Senate Community Affairs References Committee
Inquiry into Suicide in Australia

Submission by David Webb
November 20, 2009

Rather than address each item of the terms of reference, this submission draws attention to two specific issues that are mostly overlooked by current suicide prevention efforts but which have major impact on all the issues raised in the terms of reference:

1) The missing evidence – the expertise of suicide attempt survivors.
2) Do our mental health laws help or hinder suicide prevention?

A brief background of the submission's author is included at the end.

1) The missing evidence – the expertise of suicide attempt survivors

Although tens of thousands of people attempt suicide every year in Australia, the taboo around suicide means that we only very rarely hear from these people. This taboo is not just the fear and ignorance about suicide in the general community but also influences the suicide research agenda, suicide prevention programs and the media guidelines for reporting on suicide.

The expertise of those who know suicidal feelings "from the inside" represents the missing evidence in our efforts to understand and prevent suicide. The absence of this first-person knowledge is not entirely due to the fear and taboo around suicide. It is also due to the narrow and shallow definition of what constitutes valid evidence in the mainstream study of suicide. In particular, the medical criteria for what constitutes valid evidence, which dominates the study of suicide, denies the validity of first-person knowledge as subjective and therefore unreliable.

In academic terms, the phenomenology (lived experience) of any humanly experienced phenomenon is recognised as a critical component of any study into that phenomenon. It is found in the study of gender, race and ethnicity, sexuality, parenting, teaching and learning, indeed all walks of life. It has also been recognised in recent years as critical for our understanding of mental health so that 'consumer participation' is now a priority for mental health policy and practice. The study of suicide, however, stands out as a stark exception to this accepted practice with virtually no attention given to what suicidal feelings actually mean to those who live them.

The importance of this missing evidence has now been recognised for the first time in Australia in the most recent Position Statement from Suicide Prevention Australia (SPA)[1]. This Position Statement is on Supporting Suicide Attempt Survivors and begins with six Guiding Principles, one of which is:

> *The personal experiences and views of those who have survived a suicide attempt need to be incorporated not only in research, but also in policy, prevention strategies, and service provision.*

The SPA Position Statement then makes the following recommendation to address this vital missing evidence for the understanding and prevention of suicide:

[1] http://suicidepreventionaust.org/PositionStatements.aspx

The voices of suicide attempt survivors need to be included in understandings of and interventions for suicide attempt survivors. More specifically, SPA advocates for:

- *A stronger focus on the inclusion of suicide attempt survivors' views and experiences in the policy, research and development of mental health services (including community-based services) and in the development of treatments for suicide attempt survivors.*
- *A greater involvement of suicide attempt survivors in the planning, implementation, and evaluation of all suicide prevention efforts.*
- *Research and funding for projects into the lived experiences of suicide attempt survivors – in particular, projects that include first-person narratives, such as speakers' bureaus, storytelling and web galleries.*
- *An evaluation of the appropriateness of interventions that suicide attempt survivors have received.*

A very recent study from the US has broken new ground by actually asking suicide attempt survivors what had helped them in the past to not take action on their suicidal feelings[2]. It has been described as a study that "appears to be the first systematic attempt to find out from survivors of a suicide attempt what they find most helpful in managing their own suicidal thoughts". And the surprising results of the study have been described as sending "the suicide prevention field a new message to help guide our work". The three most common strategies used to help cope with suicidal feelings were found to be spirituality and religious practices (18 percent), talking to someone and companionship (14 percent), and positive thinking (13 percent). Furthermore, some of the key components of the formal mental health system, "such as emergency services or crisis hotlines, were not preferred". And the author's comments on the shortcomings of "key vision statements for suicide prevention" apply equally well here in Australia:

> *Nowhere do key vision statements for suicide prevention acknowledge the importance of shared communities of meaning – self-help and mutual-support groups, for example – that people with mental illness construct, operate, and use. This study's results indicate that religious beliefs and practices, companionship, and a social network of family and peers are key coping strategies for people with a history of attempted suicide. Reported levels of reliance on formal mental health services were ranked lower, which raises questions about how responsive these services are to the articulated needs of consumers in crisis.* (p 1217)

Finally, and on a personal note, it is now ten years since I was actively suicidal and during this time I have learned that I seriously underestimated the stigma and discrimination that exists in the community around suicide. This "stigma", which I encounter regularly, I now recognise as a great fear in the community that is also often a kind of loathing towards those who attempt suicide. In my naïveté, I thought that at my age and with the strong support of family, friends and colleagues – i.e. all the people who mattered most to me – that I would

[2] "Coping With Thoughts of Suicide: Techniques Used by Consumers of Mental Health Services", Mary Jane Alexander, Gary Haugland, Peter Ashenden, Ed Knight & Isaac Brown, *Psychiatric Services*, September 2009, Vol 60, No 9

not be too affected by this. I have learned, however, that it can hurt to discover that you live in a society that despises people like me.

What is most disturbing of all is to find this stigma – this fear and loathing – amongst those who profess to be experts in suicide prevention. Having now met and spoken with many of these experts, in several countries around the world, I can report that this is very common. Indeed, it is this stigma against suicide attempt survivors amongst the experts that explains the almost total absence of survivors from suicide conferences, not just here in Australia but all over the world.

2) Do our mental health laws help or hinder suicide prevention?

Appendix A is a submission I made to the second session of the Committee for the UN Convention on the Rights of Persons with Disabilities (CRPD) that I had the good fortune to attend in Geneva recently. A day was put aside for a Day of General Discussion on Article 12 of the CRPD, which is the article on the equal recognition before the law of all people with disabilities. It is also the Article that underpins the "paradigm shift" of the CRPD to what's called a supported decision-making approach in contrast to the prevailing substituted decision-making approach of most guardianship and mental health laws.

Australia ratified the CRPD in July 2008 and is now bound by it as international law on the human rights of people with disabilities, including people who experience psychosocial (psychiatric) disability.

It is long overdue for suicide prevention to pay attention to the human rights issues that affect suicidal people. My submission to the UN presents my argument for why I believe that our mental health laws actually add to the suicidal toll rather than reducing it. But perhaps even more important than this argument is that nowhere in the world has any evidence been put forward to show that the incarceration and/or involuntary medical treatment of suicidal people helps in way to reduce the suicide toll.

It is long overdue to ask whether our mental health laws help or hinder suicide prevention. With the CRPD, there is now a strict obligation on the Australian government to address this question.

About the author of this submission

David Webb's PhD (Victoria University, Melbourne, 2006) was the world's first on the topic of suicide by someone who has attempted suicide. He has numerous academic and other publications on suicide and the book based on his PhD thesis is to be published in the UK in 2010. He has been an invited speaker at numerous conferences and other forums on suicide, including in the US, UK and, most recently, at a major European Union suicide conference held in the Swedish Parliament in Stockholm. He is a former board member of the World Network of Users and Survivors of Psychiatry (WNUSP), which played a key role representing people who experience psychosocial disabilities during the negotiations of the UN Convention on the Rights of Persons with Disabilities (CRPD) that Australia ratified in July 2008. He has also represented WNUSP as an advisor to the World Health Organisation. He is currently employed as a research and policy officer with the Australian Federation of Disability Organisations (AFDO) where, as their International Representative, he has represented AFDO at the UN sponsored Congress on Community Based Rehabilitation (CBR) in Bangkok in February 2009, and as a delegate to the second session of the Committee of the CRPD in Geneva in October 2009. This submission, however, is an individual, personal submission and does not necessarily represent the views of AFDO.

Committee on the Rights of Persons with Disabilities
Submission for Day of General Discussion on Article 12
Geneva, 21 October 2009

Article 12 and Suicide Prevention

David Webb

Introduction

I wish to draw the Committee's attention to an aspect of Article 12 that is not currently getting any consideration. This is the relationship between Article 12 and suicide prevention. This submission is based on my PhD research, which I believe is still the world's only PhD on suicide by someone who has attempted suicide. This research, along with my current work with several disabled people's organisations, has made me increasingly aware of the need for suicide prevention to engage with the human rights discourse of the CRPD – and vice versa.

In brief, I argue that current mental health laws that permit psychiatric treatment without consent – such as we have in Australia and many other countries around the world – actually contribute to the suicide toll rather than reduce it. I summarise the key points of this argument below.

Although I will be attending the Day of General Discussion as a representative of Disabled Peoples International (DPI) – and its Australian member, the Australian Federation of Disability Organisations (AFDO) – I make this submission as an individual. The views expressed here are therefore not necessarily the views of either DPI or AFDO.

Lack of evidence for the efficacy and safety of involuntary psychiatric treatment

One of the primary justifications offered for involuntary psychiatric treatment is to protect suicidal people from themselves – i.e. to prevent suicide. To this extent it can be viewed as a medical intervention. But such an intrusive medical intervention would never be permitted without strong evidence that it was both effective and safe.

No such evidence exists for the efficacy and safety of involuntary psychiatric treatment for the purpose of suicide prevention. The reason for this lack of evidence is that it is simply not researched which, if we pause to consider, is really quite extraordinary.

There is some research, though still very little, into the efficacy and safety of involuntary psychiatric treatment for purposes other than suicide prevention. But the indications are that it is in fact not very effective. For instance, a study published by the reputable Cochrane Collaboration in 2008 is a comprehensive meta-analysis of the research literature into the efficacy of community based involuntary psychiatric treatment[i]. Although suicide prevention was not one of the variables of the study, the lack of efficacy of Outpatient Commitment (or OPCs as they are called in the study) was quite stark for the variables that were examined:

> *In terms of numbers needed to treat, it would take 85 OPC orders to prevent one readmission, 27 to prevent one episode of homelessness and 238 to prevent one arrest.*

Of particular relevance for the Day of Discussion on Article 12, the author's conclusions in this study include the following observation:

> *It is, nevertheless, difficult to conceive of another group in society that would be subject to measures that curtail the freedom of 85 people to avoid one admission to hospital or of 238 to avoid one arrest.*

The risk of danger to self or others

A common assumption in most mental health legislation that permits involuntary psychiatric treatment is that people who are "mentally ill" pose a risk to themselves and/or to others in the community. This assumption is popular throughout the community and often promoted by sensationalist media, but is not supported by any evidence.

To consider the evidence, it is first necessary to distinguish between the risk of danger to self and of danger to others. The focus of this submission is suicide – the risk of danger to self, which is more complicated – but the evidence of danger to others is quite clear. A recent study published in the Archive of General Psychiatry[ii] confirms previous studies that "severe mental illness did not independently predict future violent behaviour". It also confirmed once again that the strongest predictor of violence by mentally ill people was not their mental illness but rather other factors, most notably substance abuse and a past history of violence – i.e. much the same as for any other population.

There is, however, significant evidence that people with psychiatric disorders – i.e. with a psychiatric diagnosis – are more likely to self-harm, including suicide. Caution is needed with this data, however, as some of it comes from "psychological autopsies" – i.e. retrospective psychiatric diagnosis – rather than a diagnosis prior to the self-harming or suicide. Despite this, the evidence of a link still seems quite strong.

In this submission the issue of concern is not the specific medical interventions that might be imposed on people at such times (typically psychiatric medications). Rather, the issue is whether imposing these interventions *without consent* is helpful or harmful. But once again we come up against a total absence of any solid research for either efficacy or safety of denying people the right to refuse psychiatric treatment.

In the absence of any scientific evidence, we must look to other arguments for or against involuntary psychiatric treatment for the purpose of minimising and preventing self-harm and suicide. Until such scientific evidence appears, this analysis now becomes an imperative with the advent of the CRPD.

The common sense argument

The suicidal person, almost by definition, is emotionally distressed and struggling to find a reason to live. A common sense argument says that it does not make sense to assault a person who is struggling with such a crisis with their sense of self. Some people who have lived the experience of forced psychiatric treatment call it torture or compare it with rape, but at the very least it must be seen as an assault on the body and mind of the person. It must be stressed that it is not the medical treatment itself that makes it an assault, but the imposition of it on a person without their consent.

One consequence of this is that people sometimes abscond from a psychiatric ward specifically in order to kill themselves. This is typically blamed on the person's mental illness but once again there is very little research into why people abscond from psychiatric care. There is good research that shows that suicide rates are high for those in the first few weeks of discharge from psychiatric care, but once again there is little research into why this occurs so frequently.

A second, and in some ways even more serious, consequence of mental health laws that rely on psychiatric force is that very many people – such as myself – go to great lengths to avoid a mental health system that is supposed to exist to help people like us. The fear of being locked up and having potent mind-altering drugs forced into you drives many people who might be in need of care "underground" and out of reach of mental health care services. Mental health systems that have involuntary treatment at their foundation, such as we have in Australia, are the primary source of the so-called stigma or discrimination that most people wish to avoid.

There is no evidence that psychiatric force helps prevent suicide. There is a strong common sense argument that it can harm already fragile and perhaps suicidal people. Some already suicidal people are pushed over the edge by psychiatric force. Others are avoiding the mental health system that is supposed to help them and also falling into suicide. There is therefore good reason to at least suspect that mental health laws that impose psychiatric treatment without consent with the aim of reducing the risk of danger to the self is actually adding to the suicide toll rather than reducing it.

The human rights argument

For the Day of General Discussion, the common sense argument above is consistent with a parallel argument based on the human rights principles of the CRPD, and in particular Article 12. Human rights are important precisely because the consequence of depriving a person of their basic rights is inevitably harm and suffering.

Suicide as a crisis of the self is exacerbated when the state deprives the suicidal person of their basic citizenship rights. Article 12 is one of the most fundamental of these rights.

A note on the "pragmatic argument"

One argument that is sometimes offered to justify involuntary psychiatric interventions for suicidal people is that it saves more lives than it costs. This argument includes testimonials from people who say that involuntary treatment saved their lives, testimonials which must be respected. But following the arguments above, there can be no doubt that some people are pushed over the edge by psychiatric force, plus other suicidal people are avoiding the mental health system that is supposed to help them.

The "pragmatic argument" for psychiatric force must include the need to calculate a gruesome equation – what is an acceptable ratio of lives saved versus lives lost due to involuntary psychiatric treatment? And once again we find that is impossible to currently do this calculation due to inadequate research and insufficient data.

A note for those who advocate substituted decision-making

The need for substituted decision-making such as involuntary psychiatric treatment has been the status quo assumption behind most mental health legislation around the world. This assumption has gone unchallenged so that those campaigning for the end of psychiatric force have had to make the argument for its abolition.

With the advent of the CRPD this must now change. Advocates of substituted decision-making are now obliged to make the argument and present the evidence for it. In mental health this has never occurred anywhere in the world.

In conclusion

There is no evidence that substituted decision-making helps prevent suicide. Alongside this, there are strong arguments that it can actually contribute to the suicide toll by either pushing some people over the edge into suicide or by failing to support the needs of suicidal people.

Any attempt to dilute Article 12 in order to maintain substituted decision-making in mental health legislation must take these issues into consideration.

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[i] Kisely S, Campbell LA & Preston N, "Compulsory community and involuntary outpatient treatment for people with severe mental disorders (Review)", The Cochrane Collaboration. Published by JohnWiley & Sons, Ltd, 2008

[ii] Eric B. Elbogen, PhD & Sally C. Johnson, MD, "The Intricate Link Between Violence and Mental Disorder – Results From the National Epidemiologic Survey on Alcohol and Related Conditions", Archive of General Psychiatry Vol 66 (No 2), Feb 2009