Senate Inquiry into suicide in Australia

(a) the personal, social and financial costs of suicide in Australia

My partner was diagnosed with puerperal psychosis just after the birth of our child. Nine months later she completed suicide, leaving me a single parent and our child motherless. She had no prior history of mental illness.

Puerperal psychosis is a condition triggered by child birth. It affects about 1 in 500 women. It starts with a manic phase in which the woman loses touch with reality. It is then followed by a depressed phase. If you are lucky it lasts one month. If you are unlucky, it can last more than a year. In most cases it lasts six to nine months.

In our case the midwife identified that my partner was unwell. I thought things were not going well, but did not realise how sick she was. We were first time parents and had nothing to compare our experience with.

As a carer, I was time poor and very stressed. I was not able to find, sort though, and think about all the information about caring for someone. I was flat out caring for my partner and baby, keeping my job, and keeping my sanity. Like other people who are stressed and time poor, carers need the right information at the right time. They do not necessarily know what are the right questions to ask or where to look for the right information. They also may not make the time to look for this information. There is also heaps of information out there and this takes time to sort through; time you just don't have as a carer.

(A big problem with most publications is that they do not meet carers' needs. They assume carers have time to read and think about what they have read. They also assume carers have the mental energy to find and read the information after a long day of caring.)

There needs to be individual training and on-going support for carers focused on caring. This support needs to be started when a mentally ill person first enters the mental health system.

My experience of entering the system was not good. After going through the crisis assessment and treatment team, we arrived at the hospital and my partner was booked in. I had had 10 days of very little sleep, had little understanding of what was going on, and was extremely worried about my partner and our baby. When I asked for advice about what to I was told I could stay or go. This was not helpful and I ended up seeking advice from our midwife. When first entering the hospital, there were effectively two patients with very different needs. I needed sleep, clear directions and support. My partner needed drugs and constant supervision.

During the stay in hospital, there was no discussion of how to go about caring once I got home, or what support I might need. When my partner was discharged from hospital into my care and I was told look after her. While this seemed reasonable and straight forward at the time, in hindsight it was not reasonable nor was it straight forward.

Now that I have had time to reflect on my experience, I feel that I looked after my partner's physical needs adequately, but not her emotional, social or spiritual needs. I did not venture near her psychological needs. I think that I probably needed to do this, but I was not explicitly aware of these needs or how to go about caring for them. I also did not recognise the importance of breaks, nor could I figure out how to take one.

I attended a skills for carers courses and my only remaining thought is “thank goodness I don’t have the other carer’s problems”. The course did not look at what I was doing day-to-day or how I was interacting with my partner and give me guidance or reassurance, which in retrospect is what I needed.

My state government has a set of caring for carers policy; however, none of the strategies they contained found or helped me. Carer’s need one-on-one support and this is different to the support needed by the mentally ill person. Carers could be found through the mentally ill person.

I was unable to work at all for three months. It then took another four months of very slow return to work for me to get back to full time work.

Even though my partner was very ill, we were ineligible for the carer’s allowance for two reasons. Firstly, the Adult Disability Assessment Tool does not encompass the care provided to the mentally ill, or if it does it is written in such jargon that the health professionals and I were not able to fill it in correctly. Secondly, the Department of Health has gone on an administrative frolic when interpreting the phrase “for an extended period” (paragraph (b) of definition of “disabled adult” in section 952 *Social Security Act 1991*) and decided that it means more than 12 months. This does not accord with the principles of administrative law as taught by the Australian Government Solicitor. If Parliament had meant 12 months, then it would have said 12 months.

My partner had both the mental health and the maternal health services providing services. While both services were trying their best, they were not particularly well coordinated. In hindsight they did not meet my partner’s needs. We were over-serviced in some areas and underserviced in others. I was stressed out of my mind and was unable to pull the pieces together. It was only after my partner’s death that they started to tell me what they had been doing and I started to see what had been happening.

Reflecting on my experiences I noticed a number of things.

- The professionals involved were specialised and there was nobody coordinating care, Consequently, services were delivered in a piece meal fashion. Also they just missed things because everyone thought someone else was doing it.
- All the services were focused on my ill partner. They ignored me and the baby. Because my partner was in trouble, the whole family was in trouble; however, this was not recognised. The care model assumes that treating the ill person solves all the problems. It does not.
- Family and friends of suicidal people are a very important part of the care team, but are totally ignored by government and the professionals.

When the mental institutions shut 30 years ago it was both good and bad. It was bad because it forced the community to care for mentally ill people without support. Government shifted the cost of care onto the community and did nothing to ensure the community was capable of providing that care or could afford to.

I believe it is government’s role to find the best outcome for the community, not its own financial bottom line. I think the government has just shifted cost onto the community and in doing so has escalated the total costs of providing care, and in some ways reduced the quality of care.

e) the efficacy of suicide prevention training an support for front-line health and community workers providing services to people at risk.

This particular heading really irritates me. It totally ignores family and friends of suicidal people and the care provided by them. Whilst this is reasonable in some respects (such as when educating the general community, identifying people at risk, and identifying and treating people who are ill), it is not reasonable when discussing care for those who are ill. Family and friends are an important part of the treatment team and need comprehensive training and support, more than the professionals.

Most documents focused on suicide prevention or mental health ignore the reality facing carers or their important role as part of the treatment team. They assume that all care is provided by professionals. This is assumption is false. Family carers spend the most time with ill person and are the least trained person in the treatment team. What they do can help or hinder the ill person's recovery. To emphasise this point, below is a table of time spent with an ill person and training.

% of total hours in week	**Person**	**Description of activity**	**Time spent**	**Years of medical training**
100%	Hospital	Person hospitalised	24 hour care	
67%	Main carer	At home full time	112 waking hours	0
0.3%	Psychiatrist	Consultation	1 hour per fortnight	10
0.15%	Psychiatrist	Consultation	1 hour per month	10
0.6%	Case worker	Home visit	1 hour per week	4
3.0%	Case worker	Home visit	5 hours per week	4

If we carers care badly, then it will make the professionals job that much harder as our contact time swamps that spent by the professionals. Carers are making things up as they go along, so while they may do things with the best of intentions, it may not be helpful in terms of treatment. They also do not know what questions to ask or who to ask them of.

I would like governments to recognise the important role of family and friends who care for the mentally ill and to give them tailored one-on-one support. This may be expensive initially, but I think it will lead to better outcomes. It will mean all parts of the care team are working together effectively.

g) the adequacy of the current program of research into suicide and suicide prevention, and the manner in which findings are disseminated to practitioners and incorporated into government policy

I was given no training about suicide prevention even though my partner was clearly suicidal for an extended period. Therefore, from a carer's perspective, it is hard to see how any research into suicide and suicide prevention has been incorporated into practice.

After my partner completed suicide I came across the book "Why people die by suicide" by Thomas Joiner. This book was published by Harvard University Press in 2005. Joiner is an American academic who researches suicidal behaviour. Joiner says that for a person to successfully complete suicide, then three factors must be present. A suicidal person must:

- Be capable of suicide (that is inflicting a fatal injury to ones self);
- Perceive that they are a burden (feel that they are not contributing); and
- Lack a sense of belonging

before they will make a serious suicide attempt. Joiner's research group has recently published a number of research papers in academic journals. These papers support Joiner's theory.

I like this model because it focuses on what is going on in a person's head, rather than what is going on around them or to them. Consequently I believe that this is a good predictive model of who will make a serious suicide attempt/successfully complete suicide.

The nice thing about the Joiner model is that it gives guidance on how to care for people in at risk populations to reduce the risk of suicide. That is carers need to make people in at risk populations feel:

- effective;
- capable; and
- that they belong to at least one group.

Carers also need to try and protect people in at risk populations from exposure to violent events.

This, of course, is all about keeping the person alive while sorting out the other things that are going on in their life that are making them feel suicidal. Carers can do these three things, while they may not be able to help with anything else.

I would like governments to have comprehensive training programs for carers to help them care more effectively for the mentally ill. These training programs could use the Joiner the model to help carers when thinking about suicidal behaviour and planning prevention strategies.