
Productivity Commission

Inquiry into Mental Health

This document includes comments received after the Inquiry draft report was released, up until 27 March 2020, for which the submitter gave their approval for use of their comment by the Commission. Comment numbers follow on from those comments received prior to the draft report, which are available separately on the Inquiry website.

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 people who are a user or consumer of mental health services or supports

1.	I had a breakdown twenty years ago which was brought on in my final year of uni. study by my fanaticism as a student. Since then I have suffered recurring bouts of anxiety and depression. I have found a definite lack of understanding or care at every level of the health industry right from my initial consults with various GPs throughout years. Then, inevitably, I am either prescribed the latest go-to 'wonder drug' which (after trying several over the years) I have given up on or, most recently, I agreed to the government's total of ten subsidised therapy sessions which were helpful but still far too expensive to continue even with or without the subsidy. 'Help' is always far too bureaucratic and/or expensive - it feels like a money-making industry rather than a 'soft place to land' in an 'hour of need'. It never surprises me when I hear of yet another suicide.
2.	Dear Michael Brennan, Heard You Interview on ABC Radio 31/10/2019. I am a Lived Experience Person with Mental Health - Psychotic Episode as a result of caring for both my mum with massive stroke and dad with dementia in a NSW Remote Regional Centre. I am highly skilled yet due to stigma not being given a go like I should with the job market. I have a Bachelor of Arts in Library and Information Services - a Librarian. I have lived and worked in the Community in Remote Areas Like Broken Hill and Bourke. Help others in same situation. My mum as a Community Nurse 30 years ago was doing exactly the same things you are now wanting with a focus on quality, caring, people centred approach with cost effectiveness - not having more costs later down the track - talked with people and asked what they wanted and what she could source - not being dictated to services which will not be utilised and packages not cost effective - should be professionals in all areas not generalists - have more to say and have also been part of the CEEP input and a Submission to the Aged Cared Commission. Do as a Community not in isolation all professional services - all need to communicate with each other more and not duplicate services. People fall down the cracks and dont receive services because they don't trust people to do what they promise as they have been

	let down time and time again - Lets Do Something to Change This - the most Reforms in 30 Years Ago. My Friend is an accountant and she too has been discriminated would be able to reform all the red tape and make forms more simpler and people orientated. Preventative Measures Rather than a Bandaaid Solution. Thank You.
3.	The U.S. Food and Drug Administration have granted "Breakthrough Therapy" designation for MDMA-Assisted Psychotherapy for PTSD, and for Psilocybin-Assisted Psychotherapy for Depression. These compounds are currently in large Phase-3 trials comparing effectiveness to existing treatments, after having shown impressive results in recent Phase-2 trials conducted by the likes of Robin Carhart-Harris (Imperial College London). I believe this report should recommend that these Schedule 9 compounds be rescheduled as Schedule 8 "Controlled Drugs" in line with the likes of Cocaine, Ketamine and Opium, to reflect their clinically demonstrated medical utility and mental-health outcomes. By rescheduling these compounds to Schedule 8, the research community will be better positioned to contribute to the current global research projects, as well as facilitating swift adoption into clinical practice at the conclusion of the phase-3 trials currently underway.
4.	The UNCRPD applies to people with “mental health conditions” and “psychosocial disabilities” would you please use the observations about ceasing immediately forced treatment, ect, discriminatory legislation (MHA) and embedding supported decision making in federal and state law as a recommendation. We cannot heal from harm in a system that punishes us for distress and trauma.
5.	Thank you for a clear and concise overview and some excellent recommendations. Can the PC please expand the range of professions involved in mental health service delivery beyond GP's, nurses, psychologists and psychiatrists. Specifically diet/nutrition, exercise, meditation, physical therapies, acupuncture, and other modalities in CAM. The WHO provides a wealth of information on these. In tackling this complex problem all health care resources available need to be considered, not just existing biomedical infrastructure. Increase coverage and scope of services by looking beyond what has been traditionally supported, and give consumers wider access to more therapies - that may be more cost effective, and impact very positively on mental health outcomes. Its time to reconsider all resources available in an objective way, and develop a model that is built to last and addresses gaps through utilising more treatments/therapies than currently formally used. Consumers informally use these extensively, so remaining blind to this sector weakens any analysis of mental health care service delivery infrastructure. Specifically, a preventative focus requires much more attention to lifestyle, diet, exercise and how these can be supported to obtain and maintain mental health before recourse to GP, psychologists or psychiatrists. The idea of wellbeing leaders could be expanded from schools to nursing homes, community centres, and hospitals.
6.	Stigma! The women, esp the rich and highly educated ones, try and suicide you. The doctors, lawyers, bankers, professors, politicians. Dismal.

7.	I would like to offer the following comments. With appropriate training I (and maybe other volunteers), who have experienced serious mental health issues in the workplace, would be able to share this with employers. I could explain what I believed would have best supported me at the time. This can offer a two fold benefit. I would benefit from engagement with employers and assist with regaining confidence and self belief. I ay feel useful again for the first time in years. It will benefit employers to have a conversation with someone they do not have any commitments with and gain insight beyond professional advice. I could possibly volunteer as a Mental Health Peer support worker, with an approved program under guidance from professionals and in approved circumstances in the workplace. There are existing courses for this type of role, and I am sure a couple of additional modules can be added.
8.	Mental Health nurses must have a clear understanding of the pertinent legislation and private hospital policies must align with that legislation . All mental health practitioners must be fully conversant with assessment orders. NDIS must by change also cover for psychiatry as this is a financial burden on severe mental illness. Should be a clarified point that GP's can forward a mental health plan but are not experts or able to make a definitive diagnosis on a mentally ill person.
9.	More focus needs to be applied to the older persons with mental illness. Too much focus is on the 25 and under. Those with PTSD are more likely to commit suicide (returned service men and woman) and those with lifelong trauma where one will never be cured or will never work again. Hardship on carer is increasing as are suicide attempts by sufferers. Older generation are just as important. Lifeline etc are also focused at the young and need to reflect on others above 25.
10.	When attendance can not always be improved in the workplace either due to mental health conditions or as a result of effects of medication for that condition, it is essential that we are still ensuring the financial capacity of someone with a mental health condition to maintain an adequate standard of living, one which meets the basic requirements for not living in poverty and, which has been proven by research to reduce suicides. This means increasing minimum wage (where many people with mental health conditions are in low skilled jobs) and allowing for more respite days (especially without a doctors letter which can be stressful and resource costly to obtain) from the workplace without risk of negative treatment or threat of loss of job by employers, as well as increasing welfare payments, and considering mental illness, especially in any case where sectioning or detention has occurred be grounds for a person to be considered automatically eligible for Disability Support Payment's given sickness allowance is often inadequate to support improvement of their condition and also limits their capacity to earn, study and does not offer adequate motivation for improvement in their condition and to return to work such as a greater earning limits before welfare payments are affected, or a more adequate income bank balance allowance to promote comfortable re-engagement in long term employment, such as DSP and Austudy/Abstudy grant. This needs to occur especially if the overall rate of welfare payments are not to be raised, which once again, has been proven to reduce suicides and mental illness symptoms. Likewise, I would like to see Australia adopt the policies in regards to the UN Convention on Rights of people with a disability of which the Australian

	<p>government is a signatory, which acknowledges that forced and involuntary psychiatric treatment is a form of torture, on a federal level. And which should include the right to refuse medication, even if sectioned, and receive and/or be advised of alternative options of treatment other than medication, where people who do not take medication and are treated in medication free community care settings have been proven to have better overall long term outcomes, life satisfaction and employment rates than those who take medication. I also think it is essential that independent statutory complaints boards be active in all states, including my own of SA and that in states where Guardianship boards are established under mental health statutes that we see a separation of them from this.</p>
11.	<p>Very pleased with the focus of the need to transition professional Peer Workers in all aspects of service provision. This is a once in a lifetime change that makes so much sense it's just obvious. And your report supports this. I would however like the language of the inclusion of a Peer Workforce to be the most important workforce change. On page 200, ending paragraph 2 with "...such as Peer Workers" reduces the importance of the inclusion of the Peer Workforce as the last thing to be done. This is highlighted in the key Draft Recommendations 11.4 that are critical to transition from a Medical Model to a recovery model. On the news last night in Hobart they highlighted the fact that so many of the ED patients were people with mental illness. One person had spent 80 hrs in the ED 15/11/19. People struggling with mental illness, and many times homelessness, need Peer Worker supports in the community. And not in the Hospitals. The NDIS has most of the focus in the politic at the moment. This has taken away the need for 'Prevention and Early Intervention', in P128 the draft has put this focus back.</p>
12.	<p>there are last time I checked.680,000 unemployed, the real number is much much higher! 160,000 job vacancies, and 750,000 457 visa workers. im not overly smart but even I could work out the solution. the government punishes the unemployed who through no fault of their own cannot find employment whom they themselves created !!! this has a very real effect on peoples mental health obviously! the ndis has everyone I know completely lost. no one I know can access services anymore. the current levels of immigration are just ridiculous and unsustainable and the people you choose to bring in leave a lot to be desired....politicians are so far removed from a normal persons day to day existence its really beyond a joke now</p>
13.	<p>If the commission is truly concerned with mental health it needs to address precarious work which is a leading cause of mental stress and anguish for so many. And to avoid looking hypocritical the commission could have an honest look at itself and identify where it has a direct negative impact on the mental health of our society.</p>
14.	<p>brief comment while working on submission. I am a forced adoptee who managed to get medical qualifications and work 94-01, whole time dragged down by psyche drugs and labels until suicidal psychosis put me on DSP 18 yrs ago. Digging deep into psychiatry and not good for people. Please dont give money to same broken system. strong psychoactives cause insanity and dehumanizing labels impair recovery on social and professional level. would love support to formalize my study of this industry. will try to send documents detailing flaws you wont hear from friends of medical industrial complex. Happy to talk if you get to Brisbane.</p>

15.	I loved my job. I worked to 110 percent and never wanted to leave. I was bullied by my supervisor who used to be a friend. Management ignored my complaints and then retaliated against me. [Company name] is guilty of many crimes against my person and the Federal Government as I now have no worth literally as Human capital to the Government and am being forced to beg for the disability pension and my dad is 93 and having to support me. My basic human rights have been taken away and I wonder why the Federal Government enslaves people and rates us only on our Capital Worth and Investment. Its manslaughter to the masses. I have been robbed of my 3 million TPD payout that I was approved for by MLC not giving to me and therefore they are committing a Crime against the Federal Government forcing me to beg for the disability pension. I have been told I have to apply to newstart when it would be committing a crime against the Federal Government as I cannot work and have all the medical evidence to support my case. How can the mentally ill fight against a corrupt Federal System that only cares about Capital and shares.
16.	The Future Of Psychiatric Drugs. Psychiatry will be the instigator to people understanding more about how the brain works through its understanding of how psychiatric drugs work and how to use them so they work for almost everyone who tries them. As psychoactive drugs consistently keep healing people who have psychiatric disorders they will no longer be viewed as something only the mentally ill are suited for. In time people without psychiatric disorders will seek the same emotional relief they understand people with psychiatric disorders are getting from psychiatric drugs. Psychiatric drugs are available to everyone who seeks access. It will no longer be considered unusual for anyone who chooses to use mind altering drugs to do so. Psychoactive drugs will be used to improve mental health, how people experience life and people's ability for thought and reason. It will be normal for psychiatrists to have at least once used each of the psychiatric drugs they prescribe so they know exactly what they are exposing patients to. A psychiatrist will not prescribe a drug they have not first experienced themselves.
17.	I believe the government should increase funding for mental health, it affects areas of a huge diversity of people. I am a mental health users and mature age student studying social work.
18.	It is obvious someone has stocks in this, as all things listed can and do change from day to day. It's common knowledge that these "issues" change with a child's development, and in this age bracket it is in constant change. How can anyone possibly justify medicating for such things without taking in the actual severity of it and all factors. As a parent of two kids as well as someone who has worked with kids AND someone with permanent mental health illness, I find this very distressing. Our medical system can't handle anything as it is that doesn't meet text book standards, and now considering letting them text book this and give heavy medication is scary. Bluntly its wrong and I will be fighting meds every step of the way for my children!
19.	While working in a tertiary institutions library - my former mental health issues - stabilised over 17 years of counselling, was triggered by a number of workplace bullying incidents. On applying for Workers Comp I was surprised to find the

	<p>assessor was a retiree psychiatrist - whose report was written on a Pharmaceutical Giant - Astra Zenica letterhead. And he got his facts recorded so inaccurately and his focus was entirely on past history events - that it barely registered as a valid assessment. He won I lost and was forced out of the workforce semi-permanently. I later discovered the same fellow had worked in other orgs where people I knew had been discriminated against significantly for their mental health needs. He was listed on the Vic Human Services as a legitimate provider. I think he ought to have been deregistered and doubt he had sufficient professional quals to practice -or knowhow either?</p>
20.	<p>Most of those most clearly defined and disempowered by all their Mental Health issues and Services - are clearly defined as Singles and within those parameters have immense struggles to find answers with Isolation, forming friendships, having sustaining social interactions and/or engagements. On the other hand, it is becoming overwhelmingly more clearer - that many siblings from the same family environment who have segregated out into nuclear families of their own, have immense and ongoing and wider struggles than those clearly defined in normed psychiatric settings. Some of these difficulties concern major relationship frictions and difficulties in developing set guidelines to define their interpersonal relationships as satisfying or revolting - whatever the case may be? It seems as if siloing off of singles into one category and couples into marital guidance only - is an insufficient resolution to the problems everyone has as a result of coming from or being in nuclear family environment. And at least some of the problems of having a significantly impaired sibling rubs off on paired siblings also - and vice versa - for unemployed sick people - comparing themselves to earners and nurturers - is not a good way to go either</p>
21.	<p>I suffer from anxiety and was having counselling when there was a death in my family. I needed counselling once a week. 10 sessions a year is not enough. If that amount is increased for people who need it that would decrease the number of people who's only option is to go to the ED of their local hospital.</p>
22.	<p>16 hours in emergency overnight is not conducive to sleep and mental health. staff with prejudices against personality disorders shouldn't be working in mental health. secondary mental health care needs to exist outside the private sector. acute units should seek to provide a therapeutic environment. punitive responses are inappropriate in mental health units. more accountability for mental health care, including inpatient units. Community mental health should speak to users rather than only partners. Community mental health should actually provide follow up as promised.</p>
23.	<p>The CAT Team system - introduced when Jeff Kennett was in government - supports his radical ideas of far right (fascist style) use of force on anyone who displays any form of intolerance or challenges the ways the far right (read fascist) and punitive systems have worked in the past. The CAT Team approach instills fear in its victims (read client base). It is too easy for there to be no checks and balances in place and too easy for hard lined professionals - lacking the skills to address the needs of the client base - to use force on vulnerable victims of crime (often subsumed in early childhood and repeated throughout a persons lifespan by the same parties who perpetrated the earlier crimes (ie members close to the</p>

	<p>persons own family). When you get members of a professional body such as those employed in CAT Teams who themselves have perpetrated these forms of abuses on their own families, then the vulnerable applicant needing a dose of support and care - has no hope of ever achieving same, and will be subjected time and again to these repeated use of force styles of punishment (read treatment) ie within certain parameters of psychiatric services - punishment substitutes for treatment. This is vile inhumane practices and unethical in the extreme. Weed family abuse perpetrators out of the psychiatric carer teams.</p>
24.	<p>The issue of Beyond Blue advertising on their website - as if there is a cure to all mental health problems and issues arousing such things as depression in any of its many shades and forms - is so misleading as to qualify for misleading advertising material. This is because - when its founder J Kennett set up Beyond Blue - he saw it as a money spinner for the Psychiatric Drug companies - ie the drugs would provide the prime sources of any cure or treatment therapy devised. This is so inaccurate - as nearly every sufferer who has been forced to engage in this form of treatment therapy - and to their enormous detriment - learns in the hardest of ways. Drugs are debilitating - and lead to enforced lifestyle changes, the main one being loss of work entitlements that in turn contributes to isolation via loss of social skills via loss of confidence loss of self control and ultimately loss of all your connections with human life. There is an even worse harm connected with Beyond Blue that is so damning of its purpose and modus operandi - which is a refusal to permit any sufferer, survivor or victim of psychiatry to report any source of negativity in terms of psychiatry and/or their mental health treatment services - to air on their website - despite inviting commentary - that will in every case be audited prior to airing ie nothing of a negative nature ever gets through. This prevents potential customers from learning about the real causes behind discomforts endured through maltreatment by all mental health professionals and their services - who all arbitrarily rely on drugs and in almost every case, only drugs to disguise symptoms, shut down human potential and resources to deal with symptoms - and shove problems under rugs, by smothering all attempts by criminally treated family victims to express their ire at how they have been treated and maltreated in nuclear family scenarios - by usually someone within their own family backgrounds. Sadly it is possible that J Kennett himself falls into this category which is the sole and saddest rationale behind him trying to prevent word of such things from ever getting abroad. When Fascist operators like him are shunted out of positions of domination and power, the entire community in this state and country will be far better off, without any of them - brandishing their whip irons over us all. The worst form of con artistry to ever make it to the top of this state's governing circles,.</p>
25.	<p>The cost to the government via the PBS of pharmaceuticals far outweighs any gains made. The only winners are the big Pharmaceutical giants.</p>
26.	<p>Becoming victims of crime (at whatever age) or becoming a victim after witnessing a major crime or crimes - often committed within the family home environment and never acknowledged = hidden under the carpet for a lifetime - is what usually initiates presentation to a mental health facility with a request or requests for assistance. This is because, if the original crime was never dealt with and no justice</p>

	<p>eventuated, then the perpetrator is likely to still exist and be continuing to perpetrate against known victims/easy targets - and there is no escape from someone so inclined nor any forms of protection instituted for that persons crime related victims - and so they are free to offend and reoffend throughout their victims life. That is the reason early childhood victims of crime, suffer so extensively for a lifetime and why psychiatry (which implements punishment style treatments against victims of crime) never succeeds in addressing these subsequent and horrible problems. To fill a person with toxic harmful stimulants or antidepressants exacerbates the problem without relieving any of its symptoms. More of same is a recipe for failure. We need to reduce expenditure on unnecessary services that have been known to fail time and time again. Thanks for looking into this with a view to changes being implemented = in the very foreseeable future - and no thanks to the current Mins for Mental Health - who likely exacerbate vulnerable victims issues - simply because it suits them to prop up pharmaceutical giants - and the reasons are obvious - their kickbacks are gloriously generous??</p>
27.	<p>I applied for the NDIS and I was rejected because my needs were not serious enough or permanent and episodic. I have anorexia nervosa, complex PTSD and bipolar 1 disorder. Recently I spent over 2 months completely debilitated by mania which nearly ended in an involuntarily psychiatric admission. Despite other episodes like this my illness results in discrete episodes. My anorexia is managed through private hospital admissions. I've had 3 in the past year. I am on a disability support pension and am forced to use private health insurance to access ongoing mental health support for my anorexia and bipolar disorder. I pay for private health insurance which provides a significant dent to my income but it is the only way to get treatment when I need it due to bed shortages in the public system especially for eating disorders. I would like to see rebates for private health insurance for people so DSP so we can access much needed care</p>
28.	<p>Lifeline Mid Coast has been working with our Local Area Health District to provide a peer driven hospital to recovery program. This is largely non-clinical and to date, is proving to be significant in supporting people leaving the mental health ward, receive the consistent, reliable support needed to begin their recovery journey. This has led to a decrease in hospitalization and suicide attempts. This service is well supported by Lifeline support groups for those who have attempted suicide. Again, our research suggested this group work also has a positive impact in the recovery process. Being non-clinical, users express being more truthful about their behaviours and less threatened by the programs. This means better attendance and outcomes.</p>
29.	<p>Please find link to Senate Inquiry into medical cannabis access, it contains info re adverse effects of psyche drugs esp for PTSD, 2nd half background is probably most relevant https://docs.google.com/document/d/17Cq0MVADJQ_WGoz8StWhzaf0t8J0G0NudXOmBuGQRZ8/edit?usp=drivesdk</p>
30.	<p>I contribute a summary article in this comments section, I hope to present a more thorough examination supported by feasible initiatives addressing topics #15, #16 & Stigma in the submissions section. LIVED EXPERIENCE I, [name withheld] have lived through the broad buffet of inhumanity to date: Borne into domestic violence ; Wished death upon for being unwell at birth & for decades cursed /</p>

	<p>blamed for the financial & professional inconvenience my first year of life caused; Early grooming, exposure & prolonged conditioning to vile sexual abuses / exploitation; Early childhood & adolescent homelessness; Attempted murder x 3; Innumerable incidents of psychological, physical, emotional, financial control / deprivation / manipulation / rip off; Wilful damage to and theft of personal property (domestic & cars) & so on... Regardless, I remained an optimist (albeit oddly naive). Hence I persevered, I were a believer & striver, trusting & determined to create a safe life & home all inclusive of stability, security, family, career, wellbeing, friends, life pleasure in harmony & balance. Over & over I'd dust off, go again; my resilience was ingrained with the commitment & responsibility instilled that in good faith it was up to me to fulfill my goals. Early 2010 aged 50, I were yet again in situation & with full effort to improve / recover condition & quality of life. Everyone has their breaking point - MINE WAS 7 MEN & THE SYSTEM IN SEEKING RESTITUTION STACKED AGAINST ME. These tradesmen were privy to my hardship & need for their professional decency, collaboration & workmanship. In my case & unfortunately anecdotal evidence over time shows a significant rise in the endemic / cultural behaviours & attitudes by professionals particularly in the Building Industry & thereafter in process of / with Litigation, Consumer Affairs, Equal Opportunity Commission, Anti Discrimination Dept of VCAT etc. as -- presenting & perpetuating Inequity, Professional Bias, Gender & Health Discrimination, Contempt & Ultimate Self Righteous Perjury by Perpetrators. After decades of survival & beginnings, I finally were broken (2020 still am - so traumatised by the aggregious conduct on site & complete ruination of what was home & ability, the overall toll & enduring legacy of annihilation & mockery added to by the judiciary & impact from the stigma that ensued being labelled as 'just Mentally Ill' throughout the legal process. I do have proof of this occurring. WHY IS IT THAT THE AGGRIEVED / THE VICTIMS / THE ABUSED / THE TRAUMATISED ARE CONDEMNED TO SUFFER MORE VITRIOL, ARE JUDGED, DISBELIEVED, HAVE ADDED PRESSURE 'TO JUST DEAL WITH IT' & OFTEN LABELLED AS THE SICK LESSER BEINGS DRAINING THE ECONOMY; WHILST - THOSE RECKLESSLY CAUSING DEVASTATION, RUINING LIVES, DISRUPTING SOCIO - ECONOMIC PRODUCTIVITY TOO OFTEN WALK AWAY FREE TO CONTINUE HARMING, RETAIN STATUS AND, ARE CONSIDERED OR CONSIDER THEMSELVES AS NORMAL?</p>
31.	<p>In 2016 I spent some time in the Ipswich MHU for psychosis (later years diagnosed with bipolar). MHU was a frightening experience especially being mixed in with violent and threatening men coming off drug addictions. Because I am polite and quiet in personality I was deemed low risk and due to dwindling bed space was moved into the geriatric MH ward which was a bad experience and did not feel safe. It would be beneficial to have public mental health programs and units available for to public patience's at a small cost as the benefit of the stay is good for daily monitoring from Psychologists and psychiatrists and getting answers. I also had to return to work earlier then I should of and when I was still quite unwell due to finances (my husband had lost his job) and Centrelink knocking back my application for sickness allowance so I could have more time to get better.</p>
32.	<p>1. Psychiatrist availability in regional areas: I am medicated for bipolar, there are 5 private psychs and 1 emergency. Of those no one was able to help me unless I</p>

	<p>admitted to hospital because the wait was up to 6 MONTHS. Doctors are poorly educated. 2. More education and trials into nootropics, micro dosing, psychotropics, and cbda is required. There is so much promising evidence. 3. I work in civil construction. More likely to not get any work if I need time to stabilise. Most civil workers are employed as casual.</p>
33.	<p>If our government were to stand up to the big food and pharmacy corporations and start to regulate what actually is going into the processed foods on the shelves there would be less mental illness and other major illnesses. The big pharma would not be able to influence our government in the manner it currently is</p>
34.	<p>To Whom It May Concern, I feel compelled to make a statement regarding the Australian Productivity Commission's proposed expansion of health screening for young children to include the checking of their 'emotional development'. By framing health checks for the very young in the language of mental illness, the possibility arises for the prescription of psychotropic drugs in a demographic that I believe should never be medicated in such a way. This is further complicated by the subjective nature of mental health diagnosis, and the fact that proposed indicators such as 'difficulty sleeping' and 'tantrums' are normal childhood behaviours. My main concern is the unknown damages that psychotropic medications might inflict on the developing bodies and brains of these children. I have personal experience with SSRI medications that strongly informs my view. I was prescribed these SSRI's 25 years ago, at the age of 24, and although I used them at the time for only several months, I still, to this day suffer permanent negative consequences. On discontinuing the medications all those years ago a part of my neurology was switched off, an access to emotional and functional affect that I have never fully recovered. It was not the "depression returning", but a new thing, obvious and tangible. Although improvements have come in the last 25 years, for the most part I still suffer from what was initially the complete eradication of my sense of self, my ability to experience emotion and connection, and the loss of all forms of physical and psychological pleasure. In short, these drugs destroyed me. My research has shown that I am not alone in this, and that there is a large subset of people who have also been permanently and negatively altered during or after discontinuing these medications. Understandably, given my unfortunate experience of being one of the unlucky ones permanently damaged by psychotropic medications, I am extremely concerned about the possibility of their being prescribed to young children. I would, of course, prefer that they were not indicated for any so-called mental health disorder, but it is especially worrying to think that young people and infants might be diagnosed and medicated in such a way. If such damaging effects can manifest in an adult, then clearly a developing child is even more susceptible to the possibility of these complications and negative outcomes. Indeed, to administer psychotropic drugs to children should inherently be seen as criminal. This submission is a heartfelt plea that the proposed extensions to infant 'mental health' screenings do not go ahead</p>
35.	<p>As a consumer of mental health services, I would like to provide comment around the funding mechanisms the Productivity Commission is exploring to improve the mental health system:</p> <ul style="list-style-type: none"> • I strongly support the Commission's recommendation regarding restructuring current funding arrangements and modelling the "rebuild" option (recommendation 23.1, pg. 104). Having one funding body would allow

	<p>easy identification of where funding is being allocated, identify gaps and reduce the need for continual service mapping projects due to the current piece-meal funding mechanisms. • I support the Regional Commissioning Authorities being governed by the jurisdictions as the states and territories are more closely involved in frontline service provision and work in different legislative environments. I believe implementing RCAs governed by jurisdictions will reduce the politicisation of mental health funding and ensure resourcing goes to the areas it is needed most (preferably led by consumer input and leadership) rather than being directed to initiatives that have a current spotlight in the media or political discourse. • It would also allow for psychological services to be funded more easily by states rather than being heavily governed by MBS items (which are inaccessible for many consumers due to the lack of bulk billing providers and high gap payments). More psychologists in the community and inpatient public sector are needed urgently. • It is my view that the current collaborative efforts between Commonwealth, jurisdictions, PHNs and LHNs have not resulted in better outcomes for consumers and am fully supportive of moving to a rebuild funding model. At the very least, this option should be modelled and explored in more detail before a decision is made. • I am concerned governments would prefer the renovate option as it reduces the visionary work required to overhaul the system and will require a significant time investment. Choosing the renovate model will ensure we continue to have a “mental health implementation” problem in Australia. We need to be thinking about bigger system-wide reform that truly is led by consumers and supported by carers, not what works best for governments, service providers and clinicians. I have spoken with many consumers in my networks and all are invested in the rebuild model and seeing actual system-wide mental health reform, rather than the piece-meal reform activities we have seen to date. I am concerned if we don’t take the opportunity provided to us now, then true system reform will continue to evade us.</p>
36.	<p>I am fully supportive of recommendations for an increase in consumer-run organisations, an independent consumer peak body (there is not currently a national consumer peak, however there is Mental Health Carers Australia for carers) and a professional peer work organisation. • Peer workers are one of the best placed professions to take on a “navigator” role within the mental health system as this is already a core part of their role in supporting consumers through the system. I highly recommend any navigator role be undertaken by peer workers. This would increase the peer workforce and also ensure more consumers have access to peer workers when first making contact with services. • Access, availability and quality of the Certificate IV in Mental Health Peer Work is a major barrier to increasing and building capacity of the peer workforce. The training is not available in many areas, is too prohibitive in terms of cost or the financial supports available to access are not well advertised (such as smart and skilled funding), and the training providers vary in content expertise and quality of training. I would encourage the Commission to make recommendations about ongoing investment in rolling out the Certificate IV, particularly in jurisdictions without any training providers (e.g. Northern Territory). Please see the PMHCCNs Towards professionalisation study (pg. 32) for further information. • Increasing the qualification options available to peer workers (including qualifications below and above the Cert IV) will only help to embed the workforce as a legitimate</p>

	<p>profession, increase career progression opportunities and increase the capacity of the workforce to better meet the needs of consumers. I would emphasise the need to increase capacity within the workforce however, rather than encouraging the peer workforce to move into other health professions. Peer work should not be seen purely as a stepping stone but a career in and of itself with appropriate remuneration, career progression and increasing levels of skill and competency. • Strongly agree that a national peer work organisation is required to progress professionalisation of the peer workforce and enable other professions to recognise peer work as a legitimate and valued role. A registration or certification pathway would also be beneficial to embed the profession and ensure ongoing professional development and training is undertaken. A registration pathway would also bring the peer workforce in line with other health professions and ensure peer workers are working to core competencies and standards</p>
37.	<p>As a mental health consumer who is employed at a PHN, is an independent consumer consultant and was awarded the 2019/20 National Mental Health Award for Advocate of the Year, I would like to offer a couple of comments.</p> <p>I am the person who developed Murray PHN Stop Mental Illness Stigma Charter (www.stopstigma.com.au). The Charter is a way for organisations to work towards reducing the stigma of mental illness, for both the benefit of staff and those who visit/use the organisation. As person who has experienced first hand the impact of stigma, I see the need for all levels of government, every workplace and the community to work towards a world where there is no stigma of mental illness. Stigma almost cost me my life, as I was more scared of the label and the impact on my career than the thought of taking my life. This issue cuts across all sectors of life and hence, must be given greater importance in the final report.</p> <p>I would like to raise the importance of employing people who have a lived experience of mental health, within every organisation who provides or funds mental health services. And I am not just talking about peer workers, I am talking at all levels within the organisation. As a person who lives with a serious mental illness and is employed in a strategic capacity at a PHN, I can not tell you all the times where I have provided insight to all staff members on how the system works or doesn't work, what it is like to live with a mental illness, be suicidal, what a psychiatric ward is like and all the roadblocks/hurdles one needs to overcome to access help. If I wasn't working full time in this organisation then these assumptions or misunderstandings would be likely to never be corrected, as they wouldn't be raised at co design workshop or consultations. But having people at a higher level who can tell it how it is, is a rarity which needs to be improved. We need representation at Board level, we need more staff in the Department of Health, more opportunity to influence decisions before they reach the community or co-design stage. If we don't address this, then we will continue to point money at programs which are inefficient, not needed and overlook innovation from consumers/carers who do know what the sector needs. I also believe that this productivity report is lacking enough expertise from those with a lived experience of mental illness, which should be addressed.</p> <p>There needs to be greater flexibility in the way that funding is allocated to allow for variation for differing communities to occur, along with the differences for rural, regional and remote Australia. Too often these decisions are made in metro</p>

	<p>regions without understanding the impacts the other areas often have to face. As such, we need to place more trial sites, pilot programs, government offices and research agencies in regional/rural Australia to ensure that our regions are actually considered in major decisions. Although I am a PHN employee, I do think these agencies are best suited to working with their communities to determine needs, but with greater focus on making sure this is done correctly and not tokenistically.</p>
38.	<p>I particularly support implementation Draft Recommendation 11.4 "Governments should strengthen the peer workforce". As noted in the draft report, "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". Further to that, I suggest an effective and efficient deployment of peer workers would be in General Practice clinics. Another cogent access point for peer workers might be attached to community and public housing sites, perhaps via "Safe Haven" coffee shop type establishments. The peer workforce so developed and deployed would be an excellent place to start in forming a Mental Health Services Consumers Reference Group.</p>
39.	<p>I have had bipolar 1 for almost 7years. Latest bout of difficult to treat depression lasting for almost two years so far since the birth of my second son. Loss of the ability to work as a midwife and to function as a parent and wife and human being really has placed extreme strain on the family both financially and otherwise. Four hospitalisations, treatments with multiple drugs and combinations of these and multiple treatments of ECT have had devastating side effects the worst being memory loss effecting cognition that hasn't repaired. NDIS has been somewhat helpful but workers have no idea what bipolar is and sometimes I need them to look at the bigger picture (family unit and what they are missing out on because of my disability) rather than me and my needs. I couldn't apply for the disability support pension because my husband earns too much yet we are drowning in debt with all my medical expenses, loss of earnings and the costs of raising our children that were planned before we could foresee this disability in our future. I can understand couples that choose to keep a parent at home to be with their children but I was a working mum-we didn't choose this and I am an individual-I don't like being financially dependant on my husband-he would never deny me money but their is such thing as financial abuse and I think it is unfair that I and I imagine many disabled Australians who are unable to contribute financially to their household when they feel like their disability is already placing so many restrictions on them already. We did apply for a carers allowance because he did earn below the threshold for that. Unfortunately my psychiatrist said that my current condition of being in a severe depression despite prolonged and not responding to multiple treatments was temporary so although I don't think it can't be contested that my bipolar is permanent and long lasting and has tore away my identity, I can't just return to where I was when I got sick (impact of ECT, the effect of the drugs or the illness it's self has left me with poor memory, cognition, ability to retain new information, poor confidence, self esteem issues etc) I will most likely have more episodes in the future to have to rebuild from we were rejected as the episode is not, even though she has said we are running out of ideas going forward. I guess my hope is that money is put into research because from what I understand my story is not unique and their are so many sufferers that do not</p>

	<p>respond to the current treatment options. I have had genetic testing done to see if that would help. I came off all mood stabilisers and went on an antidepressant that was less likely to cause mania and I metabolised normally in a hospital setting and I was manic within a week. I am now on that same antidepressant with two mood stabilisers and dexamphetamine and I my depression is in my boots and I am coming up to that same combo for two months. I will continue to fight. Thankyou.</p>
40.	<p>United Nations Human Rights Office of the High Commissioner Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health The World Health Day - 7 April 2017 Depression: Let's talk about how we address mental health. "The human right to health is understood to inclusively guarantee the right to the highest attainable standard of physical and mental health. There can be no health without mental health and everyone is entitled to an environment that promotes health, well-being, and dignity." "For a large proportion of people with mild and moderate depression, cost-effective specialized or non-specialized interventions based on human interaction and on talking and listening, starting from "watchful waiting", may be all that is required and must be understood as frontline treatment interventions." "Regrettably, recent decades have been marked with excessive medicalization of mental health and the overuse of biomedical interventions, including in the treatment of depression and suicide prevention. The biased and selective use of research outcomes has negatively influenced mental health policies and services. Important stakeholders, including the general public, rights holders using mental health services, policymakers, medical students, and medical doctors have been misinformed. The use of psychotropic medications as the first line treatment for depression and other conditions is, quite simply, unsupported by the evidence. The excessive use of medications and other biomedical interventions, based on a reductive neurobiological paradigm causes more harm than good, undermines the right to health, and must be abandoned." "Biomedical interventions will remain as an important treatment option for severe depression and other mental health conditions. However, we should not accept that medications and other biomedical interventions be commonly used to address issues which are closely related to social problems, unequal power relationships, violence and other adversities that determine our social and emotional environment. There is a need of a shift in investments in mental health, from focusing on 'chemical imbalances' to focusing on 'power imbalances' and inequalities." https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=21480&LangID=E</p>
41.	<p>The current Continuity of Support for services ineligible for NDIS is inadequate. I hold the Productivity Commission responsible for rectifying this problem.</p>
42.	<p>Psychiatrist world is full of lies and hatred of seeing people being successful, and going to be successful as well as being a scapegoat for some high profile businessman or politicians, just be careful who you speak with ... the psychiatrist world is just another way of murdering with injections, electroshock, and medications, and the end of the day, death comes, ideas less, innovations stop, and only the same businessmen and politicians be where they are, and we be poorer each day, psychiatrist is a "gun" for these high profiles.</p>

	<p>Another thing is that once the psychiatrist works marks you, they will send ghost to you 24/7 talks to you invisibly, rapes you invisibly, practically explodes your mind, increases extremely high stress, makes you a drug addict, makes you very vulnerable, no employment, no friends, not allowed to do many things, everyone mocks you, it's worst than Jesus time, and ends up calling you a psychiatric term based on no proof but a set up including your family and friends, there is no proof in psychiatric world. It's based on nothing.</p>
43.	<p>I have had issues with three highly powerful people in the State of Victoria. A senior psychiatrist . A magistrate. And a highly prominent professor. All have held degrees from the University of Melbourne. None has shown any compassion understanding love knowledge empathy or achieving a just outcome within the confines of their expertise. All three of these powerful people have been vindictive totally unjust highly reactionary.all have had cushy jobs paid for by the Australian taxpayer .They have been given much but have contributed little to the society that has given them so much. Or given back to society a little appreciating their good fortune in life. Which others have not had.In revamping their courses Melbourne university must ensure that it produces graduates especially doctors and magistrates who are more compassionate and understanding towards those who have been given a life less fortunate than theirs. .Certainly better than my own personal experience has been with these people</p>
44.	<p>In 2017 I was put on anti depressant lexipro. It did not work for me, so I had it put up. From there led a complete manic episode for 1 month. Sex, binge drinking, hallucinations and false beliefs. I had my children taken from me. NOW in 2020 I have been diagnosed with rapid cycling bipolar. Anti depressants for people with bipolar are known to bring mania. I was a client to gov mental health (CAMHS) and nothing was even mentioned to me about bipolar. WHY!!! I was laughed at and scoffed at when bringing up bipolar and have suffered immensely due to mental health services SEVERAL misdiagnosis. And now that I am over 25 they have NO services to offer me!!! Someone should be held accountable for this!</p>
45.	<p>I am a University Student living at the Gold Coast aged 21 years with a diagnosis of ASD about to Graduate with a Diploma of Social Science as well as to undertake a Bachelor of Government and International Relations, therefore, I feel I am a credible neurodiverse voice to the Commission. I am writing regrettably about the broken state of the Mental Health system particularly in dealing with University Counselling Services. In my previous institution by which I am no longer a student at I was treated very rudely by my first Counsellor, she was cold, clinical, unempathetic and not understanding. This was despite disclosing my diagnoses. In addition, she pushed me in seeing another counsellor, I had concerns about repeating my story and how this would trigger me, etc. she 'fobbed' me off as 'you see different tutors/lecturers' which shocked me as unempathetic behaviour, how could a trained counsellor who was a Clinical Psychologist act in an unprofessional manner!. In confusion I contacted the University's Crisis Line for advice they put</p>

	<p>forward I would get a call from reception the next day. I didn't and this happened to me 3x times. I then complained which took for ever and it was a constant battle to find out my rights. I was then referred to a male counsellor as there was no other counsellor available at my campus again because one leaving and funding constraints. The next one was no better I was venting my frustrations with him in my tired and exhausted state from study, personal pressures on top having to fight for my rights which I tirelessly expressed to my new counsellor, he still kept acting as if I never told him as if he kept forgetting. Every time I would express myself he would sulk or look out the window or open his legs and tap his feet looking at the floor just saying ah ok ah ok like a malfunctioning robot, I wonder if this is because many in the profession particularly at Uni are stressed and overworked. In addition, waiting time were horrendous I had to wait 7 weeks and getting an appointment at a suitable time was very difficult. I feel this could be rectified with mandatory quotas as recommended by ANZSSA of 1 counsellor per 1,500 Students and with all counsellors working Mon-Fri 9-5 apparently no Institution including my current and former one meets these requirements. In addition I felt very vulnerable when one day due to my massive fatigue I was struggling to explain what was going on to this counsellor and he said your doing well, then I asked for reassurance via email and then he still missed the point on what I was saying and then he said 'I can see how you struggle with our sessions with ASD' This hurt my self-confidence and it was very sudden and I felt that as a person with ASD I had no right to just simply have a bad day feeling tired and stressed like a normal person and caused further confusion and stress he lacked empathy and compassion!. He should have said something like 'im sorry to hear that I know how you feel</p> <p>University Counselling services are abysmal I had to wait 7 weeks for an appointment first 5 then another 2 because of conflicting dates, I feel treated like the deserving poor you just got to take what there is. There is simply not enough counsellors employed in universities, as a result, waiting times are way too long and there is little choice and control because all counsellors work at scattered dates, e.g some on Mon, weds and Fri another Mon, tues and thurs. All counsellors should be employed at a full time mon-fri 9-5 pm basis to accommodate students who cannot come for the virtue on say not being able to come to campus that day or have class it's just unfair and ruins the whole point of a university counselling service really, we have classes and they should have services flexible to our timetable, not us having to be responsive to them. In addition, I think mandatory quotas such as the 1 counsellor per 1300 students as recommended by ANZSSA just how there is quotas regarding Aged care, nursing and physical health in general. it's unacceptable that mental health doesn't equally get the same amount of attention as say physical health.</p>
46.	I feel that the current 10 sessions are far from enough in fact I think it should be raised to 40 for everyone instead of for just so-called 'chronic and complex'

	<p>category I think that's stigmatizing to say well as your chronic and complex you get 40 discouraging people from getting help. This statement is backed up from the APS submission and the submission from the AASW. I also think the rebate needs to be increased to reduce the gap and allow more professionals both clinical and non-clinical should be covered under medicare including counselors, Psychotherapists. People should have the choice to edit their plan with a consultation with the GP as they please e.g. if circumstances change or become more complicated and switch between a single practitioner or a multi-disciplinary team if need be. the non-clinical staff that could be included possibly in a multi-disciplinary team should include housing officers, Indigenous cultural support officers, Advocates, Counsellors, AOD Workers, etc. I also believe people should have a choice to 'reset' their plan with a GP if things don't work out with the current counselor/therapist etc. e.g If one doesn't 'click' with their counselor. I believe this is essential because how would you feel if you are not getting on with someone and you cannot change in fear of your Medicare sessions running out. As a person with ASD, I feel this would help me and serve as a vital safety net when I have challenges in my life, Currently, I feel frustrated with the current mental health system it's broken because if it weren't for me accessing 2x counselors at University which is free by the way, I wouldn't have learned this thus this learning curve can be expensive for some. I feel as a consumer I should have the right to have freedom, choice, and control of my health! And I feel this is not possible under the current system, If I'm stuck with a counselor say halfway through my 10 sessions and I find it's not working out it's like 'oh well tough you have to see another one and pay for the rest when your other 5 runs out'. In addition, I feel to prevent cuts like this happening again when the government listened to experts like Dr. Patrick McGorry to cut the 18 sessions to 10 is too listen to the people as someone that has studied community development just simply relying on expert (although important to a degree) input in this case cutting the sessions, community consultation with consumers such as myself on a democratic and civil basis is essential, grassroots democracy by a consultant with the people on a local level is essential for policymaking some that need to be learned from this mistake and something the experts themselves need to be educated on. Another point to take home is I am not disabled by my disability but rather than societal constraints such as the mental health system also known as the social model of disability. This not just about me or people with ASD as I think everybody would benefit from this Reform</p>
47.	<p>As an adult the system took many, many years to diagnose that I lived with bipolar. I can see no way that small children can be correctly diagnosed. It is far more important that the focus be on teaching good parenting skills and supporting families.</p>
48.	<p>Assertive Outreach to be delivered to all mental health consumers I believe all mental health programs should deliver assertive outreach to all consumers. I have trouble engaging with providers because of my past experience with services. I</p>

	<p>have been strip searched, being the subject of verbal harassment from inpatient staff, experienced seclusion and weeks of restraint. I have had psychologists yell at me for coming to an appointment with no agenda, a mental health nurse from the MHNIP program had a go at me in the community saying he hates seeing my name, he thinks I am thought disordered and psychotic, a private psychiatrist from the Lawson Clinic told me not to ask for help. Other factors that impact on me maintaining contact with services are delusions, anxiety and depression. I feel as though I am not allowed to call clinicians and that I will get in trouble. This is an ongoing feeling and a thought process that impacts multiple parts of my life. I would like to see more mental health services delivered in people's homes, and in spaces outside of mental health offices, in places where individual people feel safe for example parks, shopping centres HASI and Resolve (Flourish Australia) offices. This will help people become comfortable in parts of the community they would like to participate in. Meeting outside of mental health offices will overcome any past trauma that have happened in mental health spaces. I would like to see assertive outreach extended to all people. That means that clinicians and mental health programs reach out to consumers by phone, email, sms and face to face contact. It is important to have a range of communication methods. I can write however what I say is limited, in face to face situations I can become anxious, I have a trauma history and sometimes people's faces move, I get distracted or I can't recognise people, for these reasons there needs to be a written communication system – using apps, email or sms to accompany face to face service delivery. While consumers have a choice to work with services, there are people like me who have had multiple hospital admissions and need clinical care to stay out of hospital. My experience is that GP's do not have the skill set to manage mental health. My mental health concern is currently psychosis, past diagnoses have included social anxiety, depression and bipolar disorder. I have had many GP's refuse to provide me with scripts. This burdens the resources of the police, ambulance and inpatient resources when I have been admitted for months at a time</p>
49.	<p>Guaranteed support by mental health services. I call on the mental health services to deliver contracted periods of guaranteed support including assertive outreach. For periods of 6 months at a time. Consumers should receive guaranteed support from mental health services without needing to be on a CTO. I was on a CTO with Penrith MH for 12 months, when this ended I was made voluntary and during a hospital admission told without warning nor any sort of follow up that I had been discharged from Penrith MH. I wasn't involved in any discharge planning conversations, which I need to be part of. During a previous admission I was referred to the assertive community treatment team, because I was told I needed more support after walking on the train tracks at night time. I went from needing more support than Penrith MH could provide to no support within a period of a couple of weeks. I believe I have been discharged from services prematurely and without alternative follow up on too many occasions. While people can take responsibility and be accountable for their own mental health, symptoms such as depression, anxiety, delusions, psychosis, past trauma can impact on engaging with</p>

	<p>the health system, and we need mental health services to agree to a period of definite support and provide assertive outreach to capture people whose mental health symptoms impact on how they can engage with mental health services</p>
50.	<p>It is extremely hard to access NDIS as someone with a mental health issue. I experience psychosis and have had significant trauma in my life – decades of family violence, childhood sexual abuse. Trauma within mental health services- strip searched, seclusion, restraint, verbal harassment by inpatient staff. I have trouble staying connected to clinicians due to past experience with services, thought disorder, anxiety and depression. I had 18 months of sporadic contact with a mental health nurse through the MHNIP program. He didn't fill in the NDIS form that he said he would. I didn't get access without his form. I don't have a GP that knows me well to fill in NDIS paperwork. After MHNIP my next support service was involuntary hospitalisation for 2 months, ending on a CTO x2 = 12 months in total. The CTO gave me a guaranteed period of support. I breached the CTO multiple times and was made a voluntary client with Penrith MH. During a hospital admission I was told that I had been discharged from Penrith MH with no warning, no alternative clinician. I was told that Penrith MH would apply for NDIS for me before I was discharged however, I was discharged before they applied. I am now left without a mental health clinician. I need a clinician to continue to be eligible for Resolve and HASI programs. I have seen many private psychologists and psychiatrists. Headspace Mt Druitt was fantastic, as was social worker VB at Penrith MH. The last psychiatrist I saw from the Lawson clinic private rooms asked me not to ask for help. The mental health nurse I was seeing had a go at me in the community saying he hated seeing my name, I was thought disordered and psychotic. I would have a better chance at staying in touch with providers if they provided assertive outreach and had written communication methods email and sms rather than just face to face contact and phone call contact. Social interaction, mobility and communication are elements of psychosocial disability that need accommodations when designing and delivering services. By assertive outreach, I mean for the clinician to contact the consumer, having phone conversations, sms and email contact. For face to face meetings to occur in consumer's homes, public spaces and where they are safe HASI and Resolve offices examples. This takes away the impact of past trauma that has happened in mental health spaces (Penrith MH offices, LikeMind office, inpatient unit, with the ACCESS team, in private psychologists and psychiatrists' offices). Assertive outreach is a way of moving forward with maintaining contact with the consumer that overrides delusions, trauma, depression and anxiety that can otherwise impact engagement with the service. All Resolve (Flourish Australia), HASI and community MH consumers should have support to apply to NDIS.</p>
51.	<p>As a parent and adult with previous 'mental health issues', I am concerned about 'prevention and early intervention', and what this really means. Childhood is filled to the brim with heightened emotions, peaks and falls, depression and jubilation. Children and teens are sensitive creatures, learning to navigate their way in the</p>

world, not to mention dealing with hormones, which can have TREMENDOUS effects on mood. This is, and always has been, part of growing up. I personally went through a heavy depression for almost a year at the age of 14. I didn't know what had hit me and had talked about suicide in my frustration and despair to understand why I felt so awful. My mum took me to see a GP, luckily he had the good sense to explain to me that hormonal changes at my age, and also friends and school were all probably contributing to my low state. He assured me that I would find a way through it, that it would pass and I would feel 'normal' again. Simply having someone understand and reassure me that I wouldn't feel that way forever helped immensely. And sure enough, a few months later, it lifted. I went through it again at the age of 20, though this time I found a good counsellor and talked through my fears and anxieties and learned strategies to cope when I felt overwhelmed. I haven't had another 'mental health problem' since (I'm now 40). What if that doctor I saw at 14 had prescribed psychiatric drugs with myriad side effects? I would never have worked through my problems - my mind would have been dulled for one thing, plus I would have then thought of myself as 'sick' - as if my mind was like a broken body part that relied on external intervention to mend it. I might have accepted the label of 'mentally ill' doled out to me by an adult in a position of power, and that might have stuck for life. HELP is one thing - therapy, talking, learning practical skills that empower a child or teen to guide their own thoughts and feelings. But the recommended 'help' from the medical community is often to medicate, which is unproven to work, and the side effects rendered are unpleasant at best, and horrific and fatal at worst. We do need more support for parents and their children facing tough times or confusing thoughts and emotions, but that support should never be drugs. I fear that if this bill passes, then we parents hand over some of our rights, that we may not get back. If my son - who is cheeky and a real character - is assessed at school by a wellbeing official who misinterprets and categorizes something in his personality as a mental illness trait, then will he be ordered by the government to take psychotropic drugs? Will I, who has known him all his life, have less say than a relative stranger with an agenda? We need to be very careful before we give away our power and then find ourselves in a position where we cannot get it back. Parents should always have the first and final say in all manners of mental health when it comes to their children.