disorders of the brain, not personal choices yet we know that certain life events along with the sufferer's own biological and psychological makeup may initiate/activate the problem. It is important we, as a society, take responsibility to empower the vulnerable.
Suicide- more than a psychiatric problem, so requires more than medical answers but are the right questions even being asked??

1. McMenamy JM, Jordan JR, Mitchell AM. (2008): What do suicide survivors tell us they need? Results of a pilot study. *Suicide and Life Threatening Behaviours*; 38(4):375-89.
2. Courtenay Harding. (2002): Beautiful minds can be recovered. *New York Times, 10/03/02.* Republished in Mental Illness Fellowship of Australia, Fact Sheet Series

Topics are numbered for referencing convenience and not in any hierarchical order.