Services for mental health

My family have felt like beggars in a broken system. Also, having lost my dad to suicide, can we have grief counsellors who can speak other languages? Finding support for my mum has been unsuccessful. Interpreting services won’t do as lost in translation most likely will happen and you can’t establish the same rapport. From my own experiences and observations of a family member trying three hospitals in one year (one public and two private), currently many health staff are unprofessional – eg. the GPs in mental health private hospitals not sharing reports with the patient’s GP; arrogant and severely frightening psychiatrists, both in attitude toward the patient and in giving proper diagnosis and treatment; and corrupt, unethical private hospitals run like a profit-making business and not concerned for the wellbeing and health of patients. I’ve been in distress witnessing how my own family member has been treated – Inhumane. Accountability is mandatory.

Regarding the whole process, from GP through to an acute mental health team etc. the stock standard flow chart, one size fits all approach must end. That was the biggest issue of the lot. The whole system is a nightmare. In the PECC ward in a public hospital, patients are treated inhumanely and are told “you get what you pay for.” My family are able to take out private cover, but I guarantee you, it’s just as bad, even worse as we pay for the “privilege” of more abuse. My family member has stated he would rather die than go back to a hospital. It’s been three hospitals in the span of one year! No wonder the suicide rate is increasing not decreasing. And many staff are the ones that need to be the patients. Most patients are broken people due to abusive or cruel fellow humans – staff need to remember not to insult the intelligence of patients. Many are wiser than employees I have seen, and more compassionate and kind in this indifferent world.

The training of psychologists needs to be reviewed. Some make matters worse. Also, is it necessary for them to psychoanalyse every body language they observe in a patient? We have become an over-analysed society of incorrect judgement and labels. It adds to one’s anxiety and distrust.

A patient MUST have clear communication on their treatment and be part of the conversation. I can’t begin to tell you what I’ve read in referrals from an ex-GP that are assumptions and not the truth. No wonder the referral was sealed. No conversation whatsoever. The patient never went to the referring specialist and the referral was torn in disgust. It should be mandatory for patients and carers to receive mental health treatment plans and transparent communication.

It would also be nice for psychiatrists’ offices to return a GP’s message, even if it’s to inform the GP they are not taking more patients. A courtesy reply would be nice and considerate.

Also, defenceless vulnerable people are treated badly when scheduled for hospital. My family and I witnessed police doing so with a patient in a private mental health hospital who seemed to have written something a friend was worried about on social media. He was in his bedroom resting in a hospital! The police need training in compassion and how to handle such concerns. It will only make a young adult who already feels worthless feel even more
so. How does this decrease the suicide rate? It doesn’t, it increases it. When will society just be kind and compassionate?

“While some other States have similar services, all State and Territory Governments should fund and implement mechanisms for police, health and ambulance services to respond to mental health crisis situations in a coordinated manner, including by embedding mental health expertise in police and emergency service communication centres to provide real-time support for the individual whom police and emergency services are responding to, advise on how the individuals with mental illness can be managed and appropriate referral pathways, and coordinate deployment of co-responder resources to prioritised cases.” (p.24) Yes, a good move forward.

“Complementing this, State and Territory Governments should aim to provide more and better alternatives to EDs for people with mental health problems, including peer- and clinician-led after-hours services and mobile crisis services. This may include providing separate spaces in or near EDs for mental health patients, or otherwise creating a more de-escalating environment. The ‘Safe Haven’ spaces created in Melbourne and more recently in Queensland provide an effective model for this. When Emergency Departments are built or renovated, the design should take account of the needs of people with mental health problems.” (p.24) Another good move.

Also, I question the word “skilled” – trained according to a curriculum at university where we have seen students graduate who still don’t have enough command of English and understanding of cultural mental health needs. A caring, professional and understating human being who treats a fellow human being with dignity. That’s the rapport needed for trust. (p.28)

“The merits of introducing a specialist registration system for nurses with advanced qualifications in mental health also should be assessed”. (p.29) MANDATORY – I’ve also witnessed unprofessional behaviour of staff sitting in the nurse’s station glued to their mobile phones during a shift. When patients approach, the response should not be “What do you want” but “hi (name), how can I help you?” Patients shouldn’t be made to feel they are imposing on a nurse on their mobile – it’s work hours.

It’s not only about quantity, but the quality of the workers. They need to be reviewed and assessed too. The training of psychiatrists need to include empathy, communication, etc. I cannot begin to describe the horrific bedside manner of these “specialists” – I think many of them shouldn’t even be practicing in this field of medicine. Recommendation 11.3: Whatever it takes to ensure skilled, professional and more than anything, quality nurses with a strong commitment to work ethic and patient care. It hardly exists right now.

“Peer workers ... are well placed to support people with mental illness during their recovery... A barrier to more widespread use of peer workers is the acceptance of their role by clinicians. A program to build support among clinicians for role and value of peer workers should be developed and implemented in collaboration with the relevant professional bodies”. (p.29) I have a friend who is a peer worker and this is the best therapy for all involved. Lived experience empowers those who now feel a sense of purpose to help others, and those that
need someone to inspire them to persevere by seeing the peer workers as leading by example. They are true leaders and negative attitudes by those with “qualifications” and fancy titles need to be eliminated. Recommendation 11.4: Influential and inspiring leadership – if health professionals are adding to the stigma, judgement and labels with an negative attitude, this has failed before even begun. Peer workers are essential and there are benefits all round.

Recommendation 11.5. “Improve medical practitioners’ training on medication side effects and consider specialist registration for GPs who have advanced specialist training in mental health.” Yes, listening to the patient is a start. Eg. a psychiatrist who repeatedly recommended lithium when the patient repeatedly said it caused skin issues as a side effect and he can’t be on it. It shows these doctors absolutely don’t care about the patient or what they have to say. Also, there needs to be a better plan for GPs than the stock standard referral to the acute mental health team, with their own stock standard flow chart and nightmare support. Can all start by the right of the patient to communication and being heard.

What was said by the community: “the support people do receive is often well below best practice, sometimes causing harm” (p.127). YES to all – but this one is a big YES.

“From the point of view of those experiencing mental illness, their families and carers, poor practices have devastating results: long-term hospitalisation, at times far away from family supports, and significant amounts of time trying — and failing — to find help for loved ones” (p.130): Three hospitals in one year, we were begging for help – we asked the GP is there any quality psychiatrist with evidence patients’ health and wellbeing improved? This GP turned on us too. I guess he took it personally, but when carers say they feel helpless, it is the truth and the “system” is so severely broken it’s about time the minister for health stops turning a blind eye with yet more comments of Australia having one of the best mental health systems in the world. Can he elaborate by using evidence and research. Clearly, I am frustrated. “People need to tell their stories time and time again, there is very limited sharing of information between service providers, and pathways in the mental health system are very challenging to navigate — even for those working in the system” (p.130): This has been a huge energy drainer – not to mention each professional’s own interpretation of what a patient means. They don’t engage in active listening and communication to clarify, it’s not transparent. We have read things written that are dangerously inaccurate with the mention of certain “labels” where there was no formal assessment and diagnosis. It’s a dangerous game played with the health of individuals.

“Achieving this requires meaningful use of co-design, culturally responsive care and understanding the importance of lived experience”. (p.132). Well-said and please apply in practice.

“Mental health policy and service delivery are often ad hoc and lack cohesion and coordination” (p.200): Yes and this mess needs to be organised and clearly structured and articulated. The confusion only adds to an already helpless and distressing situation for patients and carers. “The workforce available today comprises thousands of committed and
capable doctors, nurses, allied health professionals, non-clinical staff and many others; but there are still substantial shortages in clinical professions, especially mental health nurses and psychiatrists, as well non-clinical roles, such as peer workers”. (p.200). I beg to differ that it’s in the thousands. Hundreds, perhaps. The most confronting and traumatic experience for my family was with the attitude and behaviour of staff / professionals.

“More support would help GPs provide best-practice care” (p.206). Agreed. “Timely psychiatric advice is particularly important in the context of long waiting times for assessment consultations with a psychiatrist.” (p.206). Sometimes a GP tries for weeks to contact a psychiatrist, leaving numerous messages that are not returned. This is shocking. Not even an acknowledgement and courtesy reply if new patients are not being accepted at present and possibly a recommendation for another psychiatrist. Good GPs find it difficult to seek psychiatrists who are respectful toward patients, that listen and communicate clearly. Ones that do care about the patient and are not greedy (visit after visit with high fees and no progress for years) but want to see positive results in a patient.

“But it turns out finding a psychiatrist is a lot like finding a soulmate” (p.282). Well said. “Intense withdrawal symptoms were experienced and he was admitted to hospital, medication changed again, monitored several weeks then discharged again when clearly unwell due to lack of beds available”. (p.282). Add being discharged in a distressed state due to insults flung at the patient at the last psychiatrist session. As a carer, I too became very stressed and felt helpless watching my loved one being treated so badly in a hospital that was run more like a dictatorship. It was frightening.

“Timely access to initial psychiatric assessment is particularly important, but currently lacking.” (p.296). I’m going to say it straight out. There are a lot of horrors in the profession of psychiatry. I found this very disturbing. I think something also needs to be reviewed in the medical training, accreditation and accountability of these “specialists”. Also, what does a patient get out of a consultation of no more than two minutes in a private hospital – I have met countless patients who have been in and out of private hospitals for years. Why has there been no improvement in patients with OCD, anxiety disorders and other conditions that surely could be improved in that time?

“Emergency departments (EDs) are not working for people with mental illness — they are high stimulus environments, and people with mental illness must often wait many hours before they receive treatment” (p.303) Yes, agreed and the repercussions can be dangerous. Mental illness affects all people in society if the system is broken. Not just the patient and families.

“I wasn’t treated with the respect and dignity I deserved nor are many MENTALLY ILL patients in the Emergency Room. As it is not the place for us. It is designed for PHYSICAL ILLNESS” (p.304). It is a nightmare and painful for carers watching their loved one being treated like this. In PECC, some nurses were bullying and abusive toward patients. They should know better due to their own experiences. Where is the accountability and discipline toward these nurses? In a Psychiatric Emergency Care Centre! And don’t get me started on the psychiatrists. Very arrogant and patronising.
“People with acute mental illness require an environment that is calm, offers privacy and makes them feel safe (for example, Jade Weary, sub. 436). In contrast, EDs are typically high-stimulus environments with bright florescent lights, lots of noise, little privacy, and can be crowded and at times appear chaotic. These stimuli can increase agitation, worsening the symptoms of mental illness. Some people may also become aggressive or violent, requiring them being sedated, secluded or restrained” (p.305) Yes – that’s common sense that doesn’t even require a mental health qualification. But nothing has been done about it for so long. And we’ve seen the consequences in the community. It seems the solution to everything is sedation. Are we living at the turn of the 20th century or are we well into the 21st century? What’s the attitude and reason behind this “one size fits all” approach?

“In June 2019, the Queensland Government announced that it was allocating almost $11 million over the following 4 years to fund safe haven cafes in some of its hospitals” (p.307). Human dignity and social connection, that would always have been a brilliant move. I don’t know if there is evidence through research, but my hypothesis is that a basic need of humanity is human connection, love, compassion, care, support. However, we have become even more “de-humanised” and “de-sensitised” in this age of social media and sensationalised media overall. Listening to individuals, having a cuppa as they share their personal stories and experiences, is the best way to change attitudes, perceptions, judgement and decrease the stigma based on ignorance. It is also, I think, the way forward to a more caring, understanding and compassionate society. It is the way to internal peace for all.

“Three types of nurses are registered — enrolled nurses (diploma-level training), registered nurses (undergraduate degree) and nurse practitioners (post-graduate).” (p.368). A worry as there was an enrolled nurse at a private mental health hospital who distressed my family member and my mother and myself. They are not even university trained? They are definitely not psychologists and need to keep quiet when they have no idea of the situation. What exactly is the position description of “enrolled nurses”? I’d like to read one and see if it is reasonable and if so, they should stick to this.

“…there have been reforms to Australia’s psychiatric training in recent years which are expected to increase the supply of locally trained practitioners over the longer term”. (p.377). Quantity is one thing. How will you measure the quality of accredited psychiatrists?

“Unlike other medical professions, there is no formal cap on training places for psychiatrists. Rather, constraints on training more people have been the supply of suitable applicants, number of training placements and availability of supervisors”. (p.379). Watch the movie Patch Adams. Psychiatrists need to value the human dignity of each individual. What I’ve observed, I worry about “suitable applicants”. This is more than just academic scores. This is about human interaction, trust, communication etc. Not arrogance. There is no excuse for disgusting behaviour and arrogant, rude attitudes in this field treating the “psyche” which in Greek means soul. They break it many times, not treat it. “However, inquiry participants were concerned that doctors continue to be discouraged from specialising in psychiatry because training placements are often in the most stressful settings in the public sector, particularly inpatient units”. (p.379). If the other solutions in this report are applied, the stress from any kind of potential violence will reduce. Severely mentally ill patients in these uncaring clinical
environments, I feel, escalates anger and frustration. What I witnessed was the opposite in PECC – nightmare nurses & psychiatrists that did more damage than good.

(p. 382)

“Enrolled nurses are trained in the vocational education and training system with a focus on practical skills, and report to either a registered nurse or other person with higher qualifications.” What is meant by “practical skills”?

“Registered nurses are university trained (undergraduate degree), and over a longer period than enrolled nurses (3 years full-time), so have a more extensive set of skills”. English proficiency for many is not fluent or at a level that it needs to be to be able to communicate with patients and to understand, including cultural norms.

“In 2017, close to 85% of MHNs did not have a specialist mental health qualification (AIHW 2019m)”. (p.383). That’s alarming but not surprising given what I have witnessed.

“Many inquiry participants mentioned stigma, unsupportive workplace cultures, and a high risk of verbal and physical abuse from patients as deterrents to nurses choosing a career in mental health” (p.385). But how about nurses that bully and abuse patients?

“Role confusion — the role of peers workers is not always clearly defined, leading to confusion about their scope of practice, responsibilities and how other health professions are expected to work with them” (p.391). It needs to be clarified. It seems everyone in this system is confused. “Low support for value of the role — peer workers are often under-valued, marginalised, discredited and sometimes bullied by the people they work with because of scepticism about the abilities of people with lived experience of mental illness, their professionalism and validity of their qualifications... traumatisation — by advocating for the people they support, peer workers can be repeatedly exposing themselves to the risk of re-traumatisation if the professions they work with do not value and understand the role of peers.”. (p,392). I know someone who is a peer worker and the value she adds and the purpose this has given her in her own life as a valued and employed member of society. The thought of bullying is horrible and could send a person back to the start of feeling worthless and de-valued. This entire world needs to start practicing kindness and respect toward each other.

“The underdeveloped system of qualifications and professional development for peer workers needs to be addressed to facilitate a more professional workforce... It should foster even better outcomes for people who are supported by peer workers. This will require expanding training options to more than just the existing Certificate IV qualification...” (p.393). Agreed, it’s important and another step toward a sense of achievement and success. And to be able to apply best practice developed from training.

“Expose health students and practising health professionals (both within and outside mental health) to people with a mental illness (and their carers) outside a clinical environment to break down negative perceptions about them” (p.406). Do you think this term is too broad?
Many people have suffered a lot of “mental and emotional injury”. I think this term needs a conversation in itself. What do people think or associate with the term “mental illness?”

“There are gaps in services and support for people with mental health in the community, libraries provide a default, safe, neutral place. This library role is neither formally recognised nor funded by government but our open-door approach brings with it challenges; for example, requiring councils to invest in training programs for library staff so they can deliver services appropriately to people needing higher levels of support” (p.825). Yes agreed. Librarians are advocates for inclusion, community engagement, awareness, access to information etc.

Suicide Prevention

“Suicide is a stark and often-used indicator of the state of Australia’s mental health. There is a strong link between poor mental health and suicide. This inquiry makes a range of recommendations to improve the mental health of Australians, which will support suicide prevention” (p.844) Yes because the number is going up each year. That’s a huge indicator of a broken system and huge ignorance in our society that still exists. I lost my dad, a colleague and know others who lost family. Good people who give up because they can’t tolerate so much cruelty in this world. Kindness, respect, helping others is not happening. Selfies, image, narcissism, looking out for my needs even at the expense of someone else’s is the way people feel equates to survival. We’ve seen the outcome of such cruelty, especially social media. Can we also hold these companies accountable to act responsibly? It exacerbates the fear that seems to drive all this destruction. Kindness has been made complicated and it really is so simple!

“People may not access mental health services either because of a lack of appropriate services or because they choose not to seek help”(p.855) Or the services exacerbate the situation, not help. “The lack of community-based mental health and suicide prevention services has led some people in severe suicidal distress to seek help at hospitals. However, many submissions expressed concern about the poor treatment of patients presenting to hospital in suicidal distress” (p.857). Very poor treatment.

Box. 21.3 Experiences of people going to hospital in suicidal distress (p. 858) All these disturbing and confronting examples only skim the surface – an example of thousands of horror stories. “The treatment area is frightening for those who are in despair and lacks containment for those who are agitated and psychotic” (pp.858-859). Yes, and they think the answer for all is a good dose of Valium. It isn’t.

“I was not given the opportunity once to speak about why I was feeling the way I was, how they can help when I leave the ward and what we can do to prevent this from happening again. ... Once I had left the ward I was back to the beginning. I had no connections outside of the ward to help me on an ongoing basis, by changing this, people can feel like they are receiving the help they desire” (p.862). That’s exactly how it’s done. I have my own horror stories trying to support a family member. Some of these hospitals need serious investigation by external bodies or shut them down.
“systems approach to suicide prevention is likely to be a more effective means of reducing suicide rates” (p.870) Why did it take so long to see this? The system is broken – corrupt, unethical and a nightmare for patients and carers.

“Undefined responsibilities has led different levels of government to work in isolation, delivering various programs in an uncoordinated and ad hoc way” (p.873). We’ve seen the consequences of disorganised systems. “Some suicide prevention activities require coordination and co-operation between multiple parties”. (p.874). And clear communication. “... the need for proper independent and rigorous outcome evaluations of the effectiveness of suicide prevention activities” (p.877) Agreed.

“The people obtaining services from mental health settings within the private sector are a significant volume of those seen across Australia” (p.899). The private sector services are horrific.

Workplaces
Many issues stem from toxic and dysfunctional work environments. People who are bullied, harassed, and victimised need to be made aware of legislation that protects them and support structures are needed to disempower organisations covering up mistreatment through corrupt and unethical practices. Organisations need to be held accountable for their actions – a compulsory tick the box session on bullying by HR is a failure. On paper they have done what is asked of them. In practice, they are as toxic and manipulative as the bullies. “While businesses already have some obligations to ensure the (physical and mental) wellbeing of their staff, we are proposing ways to strengthen these and provide additional clarity on what is expected”. (37). YES – because they’re still not getting it. Their obligation is to ensure a safe work environment and many times, they cause the sick leave to happen.

“Workplace health and safety agencies should develop and implement codes of practices to assist employers ... to better manage psychological risks in the workplace....” (p.38) What if an employer exacerbates psychological risk and harm? Again, yes, or they could be liable for negligence.

Draft Recommendation 19.1 — psychological health and safety in workplace health and safety laws: “All WHS legislation should clearly specify the protection of psychological health and safety as a key objective”: EXTREMELY IMPORTANT AND A NIGHTMARE AT THE MOMENT.

Draft Recommendation 19.2 — codes of practice on employer duty of care: “Codes of practice should be developed by Workplace Health and Safety authorities in conjunction with Safe Work Australia to assist employers meet their duty of care in identifying, eliminating and managing risks to psychological health in the workplace. Codes of practices should be developed to reflect the different risk profiles of different industries and occupations”: YES – CODES OF PRACTICE – I’ve seen good staff get victimised even more with ignorant judgement and labels and the world is full of staff in organisations who are lazy or incompetent or simply just don’t care. The laws protect unethical practices and kick out onto the street those with a strong work ethic who are not afraid to call out unethical practices and have the emotional
intelligence or empathy needed for good leadership. May these recommendations be implemented and actually help make this society better. Not talk but action.

**Draft Recommendation 19.5 — disseminating information on workplace interventions:**
“WHS agencies should monitor and collect evidence from employer initiated interventions to create mentally healthy workplaces and improve and protect the mental health of their employees. They should then advise employers of effective interventions that would be appropriate for their workplace”: Yes – where are they at present? “…develop mechanisms to enable individual businesses and EAP service providers to evaluate outcomes for that business”: EAP is the stock standard reply and referral these days. It is important but not in all situations. Employers should listen to their employees tell them what they need than causing them more distress by deliberately not listening.

“Assumptions that may be made by employers about time out of the workforce is another barrier to employment” (p.489). What if your workplace is trying to manipulate your concern and trying to bully you out of your job? What are the employees’ rights in this very unethical treatment? “Participants noted that employment and education can be a beneficial addition to a carer’s life (if they have a manageable employment and caring workload” (p.489). See above questions. “Employment and education can provide an opportunity for carers to spend time away from the caring role and to focus on other aspects of their identity and wellbeing”. (p. 489). What if a workplace compromises wellbeing by giving no support and causing greater isolation? A carer does not need workplace discrimination. What are an informal carers’ legal employment rights in these situations? “For carers, work can be the best form of respite from caring. It is well established that carers can become very socially isolated” (p.489). What if a workplace deliberately isolates a carer, breaching their own policies?

“WHS legislation (both the Commonwealth and State and Territory) requires persons conducting a business or undertaking to ensure the health and safety of workers at work, so far as reasonably practical. This requires employers to eliminate risks to health and safety and where not able to do so, then reduce those risks as far as reasonably practical. ‘Health’ is defined in legislation to mean both physical and psychological health” (p.743). What are the employees’ legal rights if they don’t? “In part, this is because psychological risks and hazards are harder to define and investigate compared with physical risks and hazards — a trip hazard or a piece of machinery without a safety guard is easier to identify and rectify than workplace stress or workplace bullying”. (p.744). I think this needs to be implemented. Bullying causes psychological injury, a worker constantly feels sick, can be diagnosed with things like hypertension and be medicated for it, and nerves can become completely shattered. WHS – what are the rights of employees to ensure accountability and a safe work environment is established and not more victimisation?

“At present, the objectives of the model WHS legislation do not clearly specify the protection of workers from psychological harm, although a key objective is to protect workers and others against harm to their health, safety and welfare through the elimination of or minimisation of risks. Psychological health is only mentioned in the definitions of health.
Including psychological health alongside physical health up front in the objectives of the model WHS legislation would send a clear signal as to the importance of a psychological health and safety in the workplace” (p.746). How does this help employees at this point in time? Why has it taken this long to realise?

“The OECD (2015a) found that although EAPs are widely used and appeared to be highly valued by employers and employees, there has been little evaluation of the outcomes of those using these programs” (p.777). It’s the stock standard reply as a solution – it’s not a one size fits all, approach, especially when the affected employee is communicating what will help resolve the issue.

“While some employers recognised the benefits from investing in mental health, others simply took a short-term ‘tick the box’ approach to mental health” (p.780). Yes. The mandatory bullying session is a big waste of time but a tick for compliance. It is not put into practice when needed.

“A further view is that being able to take a day off for personal care may be a proactive approach to deal with issues and stress before they do have an impact on an individual’s mental health (Steen 2019). Such an approach may actually reduce overall absenteeism due to mental health in the longer term” (p.787). Please convince managers who haven’t been through trauma and have no understanding, judging with no knowledge of one’s personal story. They must stop judging, bullying and discriminating.

Insurance

“One survey found that of those who identified as a mental health consumer and had applied recently for income protection insurance, 45% had their application declined due to mental health, 34% received the product with exclusions for mental illness, 16% received the product with increased premium for mental illness, and 8% received the product without exclusions or additional premiums”. (p.41) It is a disgusting, insensitive industry, very inhumane. “Insurer practices on mental health — such as blanket exclusions, the extent to which differences between different types of mental illness are taken into account in assessing risk, information provided to applicants and claimants, and insurer access to clinical records — should be reviewed”. (41) Yes, one size fits all approach. Demeaning and disgusting and adds to feelings of being stigmatised, judged and labelled. Most cases, it was a big stressor in life that tested an individual’s endurance and it has been overcome. People are labelled but they are actually stronger and more resilient.

Draft Recommendation 20.2 — awareness of mental illness in the insurance sector: “The evaluation should consider whether the insurance industry: has removed blanket exclusions relating to mental illness.”: Yes – bad things happen to good people sometimes. Do they need to be punished for things out of their hands? And no one should feel like they are being punished for feeling unwell anyway. It’s like blanket judgement and absolute thinking on an entire group of people in society. Prejudice based on stereotypes haven’t served us as we can see in this hate filled world.
“Discrimination — whether lawful or unlawful — is a relatively common experience among people with mental illness seeking insurance” (p.810). Heaven help you when life deals blows over and over, and there are times it’s overwhelming and you’re not coping as well. And then the answer is you have depression, here are the anti-depressants and hospital, which wasn’t the answer. You get punished over and over for finally expressing all the emotions you were “expected” not to show, for losing my dad to suicide, psychological abuse from extended family in childhood, a religious community full of judgement, stigma and condemnation and won’t have a bar of you trying to end the stigma and their ignorant beliefs about suicide and mental illness, a manager who is insensitive and manipulative, then the insurance provider declines your application. You are punished over and over for other people’s “stuff”. No one ever looks at what you survived, your courage, strength and resilience. Only the friends that matter do. I guess it’s too much work and inconvenient for the insurer, much easier to ignore the holistic picture.

“A review of the Life Insurance Code of Conduct will result in insurers being required to take into account the history and severity of claimants’ mental illness rather than adopting a blanket approach”. (p.813). Good, about time. “Requests for complete medical records give rise to the concern that insurers are conducting ‘fishing expeditions’ for reasons to deny claims” (p.815). Unethical practice is what it is.

Should insurers be permitted to fund more community-based care? Yes – and there needs to be clarity because different insurers support different private hospitals. This needs to be transparent and communicated, it should really support any private hospital. Consumers pay high premiums and need to have flexibility to get use the most appropriate service and have the best care for their needs.

Draft Recommendation 24.5 — “private health insurance and funding of community-based healthcare: “The Australian Government should review the regulations that prevent private health insurers from funding community-based mental healthcare with a view to increasing the scope for private health insurers to fund programs that would prevent avoidable mental health-related hospital admissions”: The private mental health-related hospitals are corrupt, unethical, full of bullies and a failure. And people pay high insurance premiums for the privilege. I’ve had former patients say they’d rather die than be admitted again. Most patients shouldn’t have had to be there in the first place. Yes to this recommendation.

Evaluation

“Improved monitoring, reporting and evaluation are needed to support the reforms to the mental health system outlined in this draft report. Accountability for outcomes and the creation of a ‘learning system’ can only be achieved through a comprehensive and nationally-consistent monitoring and reporting framework” (p.47). YES – let’s be honest, has there been any proper reporting and evaluation that shows evidence of the outcomes being achieved? And I mean independent. Not internal by incompetent, unprofessional, corrupt, unethical bullies in the profit-making private mental health hospitals. Accountability and quality standards are needed. And action steps to show how these will be implemented. “The mental health system as a whole need to move toward collecting data on the impacts of mental illness
on the functional capacity of people and the outcomes of programs (rather than just activity data) where at all possible. Long time frames and the interaction of multiple services to improve outcomes complicate this, but there is agreement on some basic indicators and additional outcome measures are proposed.” (p.47). It is complicated, but find ways to streamline and make evaluation simple because bureaucratic red-tape is the worst delay.

“Some key data collections should be expanded and updated and priorities should be established for ensuring data that data collected is translated into useful, and publicly available, information” (p. 48). It is funded by taxpayers (us) so YES it should be publicly available information. “Evaluation should be embedded into program design, not only to ensure that public funds are spent efficiently but also that programs achieve their intended goals, and contribute positively to mental health and wellbeing.” (p.48). Yes because most programs exacerbate the problem. Families do feel helpless and become beggars for help in a system that is even worse than what society thinks.

Draft Recommendation 22.5 — building a stronger evaluation culture: That needs to be mandatory. I don’t see any effective evaluation at present.

Draft Recommendation 25.4 — Strengthened monitoring and reporting: “The NMHC should consult with stakeholders, including consumers and carers, Aboriginal and Torres Strait Islander representatives and sector experts in finalising the set of indicators to monitor progress against outcomes”: Yes.

Draft Recommendation 25.5 — reporting service performance data by region: “The AIHW should ensure that this data is readily accessible to the public, including as historical time series, to maximise their use for planning and research”. Definitely. “Publishing data that informs consumer choice and drives self-improvement.”: Yes, this will have the potential to eliminate corruption, unethical practices, professional misconduct and negligence. These providers need to be regulated by the government and real and honest reviews and feedback from consumers need to be available – not the use of search engine algorithms that only show skewed reviews that could even be from internal management from what I’ve witnessed. It is not just misleading, but unethical, dishonest and corrupt. Self-regulation clearly doesn’t work. “Benchmarking analyses where services are able to regularly compare their performance relative to similar services, that prompt discussions and information sharing”: YES! Evidence of to lift their game – do some managers in private mental health hospitals think patient and carers are stupid? We don’t want arrogant boastful comments, we want evidence. Universities use powerful tools to show and benchmark where their researchers & research specialisations rate according to various benchmarking criteria – do the same here please.

“The lack of coherent governance structures is a key reason for the disjointed service delivery that consumers experience in the mental health system — there is no clear delineation between the responsibilities of governments in different parts of the system, and as a result, there is limited accountability... Accountability for outcomes should be one of the core principles for this agreement; this can only be achieved through a comprehensive and nationally-consistent monitoring and reporting framework” (p.197) Yes, agreed. “The system
as a whole can be described as data rich but information poor” (p.197) Well-said and I definitely agree.

“...monitoring progress can highlight areas of concern where evaluations and research may be prioritised” (p.921). Agreed. “It does not have a clear mandate for independent and transparent program evaluations as such” (p.921). This is necessary. “As with any body tasked with assessing performance, a sufficient degree of independence is vital” (p.921). Important.

**Draft Recommendation 25.1 — a data linkage strategy for mental health data (p.1,003):**
This is important, but consideration is needed for security measures, privacy etc. However, data that is disjointed results in just having data. Linkages turn this into useful information as it builds the context and story of an individual’s progress. This results in knowledge for informed decisions for both consumers and professionals.

“...publishing this data has improved transparency, enabled identification of sources of local variability in mental health outcomes, and facilitated improvement” (p.1,025). Transparency is needed. “Published data at the service provider level can be a source of information for service providers to compare themselves with others to self-improve, and provide information to consumers and carers inform decisions on care and support options” (p.1,025). And expose poor performance due to reasons I’ve mentioned before – to the detriment of patients and distress of their carers. Published data at service provider level that is factual with no skewed results and bias in the interests of the service provider (hiding the truth) is horrendous, but indeed this is what is happening at the moment. It needs to end or the service provider needs to end. “…providers might ‘game’ the system, misreport or distort data to create a good impression, or focus attention on some performance measures at the expense of others”. (p.1,026). They do this now, please make sure there are mechanisms in place to stop such dishonesty.

**Patients and families**

**Draft Finding 10.1 — digital records would facilitate information sharing:** Patients have a right to have access to their health records. I can’t begin to describe the lack of transparency in what is said in a consultation session and what the doctor has recorded – very far-fetched, dangerously inaccurate and the patient had not been informed. That disrespectful attitude must change and accountability needs to be put in place to ensure that happens.

**draft Recommendation 13.2 — employment Support for mental health carers:** It must be a legal obligation for employers to respect and support carers’ leave (that’s why the policy exists) and not have managers add to a carer’s distress in such times.

**DRAFT RECOMMENDATION 13.3 — FAMILY-FOCUSED AND CARER-INCLUSIVE PRACTICE:** It would be great if family members can get the support they need too and not feel like everyone takes from them as they need them (work, personal etc) but it seems like no one cares for the wellbeing of the carers or family as a whole!

**Draft Recommendation 22.3 — enhancing consumer and carer participation:** “Consumers and carers should have the opportunity to participate in the design of government policies and
programs that affect their lives”: YES – they definitely should. Lived experience. Governments should not tell consumers and carers what they (the govt.) think people need, they should ask, listen, be informed and apply policies and programs that have more potential to work because those impacted have had a voice in the solution.

“Empowering consumers to take part in the mental health system, from making decisions about their own care to contributing to policy design. Aligning governance, funding, accountability and policy planning functions, towards the goal of a people-oriented system”. (p.183): Definitely.

“Carers play a vital role in supporting the recovery of many people with mental illness, but their needs are not always considered by the mental health system” (p.190). No they are not.

“People with mental illness still encounter stigma and discrimination, including when interacting with the health system” (p.190). I’m fed up with mental health “professionals” thinking anyone with a mood disorder (or any type of mental health concern) also has an inability to think or have low intelligence. It’s demeaning and I find it extremely offensive on behalf of my loved one and others. One temp nurse said to a patient, “Patients with mental illness are a waste of government money.” This was a private hospital where patients pay health cover and from what I can see, they’re more like a profit-making business than a mental health facility. Especially with staff like that.

“Empowering consumers to take an active part in their treatment and recovery has been a theme of mental health system reform since the commencement of the National Mental Health Strategy in 1992 (National Mental Health Strategy Evaluation Steering Committee 1997). Although much has changed, this is still work in progress” (p.192): That long and consumers are still disempowered. It’s disappointing.

Victorian Mental Health Act 2014: “Persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected” (p.240). A part of the Rights of Patients Charter, the patient’s views and preferences should always have been respected with transparent and clear information and communication about their health.

“Carers have reported to us that they find the mental health service system complex to navigate and distressing when they are dealing with multiple professionals across the public and private health systems, private practitioners, and community based mental health service providers” (p.336). I felt helpless and was begging for quality treatment for a family member – I was in tears.

“Family members, partners and friends provide significant support to many people with mental illness, and this support is often critically important to their wellbeing and recovery.” (p.458). Yes it is. And I’d like workplaces to be aware of this and not add distress to a carer in already distressing moments. When will organisations be true to the policies, missions and values they present to society? When will they be held to account?
“[I]t is the stigmatisation and discrimination in the services that are supposed to be a support that hurts the most” (p.461). Well said. The pain families feel is more than enough. The stigmatisation and discrimination is too much from an indifferent ignorant society.

“The stigma associated with mental illness can lead to carers being less likely to talk about their situation with others” (p.462). “Many carers value their caring role. Most have chosen to take on this role because they want to provide their loved one with support and because it is the best choice available for their family.” (p.463). Yes, very true.

“For some people living with mental ill-health, the support they receive from family and friends is irreplaceable” (p.464). Family is all that matters in the end. Organisations need to stop bullying and being unethical toward am “informal carer”.

“Governments have recognised the valuable contribution informal carers make to the community and the risks that informal care poses to their wellbeing”. (p.471). If that is true tell government bodies to support carers being harassed and discriminated in workplaces.

“Participants to the inquiry have raised concerns that their role, views and needs as carers or family are not being recognised and respected by mental health services” (p.495). No, it seems no one recognises or respects any carer unless they’ve been there themselves.

Box 13.3 on p. 496: Participants views about scope for improvement to carer inclusive - Yes, my view too. “One of the most valued supports for carers is the opportunity to exchange information with mental health services about the consumer. Carers often have insights on how best to support the recovery and wellbeing of their care recipient and mental health services are disadvantaging consumers by not recognising this” (p.496). Yes, instead I found myself begging for someone to help me find good professionals for my loved one. And at the same time being bullied at work and I had to suffer that in silence. “However, there is a lot that services and clinicians can and should do to support carers and seek consent from consumers for sharing information (box 13.4). For example, protecting privacy is not a valid reason for not listening to the views of carers or for not providing carers with general information” (p.496). But mental health hospitals show extreme negligence by breaching another patient’s privacy in what seemed liked poor work practices. An organisation that needs to finally be held accountable and investigated by an external authority.

“Regarding documentation, there are many options available to identify carers and record if and what information the consumer has consented to sharing with them” (p.498). See above comment on severe privacy breach and negligence.

“Consumers and their carers are an important source of information about the quality, effectiveness, accessibility and appropriateness of mental health services. They know what does and does not work for them as they are the ‘experts on the impact of mental ill-health and the types of measures and initiatives that are genuinely helpful’” (p.907). Yes they are.
“For many consumers and carers, the general aim should be for collaboration that is: ... meaningful and significant or genuine partnership (co-design) approach founded on mutual respect right at the very beginning, where all parties are equal, have expertise in different areas, and bring real value and shared knowledge to the table” (p.910). Agreed. “...some consumers may not have sufficient system literacy, confidence or skills to engage in system-wide co-design and co-production” (p.910). Yes, some, but identify & utilise each consumers’ strengths and where contribution can be valuable. “Failing to plan for a role of consumers and carers in implementation and review, particularly given the important role of consumers in supporting accountability” (p.910). Basically, not listening.

“Governments fund systemic advocacy for several reasons. First, it enables consumers and carers to influence the development of policies that affect their lives, albeit indirectly. In particular, it gives a voice to the disadvantaged and vulnerable who are ‘hard to reach’ to ensure their interests are represented in the policy process” (p.911) Yes it does. And everyone has a right to be heard.

Education and Training

Draft Recommendation 17.3 — social and emotional learning programs in the education system: “guidelines for the accreditation of initial teacher education and professional development courses for teachers, which will include social and emotional learning. These guidelines should be developed by the Australian Institute of Teaching and School Leadership”: Yes, but as a former teacher, please ensure an external learning program to support teachers. Does society understand how much workload and stress teachers are under already? What about their own wellbeing? A very streamlined and clear system for support and referrals is needed. Teachers are best placed to observe any social and emotional development problems, but it needs to be identified and then proper external support provided. Please don’t add a program to a teacher’s current workload – students are getting to university without proper numeracy and literacy skills. A reminder that teachers are there to teach the key learning areas in the syllabus documents – they are not nurses, psychologists, social workers etc. All professionals are inter-dependent. And on a teacher’s salary, they need to focus on the expertise they have been trained in – education in the KLAS especially around literacy and numeracy. They need to be trained to assess and identify weaknesses that require fellow or external professional support.

Draft Recommendation 17.5 — wellbeing leaders in schools: “All schools should employ a dedicated school wellbeing leader, who will oversee school wellbeing policies, coordinate with other service providers and assist teachers and students to access”: Yes – good move, help the teachers with a wellbeing leader in schools.

“For example, while school teachers are expected to deliver a compulsory curriculum intended to raise awareness of mental health and develop resilience, they receive limited training and support” (p.186). Teachers have cognitive overload already! And so much workload. Is there any way the compulsory curriculum can be delivered by support staff with specialisation in this area? I don’t know what’s involved in the program, but being a former teacher and working in higher education where students don’t have even basic numeracy and literacy
skills of a year 7-8 level, please let teachers do what they are actually trained to do – teach the Key Learning Areas.

“This curriculum is intended to promote mental health and reduce the risk of mental illness among children and young people” (650). It’s what I’ve already said. Given the reports on students well below average in numeracy and literacy etc. in Australia compared to other countries, how much can be added to a curriculum and a teacher on their salary and limited contact hours with kids, be expected to achieve? Is this fair? What about the emotional wellbeing of overworked teachers expected to be everything to everyone? https://www.dailytelegraph.com.au/news/national/australia-is-failing-to-ensure-students-leave-school-with-competence/video/fa4c1805d982bca6723fd58d6c552845

“Include evidence-based approaches to mental health and wellbeing in the training and continuing professional development of teachers and early childhood educators” (p. 651). To be able to detect issues in a child’s mental health and wellbeing, and to refer to a trained expert – how much more does this government expect teachers to take on? Have the politicians ever thought to ask the teachers what might be a realistic and effective solution? Adding to a teacher’s workload isn’t sustainable or realistic. “Schools have many competing priorities that mean mental health and wellbeing does not always receive sufficient attention” (651). Yes, it’s what I mentioned.

“Schools are now expected to not only teach numeracy, literacy and academic subjects, but they also play a major part in actively supporting their students’ mental health and wellbeing” (p.665). Clearly it’s not working as the academic success of students is suffering, which can cause more decline to student and teacher wellbeing. How is “support” defined? Being able to identify issues that require professional intervention and thus a discussion with parents and a referral, yes. Adding bucket loads of everything to the curriculum that’s “extra” and not the core task of teachers which is to teach and ensure kids are educated in basic fundamental skills, so they don’t fall through those academic “cracks” as well, is a priority for a teacher. The cliché “Jack of all trades and master of none” fits here. It isn’t fair on teachers and where is their voice in funding and policy decisions?

“In practice, schools need to navigate what has been described by stakeholders as a ‘crowded space’ of curricula, government programs, frameworks, service providers, NGOs and specialists of many kinds, and weave together an effective support system for their students” (p. 666). Yes! Teachers need care too, they have families too. Putting everything onto the curriculum and the teacher from a policy makers office without going and talking with the teachers in the “real environment” is an ignorant, if not arrogant way to make decisions that are not fully informed. Overloading the curriculum is just that: overload and no deep learning in anything in the end. Cognitive overload – that’s needs to be eliminated as part of overall health and wellbeing. “…inconsistent approaches to teacher pre-service training and professional development in mental health and wellbeing, coupled with numerous programs that schools can have difficulty choosing between” (p.666). University students don’t have their own basic competencies in literacy and numeracy first either. They are victims of the “system”, made to do LANTITE testing, a situation that has caused unbelievable distress. Rather than punish these students for a system that failed them, as I
said, enough talk – the Australian curriculum needs a huge review and overhaul. Funding with no success? How about teachers are given the breathing room to teach what they are trained to do, and use the funding to provide support specialist to deliver wellbeing programs or identify and intervene accordingly when mental health concerns are detected.

“The Australian curriculum includes topics in personal, social and community health, from entry into school up to year 10 — many of which are relevant to mental health and wellbeing.” (p.668). Has it been evaluated? Is it working? How does a new curriculum get developed in Australia? Who is involved in the planning, developing and implementation? Do teachers and schools have a voice?

“While there is currently a strong desire for [teaching] staff to be able to identify and respond to students’ mental health and wellbeing needs in the school setting, in practice most staff are not adequately skilled or trained to do this work, nor do they have adequate time” (p.673). They are not psychologists, they are teachers with subject specialisation. As I’ve said, knowing how to identify an issue is one thing. There need to be more trained school psychologists to be a resource to assess and communicate with the student. ... “it is important that teachers are trained to recognise kids with mental health and also to actually be able to talk to them and be helpful” (p.673). One theory why I believe teachers miss the signs is the very workload. Has anybody asked teachers what their work consists of? Getting through syllabus content, assessment, teaching, managing a classroom environment and behaviours and needs of all kinds, unreasonable parents, potentially school executives too, having extra-curricular work piled on, planning, programming, professional development and then made to feel like a failure when kids to meet the grade. Work-life balance is something everyone talks about, but never expects anyone to take seriously. In all this pressure, then they are feel guilty if they miss a sign that a student needs support and help. Teachers are an asset, dear government, not a liability. Look after them by reviewing the curriculum and workload, and this will give breathing space and clarity of mind for teachers to be aware and look after students beyond teaching and assessing in a subject area.

“The Education Council should develop a national strategic policy on social and emotional learning in the Australian education system”. (p.675). Another policy. Do policy makers confer with teachers as they write this?

“A school wellbeing leader should be part of the leadership team of a school, and should have minimal (if any) classroom duties”. (p.687). Yes – this is not a “side business”. It should be a priority and core responsibility of the role. It’s a good idea if implemented successfully.