Productivity Commission
Inquiry into Mental Health

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

Comments from other interested persons

1.	[LIVED EXPERIENCE, SUICIDE BEREAVED AND SERVICE USER]
	Suicide is a public health problem that kills over 3000 people in Australia every year (ABS, 2017). For every suicide death approximately 20 other people will attempt (SPA, 2017). In Queensland 804 deaths were recorded in the recent ABS data collection (released 2018). Resulting in Queensland being one of the highest states for suicide deaths in Australia. Compared to other states, Queensland receives minimal funding. $9.6million has been allocated to Queensland for their Suicide Prevention in Health Services Initiative. In contrast NSW recently announced similar funding totally over $90 million. Given these alarming statistics and being both a bereaved mother who's son suicided in 2014 and a consumer of services since his death, more financial support and attention is required for Queensland Government to fund and direct service provision to those who need it most. More alternate models of care are needed to ensure people do not feel stigmatised when presenting in an emergency department and more funding for the provision of training is required for clinicians, gps, allied health professionals and university students embarking on these careers to ensure they are confident and competent when assessing, managing and supporting those who attempt to suicide and those bereaved by suicide is required. Following my sons death, I have completed a Masters in Suicidology and am currently doing a Ph.D in suicide. I have made it my life's work to research, develop and drive future suicide prevention approaches and agenda that would significantly benefit in more funding. I hope that Queensland continues to move forward and the Commonwealth revisit current funding arrangements with Queensland in order to reduce suicide in this state
2.	[TEACHER]
	After experiencing intimidation and bullying I followed the DoE's complaints procedures and found that my word was of no value when matched with that of my manager. Not only that they change the process to suit themselves. None of my named witnesses were contacted and only the word of the manager was of value. Lies were told by him and I had nowhere to go. My experience resulted in me having a breakdown. There should be an independent complaints assessor. At present the DoE is a law unto itself because it

	investigates itself! Victims are left with nowhere to turn. Secrecy and lies are rife. Did you know they have a new word for lies now, its a misunderstanding.
3.	[EDUCATOR AND COACH]

From twenty years of providing mental health education in the workplace and associated interventions I feel that the availability of highly skilled insightful mental health professionals who truly listen and help their clients is woefully inadequate. My job is to tell people that they can get help and that the help is effective. But my experience is that the professionals often compound the problems even contributing to suicidal ideation. Let's face it - if you are told that "the answer is to seek help" and when you do seek help the intervention is no better than that which you can get from online self help resources then that only leaves one option...an end to the pain. We need a systemic approach that goes beyond the clunky CBT and ACT and just have grateful thoughts and be mindful approaches. There are already a lot of very smart people suffering the seeds of mental health disorders...that can read and try these approaches. They don't need patronising lectures from practitioners on what they should be doing. They need a more comprehensive approach that creates an environment for a mentally healthy lifestyle and existing in a mentally healthy world (not sure how you do that in a world where the key influencers corrupt and are spruiking hate and driven by greed) I've yet to meet a practitioner who can provide this help for anyone other than those who totally lack insight; and haven't bothered reading up on all the self help material available on line. The majority of practitioners I've personally engaged with are wedded to their theory and listen only FOR information from the client that reinforces their theory and then pretty much deliver clunky one size fits all advice; regardless of whether the client has the capacity to use and apply that theory. Rather than listening TO what's really happening for this client and developing a doable strategy. I really believe that this approach; along with counsellors who deliver nothing but tea and sympathy- there by reinforcing the client's "I'm a victim" state do more harm than good. They contribute to the burgeoning suicide statistics rather than alleviate them. Right now the "you should seek help" advice is no more than box ticking to absolve ourselves of guilt and quell our frustrations with this person and the fact that they're not "normal" ie see the world the way we do. It's often the low hanging fruit that gets help. The smarter, harder to help, are labelled as "resistant" and put in the "too hard basket" |
| 4. | [OTHER – UNSPECIFIED]

I would like to highlight to the Committee a professional group who have been identified as a high risk group for poor mental health - veterinarians. The suicide rate amongst Australian veterinarians is four times that of the general population. On average, a veterinarian commits suicide every 12 weeks. I am a veterinarian and have lost colleagues to suicide. The mental health of veterinarians matters; it matters for each individual, their friends and family, their workplace, their patients, the communities they support and the industries they serve. Ensuring good mental health in veterinarians also benefits society and the economy. There are >11,000 registered veterinarians in Australia working across numerous sectors, directly contributing hundreds of millions to gross domestic product |

and supporting major sectors including agriculture, health and education. In order to effectively serve society in these roles, veterinarians need to be supported to maintain good mental health. There are various factors which influence veterinary mental health, many of which may be improved by policy and funding investments by veterinary schools, veterinary employers, professional groups and state and federal governments. Veterinary schools must ensure support for good mental health begins from day one. Many new graduates are thrown in the deep end without adequate psychological preparation. Veterinary employers should instigate workplace mental health strategies including Employee Assistance Programs to access psychological support and address factors such as overwork, grief and compassion fatigue. Ongoing support from the AVA such as a counselling hotline and student mentorship program are steps in the right direction. However, funding is needed to ensure all vets not only new graduates and/or AVA members, have access to support services. For example, funding for charities such as Australian Veterinary Mental Health Awareness and Suicide Prevention could help provide mental health support for more veterinarians. At a state government level, there has been some investment in veterinary mental health. For example, in 2014 the WA state government awarded a grant to the Australian Veterinary Association (AVA) WA Division to conduct a suicide prevention program. Further investment is required to ensure programs like this continue and grow. At a federal government level, university funding cuts have left some veterinarians with crippling lifetime debt as a product of university loans (as well as costs associated with compulsory extramural placements) that far outweigh earning potential. Financial stress has been identified as major a contributing factor to poor mental health. Policy and funding changes could ease veterinarians' lifetime financial stress, which on top of other personal and work related stressors can tip people over the edge. I urge the Committee to highlight the veterinary mental health crisis as an issue that requires urgent attention.

| 5. | [OTHER – UNSPECIFIED] |
| | In 2016 I became ill with a virus, it lasted two weeks. When I felt a little better I went to see a doctor, he suggested blood test. I received a phone call asking me to come in. Apparently my potassium was at 2.6. It's low but not excessively. I was 70kg so not exactly thin. I was weak from being ill for two weeks. The doctor said I had to go to sunshine hospital. I told him I would go home and take potassium tablet. He would not let me go. At this stage I must add I had been and have been harassed online person for a long time. I was forced to stay at the clinic against my wishes. An ambulance was summoned. They checked my heart and said the readings were normal. The doctor kept insisting they had to take me to sunshine hospital. The ambulance crew said they were not able to as I didn't want to go. The doctor was forcing the ambulance crew. The ambulance crew asked my name, were I lived, what day it was, I answered each question, said legally they were not allowed to. The doctor wrote a mental health order whereby forcing me. I never found out what had caused my fever for two weeks. I was forced to go to sunshine where strangely enough a file had already been created. Sunshine hospital against my wishes, potassium started being injected into my body. I told them about the stalking, how the blood tests were tampered with. They kept pouring potassium into my body. Then within ten minutes |

	of seeing a psychiatrist he said I had schizophrenia, ten minutes. Both initial doctor and psychiatrist were Indian. Yes there is a reason I state this. It got worse from there. I was kept in for 6 weeks for what reason you tell me. I hadn't hurt anyone, I hadn't tried to hurt anyone else. Intact people who had committed suicide were kept for a week.
6.	[USER AND SERVICE PROVIDER] Why do you not analyse by sex? Women have vastly different causes and treatment outcomes of mental injuries - mostly acquired from male violence of different types. Most service deliverers are not trained in the complex dynamics of male violence in different contexts - so immediately women and children are systemically victim blamed by being labelled as mentally ill when their injuries are contextual to violence. The mental injuries were acquired as a result of male violence. The perpetrators and their acts of violence and coercion that caused the injuries are disappeared. The medical profession doesn't have enough women making policy who understand the systemic. disadvantage women are subjected to for example lack of safe, secure, dignified, fit fur purpose affordable social housing. Women cant leave abuse if there is nowhere to go to - the longer they stay the more mentally and physically ill they get. To stop the increase in mental illness let women leave earlier. And make sure women get what they need to get back on their feet - not be subjected to more abuse at the hands of weaponised welfare and mental health service delivery. Women aren't the problem - male violence is - put that at the centre of all your analysis- for example have all the commissioners attended specialist intimate partner violence training? Language is imperative. Also drug companies don't analyse nor consistently capture sex based differences to medication - many traumatised women can't tolerate recommended pharmacological solutions (drugs). So what treatment is effective for them? Why can't we leverage the successful clinical trials from say the USA where medical MDMA has been labelled a breakthrough therapy because of the amazing results in treating PTSD especially in traumatised women (80% success rate ie symptom free). Why do we have to replicate trials here rather than review the existing evidence from the USA. Why do defence vets get preferential treatment over women victims of DV? Is the mental health profession guilty of protecting its vested interest in keeping people in treatment rather than adopting user-focused solutions? How do you intend to centre sex based differences in your inquiry and how do you know the right questions to focus upon if you aren't asking the right questions? Are women survivors directly involved in signing off your approach? Never never forget women's experiences are very different from men's and often not listened to nor acknowledged.
7.	[FORMER CARER OF PERSON WITH MENTAL ILLNESS (died by suicide)] It is close to impossible to care for a person with a mental illness, and continue to work long term, as "service" providers overly focus on privacy, not the safety and welfare, or recovery of the person. Hence carers and families need to be at home, and probably become hyper vigilant, with or without reason. Extremely tiring to keep this up long term. Services fail to communicate with carer and family about treatment, or lack of treatment. Levels of stress and distress eventually make work impossible. Mental health services do NOT provide support. They play God with client's lives, ignore family and carer and all concerns raised. Hence clients often suicide and families are left devastated, because services fail to intervene when the alarm is raised. Carer and family can not act, as they don't have current information, hence have no idea what is going on. Mental health clients

	often believe they are fine, when in reality, they are NOT. There are NO mandatory qualifications for those employed in mental health services, and no accountability for their decision making. They should be prosecuted for failures in Duty Of Care, the same as OHS prosecutions or culpable death in the case of road deaths
8.	[PERSON FORCIBLY ON THE MENTAL HEALTH ACT] Under the mental health act people are forced to be subjected to drug taking despite the wish not to. Rather opting for a therapeutic therapy such as music lessons, physical activity a t to stimulate the pleasure centres, supressing all signs of depression or the need to escape reality living in delusion. In most cases drug recipients are more susceptible to illness than if not on the drug, and at risk of dependence. Not to mention the lack of uninforceability due to the act itself being illegal.
9.	[A PERSON LIVING WITH MENTAL ILLNESS] Barriers to Gaining Employment In Western Australia the WA State Government's online jobs application form requires prospective job applicants with a disability, including mental illness, to answer the following questions (as copied from a job advertised for the WA Department of Justice): 11. To the best of your knowledge and belief, are you of sound health? 12. If you are not of sound health, please provide details. 13. Have you ever made a claim(s) for Workers' Compensation? [noting most claims relate to a disability as defined under State and Commonwealth discrimination laws.] 14. Is the claim still current? 15. Please provide details. The form also states that "declarations are NOT a barrier to being considered for employment but will assist us to take due care in assessing appropriate placement should you be the successful applicant." However, I understand this information is provided to the selection panel for its consideration during the competitive part of the selection process. It is now well established that a very large proportion of employers in Australia and other OECD countries will not employ people known to have a mental health condition. This includes a significant body of survey evidence which shows MORE THAN HALF of all employers would not employ a person with a mental health condition. Relevant references include: 1. Department of Education, Employment and Workplace Relations, Employer attitudes to employing people with mental illness, September 2008 Extract: Employers' responses indicate that a minority of employers (one fifth or fewer) would be willing to give people with schizophrenia, psychosis or addiction problems an employment opportunity. About twice as many would be willing to consider employing a person experiencing anxiety or depression. 2. Rethink Mental Illness (UK). New survey shows people with mental illness face 'locked door' from employers. 27 July 2017 3. ABS 4430.0 - Disability, Ageing and Carers, Australia: Summary of Findings, 2015. Extract: In 2015, one in four (25.0%) people aged 15 to 64 years with psychosocial disability (living in households) were employed, compared with just over half (57.3%) of people of the same age with a disability other than psychosocial, and 78.8% of people without disability. 4. AHRC, Willing to Work: National Inquiry into Employment Discrimination Against Older Australians and Australians with Disability, 2016. 5. Waghorn, G. & Lloyd, C. (2005). The employment of people with mental illness. Australian e-Journal for the Advancement of Mental Health, 4(2), Supplement. 6. Paul Farmer and Dennis Stevenson 'Thriving at work: The Stevenson Farmer review of mental health and employers', October 2017 7. House of Commons (2018). People with disabilities in Employment, Briefing Paper Number 7540. London: The Stationary Office.

10.	[RESEARCHER AND PRIVATE MENTAL HEALTH ADVOCATE] I wish to ask, openly, how will the Productivity Commission manage the conflicts of interest in terms of: 1. Professor Harvey Whiteford's long and central role in the formulation of mental health policy to the Commonwealth (notably to the Dept of Health, Dept of Immigration and others), Federal Ministers and state and territory governments This has extended over the period of the National Mental Health Policy and across four of the five national plans, and includes the provision of contracted consultancy services to the Commonwealth, the receipt of grants and other funds over many years including in the most recent financial year. Prime facie, Professor Whiteford has had a constant presence in relation to mental health policy and strategy. How will this be managed? 2. How will the Commission deal with conflicts of interest by other parties (including myself) - will there be an obligation for all submissions to declare conflicts, real or perceived and how will these be assessed? Will these be published or remain privy only to the Commission? I raise these issues in the interest of the integrity fo the Inquiry and the Commission and in the interests of community confidence in the findings from the Inquiry. This comment can be published with my name in full by the Commission.
11.	[DISCRIMINATED AGAINST] I once worked at the Royal Park Psychiatric Hospital Parkville as a ward assistant. I was induced on false pretences to contact the Psychiatrist Superintendent of Royal Park Psychiatric Hospital on the basis that he was interested in me and wanted to help me. When I entered the Psychiatrist superintendent's office at Royal Park Psychiatric Hospital in the Presence of two nurses the Psychiatrist Superintendent Proceeded to denigrate threaten and intimidate me. Subsequent to this event He sent me a Written letter stating that it was his clear intention to ensure that I had Trouble with Victoria Police. And he was going to do everything in his power to ensure that this eventuated. And that I would eventually be in trouble with Victoria Police. Following this letter he sent police to my home and had me locked up at Mont Park Hospital.
12.	[DISCRIMINATED AGAINST] I worked as a tram conductor on Melbourne trams for 9.5 years. On the 11th of APRIL 1988 at 616 Collins street Melbourne I asked the union then ATMOEA Australian Tramways and Omnibus Employees Association for assistance. Then Secretary of the Union stated he and the union were not prepared to help me as I was perceived to Suffer From MENTAL ILLNESS. Doors Closed no help or representation from the Union of which I was a member for 9.5 years. Why? because I was mentally ill. A racist and discriminatory. The nature of the assistance sought was for the union to negotiate a dropping of charges brought by the Metropolitan Transit Authority. The Patrol division of the Metropolitan transit authority. [PSYCHIATRIC ABUSE] Mental illness and the unions .i was employed as a tram conductor for over 9.5 years. due to receiving several death threats I suffered stress and anxiety.an incident occurred on special tram zoo special on 10th April 1988.when I asked my union the ATMOEA tramways union its then secretary refused on the basis that the union believed that I was mentally ill. this is totally unacceptable.

	[PSYCHIATRIC ABUSE] I believe the state of Victoria and its judicial system heavily discriminates against people with mental illness. the Victorian courts are a relic of the past and do not fulfil their role in a way that reflects modern Australian society. i was fined $800 and a criminal record even though i had served 9.5 years as a tram conductor. this is injustice to an extreme.in Victoria we have a criminal injustice system not a criminal justice system. its magistrates live in the past and are not au fair with realities of modern Australia they are also racist. had I been a white Anglo I am sure the penalty would have been less. [PSYCHIATRIC ABUSE] The state of Victoria needs to decolonize. when I think of the state of Victoria what I am really thinking is that I still live in the colony of Victoria not a modern state of Australia. its magistrates are a relic of the past, they read and apply black letter law rather than taking into account the realities of modern life in this state. its justice system would have to rate as one of the most backward and outmoded in the world. [PSYCHIATRIC ABUSE] Obviously the magistrate who gave me a hefty and severe penalty of $800 and a criminal record while working as a tram conductor has never been in a position of having to get up at 4am in the morning to serve the public .i worked my guts out for 9;5 years as a tram conductor and all I got is court. victorias justice system is the worst in the world .i was threatened threats to kill were made against me while working as a trammie but tramways management did nothing to protect me. instead I got court instead.
13.	[MOTHER WHO LOST HER CHILD TO FORCED ADOPTION] Hi My name is [name withheld] i lost my son to adoption in 1966, I have never really gotten over it, but continue to move forward with my life the best way i can. It wasn't until later in my life that i have come across FASS where i can get some help which is great they need to be given lots of funding so they can continue to help so many people that need their services . And you need to make sure that money is spent on training people with the right skills to help people in the mental health sector
14.	[MOTHER WHO LOST CHILD TO ADOPTION] I write this submission as a mother who lost her child to adoption and to share my experience of the far- reaching damaging effects resulting from this loss not only for the mother suffering the loss, but for immediate family as well as negative impacts for future generations. In 1968 at the age of 15 I gave birth to a daughter who was taken from me before I could see her. I tried to sit up to catch a glimpse of her but was pushed down. I asked whether my baby was a girl or a boy and the nurse carrying her away called out over her shoulder that the baby was a girl. I did not see my daughter until she was 40 years of age and have only recently met my three grandchildren, who are now young adults. At the age of 18 I married the father of my daughter and had two more children, a daughter and a son. Listed below are matters that I feel have not been addressed and consequently have been problematic in leading a happy and productive life. 1. Childbirth trauma. Traumatic birth experience can lead to PTSD. Many single mothers experienced uncaring treatment during their pregnancy and birth. My experience was that

	medical staff refused to speak to me during labour and believed that I was "putting it on" and were surprised when I actually gave birth. I recall excruciating pain and isolation. For many years I experienced flashbacks of the spinal block I was given (in its very early experimental stages) and not widely used. The pain was so intense I had a fit. I remember it vividly. For many years I wanted to weep whenever I saw a pregnant woman because I believed she would have to undergo what I had undergone. Dealing with PTSD as well as indescribable grief at losing my baby has been extremely challenging. 2. Scapegoating by family. My family is one which could be described as dysfunctional and chaotic, characterised by violence and alcohol abuse. Yet it is my loss of my child which features as the most shameful event ever to have happened. My sister still states that she finds me an embarrassment and my brother once told me that whatever I said didn't matter because I was just a whore. My mother told my daughter that if she didn't behave herself, she would end up like me. My daughter didn't understand what her grandmother was talking about. My children have had lived with the family suggesting, implicitly and explicitly, that I am a flawed human being. I don't know how to deal with this. 3. Inappropriate counselling. Where counsellors are also involved in arranging adoptions there is a conflict of interest. Grieving mothers are anathema to the idealised view of adoption and the goal of such counsellors is to ultimately to silence mothers. Trauma and grief exhibited by mothers may be portrayed as dysfunction rather than a normal human response. Very much more I could say, but will stay within the 500-word limit. Thank you.
15.	[PERINATAL MENTAL HEALTH ADVOCATE] As a father and proud advocate of perinatal mental illness prevention and support in this country, I stand in support of the submissions of PANDA, Elly Taylor and Karitane. I also support that is being done in challenging the traditional parental gender roles that still exist. I experienced postnatal depression and know a lot more fathers who have. The work that service providers, clinical professionals and academics are doing in this space to raise awareness of the impacts of perinatal mental health on both mums and dads is really important. Therefore I urge the Government as a parent and as a community member to invest in research and services to help new parents. The work done in this space will influence the quality of family relationships, the welfare of our children and engagement levels in workplaces.
16.	[OTHER – UNSPECIFIED] I wish to express my extreme concern with the practice of prescribing drugs to children, as young as 2 years, for "ADHD" that are highly addictive and with side effects that include suicidal tenancies (and actual suicide) and aggression. By observation these drugs destroy the life of the person and have detrimental affects on their family and friends. Why not look at the causes of the behavior which can be as simple as diet (e.g. drinks with excessive sugar), bad sleeping habits, exposure to video games, mobile phones, iPads (and other tablets) etc. The easy fix appears to use drugs to "quieten the person down and

	control them" rather than to fix the underlying causes. These practice is ripping our society apart!!
17.	[EMPLOYER OR MANAGER] It does not seem logical that so much money is being spent on mental health yet the suicide rates are increasing. It stands to reason that the current strategy is not working so a more holistic view needs to be taken. Psychology, psychiatry and prescription drugs seem to be the key 'go to' resources and have been for decades but as mentioned this strategy is not working based on the evidence. If a genuine review is to take place it needs to be done without any vested interests.
18.	[EMPLOYER OR MANAGER] Please listen to our cry. We are not all the same and should be encouraged to be ourselves and need to be appreciated for our differences. The current mental health screening systems take away our humanity by forcing us into categories. The current "solutions" - primarily drugs - cause more harm in the risk of side effects and lack of understanding of the problem - at best they dumb people down so they're less able to feel which makes them less aware of their environment and greater risk to others. As an employer I feel hijacked by the current system. If these methods worked there would be positive change - not a continual need for more money. Not enough money is NOT the problem. The solutions are based on vested interest. Stop spending and supporting these programs that don't have proven positive results.
19.	[EMPLOYER OR MANAGER] There is a significant gap for young and older people alike, with increased risk of self harm and suicide and the inability of hospital services to provide support due to reduced funding. This then places further pressure on those services that have only been set up to provide brief and early intervention services. There is also a big gap for those client requiring longer term care, 10 sessions with a psychologist very rarely is sufficient.
20.	[EMPLOYER OR MANAGER] The support and care responses from community centres such as Communify Qld (Bardon) and Indooroopilly Uniting Church asylum seeker support hub required by individuals and families experiencing severe anxiety, depression associated with their experiences in detention and the temporary visas status are increasing. This unfunded response from non government and volunteer groups is unsustainable. Recommendations in the following research articles need to be put into action. library.bsl.org.au/jspui/bitstream/1/4092/1/Improving%20responses%20to%20refugees %20with%20backgrounds%20of%20multiple%20trauma%20%20pointers%20for%20pr actitioners%20in%20domestic....pdf file:///C:/Users/Refugee01/AppData/Local/Microso ft/Windows/INetCache/Content.Outlook/HROIA2PP/National-Report-on-Women-on-Tempo...3.pdf ile:///C:/Users/Refugee01/AppData/Local/Microsoft/Windows/INetCache/Content.Outlo

	ok/HROIA2PP/Procter_et_al-2018-International_Journal_of_Mental_Health_Nursing.pdf
21.	[OTHER – UNSPECIFIED] How does the government feel about the $9.1 Billion dollars spend in Mental Health when the latest Study in the Australian and New Zealand Psychiatric Journal releases these findings. Australia's 'Better Access' scheme: Has it had an impact on population mental health? Abstract Background: Australia introduced the Better Access scheme in late 2006, which resulted in a large increase in the provision of mental health services by general practitioners (GPs), clinical psychologists, other psychologists and allied health professionals. It is unknown whether this increase in services has had an effect on the mental health of the population. Methods: The following data were examined: per capita use of mental health services provided by GPs, clinical psychologists, other psychologists, allied health professionals and psychiatrists from 2006 to 2015 according to the Australian Government Department of Human Services; prevalence of psychological distress in adults (as measured by the K10) from National Health Surveys in 2001, 2004–2005, 2007–2008, 2011–2012 and 2014–2015; and the annual suicide rate from 2001 to 2015 according to the Australian Bureau of Statistics. Results: The large increase in the use of mental health services after the introduction of the Better Access scheme had no detectable effect on the prevalence of very high psychological distress or the suicide rate. Conclusion: Better Access has not had a detectable effect on the mental health of the Australian population. https://journals.sagepub.com/doi/10.1177/0004867418804066
22.	[CONCERNED AUSTRALIAN] It has been my observation over a long period of time of the significant slip into drugging to handle mental health issues. Drugging should be the last resort, and not, as it seems, the go to option. Funds should be directed away from any research group that has drugs as their mandate, and into any research group that does not see drugs as an option, or at least see it as a last option, and let's see if we cannot find a better solution. We cannot afford to have a generation of drugged individuals and certainly not the next generation and the generation after that. It is going in that direction right now. If drugs were the answer, the mental health problem would be decreasing, but it is not. And this is a clear indicator of a 'solution' that does not work.
23.	[VICTIM OF COMCARE] I recently had an AAT hearing on my refused claim for Permanent Impairment. I was compulsorily retired by Australian Federal Police in 1988 and continued receiving incapacity payments to 2017. Until recently I did not claim payment for P.I. compensation. Comcare refused this claim on basis that such entitlement does not exist under the 1971 Act. They also forced me to spend thousands of dollars (that I did not have) on medical assessments on my health condition in retrospect to 1988 and earlier. They claimed that my P.I. conditions is a condition that I was born with and ignored all legislation to0 the contrary of their decision. Their mindset appears to be to deny all applications at all times, without any regard for the welfare of the victim, justice or relevant laws. Very few, if any, claims are ever settled without the complex legal challenge to their unsupported decision.

	Many claimants do not have the ability to challenge their decision and even less have the resources to retail a legal professional to do that for them. Thousands of victims are suffering and are denied justice, because of this mindset.
24.	[PUBLIC INDIVIDUAL (HAVE BEEN A GENERAL NURSE)] I am aware that the money allocated toward Mental Health is irresponsibly used, as there has not been any tangible benefits or results in Mental Health since about 1874 (the era that Wundt started his development that man is an animal). Therefore, the bulk of the population are ill informed of the truth, as they are unaware of it's development and atrocities, and what really goes on behind the Mental Health scenes. Judgement is the factor which has to be substituted for law. And if you don't have excellent judgement, you've got to have lots of laws. And if you don't have lots of laws, you've got to have excellent judgement. And that's the way it works. Judgement consists of familiarity and the ability to evaluate relative importances. And the judgement consists of the importances of the fact with relationship to it's surroundings. So this inquiry, has the responsibility of making a sound and unbiased judgement, that will be the greatest good, for the greatest number or, irresponsibly pass a law that will contain undoubtedly biases and hidden standards. Basic standards and ethical conduct are paramount. Physical manipulation is not the answer to Mental Health. Education, prevention and early intervention are the solutions. Finally, the single most destructive element in our society is drugs, and the money that supports the bulk of Mental Health is used primarily for drugs, or is provided by Pharmaceutical Company's that produce the drugs. You only just have to have a look, and that is what I hope will be done. When you look at the truth, you can confront it.
25.	[OTHER – UNSPECIFIED] I'm deeply concerned about the current state of mental health provision within Australia, and more specifically about the recent proposal (Green Paper) from the Australian Psychological Society (APS) for a tiered model for consumers of mental health to access psychologists. The existing 'state of affairs' in relation to different rebates being offered to consumers of mental health accessing psychologists providing the same services has beggared belief since 2006 (see Pirkis, 2011), however the now infamous Green Paper takes this lunacy to a whole new catastrophic level. This model has additionally been supported by other apparent 'go to' mental health experts in the mental health arena. The proposal makes no practical, clinical or community-fiscal sense and is in direct contrast to evidence. It therefore begs a very pertinent and troubling question as to why such a proposal has in the first instance been tabled (i.e. funding/financial, research agendas above mental health consumer care?). I believe if this model is implemented it will restrict access for consumers of mental health services to choose a psychologist that best serves the individual's needs, will force some mental health consumers to have to change psychologist providers against their choosing, while increasing risk (worsening individual and community mental health, increasing suicide risk) to the public through restricted access to preferred individual psychologists and therefore leading to more acute and costly mental health support having to be provided. While funding seems to be moving towards the purported success of specific mental health services (i.e. Headspace) laborious intake processes (that also 'restrict' certain young people from accessing such services if there mental health is deemed to be too complex), excessive wait times and transient clinical staff lead to poor outcomes for consumers, as a mental health worker I see on a daily basis. Having more psychologists within schools is especially overdue. I would therefore

	recommend most strongly to the Commission that a national Royal Commission in Mental Health (beyond South Australia that is) be called to investigate the true agendas at play to better inform the Productivity Commission and Government policy direction.
26.	[OTHER – UNSPECIFIED] FASD is an increasing issue of concern, and not only in the Aboriginal community, but these 2 papers are "must reads" for those trying to find some solution to the high rates of youth suicide in Aboriginal communities. Connection between FASD and Suicide https://www.ihs.gov/telebehavioral/includes/themes/newihstheme/display_objects/docu ments/slides/fasd/fasdsuicide0616.pdf Connection between FASD and the criminal justice system http://sites.thomsonreuters.com.au/journals/files/2010/10/j05_v034_CRIMLJ_pt04_doug las_offprint.pdf
27.	[OTHER – UNSPECIFIED] As this Parliamentary Inquiry explores, poor sleep reduces productivity and increases the potential for mental illness. Essential reading. https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care _and_Sport/SleepHealthAwareness/Report Also essential is to be aware of social "quick fixes", eg Kratom which is being sold for it's "wellness properties" https://www.webmd.com/mental-health/addiction/news/20190411/cdc-americans-are-dying-from-kratom-overdoses#1 https://www.drugabuse.gov/publications/drugfacts/kratom Porn will become an even bigger issue if the Users see it as an entitlement to be Abusers. Obviously those being Abused will suffer greatly from physical and mental health problems https://mobile.abc.net.au/news/2019-04-12/i-dove-into-australias-porn-industry-and-this-is-what-i-learnt/10915568
28.	[OTHER – UNSPECIFIED] Time must not be wasted on reinventing the wheel if another wheel can be modified for specific Australian conditions. Here is a framework for measurement of MH outcomes in the NZ Maori population. which may have applicability here, and not just for our large Maori population.http://www.massey.ac.nz/massey/fms/Te%20Mata%20O%20Te%20Tau/Pub lications%20-%20Te%20Kani/T%20Kingi%20&%20M%20Duire%20A%20framework%20for%20m easuring%20maori%20mental%20health%20outcomes.pdf Vic Health has anotherhttps://www2.health.vic.gov.au/mental-health/practice-and-service-quality/service-quality/measuring-outcomes-in-mental-health All of the above, and even this whole Inquiry, is of absolutely no use unless a genuine and sustained effort is made in application and practical utilisation, action and even wholesale change, where necessary. Who is going to ensure that?
29.	[OTHER – UNSPECIFIED] Re the Mining Industry - and perhaps all other industries with similar issues (This site provides a short summary from a WA inquiry into mental health issues associated with FIFO http://www.tmsconsulting.com.au/key-findings-from-the-wa-inquiry-into-fifo-mental-health/) 1. A 6 week intensive mental health welfare/psychiatry course should be undergone by all medical staff, including the doctors, before they are allowed to step on site. They should also be required to complete an annual online course which updates them on any new changes in the field and Best Practice recommendations. 2. As part of their WH+S training, all members of mine management and mine workers should have to do a Mental Health First Aid Course, just as they would be expected to do a First Aid Course. eg similar to what is provided here https://mhfa.com.au/ 3. Indeed, all workplaces, clubs, charities etc who expect at least some of their employees to have a First Aid Certificate, should also require them to have a Mental Health First Aid Certificate. All Management must have both.

30.	[OTHER – UNSPECIFIED] When Beyond Blue has to let those feeling suicidal, and their supporters, know that their doctors may be prejudiced against them (Carer submission 32, this booklet, page 8 http://resources.beyondblue.org.au/prism/file?token=BL/1161), this is a clear signal that the training of our medical students is grossly inadequate. With such a high proportion of the population suffering a mental health problem, then medical student training should be increased by perhaps another year. A whole year studying such a common problem may equip them better, especially as our current system places the medical doctor in the "Gate Keeper" role. Graduated doctors and migrant doctors will need to retrain.
31.	[OTHER – UNSPECIFIED] This group shows how mentoring, preparation and engagement in the workforce can be done well. http://au.specialisterne.com/ In some areas, local ventures have successfully helped transition those with mental illness back into the workforce. The key for both the above? Focusing on the Abilities, and dealing with the disabilities just as matters of being.
32.	[OTHER – UNSPECIFIED] Isolated Centres Let's just face it, we are not going to get the Professionals into most of the isolated centres, it's difficult even getting them to areas within a 2hr drive of a major centre. Just look at this story https://www.abc.net.au/news/2019-05-09/kimberley-officer-calls-for-consistent-suicide-prevention-help/11092946 So 1.the isolated centre (IC) has to become it's own carers, with the introduction of schemes such as this https://eurekalert.org/pub_releases/2019-02/mm-u-fds020619.php 2. The community mentors have to have training. Either they are flown to training centres or the trainers flown in (so that there is a personal commitment, on both sides, to that professional relationship.) The Mentors must be given the respect of a fellow colleague by the Professionals. 3. From then on, the Mentors should be able to make timely contact with their city based Professional colleague through phone/online link-ups, and regular online training/counselling/check-ins. 4. The Service Professionals/Providers and Government have to a. commit for the long term b. stop constantly changing the rules for access, etc. 5. Let's also address what else might also scare a professional away from living in an IC, in addition to those things already mentioned in other submissions. This includes issues of a. Security b. Culture shock (both sides) c. Some communities can be hostile to anyone new, especially if they assume "outsiders" are there to judge them. These communities cannot expect help if they are intent on frightening people away, so some reflection and self-assessment is required. 6. Give these communities the belief that they can care for themselves. Language matters! eg having people like politicians, and others playing politics, constantly evoking the threat of suicides is only going to hurt the vulnerable. 7. Communities with multiple co-morbidities, drugs, child abuse, domestic violence, alcoholism, etc. have to be given extra support and safety structures from the early childhood years. The Justice System and Community Mentors have to be able to put in preventative mechanisms that will be abided by eg predators/pushers/perpetrators have to be removed for the sake of the victims, and before they make more victims and cause enormous mental health tolls. No community should be a safespace for it's perpetrators. The initial monetary cost may be high, but it's not as though what's on offer now isn't, in all it's guises and long term effects.
33.	[OTHER – UNSPECIFIED] More demarcation issues that can only lead to poorer outcomes for the actual consumers https://www.audit.nsw.gov.au/our-work/reports/governance-of-local-health-districts Re Telemedicine, this clinician expresses some concerns and some of these are responded to by Dr Yeung , Reader response # 11 https://insightplus.mja.com.au/2018/13/telemedicine-in-rural-eds-more-questions-than-answers/

34.	[OTHER – UNSPECIFIED] The following article demonstrates some of the issues facing the training of our nominated "Gatekeepers"* - please also read the comments at the end of the article. The author suggests there is now some focus on the student "gatekeepers'" mental health but that this falls away upon graduation. She does not mention if there is much focus on their patients' mental health, as well. Is this because there is very little? If mental health training were to be seriously taken as part of the medical student curriculum* then surely it would take up at least 20% of their current course or add the commensurate time to their current education? https://insightplus.mja.com.au/2019/14/a-students-eye-view-of-the-training-crisis/ *Some submissions have indicated they would like to see Gatekeepers from a different background. Some communities have had to use different models already, either due to a lack of medical Gatekeepers or because of an intentional move away from the medical model.
35.	[LIFE LONG SUFFERER OF DEPRESSION AND ANXIETY] I would like raise awareness of the dramatic improvements that lifelong sufferers of depression and anxiety have experienced with legalised ketamine based therapy in the US. I would like the therapy to become available in Australia. Here are examples of the kind of improvements people are experiencing with this therapy. I very much look forward to it being legalised in Australia... https://medium.com/@thisisgorman/30-years-of-depression-gone-3dffafabc7cf https://medium.com/search?q=ketamine
36.	[OTHER – UNSPECIFIED] Call centre staff verbal and stage calls to hang up and then demonise members of the public in records refuse to reasonable requests to speak to some Call centre or intake staff TASK FOCUSED and OUT of SCOPE are a barrier to resolving issues with organisation/departments They have limited in house training poor language, understanding, listening and communication skills. They interrupt before receiving important information They verbal what you say or request losing intention and purpose There is little engagement merely assumption responses to initial email enquires There seems to be a Task not Host policy which does not align with Health best practices. There are worrying trends of dismissive staff assuming everyone is tech savvy, has a computer open when speaking to them
37.	[EMPLOYER OR MANAGER] I am employed as the Quality and Compliance Manager of a disability service provider and it is of increasing concern that participants of the NDIS are not being afforded the appropriate care and support they need as they more clearly and reasonably require specialised mental health care services. Disability services providers and support workers are not equipped to adequately deal with suicidal ideation, delusions, emotionally erratic behaviour, substance abuse, depression or any other serious mental health conditions. The strain on disability support workers is obvious as more and more staff seek counselling of their own or take extended leave to deal with the effects of caring for a person with significant mental health concerns. Moreover, the participant is not receiving the care and support they require and the risk to each person is increased dramatically. Mental health requires further funding to get people the specialised support they require. Simply putting additional strain on a different community department is not the solution. We need to work together to let people with mental health issues know that they are seen, heard and supported; not just push them from service to service and hope for the best.

38.	[RETIRED PERSON] I am 71 years old and a retired academic. One of the few pleasures left in my life is to watch television. A number of channels show funeral insurance ads over and over again. I am not surprised there are so many older people who suffer depression as they are constantly being reminded of death. We all know we are going to die but we do not want to be reminded of it all the time. Turning off the television means one less pastime for us.
39.	[EMPLOYER OR MANAGER] Multiple sources of funding (commonwealth, state) make delivery and access rules, difficult. Commonwealth and state should siphon funds into a State for specific use. Each state should have a MH type COAG with reps from each public health service, DHS. PHNs and 1-2 key bodies to determine strategy across the state, budgeting and allocations across the state and guidelines/quality/risk review. Each Region should have Regional COAG type MH teams, chaired by the Tertiary centre, PHN co-chairs and all providers of MH in that sector, to receive funding (other than Pvt health until Funds are engaged) should require attendance. This would ensure gov pathways are clear, information is shared, regional issues identified and responded to collaboratively, definate two way MH pathway, escalation and standardisation of service quality and increased efficiencies.

Comments from Academics and Researchers

1.	There is great value in investing in the early and preventative intervention for mental health, but the value of this is magnified when it is directed to children and particularly younger children. Quantifying that value is difficult as methodologies have not been developed to reliably and validly quantify the impact of mental health in children 5 and under, let alone 0-3 years old, and this is an understudied area. Nonetheless the rationale is strong for the value of early intervention. However the evidence is not strong on how best to do this. In the case of trauma and traumatic stress, there is even a reluctance to acknowledge the possibility of this in very young children despite their vulnerabilities and the available data. We know from our work that in a significant proportion of young children exposed to trauma, there is ongoing and broadening impacts. For example trauma exposure and stress can and does sit behind the development of subsequent presentations of ADHD, anxiety disorders and behavioural disorders, which can mask the underlying traumatic stress. Furthermore there is generally little acknowledgement of the need to support very young children and families through traumas, including injury and accidents, disasters, medical illness and treatment, and physical and sexual assault. There is also a broad lack of knowledge and skill in the clinical workforce about the nature of these impacts and what can be done to mitigate them. There is emerging evidence about how to recognize and address these impacts but it is still early days, much more work is needed and more resources allocated. I would urge the Commission to consider the needs of young and very young children in their considerations of development of systems of effective intervention and workforce capacity and capability
2.	There is an internationally recognised intervention to help people with mental illness find and keep jobs. Individual placement and support (evidence summarised by Modini et al., 2016). ☐It would be useful to know which mental health services and which Disability employment services in Australia offer this intervention? To what degree of fidelity is the intervention implemented is also relevant as this intervention is administered according to a fidelity scale. It would be helpful to have publicly available information on this so consumers and carers can make choices about services they chose to work with. ☐If this intervention is not available - the question is why? Are the right incentives in place - policy, funding, national and state government coordination - for this intervention to be offered. My experience is that it is currently optional whether services provide it or not; and therefore we are not providing the best chance for people with mental illness to find and keep work. ☐If we are funding and providing other employment support services instead, then we need to know what evidence these services are based on and to have data on their outcomes. Because it seems like we are making no progress with the current set up (e.g. employment rates for people with psychosis 22% unchanged between 1997 and 2010, Waghorn et al. 2012). ☐Modini, M., Tan, L., Brinchmann, B., Wang, M. J., Killackey, E., Glozier, N., ... & Harvey, S. B. (2016). Supported employment for people

	with severe mental illness: Systematic review and meta-analysis of the international evidence. The British Journal of Psychiatry, 209(1), 14-22.☐Waghorn, G., Saha, S., Harvey, C., Morgan, V. A., Waterreus, A., Bush, R., ... & McGorry, P. (2012). â€˜Earning and learningâ€™in those with psychotic disorders: The second Australian national survey of psychosis. Australian & New Zealand Journal of Psychiatry, 46(8), 774-785.
3.	There is some evidence that the rate of Indigenous suicide varies regionally and that it is generally higher in the remote than non-remote areas. Followers of Durkheim would propose that suicide is related to life circumstances. From this, it is possible that a comparison of Indigenous life circumstances in remote and non-remote Australia might tell us something about which circumstances are most influential re the incidence of suicide. By virtually all standard measures - including income, employment, education, residential crowding, health etc. - the socio-economic status of Indigenous people in remote areas is lower than that of those in the non-remote. On the other hand, other measures such as the level of traditional language spoken, ceremonial activity, area of land held, levels of hunting etc. – are higher. We can assume that people who commit suicide have experienced a low level of subjective wellbeing. The 'theory' of subjective wellbeing says that there is a range of elements and measures that can indicate the standard of wellbeing in a society. However, exponents also point out that certain elements are rather more critical than others; going as far as to say that without the more objective conditions of, for example. good health, a job, an education, good shelter, a certain level of income etc, it is unlikely that people will experience subjective wellbeing no matter which other conditions exist. That is to say, some measures – namely the more objective - are more necessary for wellbeing than others. The above might be taken to suggest that the more cultural measures of Indigenous wellbeing are not important. Not so, but they are, by themselves, unable to create full wellbeing: they may be necessary but they are not sufficient. Returning to our case, the rate of suicide among non-remote Indigenous people appears to be lower than that experienced by those living in the remote areas, while their objective measures of wellbeing are higher. Remembering that some theorists contend that wellbeing is more dependent on these objective measure than others, it is very likely that rates of suicide in remote areas can only be reduced if the level of objective wellbeing there is raised.
4.	In order to achieve a beneficial outcome the government must understand that the statistics encompassing mental health and suicide Australia wide need be accurate not wrong. In accordance to the ABS statistical data, I and many others have been able to quantify a large discrepancy in figures that subsequently are handed down to advocates, institutions, governing bodies all in which are receiving incorrect data. For instance the national suicide rate if goggled to attain the Australian figure, you would notice many alarming discrepancies though all seem to be at the 3,500 per year effective rate of suicide for male and females in Australia. This unfortunate rate is a crude rate not effective rate, not only is it incorrect, it's a catalyst for many advocacies and department bodies even governmental bodies that rely on these figures for forecasting and budget setting. The figures for suicide in Australia as of the last ABS report account for 355,000 deaths by suicide in 2017. In addition to this the 2016 was 298, 000 and the last ten years effectively remained at suicide as the number one killer Australia wide. Now, as devastating as this is, the mere discomfort was on the level of departmental knowledge, whereby all that have

been using these incorrect figures are also contributory to essentially creating a better Australia. If no department have the correct figures for issues within this country, how on earth are we as a country supposed to gain momentum and become a greater nation? Another startling fact; Yemen, has a population similar to that of Australia and they are at war. A total of 16 people die every day in Yemen, compared to 2,601 deaths per day in Australia. Now, surely one can only agree what is happening with so little deaths in a country that is of 3rd world compared to a democracy of Australia, which has so many people dying? Whether it is caused by human error in using crude methodology or whether it is calculated intentionally, these issues are merely irrelevant. The fact is the figures are evidently causing more havoc within Australian cultural and societal benefit than anything else. This need be addressed with immediate action.

Comments from Peak body or advocacy group

1.	We are a peak advocacy group for people with intellectual disability and their families. We have a deep interest in the poorly met mental health needs of people with intellectual disability and led the first national roundtable on this issues in 2013. See http://www.nswcid.org.au/what-we-do/advocacy.html#Mental We support the submission of the Department of Developmental Disability Neuropsychiatry UNSW with whom we work closely. Unfortunately, other pressures have prevented us from doing our own submission.
2.	The use of both voluntary and paid Mental Health Peer Workers who are suitably qualified (E.G. CHC43515 Mental Health Peer Work Course or better) be greatly increased to reduce the pressure on existing Health Facilities and the demands upon the already limited numbers of more highly qualified (and expensive) Mental Health Professionals. This should not be seen as a substitute for the duties of those professionals but as an additional and more client-oriented facility. Two examples would be accompanying emergency vehicles where appropriate, and as a standard amenity in Departments of Emergency Medicine - there are many more.
3.	In remote areas where phone service providers and/or NBN charge the user more than the price of a local call when they contact a recognised mental health crisis line (E.G. Lifeline, Beyond Blue Crisis line, Suicide Call Back Service, etc. using either a land line or mobile phone then the Federal Government should subside the call the provider to the extent that the caller only pays the price of a local call. Similarly, should any of these services offer a web-based facility – E.G. web-chat, web form or email - then data charges for these session(s) should be subsidized to the provider and/or NBN so that the user is not limited in their use.
4.	Men's Sheds have long been recognised for their demonstrated success in contributing to improvements in male health and wellness by reducing social isolation and increasing social engagement and connectedness. Sheds provide men with a safe, male-friendly environment for men to come together and have a meaningful purpose, to share experiences and sometimes share their problems. The Men's Shed movement is also well known for participating in contemporary research and evaluation into the benefits of men's sheds, and has proven their overall contribution to men's physical and mental health and wellbeing. Beyond Blue, in its research paper "Connections matter: Helping people stay socially active" found that strong ties with family, friends and the community provide people with happiness, security, support and a sense of purpose. Research shows that being connected to others is important for mental wellbeing, and can be a protective factor against anxiety and depression. The Australian Loneliness report, released last year, revealed that one in four Australians are lonely, which affects their physical and mental health, and that nearly 55% of the population feel they lack companionship at least sometime. It also found that loneliness increases a person's likelihood of experiencing depression by 15.2%, and the likelihood of social anxiety increases by 13.1%. Those who are lonelier also report being more socially anxious during social interactions. Having meaningful contact with other people and being part of a community can help you feel

	more positive and avoid loneliness. Men's Sheds provide men with a place of belonging and a feeling of connectedness. Having meaningful contact with other people and being part of a community can help you feel more positive and avoid loneliness. Men's Sheds provide men with a place of belonging and a feeling of connectedness, a factor often overlooked in inner-urban localities where there are many older single or retired men living alone in boarding houses and apartments with limited spaces for hobbies and recreation. There is a well-established link between loneliness and both mental and physical health. Research has found that lonely people, in comparison to their non-lonely counterparts: • are more likely to report symptoms of depression • are admitted to hospital more frequently • have double the risk of obesity • have higher blood pressure and a greater risk of heart attack. Social connections are closely tied to physical and mental wellbeing: having someone to talk to and give support is important. Older people who remain connected with others and have strong relationships are likely to: • report better quality of life and satisfaction with their life • have delayed progression of dementia and mental decline • need less domestic support and enjoy greater independence. Simply put, social connections, interactions and networks matter. Overall, social connections can improve physical and mental health and well
5.	The Medical Consumers Association received a reply in Sept from the Federal Health Minister to the effect that, given the Productivity Commission and Victorian Royal Commission activity, it would be "premature" to task the Australian Competition and Consumer Commission with an inquiry into the mental health sector workforce. The response is reasonable but the ACCC is the only body that can reverse onus of proof. ACCC was supposed to be the "principal legislative weapon" and its default position that professions should "not be registered" unless there is proven benefit. MCA warns that further gaps in government subsidies and recognition tiers between Allied Health and the clinical psychologists and psychiatrists will have a flow-on effect to first-responders: the volunteer sector. These volunteers commonly do 'placement hours' toward registration. When they see their Allied Health role models not making a living there will be no incentive for them as they will have to consider an alternative paying career. The sector is currently running on the back of these lower rungs of the workforce and many proposed changes could create a catastrophic exodus. In their place will be the more invasive psychiatric labels and treatments with higher fees and wait lists. There is no scientific justification for any of this. MCA has sent more detailed referenced submissions on this. The issue now is that the Productivity Commission, has been tasked with issues that rightly should have long ago been dealt with by the ACCC.

Comments from people in a Government or a Government agency

1.	Please examine or request information from the WA Police Force or WA Mental Health Commission on the successes of their joint Mental Health Co-Response model. This model has gone through a 2 year trial period and has provided an exceptional result for Mental Health Consumers, Practitioners and Community Mental Health Clinics. The mobile trial is composed of 2 Police Officers teaming up with an Authorised Mental Health Practitioner to attend Police orientated tasks involving persons in crisis. Members of this model are proud to claim Worlds Best Practise in this arena.
2.	The Clarence had been in the grips of a suicide cluster over the last five years which had resulted in community demand for action within the area. Major concerns were raised over lack of services. There was significant community energy to react to the problem. This often created situations that were not ideal for people at risk of mental illness. It is very important for the community to have pathways to respond in times of crisis – this could be simply fundraising as opposed to awareness raising. Another major issue is in relation to preparing this for suicide. The community is educated on planning for other emergencies – fire or flood – but planning for your mental health is not something that is on the community radar.
3.	Mental health is a key issue in Wyndham. Through the development of its Advocacy Strategy, Council found that Wyndham has significant service and funding gaps in relation to mainstream and specialist mental health services, including family violence and alcohol and other drug support services. Therefore, we recommend that the Productivity Commission investigate funding models which prioritise equitable social service distribution and needs-based service delivery. It is widely accepted within the youth mental health field that family inclusive practice is a highly beneficial way of working with young people. However, few services are funded to provide this targeted intervention, and family therapy is not included under the Medicare mental health care plan. There is also a lack of training about how to include families in treatment, and limited consideration of the context for young people within the family (especially for CALD young people). Therefore, we recommend that the Commission investigate options to include family-based services within the Medicare system, as well as the funding and support to train clinicians in Single Session Family Consultation methods. Local data collected by the H3 Alliance has found that one-quarter to one-third of the people presenting to the homelessness system in Wyndham have a mental ill-health. Research from the Alliance has also shown that lack of suitable accommodation and support compounds mental health issues, increasing the risk of recurring homelessness. This increases costs to government as people are being recycled around the system. Therefore, we recommend that the Commission investigate the costs and benefits of more integrated service models, which address the central relationship between housing, homelessness and mental ill-health. A 2011 study found that just over one in four new mothers experience emotional distress. Given Wyndham's rapidly growing population, more than 5,000 Wyndham mothers may

	be affected. Help-seeking for women in this situation can be limited by a range of factors, including stigma and feelings of guilt and failure. Local maternal and child health services are well-placed to support mothers' mental health, and further investment should be provided to build capacity to respond. Therefore, we recommend that the Commission focus on maternal mental health which seeks to integrate prevention, early intervention, community-based and acute services. Finally, recent research from the Australian Institute of Health and Welfare found that refugees in Melbourne are 3.1 times more likely to have mental disorders, compared to the Australian born population. Coupled with lower rates of help-seeking and recent cuts to refugee support services, mental health remains a critical issue for Wyndham's CALD communities. Therefore, we recommend that the Commission examine the social and economic impacts of improved mental health within CALD communities.
4.	I believe it is important that 'mental illness' is not seen as a discreet illness, treatable by mental health professionals alone. Any strategy that increases the knowledge and understanding of mental health issues across the population at large will improve the outcomes of people with mental illness. Within the health profession (and allied groups) the most important element is support for the frontline workers; not everyone needs to be an expert in managing mental illness but all those entrusted with the care of the mentally ill need to feel supported (e.g. phone or telehealth support, access to prompt review, access to inpatient care when required). Access to debriefing/peer support is also important to reduce stress and turnover of mental health workers. Programs to improve mental health of communities: the WA Program 'Act, Belong, Commit' (https://www.actbelongcommit.org.au/) has been very successful.
5.	The capacity for young people in care to seek the appropriate mental health services is limited. It is often a complex web of both mental health and trauma based behaviours that the system uses to send young people away and label them as behavioural. We leave residential staff with limited experience to manage the complex profile of the young person. This leads to burnout, placement breakdowns and young people moving from placement to placement. The ability then to do any quality rehabilitation work is limited because they have no stability, no trust in adults to protect them and keep them safe and an internal self view that they are inherently to blame or at fault for what has happened to them.