I respectfully request that this submission be accepted and published
<u>Anonymously</u>

A Follow-Up Submission To The Australian Government's Productivity Commission Inquiry Into Mental Health

Contents

Introduction

I made a submission to the first round of this inquiry, which was accepted as submission #482[1]. I am now making this second submission, in response to the inquiry's "Draft Report" and other material associated with this later stage of the inquiry.

Once again, I would like to begin by thanking the government for providing me this important opportunity to comment on it's future policy agenda.

The inquiry's draft report covers a broad subject area, and there is much to comment on. In many cases, I've found commenting on this material to be difficult, due to the complicated and/or highly ambiguous language used throughout the report.

With that in mind, I am basing much of my commentary in this submission off my best guess as to what the report is proposing, and will clarify, as best I am able, the areas where the report's ambiguity creates openings for major foreseeable problems.

I would also like to clarify that many of the areas covered by the report fall outside of my own personal field of experience or concern, so I do not intend to comment on them. I will leave it to others who are familiar with those issues to address the report's response to those issues.

What The Inquiry Has Gotten Right

First of all, I would like to briefly compliment the productivity commission on the things it has gotten right so far.

First and foremost, I would like to thank you for acknowledging the importance of involving past and present mental health patients and other people in crisis in all future policy development regarding mental health, suicide and related issues.

As countless others have repeatedly stated, policies regarding these issues simply cannot be helpful or effective, unless they are primarily based upon the experience and self-stated needs of the people who they are targeted towards.

It is also encouraging that the inquiry seems to be aware of the problem of 'tokenistic' involvement of 'mentally ill'/suicidal/suffering people in policy development. No doubt, the specific measures you devise to insure the involvement of patients/sufferers in policy development will be specially designed to prevent this involvement from being tokenistic, as much as possible.

[1] http://www.pc.gov.au/__data/assets/pdf_file/0005/241277/sub482-mental-health.pdf

Along this same theme, it is also pleasing to see that you acknowledge the importance of assisting 'mentally ill'/suicidal/suffering people to publically advocate for their self-stated needs and to communicate their plights directly with the public.

Secondly, it is somewhat pleasing to see this inquiry acknowledge (more or less) that many suicidal or otherwise distressed people are in crisis not because of what's going on in their brains, but because of what's going on in their lives.

You acknowledge the significant roles that homelessness, legal problems, unemployment, financial crisises, social problems[2], and other real-life issues play in our overall suicide and mental health landscape. Just as importantly, you acknowledge that these are often the true problems that need to be addressed in a patient's case - not the depression, anxiety, or suicidalness they experience as a direct result of these crisises.

In that spirit, it is also very pleasing to see that you've devised plans to significantly combat some of these real-life problems; such as your "Individual Placement and Support" plan[3] that aspires to a future where Australians will be assigned the right jobs to satisfy their higher needs as much as possible, rather then simply being assigned a job for the sake of getting a paycheck.

And it is likewise pleasing to see that you've recognized the importance of forging connections between all the available help systems, to insure that people in need will be properly directed to the people/departments best suited to help them.

These are all significant steps in the right direction. As I hoped to convey in my initial submission, these sorts of real-life crisises - and the anguish they cause their sufferers - make up a huge portion of what Australia deems to be 'mental health problems'. It is well past time that our 'help' mechanisms begin treating these broken lives, not the justifiably distressed brains that are enduring them.

These things being said, there are many areas of the inquiry's draft report where there is significant room for improvement.

Money First, Heart Second

In my original submission, I objected to the fact that the government chose the productivity commission to run this inquiry[4], and I stand by that objection.

[2] e.g. loneliness, bullying, ect.
[3] Described on pg. 519 of Vol. 1 of the draft report.
[4] pgs. 9 - 12 of my original submission.

It is clear that the productivity commission made a strong effort to give due considderation to the immense emotional and spiritual stakes hinging upon the outcome of this inquiry, and for that they are to be commended. But throughout this report, it is obvious that money was the primary considderation of the inquiry.

Disappointingly, but unsurprisingly, the inquiry's media release begins with a statement about how much suicide and mental illness cost - in financial terms[5]. I say "unsurprisingly" because this is always how government media commentary on the issues of suicide and 'mental illness' begins. Our sorrow, our anguish, our emptiness; it **always** takes a backseat to the disappointment we impose upon the treasurer and Joe Taxpayer.

Just once, it would be nice to hear a media segment lead with: *"For thousands of Australians every year, their quality of life sinks below the limits of what they considder acceptable. For thousands of Australians every year, death becomes preferable to the life that lays before them."*

Admittedly, the report itself begins much more considderately. But the format of the press release remains concerning because it plays a role that, in many ways, is just as important as the full report. Time-poor Australians[6] are unlikely to dive in to the whopping 1238-page full report, or even it's 112-page condensed version; and will likely rely on the 1-page press release to gauge the key talking points of the report and the inquiry's direction.

And I would like to reiterate the concern I voiced[7] in my original submission, about how members of the 'mentally ill', ect. community percieved the government's choice to have the productivity commission run this inquiry. From the beginning, many of us have feared that the inquiry's true focus has been money, and not the unbearable anguish we live through every day. In that respect, the press release's opening lines have not been reassuring.

Once again, a great many of this community may have read nothing more into the inquiry's findings then the press release; either due to lacking the time or energy to wade through the full report, or simply because they found the press release itself disappointing and were discouraged from bothering with the full report.

Rightly or not, the first lines of the simple press release are among the most important lines published throughout this entire process. Their focus could've been much better.

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[5] *"Mental ill-health and suicide cost Australia nearly $500 million per day.\ The Productivity Commission estimates that mental ill-health and suicide are costing Australia up to $180 billion per year..."* - http://www.pc.gov.au/inquiries/current/mental-health/draft

[6] Including, I suspect, many MPs and other important leaders.

[7] On pg. 9.

Suicide Policy

Much more concerningly is the way that the inquiry seems to have based it's stance on issues like suicide primarily on financial concerns. Specifically, the report is overwhelmingly opposed to suicide because suicides are financially costly to the economy.

Although there is indeed noteworthy mention of emotional impacts associated with suicide - specifically the grief/unhappiness felt by the dead person's survivors - these concerns seem to be tacked-on as afterthoughts, to support the inquiry's pre-determined conclusion that suicide should be aggressively opposed, for economic reasons.

The emotional considderations surrounding the suicide policy have been cherry-picked to only condemn suicide. Where is the acknowledgement of the emotional considderations that justify suicide? Where is the acknowledgement of the anguish that a suicidal person must continue to endure if they abstain from committing suicide? Where is the acknowledgement of the torment they must endure when self-righteous, *"we know what's best"* anti-suicide zealots keep them confined - in one form or another - from escaping the life they despise and reaching the merciful peace of the grave?

The financial economic case made against suicide in the report is clear, sensible, and more or less a complete picture. When a bunch of workers die, it has a dollar cost to the economy. We get it.

But what absolutely needs to be understood and acknowledged is that the issue of suicide plays out on **two** parrallel economies; the financial one, and **an emotional** one.

Emotionally, there is a cost to remaining alive. Every day, every month, every year, every decade we live on this earth we rack up a tally of sadness, disappointment, boredom, frustration, fear, grief and discomfort. It's unavoidable; life has a cost. The big question is, whether or not that cost is out matched by the scope of the profit: love, happiness, joy, laughter & contentment.

In economic terms, suicidal peoples' lives are like failing businesses. The costs outrank the profits; every day of opperation is harmful to the owner and their wellbeing. Now yes, in this *emotional economic* metaphore there may be significant costs[8] associated with closing that business down. But we must still weigh those costs against the ongoing costs of keeping the business open before we condemn the decision as "wrong"[9].

[8] i.e. the grief/displeasure experienced by the suicide victim's survivors.
[9] I attempt to explain this more effectively in my original submission, on pgs. 57 - 58, under the topic "The System's Attitude Towards Suicide - The Frail Arguments"

And yes, in addition to this *'emotional economy'*, we must also factor in the dynamics of the financial economy into our public national stance on the issue of suicide. And at the end of it, we need to do some thorough soul-searching and have an open public dialog about how the sacred rights of the individual compare to a person's community obligations.

What we absolutely mustn't do is pretend the emotional factors that justify suicide simply don't exist.

They do exist. Every suicidal person - every person who has **ever been** suicidal - knows this intimately. And these factors are of utmost pertinance to any public discussion we have about suicide.

You simply cannot have a public discussion without admitting that suicidal people have a compelling case to die. Any attempt to do so will ultimately accomplish nothing. Measures that fail to acknowledge the real *emotional economics* of suicide will fail to correct the problem. You can try as hard as you want to coerce or restrain the owner of a failing business into not closing it down; but if you don't change the fact that the costs consistantly outweigh the profits, then the collapse of the system is inevitable. As economists, you must surely realize this.

Not to mention the fact that by cherry-picking the factors you considder in developing this policy, you make it clear to the suicidal community that this policy is being deliberately constructed with a bias towards interests other then their own.

In my original submission, I posed the following question about the productivity commission's intentions for this inquiry:

"If there was a treatment that would, in private, leave the patient weeping as they went to bed every night; continuing to wish they were dead every day; feeling jealous every time they heard about someone being diagnosed with terminal cancer or dying suddenly; yet outwardly turn that same patient into a model employee who would turn up to work every day without fuss - no nervous breakdowns, no suicide attempts, and keep doing their job all the way up to when they turned 67 and the economy was done with them - would the productivity commission encourage this treatment to be used, as a solution to it's "productivity concerns" about the suicidal patient?"[10]

Reading between the lines of the draft report's commentary on suicide, my understanding is that the answer to that question, tragically, is "yes".

While this is hardly surprising for the suicidal community, it is disappointing, and an unfortunate lost opportunity for the government and Australia as a whole to make some real progress in this issue.

[10] pg. 11 of my original submission.

We in the suicidal community are trapped in a hostile and exploitive culture. There is an ideological camp that finds suicide morally (or financially) offensive and is determined to impose this moral code on the entirety of society, with no regard for the turmoil that we, the suicidal, must endure every day. Despite repeated claims to the contrary, they care nothing for us; they care only about inforcing their own dogma. Other peoples' agony doesn't offend them, but other peoples' suicides do.

Every system, policy and media item relating to suicide in this country is built to appease this ideological camp. Because of this, the suicidal can't get a look in. We continue to suffer. It is virtually impossible to be able to voice our grief in any meaningful way. And on the exceedingly rare occasions where our concerns and points-of-view do seep in to the public dialog and attract recognition, they are always dismissed as being "distorted thinking".

We all have our unique personal lists of fates worse then death - states of life that are too horrendous, and realistically too hopeless for the continuation of that life to be reasonably justified.

A system or a policy that is obsessively geared to prevent suicides *'at all costs'*, is one that considders it more preferable to trap someone in those living hells, then it is to have them die peacefully. That is, by definition, what *'at all costs'* must mean. And it is we, the suicidal who have to bear that horrible, horrible cost, while anti-suicide activists smugly pat each other on the back and say: *"Oh well, they may be unhappy, but at least they aren't dead! Good job, lads!"*

This seems to be the nature of the anti-suicide stance taken in the draft report. It idealizes the *"$16 billion to $34 billion each year"*[11] that could be saved for the economy by achieving a zero-suicide target. But it expresses no concern whatsoever that these financial savings may come at the expense of thousands of miserable souls praying for the escape of death, but being unable to reach it.

And as long as policies like this dominate the national mental health landscape - polices built upon skewed, inadequate considderation of all the concerns at play[12] - suicidal people like myself will never be able to really trust our government, our society, or the systems put in place to supposedly "help" us.

Until you can openly acknowledge **and respect** the fact that there are outcomes that are even less preferable to us then death, we will never be able to trust you.

I realize that non-suicidal people have trouble understanding the point-of-view of suicidal people. So please, if there is any confusion about this; any area where I've failed to make myself clear, please feel free to contact me for further explaination and clarification, because it is just so important that you understand this!

[11] pg. 848 of Vol 2 of the draft report.
[12] Particularly in terms of ignoring the suffering of the countless living suicidal people across the country.

Anti-suicide policy must be built with due considderation for the anguish of the suicidal people themselves, and due considderation and respect of the potential pitfalls that, to them, are even less desirable then death by suicide.

As I reccommended in my original submission[13], I strongly urge the government[14] to **abandon** it's anti-suicide policies and instead commit to a policy of making life worth living. This policy direction will not only have a strong suicide prevention effect, but it will also safeguard national systems and government policy from condemning innocent people to fates that are worse then death.

In the hopes of finding common ground, I'd like to suggest that you considder that that $34 billion suicide bill ultimately arises not from suicide, but from the fact that life in Australia is often less desirable then death. This turmoil is where your prevention efforts ought to be targeted. Eliminate the fates worse then death and you will automatically eliminate peoples' $34 billion p.a. usage of the expensive emergency exit they need to escape those fates.

The Worst Lines of the Report

I could not leave this review of the report's stance on suicide without mentioning what I found to be the most shocking lines of the report:

"Beyond the short term, the linkage of data on agreed risk factors for suicidal behaviour could be useful in preventing some suicides. ***This may require, however, Australia to place a higher priority on preserving someone's life, than on preserving their privacy.****"*[15]

To it's credit, the productivity commission stops short of actually reccommending these priorities and merely presents the options that are available. But I still find it shocking that such a violation of individuals' rights would even be considdered.

I would've hoped that broaching such an ethically-worrisome line would've given the productivity commission pause for thought about the extent of it's obsession with suicide prevention, and prompted it to ask itself whether it is seeking to do what's right and fair; or whether it's blindly pursuing a biased agenda without an ethical compass.

It is also a strikingly frank reflection of the true character of modern suicide prevention ideology. It is not about respecting and helping the suicidal; it is about violating and controlling us, in the interest of serving other peoples' agendas at our considderable emotional and spiritual expense.

[13] Reccommendation #3, beginning pg. 131 of my original submission.
[14] Including in it's management of this inquiry.
[15] Pg. 15 of Vol. 1 of the report. Emphasis added.

Not to mention how demeaning it is to imply that we are less deserving of the basic human right to privacy; how such a policy would officially reduce the suicidal[16] to 2nd-class citizens with lesser rights then the 'normals'.

What is being suggested here is thought policing of the worst kind!

What would be next? Forbidding suicidal and so-called *'mentally ill'* people the right to free speech, for fears that their unconventional thoughts might pose a 'public health risk'[17]? Perhaps next we can deem scepticism of official government policy to be a *'mental illness'* and truly streamline our society of good little workers?

And the timing of this suggestion couldn't be more inappropriate.

We are living in an age where the internet giants, social media giants and 'targeted advertising' firms already collect disturbingly high amounts of our private information. Surveilance of our movements and interactions has never been higher. The last thing we need to be talking about right now is sacrificing our concept of privacy even further. We really ought to be discussing ways to protect and reclaim our precious privacy; but that is another discussion for another day.

Privacy is a precious, sacred right that is essential to freedom and happiness. If we are eternally under the thumb of "the state"; if our thoughts, behaviors, beliefs and feelings[18] are perpetually open and subject to the scrutiny of the powers that be; if we are never free to think and ponder for ourselves whether or not remaining alive is truly more desirable then dying - then we are not free, by any definition of the word, nor can we ever be truly happy.

And as if it wasn't bad enough that surrendering privacy is being discussed at all, the cause that you are suggesting it could be sacrificed for is not even one of sound merit! As I've pointed out in the previous section, the case for endorsing suicidal prevention at all is lopsided, with no due considderation for the suicidal sufferer's plight! How can we even begin to considder sacrificing one of our sacred human rights, for a cause that can't even demonstrate itself to have ethical integrity?

In case you couldn't tell, my vote on this question you've posed is a firm and unyielding: **"NO!"**.

We must **never** place a higher priority on the preservation of life then we do upon our privacy. To do so would render those preserved lives worthless and abhorrant to all who would have to suffer them.

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[16] And suspected suicidal.

[17] As a matter of fact, this scenario isn't too far from the way things are now. Suicidal people have great difficulty speaking freely about their plights without being sensored. This problem - and the need for things to change - is discussed at length in my original submission, under "Suicidal People Are Not Aloud to Properly State Their Case or Explain Their Plight" (pgs. 99 - 109).

[18] Including thoughts, behaviors, beliefs and feelings that skew towards suicidalness, or a respectful/tollerant attitude towards suicide.

Other Matters

Broadly speaking, the overall report seems to be governed by a focus on money. While there are many admirable reccommendations that will surely be of great benefit to many members of the 'mentally ill' and otherwise-suffering communities, my general impression is that equally important problems may have been given less attention in the report if there weren't noteworthy economic benefits in addressing them.

All things considdered, this report feels as if it is advocating first and foremost for the Australian economy, with the 'mentally ill' and otherwise-suffering communities intended to be the chief secondary winners.

My problem with this is that the government is **always** advocating for it's economy, 365 days a year. This major government inquiry was a rare opportunity for the government to advocate first and foremost for the 'mentally ill' and otherwise-suffering communities; a group that is in desperate need of real attention and assistance. Sadly, this precious opportunity seems to have been watered-down by it's diverted focus on money.

It is not a case of the report doing wrong; it is a case of it not being all that it could have been for the 'mentally ill', suicidal and otherwise-suffering.

The productivity commission's efforts in considdering the human needs and turmoils of people in crisis are surprising, impressive and to be commended. But it was always unreasonable to expect that a beauro that revolves around economic/productivity issues could simply "switch off" it's economic/productivity mindset and give this humanitarian crisis the humanitarian attention it deserves.

If there is still adequate leeway in the inquiry process before the final report is published, I would urge the productivity commission to reach out to other departments & organizations that focus on human rights and humanitarian needs, to co-author the final report with you. My impression is that there needs to be a voice added to this process that is separate from a productivity commission mindset. A voice that can say: *"Forget about financial costs, forget about economic benefits; emotionally, spiritually, this is what people in crisis need..."* I am not suggesting that financial concerns should be utterly ignored; I am simply suggesting that outside-the-economic/productivity-box insight would be beneficial to the inquiry.

The Mental Health System's Ideology is Still Treated as Being Trustworthy

To an immense degree, the draft report leans on our existing mental health system regime as a trustworthy judge of what constitutes a *'mental illness'*, and how to best treat such *'mental illnesses'*. This is a disturbing pattern to see in this report.

The existing mental health system regime is grossly unreliable, and widely corrupt to the point of bordering on criminal (many would say I'm being too kind). I explained this - at length - in my original submission[19]. But more importantly, mine was only one of numerous submissions to this inquiry which alerted you to this state of affairs.

While your report does, in many ways, lay out a bold vision for a new, broad-scope mental health system, it is clear that our existing mental health system remains a core element of this plan.

Any builder will tell you that you can't start work on an ambitious architectural project if one of the key existing supports it is to be built upon is rotten. Likewise, your bold vision of a new mental health landscape is doomed to significant failure unless you acknowledge the unreliable state of the existing mental health regime, dutifully investigate it's failings, and commit to all the repairs that are deemed warranted. You cannot hope to build your bright new future using our currant, rotten system as a central support column.

In your report, you ask the public to nominate whether you should *"rennovate"* or *"rebuild"* the mental health system. While I, personally, would reccommend that you "rebuild" the system, I find it disappointing that your definition of *"rebuilding the mental health system"* seems to considder only the beaurocracy that sustains the system.

To me, an essential step of "rebuilding the mental health system" is putting the entire existing doctrine about what is and what isn't a *'mental illness'* through the shredder. It would entail lengthy debate and dialogue between supporters of currant 'mental health' doctrine, patients, and a broad field of human rights advocates. All views would need to be welcome and duely considdered.

Likewise, we would need to embark upon a series of thorough, impartial investigations of each and every treatment the system currantly dispenses to it's patients. Likely there are many treatments used today that are beneficial, but there are almost certainly a great many that are useless and/or harmful. A thorough evaluation of the system's treatment protocols is necessary to determine which is which. It must also be considdered that some treatments may be appropriate in some cases, and inappropriate or inadequate in others. All this will need to be examined.

These investigations **must** be conducted by people from outside the mental health system and it's mindset[20]; with an emphasis on patients' concerns, and must broadly considder patients' **self-reported** experiences with these treatments.

"Rebuilding the mental health system" must include relieving the currant governors of the mental health system of their powers, until the doctrine they have built and maintained - and it's worthiness to lead Australia in mental healthcare - has been thoroughly investigated.

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[19] pgs. 21 - 64, the majority of the section "PROBLEMS WITH THE MENTAL HEALTH SYSTEM".
[20] i.e. No therapists, people with pharmaceutical connections, or non-practicing "experts" in mental health and/or suicide.

My impression is that the people running this inquiry are reluctant to take on this task themselves. In watching one of the public hearings, I was struck by one of the committee members' comments:

PROF WHITEFORD: *"...we're not a clinical group here so a recommendation is more at a certain system level so can I just stop you there and ask you one question before you finish. In the interactions you've had with the mental health system is there any recommendation about,* ***not from the clinical point of view****, but from a service point of view that would have made it a better outcome for you?"*[21]

I can appreciate the committee's reluctance to delve into the questions of what is 'right thought' and what is 'wrong thought' - or, for that matter, to pass judgement on other peoples' efforts to do the same. It is indeed a can of worms.

But as I say, your plans for the future simply cannot be based upon the assumption that the system that has traditionally made these calls is beyond reproach. Numerous participants in this inquiry have told you this is not the case. I would suggest that that at least warrants an investigation into the existing doctrine.

Therefore, if you are unwilling to conduct a thorough investigation into the doctrine of the mental health system, I believe that you must direct some other branch of the government to do so. As I originally reccommended[22], I believe a royal inquiry[23] would be best suited for this task.

I acknowledge and applaud the attention you pay to the need for greater advocacy for patients. Regardless of improvements made to the mental health system, this is an essential step that needs to be taken to secure patients' rights and wellbeing.

But excellant advocacy is not a substitute for good system governance.

We need a mental health system where top-quality advocacy is **always** available if needed, but also where the need for it is minimalized due to the system not being prone to being antagonistic towards it's patients. We need a system that is governed by good doctrine - much better doctrine then what we have today - so that the need to advocate against it is minimalized.

This can only be achieved through a thorough reevalution of the mental health system's entire doctrine on diagnosis and treatment of *'mental illnesses'*/*'mental disorders'*.

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[21] Partial quote from Sydney Hearing of 26/11/2019 (https://www.pc.gov.au/__data/assets/pdf_file/0008/248444/20191126-sydney-mental-health-transcript.pdf), pgs. 147 - 148, emphasis added.
[22] Reccommendation #1, pgs. 125-156 of my original submission.
[23] Such an inquiry would need to be run by a committee with no ties nor loyalties to traditional mental health system ideology, in order to insure impartiality and fairness.

Usage of the Term 'Mental Illness', ect.

The draft report proposes many promising new changes to provide much-needed help to people who are suffering.

However, I have worries about the way that many of these services are proposed only to be offered for people who have a 'mental illness'. Does the inquiry's usage of the term *'mental illness'* in this way include people who have no malfunctions in or around their brains, but are nonetheless depressed/distressed/suicidal/anxious/ect. due to unbearable real-world circumstances? In my reading of the report, I have picked up the impression that the answer to this question is: "no".

Similarly, many of the measures proposed seem to be linked to the NDIS; implying that people in need will need to meet some official classification of being *'disabled'*, before they will be able to access help that they need.

There are two obvious major concerns that arise from these issues:

The first is that many people in need won't be able to access fine services that they desperately need, simply because they aren't disabled enough or *'mentally ill'*.

The second is that it could easily lead to completely sane people feeling pressured to falsely agree to a label of being *'mentally ill'*, in order to access services they desperately need.

As a man who is neither *'mentally ill'*[24], nor disabled, yet still in desperate need of help, I find both these prospects very concerning.

I would hate to see valuable programs, rolled out as an outcome of this inquiry, be tarnished by a culture where some people in need get this sort of treatment:

> **Service:** *"Are you depressed or suicidal?"*
> **Citizen:** *"Yes"*
> **Service:** *"Are you depressed or suicidal because you have chemical imbalances in your brain?"*
> **Citizen:** *"Yes"*
> **Service:** *"Okay, we'll help you."*

...and others get this sort of treatment:

> **Service:** *"Are you depressed or suicidal?"*
> **Citizen:** *"Yes"*
> **Service:** *"Are you depressed or suicidal because you have chemical imbalances in your brain?"*

[24] As explained in my previous submission, my desire to end my life is justified, sane, and due entirely to my terrible life circumstances. My brain is functioning perfectly legitimately with regards to my circumstances, therefore I do not have a "mental illness."

Citizen: *"No."*
Service: *"Are you depressed or suicidal because you are lonely, poor, homeless, unemployed, or trapped in a professional or personal situation that makes you miserable?"*
Citizen: *"Yes."*
Service: *"Sorry. Your on your own."*

The Over-Emphasis on Education

Peppered throughout the report are reccommendations that all manners of workers across our national workforce[25] should be forced to undergo more education or training, as a proposed remedy to the many mental health issues plaguing this country.

I firmly believe that these reccommendations, buy and large, will not be helpful to our national mental health landscape. I urge the inquiry to reconsidder this fiercely pro-education policy.

I can see two major problems with this approach. The first being that the education is simply unnecessary; the second being that I believe there is a real risk of cultivating a culture of arrogance that 'mentally ill' people and people in crisis will have to navigate through.

It's Unnecessary

My own experience in therapy was terrible[26]. But as far as I'm concerned, none of the turmoil I endured in therapy can be put down to a lack of education or training on the part of anyone involved.

In fact, the closest thing I have ever had to a good therapist[27] was someone who had no college education at all, and was less then a star pupil in terms of their highschool education. But what they did have was:

1. **A willingness to actually help me.**
2. Social connections that aloud them to offer me assistance that was roughly in the right neighborhood of what I actually needed[28].

[25] With a particular emphasis, I felt, on the health industry, especially the mental health industry.
[26] As documented in my original submission, particularly under "My Own Personal Experience" (pgs. 49 - 53) and the confidential attachment document; with additional significant details under "Therapists Have a Disturbing Tendency to be Arrogant" (pgs. 34 - 37)
[27] To clarify, this person was not a professional therapist at all, but did a much better job of fulfilling the duties of a professional therapist (i.e. helping a person with an unbearable life) then any professional therapist I've ever met.
[28] Though ultimately these connections were inadequate to provide me assistance of actual benefit, I remain stunned that the quality of care offered by a regular citizen can be so much more promising then what is offered by the professional therapist industry.

Throughout countless conversations with other people in crisis over the years, and through reading/watching countless media pieces on the themes of depression and suicide, I have come to the conclusion that a huge portion of the people who feel compelled to seek out help don't need a degree-bearing know-it-all with a ton of letters trailing after their name. They just need a regular person who meets those two basic criteria: 1. A genuine willingness to commit to helping, and; 2. The capacity/resources[29] to deliver the help **that is requested**[30].

The truth is that most people in crisis don't need to be handled by a college-educated "expert", they really just need a genuine friend - a resource that is sadly quite uncommon these days. And I would certainly say that a person's capacity to help a person in crisis is much less about *what* they know, and much more about ***who*** they know.

I'm not denying that there is a need for educated workers in the nation's mental health landscape; plenty of patients & former patients will state that the knowledge their therapist(s) acquired in their mental health courses has been an invaluable asset to them.

But I suggest that Australia's existing amount of education & training-acquired knowledge is more then enough to meet our currant mental healthcare needs. We may not have an ideal geographical distribution of that knowledge[31], but overall, I believe that Australia more then likely has enough of it.

We **do not** need to increase the number of people who undergo mental health training/education, nor do we need to increase the amount of training/education that workers in any given field undergo.

I make that second clarification, because I noticed that the draft report's numerous reccommendations about education/training are not limited to the mental health industry alone. There seem to be countless career lines - from GPs, to school teachers, to all manner of employers, who would be expected to undergo mental health-themed education or training under the report's reccommendations.

I cannot recall finding a single instance in the report where I believe such a reccommendation was warranted; especially when considdering the presumed cost and inconvienience imposed upon the person expected to undergo such education/training.

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[29] Common forms of these needed resources are: money, the capacity to offer accommodation (temporary or long-term, depending on needs), or adequate social contacts that allow for opening doors for the person in need, cultivating relationships, or offering guidance that the initial 'helper' isn't able to.

[30] Note: **Not** "help" that is contrary to what the sufferer has requested, but is what the helper had personally decided the sufferer *"really needs"*.

[31] From what I've read, it seems that educated therapists, ect. tend to cluster together more in the big cities, leaving rural regions with great difficulties in accessing their services.

There is undeniably a massive shortfall across our society, in delivering the help that is desperately needed to the people who are desperately in need. As the draft report notes, this shortfall is seen across all areas of our society; families, healthcare, education, employment, and the legal system, just to name a few.

But this shortfall scarcely comes down to a shortage of education. More then anything else, it comes down to a shortage of compassion. And compassion is not something that can be *taught* in a lecture hall, or earned by penning a 5000-word essay. You either have it, or you don't.

To the best of my knowledge, the two therapists who defined my time in the mental health system[32] had all the education, all the degrees, all the letters trailing after their names that they needed to be proper, official therapists. But what they were both utterly bankrupt in was compassion. I am certain that this, above all else, is why my time in the system was as disastrous as it was.

Similarly, my inability to find any beneficial assistance outside of therapy comes down almost entirely to a lack of compassion on the part of the many people I've had significant contact with since my problems started. I'll probably never know if any of them actually ever had the capacity to give me the help I needed. But it's a moot point, because even if they did, they did not have the willingness to help that would've made all the difference.

One thing that I am certain of, however, is that formal education or training would not have made a differance. The compassion and assistance I needed was never something that anyone I've been associated with could ever have picked up in a classroom[33].

Through my many discussions with other people in crisis and patients/former patients of the mental health system, I have discovered that countless people are in more or less the same boat as myself, in this regard.

I must admit, however, that there may be one area in which education/training of people may be beneficial, from a national mental health standpoint, and that is in instructing them how to navigate the government beaurocracy and connect with services that are relevant to the person in need's predicament.

However, aside from this, further education is not warranted.

[32] The worst being documented in my original submission, under "My Own Personal Experience" (pgs. 49 - 53)
[33] Aside, perhaps, from the off chance of meeting a potentially helpful new contact in such a class.

The Risk of Cultivating Arrogance

If this inquiry insists on pushing forward with it's numerous reccommendations for more education & training, I would strongly urge them to first ask: *"Who is going to be teaching these classes, and what, **precisely**, are they going to teach?"* I would urge the inquiry to look closely at the culture that might quietly be passed on in these lessons, and not merely the textbook knowledge.

As I noted in my original submission[34], our existing mental health education may bear significant responsibility for the strong culture of arrogance that therapy patients often endure in the mental health system.

For this reason, I have significant concerns that a highly-educated national mental health landscape could cause people in crisis[35] significant distress in trying to deal with any number of people in their daily lives.

The shorthand example of what I'm talking about would be as follows:

> **Person suffering:** *"I have a problem. It's 'A'"*
> **Responder:** *"Well that's not how the training I've been forced to undergo told me to interpret your behavior! It told me that your behavior means you have problem 'B'! So you must be mistaken!"*
> **Person suffering:** *"No, that's not right at all! My problem is 'A'!"*
> **Responder:** *"Please calm down. Your mental health problem 'B' has disordered your thinking and made your judgement less reliable then my formal training. That's why you mistakenly believe you have problem 'A'. Don't worry, I'll help you. I've been trained by experts to help you manage your problem 'B'."*

The potential scope of this problem is deeply concerning when one looks at the broad range of professions that the report reccommends some form of mental health-themed education or training for. It's not hard to imagine a scenario where many unfortunate people seem to be getting assaulted from all sides at once because their GP, sports coach, teachers and employer have all identified them as having a problem that they don't actually have, or are harassing them to get "help" that they either don't need, or is inappropriate for their actual situation.

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[34] See "Status" (pgs. 37 - 38) & "Education" (pg. 38) of my original submission.
[35] Including those suffering from a mental illness.

In my experience, education and training - particularly in terms of the subject of other peoples' distress - tends to cultivate an unhelpful swell of self-confidance in the person who receives it. The degrees & qualifications they are given too often prompt a sense of *"I know what's what"* within them and they become much less likely to properly listen to a person's commentary about their own distress or situation when that commentary conflicts with what they've been trained to believe.

I am reminded of a line from the 2009 hit movie *Avatar*: *"It is hard to fill a cup that is already full."*

For many people in crisis, such as myself, we tend to find that we do much better dealing with people who's cups are empty. People who haven't already been told what to think about us tend to be much more prone to listen to what we have to say about our own situations, because they have no other significant reference points to draw from.

That is what people in crisis, the suicidal, and *'mentally ill'* people need much more then system-prepared *'expertise'* - they need people to listen; **really** listen to them. We would all do much better if, instead of a national mental health landscape where everyone around us says: *"I know what 'X' needs"*, we had one where everyone around us said: *"I have no idea what 'X' needs, so I better ask them, and be guided by what they tell me."*

The Issue of Workplace Safety

I have deep concerns about the way the draft report addresses the issue of workplace safety; not only in terms of how it addresses "psychological health & safety", but also in terms of the lack of scrutiny it imposes upon existing workplace safety laws & conventions, and the role they play in currant depression & suicidalness trends.

One of the key points from my original submission that I would like to remind you of here is that depression, suicidalness and similar conditions often do not arise out of the presence of some 'badness', but rather out of the absence of adequate 'goodness'[36].

Thus, I would suggest to you that you can't investigate the role of the workplace environment on peoples' mental health solely in terms of seeking out negative elements in the workplace to eliminate. You must also focus significant energy on **vastly increasing the amount of positive elements** in Australian workplaces; the things that make people happy, and thereby lend support to the dubious claim that being alive is better then being dead.

[36] Discussed under "The Poor Recognition of Shortage as Motivation for Suicide" (pgs. 71 - 73) and "Lack of Uplifting Presence" (pgs. 80 - 83).

Existing Workplace Safety Laws

The report makes repeated references to our existing workplace safety laws, mostly as a measuring post for the future 'workplace psychological safety' laws that the inquiry proposes to enact. As far as I can see, all these references seem to be favorable, as if the inquiry holds our existing workplace safety laws in undisputed high regard.

I disagree with this stance, and I reccommend that this inquiry seriously investigates the massive role that existing workplace safety laws play in stifling the frequency of enjoyable experiences in the workplace.

Many people, myself included, would argue that our modern 'bubble-wrapped', 'nanny state' culture bears a significant responsibility for why life is so dull and unenjoyable[37]. Too often, our governments have committed us to unwanted and ultimately detrimental sacrifices, in an obsessive pursuit of further 'safety'. Each time, they leave us in a predicament where our survival has become a little more guaranteed, and yet immensely less desirable.

The overall tally of these sacrifices has mounted up terribly.

And it's not just the people unfairly bound by these safety laws who pay the price; it falls even more heavily upon their communities.

I reccommend that this inquiry seriously looks in to how these workplace laws can be ammended - or better yet, scrapped - in the interest of cultivating a massive increase in the sorts of incidents known to make communities laugh and smile.

I also reccommend that you seriously considder the **full** impact that our existing workplace safety laws have had on our society, **before** you enact new 'psychological safety' laws that are intended to replicate those impacts.

The Proposed 'Psychological Safety' Laws

While there are certain elements of the report's section on workplace 'psychological safety' that, on paper, seem very admirable[38], the ambiguities of this section present some very concerning implications.

Specifically, I have extreme concerns that many of these laws may have an emotional *"robbing Peter to pay Paul"* dynamic. While some workers may benefit from these laws, such benefits could potentially come at significant cost to others. I have further concerns that the scope of these costs may not receive adequate respect until the laws have already caused a devastating reduction in many citizens' quality-of-life.

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[37] And therefore, why claims that life is worth prolonging and suicide ought to be abstained from seem so implausable to the depressed and suicidal.

[38] Notable examples include the report's interest in combatting "job demand and control" problems, "effort-reward imbalance" (which impressively defines "reward" in broader terms then money alone), and "job insecurity", as noted on pg. 739 of Vol. 2 of the draft report.

The most obvious example of these concerns would be a law that forbids workers to share raunchy or risque jokes around the watercooler, because some worker(s) don't like raunchy/risque jokes and recieve *"psychological injuries"* when they overhear them.

This is a simplistic, kneejerk reaction that benefits the person who doesn't like the risque jokes, without offering any due considderation to the negative impact it has on the people who were getting pleasure out of those jokes.

While certain peoples' offense to risque jokes is a legitimate issue, as is their right to not be *"psychologically assaulted"* by such things that are toxic to them, a legitimate solution to this dilemma does not strip others of something good that brightens up their own lives. A legitimate solution must:

1. Acknowledge that raunchy/risque jokes are enriching for some and toxic for others, and seek to create two separate environments that can accomodate these two very different types of workers; one where raunchy/risque jokes are encouraged, and another where they are forbidden, for the workers' protection.
2. Seek to inject some alternate delight into the lives of the non-risque-joke workers, that allows them to reap as much enjoyment from their working day as the other workers' risque jokes give to them.

Many people would be inclined to say that raunchy/risque jokes aren't important and the joke-sharers don't *need* them. Nor, would they say, does our broader society need to considder the full impact of silencing those jokes.

But I believe it is folly to trivialize anything that allows us to take pleasure in the company of other human beings. Such things strengthen our bonds not only with those around us, but with humanity and life as a whole. Which does more to cultivate an appreciation for the value of human life within us? Humanity's ability to make us laugh? Or it's ability to incessantly complain about the laughter until the laughter stops?

I also believe that it is folly to carelessly deem that people who enjoy the raunchy jokes they hear from their mates at work *"can afford to"* lose their jokes, without taking any stock of what incentives they have to live, nor taking stock of how heavily burdened they are with grievances that make life less desirable.

As I explained in my original submission[39], the choice between prolonging one's life or committing suicide all comes down to weighing the pros about living against the cons. This is standard rational decision-making practice.

Regardless of how 'relevant' they are to us, jokes that make us laugh are chips that fall on the "pros" side of the scale, and tip the needle in the right direction for us.

[39] Under "The Poor Recognition of Shortage as Motivation for Suicide" (pgs. 71 - 43).

So as I say, how can a system that is blind to the contents of both those scales, for any given individual, reasonably proclaim that said individual *"can afford to"* have their enjoyable jokes stripped from them?

In many cases, the "cons" a worker carries - making suicide seem more attractive - may be very closely matched against the "pros" that encourage them to survive. The raunchy jokes they get a good laugh out of around the watercooler every morning may be one of the few pleasures they have tipping the balance and convincing them that, all things considdered, prolonging their lives is indeed worth the effort.

What right does a government mental health policy have to strip such a citizen of one of the essential glimmers of light in their life?

I won't even go into the significant free speech concerns that arise from such policies.

I know I probably don't explain these concepts very well, so if there is any confusion about what I'm trying to say, please don't hesitate to contact me and I will try to explain it more clearly.

To clarify: my concerns regarding this aspect of your draft report are not confined solely to the subject of raunchy/risque jokes, but to any proposed "*psychological safety"* measure where the 'safety' of one person or group comes at the cost of robbing another person or group of something that gives them happiness.

References To 'Compensation' of Mental Health Injuries

The report makes significant reference to 'compensation' of *"mental health conditions"*. Unsurprisingly, these references all seem to talk about compensation in terms of money.

I feel it is worth noting that a *"mental health injury"* - an incident that reduces our willingness to continue living, or that undermines the plausability of the idea that life has the capacity to be worth prolonging - cannot be undone, counterbalanced, or 'compensated' with money.

Financial compensation is only an adequate remedy mechanism for financial or material damage. In simplistic terms, if something happens that somehow worsens my overall financial situation by $10,000, the way rectify that misfortune is to make sure that I am given $10,000, so that I can say: *"All things considdered, I am no worse off now then I was at the beginning."*

Likewise, incidents that grieve us; that leave us in a worse state, either emotionally, spiritually, or both, can only be remedied by equally powerful rewards that give us joy. Remedies to 'mental health injuries' must leave us saying: *"I've had some pain, and I've had some fun. All things considdered, I am no worse off now then when I started. So if being alive means having to weather blows like* [the misfortune] *in order to enjoy things like* [the compensation]*, I believe that's a fair trade, and I am willing to continue living under those terms."*

Emotion and money opperate on two separate economies. As human beings, we may need to have balanced[40] personal financial budgets in order to survive; but much more importantly, we need balanced[41] personal emotional *'budgets'*, in order to considder survival to be desirable.

I urge the committee presiding over this inquiry to seriously considder this fact as it explores the question of compensating 'mental health injuries'. I suggest that the best strategy for compensating mental health injuries might not be to dispense money to the anguished, but to seek out and cultivate as many opportunities as possible to cultivate happiness in our workplaces, and in our society.

The Report's Focus on Children

There are many aspects about the report's focus on children that are concerning. Most of these concerns are rooted in the fact that the report effectively presents our existing mental health system as a reliable judge of what are legitimate thoughts & behaviors, and what aren't. I have already addressed the report's misplaced trust in the mental health system's doctrine previously in this submission.

Serious concerns arise when you apply this questionable doctrine to widespread screening programs of young children, and new & expecting parents.

I notice that many other submissions have voiced their extreme concern about the government increasingly exposing 0-3 year olds to the whims of "mental health experts", so I will avoid repeating their concerns and merely state that I share them.

In terms of older children - preschoolers, primary school students and beyond - I believe the report is generally headed in the wrong direction.

The report's attention to real-life problems[42] causing children distress is admirable, as is the report's acknowledgement that school bullying has the gravity of a national "public health issue"[43] that needs to be properly addressed.

[40] Or, more ideally, profitable ones.
[41] Likewise, more ideally profitable ones.
[42] Pg. 661 of Vol. 2 of the report.
[43] Pg. 1115 of Vol.2 of the report.

However, beyond these matters, the report's general approach towards children seems to be to subject them to an increasing amount of government "mental health"-themed programs.

Under it's surface, the report seems to be driven by the question: *"how can we better control children?"* instead of the far more ethical: *"how can we better* ***serve*** *children?"*

It is bad enough having a school system that dictates to children how they must think. But many of the measures proposed in the draft report seem geared to begin dictating to children how they must *feel*. This is unacceptable.

What we should be spending more time doing in schools is **asking** children who they are, not telling them. We should be non-judgmentally asking them what it is they like, what they considder virtuous, what they are attracted to, what they enjoy, what frustrates and bores them, what they wish to be distanced/shielded from, and what offends their personal values. We should then use this information to help steer the course of their lives to suit the preferances they've expressed as well as possible; ultimately using this information to determine how to assign them residency and employment as they enter adulthood.

I am not proposing that we hard-lock a child into becoming a fireman when they turn 18, just because they said they wanted to be a fireman when they were in kindergarden. I am merely proposing that we constantly steer the course of the child's life based upon the direction that the child has personally stated they wish to go in.

For example, in earlier years of their schooling, this system could be used to help decide who the student's classmates will be, which subjects will be emphasized in their studies, and possibly even which teacher they will be assigned or which school they will go to.

Both in the short and long term, successful execution of a system such as this will help society tailor the student's life to match their self-stated needs and insure that they are ultimately placed in their best-possible environment. By knowing what makes the student happy, we will be better able to direct them towards these things and thus do a much better job of convincing them that life is worth prolonging.

A scheme that respects the individual, and their individual needs would be far more effective at producing a happy population then a scheme that, in effect, merely lectures to the masses that they should be *"mentally healthy"* and *"manage their dissatisfaction in a non-disruptive way"*.

As I noted throughout my original submission, simply dictating to people that they should believe that life is worth prolonging doesn't work. A handful of "experts" or "leaders" preaching that *"suicide is the wrong choice"*, can't compete with the ongoing reality of someone who has found that hour after hour, day after day, year after year, life is much too sparse on virtue and benefit to justify it's continuation.

If you want your population to seriously believe that life is worth prolonging, then you need to make sure that life itself gives them a pretty compelling demonstration of that idea.

This principal holds true for all the symptoms we see of life-dissatisfaction, not just suicide. It includes problems such as depression, anxiety and drug/alcohol abuse. They all hinge on the sufferer's genuine feelings about life.

Study Load

One other area of the report's section on children that was disappointing was that it didn't seem to make any significant mention of the role that modern schoolwork loads play in the distress that many students suffer in this day and age.

The massive emotional burdens that the HSC level of schoolwork places upon students[44] has been well known for decades. Yet far from addressing and attempting to reduce this issue, it seems we have actually encouraged it to grow!

Relatively recent changes to the governance of the schools system (e.g. the introduction of the NAPLAN system) seem to have increased the study burden and related stress upon increasingly younger grades of students. Equally as bad, the convoluted nature of modern education seems to be pushing our teachers to their breaking point; with all the things they are expected to be trained for, and to effectively teach within a finite school year. I have read countless pieces stating that this is the modern state of affairs in our primary schools.

Along with the stresses of the study load itself, and the associated exams, the fact that the students are largely being lead by stressed-out teachers only compounds the distress of everybody involved. Teachers don't need to overtly show their persistant frustrations with their modern jobs to have a negative effect on their students. Kids are often more intuitive then many would give them credit for. In a subconscious way, the long-term distress of a teacher will be prone to filter out and have a negative impact on the communal contentment and sense of security within his/her class.

Our significant over-burdening of study load within schools has a lot to answer for, in terms of the mental health woes of many of our younger Australians. So it was disappointing to not see this matter really addressed within the report[45].

I think the committee presiding over this inquiry should seriously think about reccommending a sizable reduction in school study loads, especially within our primary school system, to help bring student & teacher study stress levels back down to how they used to be before the NAPLAN system.

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[44] Largely due to the significant implications HSC results have upon the students' futures.

[45] Although I did notice a section addressing excessive course loads in schools, it seemed to be exclusively concerned with an excessive amount of "mental health"-themed education, and an interest in condensing this load down into a more manageable parcel. My concerns relate to the entirety of school study loads upon students and teachers.

Homelessness

The draft report duely notes the significance of homelessness upon the issues of depression, suicide, and other mental health matters, and poses some admirable reccommendations towards this crisis.

I feel, though, that it is worth mentioning that a closely-related issue to homelessness - especially in regards to the mental health impacts - is a problem that hasn't really been given a name, but which I shall call *home-loneliness*, for the purposes of this submission.

Whereas the issue we traditionally call homelessness is generally a lack of bricks-and-mortar, 'home-loneliness' is more a lack of compatable human presence. The effect can be similar, in that the sufferer feels that they don't truly have a 'home'.

For many people, the concept of 'home', isn't a building, but rather a select group of kindred spirits who we settle down and live our lives with on an enduring, daily basis. Thus, a person who doesn't live with anyone they connect with and trust may indeed have a legal residence; but they don't have a 'home'.

Of course, there are doubtlessly many people who don't have either.

Thus, I would ask that this inquiry remain mindful that, while many people merely need to be matched with a bricks-and-mortar residence to call their own; others need to be matched with compatable, like-minded housemates who will give them a family they truly connect with and cherish.

The National Mental Health Commission

I find it hard to comment on the report's reccommendations for the National Mental Health Commission (NMHC) because I couldn't really understand what the report was saying about it.

On the surface, it would seem as if this inquiry has followed my Reccommendation #2[46] from my original submission, to *"Establish a Permanent, Impartial Overseer of the Mental Health System"*.

However, reading between the lines of the report, I get the impression that you only intend the NMHC to opperate as an overseer of the beaurocratic management aspect of the system, and not the system's stances on what is and what isn't a mental illness, nor it's treatment protocols.

[46] Pgs. 127 - 129

I dearly hope I have misunderstood the report in this regard, because, as I originally explained to you, these aspects of the system are where the most harm is being done to patients. Therefore, they are the aspects of the system that are most desperately in need of an impartial, compassionate overseer that can double-check the system's conclusions and prevent inappropriate treatments and flawed diagnosises from being inflicted upon the mentally ill and suicidal communities.

I'll pose a hyperthetical situation to allow you to see whether the role your draft report proposes for the NMHC is adequate:

Let's say we were still living in the bad old days when the mental health system still held the official stance that homosexuality is a mental illness.

Under your proposed changes, would the NMHC now double-check that ruling to see if it's fair? Would it explore the issue itself, from a blank slate - outside of the mental health system's doctrine and preconceptions - to see if it too would come to the unbiased conclusion that homosexuality must be a mental illness? Would it give the gay community a chance to plead a counter-case? Would it give them an opportunity to defend their orientation[47]? Would it fairly weigh the mental health system's arguments for why those thoughts/behaviors are a *"disorder"* that ought to be corrected, against the community-in-question's defense of their personal natures[48], and a due considderation of the peoples' individual rights?

Or, under your proposed changes, would it simply be business as usual for the mental health system? Would the system continue to persecute the LGBT community freely, because there was no official overseer to make sure that the way they practiced "mental health care" in our society was just and fair?

I would urge the committee presiding over this inquiry to not settle into a false sense of security simply because, in reality, the system reversed it's stance that homosexuality is a mental illness many years ago. Because, although this particular injustice has been corrected, many, many people are still being persecuted by the system because their mindsets fall under the system's dodgy concept for what is a *"mental illness"*.

People are still suffering under the system's poorly justified doctrine and, at the moment, there is nobody double-checking it!

Likewise, many patients suffer harm under treatment protocols that are not adequately tested and justified by any impartial overseer department.

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[47] Thoughts, feelings, worldview and concept of self are issues that might need to be defended by their respective communities when other "mental illnesses" would be put to the test.

[48] For the record, I **do not** favor a system where an allegedly mentally disordered community would be required to mount a compelling defense of themselves in order to retain freedom and respect for their mindset. I am a great admirer of the principal of "innocent until proven guilty beyond a reasonable doubt" in our justice system, and I would suggest that the same ought to be applied to mental health system doctrine. The burden of proof should not be placed upon a particular community to prove that their feelings/mindset is legitimate. The burden of proof must fall upon the mental health system itself, to compellingly prove that any mindset it wishes to denounce must be a *"disorder"*.

So I dearly hope that the inquiry's draft report has assigned the NMHC to take on a role such as this, and that my impressions to the contrary simply come down to my misreading the report.

But in any event, I still have additional concerns about the report's plans for the makeup of the NMHC.

One of the report's reccommendations is that: *"The NMHC should be governed by a skills-based Board of multiple persons"*[49].

The meaning of "skills-based" isn't entirely clear, but I've interpreted it to mean that the board should largely be made up of people who have been educated/trained under existing mental health education regimes.

I personally believe this goal to be unwise. I have strong concerns that existing mental health education encourages close-minded attitudes towards mental illness/mental health, and a tendency to 'tow the mental health system's company line', without free thought or due, impartial considderation of the issues at hand[50].

We should strive to have a NMHC that has no significant ties to the mental health system, or it's doctrine; either due to education, training, or employment history. Only when the NMHC is staffed by people from an outside, unbiased mindset will it truly be able to act as a fair, impartial overseer of the mental health system, and an effective defender of patients' rights and outcomes.

Another line of concern in the report is that *"at least one non-executive director"* on the NMHC board should have lived experience[51].

While this is certainly a step in the right direction, I feel that this reccommendation veers towards the trap of tokenism.

I would reccommend that the board have **many** members with lived experience - ideally about half of them - and that several of the executive directors have lived experience, as well - once again, half would be an admirable target.

Increasing the Amount of Discounted Therapy Sessions

The draft report is merely the latest in a long list of documents and articles I've read recommending that the amount of discounted therapy sessions that Medicare offers patients per year should be increased. 20 sessions - the same number that the draft report seems to favor, tends to be the most common suggested target.

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[49] Pg. 924 of Vol.2 of the draft report
[50] As discussed under "Education" (pg. 38) of my original submission.
[51] Pg. 923 of Vol. 2 of the draft report.

I've read and respect the various arguments for this increase. Most of them come from honorable sources who's position I can respect.

While I don't wish to contradict any of these arguments, I would like to make the inquiry aware that there is another side to this issue.

For people trapped in bad therapy situations, as I once was[52], every government-discounted therapy session means another nightmare in their year. If the government had cut the amount of discounts I could get per year from 10 to, say, 4, that would've been quite a relief for me. If they had completely cancelled the Medicare discount program, that would've ended my therapy nightmare altogether! Alternatively, if they had doubled the amount of discounted sessions per year from 10 to 20, that would've been unbearable!

For that reason, I reccommend that, before the government makes any increase to the amount of discounted therapy sessions it offers patients, it first overhauls the Medicare discount system to insure patients have easy, convincing and secure escape routes from bad therapy situations.

I would suggest that a key change to make in this regard would be to remove the requirement that patients need to sign away their doctor-patient privelage with their GPs in order to access the discounts[53]. Being able to speak freely with their GPs about their terrible therapists could potentially make it a lot easier for patients to escape from bad therapy situations.

Beyond that, one solution to this problem that warrants serious considderation would be to change from a system that dispenses fixed discounts for therapy, to a system that grants patients a set Medicare funding 'pool' each year[54], and allows them to spend that money on their mental health treatment, as they see fit.

Such a free approach to the Medicare discount system would not only allow patients to receive discounted therapy, but would also allow them to use that the same amount of money in a manner that accommodates their financial and mental health needs much more appropriately. e.g. They could use it to alleviate the considerable costs of their mental health medication; to have less therapy sessions, but at a much more affordable price[55]; or to engage with other helpful treatments, such as meditation spas, which may currantly be out of financial reach for them.

I have read numerous pieces from others praising the merits of such a system. No doubt you have probably already received several submissions reccommending such a system yourselves.

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[52] See "My Personal Experience" (pgs. 49 - 53) of my original submission, as well as the attachment to that submission.
[53] I have already voiced my criticism on this policy in my original submission, on pg. 67
[54] With an amount of money equivalent to the discount funds already offered to patients; or, with regards to your plans to expand the scheme, an amount of money equivalent to the 20 proposed sessions' worth of discounts.
[55] Which could be essential for patients on very tight budgets.

But from my point of view, such a scheme would be an effective solution to bad therapy situations, because it would allow a patient to tell their therapist that they've already used up their funding pool for that year on other treatments, and thus, can no longer afford to attend therapy with them.

Of course, for such a system to work, the therapists must not be able to view the patient's Medicare records to determine for themselves how much money the patient still has in their 'pool'.

The Report's Overall Reliance on "Evidance-Based Treatments"

In many places, the draft report falls far short of being helpful, due to it's reluctance to venture in to territories where there aren't "evidance-based treatments" for it to promote.

I can respect the inquiry's reluctance to support questionable treatment programs, particularly with regards to the mental health system's shocking track record of churning out harmful treatments.

Yet at the same time, I am also disappointed that the inquiry hasn't siezed this opportunity to be bold and innovative in the face of major national crisises that are having huge impacts on national mental health, and for which there are currantly little to no measures in place to meaningfully combat these problems.

Loneliness is a noteworthy example; having received some mention in the report[56] as an issue of concern, but no significant proposals on how to combat it.

I have a suspicion that, to a large degree, this shortfall of remedies may come from an underlying perception that people in crisis need to be *'managed'*, rather then helped. I strongly suspect that the need to lean upon "evidance-based treatments" could be greatly reduced if the system adopted a straightforward policy of striving to provide the help the patient requests, as it's first and favored approach to each and every case.

Many of the major problems that cause great suffering in Australia don't need some convoluted, laboratory-cooked scheme to remedy them. They just need some regular Australian to step up to the plate and say: *"No problem! I'll help you with that!"*

[56] I feel it is also worth noting that the length of

Even in situations where therapists/helpers themselves don't know how to deliver the help that the patient needs, we could deliver satisfying outcomes with far more frequency if we had a system where therapists ask their friends, their families, their colleagues, their sports teammates, their other patients, the mob they hang out with at the pub, the old acquaintances on their Xmas card lists: *"If I wanted to do this...; If I wanted to find and make some new friends who are these types of characters...; If I wanted to get into a new home...; If I wanted to relocate to this type of community...; If I wanted to get into a career in this industry/company...; If I wanted to solve this beaurocratic hassle...; If I wanted to get around this screwy law... how would I go about it?"*

For most problems that plague us, I believe that there is almost certainly someone out there in the community who knows what the solution is. Someone out there must have a friend, a neighbor, a coworker, a cousin, or some other contact who either *is* the solution to our problem, or who knows what the solution to our problem is.

The catch is that everybody in the chain must be willing to help the person in need to accomplish their goal, regardless of whether or not those 'links in the chain' personally approve of that goal. This is where our currant system routinely breaks down.

Instead of helping people in need to be who they want to be, and go where they want to go, our currant approach towards mental healthcare leans towards 'managing' them towards an outcome that suits the system more then the individual. And this agenda is largely where the demand for "evidance-based treatments" comes from.

That being said, there are certainly many situations where the need for "evidance-based treatments" can be legitimate.

One such situation would be where the patient can't narrow down what they need to a meaningful description that the therapist can work with.

Another would be where the patient's needs are genuinely too expensive or difficult to actually accommodate. While cases such as this do need to be factored in to the system's design, I would reccommend that safeguards be put in place to insure that a therapist/helper isn't redirecting a patient into an "evidence-based treatment" simply because he/she doesn't approve of their personal goals and doesn't want to see them succeed.

If a patient's preferred form of help has been clearly stated, and refused, then usage of an "evidance-based treatment" should require signed proof that the therapist/helper has consulted with other therapists/helpers to confirm that the patient's requested help is indeed unattainable and that this conclusion was sufficiently investigated before being settled upon. It should also require proof that alternate avenues that more closely resemble the patient's desired outcome were explored before the "evidance-based treatment" was begun.

More broadly, the NMHC should keep watch over these types of cases to make sure the process is being performed with integrity.

If the inquiry's final report favored a policy of straightforwardly providing the help that patients actually ask for, the need to rely on "evidance-based treatments" would be greatly reduced; and the shortage of such treatments would be much less problematic.

Conclusion

I would just like to conclude by once again thanking the committee presiding over this inquiry for reading this submission, and for whatever considderation they were willing to give to my original submission.

Although I have spent much more of this submission voicing criticisms about the inquiry's draft report, I'd like to clarify that that's more or less a case of *"the squeaky wheel getting the grease"*. All things considdered, the report gets an awful lot of things right and in many areas it was quite impressive and a very welcome surprise. The productivity commission are to be commended for their hard work and thorough considderation of these many issues causing anguish for so many Australians.

That being said, there was also much room for improvement and those were the areas that I hoped to shine a light on with this follow-up submission. I hope my commentary has been helpful.

For your convienience, I have included a summary list of my reccommendations on the following pages.

My Thanks and Kind Regards once again,

A Concerned Citizen
22/01/2020

Reccomendations

Reccommendation	Detailed On Page(s)
Abandon suicide prevention policy; focus on making life worth living.	**8**
<u>Do not</u> prioritize suicide prevention over peoples' right to privacy.	**9**
Reach out to a human rights and/or humanitarian issues department for insight into the shortcomings of the draft report, and assistance completing the final report.	**10**
Either this inquiry, or some other government department must conduct a thorough investigation into the mental health system's currant doctrine.	**12**
If it's not already the draft report's intention, insure that all people in crisis have access to the services created by this inquiry, not just the truly 'mentally ill' and disabled.	**13 - 14**
Do not proceed with your numerous proposals to demand more mental health education/training across the workforce.	**14 - 16**
If you do insist upon demanding more education, conduct a thorough inspection of all the courses that are being proposed, so that you know precisely what is being taught, both directly and culturally. Be especially on the lookout for areas where the courses might cultivate community arrogance towards mentally ill people and others in need.	**17**
Investigate the role that currant workplace safety laws play in stifling & preventing happiness in the workplace.	**19**
Check your "psychological safety" laws to insure that their protective benefits don't come at an unjust cost to others.	**19 - 21**
Recognize that "psychological injuries" can only be 'compensated' with happiness. Invest in cultivating national happiness.	**21 - 22**
Adopt a mental health strategy for the school system that primarily focusses on assisting students to attain their own desired outcomes.	**23**
Reduce the study load imposed on all school students to reduce the stress and anxiety it inflicts upon both students and teachers.	**24**
Factor the need for meaningful, enriching household companionship into your plans for addressing homelessness.	**25**

Reccommendation	Detailed On Page(s)
Insure the NMHC has the powers and the stated duty to scrutinize all the mental health system's designations of "mental illness", and all it's treatments, and the powers to block these diagnosises & treatments from being used, as necessary. (Incase such measures aren't already proposed in the report.)	**26 - 27**
Insure the NMHC is made up of people with no connections or loyalties to the mental health system, or it's doctrine; and insure it has a non-tokenistic presence of lived-experience members.	**27**
Insure that any increase in the number of Medicare-discounted therapy sessions comes with safeguards that protect patients from bad therapy situations.	**28**
Eliminate the requirement for patients to surrender their doctor-patient privelage before accessing the Medicare discounts for therapy.	**28**
Considder shifting from the 'set-number-of-sessions' model for Medicare therapy discounts, to a model where patients are assigned a 'money pool' of equal value to spend as they see fit on their mental health needs.	**28**
Insure that straightforwardly providing the specific help requested by the patient should be the system's primary treatment method. Recognize that "evidance-based treatments" should only be used as a back-up alternative for when straightforward help is not available.	**31**