

## **Submission to the Productivity Commission Review of the National Mental Health and Suicide Prevention Agreement, July 2025**

I appreciate the work completed so far to review the National Mental Health and Suicide Prevention Agreement. As a parent of children involved in the mental health system, I can see the gaps and problems and want this system improved.

My 14 year old daughter died by suicide in February, and I have no doubt this was preventable had we been able to receive reasonable care and if we, as her parents, were considered valuable partners in her treatment.

My younger sons are now suffering and receiving treatment as part of this system. We still hit roadblocks and problems that simply should not exist.

I did not have the opportunity to participate in this review process earlier so have shared some of my experiences below in the hope that it can bring about positive change.

I completely agree that integrating lived and living experience is integral to the next agreement.

### **Excluding parents from their child's care**

While I see much discussion about parents and carers being excluded from their loved one's adult care, this also happens with children under 18.

Our daughter was just 13 when we first were in contact with Austin Health and Headspace. She always gave permission when asked to share information with us (as her parents), and we did not realise permission was required.

We received her medical records after she died and only knew about 10% of the content. We were never told she was suicidal, despite her consistently being rated as a moderate risk of suicide and sometimes higher.

We were not told she had previously attempted suicide. We did not know the methods she was considering so we could be extra vigilant. The day before she died, she told her caseworker exactly how she would do it and told him to tell me, but he did not.

We could not protect her without this knowledge.

She also repeatedly told her carers that she couldn't talk to us because she didn't think we would understand. She would have thought they were telling us, since she gave permission and was talking about self-harm and suicide, which would have increased her feelings that we didn't understand.

When we weren't told how bad her situation was, we thought it was because she was getting better and not suicidal.

We talked to so many mental health professionals throughout the 9 months we dealt with this system and not one person was honest about how our daughter was feeling. It seems systemic not to talk to parents of children in suicidal crisis. It would not take more funding to talk to parents honestly.

**Recommendations:** Children should not be treated like adults in this system. Parents should have the full picture of what their kids are experiencing. The word “suicidal” should not be avoided. Symptoms should be clearly described to carers as well as what is an escalation that should be concerning. There should be a realisation that if mental health professionals don’t be honest, carers can assume their loved one is ok when they are not.

### **No support in understanding our daughter’s condition**

What we were told was not explained sufficiently. We were told we were lucky she didn’t have schizophrenia and “just” had depression. Depression was not described. I have not had any experience of depression and thought it meant that she was sad.

We were also told she had negative self-talk and this was normal in depression. I found out from her medical records that by negative self-talk, they meant aural and visual hallucinations that incredibly disturbed her. She saw spiders on her body and heard voices detailing exactly how to kill herself. We were not told this. I thought it meant things like thinking you are fat when you are look in the mirror.

All of this minimised her condition and meant we couldn’t support her appropriately.

The Mental Health and Wellbeing Act 2022 has a family and carers principle that families of a person receiving mental health and wellbeing services are to be supported in their role in decisions about the person’s assessment, treatment and recovery. This did not happen.

We had to make medical and safety decisions for her without knowing the extent of her condition.

**Recommendations:** Help carers look after their loved ones. We didn’t know what to ask or do to support our daughter. Further, we were overwhelmed and didn’t know how to ask this of her clinicians in their language so they would help. Have frank discussions with carers.

### **Long assessment periods that lead nowhere**

We first sought crisis help for our daughter on 30 April 2024. Headspace quickly escalated her to Austin Health as they said she was too high risk for them.

This assessment process took a couple of months. After her first meeting, they even rated her as “moderate to high suicide risk” and quote, “continuous monitoring of her safety is critical”, but didn’t see her for another month and didn’t tell us so we could protect her.

At the end of the assessment process, the recommendation in her medical records was, quote, "a combination of individual therapy, family counselling and psychiatric oversight... Continuous monitoring of her safety is critical due to her history of suicidal ideation and non-suicidal self injury". But the

outcome – “one family session”. This is all we were offered. No one told us more was recommended or that she needed anything else.

We were then referred back to Headspace when we pushed for more help. This took two more months before someone was available to talk to her.

Our daughter thought the delays and no real help offered meant no one believed her in the assessment process. During this time, she could also not talk to Kids Helpline anymore as she was considered too high risk. They had been her outlet before.

She had also been told by the assessment team that they saw her and they would help her. They shouldn't have promised something they couldn't deliver. It further degraded her mental state.

Five months passed before she could get into a counsellor and at this point, she had given up that anyone could help.

This illustrates how a big part of the mental health system seems to be missing. She was too high risk for any services but the hospital units, and they didn't accept her. We were left with no help. And no one told us the severity of her condition and how much she needed help. We thought no one helped because she was doing ok.

Help at this point may have stopped her needing hospitalisation in January and from acting on her suicidal ideation.

**Recommendations:** Having four assessment sessions over a few months that recommend a lot of help but give none is a waste of resources and can damage the mental health further of a young person. It would be more useful to use those sessions to help the suffering person and educate their family on how to help them. If hospital units are not going to follow through on recommendations, they should at least tell them to the families so they can seek help elsewhere.

### **No continuity of care**

My daughter was in the youth mental health unit for 9 days and saw a different psychiatrist just about every day. They would want her to tell her story from the beginning. She told me and her case worker how she was sick of doing this.

How can young people grow trust with a psychiatrist when it is always someone different? Plus, they never progressed to get to know her better as she always had to start again.

**Recommendations:** Place a priority on continuity of care and seeing the same psychiatrist. If this is impossible, at least handover notes and don't make the young person start again with their story.

### **Unwillingness to look at anything beyond depression**

We believe strongly our daughter had ADHD and were in the process of getting this diagnosed when she was admitted to the inpatient unit. However, the psychiatrists at the hospital, despite believing getting this diagnose under control could relieve her problems, would not look into this.

**Recommendations:** These conditions should not be looked at separately by different health professionals who aren't communicating. Mental health units should be able to look into neurodivergence as well.

### **Ongoing care was vastly insufficient**

No one saw us between the one family session we had in August and when our daughter was admitted in late January.

Once she was discharged from hospital, we didn't get the promised level of care either. They did not do the promised parent sessions and did not see her within 72 hours as per regulations.

The only safety plan we were given was things like "if your heart beats fast, have a bath". There was nothing for my husband and myself and that is insufficient for a suicidal 14 year old.

Our talk on discharge was about getting her back to school rather than keeping her safe. We should have been told to watch her every minute until the medicine had a chance to work.

After our first visit after discharge with our newest caseworker, I asked to come in again sooner a couple of days later but was told we couldn't. The next week we saw her newest psychiatrist and case worker the day before she died. I told them it was worse, she wasn't going to school as planned and had stopped eating. Everything was dismissed.

After I left the room, she told her caseworker how she would kill herself and gave him permission to tell me. Nothing was done.

**Recommendations:** Sit with the family. Understand their situation as well as the child's individual needs and come up with a detailed in-depth plan for kids identified as suicidal. School shouldn't be a general recommendation for a terrified teen who is being bullied and unsafe there. The parents should have a plan too with clear guidelines on when to escalate that will be taken seriously by other mental health professionals. When the parent talks to caseworkers, etc, they shouldn't be dismissed.