Submission to the Review of the

National Mental Health and Suicide Prevention Agreement (2023–2026)

From Pathology to Dignity: An Ethical Framework for Healthcare Reform

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Acknowledgement of Country

I acknowledge the Traditional Custodians of the lands on which I live, work, and write. I pay deep respect to Elders past and present, and to all Aboriginal and Torres Strait Islander peoples whose sovereignty has never been ceded. This always was, and always will be, Aboriginal land.

I recognise that meaningful justice requires more than symbolic acknowledgment. It demands a commitment to truth-telling, reparations, and a treaty that honours First Nations sovereignty, self-determination, and the right to live free from systemic violence, silencing and dispossession.

Statement of Lived Experience

As someone with lived experience of mental distress and suicidal ideation, I recognise that my perspective is shaped by my own intersectional position. In advocating for individuals and systemic change, I do not seek to speak for others, but to stand alongside them and contribute to the growing chorus of lived experience voices calling for justice and ethical reform.

I hold deep respect for those whose experiences of marginalisation and mental health challenges remain unheard—especially those whose suffering was so great that they are no longer here to speak.

May they be remembered, believed, and never forgotten.

Confidentiality

I consent to this submission being published, with attribution.

Overview

This submission directly responds to the concerns raised in the Productivity Commission's Interim Report on the National Mental Health and Suicide Prevention Agreement. It offers a lived-experience-based, structural, evidence-based critique of the current system, and proposes bold, measurable reforms that align with the Commission's call for a person-centred, integrated, and accountable mental health framework.

Specifically, this submission:

- **Addresses system fragmentation** by exposing how dominant diagnostic and behavioural treatment paradigms alienate those in greatest distress—especially victim-survivors of violence, First Nations women, and racialised communities—and proposes alternative, trauma-informed, relational modes of care that restore dignity and inclusion.
- **Supports systemic reform** through a principled rejection of corporatised, risk-driven models and a call to abolish personality disorder diagnoses. It advocates for a publicly funded, victim-survivor-led, and justice-centred mental health system that can respond to human suffering with depth, humility, and ethical clarity.
- **Responds to the psychosocial support gap** by opposing private insurance-driven rationing of care and proposing a pluralistic ecosystem of public services that are trauma-informed, culturally grounded, and free from diagnostic exclusion.
- **Aligns with the need for a National Stigma and Discrimination Reduction Strategy** by identifying how stigma is structurally embedded in psychiatric diagnosis and practice. It calls for a national inquiry into psychiatric harm, with a focus on gendered, racialised, and coercive treatment.
- **Advocates for genuine co-design** by challenging the conditional and tokenistic inclusion of lived experience. It calls for the protection of dissenting victim-survivor voices and for independent oversight to ensure lived experience leadership reflects ethical, critical, and representative perspectives.
- **Supports an extended Agreement and long-term reform strategy** by proposing educational, clinical, and policy-level changes that require sustained investment in ethical care models, decolonial practice, and victim-survivor-informed accountability mechanisms.
- **Calls for specific, accountable reform** by outlining actionable recommendations that can be measured and tracked—for example, the expansion of Medicare-funded long-term therapies, the removal of diagnostic

barriers to care, the establishment of protections for whistleblowers, and the banning of private insurer influence over policy.

- **Echoes the call for Indigenous-led policy** by foregrounding the psychiatric misdiagnosis and erasure of First Nations people’s trauma and resistance. It advocates for separate, self-determined funding streams and governance structures for Aboriginal and Torres Strait Islander social and emotional wellbeing and suicide prevention initiatives.

In alignment with the Interim Report, this submission affirms that mental health reform must move beyond administrative reshuffling and toward ethical transformation. It insists that meaningful change requires not only services—but justice.

Australia does not need more reform that repackages harm in new administrative language. We need a principled break. This means confronting the economic and ideological interests shaping care, phasing out pathologising diagnoses, decommissioning behaviourist default models, and removing corporate actors from policy influence.

Above all, it means building a system capable of responding to human suffering with depth, humility, and justice. This submission sets out how that transformation might begin.

Introduction: Ethics as Compass, Not Map

This submission to the Review of the National Mental Health and Suicide Prevention Agreement (2023–2026) calls for a fundamental shift in the guiding principles of Australia's mental health system: from bureaucratic compliance and risk management to a renewed emphasis on ethics as the cornerstone of care.

At present, many reforms operate like a map—offering a predetermined route through diagnostic categories, service pathways, and performance metrics. But mental distress, especially in the wake of trauma, systemic neglect, and intergenerational harm, cannot be mapped in advance. People do not heal through imposed rules—they heal in spaces where their experiences are recognised, and their trust is earned.

Too often, reforms fail not because they lack technical sophistication, but because they impose structures and rules that those on the ground—practitioners, peer workers, and those seeking support—do not believe in. Without ethical conviction, no policy can create meaningful change. To truly transform mental health care, we must win hearts and minds, not just implement frameworks.

This requires more than strategic reform—it requires a reckoning with the ideological terrain in which care is delivered. Under capitalism and neoliberalism, mental health is increasingly reduced to individual responsibility, risk calculation, and cost containment. These frameworks are inherently unethical because they disavow the social, political, and relational roots of suffering. They incentivise surveillance and compliance over trust and dignity, and in doing so, betray the very people they claim to serve.

Ethics, by contrast, functions not as a map but as a compass. It does not guarantee certainty or efficiency, but it orients us—toward responsibility, toward relationship, and toward the singular truth of each person's suffering. An ethical approach to mental health cannot be reduced to a checklist; it must remain grounded in listening, in care, and in the courage to resist dehumanising systems.

This submission argues that real reform begins when we let ethics lead. It is time to move beyond rebranding and symbolic change. What is needed now is a bold, collective reorientation—toward justice, compassion, and the shared belief that care is a moral act, not a market transaction.

1. Pathologising Trauma as Femininity: Personality Disorder Diagnoses Function as Diagnostic Violence

Personality disorder labels—especially borderline personality disorder (BPD)—are not neutral clinical tools. They function as modern instruments of psychiatric control, disproportionately applied to women, queer, and gender-diverse people whose pain, protest, or refusal to comply with normative expectations is misinterpreted as pathology (Ussher, 2011; Caplan, 1995). As Shaw and Proctor (2005) argue, these diagnoses do not acknowledge trauma—they actively erase it. By converting histories of violence into signs of dysfunction, psychiatry classifies victim-survivors as unstable, manipulative, or disordered.

This diagnostic practice is not merely sexist—it is structurally racist. First Nations women's grief, rage, and resistance are routinely misread through a white clinical lens that fails to account for the ongoing realities of colonisation, poverty, and gendered violence (Moreton-Robinson, 2000). As with the colonial legacy of hysteria, the further one is from the white, middle-class ideal, the more likely one's suffering is to be misdiagnosed—and dismissed.

Crucially, the psychiatric language of personality disorders reframes trauma responses to violence—such as sexual abuse, racism, and institutional betrayal—as symptoms of an inherently broken self. This is diagnostic violence: the misuse of clinical authority to individualise and depoliticise trauma, silencing those whose stories threaten the status quo.

There is also a cognitive phenomenon known as the Barnum effect—the tendency to accept vague, generalised characterisations as uniquely true of oneself—which amplifies the harm of these diagnoses. Many criteria for BPD, such as being "emotionally unstable," "interpersonally chaotic," or "attention-seeking," are so broadly defined that they feel personally relevant to anyone in distress. When individuals internalise these labels, they may mistake externally imposed diagnostic narratives for genuine self-understanding, reinforcing feelings of shame and defectiveness while obscuring the relational and structural roots of their suffering (Forer, 1949; Furnham & Schofield, 1987). In clinical settings, this can reduce a person's experience to a static identity category, discouraging authentic therapeutic engagement and obscuring the ethical and unconscious dimensions of subjectivity (Shaw & Proctor, 2005).

The consequences are not abstract. In 2021, a woman fleeing family violence was detained at a hospital and labelled delusional. Her psychiatrist arranged a meeting with her abuser—despite an active intervention order. Her terror wasn't believed. It was medicalised and used to facilitate further control by her abusive husband.

In 2017, nine days after the death of my father—who sexually abused me from the age of 4 or 5—I was diagnosed with BPD by the psychiatry team at a major hospital without a case history or medical examination. I was subjected to electroconvulsive therapy which appears to have been ordered for the sole purpose of allowing new psychiatric residents to practice ECT. My history of sexual abuse was never acknowledged. I was not helped. I was disappeared.

BPD is scientifically unsound, ethically indefensible, and routinely weaponised against those who speak the unspeakable. Until psychiatry reckons with its colonial, gendered, and classed foundations—and recognises that trauma is political, not merely psychological—mental health care will continue to reproduce the very violence it claims to treat.

It is therefore essential that we cease the use of personality disorder diagnoses and transition to trauma-informed, narrative-based, and victim-survivor-led formulations. These approaches validate individual experiences without reducing them to static labels. They allow for complexity, contradiction, and the ethical work of meaning-making, rather than enforcing conformity to pathologising categories. Such a shift would foster safety, accountability, and genuine healing in mental health care—especially for those most frequently harmed by the current system.

2. Behaviour Therapies: Ethical, Clinical, and Financial Failures

In Australia, two dominant approaches to mental health care are behaviour therapies and psychodynamic psychotherapies. While both are widely used, they rest on fundamentally different assumptions about the human psyche, the causes of psychological suffering, and the nature of therapeutic change. Behaviour therapies aim to modify observable behaviours and thought patterns that contribute to distress or dysfunction. Grounded in learning theories such as classical and operant conditioning, these therapies prioritise symptom reduction and behavioural normalisation. Techniques include exposure therapy (gradual confrontation of feared stimuli), cognitive behavioural therapy (CBT), which combines behavioural strategies with cognitive restructuring, and applied behaviour analysis (ABA), which uses reinforcement to shape specific behaviours. The underlying goal is to increase regulation and functional compliance with normative expectations.

Psychodynamic psychotherapies, by contrast, focus on unconscious processes, unresolved emotional conflicts, and the enduring impact of past experiences on present mental life. Rooted in psychoanalytic theory, this approach aims to foster self-awareness and personal growth by helping individuals understand the deeper meanings behind their thoughts, feelings, and relational patterns. Techniques such as free association and interpretation of transference illuminate how early relational dynamics are unconsciously repeated in the present, including within the therapeutic relationship. The goal is not simply to manage symptoms, but to support enduring psychological transformation through insight and relational repair.

Despite their superficial appeal as short-term and "evidence-based," behaviour therapies—especially CBT and Dialectical Behaviour Therapy (DBT)—have consistently produced only modest clinical results. Yet they continue to dominate funding, policy, and service delivery models. This dominance does not reflect superior outcomes, but rather a system that privileges bureaucratic efficiency over ethical care. These therapies are designed to be cheap, scalable, and easily audited—qualities attractive to governments and health institutions seeking to demonstrate cost-effectiveness. However, this comes at the expense of clinical depth and relational complexity.

Even DBT's own founder, Marsha Linehan, concedes in the treatment manual that the method is only *believed* to be evidence-based (Linehan, 2015), highlighting its uncertain scientific foundations. In practice, DBT is often performative rather than rigorous—implemented to satisfy institutional metrics rather than meet the real needs of people in distress.

The tragic death of 20-year-old **Kobee Huddy** in 2019 exemplifies systemic ethical failures. After calling a mental health service (Headspace's Mental Health Triage) seeking help to stop self-harming, the operator responded bluntly: **"I haven't got any special magical advice, it's just nonsense to think that mental health triages could do that"** (SA Police News, 2023). The South Australian Deputy State Coroner later concluded that the conduct of the call was **"not satisfactory"** (Paspaliaris, 2023; Merritt, 2024). His mother characterised the system's response as "disgusting" and "heartless" (Merritt, 2024). In defending the system, Health Minister Mark Butler referred to Kobee as part of a "complex cohort" supposedly beyond the reach of services like Headspace (Merritt, 2024). This is not only untrue—it is dangerous. All mental health needs are inherently complex, and to label some clients as "too difficult to help" is to divert accountability from systemic shortcomings to those already failed by the system.

Behaviour therapies are not effective—they are convenient. Their continued dominance reflects a system more invested in control than in care.

By contrast, long-term psychodynamic and relational therapies offer deeper, more enduring outcomes, especially for individuals with complex trauma histories. Meta-analyses have shown that psychodynamic therapies produce larger and longer-lasting effects than behavioural approaches (Leichsenring & Rabung, 2008; Shedler, 2010). Moreover, process research consistently identifies the therapeutic alliance—not symptom-focused technique—as the most critical factor in healing, particularly for those harmed by institutions and interpersonal betrayal (Horvath et al., 2011; Schore, 2012).

If mental health care were guided by outcomes rather than optics, funding would follow the evidence. Instead, we reward therapies that ask less of systems—and too much of victim-survivors.

3. Neoliberal Psychology: Efficiency Over Ethics

The dominance of behaviour therapies and personality disorder diagnoses reflects a broader neoliberal logic in Australian mental health—one that prioritises cost-efficiency, compliance, and control over care, complexity, and justice. Under this model, distress is reframed not as a response to trauma or systemic harm, but as a personal failure to self-regulate.

This is not care—it is institutional discipline. Treatment becomes a set of manualised, short-term strategies designed to suppress symptoms and produce compliant subjects. Branded as "evidence-based," these approaches serve the system—not the person—by keeping care predictable, cheap, and risk-averse.

This logic begins in university training. Psychology and psychiatry programs teach students to diagnose, intervene, and follow risk protocols, while marginalising ethics, critical theory, and historical context. Students are trained to pathologise distress—not to listen, reflect, or think politically.

The consequences are profound. Although longstanding allegations of child sexual abuse eventually led to his conviction in 2020, a prominent psychologist was nevertheless promoted to positions of national authority, including President of the Australian Psychological Society (Carmody, 2020; Robertson, 2021). His rise signalled a disturbing lesson: those who serve and reinforce the system will be shielded—even when they cause serious harm.

Academic research is no exception. During my Honours year, I witnessed normalised p-hacking, data distortion, and ethical shortcuts driven by funding pressures. This culture of expediency extends beyond the lab. In 2021, a university entered into an arrangement with a for-profit company it co-owned to roll out a mental health app to staff and students, collecting their data without transparent disclosure. The app was promoted despite clear conflicts of interest. A Senate inquiry into mental health research funding noted serious concerns about these kinds of arrangements, stating: *'The committee is concerned that large sums are being directed to programs without sufficient independent evaluation, transparency, or accountability for outcomes'* (Senate Community Affairs References Committee, 2022).

Even psychiatric education is compromised. A widely used psychiatry textbook claims that "the science of personality disorders has taken centre stage," and that only BPD has evidence-based treatment. The author of this uncritical claim is not only an academic, but also a Deputy Chief Psychiatrist—lending state authority to a medicalised framework that excludes trauma-informed and victim-survivor-led perspectives.

This is not accidental. It is systemic capture. A mental health system governed by neoliberal values will always favour regulation over relationship, profit over people, and loyalty over truth.

Reform must dismantle the behavioural paradigm. We need funding for long-term, relational therapies that honour complexity, and education that trains clinicians to listen, think critically, and remain present with what cannot be fixed. Mental health care must become a space of ethical care—not institutional betrayal.

4. Accountability and Co-optation in Mental Health Advocacy

A major barrier to ethical reform is the co-optation of advocacy by powerful institutions that reward loyalty over truth. In my many years as a mental health advocate, psychology student and outspoken critic of institutional power I have witnessed clinicians and fellow "lived experience" advocates elevated—not for challenging the system, but for protecting it. Awards, funding, and influence go to those who uphold dominant frameworks, not those who expose harm.

Though lived experience is now publicly celebrated, our inclusion remains conditional. When I speak about psychiatric coercion, institutional betrayal, or systemic abuse, I am often mocked, marginalised, and at times threatened—both physically and reputationally. On one occasion, I used my personal social media account to raise concerns about occupational therapists overstating their mental health qualifications and working outside their scope of practice by completing psychological formulations through the NDIS. In response, I faced threats of legal action unless I removed the videos. Although I stand by my position—that occupational therapists without mental health endorsements are acting outside their scope—I took the videos down out of fear for my professional safety. This experience made painfully clear that there is a two-tiered system: one for safe, sanctioned advocacy, and another for those of us who dare to speak uncomfortable truths.

Terms like "consumer," which were originally intended to reduce stigma, now function to impose market logic onto mental health care. The distressed person is reframed as a passive, ungrateful client—someone to be managed rather than heard, treated rather than taken seriously as a political subject with the right to resist. This framing rewards compliance and emotional restraint while marginalising those who speak with anger, name systemic harm, or challenge institutional authority. It disproportionately excludes racialised people, victim-survivors, and anyone whose truths disrupt the dominant narrative. In this way, lived experience is only welcomed when it conforms—when it is self-negating, depoliticised, and convenient for those in power.

Lived experience is now routinely used to legitimise power, not to transform it. Victim-survivors like me are expected to deliver polished recovery narratives—stories that celebrate resilience without naming the systems that caused our harm. We are welcomed only when we appear to have "moved on," and remain silent about ongoing abuse, neglect, or betrayal. I cannot count the number of times I've been cautioned against holding a "victim mindset" simply for speaking honestly about my experiences. This pressure to perform wellness—to appear grateful, rehabilitated, and apolitical—functions to protect institutions and hierarchies, while discrediting those of us whose pain remains unresolved, and whose voices remain inconvenient.

An example of what is considered acceptable advocacy appears in the widely used textbook *Mental Health and Collaborative Community Practice*. The lived experience voices featured are overwhelmingly white, university-affiliated individuals—most notably from the University of Melbourne (Meadows et al., 2020). The text offers no discussion of abuse or neglect by clinicians, nor any critical engagement with structural power or how it is wielded against the vulnerable. Instead, lived experience is framed through a recovery narrative in which individuals are portrayed as damaged but redeemed through medication, coping strategies, and self-discipline—ultimately reinforcing, rather than challenging, existing structures of clinical authority.

5. Private Insurers Undermine Ethical Care

The growing role of private health insurers in Australian mental health policy is a direct threat to ethical, equitable, and trauma-informed care. Though framed as expanding "choice," their involvement deepens inequality—shifting care toward the wealthy while excluding those in greatest need. This is not reform; it's structural abandonment.

Private insurers are not neutral. Their business model depends on reducing costs, standardising treatment, and avoiding complexity (Rose, 2007; Timimi, 2015). As a result, only short-term, manualised therapies are funded, regardless of appropriateness, while long-term relational care is denied because it cannot be easily measured or monetised.

This creates a two-tiered system: those with insurance receive faster access and more options, while others face overloaded public services, diagnostic gatekeeping, and coercive treatment (Boyle, 2011; Bracken et al., 2012). Care is rationed by profitability, not need.

Private insurance aligns with the broader neoliberal shift in mental health: stepped-care models and outcome metrics prioritise efficiency over ethics and human dignity (Bracken et al., 2012; Timimi, 2015). Corporate incentives now shape not just access to care, but policy, training, and definitions of success—a structural conflict of interest (Rose, 2007).

In 2022, a major private insurer acquired a plan management service, gaining access to the private data of thousands of disabled people—without consent. As a client, I experienced delays, pressure to reduce supports, and disregard for clinical advice.

Despite raising this with the relevant minister, no regulatory action followed. This merger exemplifies the risks of allowing profit-driven corporations to govern mental health and disability care.Mental health reform must reject further encroachment by private insurers. Ethical care must be publicly funded, trauma-informed, and grounded in relational ethics and survivor expertise—not corporate profit.

6. Ethical Injuries Among Frontline Practitioners

Amid the institutional harms outlined in this submission, another form of suffering persists: the ethical injuries carried by frontline practitioners.

Nurses, peer workers, social workers, psychologists, and psychiatrists often enter the field to help others—but many are soon coerced into practices that betray that purpose. They are pressured to follow coercive protocols, reductive diagnoses, and risk-averse policies that erase the historical, relational, and political roots of distress. This creates moral distress: the internal conflict when professionals must act against their ethical beliefs (Lamoureux, Mitchell, & Forster, 2024; McCarthy & Monteverde, 2018).

These are not individual failings—they are the predictable outcome of working in systems that prize compliance over integrity, documentation over presence, and policy over ethics.

Practitioners who resist—who speak up, advocate for clients, or challenge harmful norms—are often punished. They face ridicule, isolation, burnout, and professional consequences for refusing to abandon those they serve (Hendin et al., 2007; Newell & MacNeil, 2010). This is not a failure of resilience—it is a system disciplining moral agency and suppressing relational care.

If Australia is serious about reform, it must protect the ethical wellbeing of its workers. Ethical injury must be recognised as professional trauma. Confidential spaces must be created for staff to process moral distress and institutional betrayal—free from fear of retaliation. Whistleblowers and dissident practitioners must be protected, not penalised.

The wellbeing of clients and the integrity of carers are not in conflict—they are inseparable. A system that punishes ethical care cannot offer it.

Recommendations

1. **Cease the use of personality disorder diagnoses.** Replace them with trauma-informed, narrative-based, and victim-survivor-led formulations. Recognise emotional pain as a response to harm, not pathology.
2. **End the behavioural monopoly.** Stop defaulting to CBT and DBT. Fund a diverse ecosystem of care, including long-term relational, feminist, liberationist, psychoanalytic, and culturally grounded therapies.
3. **Reform research funding.** Audit public mental health funding for structural bias. Redirect investment toward victim-survivor-informed, context-sensitive approaches that address social, political, and historical trauma.
4. **Transform clinical education.** Replace protocol-driven training with curricula centred on ethical inquiry, decolonial critique, Lacanian theory, and the clinical skill of deep listening.
5. **Launch a national inquiry into psychiatric harm.** Focus on gendered, racialised, and coercive practices—especially the misdiagnosis and mistreatment of First Nations women and children. The inquiry must be co-led by First Nations women, not white institutions.
6. **Expand access to long-term therapy**. Increase Medicare-funded sessions. Introduce new MBS items for trauma-informed, psychodynamic, psychoanalytic, and victim-survivor-led care. Fund clinician training in culturally diverse relational practice.
7. **Protect lived experience advocacy.** Establish independent oversight of advocacy funding. Safeguard dissenting voices and prevent co-optation by institutions invested in maintaining the status quo.
8. **Mandate transparency.** Require public disclosure of financial ties, honours, and affiliations for all individuals and organisations influencing mental health policy.
9. **Ban private insurer influence.** Exclude for-profit health insurers from shaping mental health services. End profit-driven care models and fully invest in a public, trauma-informed, justice-centred system.
10. **Recognise ethical injury.** Treat moral distress and institutional betrayal as legitimate workplace harms. Provide protected spaces for reflection and legal protections for practitioners who speak out against abuse.

Conclusion: This Is Not Care, Its Control

Australia’s mental health system is in crisis—not only of resources, but of ethics. The continued use of personality disorder labels, behaviourist therapies, and corporate models is not neutral. It is a form of institutional violence that punishes pain, silences protest, and pathologises those who refuse to comply.

Every missed reform is a choice.
A choice to ignore victim-survivors.
A choice to protect profit over people.
A choice to preserve systems that retraumatise, exclude, and erase.

This is not a moment for cautious reforms or cosmetic change. It is a moment for moral courage.

The government must choose:
Will it stand by a system built on coercion, compliance, and commercial interest—
Or will it build one rooted in justice, humility, and care?

Because the truth is this: people are suffering and dying under the weight of policies that call harm help. And every day that passes without action is another day of preventable deaths and suffering.

The future will ask what we did when we knew. Let the answer be: we refused to look away. We spoke the truth. We demanded better—not from others, but from ourselves.

Abolitionist minister Theodore Parker once wrote, "The arc of the moral universe is long, but it bends toward justice."

Are we willing to bend with it?

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Appendix: Arguments Against the Proposed Changes – And Why They Fail

Argument	Rebuttal
1. “We cannot afford long-term, relational therapies at scale.”	It’s a false economy. While relational, trauma-informed therapies may involve higher upfront investment, studies consistently show they reduce long-term costs through lower rates of hospitalisation, suicidality, medication reliance, and workforce burnout (Bateman & Fonagy, 2008; Leichsenring & Rabung, 2008). Ethical, consistent care prevents chronicity. Short-term symptom suppression often leads to relapse, revolving-door admissions, and greater human and financial cost over time.
2. “Evidence-based brief therapies like CBT and DBT are the gold standard.”	The term “evidence-based” has become a gatekeeping tool, favouring what is easy to measure over what is effective in real life. RCTs systematically exclude complex, comorbid, or trauma-affected populations (Carey et al., 2007). Long-term psychodynamic and relational therapies consistently outperform brief therapies in maintaining gains, especially for personality, trauma, and attachment-related concerns (Shedler, 2010; Leichsenring et al., 2015). Clinical effectiveness must not be conflated with bureaucratic efficiency.
3. “We need to preserve consumer choice—calling people ‘consumers’ empowers them.”	Framing people as “consumers” imports neoliberal market logic into spaces of vulnerability. It reduces identity to purchasing power and masks the unequal conditions under which choices are made. This language privileges white, educated, middle-class voices while sidelining racialised, poor, and trauma-affected individuals (Costa et al., 2022; Rose, 2007). True empowerment means recognising people as political subjects—witnesses, survivors, victims, comrades—not passive service users.

Argument	Rebuttal
4. “Private insurers relieve pressure on public services and drive innovation.”	This is demonstrably false. Private insurers ‘cream skim’ low-risk clients while pushing complex cases onto under-resourced public services, exacerbating inequality and waitlists (Timimi, 2015; Bracken et al., 2012). Their innovations are geared toward profit, not care standardised treatments, minimal contact hours, and algorithmic triage. They do not relieve pressure—they reallocate it unfairly and unsafely.
5. “Lived experience is already at the table—diverse voices are included.”	Inclusion without power is performance. Many “lived experience” advocates are selected for institutional compliance, not critical insight. Those who speak uncomfortable truths—about racism, coercion, or sexual abuse—are marginalised, pathologised, or excluded. Without protection for dissent and mechanisms for accountability, inclusion becomes tokenism. Representation without redistribution is not reform (Costa et al., 2022; Moreton-Robinson, 2000).
6. “Private influence is embedded—we can’t remove it.”	Systems are changeable. Australia already has examples of universal, publicly funded healthcare (e.g., Medicare, PBS). The UK’s NHS restricts insurer interference; Scandinavian countries regulate profits in health sectors. The problem is not feasibility—it is political will. We can—and must—build a mental health system where clinical decisions are made by practitioners and service users, not corporate boards (Boyle, 2011; Davies, 2016). The status quo is not destiny.