Sustainable Health Review Interim Report: Feedback Survey

The Sustainable Health Review Interim Report feedback survey consisted of 14 questions. Responses to questions 9-12 are published in a summarised report on the SHR website. This represents the open feedback section of the survey.

Your Personal Details	
1. Title	Mr ☐ Miss ☐ Mrs ☐ Ms ☐ Dr ☐ Other ☐
2. First Name(s)	
3. Surname	
4. Contact Details	
5. Organisation	
6. Location	☒ Metropolitan ☐ Regional WA ☐ Outside WA
7. Are you providing a response on behalf of your group/organisation or as an individual? **(Required)**	☐ Group/organisation ☒ Individual ☐ Other, please specify_____

Q8. Do you consent to your feedback being published, in summaries or in the Final Report? (Required)
☐ I consent to my feedback being published
☒ I consent to my feedback being published anonymously
☐ I do not consent to my feedback being published

The next two questions will allow you to provide more detailed feedback on how to maximise improvements in each of the Directions or suggest other areas or actions for the Sustainable Health Review Panel to consider to develop a more sustainable health system.

13. In regards to the 12 Directions, please provide detailed comments on how to maximise improvements in each of the Directions. Where possible, please indicate which Direction your comments relate to.

1. Getting serious means shifting away from tokenistic responses to consumer need and investing good leadership, and accountability of health service delivery.

2. Person centred approaches actually involve caring and not seeing people as a number, but remembering that they are human.

3. Currently for those people in the communities - the care that they are receiving is often haphazard and irregular - especially when they are reliant on family members for the care. this potentially can open them up to Elder abuse. Additionally, other concerns include the lack of carer support for Carers of people with mental health conditions (and other conditions), which impacts negatively on the health and well being of the carers.

4. Better use of resources, includes having those human resources transparent and also accountable. Lots of meetings with poor performance equals a lot of talk and no or little action, and within remote communities there is a lot of lip service with little investment and little action.

5. Equity in Country Health means the provision of services to those outside of the urban area. Elderly people for instance are now not necessarily able to access services, people with mental health conditions such as BPD currently miss out on early intervention/prevention and supports as part of reducing suicidality (and where the condition is fully recoverable).

6. Partnerships with Aboriginal people toward better outcomes are improving - but they are still lacking. For instance, in remote areas, they may get treatment in an emergency or crisis, but there is a lack of understanding by professionals around how to follow up, (or whether to) and if there is knowledge - then there is a lack of capacity due to under resourcing of staff. Many positions are now being filled by New Australians who in my experience do not understand the culture and who are in fact judgemental about the Indigenous people, and this conveys through their body language, if not verbally.

7. Creating the "right culture" presumably is where the health professionals treat the "consumer" with dignity and respect, kindness and compassion and not as a commodity and just a thorn in their day.

8. Technology such as Telehealth is vital in the remote areas, and could also be used as a Mental health tool - particularly in areas such as Kununurra or the inland communities where there is heightened teenage suicide risk and substance misuse/abuse and where there are little if any resources for the community to use. Indigenous persons don't like travelling to the city for help.

9. It would be helpful if the staff collaborated with the researchers particularly in relation to the evidence based studies on Borderline Personality Disorder, where consumers are often denied access to services, have multiple or comorbid diagnosis that are life threatening due to the links with suicideality. Current staffing perceptions are that BPD is too hard to treat, yet evidence shows it is fully recoverable and where it is identified as a risk sooner rather than later there are better outcomes - and this collaboration could be part of addressing increasing numbers of teenage suicides (particularly in remote areas).

10. Developing and supporting a flexible workforce might look like telehealth supervision, and supporting practitioners to reflection practice and improve it. It might also look like improved training for clinicians and professionals to adapt and respond to mental health crisis

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appropriately in ways that sustain lives for more than just the application of a sedative - but rather teaching skills the person can take with them upon discharge.

11. Planning on wise investments also includes ensuring that meetings focus on the tasks of improving service delivery and where there are actions. Many meetings in remote areas tend to be a rehashing (due to staff turnover, or where Indigenous are involved - irregular attendance due to funerals). these elements combined seemt o undermine the investment in time and travel to areas to address the social and health problems in any given community.

12. Government needs to stop relying on NGOs to fill the void of service delivery. Often the staff are unqualified for the roles that they are expected to perform, and might not even know their legal obligations. Ultimately they are not accountable for poor service delivery and this can compound the delivery of health to remote and regional areas. Government needs to step up to the plate - money can be saved by making sure that the right people are employed, through accountable and transparent leadership. Corporations have already realised that it actually costs more money to subcontract out than it does to employ full time employees, and there is a better quality of service provided because employees aren't living in fear of where they will work once the contract ends or if the funding is withdrawn. This is probably the biggest barrier for people with a diagnosis of Borderline Personality Disorder and their carers.

14. Is there anything else that the Panel has missed so far that is important in developing a more sustainable health system for Western Australia?

14. Yes - diagnosis of Borderline Personality Disorder is on the increase, and it is so closely tied to suicide, that it must be part of the increased suicide in young people. IT is not only a debilitating condition it also impacts dreadfully on the Carers and family around them. It is fully recoverable where the person can access funding, and there is a national drive to address BPD from the National mental health commissioner Peggy Browne across Australia, but at the same time - BPD misses out on all the funding and the resources and supports that they need. School based interventions focus on CBT as opposed to DBT (which is pivotal for BPD and where symptoms start at approximately 14 years of age). This is a massive oversight by the authorities responsible for the disbursement of funding. Family members and carers become incredibly unwell trying to source support for family members (at best) and at worst, where the outcome is a suicide, there is the trauma for the family, the person that finds the body and the impacts of a suicide reverberate over the wider community. BPD MUST be addressed and funding found to include this in the current national and state strategies toward health and well being.