Phoenix Cottage

14/04/10

Committee Secretary
Senate Community Affairs References Committee
PO Box 6100
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SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE
INQUIRY INTO SUICIDE IN AUSTRALIA

Phoenix Cottage welcomes this inquiry.

Phoenix Cottage is a privately run counselling and education service specialising in working with Forgotten Australians and Trauma Work. Suicideality is an issue that presents itself in the work undertaken at Phoenix Cottage.

My name is Margaret Spivey l am the Manager of Phoenix Cottage. I hold a Social Worker Degree and am an Approved Victim of Crime Therapist
I am a Forgotten Australian and an attempted Suicide Survivor. My memoirs being published through Jo Jo Publishing is due to be released in June 2010.

As both an attempted suicide survivor and a counsellor working in the field l would welcome the opportunity if possible to both present this written submission and to speak to the inquiry personally.

My circumstance of the Impact of Suicide can be broken into two domains

1. **Personal**

2. **Professional**

The idea that suicideideation is akin to a surviving a storm is all to common in our society and one that keeps survivors marginalised and feeling alone in their experiences. The concept that all one has to do is survive the storm then the survivor will able to resume their 'nomal' day to day functioning, is l believe such a harmful falsehood that it perpetrates serious harm and destruction to the life of the survivor.

l believe this myth serves to minimise the significance and devastating impact on the life of the survivor and eradicate the responsibility for the professional towards the individual. If the person is okay then l as his/her therapist do not have to concern myself with going to deep into their struggles and heartache. Hard questions are not asked and difficult counselling support and assessment is avoided.

Many Trauma survivors enter into the therapy under the belief that counsellors are competent in their field with a proficient understanding of the issues being faced by the client. They have every reason to expect the counsellor is highly skilled in the art of therapy work, that the counsellor will not shun away from the darkness they are facing, no less than a surgeon will collapse at the sight of a patient's blood or internal organs. The therapist will not withdraw from work that requires extending himself or herself, and the therapist will honour the dignity and sacredness of the work they have agreed to undertake.

Phoenix Cottage

14/04/10

They have the right to assume the counsellor holds great respect for the human person, unfortunately this is all to often not the case and the ramifications can be devastating with the client leaving the sanctuary of the therapists room not with renewed feelings of hope and faith but rather with deepened feelings of self disgust and shame. All to often the help that should be given at the hands of therapists is instead turned against the client by way of their inadequacies that they refuse to take responsibility for and create feelings of self annihilation for the client.

As an attempted suicide survivor l was never asked about any issues around my history of suicide, it was as if it never existed. My past and even current trauma were either dismissed or their impact trivialised and l was subjected to a domain that was safe for the therapist but harmful to me. It was as if the therapist was only interested in their own welfare and lacked the courage and fortitude to enter into the darkness or the domain of my experiences, which is what l have come to believe is vital for effective therapy to take place.

Throughout my many years of therapy only one therapist was to me competent in her field and yet she did little more that listen and allow me the scope to experience what my body and my psyche needed to feel. It did not alter matters but at least it was a safe space to feel my hurt.

Personal

I am a 'Forgotten Australian'. My life in institutional care began at the age of 18 months following the abandment of myself and my two sisters by our mother who found herself a single parent of four children following the death of our father. We were separated, my sisters were sent to St. Aidan's Catholic Home where they became adopted and l was sent to St Joseph's Baby Home Broadmeadows. From there l was transferred to Abbotsford Convent where some year or so later l was placed out for adoption. The fostering failed terribly as a result of profound abuse.

It was at the age of 6 following the trauma, when returned back into state care that a Psychiatrist was consulted. Shunted from one home to the next, my first suicide attempt took place from an overdose whilst a resident of a family group home I was about 12 years old. Many other attempts followed all whilst being removed from one institution to another.

My feelings of suicide stemmed from

- Feelings of worhliness
- Feelings of no value
- Feelings of being a drain upon society
- Feelings that the world would rejoice if l was dead
- Belief that my existence was a mistake
- Ongoing struggles to find a sense of belonging and place in a world l feel constantly in conflict with
- Strong feelings of self contempt and self annihilation
- Feeling completely alone in my experiences
- Feeling to terrified to share my feelings
- Not having one person that l could trust to speak about how l felt
- No one (including counsellors) interested enough to even ask

At 13 under the care of a Psychiatrist l was placed on a heavy regime of anti psychotic medication and for the years that followed these formulated the basis for my suicide attempts and my feelings of self hatred. Even in the homes amongst the unwanted and rejected l felt odd.

Phoenix Cottage

14/04/10

Professional

I am a Social Worker having obtained my Degree in Social Work from the University of New South Wales in 1994. I am in Private practice specialising in Trauma Work. I am also an Approved Victim of Crime Specialist working with children and adults.

All to frequently I am faced with the issue of suicide. And in my work l am confronted with the reality of its harm to the survivor, its ramifications and its on going prelude towards further harm for the individual and the loved ones left behind if the act is completed. The research revealing the connection between childhood trauma and suicide and/or self-harming behaviours informs the need to extend oneself beyond the bounds of the immediate issue and yet my experience and knowledge of practice would argue this still seems to be a field still left virtually untapped. With more and more focus upon the Brief therapy Model of practice it would seem quality and efficiency of practice is being sacrificed for numbers under the justification of economics.

In my work l am privy to the agony of the survivor who speaks of the darkness they feel within. The feelings of despair, of lack of meaning in their lives. The sense of being utterly alone in their struggles and the relief they feel having actually made the decision to take action in the attempt to end their lives and the disappointments they feel when awakening to discover they are still alive. All too often their sense of alonenessss is compounded when reaching out to those they believe should understand they discover comments of dismissal, comments are flippant and sound rehearsed and without any real depth. They are once again feeling alone.

Competency amongst psychotherapist counsellors' psychologist and social workers in the art of trauma work and intervention varies greatly and for the client there is no way of knowing as therapists like the all sellers can seel their wares quite well. So all the client truly has is trust and not until they have opened themselves up and are vulnerable do they come to realise the have been dissected but then the therapist has no idea what to do next so they fumble with the inner being in the hope of making the right guess.

Working with the individual in their struggles around their dark emotions is most often long-term complex work, requiring deep commitment. It takes a brave heart of walking alongside the client into the unknown. And when realising the work is too painful and the therapist incompetent very often the client will depart feeling even more suicidal and a great deal more at risk.

The stats of 2,000 Australians dying each year from suicide is alarming undeniably an important social issue that needs to be tackled from multiple layers. The National Suicide Prevention Strategy with its whole of community approach towards suicide prevention and increasing support and care to people families affected b y suicide or suicidal behaviour is an important step towards addressing the issue but much more needs to be done towards tackling this endemic social issue and l believe it needs to begin with much more accountability for the practice of therapists whatever their background. Unfortunately academia does not necessarily produce competent practitioners all it does is award diligent academic achievement and hanging out a shingle and advertising oneself very often proves itself to be nothing more than laying a trap. Unfortunately for a field that should be one of the most diligent most caring most professional the welfare sector it often proves itself to be one of the most harmful. Its systems show themselves to be abusive to its workers and employees do not necessarily come with high level competencies they operate under a brief therapy model and when issues are brought to the attention of Management it can result in either denial oppression or disciplinary action for the whistle blower. Under these circumstances it can be argued how can such services possibly be helpful for the high needs client?

Phoenix Cottage

14/04/10

Research conducted by SANE Australia identifies a concerning gap in followup treatment and support for attempted suicide survivors most particularly those with a mental illness. Minimal research has been conducted in this field but it does however reveal a need for

- More effective training for professionals in dealing with the issues concerning trauma and suicide
- Consultation with attempted suicide survivors to gain a better deeper understanding about the real factors that cause a person to despair of life as to want to and take action to end their life to date there is only minimal sincere dialogue with survivors and even then it is more focussed with statistical data rather than gaining a deeper understanding of suicide
- Therapists, Counsellors, Psychologists and Social Workers , Medical personnel to ask questions about suicidality ,to be prepared to explore the darklands of the clients world rather than brush over it and dismiss their feelings and anxieties etc.
- To give at –risk -clients much more additional support

Overworked and under resources service providers can find the additional burden of working with attempted suicide survivors and at-risk clients all to problematic and will therefore minimise their needs. They are often diagnosed with Personality disorders etc and therefore use that diagnosis as an escape clause and one can't help but wonder if perhaps therapists were challenged more about their practice in the courts if we would have better outcomes. As humans we cannot be perfect on any level but l do call to account as l call myself to account we have undertaken a scared oath to uphold the dignity and worth and take responsibility for the choices we make no less than any other practitioner and it is to this that l challenge my colleagues to account.

I hope this submission assists towards deepening the understanding of suicide.

Please feel free to contact me in regards to this submission.

Yours truly,

Margaret Spivey BSW MAAASW