

## Productivity Commission Inquiry into Mental Health

*Included are only those comments received as of 30 October 2019, for which the submitter gave their approval for use of their comment by the Commission. Some comments have been edited to remove information which the Commission considered could enable identification of the submitter or a non-public third party individual.*

### Comments from Carers or family members

1.	My husband was diagnosed with depression 20 yrs ago. He has been unable to work for the last 12 years. Dealing with centrelink was a nightmare. Even though he was so unwell , he was unable to get the pension till last year. It's very hard to get the medical treatment that is needed when you don't respond to any antidepressants. The mental health units just put you on an antidepressant and discharge you. Psychologists are expensive even after the medicare rebate. TMS needs to be approved and be offered under medicare and health funds need to allow this to be done as an outpatient . This would help my husband very much.
2.	Older people living in the community and experiencing mental illness are eligible to Aged Care Program services. However, those services have been impacted by the emphasis on NDIS. If over 65 one is not eligible to support through NDIS.
3.	Explore nutritional neuroprotection
4.	I am a retired nurse and my son, 38 years old, has had a serious mental illness, with extreme anxiety and occasional psychosis, since the age of 20. He has never been admitted to hospital and actually I believe there is a disproportionate emphasis on hospital funding for mental health. The hospital experience for someone with psychosis can be extremely traumatising and actually exacerbate the illness. The emphasis in the hospital setting on drugs to control symptoms is often detrimental and can make long-term outcomes worse. Because of extreme social anxiety my son has rarely been able to use the group activities available over the years. More money needs to be spent on individual, one to one support in the community, being delivered by well-trained, well-paid people in the home environment and taking a very long-term view of outcomes. Peer support, becoming available now through the NDIS, is currently delivered, on the whole, by poorly trained and poorly paid workers. It is very important that someone in this role can provide continuity of care into the future and not just be, for example, a student passing through on their way to something better. However well-meaning they may be, they do not have the necessary knowledge and experience to meaningfully help people like my son. People like him need a committed, experienced psychologist/social worker to come to the home and take a slow, long-term view in regard to progress, taking time to develop a relationship, with gradual introduction of social activities, through to, perhaps years later, some part-time employment. Another issue that needs to be urgently addressed is the plethora of agencies competing for the NDIS dollar to provide services. For the mental health sector immediate changes are needed, both to help consumers and to save wasted administrative costs. People with severe mental health issues are completely unable to navigate their way through to find the services they need, even if they are actually

	<p>available. The current set-up is not at all cost-effective; there should be one, preferably government-run, provider, with clearly stated types of service. There also needs to be, as I have said above, a different type of category of service available, in home, long-term and well funded. It is probably too late to change my son's life much, but I would like to think that others like him would fare better in the future. There is a lot of publicity surrounding less serious mental illness, such as depression, which is usually something that passes with time and support, but no one seems to have spent much time thinking about the best way to help people in my son's situation. The NDIS is excellent for those with easily defined, physical disabilities, but serious mental illness is very different and drastic changes are needed to address this.</p>
5.	<p>I am the carer of relative who has suffered to periods of major depression across a decade during in which he was forced to withdraw temporarily from the workforce for a total of close 36 months. On the first occasion his employer was government, on the second occasion in the private sector. Where the public sector employer was concerned he was supported in a phased return to work and to his full powers in the workplace. On the second occasion, in the private sector, in a position he had been encouraged to apply for, he received no such comparable support, was stigmatized and ultimately forced to resign his position. He is now returned to the workforce, in the same sector, but has lost the middle management status which he had worked hard to attain over more than 10 years. Different unions were involved in each case. Support in the former case was better than that offered in the latter from one of Australia's largest unions in the area of service delivery. However, the principal factor that allowed a return at the same level in one case and compelled resignation in the other was the attitude of the public sector employer as contrasted with the private sector one. My relative has suffered accordingly. In the interests of productivity and self-respect, Australia needs institutionalized low-key procedures for mediating the circumstance of employees requiring extended leave due to mental illness across both public AND private sector organizations. These procedures should cover Fair Work, union roles and the responsibilities of employers and be legislated. The treatment of my relative in a private sector situation was in excusable and amounted to a radical form of discrimination. There was however no real court of appeal for a person who was ill at the time and has now, belatedly, return to good health and a full-time position elsewhere.</p>
6.	<p>INJECTIONS CAUSE INFECTIONS ,SO THEN THEY CHANGE THE NAME TO HIDE IT AND THEY LIE IN THERE REPORTS , I KNOW I HAVE READ IT Schizophrenia drug blamed for 17 deaths janssen Pharmaceuticals is advising caution in Japan following the deaths of 17 patients who were given injections of its schizophrenia drug. <a href="https://www.sbs.com.au/news/schizophrenia-drug-blamed-for-17-deaths_1">https://www.sbs.com.au/news/schizophrenia-drug-blamed-for-17-deaths_1</a></p>
7.	<p>My daughter is married to a man who suffers from depression and is virtually unemployed. On the surface he appears cheerful. It's hard to talk with him. He seems to be defensive. He loves playing drums in two bands, which don't pay much. He teaches drums once a week. My daughter has to give him money to go shopping. The only thing he contributes to the family is to mind their two sons when it suits him. He does very little house cleaning and loads the washing machine for himself, not for the family. He has visited a psychologist but he is such a good actor and a good liar that the psychologist thinks he's normal. In the past he told my daughter that he had finished the requirements for a university degree in music when in fact he had not – that's how good a liar he is. I don't think he is serious about wanting to work. He's happy playing drums in his bands. We don't know what to do.</p>

8.	<p>My daughter committed suicide on May 10th 2018 after many years of un-treated mental illness. She had well over 20 hospitalisations over a period of 10 years and ongoing involvement with police. There was no consistency of care in any of these hospitals and despite suffering from suicidal depression, bi-polar disorder (Type 2), PTSD and Borderline Personality Disorder and despite the regular harm she came to and over-doses she never received the specialist intensive treatment she needed for her to survive. I have all her medical records from the past year of her life - around 20 hospitalisations and 30 kg of medical records and in each one my daughter has disclosed her hopelessness and plans to commit suicide. It was no secret and she was serious. From August 2017 after years of estrangement from me and every friend and nearly all of her family she rang me screaming for help as she had been locked up, raped and bashed by a criminal who 'owned' her as his sex slave - she was in no way making a rational choice to live with this man who is known to police, but she had nowhere else to go and was at her rock bottom. I told the doctors at the hospital everything and so did police but after 9 months of repeated admissions, section by police, police involvement, over-doses of prescribed medication and suicide attempts she was still given no actual real treatment and she was absolutely not safe from herself or the criminal out of a hospital setting. The treatment she needed a long time ago was DBT - following detox and rehab and support with real housing. I was completely locked out of her care but she had no one else. She needed her mother and I was refused continually. Only the police would speak to me and they did often. Finally she went to [location] to jump off and end her life. There were many witnesses to that concrete plan. Police took her twice to Katoomba Hospital within 24 hours. But despite all the evidence including an urgent email from The Minister for mental Health, Tany Davies, the doctors released her. She caught a taxi - all alone - climbed over the safety barrier a second time and jumped, smashing her body to pieces. The HCCC is a waste of time - those doctors have covered their tracks and refused to send me my daughter's medical records due to her 'right to privacy' which is no use to her now she is dead. 6 police had to recover her body - a policeman had to take leave, he was so distressed. I had to quit my job, my [relation] was very close to wanting to take their own life, I suffer nothing but constant anxiety and rage. My daughter did not have to die. She died due to the lack of any actual mental health treatment over a 10 year period. She got treatment at Rivendelle Hospital as an adolescent but after she left home - nothing but police-over-dose-drugs-casualty-section and round and round till she gave up hope.</p>
9.	<p>Carers need respite arrangements or access to monetary funds. Care recipients/consumers who do not qualify for the NDIS need to be able to keep or access minimum supports Consumers in inpatient facilities need more choice and control with their dietary needs and physical health issues address as well.</p>
10.	<p>My son did not have his depo injection yesterday. He doesn't want injections. I have asked if he could have medication in a tablet. The staff would rather he became unwell and ended up in hospital than change the way they administer his medication. Is there more funding for the hospital if they give patients injections? My son has ndis funding but I have been told that seeing a psychologist is not in my sons core funding.</p>
11.	<p>Accommodation Needs for Consumers who have a Chronic Mental Illness. Early intervention is critical. We all know that serious mental illness is not curable. However, the majority of consumers over the age of 25, who continue to have poor mental health, experience many hospitalisations and worsening systems. This causes them to be so disabled they are unable to be productive and work, must be looked after, not just by their carers and families, but the Mental Health system.</p>

	<p>1. Many families care for consumers with chronic Mental Illness, such as Schizophrenia and Bipolar, at home. Some consumers, without family support, are homeless.</p> <p>2. What care is available in the Mental Health system when the carers are too old, have died or due to poor health are unable to provide the caring?</p> <p>3. Consumers who have a serious mental illness which is controlled by daily medication need to be compliant; however many are not and need daily care for the rest of their lives to ensure they take their medication.</p> <p>4. Supportive accommodation options currently are more available in Cities. Rural regions have very little or none. Suggestions regarding accommodation for people with a chronic mental illness which needs to be available in rural regions. (a) Community Residential and Care Units (CRCUs), which provide supportive care daily including medication. Consumers learn independent living skills and must abstain from alcohol and drugs. They must be connected with the nearest Community Mental Health centre. Consumers can come and go provided they sign a daily log book. We do not have a CRCU facility in the Shire of South Gippsland, Victoria. A mental health advocacy organisation called Barrier Breakers Inc. is trying to set up permanent and supportive accommodation, similar to CRCUs, in Gippsland, Victoria. They have built a 10 unit complex in Traralgon with MIND workers seeing to daily needs of consumer tenants. Barrier Breakers need financial support to accomplish their future plans for other towns in Gippsland. (b) Supportive Residential Service (SRS) houses, which are hostels, be set up in rural regions, either by not for profit organisations or private operators. The Shire of South Gippsland in Victoria doesn't have any SRS houses for consumers with a mental illness. The consumers, who must be on a disability pension, be provided with full board, support with medication, a weekly doctor's clinic on the premises, and be able to independently come and go. Alcohol and drugs would be banned at these hostels. Current Situation - There is no doubt the far reaching effects of unmonitored, out of control people with serious mental illness can be devastating throughout the community and for families. The Mental Health System's reaction to this has been negligible. More funds need to be spent on supportive accommodation for people with serious and chronic mental illness, particularly in rural regions where there are none.</p>
12.	<p>I am the carer of a family member who has Borderline Personality Disorder, Schizophrenia, Complex PTSD, anxiety and depression. I would like to start by saying how disappointing it is that the NDIS no longer funds for psychologist therapy. My daughter has participated in DBT through Headspace which has been very beneficial. Following this she was discharged from Headspace and we then found a fabulous psychologist who has really made a difference with her varied and many issues. The visits were initially weekly, then fortnightly and this frequent therapy has been a real stabilising influence to my daughter's quality of life. Now that NDIS have ceased the core funding for psychology therapy, we have been forced to utilise the 10 sessions allocated by Medicare in a Mental Healthcare Plan. This means that instead of seeing her therapist fortnightly, she has gone to every 4-5 weeks. I have seen how this has impacted on my daughter's mental health. Anybody can access the Medicare funded sessions, but why can't there be more funded sessions for those with a diagnosed mental illness when those sessions form the basis of their treatment? Once the ten sessions are used, it means \$150 out of pocket for each essential therapy session. This is a constant source of frustration, stress and angst.</p>
13.	<p>My son is now 28 - he has an intellectual disability and mild autism. Aged 18 he had a first psychotic episode and again in 2012 and 2017. He is now also bipolar - very complex. He was school captain before falling ill and would have been able to work in an ADE for</p>

	<p>3-4 days a week. The school did not see the psychotic episode pre signs. The Catholic Education office has now implemented a range of training because of my son. He was in hospital for 6 months aged 18 in a public hospital. It was terrible. I became a very prominent advocate and adviser since 2007 and campaigned for a special Unit for people with an intellectual disability. Concord and Westmead have just been announced. My son did work at an ADE for 3 days a week but since 2016 has not worked at all. He wants to be a radio presenter and is an artist. He took that up in hospital with his first episode. He has the NDIS package and has his goals. His life and mine were destroyed by the psychosis. The autism and intellectual disability were nothing compared to psychosis.</p>
14.	<p>People with BPD need access to quality, longterm psychological treatments. If these treatments were available the suicide rate could be reduced. I would like to see the inclusion of longterm treatment options for anyone with emotional dysregulation, included in suicide prevention programs.</p> <p>There are significant gaps in services for those with BPD, who need longterm, quality treatment options. Short term treatments are not at all adequate and increase distress on termination. A longterm therapeutic alliance must be nurtured to build trust enough to feel safe to examine thoughts and behaviours. Those with BPD are always missing out on funding and care, which contributes to the suicide rate. Longterm treatments work - we are cheaper to treat than not. Give us a life worth living, pls.</p> <p>Without longterm treatment options, those with BPD will be overly represented in prisons and suicide stats. Males are particularly affected, as hospitals do not cater to male expressions of trauma, such as rage. We need programs and treatments that are cognisant of men's presentations and expression of trauma and distress. Males are not help seeking and complete suicide at an alarming rate. Treatment programs aimed at emotionally dysregulated males will reduce DV, homelessness, suicide, murder, prison, and lives of misery, and save the country millions.</p>
15.	<p>Centrelink doesn't cater for carers who have episodic mental health caring responsibilities because the carers payments are geared towards people with physical health disabilities and not psycho/social disabilities and the types of actions a carer in that context supply rather than the support needed for people with mental illness. It doesn't take into consideration the impacts on hours worked per fortnight, having to leave work to attend to a family member having an anxiety panic attack, or accompanying them to appointments to ensure they get the right supports or just being present to ensure the safety of family members has on your work availability. This is especially true when providing the support to adult children, as it is not even recognised. There is very little flexibility in the system. Additionally, it is my experience that Job Networks bully carers without giving regard to their circumstances. Under the guise of fulfilling their contractual obligations, they ignore the whole question of capacity and meaningful activities. In my experience the government is paying for an ineffective service. This places significant additional stress on carers and negatively impacts on their opportunities in life. I have been forced to apply for jobs that I am incapable of accepting, as I am currently at capacity between my casual employment, my advocacy work at State and National levels and my caring responsibilities.</p>
16.	<p>I have been dealing with the mental health team at Toowoomba Base hospital in Qld for over 2 years. In January 2019 I put a 4 page letter of complaint in on the poor and inadequate service we have received for our now teenage daughter. After 30 days I received a 1 page response, which quiet frankly did not address my concerns. We have been constantly told it is just "behavioural" and attention seeking. My daughter has</p>

	<p>attempted suicide and self harm. Although the psychiatrist at Toowoomba Base hospital diagnosed depression and anxiety, we are constantly told she does not have mental health issues. I then sort private psychiatrist and psychologist however have to travel to Brisbane 250km away. Now a diagnosis of ASD 2 (autism) extreme anxiety and depression, ODD and conduct disorder. HOWEVER Toowoomba Base hospital child mental health team refuse to acknowledge she has mental health issues it is classed as behavioural AND have been told the best place for her is the watch house ! This is from mental health professionals. Nil support has been given to our family. Of course she has behavioural issues because she has autism !!! However because the mental health team at Toowoomba Base hospital have been focused of whether or not our daughter has suffered a trauma they have refused to look at any other possibilities and refused to accept she could have autism. Refuse to admit her into hospital when she is self harming and in a heightened state because she is not psychotic. GOD help our poor kids and families of children with mental health issues as I truly believe there is no help out there only bandaid solutions. This is why suicide in our communities is so high !!</p>
17.	<p>I am concerned we have not got the services in our rural for immediate treatment. carers have to travel long distance with consumers, this can be very taxing costly and unworkable especially with elderly or children. also support is being taken away in the form Of support groups. we are expected to fund our own groups with or without a worker Please review carer groups</p>
18.	<p>The Brisbane North phn has been funded to deliver services for those with severe mental illness who do not qualify for the NDIS. Funded for 3 years, this is a short term service, that will provide integrated clinical and non-clinical support from a hub. This is a much needed and welcomed service. However, my concern is that those with trauma, emotional dysregulation, and AOD complexities, i.e. Personality Disorders, who require integrated, long-term, quality treatments, will not get their needs met due to, 1. the service being time limited, and 2. there being a distinct lack of long-term treatments available. These clients need considerable time to build a therapeutic alliance to build trust and capacity before behaviour change can occur, often many years. There is a significant risk with short term interventions, of exacerbating their condition (seen as rejection and abandonment), leading to retraumatisation and deterioration. Ten, one on one, and ten group sessions funded under MBS is grossly inadequate for this group. Without long-term treatment options these clients will again miss out and the suicide rate will not reduce. Quality, long-term treatment and capacity building will enable these clients to develop relationship skills to better interact with other services, such as housing etc. Throwing a range of psychosocial services at this group, without giving them the fundamental basics of relationships is fiscal mismanagement, misguided, and cruel. In terms of equity, this new service needs to incorporate long-term measures for all those who need it. Otherwise, it is only delivering a services that meets the needs of some of those with severe mental illness.</p>
19.	<p>I gained access to the DSP in my 50s due to my life long mental illness. This has been paramount in my recovery as it takes away a lot of daily living stress and Centerlink reporting. From this payment I bought private health cover to access treatment not available publicly. I undertook 18 months of dbt. I had to pay 42% loading on my premium as I was in my 50s. My son also has severe mental illness so I also purchased private cover for him in the hope that one day he will be well enough to know how ill he is. Being rejected by public health for many years due to the ignorance and stigma around PDs, and feeling powerless, this was all I could do to potentially help him, and not kill myself in despair. I have had to cancel my cover, as paying for 1, let alone 2 private health covers on the DSP is not sustainable and life has to be pared back to survival. I know others with</p>

	<p>PDs on DSP also buy private cover to get the treatment they need. We also pay for private psychology sessions when our 10 funded ones run out, because we need years to build trust with a therapist to feel safe enough to explore trauma and make changes. This is a huge burden on those with very high needs having to fund their own treatment. And to top it off, very few with PDs are getting an ndis package, so again we are neglected. Please not this financial burden on those who can least afford it. Plenty of research around to show PDs/BPD is cheaper to treat than not.</p>
20.	<p>My 26 year old son committed suicide in March 2019. He was high functioning and held down full time employment in regional NSW. Apart from the issue of not having enough resources for mental health treatment facilities we discovered on his journey that the services that are available are totally fragmented and difficult to access for working patients especially in regional areas. The financial burdens that these problems create in no small way increase the strain on victims of mental health issues. If all the services were to be centralised , ( each case to be handled by a single case worker eg aid in settings appointments for the employed ) then each case could be allotted for correct facilities immediate care and assistance should and would be utilised in a more effective manner with positive outcomes more probable. Suicide as we all know is an epidemic at this point in time , NOW is the time to act , we are losing a generation of bright and loving people and this cannot be allowed to continue. When the vulnerable ask for help they should in all reasonable expectations , receive the help they need. Our society currently gives aid to all but their own , it needs to change , it has to change , simple kindness and care goes a long way to proving our collective humanity which seems to be almost non-existent at the moment . Our elected leaders have an obligation to repair the broken system which is in turn leading to many broken loved ones in this society . My sons battle in this system was 6 long years and no one should be subjected to that.</p>
21.	<p>The Carers Recognition Act ought to be implemented within SACAT to enable Carers to act on the consumer's behalf given the fact consumer has already given their consent. Many Carers are the Consumers main support person/people. It is sufficient to consider Carers are representatives. One doesn't necessarily have to be Guardian to be a Consumer's representative. In relation to Inpatient Treatment Orders necessitating a hearing, any anomalies, errors or concerns appearing in medical reports can be addressed at a hearing. A Carer should be able to correspond with a Consultant Psychiatrist via email. It is reasonable to expect personal email acknowledgement from the psychiatrist not from a 3rd party. One Registrar did offer his email address and communicating this way worked well. Common sense and curtesy prevailed. Carers should always be informed regarding medications and the introduction of any new medications. I can think of a particular medication that carries a significant warning. I was not informed at the time about the introduction of this new medication. Peer Support and having Supports Workers has worked well for the person whom we support. Roaccutane was a catalyst for a number of health complaints for the consumer we support. A specialist who prescribed this product acknowledged the impact of that drug. I believe too many problems and harm arise from the use antipsychotics. I sometimes have wondered if medications were taken with a full glass of water part way through a meal whether side effects may be lessened. Worth a try. Our relative took up smoking after being on antipsychotics. According to a specialist physician and family friend the antipsychotics block one's will. One of two people I knew very well experienced such awful trauma in her life and has since passed away. Such a phenomenal account. Antipsychotics keep a person's fears well and truly alive apart from the damage caused. I am interested to see the Carers Recognition Act be more fully implemented. Better communication via email should assist to resolve errors relating to medical information and general information more timely manner. I highly recommend</p>

	<p>the Carer Consultants are most supportive in their roles and with most helpful assistance given to Carers. The opportunity to be involved in the Redesign Project and being presented with information about other conferences or courses on offer. Furthermore spending a little regular time with a Carer Consultant has made a such a difference. Hoping more nurses can be employed in the hospital setting. When kitchens are available on Campus it is far better to have meals prepared by a chef on site rather than meals being prepared at another hospital a long distance away from Campus, the other side of the city then having meals be reheated.</p>
22.	<p>I am the mother of a remarkable young woman who has been diagnosed with Bipolar Disorder 2. As is common, it took about 15 years to secure an accurate diagnosis, and my daughter was perilously close to suicide. She is now well and working part-time. Without extensive family and financial support, she would be homeless or a suicide statistic. It needs money to obtain good mental health care, money to continue to purchase medication and fund ongoing care. I fear for her financial future and plan to continue working into my seventies to secure those funds. It shouldn't be this hard. She should not have to be afraid of workplace discrimination if she discloses this illness. There should be better funding for those who can work part-time, but never fully support themselves. Please closely examine the financial and workplace implications of chronic mental illness.</p>
23.	<p>We live in a regional city. Three years ago my husband was commuting up to 5 hours a day to work in a metropolitan area, for the job satisfaction than remuneration, in a specific health sector role. At age 61, he was retrenched from this full position. It took over 12 months to secure a local, shorter part time contract at a lower level and much lower pay grade, with a similar organisation. As that contract was coming to an end, he secured another part time 12 month contract in the mainstream public health sector. He, and two other employees, was retrenched from this position within 4 months due to budget blow outs. All of this has taken an immeasurable toll on his mental and physical health. Each time he has been out of work, he has spiralled into depression. At times, he was exhibiting and verbalising suicidal tendencies. When I left for work each day, I was not 100% certain that he would be home when I got back and not dead somewhere (He told me he would not do it at home). In this period he suffered a heart attack, requiring resuscitation and hospitalisation. This lead to further depression which although recognised by hospital staff, was not dealt with as there was no funding for a treatment pathway. When I was diagnosed with cancer last year, he has a purpose and focus which was caring for me. I continued to work part time as we rely on my wage. As I needed time off to attend treatment, I was demoted in my workplace. I have since returned to full time, still in the lower position with lower pay. My husband is now on his own, feeling guilty that I'm working. He applies for job after job and hears nothing. He says he is useless; that I would be better off without him. He refuses to seek counselling because he knows most of the counsellors in town. He cites that it costs and he's not worth spending the money on. He will only eat if I am eating with him. I have become his carer and 'accidental counsellor' without the skills or knowledge to make any real difference, trapping us both. He doesn't qualify for any government assistance. Employment agencies won't assist him finding meaningful work as there is no government support for them to do so. He is too young for the pension, too old to fit any employment scheme and his wife earns too much for him to get another form of government income assistance. A very proud, professional man with excellent skills in training, facilitation, systems and productivity and quality assurance, is not considered for employment because of his age – Ageism is alive and well in this town. Typical of a man of his generation, his identity is connected to his career, his worth to the</p>



	size of his pay packet and his success as a husband being a good provider. His mental health is directly linked to his employment and productivity.
24.	My observations are that too little is done too late. Mental illness appears to occur as the result of childhood trauma including School bullying and child sexual assault. Poor training and low qualifications of staff in Mental Health lead to many issues being overlooked. I worked for CRS when Case Coordinators required a solid work history and a Post Graduate Qualification. Now it seems to be run by Social Workers, they go for the cheapest option
25.	For more than 15 years we have supported our daughter (the eldest of five children) while she struggled with depression. She struggled to find and keep employment, finally getting a job with the Federal public service. There was no understanding of her condition and, indeed, outright cruelty from managers. Ill advisedly she finally quit. She ran away to the US and used all her superannuation funds on ketamine treatment. For five months we didn't know where she was. The stress was extraordinary. Now we pay her rent (364 per week for tiny bedsit) as she tries to find employment, sending three to five applications a week and doing volunteer work for political parties and an animal shelter. All to no avail. She despairs of her life. We worry about how she will manage in the future. I cannot bear listening to people talk disparagingly about the unemployed. Our daughter is attractive, clean, well educated, polite. Can no employer/employment provider/agency give her a second chance? Our situation colours the lives of all our children who know that when my husband and I are no longer here (we are 70+) they will need to take over. I am so tired of the talk, the promises, the 'plans' and the platitudes.
26.	The comments I make are not intended to take anything away from or disparage those who experience ill mental health. I make them as someone who has one parent with a comparatively milder condition (anxiety) and another with a comparatively more serious condition (bipolar, later assessed to a diagnosis of schizophrenia). Of course, those experiencing ill mental health need access to appropriate levels and types of care and they are the focal point. If there are children too though, I think it is critical that consideration is given to the kids' comfort, wellness, security and safety. Particularly where a parent(s) have chronic and/or serious ill mental health. This did not, in my experience, seem to be thought of in the 80's and 90's. Kids were perhaps only an externality on the sidelines, when in fact, every day, they were right there in it. Australia's mental health system should support children of parents with chronic and serious ill mental health, importantly if they remain living with the parent(s) and are under their care. In the beginning, professionals could help explain to the child what is happening with their parent and check in on the child's welfare. Professionals may also need to have a role in encouraging young children and teenagers to speak up about what is occurring in the home and in their life, via counselling, psychologists and referral to other services as required, so that the kids are well set-up, not at a disadvantage or at-risk of maintaining good health themselves over the course of their upbringing and life.
27.	It is not generally acknowledged that Adoption has a life long effect of disenfranchisement and an irretrievable family connection. The mental health of both, the adopted child, Natural Mothers and Fathers, siblings, and extended family. I believe that the lies and trauma experienced by adoption needs to be prevented from executed to prevent the extended and future mental health of our society. As an older adult I am living in regret and the knowledge of the lost years to all my family and future loved ones. This brings me

	and my husband to struggle with the bitterness and ill health brought on by the affect of the lies and treatment of the practice of Adoption.
28.	<p>Between the ages of 13-15, my daughter would self-harm on a daily basis, including cutting; she engaged in other risky behaviours such as drug-taking; running away; and high-risk sexualised behaviour, leading to her being raped. She attempted suicide on numerous occasions, including by over-dosing and by hanging. The Police became a constant fixture in our lives. My daughter was a patient with CAMHS (she was diagnosed as suffering from Borderline Personality Disorder, however, they refused to diagnose her further due to her age, instead stating that she "displays depressive-like symptoms and anxiety"); she was provided some counselling services through the school; and she was admitted to the paediatric ward at the Canberra Hospital many times, as there are no adolescent treatment facilities in Canberra. There is also no adolescent psychiatric ward at the hospital, meaning that my daughter was assessed in the adult psychiatric ward, where she also mingled - at times, without direct supervision by hospital staff - with adult patients. On one occasion, after my daughter was involuntarily admitted due to a psychotic episode in which the Police transported her to hospital, and after a clinician assessed her and informed me that they were going to release her, I was physically attacked by my daughter in an interview room after hospital staff left the room. The ward staff were called and they had to physically restrain my daughter, after which, she was admitted for treatment. As a parent, I was told that my daughter's "human rights" outweighed my "parental rights" - meaning that if my daughter chose not to receive treatment, I could not force her to. This made no sense to me, as she was under the age of 16 and could not legally make her own health-care choices, nor was she of sound mind to be able to make choices regarding her health-care. I did everything I could to help my daughter get well, however, I failed. The current system failed my daughter and it failed me. It failed my daughter's siblings, the youngest who was threatened with physical harm by my daughter (he was aged 4!) and he was emotionally and psychologically abused by her. The current system enabled my daughter to manipulate, control and emotionally blackmail her family and others. I used to wake up every single day terrified, wondering whether that would be the day that my daughter successfully committed suicide - and then I woke up one day, hoping it would be. I just wanted it to end. I was so broken. Our family was so broken. My daughter at age 19 remains untreated after exercising her human rights not to have treatment. There are so many gaps in the current mental health system. I strongly believe that early intervention is critical, as I believe that carers need more support. And they need to be believed.</p>
29.	<p>There are numerous articles and policies which recognise the essential roles family and friends (and the rest of the village) can play in providing support for the individual with a mental illness yet there seems to be extreme reluctance by the psychomedical system to embrace it. "Patient privacy" is often used as the excuse and yet there seems to have been little attempt made to ask the patient if they would give permission or even to explain to them how involving family/friends/mentors may actually be able to help them. It is as though the providers don't recognise that once the client is out the door, they are back in the real world and have to live with their family/friends and visa versa. One hour in the consulting rooms isn't the salve for reality. The following article is about a suicide prevention methodology that appears to work (one of very few!). It allows the consumer to choose who in "the village" (community) they would like to help keep them safe. Note: Permission was obtained from the consumer, and the consumer chose their "safety lines"- who were then given training in the consumer's needs . Is it really so hard to provide this, especially with the ease of e-learning facilities? This article also indicates that accidental overdose deaths may have been prevented. <a href="https://eurekaalert.org/pub_releases/2019-">https://eurekaalert.org/pub_releases/2019-</a></p>

	<p>02/mm-u-fds020619.php The following Australian Institute of Family Studies paper on "Family Relationships and Mental Illness" is essential to understanding why the above methodology is such a big break through <a href="https://aifs.gov.au/cfca/sites/default/files/publication-documents/issues4.pdf">https://aifs.gov.au/cfca/sites/default/files/publication-documents/issues4.pdf</a> Family life can become very fraught when a member is suffering from a mental illness and the family, not understanding the illness and the effect on their loved one, can unwittingly make things worse, sometimes much worse. It is important that a system of learning and involvement is tailored for them as well - dependent, of course, upon consumer acknowledgement* and carer willingness and all the other psychomedical and medicolegal hoops which may, or may not, be there. * Sometimes the consumer is too ill to give this, sometimes even unwilling to acknowledge they are ill, or have become estranged because of their illness. In this case a willing family should be able to call upon a psychomedical provider to at least help them to understand the condition. by being provided counselling themselves (obviously not the consumer's provider in many cases, because of the sanctity of the therapeutic relationship) . Someone should at least be available to provide a list of more reliable e-learning sites - there being so many available that an ordinary person does not know how to choose which is best for their particular situation.</p>
30.	<p>Through divorce and separation, some fathers are subjected to parental alienation of their children by their former partners. This is very detrimental to the health and well-being of both fathers and their children; and is a form of emotional and psychological abuse perpetrated by the former partner. In addition to this, some fathers are falsely accused of being abusive and violent, which aids the other parent in the Family Law process, and adds stress to the father having to prove his innocence. Typically, Family Law matters take a long time to resolve through the Family Court process, and the current laws are still biased towards mothers retaining majority care of the children. My brother in law developed severe depression and anxiety during his divorce, particularly as a result of parental alienation. He became very angry with the world, and he lost hope. He became suicidal on a number of occasions. After gaining consistent care of one of his children after 18 months of being alienated, his mental health began to improve. After almost 3 years in Court, his Family Law matter was recently settled and his mental and emotional health continues to improve. Unfortunately, many fathers and children remain separated, contributing to severe mental health issues including depression, anxiety, post-traumatic stress, fear, feelings of worthlessness, guilt, shame, low self-esteem, self-hatred and problems with attachment. This is becoming a very common tactic used (primarily) by mothers (toxic mother syndrome) during separation - it's not always men who are toxic and who are perpetrators of family violence.</p>
31.	<p>Loss of economic opportunities has a big impact on families, especially where the usual main income earner is affected. I am currently caring for five family members with varying levels of mental illness - depression, anxiety and PTSD. At different times different family members are triggered and I am called to provide support. This interrupts my ability to work, as I can only access casual employment to allow me the flexibility to be responsive to episodic caring responsibilities. This is okay if your employer is flexible, as is mine. The issues start to come into play when you are not regularly earning enough money and are reliant on Centrelink for a top up, as is sometimes the case for me. Firstly, if I have 12 weeks of work where I haven't had a top up from Centrelink, I get kicked off their system and it is usually around this time that I either don't have hours due to holiday seasons or things go pear shaped and I haven't earned enough money. When I don't earn enough money, I have the job network on my back demanding that I apply for jobs that I cannot in good conscience take. I have also been requested to participate in meaningless activities, like Job Search Training. As a past employment consultant and Job Search Trainer who</p>

	<p>received 4 awards, this demeaning. There needs to be a stream for people who are underemployed, genuine, hardworking Carers who deal with episodic mental health on an irregular basis. In my case, I have a husband who is affected by PTSD who I am constantly concerned about due to impaired memory, lack of medications compliance, no license to drive and with rage sitting just under the surface due to a lack of justice for past criminal injury. He doesn't require me to wipe his bottom, but he does need me to be around as much as possible to keep the stress levels low and keep the family moving in a positive direction. Obtaining a disability for my husband, who has physical and mental health impairments has been very difficult, which has meant a Carer's payment for me is impossible. I am looking down the barrel of an extremely difficult senior life due to no opportunity to amass superannuation after raising four children. I think the government could do more for Carers like myself who are diligent and committed to making society better.</p>
32.	<p>When Beyond Blue has to place this warning (a warning, mind you!) in one of its publications, then the Mental Health system is truly broken! Quote: "How the health professional responds to someone who has attempted suicide will depend on their personal attitude towards suicide and their level of skill in responding to suicide attempts."* This in a booklet called "Guiding their way back. A resource for people who are supporting someone after a suicide attempt." (p8) Hundreds of millions of taxpayers' hard earned taxes are spent on the Mental Health system each year and this is still what we get? Yet it seems to be true ... just look at the many broken hearted submissions to this Inquiry. *<a href="http://resources.beyondblue.org.au/prism/file?token=BL/1161">http://resources.beyondblue.org.au/prism/file?token=BL/1161</a></p>
33.	<p>One cannot be other than absolutely appalled by evidence of the demarcation disputes between providers displayed in the Submissions. This Inquiry is not about them, but about the patients/clients/consumers (PCC) however it an issue which must be dealt with immediately.. Indeed, 1. there is every possibility some providers will end up PCCs themselves, if it is left to fester 2. PCCs will suffer if their provider is too stressed themselves, and more so if they leave the profession completely as may be happening in rural areas. What a toxic work environment, trying to be precise (getting it right for their PCCs) while under such intense workplace threats, including (biased?) regulatory compliance, is not a healthy state for anyone to be in.</p> <p>Actually, I err, this Inquiry has to also be about the Providers. If they are not cared for than they cannot give care, just as the PCC and their families/carers need care. The care needs will be different at their professional level, but at that personal level perhaps not so much - dis - empowerment, confusion and having no way to overcome an issue because of artificial or deliberate barriers are common frustrations. At the professional level, I believe there are many innovative ways MH workers can be recruited, educated and supported. Many of these, however, would require political, regulatory and bureaucratic plasticity, - is our system up for it? Quick and competent change?</p>
34.	<p>I looked after my mother for 19 years who has passed in the last 10 months. She was constantly sent home from the GP with no real strategy or support plan in place. Mum had severe depression and would be sent home with people to ring ,appointments to remember or make. She never remembered anything. She chose not to make the appointments when she clearly needed them. No one ever followed up when she missed appointments. A family member should be consulted when someone misses 2 appointments. I was nominated as a guardian for mum and mum approved me attending the appointments. I would have appreciated the calls. I don't feel GPs or some hospital professionals understand the need for social engagement and also getting out of the house weekly. I</p>

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<p>found when mum was admitted to hospital she wasn't entitled to decline suggestions for her health. Mum often declined suggestions to join groups and was allowed to decline support in hospital but she clearly needed a push. When someone suffers anxiety they don't want to mix with people as they feel embarrassed. Unfortunately without social contact the illness eats you alive. Sometimes common sense must prevail. I would really like the GPs to get more training on depression and visit the hospitals to see the clients first hand. They all need to see and share their knowledge with specialists. I also worked with a Victorian Assessment team to get mum a package and the initial contact was awful. Families really struggle with the elderly with mental health issues so it's important to support us not roadblock us at reception. I got off the phone crying and tried again the next day again being treated like an idiot. Hopefully the non professionals can be advised to be a little more patient with clients and their families. I hope this is helpful.</p>
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