Productivity Commission
Final Review of the Mental Health and Suicide Prevention Agreement
Submission to Interim Report

I appreciate the structural problems raised with the national agreement by this Interim Report, and in principle, I agree that those aspects need to be more convincingly addressed by government. However, my primary concerns lie with the issues I wish to raise here.

I am not able to see that the failures to substantively reduce the incidence of suicide or to prevent preventable mental health issues or to qualitatively improve the lives of all Australians are due solely, or even primarily, to structural limitations in the national agreement or the points raised by the Interim Report, or that they will ever be achieved by implementing this national agreement. I believe that the entire approach taken here is fundamentally flawed.

At the same time, it is intensely frustrating that governments have had at least three decades to get this right, and in all of that time, they never have. The first National Mental Health and Suicide Prevention plan of 1992 was already supposed to ensure that governments provided sufficient and appropriate mental health care both within the community and in psychiatric units in general hospitals – but it didn't, and ever since, no subsequent plan ever has, and governments are the flies in the soup. They have left tens of thousands of people without any of the care, support, services and treatment that we should all have had access to, they have knowingly refused to address issues of cost and affordability and other access, such as local service delivery across the country including regional, rural and remote community needs, they have failed to resolve problems of recruitment, training, sustainable full professional employment and retention of staff, a national shortage of psychiatrists for the past 40+ years, as well as chronic problems with hospital bed shortages, failure to resolve challenges experienced by GP practices and Medicare rebates, they have done nothing to regulate or improve university education and training, all while watching tens of thousands of lecturers lose their jobs with their education and lives wasted, and more. In Australia around 1980, we had the best *per capita* ratio to doctors in the world, but then, greater limitations were imposed upon university admission to Medicine and the numbers dropped until a decade ago, we knew that we had a shortage of 4,000 doctors nationally, but still the problem was not resolved, but instead compounded by making GPs and public hospital employment unsustainable, so that governments actively caused more attrition. Professional burnout is primarily caused by the working and employment conditions of staff in our health systems for which government is essentially responsible – and could have prevented.

All of these failures are the result of unresolved conflicts with government priorities, notably, the desire to cut costs wherever possible instead of investing properly and proportionately, allowing for increasing costs due to both natural inflation, wage and salary increases, and also growing need including due to population increase and longevity, and this has created mental health issues and attrition and suicide even amongst the very mental health professionals who are expected to help others. Governments have not responded appropriately at any time over decades to any of these issues, and until they have an unconditional commitment to fund and invest in all of the staff (all career professional employment of which should be secure, permanent, adequately remunerated, and lifelong), resourcing, capacity and new services required proportionate to demographics and population growth, and to find ways of funding that which do not impose unaffordable costs upon the public (by better management of the national economy and major tax reform, for example), it is not foreseeable that any of these issues will be resolved and that we will all get the care we need. These are all completely preventable problems, they have been caused by consecutive governments, and they have to be reversed or changed by government. I do not see any understanding of these issues in the Interim Report, and I therefore find it inadequate on this basis.

It should be a reasonable expectation of the Australian people that irrespective of who forms government at either Commonwealth or State & Territory level, those governments remain permanently committed to full funding and public service delivery, and that no incoming government feels the need to undertake yet another review or to seek ways of reducing necessary expenditure. Australia should have sufficient financial means to fully fund all such services in the same way that more advanced and social democratic countries have been doing for decades, and with better economic management, we would. The only reasonable priority here – and everywhere else – ought to be the health and well-being and prosperity of the entire population, without discrimination or exception.

I also believe that dentistry should be included under general health, and that governments should resolve the unacceptable difficulties of access to dentists and resulting worse oral health care. This is not directly relevant to mental health, but the inability to access such care and the consequences of poor oral care do have mental health effects, which are typically not recognised.

Both the national government agreement and the Productivity Commission review appear to regard all mental health issues as unavoidable for those who experience them, and any mental health plan as only serving to support people once they have developed symptoms and sought help. This is not an adequate response.

Most mental health conditions are *preventable*, and I am confident that most people would like them to be prevented, but preventing them requires government to act in ways that it doesn't, and which is not envisaged by this current agreement or review. That is, they are caused by how people re-act to abuse, stress, trauma, and any other form of mistreatment, all of which is typically caused by other people in their environment, be it their own family, or other bullies, predators, abusers, or socio-economic disadvantage, other stress factors, such as unsustainable household debt, unemployment and the many consequences of it, toxic working and employment conditions, lack of suitable opportunities, and climate change. Not all of these things can be prevented in every case, although in some cases the incidence and risk could be credibly reduced. In some cases, like schizophrenia and other associated conditions, they can be highly unpredictable ways that individuals react to stressors, including their own expectations of themselves. In many other cases, however, they could be more easily and largely prevented, Australia did not always have this incidence of many conditions, and a national mental health plan should have looked at what government could actually do to address these ambient determinants. Psychosocial responses, assuming that they are ever acted upon, will not achieve this. The WHO reported in the mid-2010s that mental health was now the leading global health challenge, and the only possible explanation for that, is our socio-economic environment. It can't all be because of genetic mutations or brain damage or worsening imbalances in neuro-chemicals, it can only be caused by the stressors under which we are forced to live, which for many people have been palpably worsening since the 1990s. Australia had the opportunity to respond to that WHO assessment a decade ago, but we didn't.

If it is true that 1 in 5 Australians (or more) will have some mental health issue at least once in their lives – and perhaps half of those will have long-term or chronic, complex and multiple issues – then that means that in aggregate, we need the beds and staffing, GP and clinical capacity to serve approximately 5 million Australians of all ages at any given time across the country, without waiting times, with a diverse range of mental health issues; even if 5 million do not all need help at any particular time, and beds are temporarily unoccupied and hospitalisation is not required for all, and clinicians are not all fully booked, we should have the capacity to serve that number, which would include times when there are spikes in demand, which we have seen for multiple reasons in recent years. People should always have the opportunity to be admitted to a hospital as needed, and to remain there for as long as required for their treatment; in mental health cases, that can mean a prolonged admission. In Australia, there is evidence that governments could have considered dating back over 20 years of how these stressors have worsened over that time, but they have not considered that evidence. Australia is also permanently in breach of most of our human rights obligations under agreements we have ratified, mental health and all of the ambient determinants that cause or contribute to those problems are, explicitly, human rights obligations that our governments breach and neglect.

These ambient determinants are also directly contributing to some incidence of Domestic, Family and Sexual Violence, to multiple school "behaviour" issues, and to all of the other issues confronting people, and none of those issues will be reduced in incidence until government understands what is actually causing them and addresses those causes. To date, they have not done that, no matter how many inquiries they have conducted.

Government also continues to ignore the fact that it is itself one of the greatest perpetrators of violence against Australians that causes suicide and other distress, both by omission and by commission. No national agreement that ignores the enormous role of government in causing, compounding and tolerating adverse ambient determinants affecting people's mental health and suicide will be acceptable.

All of these ambient determinants are outside the capacity of any mental health professional to address. None of them can end toxic workplaces or improve industrial relations, or end anybody's household debt, or provide secure lifelong employment for everybody in jobs that are appropriate to them and which are commensurate with their education and potential, or end juvenile detention or homelessness or unemployment or government discrimination against multiple population groups, or do anything about the impacts of extreme weather events, or stop the government from approving new fossil fuel development projects and tolerating environmental, species and ecosystem destruction. All of these things are affecting people's mental health, but none of them can be diagnosed and dealt with by any GP, clinical psychologist or psychiatrist.

There is also no response in this agreement evident that addresses the implications for several million Australians of the 2023 Australian Child Maltreatment Study, which potentially has enormous implications for every single one of those abused and traumatised children's mental and physical health for the rest of their lives. This agreement cannot seriously be viewed as adequate in that respect. One is forced to conclude, either, that government has no understanding of the nature of such complex trauma but would act appropriately if it did, or, that it does have some understanding but is not going to address it anyway, and that every new mental health policy iteration is window dressing and a farce. If the former, then *when* will it finally educate itself?

This national agreement is therefore not fit for purpose as long as those ambient determinants continue to be ignored and the only response is to wait for people to get sick and then offer them aspirin; and as long as the needs of multiple population cohorts are ignored. This simply is not acceptable.

I am sick to death of government incompetence and utter contempt towards the needs of the public to whom they owe responsibility to deliver services and to ensure adequate well-being, care and protection, none of which is being provided. I have no wish to participate anymore in such futile deliberations. It is not a question of developing and implementing a plan taking time, such as the past three years. Australian governments have had thirty years to get this right, and there is absolutely no excuse for them not having been able to do everything necessary over the past three years, or as a continuation of what should have been commenced long before. The reality is that the failed experiment of Neoliberal democracy in Australia treats every Australian who cannot afford to fend for themselves as collateral damage, and there is no willingness to act on what government has already been told or to act effectively to save any life. What is missing here, which is equally missing in relation to DFSV and many other challenges confronting this country, is a sense of the *urgency* of it all. Nine people end their lives every single day, on average, in this country, and another 60+ attempt to end theirs (some of whom will succeed on the next attempt), and yet in all the years we have known this, no government has evidently done anything – or enough - to save *any* of them. How do you explain that? I have been narrating my own story and experience to governments and to endless submissions like this for the last 14 years, during which I could have ended my life at least 5110 times, and yet what has any government done in that time to assist me? Nothing. Stigmatise me, treat me in ways that encourage suicide and chronic severe treatment resistant depression, impoverish me, but never actually help me. That goes for millions of Australians.

Right now, we are all watching yet another disaster unfold: the revelations of the sexual abuse of children in child care. We have had a national and a state Royal Commission into child sexual abuse (the national Commission reported in December 2017!), we have had an AHRC report on sexual abuse of children in sport, we have had countless other investigations and reports about child sexual abuse perpetrated by individuals or within particular communities or contexts, and how so often repeated complaints resulted in no action being taken by anybody, not even by ordinary staff in organisations, service providers, institutions and departments. In the wake of all of that, it would have been a reasonable expectation that our governments had immediately implemented all of the recommendations and acted to ensure that, as far as humanly possible, this could not happen again – just as it would have been reasonable to have seen Indigenous deaths in custody STOP from 1991, instead of continuing with impunity and no accountability whatsoever. Evidently, nothing has been done either at all or adequately, the childcare sector is clearly not effectively regulated or self-regulating, we have not acted to protect our children, complaints and warnings and early risk factors have, as usual, been ignored, working with children checks have not been made effective, while the focus now is on males, it continues to be downplayed, trivialised and ignored that females also abuse children and that the statistical incidence of their doing so is reportedly around 40% in one earlier study,[1] not too much shy of half, and some of those abused children will have significant mental health, medical and behavioural problems for the rest of their lives, which I understand but obviously neither politicians nor most clinicians understand – I was also neglected like that and I still am - for which our grossly unjust and incompetent and inadequate public mental health system will never be able to provide them with the care they may need, and the rest of our society will also not help them. They will also risk being stigmatised, criminalised, and perhaps driven to suicide because of our failures to understand and help them. Some perpetrators were themselves child victims who were never helped. And meditating upon this situation, one is forced to ask, are our governments actually capable of doing *anything* at all? Because it does not look as if they are. This is not an isolated issue: it is merely the latest in a national history of policy failures. It does not look as if *any* government actually cares about anybody else's life at all, because if they did, they surely would not behave the way they do. Government in Australia is itself not fit for purpose.

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[1] "Childcare sexual abuse is mostly committed by men. Failing to recognise that puts children at risk" — https://theconversation.com/childcare-sexual-abuse-is-mostly-committed-by-men-failing-to-recognise-that-puts-children-at-risk-260292
Cf. also e.g. "How many serious incidents are happening in Australian childcare centres? We don't really know" — https://theconversation.com/how-many-serious-incidents-are-happening-in-australian-childcare-centres-we-dont-really-know-260410
"10 steps governments can take now to stamp out child sexual abuse in care settings" — https://theconversation.com/10-steps-governments-can-take-now-to-stamp-out-child-sexual-abuse-in-care-settings-260405
"Parents of kids in daycare are terrified following Melbourne abuse allegations. What can they do?" — https://theconversation.com/parents-of-kids-in-daycare-are-terrified-following-melbourne-abuse-allegations-what-can-they-do-260285
https://www.abc.net.au/news/2025-07-06/male-childcare-workers-feel-judged-amid-abuse-allegations/105496380?utm_campaign=abc_news_web&utm_content=mail&utm_medium=content_shared&utm_source=abc_news_web
This begs the question why appropriate measures are not already in place and why it always takes a major news story to force governments to do things they should have already done as a normal act of governing.

It is not possible to continue being polite under such absurd and utterly outrageous circumstances. Sooner or later, it must be accepted that anger, frustration, moral indignation are entirely justified by these failures, and that government ought to be answering for every single life it has ever failed to protect or help, the harm to or loss of it has indifferently tolerated. One wonders how and why this country thinks it is so urgent to spend $360+ BILLION dollars on the AUKUS submarines to protect this country, and yet we cannot spend a fraction of that money to make the country worth defending by caring for our population.

I wish to respond to Information requests 4.1, 4.2 and 4.3.

4.1: My response to this should also be related to 4.4, but I am not answering either question directly.

Re: 4.1, In my opinion, how alcohol and substance abuse is viewed is dependent upon whether it is recognised – in some cases, at least – as a cause or as an effect of other conditions and issues. Certainly, both alcohol and substance abuse can result in other mental (and biomedical) health conditions.

It is less obvious that such abuse itself leads to suicide, and I think that this would need to be established. It is not always established that deaths involving alcohol and/or substance consumption were intentional suicides. Where it is obvious that a death involving one or both factors is a suicide, the question remains whether that long-term abuse led somebody to become suicidal, or whether they were aids to the suicide, in the same way that a medication overdose is also an aid to a suicide, without actually being the originating cause. These distinctions would need to be clear in any proposed additional schedule. I am not aware of any evidence or research that would confirm that alcohol and/or substance abuse are the primary or only cause of suicide, not even when the effects of substance abuse result in neurological or hallucinatory or psychotic states. This would need to be established, in my opinion.

On the other hand, alcohol and substance abuse are known to often result from a range of other conditions, from the effects of childhood abuse and trauma of any kind, to schizophrenia. There are specific reasons for this, and I engaged in several years of alcohol abuse and substance experimentation in association with sustained childhood abuse and trauma from multiple sources, severe depression and a suicide attempt in adolescence. In such cases, alcohol and substance abuse are secondary problems, not the primary cause. Unfortunately, the significant emphasis upon addressing alcohol and substance abuse perceived as problems in their own right as well as poor clinical education in the nature and effects of complex trauma resulting from childhood abuse have often tended to result in that originating abuse and trauma being overlooked and receiving no dedicated treatment and care; I have encountered psychiatrists who have not understood the connection, and who have simply assumed that once you have cured somebody of their addiction, you have solved their problem, but you haven't at all. Any underlying or principal cause must be identified and addressed as its own specific problem.

Here, too, therefore, I suggest that distinctions need to be made as to whether perfectly well-adjusted, socially integrated and successful individuals with no history of childhood abuse and trauma or any other mental illness abuse alcohol and/or substances and whether this alone constitutes a mental health condition (I do not know how common that would be), or whether such alcohol and/or substance abuse occurs as an effect of prior abuse and trauma, depression, and/or any other such condition. It is certain that the mental health issues in many individuals and the reasons for them are not recognised, with the consequence that their behaviour is assumed to be "normal", or explicable in other terms, which may not be justified at all.

Re: 4.4, I have no personal experience of being a peer worker within a clinical setting, and I have completed no qualification or training to fulfil such a role. I wish to comment only on the aspect of suicide prevention, in which I have assumed a private peer support role. I perceive several difficulties here.

It is not clear to me what the relationship would be between a peer supporter and a clinician. I assume that somebody experiencing suicidal ideation would either call a helpline or would seek an appointment with their GP or present to a hospital emergency department. In the case of calling a helpline, they would usually then be referred to mental health services, and in any case once in the care of a clinician, any role of a support worker would be secondary. Much depends upon the assessment of a clinician and also of what other services they may wish to refer somebody to, and what services are in fact locally available. A clinician may also simply tell somebody experiencing suicidal ideation to call their practice or go to the local hospital and not attempt to link them up with other services; this has occurred to me. I am not sure how well clinicians understand suicide, but I suspect that most do not.

Much would also depend upon the resources and training of any peer supporter, as well as their relationship to the person experiencing suicidal ideation, and also the cause of that ideation. Somebody experiencing sometimes acute suicidal ideation over weeks, months, or longer, requires a level of peer support, if it is available at all, that exceeds any normal capacity to meet that need. They would also not normally be hospitalised with suicidal ideation for any length of time.

I have provided such support to one person often on a daily basis for a period of more than twelve months. I could only do that because I am de facto permanently unemployed, but were I still exercising my professional *métier,* I could not have done this. It was extremely time consuming and emotionally demanding, and I believe that I was the only person available to them in effect 24/7 and who provided any adequate support. They have told me that had I not been there, here were points at which they would have attempted suicide again. I do not know how any existing suicide prevention strategy would have helped them.

It was also obvious that they had prior childhood abuse and (complex) trauma which was exacerbating the difficulties that they experienced in dealing with the immediate trigger cause; they also had sessions with several therapists or clinical psychologists over this time, with none of whom I had any contact, but none of whom obviously understood the way in which his prior and current trauma interacted with his suicidal ideation. I found their ability to help him severely deficient, one of them was clearly incompetent and should not have been allowed to practice, they obviously had little understanding of complex trauma, and he has not obviously been helped by any of them. He is still alive, but his mental state is deplorable, I cannot help him to address the longer-term effects of his previous abuse and trauma, but I am not confident that anybody else can, either. Although intelligent and having a Bachelor degree in Psychology, he does not have any insight into his own condition and has repeatedly failed to take any advice about informing himself better so that he could perhaps help himself or then discuss issues with me. He has a previous suicide attempt, and it is foreseeable that without more competent and appropriate therapy, he could again attempt suicide under the influence of another trigger or adverse life experience. I cannot see in what adequate sense there has been any suicide prevention here.

I had some acquaintance with him prior to the trigger that caused this episode, as we were both lived experience advisors in a men's suicide prevention research project. My own experiences are analogous to his own, and it is on that basis that I was able to support him. Although I do not have any formal qualification in mental health, I probably know and understand more than many accredited clinicians, and if I were paid, I could probably also offer him regular therapy sessions weekly or more frequently (which is normal practice in international psychotherapy, which is also covered by normal health insurance), but I expect that an effective period of therapy would require several years. He will never be able to access such therapy in Australia, although one can in other countries. I was able to access five years of psychoanalysis while working in Germany, with a fully trained and qualified psychiatrist, with no waiting time, and which was fully covered by normal health insurance. Australia is unlikely to ever achieve that level of public mental health care delivery.

I do not imagine that many peer supporters could provide the level of support that I have provided to him over more than the past year, no clinician would, and at best, people would be told to call somebody in an emergency. That may be understandable, but it is not genuine suicide prevention. If you are referred to a peer support network and to people whom you do not know, have no relationship with, and become dependent indefinitely upon their help, I do not know how successful or effective this model actually is. I also do not know what financial support such peer workers would receive, and whether it is enough.

His triggering experience was not in his head: it was something that somebody else actually did to him, which then caused a chain of further circumstances, against which he was unable to find any recourse or appropriate assistance, and crucially, his sense of the injustice of this situation, which he felt he had done nothing to cause or provoke, combined with his helplessness, which also repeated what it feels like to be mistreated as a child (where again a sense of injustice plays a greater role than is usually recognised), were what made him suicidal again. Other professionals who should have treated him with greater respect failed to do so. There is no adequate means associated with suicide prevention that is able to address practical situations that lead to suicide, and it is reduced to a purely medicalised response, but this response is not adequate, and there should be a concrete focus in suicide prevention that is capable of doing things to help improve people's quality of life, to resolve their practical problems for them, to eliminate the ambient causes of that ideation. There isn't. Even if there were, peer supporters would be largely unable to contribute to that.

I belong to the cohort who do not seek help for suicidal ideation. Suicide prevention in Australia ordinarily assumes that anybody experiencing suicidal ideation will regard this as intrusive thoughts and seek help. The reality is that this approach is not reducing the incidence of suicide, and research finds that a majority of people experiencing such ideation do *not* seek help, and will attempt or complete suicide alone.[2] This means that for such people, peer support workers also have nothing to offer, and will not be sought by us. I am not able to see that any current suicide prevention plan understands this or includes any strategy that would address the needs of those people, and this is precisely one reason why the national incidence of suicide

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[2] Cf. e.g. Hallford DJ, Rusanov D, Winestone B, Kaplan R, Fuller-Tyszkiewicz M, Melvin G. Disclosure of suicidal ideation and behaviours: A systematic review and meta-analysis of prevalence. Clin Psychol Rev. 2023 Apr;101:102272. doi: 10.1016/j.cpr.2023.102272. Epub 2023 Mar 26. PMID: 37001469. See also below on 4.3.

has not been reduced. I have myself repeatedly emphasised this problem, but it has never been recognised and addressed. Convincingly reducing the suicide rate requires us to do things we have never done before. Anybody having an adequate clinical understanding of suicide should know this.[3]

A number of population cohorts with known incidence of suicide have little or no direct access to any mental health services, either to clinicians or to any other support networks; it should be a priority of governments to improve all of those people's access to adequate and appropriate mental health care, but governments have not done that.

There are multiple reasons why people do not seek help, which it is possible to explain, but I do not see any evidence that they are understood or being addressed. Genuine suicide prevention does not mean waiting until somebody has acute suicidal ideation, which they may then act on without seeking help, or waiting until they have attempted suicide and then offering them some help: Genuine prevention means eliminating and preventing all of the known causes for anybody's suicide as far as possible *before* they can become suicidal. This would require a radically different response, but Australia has not considered this. Once people have acute suicidal ideation, and can be considered at risk, they may act upon that ideation within minutes, or within several hours, or at most within a couple of days; during that time, they may appear perfectly happy and not at risk at all, they may appear in remission from a mental health condition, and they may conceal their thoughts. They will not seek help, they will be focussed and not wish to be stopped or interfered with, and they will usually act on that ideation. I belong

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[3] I am currently researching and writing my own book on suicide in Australia from a lived experience and academic perspective, because of the continuing deficiency in understanding of this topic, and the many problems with current responses, 'research', academics' and organisations' approaches. I also submitted a response to the NSW government's discussion paper (2024) about proposed suicide prevention legislation, and have responded to other prevention strategy iterations. I have also had contact with the NSPO, but have not been impressed by them. Many people now working in this sector cannot be described as genuine experts on suicide, not even major organisations receiving government funding and advising government on suicide prevention; I have had contact with a number of those organisations. We do not seem to have researchers or academics whose employment is secure and lifelong and sufficiently funded that they are able to engage in genuine original research beyond meta-analyses, on the level of what is being done internationally, nor do we have people fully conversant in all of the relevant literature. This agreement speaks of improving the knowledge of the suicide prevention workforce, but currently, we do not have the capacity to do that, it is exceptionally concerning that government does not understand why we cannot do this, because it should know, and we probably won't. Governments have done nothing to stop the massive academic attrition in our universities, and until that problem is better addressed, no Australian university will ever deliver better education, training and research in any of these areas. There is, obviously, an enormous literature on all aspects of suicide, including the history of suicide and cultural, philosophical and other perspectives, and there are a number of major theoretical approaches, which "experts" should know. While it has some limitations, Kay Redfield Jamison, *Night Falls Fast: Understanding Suicide* (New York: Vintage, 1999), is perhaps the best introduction to recommend; Anna Mehler Paperny, *Hallo I Want to Die Please Fix Me: Depression in the First Person* (New York: The Experiment, 2020), is also illuminating. Cf. also *The Ethics of Suicide: Historical Sources*, ed. Margaret Pabst Battin (Oxford: Oxford University Press, 2015).

to that group. There is no evidence that existing suicide prevention plans understand this, or have any adequate strategy that could prevent such suicides.

As I listed in my earlier submission to this Review, suicide is caused by one or more of several dozen different causes, or occurs with known incidence particularly amongst groups characterised by those causes, even if the majority of people identifiable with any of those groups do not attempt suicide. Actual incidence of suicide amongst any such group relative to that in other groups varies. Effective prevention would mean addressing *every one* of those causes, but we don't, and the vast majority of such causes or groups are never mentioned. Arguably one element common to all of those groups is some assault or undermining of individuals' sense of self, of their own sense of identity, integrity, autonomy; this is usually caused by others, or by government, or by circumstances over which they feel they have lost control, it is not primarily a genetic or neurological cause, and it may be compounded by the same feelings being caused by multiple experiences or circumstances, such that suicide seems to be the only genuinely *autonomous* and *dignified* act left to them, and/or the only escape from those feelings. My favourite observation about suicide is that of Arthur Schopenhauer: the person attempting suicide is not anti-life, they are only anti the life that they are forced to live or which is offered them.[4]

Both suicide itself and factors that lead to it are deeply personal matters and involve a considerable degree of trust in another person to confide in them and to rely upon them during a crisis. Many mental health conditions make it very difficult to trust and confide in somebody else, even if you do already know them. A particular relationship first needs to be established, but it cannot always be established. Exactly the same problem is known when seeking a therapist or clinician: an effective therapeutic relationship depends upon whether the patient can trust and interact openly with that therapist, but that is not always possible, and one may need to test a number of clinicians before one finds somebody whom one can trust. I once changed my GP because I did not feel that one GP had any convincing understanding of my mental health issues, however good a physician they may have been in other respects, and I lost confidence in them. These issues are very real, but I do not know how seriously they are taken in such policy iterations; they are certainly not adequately provided for under Medicare. I assume that peer supporters would often be complete strangers to those whom they are asked to help,

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[4] Arthur Schopenhauer, *Die Welt als Wille und Vorstellung* ([^{3}1859] Munich: Deutscher Taschenbuch Verlag), p. 512.

In view of these and other considerations, it seems to me that the role of peer supporters would be limited as a contribution to suicide prevention, as in many cases, they would not be included or able to contribute, and even if they were, what they could offer in support would also be limited. I assume that their principal role would be to be available to somebody undergoing a short episode of acute suicidal ideation, or to be physically present with them, assuming that that person had sought their assistance or been put into contact with them after having sought other help. This assumes in turn that the person affected has in fact sought help, as many do not, that their episode is not prolonged or indefinite, and that they can reasonably be prevented by this means. There is considerably more that government could do directly to reduce the risk of suicide and contribute towards prevention, but government has not so acted, and other ideological or political attitudes and priorities often tend to militate against effective action. Juvenile detention in Australia, for example, has been known to have a steady incidence of suicide and self-harming for more than 70 years, but evidently, no government will ever shut down all juvenile detention facilities, or adequately reform them, or seek to resolve the reasons for them by other means, and to that extent, nothing will be done to prevent suicides in those facilities, or the antecedent causes. The same is true for other at-risk population groups, for whom government also has no intention of changing or improving its attitudes and behaviour in order to reduce their risk of suicide. I do not understand how any government ever intends to reduce the incidence of suicide as long as it refuses to reduce the causes of suicide amongst multiple population cohorts.

4.2: Lived experience consultation is supposed to make government, other organisations, and clinicians more conscious of the experiences of people with, in this case, mental health issues, both so that those needs can be better met by services and policy iterations and their implementation, and also to complement the theoretical and research-based content of mental health professionals' education and training with actual experience, so that when they encounter people with specific conditions, they have a better insight into their patients' perception and experience than their formal education typically provides them with. They can inform clinicians about their needs, what approaches may be most effective, how to navigate people's difficulties with trust, and what to avoid.

Unfortunately, this process has become a box-ticking exercise and, presumably, a condition of funding, but it is sometimes done in what feels like a perfunctory manner that is now alienating many people with lived experience and making them more reluctant to contribute. Major independent mental health organisations and institutions that receive government funding and are consulted and contracted by government are not performing in this respect any better than government itself. One often feels that such organisations do not in practice exist in order to help or represent people needing help, but that they are dominated by a corporate mentality that is self-perpetuating and self-serving.

In order for both this process itself to be improved, and also for more people to be willing to participate, government (and everybody else) would need to substantively change how this is conducted. There are a number of issues to be considered.

Lived experience is not homogeneous, or a specific quantity or entity. Two people with the same experiences or the same conditions may have vastly different needs, they may experience and respond to those identical experiences and conditions differently, they may have had different experiences of care, treatment, and services. Any mental health condition in itself is a flexible diagnosis, not something for which all of the symptoms are present and experienced in the same way by everybody all of the time; there are problems with the classifications of these diagnoses themselves as well as with how generalised terms are being used without differentiation; many people are misdiagnosed, and/or those diagnoses are not reliable; symptoms are comorbid, i.e. found in more than one condition or diagnosis; conditions may unfold or have different trajectories and prognoses in different people, they are compounded by other mental health and biomedical conditions, and many people will have multiple diagnosable problems, which may require discrete separate treatment. There is, potentially, also a wealth of knowledge available here that, if more were invested in actually recording, studying and applying it, might deepen our understanding of conditions and improve therapeutic and other responses, although sadly, in Australia that kind of research is not being undertaken.

In view of all of these variables, nobody can seriously recruit one or two people with the same condition or from the same demographic and assume from what those people say that they then have an adequate understanding of anything. Any lived experience consultation requires multiple people representing the same condition from both/all genders, all affected age groups, and multiple demographics (including regional, rural, and remote, variable SES determinants, and all ethnicities). Credible lived experience consultation for a range of issues and conditions could require several dozen (or more) lived experience advisors, every one of whom will have something to offer, who may appear to contradict others, and the consultative process would need to be able to identify the relevant issues and messages from each of them, extrapolate and distil from them all, and then translate that into practical usefulness.

It is very noticeable that multiple population groups with known incidence of mental health problems, often severe and chronic and poorly cared for, are routinely excluded from both policy iterations and prioritised cohorts and from consultation. In many cases, this exclusion is stigmatising; it seems ironic that government should recognise stigmatisation as discriminatory and potentially as a factor in mental health, and then routinely engage in it itself, but it does. Those who are routinely excluded are older people living with chronic conditions or at risk, potentially anybody older than the "youth" cohort, the prison population, the homeless, the unemployed, younger children, child victim survivors of abuse and trauma, domestic violence and sexual abuse perpetrators, but also people living with chronic, often more severe conditions such as schizophrenia, bipolar and BPD, and those on the autism spectrum, among others. It strongly appears as if government literally does not want to hear from those people, and neither do mental health organisations, and/or recruiting them has been deemed to be not worth the effort. Under Australia's UN human rights obligations, none of these people should be discriminated against in any way, and all of them should have the same right as everybody else to any mental health care that they need, and to contribute as appropriate to mental health lived experience consultation. Their rights are not abrogated by their situation or behaviour – or they shouldn't be. We do not improve our understanding of their behaviour or circumstances by refusing to engage with them. Neglect of older people's experience tends to look like age discrimination perpetrated by government.

Neglect of child victim survivors of any form of abuse and trauma is not only discriminatory, but it also displays a disturbing ignorance of the mental health and often other problems that they face, often for the rest of their lives. Their problems do not simply go away once they become adults or once the abuse stops: the effects remain, and that means that they may need intermittent mental health care throughout their lives, which is frequently not available to them, and they may also develop more severe and chronic conditions as a result of that abuse and trauma, and/or because of other neglect; they may also engage in alcohol and substance abuse, in criminal and risk-taking behaviour, again, because of that abuse and trauma, and because they could not access appropriate care when they needed it. It is estimated that 50% of all mental health problems begin in childhood and "youth", but people in their 60s or older are often still living with the effects or the condition of what began in childhood and "youth", but they are being completely neglected; they are also scarcely ever consulted as lived experience advisors. This is one example of the fundamentally inadequate understanding of the nature of mental health issues and of the needs of many Australians, and while government has also been informed of this, or could reasonably have known it, it has not confronted any of these issues. Government should also include all of these cohorts in lived experience consultation.

Such a process requires considerably more time than is often allocated, it would also require more researchers or staff, and it would require clear and equitable means by which everybody can be heard and enabled to contribute. If it is conducted via online workshops or seminars, then the large numbers of participants may need to be divided into groups, or to participate in separate sessions, but without having heard what others have said and without being able to interact with all of the other participants. Adequate representative consultation therefore poses a number of organisational and practical challenges.

Where financial compensation is offered, this would obviously also need to be greater, proportionate to the numbers of those consulted, however the hourly or total rate of payment is calculated.

Government now tends to identify target population cohorts, and to select lived experience advisors only or primarily from Indigenous, LGBITQA+, "youth", and possibly CALD groups. I find this prioritising discriminatory, and that it also has an effect of excluding other affected people. Prioritising those groups is not necessarily based on evidence that they are always the most or the only affected, and in many cases, other population groups have just as much incidence of conditions or issues, but are by this process silenced. Prioritising them also suggests that policies intended to support them are failing and need to be bolstered and lent additional funding and engagement, although the actual reasons for such failure never seem to be understood and addressed. While it is acknowledged that Indigenous and LGBTIQA+-identifying people do have high incidences of various issues, I do not see that they should attract prioritisation if that means that everybody else does not attract sufficient representation, access to care and services, other neglected cohorts should be equally prioritised precisely on the same basis that this is done for these groups, and it should not be viewed as racist to raise this problem.

I also now disagree with the concept of the "missing middle". In a sense, this looks like another prioritising, as if those at either end of the "missing middle" are believed to be receiving the care they need and it is only the "missing middle" who need more focus, but that assessment is not justified. NOBODY with any mental health needs in Australia today has affordable or free access to whatever appropriate care they may need, when and where they need it, and that includes children with psychosomatic allergies or ADHD or mental health-related autism spectrum conditions to the under-estimated effects of the absent father through to severe treatment resistant depression and sustained acute suicidal ideation to lifelong effects and complications of childhood abuse and trauma through to people with schizophrenia, bipolar and BPD, among other conditions. There is no "missing middle" here: *everybody* is being failed, or may be failed, too many people with complex needs are falling through gaps created by the fragmented system as well as chronic under-resourcing and under-staffing, as well as not having all of the specialists in the one place available at the one time to care for complex needs in a single patient; and neglect of their needs causes further problems, both for them and also for government and, potentially, for society. Many are not even able to access care with a GP, while GPs are being assumed to be much better trained in mental health than many of them are. The concept of the "missing middle" is factually unjustified, it is misleading, and it is potentially dangerous.

For all of these reasons, I think that the prioritising of specific population cohorts should cease and be abandoned, and that any lived experience consultation should also stop limiting itself to a handful of people supposed to represent sizeable target populations while ignoring everybody else, and typically not even properly representing those target populations.

The lived experience of family and friends of people who have committed suicide, and carers and peer support workers etc. in mental health is not the same as that of people living with any condition or of those who have actually committed or attempted suicide. Immediate family members of people who have ended their lives can experience extreme emotions that sometimes distort their perspective, however understandable their grief is. These should also be consulted and included, and they also have useful insight and perspectives, but their contributions should not be confused with the experience of those actually living with conditions, unless they also have conditions themselves.

Some lived experience consultation is conducted via online surveys. These are frequently very irritating. It is perhaps understandable that they are designed in the way they are, but they have the effect of pre-determining the information provided, or not provided, which does not always allow for sufficient individual experience. They are always framed from a particular perspective and based on particular assumptions, but respondents may not agree with those assumptions. Some research surveys are now offered in several lengths, the longest allowing greater capture than the shorter versions, even if they are also multiple choice or yes/no questions. Every survey should have boxes for respondents to provide as much additional information as they wish to provide. They should always be read by a qualified human clinician, and not analysed by AI (the use of AI in mental health should be very restricted – I do not support the ways it is now being deployed), and ideally, a survey response would be followed by a qualitative personal interview.

Lived experience is predicated on the assumption that the person with that experience is able to offer insight and knowledge that others do not have. A common problem here is that health professionals often assume that their education and training are superior, and that they are in a position to assess what they are told and may ignore it at their discretion. They are not actually listening: they are assessing and judging. There is here a power imbalance, which has the effect of limiting what professionals (and others) may do with lived experience. People with lived experience may not have the formal professional education of clinicians, but they will have had experience of clinicians, they should be assumed to have some knowledge of their condition and of how clinicians have attempted to help them, and they therefore should not be assumed to be entirely ignorant from a clinician's position. Some people with lived experience will have studied textbooks and research publications and understand more than they may be given credit for. Their experience should be considered on an equal footing with the knowledge of clinicians, as different, and complementary, but not inferior, and the purpose of any consultation is, supposedly, precisely to facilitate that complementarity. It is counter-productive to make people with mental health conditions feel like idiots and to treat them in a patronising manner, but this does happen.

As an academic myself, I have good reason to not have confidence in any education and training provided by our universities to clinical psychologists, psychiatrists, and GPs. The quality and standards of that education, together with every other faculty, have been permitted by governments to decline under the corporate management of our universities since the 1990s, and that decline is still continuing unabated. This is not to impugn every clinician indiscriminately, but it is to recognise that there is a very serious problem here. Lived experience advisors – and I have repeatedly experienced this myself – cannot rely upon clinicians to fully understand what they tell them or that their contribution will be genuinely complementary with what clinicians think they know. This problem becomes infinitely worse when politicians, management consultants, public service staff, managers who peregrinate from one senior administrative position to another, but few if any of whom actually have a professional qualification in mental health and suicide, or any adjunct issues, and yet are empowered to make major decisions affecting the lives of "consumers". In order for these people to understand what is being said to them and what is being asked of them, they would have to spend days or longer listening to individuals' stories, until they feel that they have been in their skin, in their heads, in their shoes. It is not evident to me that this happens. I have repeatedly exposed myself to considerable vulnerability and risk in order to explain my own experiences, including in submissions like this, and yet in all of the years I have been doing this, I cannot see the slightest evidence either that what I have said has even been understood, or acted upon, or that anybody even cares. This very national agreement is not even sufficiently informed by lived experience at all. Somewhere, government needs to ask itself what the purpose of lived experience consultation is, if it refuses to understand or to use it?

The lived experience advisor is often participating because the care they have been offered is not satisfactory, and through the process of their consultation and other advocacy, they hope, and expect, that something will be changed and that in future they will receive better care. Of course, people may also participate who have had more positive experiences, although as a general impression, most people's positive experiences are likely to have been had through private sector providers and for non-severe/chronic or more easily managed conditions and those who are more responsive to lifestyle interventions and CBT-based therapies. Many people accessing public sector services do not have positive experiences, and the level of frustration, anger and dissatisfaction is in fact quite significant.

Government (and others) obviously do not know, and many clinicians may also not sufficiently appreciate or admit, that the quality of all university education and training is now sub-standard, and without major review and improvements and better funding and regulation by government, this situation will not improve. There is an emergency here that has been entirely ignored. This means that many people needing mental health care will not receive the best possible care even if they do access a clinical psychologist, a psychiatrist or a GP. This observation is not speculative, but factual. Government needs to stop assuming that our education and training systems are working as intended – unless ignorance, harm, misdiagnoses, preventable deaths are intended. Some of the reasons for that are identical to the reasons for failure in mental health services and suicide prevention.

There are vast amounts of knowledge that graduates have not been taught, and masses of international research over decades that is also not integrated, while Australia is not funding genuine original and innovative long-term mental health research comparable with other countries.

Partly for this reason, partly because government's approach to mental health (as to everything else) is to reduce costs as far as possible, this situation in turn results in often inappropriate therapeutic options being offered as short-term cheap fixes. This is tantamount to the dehumanisation of everybody with any mental health problem, because it ignores the reasons *why* anybody has those problems in the first place, it refuses a genuinely individually tailored response (even when it acknowledges that this should be the ideal, but under current conditions, we are unable to deliver that), and it aims to resolve the problem not for the well-being of that individual or because it has any empathy for their suffering, but only because mental health is a cost-benefit equation calculation that is perceived to be imposing a significant burden upon the Australian economy and upon government. There is also a punitive aspect here. Government has no interest in anybody as an individual human person or in creating effective systems that would treat them as such.

This approach has made us over-dependent on medications, on encouraging people to change their lifestyles without any consideration of why that might be difficult or impossible, on nebulous catchphrases and fashionable trends (or snake oil), and on CBT-based therapies,[5] but medications have serious side-effects and should not be indefinitely prescribed without close oversight and review,[6] while the ambient determinants of people's mental health issues are not being addressed or improved at all, because they require other, primarily socio-economic responses from government that are not being considered. As already noted, there are also serious problems with the *DSM* as the diagnostic reference work for psychiatrists.[7] The

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[5] Cf. e.g. Soraya Chemaly, *The Resilience Myth: New Thinking on Grit, Strength, and Growth After Trauma* (New York: Simon & Schuster, 2024); Judith L. Herman, *Truth and Repair: How Trauma Survivors Envision Justice* (London: Basic Books, 2023); Farhad Dalal, *CBT: The Cognitive Tsunami: Managerialism, Politics and the Corruptions of Science* (London: Routledge, 2018); Patrick D. Hahn, *Obedience Pills: ADHD and the Medicalization of Childhood* (Toronto: Samizdat Health Writers' Co-operative, 2022); Thomas Joiner, *Mindlessness: The Corruption of Mindfulness in a Culture of Narcissism* (Oxford: Oxford University Press, 2017); *Routledge International Handbook of Critical Mental Health*, ed. Bruce M.Z. Cohen (London: Routledge, 2018); *Routledge International Handbook of Theoretical and Philosophical Psychology: Critiques, Problems, and Alternatives to Psychological Ideas*, ed. Brent D. Slife et al. (New York: Routledge, 2022); *Humanising Mental Health Care in Australia: A Guide to Trauma-informed Approaches*, ed. Richard Benjamin, Joan Haliburn and Serena King (London: Routledge, 2019); *Reframing Trauma Through Social Justice: Resisting the Politics of Mainstream Trauma Discourse*, ed. Catrina Brown (London: Routledge, 2024); Patrick Morrell, *Insane Society: A Sociology of Mental Health* (London: Routledge, 2020).
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https://www.theguardian.com/science/2016/jan/07/therapy-wars-revenge-of-freud-cognitive-behavioural-therapy?CMP=share_btn_url

[6] There has been an international debate about the corrupting role of Big Pharma in mental health for more than 20 years, but which has been almost entirely and very irresponsibly ignored in Australia. Cf. e.g. Gail Bell, *The Worried Well: The Depression Epidemic and the Medicalisation of our Sorrows*, *Quarterly Essay* 18 (2005); John Abramson, *Overdosed America: The Broken Promise of American Medicine* (Harper Perennial, 2008); idem, *Sickening: How Big Pharma Broke American Health Care and How We Can Repair It* (Mariner Books, 2022); Allen Frances, *Saving Normal: An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life* (HarperCollins US, 2014); Ben Goldacre, *Bad Pharma: How Medicine is Broken, and How We Can Fix It* (London: 4th Estate, 2013); David Healy, *The Antidepressant Era* (Cambridge MA: Harvard University Press, 1999); idem, *The Creation of Psychopharmacology* (Cambridge MA: Harvard University Press, 2004); idem, *Let Them Eat Prozac: The Unhealthy Relationship Between the Pharmaceutical Industry and Depression* (New York: New York University Press, 2006); idem, *Pharmageddon* (Berkeley: University of California Press, 2012); David Healy, Joanna Le Noury, and Julie Wood, *Children of the Cure: Missing Data, Lost Lives and Antidepressants* (Toronto: Samizdat Health Writer's Co-operative, 2020); Ray Moynihan and Alan Cassels, *Selling Sickness: How the World's Biggest Pharmaceutical Companies Are Turning Us All Into Patients* (Bold Type Books, 2006); Edward Shorter, *The Rise and Fall of the Age of Psychopharmacology* (New York: Oxford University Press, 2022); Patrick D. Hahn, *Prescription for Sorrow: Antidepressants, Suicide and Violence* (Toronto: Samizdat Health Writers' Co-operative, 2020); Abigail Shrier, *Bad Therapy: Why the Kids Aren't Growing Up* (London: Swift Press, 2024); James Davies, *Cracked: Why Psychiatry is Doing More Harm than Good* (London: Icon Books, 2013); idem, *Sedated: How Modern Capitalism Created Our Mental Health Crisis* (London: Atlantic Books, 2022); among many others.

[7] Cf. e.g. Allan V. Horwitz, *DSM: A History of Psychiatry's Bible* (Baltimore: Johns Hopkins University Press, 2021).

dominant biomedical approach to mental health is now to a significant degree discredited, or at least requires considerable reframing, greater nuance and sophistication, and a paradigmatic shift in how the cause-effect relationship is understood,[8] there is sufficient awareness of the fact that most problems are caused or contributed to in the first instance by the actions of other people, by governments, by socio-economic adversity, by permanent stressors (such as the absence of a realistic, desirable and sustainable future; insecure, inappropriate and inadequately remunerated employment and BS jobs; climate change; household debt and financial insecurity; worsening inequality and the end of meritocracy; toxic corporate managerialism etc.), and other ambient determinants, and only government can address these, but it doesn't. "Consumer" driven movements are now shifting away from traditional biomedical approaches and both re-defining the nature of mental illness and also seeking alternative therapeutic and other responses; they are forming alternative support groups on the fringe of the existing system. At the same time, they also recognise that the ways in which individuals are affected are considerably more complex than tends to be acknowledged. Ultimately, therefore we continue to have a higher incidence of preventable mental health conditions which other responses would reduce but which government refuses to contemplate.

Once lived experience advisors have told governments this, and government refuses to act, what more can they reasonably expect, what usefulness is such consultation, and why should anybody continue contributing? Lived experience is now becoming a serious threat to the entire paradigm in which governments and clinicians still frame mental illness and their responses to it, and it is demanding radical change.

I do not expect this Review to devote any attention to it, but there is a long and influential history of psychology and psychiatry from the second half of the 19th century through the 20th century, and in some respects dating from the 17th century, as well as national idiosyncratic Australian attitudes, all of which have contributed to this situation. There has always been some biomedical conception of the causes and therefore appropriate treatment of mental illness, but the psychoanalytical approaches from the early 20th century and their various developments and schools, however limited, shifted the focus of causation onto the psycho-social and emotional impacts of trauma and abuse, and other ambient determinants, how our entire society influences, causes, and defines mental illness, which could then have biomedical manifestations, but which required some form of psychotherapy. Combined with this was a

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[8] Cf. e.g. Allan V. Horwitz and Jerome C. Wakefield, *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow Into Depressive Disorder* (Oxford: Oxford University Press, 2007); also Anne Harrington, *Mind Fixers: Psychiatry's Troubled Search for the Biology of Mental Illness* (New York: W.W. Norton, 2019).

very humane and therapeutic philosophy underpinning the idea and function of the asylum, at least in its best examples, which genuinely viewed the mentally sick individual as a human person who could be helped by humane treatment. This psychotherapy paradigm dominated until the post-war period, but it is still accepted, funded and trained for in European countries, America and Britain, and it is particularly Australian clinicians (and our mental health system) that rejected this approach in favour of a self-help, behavioural modification, and drugged, or primarily biomedical approach with questionable scientific basis. The attack on psychoanalysis could even be said to have been self-interested, while what has replaced it is not, in fact, any more "evidence-based" than psychotherapies, and perhaps even less so. Australian clinicians with whom I have discussed this have not been well-informed about how psychoanalysis is done overseas today. Asylums also came to be viewed as too expensive and as saleable assets, which resulted in the mentally ill no longer being treated or viewed humanely (allowing for some institutional abuses), community-based services and accommodation were never adequately invested in as the asylums were sold off, many were left homeless – and still are – and people died needlessly.[9] Ironically, the closure of asylums and the transfer of seriously unwell patients back into society had the effect of returning some to the very environments that had made them sick, and which are still making us sick. There is a long and nasty history in the shadows of these developments, including how antidepressants and psychotropics came to be developed and applied, as well as the influence of eugenics and social Darwinism, but that approach is now being rejected by lived experience, whether governments and clinicians like it or not, and it is also being recognised that it has not been effective or adequate, and it isn't curing anybody or actually preventing anything.

The ways in which many problems persist over the course of a lifetime and result in multiple different manifestations is also often ignored. I live with multiple diagnoses and problems, all of which result from childhood abuse and trauma and from long-term (*de facto* permanent) unemployment. Childhood abuse and trauma does result in multiple biomedical, neurological, behavioural, and potentially genetic/epigenetic effects, but all of it originates with what others actually did to me as a child. Despite 30 years of primarily American research into these causes and effects,[10] I have not met one Australian clinician who has been educated in

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[9] https://www.thepolicypost.net/2025/01/the-great-mental-health-experiment-and.html#more, offers one useful account.

[10] I include here merely a sample of relevant publications but I have many more such references; this is merely to indicate what most Australians are evidently still unfamiliar with: Bessel Van Der Kolk, *The Body Keeps the Score: Mind, brain and body in the transformation of trauma* (London: Penguin, 2014); Judith Herman, *Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror* (New York: Basic Books, 22015); Yifat Carmel, *Children's Exposure to Domestic Violence: Theory, Practice, and Implications for*

that research and competent to offer me appropriate therapy and support, nor have they understood that problems I develop in middle age have their origins in that childhood experience. I should never have been allowed to become unemployed, and I am not unemployed by choice. Nonetheless, Australian governments have not addressed the need for all of the long-term unemployed to be able to return to appropriate employment, the conditions of Centrelink, JobSeeker payments, and agencies, often complicate efforts to return to work rather than facilitating them, they persist in punitive attitudes and discrimination and impoverishing, and the material, financial, social and other benefits of employment (including health and mental health) are all lost and denied. Completely ending all unemployment for every Australian, as well as all of the consequences of it and the abuse to which government subjects the unemployed, ought to be a core pillar of this national agreement's psychosocial strategy – but is it? There is here a serious cognitive dissonance between what government claims to want to improve in terms of mental health, and the ways in which it actually exacerbates poor mental health. My current mental (and now also physical) health problems could all have been prevented by a more constructive response by government to my circumstances, but in 14 years, government has not responded accordingly, and probably never will. That is not a useful mental health strategy.

Policy (New York: Routledge, 2024); *Intimate Partner Violence: New Perspectives in Research and Practice*, ed. Elizabeth A. Bates and Julie C. Taylor (London: Routledge, 2019); *Domestic Violence against Men and Boys: Experiences of Male Victims of Intimate Partner Violence*, ed. Elizabeth A. Bates and Julie C. Taylor (London: Routledge, 2023); Nadera Shalhoub-Kevorkian, *Incarcerated Childhood and the Politics of Unchilding* (Cambridge: Cambridge University Press, 2019); Polly Curtis, *Behind Closed Doors: Why We Break Up Families - And How to Mend Them* (London: Virago, 2023); Antonieta Contreras, *Traumatization and Its Aftermath: A Systemic Approach to Understanding and Treating Trauma Disorders* (New York: Routledge, 2024); Kathleen Brewer-Smyth, *Adverse Childhood Experiences: The Neuroscience of Trauma, Resilience and Healing through the Life Course* (Cham CH: Springer, 2022); *The Handbook of Complex Trauma and Dissociation in Children: Theory, Research, and Clinical Applications*, ed. Ana M. Gómez and Jillian Hosey (London: Routledge, 2025); Ruth Cohn, *Working with the Developmental Trauma of Childhood Neglect: Using Psychotherapy and Attachment Theory Techniques in Clinical Practice* (London: Routledge, 2022); Robert Scaer, *The Body Bears the Burden: Trauma, Dissociation, and Disease* (London: Routledge, ^{3}2014); Jill Salberg and Sue Grand, *Transgenerational Trauma: A Contemporary Introduction* (London: Routledge, 2024); Peter Morrall, *Insane Society: A Sociology of Mental Health* (London: Routledge, 2020); *Complex Trauma: The Tavistock Model*, ed. Joanne Stubley and Linda Young (London: Routledge, 2022); *Understanding Trauma: Integrating Biological, Clinical, and Cultural Perspectives*, ed. Laurence J. Kirmayer et al. (Cambridge: Cambridge University Press, 2007); *Traumatic Pasts: History, Psychiatry and Trauma in the Modern Age, 1870-1930*, ed. Mark S. Micale and Paul Lerner (Cambridge: Cambridge University Press, 2001); *Trauma and Cognitive Science*, ed. Jennifer J. Freyd and Anne P. DePrince (New York: Routledge, 2012); *The Effect of Childhood Emotional Maltreatment on Later Intimate Relationships*, ed. Nancy Dodge Reyome (London: Routledge, 2011); Joseph Spinazzola et al., *Treating Adult Survivors of Childhood Emotional Abuse and Neglect* (New York: Guilford Press, 2018); Margaret E. Blaustein and Kristine M. Kinniburgh, *Treating Traumatic Stress in Children and Adolescents* (New York: Guilford Press, ^{2}2018); Janina Fisher, *Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-Alienation* (New York: Routledge, 2017); Joanne Zucchetto, Simone Jacobs, and Ly Vick Johnson, *Understanding the Paradox of Surviving Childhood Trauma: Techniques and Tools for Working with Suicidality and Dissociation* (New York: Routledge, 2019); *International Handbook of Multigenerational Legacies of Trauma*, ed. Yael Danieli (New York: Springer, 1998).

It is well-known that unemployment is a causal factor in suicide, but no suicide prevention strategy actually aims to end all unemployment or to compensate for what people have lost by being unemployed. We are encouraged to be resilient, but government neither recognises nor validates nor supports efforts to be resilient, and is just as likely to undermine them. I have provided this lived experience perspective repeatedly, but it has not resulted in any improvements, so why should I continue contributing? This is not just about me: Australia has an estimated 1 million+ long-term or permanent unemployed, many of whom, like me, are no longer actively seeking employment that doesn't exist, and are therefore no longer included in published statistics, but there shouldn't be *any* of us, we should never have become long-term unemployed at all, we should all be able to work in appropriate jobs. Why can't we? There are multiples of millions of victim survivors of diverse childhood abuses and traumata in this country, but most of them – including victims of sexual abuse - have never received any appropriate care and most of them never will.

It is now a common complaint that people are recruited to provide their lived experience insight and stories, over and over again, and yet nothing ever changes.[11] This consultation often comes at considerable cost to those participants, which is not compensated for by any remuneration or gift voucher, which is primarily emotional and psychological, and which often involves people reliving their trauma every time they provide their lived experience, and yet government (and other organisations) remain completely indifferent. They are formally aware of this cost, but providing or referring to peer support or to helplines is not an adequate response. The fundamental issue here, is that they never *do* anything about what they are told, and that eventually becomes too high a price for people to pay. It begs the question: If government has no intention of ever acting on what it is told, then why should people with lived experience continue to engage with it?

I therefore suggest that government needs to seriously re-evaluate why it is even inviting lived experience participation, and that it must ensure that there are significant, appropriate, urgent positive outcomes informed by any such consultation, and that if it has no intention of doing anything, that it then inform everybody beforehand of that fact and explain exactly what the purpose of the consultation then *is*. Lived experience advisors, or mental health "consumers", live life one day at a time, they are suffering, they are confronted by many

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[11] Cf. e.g. Cathy J Francis, Amanda Johnson, Rhonda L Wilson, The personal cost of repetitive mental health inquiries that fail to result in change, Collegian 29/5 (2022), 728 – 737. Also e.g. S. Lake et al., 'Lived experience perspectives on a co-design process: the 'Under the Radar' men's suicide prevention project', in *Disrupting the Academy with Lived Experience-Led Knowledge*, ed. Maree Higgins and Caroline Lenette (Bristol: Bristol University Press, 2024), 53-79.

challenges and struggles both with their conditions and with trying to live functional lives, they do not have adequate or appropriate care, treatment, and assistance, they do not live very dignified lives with any quality, and they need change *NOW!* Not sometime in the next forward estimates, not sometime after they have committed suicide or died premature deaths, or by 2050: they need change *immediately*, which government could often deliver but never does, and to this extent, it displays no respect for lived experience advisors and everybody else whom they represent as human persons, no empathy, no comprehension or imagination, and the usefulness of even developing new policy iterations or conducting yet another useless inquiry is far from self-evident.

Lived experience is also consulted in research projects, which is legitimate, but in such cases, participants are advised at the outset that they will not normally derive any benefit from their participation and that it is research that may not achieve any identifiable or practical outcome for years into the future. Lived experience consultation with government, however, assumes that there *are* intended outcomes, that participants should expect to benefit once findings can be collated, evaluated, framed within a report or policy iteration, and implemented. The problem here is that no such positive outcome or improvement ever eventuates and people derive no expected benefit from their contributions.

4.3: It is now common for government policies and the recommendations of inquiries to include measures of progress in implementation and progress, as well as reporting and review instruments. It would appear that the proposal of a dashboard would be another example of such practice, with the principal benefit being that it would, presumably, track implementation and progress closer to real time and be more transparent than other mechanisms. Ordinarily, such information would be available on other sites or from other sources, and a dashboard would only make it more easily accessible and intelligible all in one place.

The principal question here for me is what purpose any of this is supposed to serve? It is not the case that much is tangibly improved by any policy or implementation. The *Closing the Gap* agenda, for example, is almost 20 years old since its first conception, but it is nowhere close to ever being fully achieved, it may never be, and every annual parliamentary progress report achieves precisely nothing. As the Interim Report itself notes, despite the fact that governments have implemented many of their responsibilities under the national agreement, such implementation has not improved people's experiences and circumstances, which means that a dashboard showing such implementation would actually be useless, if it is a question of tracking implementation. Under these circumstances – and, in varying ways, every other policy iteration or portfolio that is not implemented effectively at all, or even if it is, does not achieve the outcomes needed and, presumably, intended – the fundamental problem is to understand *why* implementation has not achieved what it was, supposedly, intended to achieve?

In my observation, nobody usually identifies and resolves those problems. Do we actually know why no national or State & Territory suicide prevention plan since 1992 has actually significantly reduced the incidence of suicide in Australia? Despite numerous new five-year plans and other strategies, has any of them identified the reasons for that failure and implemented a more successful strategy, measured in terms of substantively reduced numbers of annually completed suicides, down from 3,000 to 1,000, for example? Has any of those plans confronted the estimated 5-65,000 attempted suicides, plus deaths from eating disorders, self-harming, and diverse other suicide-like behaviours, all of which one assumes we would likewise wish to prevent, but never will if we don't even include them in a suicide prevention plan? We could actually know this, but it appears as if we don't.

Why has no government expanded psychiatric bed capacity in general hospitals to meet demographic and other need; recruited and retained the numbers of psychiatrists needed in public hospitals, including specialists in different age groups and conditions; increased the numbers of qualified graduate mental health nurses in all hospitals and in community services and employed them all properly; resolved the reasons why trainees cannot all get suitable qualifying placements; ensured that no matter where anybody lives, they have immediate access to any mental health care they may need, within their nearest hospital or social services centre; reviewed and reformed all university education and training in mental health; and so on? Why have existing implementation, progress, reporting and review mechanisms not ensured that the public mental health system works as it should under its existing organisation and administration, and why are reviews such as these even necessary?

Australia has a national history spanning more than 80 years of *never* fully implementing *any* policy iteration or all of the Recommendations of any Royal Commission, Senate Select Committee Inquiry, or any other such review – not *ever!* Not even when we have conducted literally dozens of inquiries into exactly the same problem. It is therefore not a question of the occasional and random glitch that needs to be spotted and corrected: it is a question of a bipartisan, intergenerational, systemic chronic inability, or refusal, to ever do anything that benefits and protects the well-being of the entire Australian people to the best of our ability. We cannot do that, and so there will invariably be many failures in any future version of the National Mental Health Agreement, it will not be implemented in a manner that achieves its purpose, nobody will ever know why, and nobody will fix it. Under those circumstances, what is the point of a dashboard? This suggests that a dashboard would be more likely, if it were reliable, to report failures than successes, and it would not by itself have any capacity to prevent or resolve any of those failures, which is, ultimately, what the public needs.

I would have no confidence in any reporting by the government departments responsible. I would also have no confidence in any ranking of providers or sectors.