

## **SUBMISSION TO THE PRODUCTIVITY COMMISSION: MENTAL HEALTH AND SUICIDE PREVENTION AGREEMENT REVIEW 2025**

I welcome the opportunity to contribute to the Productivity Commission's review of the current Mental Health and Suicide Prevention Agreement. I write today as someone with an extensive lived experience of mental ill-health, having navigated depression, anxiety, autism, addiction and disordered eating. Having lived in both Queensland and Victoria, I offer insight as someone who has accessed clinical services as well as community or peer-led services across two states. I, like many others with a personal lived experience of mental ill-health, hold experience in supporting those in my immediate community, which at times included providing first aid and post self-harm or suicide attempt care. Determined to utilise my lived experience within community, I now provide peer support through my volunteer role with Roses in the Ocean Peer Care Companion Warmline. Alongside my lived experience, I am currently studying a Certificate IV in Mental Health and various holistic modalities such as breath work from a trauma-informed perspective.

My submission reflects not only my personal experience but draws on community observations and professional insight and is offered in the hope of contributing to a more comprehensive, accessible and effective mental health and suicide prevention system. Importantly, I would like to contest the statistics of Australian citizens living with mental ill health. Currently we report that one in five people in Australia is living with mental ill health. Due to the lack of information regarding symptoms for the various mental illness, I know that those numbers are incorrect. Many people in my immediate community don't recognise every day challenges as mental ill health as "everyone thinks or feels like this". As a society, we are deeply unaware of how to recognise the symptoms of mental ill health until it's too late. Something I have witnessed in my own family after losing my uncle to suicide in 2023 and shock ricocheting through my family because no one suspected he was struggling. Often when someone is lost to suicide, we say no one knew they were struggling but I think what is more accurate to say is no one knew the warning signs, how to recognise them or what to do if we noticed them.

Drawing on the lived experience of not just myself, but those around me, I can confidently say there are key issues creating gaps in the mental health care and suicide prevention that Australian's are able to access. These key issues include access to services, integration & continuity of care, crisis support & suicide prevention, trauma-informed & culturally safe care and peer support & the lived-experience workforce. Details of the limitations of each issue are as follows;

### **Access to Services**

In 2022, I had to exclusively rely on my immediate community and community organisations such as Lifeline and the Butterfly Foundation, to support me through a high-risk time while awaiting appointment with my general practitioner to access anti-depressant medication. I faced a 2-3 week wait whilst living with constant suicidal ideation and being at a deeply concerning body weight due to my anorexia. The wait time for an available appointment with my general practitioner was so long that at times I was scared I wouldn't make it and had to resort to friends taking shifts at my apartment so that I wasn't alone. During this time I repeatedly accessed Lifeline and Butterfly Foundation support services to an extent that I was advised I could only have 30min support windows due to the frequency of which I had accessed these services. Additionally, there were times where Lifeline's text service (something I was restricted to using as calling was beyond my capabilities at the time), had wait times of over two hours. As Victoria was still recovering from

COVID and the immense toll on hospitals, I couldn't get hospital support despite knowing how high my risk of suicide was. To this day, I cannot thank the friends who gave up their time to be with me and supervise me until I could access the limited clinical support available. After several weeks of living under constant supervision but untrained family and friends, I finally saw my GP and was able to get back onto medication and access therapeutic support.

### **Integration and Continuity of Care:**

Having accessed both clinical and community services for support, the gap between the two is cavernous. To this day, I still have not had community service recommendation whilst accessing clinical services. In my volunteer role as suicide support with Roses in the Ocean, I speak with people from all across the country at a loss for where to turn because the clinical and emergency spaces we have and are encouraged to access are not capable of care for a variety of reasons. People are turned away from hospital emergency rooms across the country because they present knowing the danger they are to themselves. As they have not caused harm already, they are dismissed, quite often accused of faking or brushed aside as not being "enough" of an emergency. This is common knowledge in the mental ill-health community and contributes to people shouldering their symptoms and conditions and suffering in silence. For this reason, I heavily contest the statistic the 1 in 5 Australian's are living with mental ill-health. The number is far higher as many are not informed on what mental ill-health looks like. Whilst we have societally come so far around our discussions of mental ill-health, our emergency and clinical systems still carry strong undertones of institutional approach.

### **Crisis Support and Suicide Prevention:**

The current capabilities of emergency services and hospitals deeply requires change. In 2023, my housemate self-harmed. I was the first on the scene and performed emergency first aid whilst on the phone with 000. The 000 operator I spoke with didn't provide a safe space on the call and was condescending in the way help was advised. The situation involved heavily intoxicated people (myself included) and we were advised that the wait for an ambulance would be a minimum of three hours and that we should put my housemate in a car and drive them to the nearest emergency room. I had six intoxicated people in an apartment, one of those people on the floor with their ankle bandage, blood everywhere and the advice given left me feeling stranded. Even when we're hurt and bleeding, we're the ones who have to fix the situation because no one is coming to help us. Thankfully, we found someone to drive my housemate.

At this time, my housemate had an extensive history of mental ill-health, self-harm and previous attempts on their life. When they were at the hospital, they were provided first-aid care for the self-inflicted wound and sent home within a few hours. There was no recommendation to visit a general practitioner and no referral for mental health support, just some pain killers for the discomfort over the coming days.

### **Trauma-Informed and Culturally Safe Care:**

Whilst not experienced personally, I would like to raise concerns about barriers accessing mental health services that are culturally safe and trauma informed. As a white Australian born to white Australian parents, barriers I have experienced in accessing adequate mental ill-health support are limited to financial or service based limitations. I recognise that there are many other hurdles in accessing care and more importantly feeling like care is accessible. I am glad to have learned of many community organisations that are upholding culturally safe care standards and implore the new agreement to include considerations on how clinical services are able to improve the culturally

informed position to their care. With this said, our First Nations and Torres Strait Islander people deserve mental health support that reflects their cultural practices and moves away from heavy clinical recommendations. It's not just a matter of improving funding but improving awareness of organisations. Many people don't reach out because they think the only option is a doctor or a psychologist; we need to improve the safety around accessing support and this includes being more culturally informed and appropriate in care.

### **Peer Support and Lived Experience Workforce:**

As a positive, I would like to commend the peer support and lived experience workforce across Australia. This is an area where I have seen the most effect when receiving care, support or recommendation. Unfortunately, information about all of the unique and specific organisations, the care, support and help they provide is extremely difficult to find. As part of my studies, we are encouraged to start compiling our own list of services that we can refer to when working with the public. This has left me wondering why we don't have a State or Nationally available list of organisations, their contact details and what pocket of the community they service. If there is a comprehensive list, I haven't been able to find one. As we stare down a severe mental health epidemic, we need resources and more importantly, easily searchable or recommended resources. Additionally, the funding available to lived experience organisations needs to be addressed. We know the clinical approach alone cannot cope with the demands from the public for mental health support and it's arguable that the lived experience space provides support that clinical roles are unable to.

Whilst many may argue more funding is required and perhaps it is, I believe awareness and education is a crucial step in addressing the mental health crisis Australian's are facing. For this reason, the recommendations towards improvement of the mental health framework in Australia are as follows;

### **1. Early Education on Recognising Mental Ill-Health**

In this recommendation, I draw upon lived experience from my childhood, specifically the first time I self-harmed. It wasn't in response to a life event or because my mental health had become particularly unbearable. The first time I self-harmed, whilst admittedly in a low, was because I thought it was just as much a part of growing up as getting my period, having my first kiss or experiencing my first heart break. As a child, I genuinely believed that it was something everyone "went through". In adulthood, I've learned that not only is this not true but there are also people who never have those thoughts. It's through connecting with friends and my partner that I've learned how unique (in my immediate community) these thoughts are. Which immediately told me we need education in schools about recognising changes in mental health.

Important to note here, is that it's not just education on the names of conditions and what they can feel like to experience. We need to also be providing education on how to talk about these issues

within our community, how to approach people we feel may be of risk and what avenues of support are available.

I recognise the fear of inputting thoughts like this into the minds of children and for that reason I believe lived experience peer workers are a huge asset in providing community education on what it's like to live with mental ill health, how to recognise it, when to speak up and where to get help or support. I believe that by educating early in life we can reduce the severity to which people suffer with mental ill health and strengthen the response when people recognise symptoms. Education and understanding are also major contributors to reducing stigma. Although very advanced by historical standards, we are not that far removed from mental institution language and this reinforces the stigma felt within community. People are not crazy - they are doing their best to live with conditions that people are still deeply uncomfortable talking about.

## **2. Improved Support, Funding and Awareness for the Lived Experience Workforce**

In this recommendation, I draw upon my lived experience of improved understanding and acceptance of my different living requirements as someone with diagnosed mental ill-health. After many years pursuing clinical methods of support and/or treatment for my conditions, I have only found maintainable improvement to be achievable through connecting with lived experience avenues. It was talking with people who have lived experience that allowed me to change how I view the conditions I live with and the expectations I place upon the rest of my life as a result. Volunteering in suicide support has granted me opportunity to speak with people from all over the country and I hear in their stories as well, how there are undertones of achieving a "normal" life once they are no longer "ill" with their condition. For many people living with mental ill health this is a life long condition that doesn't require treatment but management. Lived experience allows people to see how possible it is to not just live but be successful in life despite a diagnosis.

Clinical spaces would benefit from uniting with the lived experience space to provide comprehensive care. Where clinical spaces cannot utilise the expertise of lived experience persons or organisations, I believe there is a duty of care to inform patients of the appropriate organisations available for support. This relates back to the State/Territory or National recommendation for a comprehensive list of community organisations and could be a crucial step in changing the way people living with mental ill-health receive post appointment support and care.

## **3. Improved Cultural Safety and Trauma-Informed practice in clinical services**

An area that I believe many community organisations succeed in is their recognition of cultural diversity. However, where clinical treatment is required, the clinical framework creates many barriers in accessing care. As a white Australian, born to white Australian parents, I can admit to not accessing services for fear of discrimination; based on my personal experiences or the experience of someone I know directly. I don't possess cultural barriers to accessing clinical care but many citizens do. The statistics of First Nations people being lost to mental ill health and suicide is continuing to increase due to a distrust of clinical services and a lack of comfortability due to their non-existent consideration to cultural values and developing care plans for individuals. Trauma informed care includes recognising the ongoing impacts of colonisation on the mental health of First Nations people and recognising that clinical frameworks echo this colonisation tone and create perceived barriers in accessing care. In this regard, clinical care and support needs to be addressed in a way that makes access feel possible to First Nations people. As a white Australian, I

don't possess the suggestions for rectifying this enormous issue but encourage the Commission to liaise with Indigenous community on how to make mental health support more accessible.

#### **4. Collaboration between services: A United Front-Line**

A final suggestion towards the improvement of mental health support in our country is to bring unity or at least deeper collaboration between clinical and community/peer led/lived experience support services. Let's take the real world insight of people living with mental ill-health, their experiences in accessing clinical care services at all levels and allow that to highlight the areas upon which we need improvement. Do we need diversity in our general practice practitioners? Do we need to see specialty Mental Health General Practitioners established in medical practices across the country? I believe we do. All general practitioners know of mental health conditions but do they understand them enough to provide efficient next steps and recommendations? Can community organisations be part of the treatment plan and provide an intermediate support between GP and psychologist or psychiatrist? An effective mental health management plan should include recommendations of community organisations to go to or reach out as this can ease the strain on emergency services during the extensive wait times between clinical steps.

I would like to acknowledge the enormous task of addressing the mental health system in Australia and recognise the insurmountable number of problem areas due to the overlapping intersections of criteria both from a framework position and from a community demand position. With that said, I think this specifically highlights the issues that we are facing; clinical frameworks are not coping with the demand and are also not informed to provide adequate care. This is where community organisations and the lived experience workforce is making change. The lived experience workforce will tell you that connection is the key to resolving the mental health crisis Australia is facing. So how do we build connection that allows for true support, care and management of these conditions majority of Australian's are living with? Community. We prevent isolation by providing education early on and recommending community services as intermediate steps in the clinical framework. We listen to the voices of those with lived experience who can identify the gaps in our clinical treatment system. We listen to those working in the clinical system and how the current framework prevents them from providing a standard of care that adheres to their professional care commitment.

I would like to thank the Commission for taking time to hear from the community and hope that this review leads to structural and cultural improvements across the mental health and suicide prevention sectors. I welcome future opportunity to collaborate with the Commission and be a part of the conversation to improve mental health care and support in Australia. We don't have two years to wait for the system to be reviewed and new frameworks implemented. We're losing people daily and the answers for how to fix are here already. Not more policy or review. The answers are in community.

Sincerely,