A Submission
To The
Victorian Government's
Royal Commission Inquiry
Into
Mental Health

Contents

Introduction

I would like to begin this submission by thanking the Victorian government for the opportunity to address the numerous important issues contained herein.

I make this submission both as a former patient who was woefully failed by the mental health system, and as an Australian who has, for most of his life, had to endure a terrible quality of life that no one should ever be expected to suffer. I write this submission as a man who wishes he was dead.

I am not a Victorian, and none of my personal experience with the mental health system took place in Victoria. However, it is my belief that the most grievous problems with the Victorian mental health system are common to mental health care throughout Australia. Statistics may vary from state-to-state, but the problems nonetheless exist to a significant degree everywhere. Thus, as a former patient of Australia's mental health system, I believe I can offer you important insight into the issues that this inquiry is set up to examine.

I would also like to address numerous issues with broader society[1], which have significant impacts upon the matters of suicide, depression, mental illness, and other major life crisises. As one of the countless Australians who's quality of life has, at one time or another, suffered significantly due to these issues[2], I believe that my perspective on these subjects is also relevant to this inquiry; even though it is not a Victorian perspective.

It is my understanding that out-of-state input is welcome in this inquiry. Apologies, if I am mistaken.

I was a patient of the mental health system for roughly 8 years: roughly 9 months under the care of a psychiatrist, 7 years under the care of one psychologist and about 3 months each under the care of two other psychologists, with some overlap between them.

My time in the system was a horrendous ordeal that I have no intention of ever repeating[3]. It was not at all beneficial in any meaningful way. I would later discover that none of the therapists I dealt with had any intention of actually helping me, due to official mental health system policy[4]. By itself, I considder this to be quite appalling, considdering the financial cost, the time I invested and the fact that I desperately need help.

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[1] Including general Australian culture, government policy, the various mental health/anti-suicide organizations (e.g. [redacted] ect.), and the media.
[2] In many cases, they are issues that continue to have a significant, negative bearing on my quality of life.
[3] Detailed in "My Own Personal Experience" (pgs. 58 - 62)
[4] See "The System's Unwillingness and Inability to Address Real World Problems" (pgs. 36 - 39)

But even worse, I believe my treatment had a dammaging effect on me, and was the direct cause of problems which still effect me to this day. In addition to my original problems (which were not remotely remedied by the treatment), I believe these new problems are significant hinderances to any chance I might have of achieving a life that is worth enduring.

If anyone asked me for my opinion about seeing a therapist, I would strongly advise them to avoid therapy at all costs.

Despite the fact that my life is a living hell and that I still desperately need help, I will never go back to the mental health system. Not until it undergoes a major reform, at least. For myself and a great many other patients, the system is not anything close to a help; it is yet another heavy burden, typically inflicted upon someone who is already carrying far too much.

I feel I ought to make a few of clarifications at this point, regarding the sections to follow:

Firstly, I do not deny that many patients of the system have found it to be very helpful, if not invaluable. My intention is not to imply that the mental health system is entirely bad. It is merely my intention to convey that the frequency of mental health treatment being unhelpful, if not outright dammaging, is unacceptably high. This document will be mostly critical of the mental health system and it's staff. But I acknowledge that there are also good aspects to the system as well. I will leave it to someone who has actually benefitted from therapy to state exactly what those might be.

None of the criticisms I make about therapists can be levelled against each and every one of them. Most will be traits that are common in this line of work, and they are all too often the rule as opposed to the exception. But they are certainly not unanimous. I acknowledge that there are indeed good therapists out there; but their presence is extremely watered-down by the abundance of terrible ones.

Secondly, only a small portion of the issues I address in this submission can be blamed on rogue, backalley 'unofficial' therapists, or the predatory and criminal therapists who flagrantly violate the system's ethics, if not the law[5].

The vast majority of unacceptably bad patient care is performed by official, 'trained' therapists who are acknowledged and respected by the health system. The vast majority of patient care which psychologically harms patients, or leaves them floundering unaided in a severe crisis, is perfectly legitimate in the eyes of the law and the internal rules and guidelines of the mental health industry.

[5] e.g. By physically or sexually abusing a patient.

Thirdly, this submission's criticisms towards the mental health system does not adequately address the atrocious things that go on in psychiatric wards and similar facilities, as I have no personal experience with such facilities. My treatment consisted of only daytime appointments at small clinics and a hospital and never involved any overnight or long-term stays. I have faith that patient advocate organizations such as [redacted][6] will address you at length on the appalling abuses of care that occur in psych wards, ect., as hopefully will numerous currant and former patients of such facilities.

While I acknowledge that some truly appalling things occur in psych wards, ect., I must emphasize that reform of the mental health system mustn't settle for simply ending these abuses, alone. The Victorian government mustn't adopt an attitude of: *"We've shut down the most grievous offender. Mission accomplished!"* Therapists don't need to inject volatile chemicals into a patient's bloodstream, electrocute them, or tie them down to a bed to ruin their lives. Plenty of therapists manage to do this simply through talking to their patients, in relatively cozy settings.

Therapy performed by small, business-hours clinics **ruins lives**, just as surely as aggressive psych ward treatment does. For this reason, it is essential that the Victorian government takes care to adequately address the failings and abuses that occur in these small clinics, just as surely as it needs to address the multitude of failings and abuses that occur in psych wards.

And fourthly, none of the issues I address within this submission are uniquely Australian problems, let alone uniquely Victorian ones. Talking with the global suicidal and "mentally ill" community, you will find that most all western countries experience the exact same failings with mental health treatment, and the same flawed attitudes from both government and society towards happiness, mental health and suicide.

I would also like to apologize in advance for any parts of this document which may come across as being patronizing.

I have found that there is a massive communications rift between suicidal and anti-suicide people. You seem to be unable to understand why we would rather die then continue living, and we likewise cannot understand why you keep insisting that being alive is better then being dead. I believe that mutual understanding is crucial if we are to see positive changes in the matters of suicide and unbearable life circumstances. So I have tried to express the position of suicidal people in the simplest, most relatable way I can, in the hope that it will minimize any confusion. I apologize if this makes the submission seem patronizing or childish in some places.

[6] [redacted]

Before I conclude this introduction, I would like to note that this submission is largely based upon a previous submission I made to the inquiry the fedral government conducted last year into the "Accessibility and quality of mental health services in rural and remote Australia"[7]. It was accepted as submission #138[8]. I have also sent a similar re-adaptation of that submission to the fedral government's currant productivity commission inquiry into mental health[9], which has been accepted as submission #482[10] for that inquiry.

Beyond these brief introductory sections, I have divided the bulk of this submission into 3 main segments: the first details problems with the mental health system, the second details problems in the broader national culture, and the last is my reccommendations for dealing with these problems.

Although I have tried to categorize the issues as straightforwardly as possible for your convienience, the subject matter of this submission is really a 'web' of many inter-connected issues that relate to one another in numerous ways. So certain parts of this document might depend on detailed explainations of related issues that are found elsewhere in the document. Apologies, if this makes the reading difficult.

As I'm sure you can appreciate, these are all issues of immense importance. To be honest, the original version of this document was quite difficult for me to write. Re-adapting it for this new inquiry has not been much easier.

I hope you give serious considderation to the matters raised within and the resulting reccommendations. A great many Victorians, both now and in the future, desperately need you to.

If there are any matters addressed in this submission that you require further explaination in, or any related matters you would like my input on, please feel free to contact me and I will do my best to answer your queries. Even though I'm requesting that this document be published anonymously, you should be able to contact me through the contact details provided with this submission.

My Thanks and Kind Regards,

A Concerned Citizen
From Out-Of-State
03/07/2019

[7] http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MentalHealthServices
[8] http://www.aph.gov.au/DocumentStore.ashx?id=90f99a74-2e12-4b3b-855a-90ca7d8dfe94&subId=662988
[9] http://www.pc.gov.au/inquiries/current/mental-health
[10] http://www.pc.gov.au/__data/assets/pdf_file/0005/241277/sub482-mental-health.pdf

An Objection To The Nature Of This Inquiry

Before I being this submission proper, I wish to add my voice to the multitude of others who have expressed disappointment and objections to the fact that therapists and other "mental health experts" were aloud to design this inquiry, and in doing so, were aloud to make sure that this inquiry's terms of reference did not include calling the mental health system to account for the countless abuses and other willful wrongdoings it has performed and continues to perform.

In allowing therapists and their "expert" colleagues to design this inquiry, the Victorian government has robbed it of it's integrity and sabotaged it's opportunity to effectively investigate the dire issues that, on face value, it was created to address. The most basic principals of effective investigation and fairness demand that the institutions, ideologies, theories and initiatives that these people support should not be defining the investigation, they should be **under** investigation! As a glaring example, how are Victorians supposed to trust that this inquiry will adequately and impartially evaluate the role [redacted] plays in the Victorian mental health landscape, when [redacted] was the architect of this inquiry?

For the sake of this inquiry's integrity and fairness, and even more so for the sake of the suffering, mentally ill and suicidal Victorians who's fates rest on the outcome of this inquiry, I strongly urge you to remove all connections to past and present members of the mental health field from your investigative team, and to completely reevaluate your agenda of investigation once you have cleared your workspace of the influence of such people.

This inquiry is meant to be the thoroughest of investigations into the mental health system. Don't let advocates of the mental health system, or the ideologies which govern it, decide what is worth looking in to, and what isn't.

Answers To Submission Form Questions

> ***Question 1:*** *What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?*

In terms of the broad picture, we first and foremost need to do away with all the unwritten rules about discussion of these topics that stifle the sufferers' ability to speak freely about them.

While this will probably be very difficult, if not impossible, to accomplish in the *'family dinner table'* and *'pub chat'*-type settings, I believe we can take steps to open up the more public arenas of the mental health & suicide discussion.

We need to recommit to freedom of speech in the public discussion about these matters, to insure that sufferers are publically able to:

- Talk openly and frankly about their issues;
- Clarify pertinant aspects about their situations which may be taboo, or at odds with official mental health or anti-suicide policy;
- Demonstrate, as compellingly as necessary, the wisdom for choosing death over life, as they see it, so that the essential point-of-view of suicidal people can be adequately factored into our discussions about their fates;
- Compellingly defend attitudes, points-of-view, preferances, desires and values they hold, which the mental health system denounces as 'mental illness'.
- Present frank and even scathing critique of the mental health system, including it's foundational philosophies;
- Present and compellingly defend points-of-view that people in need might be better off avoiding the mental health system rather then turning to it; and:
- Contradict popular statements and views presented to them, such as suicide being 'the wrong choice', or the mental health system being 'helpful', which significantly contradict with the person's life experience or cherished values.

To this end, we need to insure that there are adequate internet facilities (e.g. forums) where this freedom to speak allows them to communicate not merely with one another, but with the broader community as well. In contrast to many currant mainstream internet forums where discussions are typically strongly restricted to prevent statements that discourage others from seeking 'help', or which legitimizes 'mentally ill' mindsets (including suicidalness), or paints them in a positive light.

We need to make sure that all citizens can testify freely in these matters, without needing to fear being committed to a psychiatric ward for expressing "mentally ill thought" - including expressing a desire to kill themselves - or even being at risk of being pressured/coerced into entering into the mental health system.

Answers To Submission Form Questions
Question 1

We also need to make sure that major media coverage of these issues features a much stronger presence of direct testimony from sufferers, and in particular, from currant sufferers. When the media decides to talk about mental illness or suicidalness, it ought to be an actual suicidal, depressed, or mentally ill person on camera, telling the public what the deal is - not some so-called "expert" on the subject talking about these situations from a sideliner perspective.

And we need to massively reduce the restrictive 'guidelines' imposed upon the media by so-called "experts". These guidelines have the media running so confused and scared of putting one foot wrong that their coverage has become hollow and all but worthless to the depressed, suicidal and mentally ill communities. Modern media is so intimidated, they are scared to even mention the word "suicide" now - instead they tend to say: "police do not considder the death suspicious", which most readers now automatically assume means suicide.

Adequate public awareness can never be achieved while our media are cowering in the corner. We need them to be bold, frank and clear about these crisises. We need to be able to trust them to hold a corrupt and abusive mental health system to public account, instead of turning a blind eye for fear of creating "an unhelpful attitude towards help-seeking". We need them to convey an intact and adequate understanding of why people get depressed and why many come to prefer the idea of being dead to the idea of surviving.

It is controversial but legitimate and important information that the public has a right to know, and needs to be informed on. And we need our media to be bold enough to report it. Currant guidelines are immensely sabotaging in this regard.

For further information see:

- "Gaps in the Public Forum for Discussion of Mental Illness, Suicide and Related Issues" (pgs. 99 - 135)
- "Unwillingness to Help" (pgs. 94 - 95)
- **Reccommendation #4:** "Promote Public Awareness of the Dangers of Therapy" (pgs. 149 - 151)
- **Reccommendation #5:** "Encourage the Media to Provide More Balanced Coverage of Suicide and Mental Health Issues" (pgs. 152 - 153)

Descrimination is a harder challenge to address. But I believe that it can be significantly addressed by making sure that people are directed into environments that are naturally more in-line with their mindsets, and will therefore be less discriminatory towards them.

For further information see:

- **Reccommendation #7:** "Recognize Happiness as an Essential Resource" (pgs. 157 - 162)

> ***Question 2:*** *What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?*

What is working well? Pretty much nothing.

If you are fortunate enough to have friends/family/ect. who are **genuinely** respectful, supportive, and helpful, then they are usually a very valuable and effective asset. But for the rest of us, there is nothing that we can really say is "working well".

For more information see:

- "PROBLEMS WITH THE MENTAL HEALTH SYSTEM" (pgs. 30 - 79)
- "Lack of Uplifting Presence" (pgs. 90 - 93)
- "Unwillingness to Help" (pgs. 94 - 95)

What can be done better to prevent mental illness?

Most importantly, we need to raise overall quality of life in this country, to the point where life is well worth prolonging for as many people as possible. It is of crucial importance to understand that this does not mean simply throwing money at people.

We need to thoroughly and effectively address loneliness, and come up with systems that unite lonely people with other kindred spirits; including, but not limited to, an effective system for uniting people with highly-compatable romantic partners.

We need to redesign the positioning of our citizens, so that the jobs they are given and the schools/colleges they are sent to are places they will be highly compatable with. This is most important in terms of their coworkers & fellow students; every Australian should be able to say of the people they spend their day with: *"I love getting to share my life with these people!"* It is also highly important that they find the work itself meaningful and personally fulfilling, not merely a source of money.

An important step towards achieving this will be to make all careers much more accessable to people, for example by reducing the educational and experience requirements imposed upon them as much as possible.

We also need to devise a system for repositioning people, in the residential sense, into environments that are far more compatable with them. People should feel a genuine connection and appreciation to their neighborhood, and feel that the character, the values, the ideals and the ambitions of their local community strongly reflect themselves. All Australians should not merely feel truly at home within their own particular house, but throughout their entire town or suburb.

Answers To Submission Form Questions
Question 2

We need to place an immense national focus on cultivating happiness and recognize that even more importantly then making a living for our community, we all have a duty to make life **worth** living for our community, as best we can. Australians need to have the freedom, and hopefully the willingness as well, to make others happy as much as possible as they go about their work and private lives. Community and business management should not be oriented merely around smart decisions and profit, but also around outcomes that will make community members happier.

For each and every service, industry and job, we need to ask: *"What opportunities are there to do this in a way that makes the community happier?"* And we need give those industries and individual workers the freedom they need to make those opportunities a reality.

The less likely someone is to get trapped in a life that is lonely, meaningless, boring, joyless, and without accomplishments, the less likely they are to develop depression, suicidalness, or other anguish.

For more information see:

- "The System's Unwillingness and Inability to Address Real World Problems" (pgs. 36 - 39)
- "The Poor Recognition of Shortage as Motivation for Suicide" (pgs. 81 - 83)
- "Lack of Uplifting Presence" (pgs. 90 - 93)
- "Unwillingness to Help" (pgs. 94 - 95)
- **Reccommendation #3:** "Create a Service That Will Provide Respectful, Meaningful, Effective and Timely Assistance to People Suffering Real-World Crisises" (pgs. 144 - 148)
- **Reccommendation #7:** "Recognize Happiness as an Essential Resource" (pgs. 157 - 162)

What can be done to support people to get early treatment?

It is of crucial importance that we insure that treatment is genuinely beneficial to patients, **before** we fixate on how to get them in to it. At the moment, a great many patients are much better served by avoiding treatment (including early treatment) as much as possible, because the quality of the system is so appalling. Today, "early treatment" mostly means expensive time wasting, masking of malignant crisises, and in too many cases, system-inflicted harm.

For more information see:

- "PROBLEMS WITH THE MENTAL HEALTH SYSTEM" (pgs. 30 - 79)

Question 3: *What is already working well and what can be done better to prevent suicide?*

What is working well? Once again, pretty much nothing. And I believe this is supported by our currantly rising suicide statistics.

The problem, unfortunately, is deeply rooted, in that our currant system is based primarily upon a confinement agenda. The strategy for keeping citizens imprisoned in life is based entirely upon sabotaging escape attempts, including by publically shaming any and all *ambitions* of escape, with depressing and disturbing labels like 'mental illness', 'impulsive action' and 'distorted thinking'.

The true, nefarious intent of our modern suicide prevention strategy is well illustrated by the fact that one of the key tactics of that strategy is to deprive suicidal people of access to the tools they might use to accomplish their suicides. This is a very telling indication that the people who formulate this policy are not so averse to people deeply yearning for their lives to end, as they are to people actually acting on these desires. Comparitively speaking, it's fine to have someone wallowing so deeply in anguish that they constantly pray for the swift mercy of death; but it is not fine for that person to actually die.

Suicidal people are not fools. They recognize that our suicide prevention policy is more geared towards appeasing those sections of the community that find suicide morally offensive then it is towards appeasing suicidal people themselves. And that is why so many of the suicidal community go to great lengths to avoid all anti-suicide groups and people - especially the mental health system - and likewise go to great lengths to conseal their own suicidalness, until they have actually committed suicide.

Additionally, when more naieve or trusting suicidal people enter in to the mental health system seeking a non-fatal remedy for their unbearable quality of life, they are confronted by the fact that the system invariably will do nothing for them, and also that it's ideology towards suicide is, in truth, unbalanced, unreasonable and of highly questionable legitimacy.

A person who goes in to the mental health system believing that: *"I ought to think and act as if life is worth prolonging, because that's the sane thing to believe"*, will very often come out of their treatment with their faith in that principal severely shaken, if not destroyed. In putting mental health system doctrine on suicide to the test, patients discover, for the first time in their lives, that this doctrine fails woefully to support the idea that being alive is better then being dead.

Answers To Submission Form Questions
Question 3

For more information see:

- "The System's Attitude Towards Suicide" (pgs. 63 - 69)
- "The System's Unwillingness and Inability to Address Real World Problems" (pgs. 36 - 39)
- "Thought Shaming" (pgs. 88 - 89)
- "My Personal Grievance With 'Expert' Statements on Suicide" (pgs. 121 - 127)
- **Reccommendation #2:** "Abandon Suicide Prevention Policy; Focus on Making Peoples' Lives Worth Prolonging" (pgs. 139 - 143)

What can be done better?

Listen to the suicidal, and stop trying to control them. Let **them** tell you where **they** need to go, and help them, as best you are able, to get there.

Respect their values and respect their boundaries. Respect their stances on what amounts to a fate worse then death and commit to a helping strategy that will avoid those fates even more aggressively then it avoids that persons suicide. Stand side-by-side with the suicidal person and tell them sincerely: *"If **you** would rather be dead then be subjected to that fate, then **we** would rather you be dead then be subjected to that fate."*

Stop being an ideological dictatorship, or a 'movement' with a cause, that fixates on reducing suicide statistics, regardless of whether or not the people whose suicides are prevented are actually happy to continue living.

Stop fixating on preventing suicides and focus on making life worth living.

Be a true ally to the suicidal. Abandon your own personal agendas (i.e. reducing suicide statistics) and join with them in seeking their best possible outcome, even if that outcome is death. Make yourselves worthy of suicidal peoples' trust and you will eventually receive it. And once you have their trust, you can truly work together as an effective team, to achieve the best outcomes possible.

For more information see:

- "My Personal Grievance With 'Expert' Statements on Suicide" (pgs. 121 - 127)
- **Reccommendation #2:** "Abandon Suicide Prevention Policy; Focus on Making Peoples' Lives Worth Prolonging" (pgs. 139 - 143)

Question 4: *What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.*

What makes it hard for people to experience good mental health?

- Loneliness
- Community Incompatability (i.e. feeling like you aren't really a part of your family, company, school, neighborhood, town, church, ect.; Feeling like your values, ideas, preferances, ambitions, ect. are alien amongst your environment)
- Nationwide Lack of Interest in Cultivating Community Happiness
- Unemployment/Inappropriate Employment
- Excessive Education
- Constant Media Negativity
- Bullying/Descrimination
- Domestic Violence
- History of Trauma
- Bad Fortune (e.g. natural disasters, droughts)
- Major Illness (e.g. cancer, MS, ect.)
- Poverty/Homelessness
- The Mental Health System itself (in far too many cases)

Many of these problems already have measures in place to help correct them (e.g. illnesses, natural disasters).

Many of such programs are, from what I've heard, horrendously unfit for purpose and need either a massive increase in government support, massive reform, or both (e.g. measures for addressing homelessness, bullying, the mental health system).

Our approach towards unemployment needs serious re-evaluation from a mental health standpoint. My understanding is that government's approach towards unemployment is only interested in assigning people their jobs for the sake of getting them a paycheck. It utterly disregards the question of whether or not those people will get any happiness from the jobs they are assigned. The consequences this has upon national mental health are glaringly obvious, because what use is a job that provides a living, if it offers the worker no reason to live?

Loneliness, and the closely-related issue of community incompatability, need bold new strategies, as they are not really being addressed at all at the moment. We need to create a nationwide matchmaking system that seeks out individuals, small friend clusters, or communities (whichever the patient is in need of) that is deeply compatable with the patient in question, then sets up and subsequently cultivates a relationship between that patient and the person/people/community.

Answers To Submission Form Questions
Question 4

Such a service will need to lean heavily upon a staff of people with strong social networks and a knack for tracking people and locales down, based upon the character traits that define them.

The nationwide lack of interest in cultivating happiness also needs to be addressed, as I previously noted in my response to Question #2.

For more information see:

- "The Poor Recognition of Shortage as Motivation for Suicide" (pgs. 81 - 83)
- "Public and Government Don't Respect Their Own Large Role in Mental Health Cases" (pgs. 86 - 98)
- "Therapists Often Do Psychological Dammage" (pgs. 53 - 62)
- **Reccommendation #1:** "Establish a Permanent, Impartial Overseer of the Mental Health System" (pgs. 135 - 138)
- **Reccommendation #3:** "Create a Service That Will Provide Respectful, Meaningful, Effective and Timely Assistance to People Suffering Major Real-World Crisises" (pgs. 144 - 148)
- **Reccommendation #7:** "Recognize Happiness as an Essential Resource" (pgs. 157 - 162)

> ***Question 5:*** *What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?*

I think that one significant problem is the 'human livestock' culture that exists in this country. Basically, the attitude is that the primary, and perhaps only relevant factor in a person's life is whether they have the means to keep their bodies functioning optimally; do they have food, water, shelter, warmth and appropriate medical care? Essentially, it's about treating people like animals or livestock.

Via my travels and through contacts I have across various types of regions, I have picked up the impression that this human livestock culture seems to be stronger in more agricultural communities.

The massive problem with this culture is that it ignores the higher needs of a person, which don't fit in to any biology text book. Things like love, friendship, being part of a family, happiness, laughter, respect, sense of community, sense of purpose, motivation, sense of accomplishment, sense of being appreciated, ect. Because the culture has no regard for these needs, it makes little to no effort to satisfy them, and so they largely go unfulfilled.

Subsequently, conditions like depression and suicidalness grow rife in these communities because, while citizens might have adequate food, ect. to sustain their survival, they begin to feel that their hollow, unsatisfying lives are not worth sustaining. They have the means to live, but they have no reason to live.

You can't appreciate this dilemma when you look at a human being as just a piece of livestock - an animal that should just keep eating, drinking and breeding because that's what the laws of biology say it's supposed to do.

So what's the solution? I think the main solution is to help people stuck in communities that don't satisfy their deeper needs to relocate to a community that is highly likely to meaningfully connect with them.

Another approach would be to simply treat the individual untended needs of the citizen one by one. But I believe that in most cases, this approach would be less effective. Leaving the citizen lingering in a community that is unable to appreciate that they have higher needs, beyond their basic biology, will most likely result in a continuous series of difficulties and disappointment, for all concerned.

For more information see:

- "The Poor Recognition of Shortage as Motivation for Suicide" (pgs. 81 - 83)
- "Public and Government Don't Respect Their Own Large Role in Mental Health Cases" (pgs. 86 - 98)
- **Reccommendation #3:** "Create a Service That Will Provide Respectful, Meaningful, Effective and Timely Assistance to People Suffering Major Real-World Crisises" (pgs. 144 - 148)
- **Reccommendation #7:** "Recognize Happiness as an Essential Resource" (pgs. 157 - 162)

Another significant problem for many communities is the lack of employment opportunities.

One major remedy to this problem, which often goes overlooked, is to minimize the requirements that make it difficult for people to get in to the jobs that would make them happiest; particularly in terms of education and experience.

Of course, government initiatives to create new jobs in particular communities can also be extremely helpful - so long as they are the right types of jobs for the people in the community and that they are filled via an employment policy that respects an employee's need to earn happiness/satisfaction from their job, not merely money.

For more information see:

- **Reccommendation #7:** "Recognize Happiness as an Essential Resource" (pgs. 157 - 162)

Answers To Submission Form Questions
Question 5

Finally, in many communities, widespread distress that is based in some common community issue can be dramatically compounded when the mental health system misdiagnoses peoples' suffering as mental illnesses, rather then a legitimate response to terrible circumstances.

Misdiagnosis and subsequent mistreatment of real-world problems is a massive problem with the mental health system, and is the cornerstone of so much of the anguish that many patients and former patients endure.

This dynamic is often amplified when a major real-world problem impacts a whole community or demographic. Though the mental health system often acknowledges the true crisis as a common 'factor' between all the cases of anguish, it tends to adopt the view that the main strategy for remedying this anguish is to treat the *"now-mentally ill"* brains of the sufferers. Addressing the actual source of the distress tends to be regarded as a lesser priority, and hence, is handled much less effectively then it ought to be.

This problem is one of the countless reasons why the entire mental health system needs to be overhauled, right down to it's founding ideologies. We need to remake it so that it stops misdiagnosing legitimate anguish, distress or anxiety resulting from real-world problems as 'mental illnesses', and starts treating peoples' **actual** problems!

For more information see:

- "Real World Problems" (pgs. 30 - 39)
- "Unwanted Character Conversion" (pgs. 55 - 58)
- "My Own Personal Experience" (pgs. 58 - 62)
- **Reccommendation #1:** "Establish a Permanent, Impartial Overseer of the Mental Health System" (pgs. 135 - 138)
- **Reccommendation #3:** "Create a Service That Will Provide Respectful, Meaningful, Effective and Timely Assistance to People Suffering Major Real-World Crisises" (pgs. 144 - 148)

> ***Question 7:*** *What can be done to attract, retain and better support the mental health workforce, including peer support workers?*

You need to stop gauging therapists' capacity to help by their amount of education, training, or 'work experience'.

Personal life experience of mental illness, depression, suicidalness, and/or major life crisis **is** a valuable asset for therapists, managers and policy-makers to have, but it must also be recognized that a therapist/helper can still be very useful even without any personal experience of these things.

Answers To Submission Form Questions
Question 7

The type of employees the mental health workforce desperately needs to recruit in large numbers are the "Huggy-Bear"-type characters; those sorts of people who seem to know just about everybody in their community, who always know where to go locally to find whatever your looking for, and who have a wide array of contacts that allows them to deliver just about any manner of favor for a friend in need.

The mental health system is in desperate need of staff that have the capabilities to offer their patients **actual** help for the problems making their lives miserable. So staff who have the contacts to set their lonely patients up with compatable partners & groups of friends; get their patients into the career path that will make them happy; get them into a better living/residancy situation; help them accomplish a currantly unattainable life goal; or help address any other real-world crisis, **must** be the focus of any recruitment campaign.

For further information see:

- "The System's Unwillingness and Inability to Address Real World Problems" (pgs. 36 - 39)
- **Reccommendation #3:** "Create a Service That Will Provide Respectful, Meaningful, Effective and Timely Assistance to People Suffering Real-World Crisises" (pgs. 144 - 148)

So what can be done to recruit these types of people? Obviously a key component of the process must be informing whoever it is that hires therapists for the various hospitals/clinics/ect. of the mental health system that these are the types of people that they need to get a hold of.

The government's employment system should be organized to chanel these sorts of people into the mental health system, provided, of course, that assigning them such a career path is absolutely agreeable for them, just as it must be agreeable for their future patients.

The next time the government pledges to *"create X new jobs"*, either as an election pitch, or just in the course of general economic management, it should make sure that a significant portion of these jobs are for these sorts of 'connected'-helper style therapists in the mental health system.

As for supporting and retaining good workers: well, a major factor there is making sure that nobody gets overburdened with case load. So insuring adequate staff numbers is a must.

Also, it will be essential to insure that therapists are given all the appropriate **resources** they need to provide their patients the assistance they are looking for.

Obviously this will include adequate, well-maintained buildings/facilities.

Beyond that, purpose-built IT resources are of immense importance, such as a network system that allows them to find and connect with the people who are most likely to be able to assist their patients with their problem(s); and which also allows them to share patient personality profiles (with their patients' consent, of course) with other therapists, for the purposes of matching and uniting compatable patients as prospective friends or romantic partners.

They must also include access to an extensive database of information which is likely to be helpful to a patient's needs, such as information on the numerous communities & subcultures which the patient is likely to relate to, and how to enter such communities; religions which are likely to cater to the patient's **self-stated** unsatisfied spiritual needs; and geographical regions to which the patient - with respect to his/her values, tastes, needs and ambitions - would be a welcome addition.

It goes without saying that securing patient privacy must remain the highest priority throughout the use of such digital resources.

Resources such as these are essential not only for patient satisfaction, but by extension for therapists' own sense of accomplishment in being able to genuinely make a positive difference in their patients' lives. Their overall job satisfaction depends on them having the appropriate resources to be able to **genuinely** help their patients. Simply put, retaining good therapists requires that they are provided with the proper resources to do their job.

> ***Question 8:*** *What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?*

I reccommend that this inquiry examine this issue from both directions.

Certainly, many 'mentally ill' people are faced with limited opportunities for social and economic participation, as an ultimate consequence of their condition.

However, it is also true that many cases of depression, anxiety, suicidalness, and many similar conditions commonly labelled as 'mental illnesses' arise due to the fact that the sufferer has found themselves with limited opportunities for social and/or economic participation, for reasons unrelated to their 'mental health'.

For that reason, I suggest that the inquiry looks in to the many common factors of our society that have negative impacts on peoples' opportunities for social and economic participation, as being relevant to the issue of mental health in Victoria. In particular, I would suggest that you look at the laws, government policies and elements of workforce culture that create situations where it can be said that: *"Realistically, only certain types of people are usually given the opportunity"* to do a particular job or activity, with an ultimate aim of removing as many of these obstacles as possible. I would expect that educational barriers would feature highly on that list.

For further information see:

- "Real World Problems" (pgs. 30 - 39)
- "Lack of Respect" (pgs. 86 - 88)
- "Lack of Uplifting Presence" (pgs. 90 - 93)
- "Unwillingness to Help" (pgs. 94 - 95)

Regardless of whether a 'mentally ill' person's limited opportunities are a result of, or the cause of their 'mental illness', often the best opportunity to increase their social and economic participation is to insure that they are placed - socially, professionally, and residentially - amongst a community who they genuinely appreciate and who genuinely appreciates them.

Social and economic participation becomes much, much more difficult to commit to when it is a lonely experience. This is especially true when such participation requires you to be around people who are unpleasant to be around; regardless of whether that unpleasantness is deliberate on their part, or unintentional.

However, when social or economic participation involves being around people who are great company, these exercises become ones that the participant actually looks forward to. As a result, they will actively engage in them. Economic participation, in particular, can be greatly increased by partnering the person with a team who it is a genuine pleasure to work with, and with who the worker is consistantly 'on the same page' with.

For further information see:

- "Lack of Uplifting Presence" (pgs. 90 - 93)
- **Reccommendation #3-A:** "Develop a Strategy for Loneliness" (pgs. 146 - 148)
- **Reccommendation #7:** "Recognize Happiness as an Essential Resource" (pgs. 157 - 162)

As discussed in my answer to the previous question (7), far too many people, especially amongst the 'mentally ill' and suicidal communities, are faced with limited opportunities due to the fact that they lack the contacts people need to 'make things happen'.

They lack the contacts necessary to locate and enter in to the community or social group that could offer them an essential sense of connection to the world. They lack the contacts necessary to be able to access limited-vacancy or difficult-to-access services which they might be in dire need of. They lack the contacts necessary to get a decent job offer. Or they lack the contacts necessary to resolve some other serious practical problem with their life.

In essence, all these opportunities: for meaningful relationships, meaningful employment, and an acceptable standard of living, technically **do** exist for the sufferer. The problem is that they are simply inaccessible because they lack a route to these opportunities - a contact who can connect the sufferer with these things.

So once again, it is essential for the mental health system to be expanded to include a new system that places people in need in contact with these sorts of people; people who can build inroads and open doors for the sufferer, whether they be in a romantic, social, or professional context.

For more information see:

- "The System's Unwillingness and Inability to Address Real World Problems" (pgs. 36 - 39)
- "Unwillingness to Help" (pgs. 94 - 95)
- **Reccommendation #3:** "Create a Service That Will Provide Respectful, Meaningful, Effective and Timely Assistance to People Suffering Real-World Crisises" (pgs. 144 - 148)

On the subject of economic, and particularly **social** participation, I would just like to emphasize that the absolute worst policy you can have in this matter is to coercively or forcefully push people into such participation against their will. And it doesn't matter if this policy is official, or if it just comes about due to the government and governors of the mental health system turning a blind eye to the widespread use of such tactics by individual therapists.

Therapists are embassadors of society, as far as the patient is concerned. And when that embassador seeks to exploit the patient's troubles to bully or coerce that patient into increased social/economic participation, it reflects very poorly on the society that that therapist is advocating for.

Ultimately, such approaches will make the patient far **more reluctant** to engage with their society, on both a professional and social level. People will not want to expose themselves to a culture that is characterized by a tendency to manipulate or bully them into serving it's own agenda. Nor will they want to play any role in economically sustaining such a cruel culture.

Question 9: *Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?*

1. Develop a system that provides genuine and significant assistance for patients' real-world problems, with a special emphasis on remedying loneliness. (See **Reccommendations #3** & **#3-A**, pgs. 144 - 148).
2. Investigate and put a stop to the numerous ideological and cultural issues within the mental health system that fuel disrespect towards patients and disregard for their wishes, needs and values within the treatment process. (See "The Poor Quality of Care - Therapists", pgs. 40 - 62; and "The Poor Quality of Care - The System", pgs. 63 - 73).
3. Create an overseer department that holds complete authority over the mental health system, to insure that the system's ideology, conventions, practices, treatments, and therapists all serve their patients, rather then exploit, abuse, or neglect them. (See **Reccommendation #1**, pgs. 135 - 138).
4. Do a complete reevaluation of official policy on suicide; beginning with a thoughtful questioning about whether suicides should be officially discouraged, or interfered with and prevented. Insure that there is thorough, unbiased, and tested justification for such interference, in all circumstances where it is deemed to be warranted. Thoroughly examine the question of whether it is always better to be alive then dead, and do not rest until your stance on this issue is compellingly, impartially justified, so that that justification can be shared with the suicidal community as persuasive proof that life is indeed worth prolonging. Hold your policy to a standard where you must prove anything you expect others to believe. (See **Reccommendation #2**, pgs. 139 - 143)

Question 10: *What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?*

You can begin by laying the groundwork for a system that offers real-world help to patients in need (see **Reccommendation #3**, pgs. 144 - 148), and also for a permanent overseer department for the mental health system that has no ties to the therapist community, nor mental health system ideology (see **Reccommendation #1**, pgs. 135 - 138). Consulting heavily with organizations who already advocate very well for patients and 'mentally ill' people, such as VMIAC, would be an excellent first step for this second undertaking.

You should also get to work developing a recruitment strategy for hiring the sorts of connected, practical helper-therapists indicated in my answer to Question #7, as the mental health industry is in most dire need of such effective helpers.

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Question 10

Last but certainly not least, you should look into developing a permanent forum - perhaps based upon a similar format to this inquiry - where people can openly discuss these issues, with the hard clarity necessary for government and communities to adequately understand and address these issues.

For one thing, that means allowing suicidal people the freedom to publically present their sensible, compelling cases for why they are better off dying then facing their most probable living future, and also to publically debunk the flimsy and misleading arguments put to them for why they would be better off surviving. It has become painfully apparent that suicidal people need to clarify the situation for everybody in this fashion, in order to prove that the key elements that define a "life worth living", for them, cannot be dismissed. Only when the essential nature of these key elements is respected will suicidal people be able to reliably get the actual help they need from the community, to get to a place where they are sincerely willing to survive.

It would also mean allowing people to publically criticize mental health system ideology, treatments, and therapist culture, even to the point of proclaiming that a sufferer is better off trying to solve things on their own, rather then subjecting themselves to the mental health system.

Such a forum would need to be recognized as not merely a place for mental patients and other people in crisis to 'talk amongst themselves', but as a purpose-built direct line of communication between sufferers and the people who shape their world; especially those governing the facilities that are intended to help them.

While it would ultimately be important to incorporate a real-world side to such a forum, an online version is essential, and establishing such a web service could almost certainly be established by the government very promptly.

Question 11: *Is there anything else you would like to share with the Royal Commission?*

Please, please understand that people desperately need help. They don't need to be doped out of their gourds, they don't need to be branded as defective (or *"mentally ill"*) units, they don't need to 'talk about' how terrible life is, and they don't need to be told to 'accept' that life is so devoid of appeal that it is less desirable then death.

They. Need. Help!

They need help to find love. They need help to get true friends. They need help to be inserted into a community that they can genuinely relate to and connect with. They need help to be inserted into an environment that is oriented towards nourishing the things that make them happy; and working against the things that make life ugly. They need help to be placed in a job where they can enjoy the company of their workmates, enjoy their working life, and take genuine satisfaction in their accomplishments. They need help to escape the bullies who make their lives a constant, living hell. They need help to cut through the unnavicable beaurocracies of government, banks, utility companies, and/or insurance companies that are inflict untold heartache upon them. And they need help with the countless other significant real-world shortcomings and crisises that make their lives an ordeal that is not worth prolonging.

They also need freedom.

They need freedom in their workplace and general societal laws and cultures to cultivate the outcomes that make them, and their kindred spirits, happiest. They need freedom to choose happiness over cold clinical intelligence, profit, productivity, efficiency, biological sustenance, safety, and yes, even survival itself. They need the freedom to devote themselves to happiness as the highest priority of both themselves, and that of their chosen community.

They need the freedom to focus on making life **worth** prolonging first and foremost, so that any subsequent actions they take to maintain their survival will be made willingly, rather then behaviors that they are aggressively enforced to adopt. They need the freedom to know that living is something they do because they want to, not because they are made to, instructed to, or obliged to.

At the end of this inquiry, please don't just cut a blank check to fund more of the grievously ineffective, and all too often harmful therapy services we've been saddled with for all these decades. Please don't just make a handful of token adjustments to the way the system works and market it as "the much-needed reform that the patients called for". And please don't palm off the difficult or low-key opperational decisions of the reform to "experts" who adhere to the traditional mental health ideologies that have been failing and harming us for all these years.

Please don't subject the suffering and the suicidal to any more policies or "professionals" who are only interested in finding a way to explain away their anguish and dissatisfaction as a brain defect within the sufferer. Please see fit to recognize that so much of the crippling anguish and emptiness which has become epidemic in our society is the result of broken lives, not broken brains.

The thousands upon thousands of Australians who are suffering these broken lives need help - real, effective, practical help. Please, for the love of god, hear their cries, and send it!

Not A Question Of Money

The sorry state of the mental health system is no secret. It is mentioned so frequently in the media and political speeches these days that you would have to be living under a rock to not be aware that the system is failing far too many of it's patients on a daily basis. The very existence of this inquiry shows how well recognized this problem is.

But unfortunately, almost all of the media reports and governmental soundbytes **still** repeat the same, persistant misconception: that the essence of the problem is a lack of funding, a lack of staff, a lack of resources and occasionally, a lack of education/training.

I must emphasize the following truth, because it is just so important that you understand it:

THE BIGGEST PROBLEMS WITH THE MENTAL HEALTH SYSTEM CANNOT BE SOLVED BY ANY AMOUNT OF MONEY!

Please, if you take nothing else from this submission, remember that.

The mental health system is a rotten device, all the way through to it's deepest level. Although there are indeed many hard-working and caring therapists, the system is nonetheless plagued with other therapists, who are neither underpaid nor overworked, yet constantly fail their patients because they simply don't care, or because they are more interested in imposing their own ideas on the patient then tending to the patient's needs.

It's entire business model is based upon a lie: a misconception widely held by the general public that it exists to help those who have lives that are not worth enduring. In actuality, the system instructs it's therapists to abstain from providing any actual help to their patients, or even offering them direct advice about how they are supposed to solve the problems that make their lives unbearable[11].

It is a corrupt law unto itself, which decides amongst itself which manners of thought qualify as 'right' and which qualify as 'wrong' or 'disordered', without any external oversight or evaluation of it's rulings. There is no court of appeal, for citizens who have been declared to be "mentally disordered" under this regime, to plead for legitimacy and common respect for themselves and/or their unconventional ways of thinking[12]. Worst of all, the system makes these rulings under the guise of stating science, when true science demands compelling **proof** before a claim is accepted as fact; something the mental health system consistantly fails to offer when it declares a certain manner of thinking to be "wrong".

[11] See "The System's Unwillingness and Inability to Address Real World Problems" (pgs. 36 - 39)
[12] Detailed throughout "The Poor Quality of Care - The System" (pgs. 63 - 73)

It is a culture saturated with arrogance; where all too often the doubts, concerns or disagreements of the "mentally disordered" patient hold no weight against the "professional" opinion of the fancy-degreed therapist. I've lost count of the amount of fellow patients who have told me stories about how their therapist would speak and carry themself as if they were superior to the patient[13]; as if what the patient had to say didn't matter when it was at odds with what the therapist thought. This was often my experience, as well.

It is an industry suffering from very low motivation to perform, on a nationwide level. Therapists don't merely tollerate the failure of their treatment to be of any benefit to their patients, they expect it. It's hardly a wonder that many patients feel as if their therapist is phoning it in. And when treatment does fail, it is always a case of the patient failing the treatment, as far as the therapist and system are concerned; never a case of the treatment failing the patient.

The most grievous problems with the system are in it's structure, ethics, agenda and attitude - **not** in it's lack of funding, staff or other resources.

If you were to double the existing mental health system's funding, you would not, buy and large, improve the quality of a patient's care; you would only see that they waste two hours a week sitting through useless sessions, as opposed to just one. Or they would suffer twice as much dammage at the hands of their harmful therapist.

If you were to double the number of staff, it's most notable effect would be that most naieve new patients would need to wait only one month to discover that modern mental health care is utterly useless, instead of two.

If you were to double the resources, it would mean that twice as many vulnerable Australians would get to stumble in to the flip-of-the-coin experience that is mental health treatment: where "heads", things don't get any better; "tails", things get even worse; and on the off chance the coin lands on it's side, you might actually solve your problems.

Although most of them don't realize it, the saving grace for many present day Australians is that they **can't** access mental health treatment when they are at their lowest point.

Before you even think of nourishing the system with more funding or resources, you really need to do a thorough examination of it's culture, agenda, protocols, ethics and attitudes, so that you can really understand precisely what it is you are trying to 'grow'.

[13] See "Therapists Have a Disturbing Tendency to be Arrogant" (pgs. 43 - 46)

Not A Question Of Money

You need to first and foremost **reform** the system into one that is predominately caring, compassionate, humane, humble, respectful, genuinely helpful and motivated. You need to reform the very nature of therapy, so that it can be counted on to be **beneficial** to it's patients, as often as humanly possible, and where harmful therapy is virtually unheard of.

You need to focus 95% of your attention for this issue on fixing the character of the system, not it's strength. So that when the time comes to use that remaining 5% to sign over the additional funding & resources the system needs (and yes, it most definitely **does** need those things), you will be providing the suicidal and mentally ill people of Australia with a much-needed asset, rather then an even bigger nightmare.

PROBLEMS WITH THE MENTAL HEALTH SYSTEM

Real World Problems

The Misdiagnosing of Real World Problems as "Mental Illness"

The mental health system has it's own particular ideas about how a person should act, think and feel. When people violate these standards, the mental health system considders them "mentally ill". That is, their supposedly illegitimate actions, intentions or thoughts are due to a defect in their brain, which may be anywhere from permanent to momentary.

However, the truth of the matter is that in a great many cases, the person in question's 'wrong' actions or thoughts are a very rational and reasonable response to very **un**reasonable circumstances!

Consequently, this stance by the mental health system is the source of a great deal of misdiagnosis and subsequently, horrendous failure to treat the actual problems at play.

Nowhere is this more evidant then in the issues of depression and suicide.

Suicide

The mental health system has deemed committing suicide to be unquestionably illegitimate behavior. It deems contemplating suicide to be illegitimate thought - mental illness. In short, the only possible reason that you might deliberately kill yourself, or even considder killing yourself is if you have some major defect in your brain. They may acknowledge that other "contributing factors" are involved, but a rational, healthy brain can never, ever considder suicide to be anything other then absurd and unjustifiable.

However, in spite of the mental health system's very close-minded ruling on the legitimacy of suicide, I can assure you that for a great many people, the value of life is so low that it doesn't begin to justify the cost/effort of maintaining it. In other words, ending one's own life is very often a very rational and well-justified choice.

Some people are suffering unbearable loneliness: no spouse/soulmate, no friends, no appreciated family, no community, no love. Try to imagine for a second that you did not have one single person in your life whose presence made you feel good; not one person who strengthened your morale or gave you cause to have any faith in humanity. Can you honestly say that someone trapped in a life like this would need to be mentally defective before they'd contemplate suicide?

Some people are chronically unemployed, with no realistic prospect of a fulfilling long-term job. All but conclusively denied any opportunity to make accomplishments that they would be proud of, or of having the essential sense of pride that can only come from knowing you have made a meaningful contribution to your community. Essentially reduced to being given token busywork and/or financial support, out of pity, rather then genuine appreciation or community value. Essentially just waiting around with nothing meaningful or important to do, until death sees fit to take you. Try to imagine for a second knowing with near-certainty that your life had no chance of amounting to anything good; that your presence will only ever make the world uglier and more barren. Can you honestly say that someone trapped in a life like this would need to be mentally defective before they'd contemplate suicide?

Some people are trapped in jobs that might offer a life-sustaining paycheck, but offer no meaningful fulfillment to give value to the life that that paycheck sustains. Try to imagine being in a situation where your capacity to survive is not in question, yet you cannot name a single aspect of your life that you have any desire to continue experiencing. Can you honestly say that someone trapped in a life like this would need to be mentally defective before they'd contemplate suicide?

Some people find that they are profoundly incompatable with their culture; e.g. gay people in communities where homosexuality is unacceptable, dumb people in communities that prize high education, people whose religious stance is at odds with their community, ect. Try to imagine a life where every set of eyes stares at you with anger and disgust. Try to imagine being shunned and treated like trash every single day. Try to imagine a life surrounded by sinister whispers and hateful innuendo. Try to imagine knowing that *your* entire world[14] despises you; not just a handful of rogue bigots, but **everyone**, including those you are supposed to have ties to, such as close family, neighbors and old work/schoolmates. Can you honestly say that someone trapped in a life like this would need to be mentally defective before they'd contemplate suicide?

Some people end up in situations where they are being demeaned, defamed, bullied and tormented constantly, either online, offline or both. Try to imagine the most vile, hurtful allegations a person could possibly make against you being repeated to you a hundred times a day. Try to imagine listening in helplessly as *your* entire world broadcasts amongst itself - literally non-stop - that you are a communal sex toy who is anybody's fair game. Or that you are such an abominable excuse for humanity that you would be doing a public service by killing yourself. Try to imagine how these notions effect all your real-life interactions; how seeing who can drive you to tears first becomes the popular daily lottery of your environment. Can you honestly say that someone trapped in a life like this would need to be mentally defective before they'd contemplate suicide?

[14] i.e. Your local community, neighborhood, town, ect. - notably including school/college and/or workplace. The environment where the entirety of your everyday life plays out.

This final example has gotten plenty of press in recent years. So much so that we are, thankfully, beginning to see some long-overdue changes in public attitudes when it comes to suicide.

In bygone years, suicides that were committed to escape constant bullying were typically reported as: *"a combination of mental illness and bullying lead 'X' to commit suicide"*. However, the major media coverage of last year's suicide of young Dolly Everett made almost no allegations that she was mentally ill. Their stance is that her death was caused by the unreasonable and utterly intollerable barrage of unrelenting torment she suffered. The media seems to have adopted a trend of acknowledging that it is the scourge of bullying we need to invest our energy in correcting, not some 'broken' component in Dolly's brain, or the brains of other teenagers suffering through what she suffered through.

It is my understanding that the mental health system is at odds with this new media stance. Their stance is that Dolly killed herself due to mental illness[15], or at most *"a combination of mental illness and bullying"*. Apparently, the fact that she killed herself proves that there was something terribly wrong with **her**, not necessarily her life.

Depression

Similarly, real world problems that strongly upset a patient, yet aren't quite of sufficient magnitude to make them prefer death over their present standard of living[16], are typically misdiagnosed as "clinical depression". That is, when the patient's sadness or distress effects them consistantly for a significant length of time (usually 2 weeks+).

Once again, this is the mental health system passing judgement that a person trapped in horrendous circumstances must have a malfunctioning brain if they feel perpetually bad about those circumstances.

Depression is a diagnosis also dealt out when people exhibit a lack of motivation, an 'inappropriate' lack of interest in something, or the abandoning of personal habits. Once again, these cases are often frequent misdiagnosises that occur because the system fails to acknowledge the real world factors that compellingly support a rational basis for these behaviors.

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[15] *"...the actual reality is that this little girl died of depression and she was so troubled by her depression that her thoughts made her think it was all hopeless."* - http://www.dailymail.co.uk/news/article-5320597/Doctor-claims-Dolly-died-depression-not-bullying html

[16] Or in which the patient is consealing their desire to end their life.

For example, a student who seems to lose motivation at her schoolwork may do so because her long-term observation of family and other adults in her community has demonstrated to her that education is not an effective pathway to success or happiness. She may have noticed that none of the highschool or college graduates she knows have achieved a life she would want to replicate and thus reasonably conclude that school is a waste of time, if not a hinderance to achieving a worthwhile life.

A man who used to go to the local pub every Friday night may cease to do so because the friends he used to hang out with there have all moved out of town. Or they may be physically present, but some real world factor has resulted in tension or bad blood that makes their company unenjoyable. The man's decision to stop going to the pub is a direct and rational reaction to a real world change in what the "going to the pub" experience entailed, and **not** a result of some malfunction that has suddenly developed in the man's brain.

Expanding upon this, if the man's entire outing routine revolved around enjoying the company of his mates, then it is easy to see how a separation or devastating change in the friendship could leave the man without any rewarding outings to go upon, and subsequently make him appear to suddenly "withdraw". Yet many therapists would have a disturbing tendency to blame this man's "withdrawal" primarily upon a non-existant defect in his brain.

Other Disorders

Similar misdiagnosises are made in which instances of excess drinking, drug abuse or persistant anxiety[17] are blamed upon mental disorders, when in fact, these matters are the legitimate reactions of perfectly rational brains to utterly unreasonable circumstances.

I could not possibly list all the real-world crisises that will provoke supposedly "mentally ill" behaviors, thoughts, or emotions; nor could I possibly list all the mental illnesses that are misdiagnosed in their place. So I hope that the above list will suffice to illustrate the nature of this pattern.

Why Is It Misdiagnosis?

Simply put, instances like these are misdiagnosises because they place focus on the patient's brain, when the problem at hand is in the patient's **circumstances**. The patient's brain is deemed to be faulty and therefore in need of correction, when in fact it is functioning reasonably and legitimately.

[17] These are just a few of the behaviors and conditions that are often falsely deemed to be a "mental illness", or the symptoms of one.

A mental illness - a defect in or around the brain - will rarely be significantly corrected by altering the patient's pertinant circumstances, because the problem area, the brain, is left untended. The problem remains in place and will often even grow.

By contrast, a real life problem will not be significantly improved by attempting to alter the patient's thoughts or brain chemistry via medication or therapy, because the problem isn't in the patient's brain. Short of radically mangling the patient's identity[18], you will not significantly change their unwillingness to tollerate intollerable circumstances.

For example, the lonely man, who wants to die because he can't bear wandering through life all by himself any more, will find very little incentive to live in perscribed medication, or verbal efforts to reconfigure his thoughts, because the very real absence of meaningful connection is still ever present in his life and still delivering a very compelling argument for ending that life. 1 hour of therapy a week and some weak blood chemistry tweaking cannot counteract the harsh reality of 60+ hours of rattling around an empty house a week, or 60+ hours of wandering through faceless, unrelateable crowds.

However, if a compatable companion was introduced into that same man's life, his suicidal urges would be significantly reduced[19], because the problem that made his life undesirable[20] had been significantly remedied. Meaningful companionship **does** counteract the opposite hours of isolation, but more importantly, it actually eliminates a great deal of a person's lonely hours and replaces them with life-affirming hours of cherished connection.

Likewise, the woman who wants to die because she is stuck in a job that offers her no fulfillment will not significantly benefit from ethical mental health treatment either. Only the most drastic of personality conversions would eliminate or reduce the bearing that the key personal needs, that her job is failing to fulfill, have in her live-or-die decision making process.

However, if the nature of the woman's job was changed so that it did grant her adequate fulfillment, or if she were transferred to a different job that offered her adequate fulfillment, the main problem[21] would be remedied and thus she would have sufficient incentive to choose to prolong her life, rather then end it.

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[18] A horrendously unethical practice, which tragically is often attempted, typically to devastating effect upon the patient. See "Unwanted Character Conversion" (pgs. 55 - 58)
[19] Perhaps even eliminated.
[20] i.e. His loneliness.
[21] i.e. Her lack of career fulfillment.

In a case of genuine mental illness, the patient's suicidalness, depression, anxiety, or other undesirable experience cannot be sufficiently traced to a fault in their life circumstances. Patients who have romantic partners, families, careers, finances, accomplishments and social lives that all adhere to their own personal ideals and satisfy their needs have often been known to experience overwhelming senses of misery, and even a desire to end their own lives.

Such cases, in which depression/anxiety/weariness/ect. occur even when the patient is satisfied with their life circumstances, would indeed indicate some form of malfunction in the patient's brain and thus, would be appropriately addressed by treatments that seek to remedy the brain.

Mental illness does exist and is a very serious situation. Life circumstances that are inhumane, unbearable, grossly inadequate and/or a fate worse then death do exist and are very serious situations. Misdiagnosis occurs when one of these terrible conditions is mistaken for the other, and hopelessly inappropriate treatment is almost always applied as a result of such misdiagnosises.

Please note: I am not denying the existence of more complex cases in which both unbearable life circumstances **and** mental illness both play a role in a patient's crisis. I am merely drawing attention to the excessive amount of cases where a misdiagnosis of mental illness is made, or where a mental illness's role in a patient's crisis may be grossly overstated.

The System's Unwillingness and Inability to Address Real World Problems

Probably the biggest misconception about therapists that is held by the general public, including future patients of those therapists, is that it endeavors to help people in crisis.

In fact, the system directs it's therapists to not provide any actual assistance to their patients, or even practical advice. I have even read unofficial statements by therapists in which they refer to this as "the golden rule" of therapy.

This has effectively left Australia without any system whatsoever to address many of the unacceptable life situations that cause depression, suicidalness, anxiety, ect.

Patients who confront these situations have no one to help them remedy them - they are stuck in their crisis all alone. And because many of these problems are beyond the scope of what that single person can realistically fix by themselves, or because the person enduring these ordeals doesn't know how to fix them, the absence of real help inevitably means the absence of any **hope** of overcoming these problems. Subsequently, the depression that is caused by their plight worsens, and often the case for committing suicide becomes more compelling then the case for prolonging their lives.

Perhaps the most insidious aspect of this major shortfall in mental health care is the fact that very few people are aware that it exists, and that upcoming first-time patients of the system are given little or no warning about it.

I myself spent roughly 8 years in therapy and was never informed **at all** that the therapists I was seeing had no intention whatsoever of helping me with my problems; nor even providing me with the essential directions I would've needed to solve them alone[22]. It was not until 2 years after I had completed my therapy that I was informed, through a chance online encounter with a therapist, that none of my therapists ever actually intended to give me advice, let alone practical assistance, in fixing or remedying my main life problems!

Remedying these problems was the whole reason I went in to therapy! I would never have gone into therapy at all, had I been aware from the beginning that therapy never offers it's patients practical help or clear advice!

But the problem goes beyond unwitting patients who are stumbling blindly in to a useless system. The fact that the vast majority of the population including, I suspect, most of the government, mistakenly believe that therapists exist to help those in need, contributes significantly to the sorry state of the system.

[22] Assuming such a feat was even possible. For most of those problems, it was not.

Real World Problems
The System's Unwillingness and Inability to Address Real World Problems

First and foremost, with the majority of the populace, including it's leaders, mistakenly believing that there is an existing system geared towards remedying the issues that make people depressed, suicidal, ect., there is no significant push to provide the actual aid that people need - because everyone assumes their already getting it!

Secondly, it leads communities, social groups and family groups to place undue pressure on people in crisis to enter in to the mental health system, due to their misguided trust that the system is interested in helping their friend/neighbor/family member. This in turn will often create rifts between said individual and said group of 'well-wishers', particularly in cases where the individual has lengthy experience with the uselessness of therapy. The individual might protest that therapy is useless, a waste of time/money, and/or dammaging. The group will often refuse to listen to these protests, as they believe their friend/family member, ect. is speaking out of either confusion, irrationality or stubbornness.

It is immensely hard for an individual to overcome other peoples' *"common sense knowledge"* - the kinds of supposed 'facts' that everyone just knows to be true[23]. This is especially true for 'troubled', 'disturbed', or 'mentally disordered' people – essentially, anyone percieved to be in need of therapy - who find that their friends and family typically regard everything they have to say as being unreliable, due to their "dysfunctional mental state".

It is unfortunate enough that this misconception about the therapy system is so deeply embedded in our society in the first place. But rather then alerting people to the truth, the dominant organizations in the national mental health discussion are actually reinforcing this lie in the public mindset.

Though most such organizations are legally savvy enough to not explicitly state that: *"therapists will do their best to give you real assistance, or at least advise you on your best course of action for remedying your problem(s)"*, this is the message that is buried within their creative and ambiguous language. This is the simple-form message they want their viewers to take away from their campaigns. The phrase "there **is** help available"[24] is passed out frequently by anti-suicide/mental health organizations (e.g. [25],[26],[27],[28], just to name a few), where the word "help" is strongly implied to refer to therapists and their public access alternatives, such as Lifeline.

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[23] e.g. That the mental health system exists to help the suicidal, depressed, ect.
[24] As well as it's similar variations.
[25] *"...it's very important to understand there is always help available - regardless of who you are, where you live, or the challenges you're facing."* - http://www.sectorconnect.org.au/assets/00Suicide.pdf
[26] *"There is help for you...", "You don't have to do this alone. There are people and organisations out there to help."* - http://www.blackdoginstitute.org.au/clinical-resources/suicide-self-harm/seeking-help
[27] *"There is help at hand.", "If you are experiencing great pain, or feel that there is nothing to live for, there is help and support available."* - http://www.healthdirect.gov.au/are-you-experiencing-suicidal-thoughts
[28] *"As a friend you can support them and let them know that there is help available"* - http://www humanrights.gov.au/sites/default/files/Submission 78- beyondblue Attachment B.pdf (page 4, under "For A Friend")

Considder how the constant promotion of this misconception plays out in a real life scenario involving a person with real life problems:

Say you have a person who has no friends, nor beneficial family; they are perpetually alone and, having thoroughly considdered this sorry state of affairs, and the likelihood of it being remedied, they have decided their best course of action is to commit suicide.

Now let's say that some bystander happens to be passing by, just as this suicidal person is about to throw themself off a bridge. The bystander, predictably, conveys to the suicidal person that: *"you shouldn't do it! No matter what's wrong, there* ***is*** *someone who can help you!"* - the message that their culture has long educated them to dispense to suicidal people.

Place yourself in the shoes of the suicidal person. Does the word "help" mean 'someone will sit politely and listen while you natter on about how horrible it is to be all alone, for ≈ $200/hr, and more then likely finish up by making the absurd assertion that *"it's okay to be alone forever"*'? Or does it mean some form of direct assistance or clear, effective advice, that will ultimately lead to you having a significant amount of meaningful relationships?

Assuming the suicidal person on the bridge takes the bystander at his word, the situation can play out in one of two ways:

The first is that the pseudo-friendship offered by the therapist who subsequently "helps" the suicidal person, in which the therapist sits and politely listens to the suicidal person for ≈ $200/hr does indeed prove to be enough of a "friendship" to alleviate the patient's loneliness and thus make survival a more ideal choice then suicide. I have heard several testimonies from ex-suicidal people where they state that this was indeed enough to give them reason to live.

The second possible outcome is that the pseudo-friendship offered by the therapist proves to be inadequate. It may even prove to be a displeasing counterfit of the genuine, meaningful, human connection that the patient sorely needs, thus compounding their sense of disconnectedness from society and their overall negative impression of life as a whole[29].

The patient may well require proper, consistant, non-commercial friendships or even a committed long-term romantic relationship in order to have a life that is worth prolonging. Thus, any form of "help" that falls short of introducing compatable new friends/loved-ones into the patient's life is effectively useless, if not harmful.

[29] i.e. Discovering that they are surrounded by a culture that would attempt to pass off hollow, store-bought friendship for the real thing, to someone desperately in need of it, leaves them unable to trust that society, and completely at a loss to understand how they the members of that society cannot recognize meaningful relationships and their importance. The society around them becomes more alien and disturbing then ever.

Cases like this are where the government needs to focus a great deal of attention and acknowledge the appalling inadequacy of our currant system. Because the fact is that the typical lonely suicidal Australian would get more effective assistance from a TV show like *"The Farmer Wants A Wife"*, or *"Married At First Sight"* then they would from the billion-dollar industry that is supposedly set up to deal with cases just like theirs![30]

Also, keep in mind that chronic loneliness isn't the only real world problem that can make a person depressed, anxious, suicidal, ect.

Problems like chronic unemployment, community incompatability, financial crisises, toxic family environments and bullying, just to name a few, are even less likely to be significantly remedied by a pseudo-friendship that is devoid of clear, effective advice or actual assistance.

If the suicidal person on the bridge is familiar with the mental health system - either through personal experience, or significant discussion with people who have been through it - they will be more inclined to correct the bystander and inform them that, in reality, there is no apparent way to access actual help.

The utterly absurd thing about this scenario is that, after the fact, the well-meaning bystander will typically chalk the suicidal person's insistance of the absence of help up to a deep mental malfunction that left them unable to 'listen to reason'. Whereas in reality, the suicidal person was talking from a clearheaded position of **personal expertise** that made them more knowledgeable about the subject then the bystander!

And because we, as a society, are more interested in branding suicides as acts that defy rational explaination then we are in finding legitimate critique in the final statements of someone who kills themself, the myth of the "helpful" therapy system gets perpetuated ad nauseum.

Odds are, when the media run the story of the man who jumped off the bridge, the article will conclude with a line like: *"No matter who you are, or what you are going through, please know that there is help available for you!"*

[30] I am well aware that such commercial television shows are designed to rate well and are not run with a primary or dedicated purpose of creating fulfilling long-term marriages. Nonetheless, their unreliable interest in helping people in this regard still puts the mental health system to shame, as the mental health system has no intention of helping to forge meaningful relationships, whatsoever.

The Poor Quality of Care - Therapists

Under this topic, it is my intention to address the problems that are commonplace amongst the individual therapists within the mental health system.

Only a Small Percentage of Therapists Are Effective

I strongly believe that the government and the community has cause for concern in the high proportion of therapists in the system who do not provide any relevant benefit for their patients.

It has practically become a running joke amongst the community of currant and former therapy patients: you aren't really part of the group unless you've served your time under the care of a useless therapist. Spend a little time talking with the therapy patient/mentally ill community and you will hear time and time again about how not merely a patient's first therapist was ineffective, but their first **three**, **four** or **even more** therapists were completely ineffective!

Patients and former patients who have merely struck time-wasters, as opposed to therapists who are actually dammaging[31], often seem to take the low proportion of effective therapists in their stride. Wasting time and money in useless therapy is more or less treated as a petty nuisance that everyone just has to put up with as part of the therapy experience. This stance seems to be championed by people who have actually found some eventual benefit to therapy after striking a good therapist, and reason that the cost[32] is worth the reward.

While it is great that things have worked out well for such people, I believe that there are many hazards that arise when government and the community adopt a similar dismissive attitude about the low proportion of decent therapists.

First and foremost, we have to remember just how serious quality of life crisises and mental illnesses can be. People who seek therapy are very often teetering on the edge of choosing to end their own lives; they need help - **effective** help - immediately! Alternatively, they may be facing some form of time-sensitive crisis[33]. Such people don't have the luxury of time to be able to bounce around a series of useless therapists.

[31] As addressed in "Therapists Often Do Psychological Dammage" (pgs. 53 - 62)
[32] This cost being not merely money, but also wasted time, inconvienience, frustration, disappointment, ect.
[33] e.g. They may be days away from being evicted.

Hope is a finite resource; especially for people who have no goodness in their life to cultivate a fresh supply of it. Much like a gunshot victim who is bleeding out, many people have only just enough spirit left to get themselves to the first care professional they can find. They are lucky if they can even get that far. Giving such people the run-around; stalling them, however unintentionally, at an ineffective care center when they clearly need to be sent immediately to effective care, is an unacceptable failing of our health care system.

Secondly, we also have to remember that most quality of life issues and mental illnesses that drive people into therapy are malignant in nature. Their problems get progressively worse with every single day that passes without them getting treatment.

Also, as these problems eat away at the patient's ability to remain positive, motivated, patient and accommodating, they can find that important supportive elements of their life begin to fall apart in a domino effect.

For example, a lonely single woman might lose the motivation to turn up for work day after day and subsequently lose her job. A man who gets fired might become bitter and impossible to live with and subsequently lose his girlfriend, ect., ect.

Thus, administering timely, effective treatment for a patient's problem(s) is very important, not only to begin fixing them before they grow to an unmanageable scale, but also to prevent any severe follow-on crisises in the patient's life, which may be even worse then the original problem(s).

Thirdly, useless therapists cannot be counted upon to admit that they can't help the patient, which presents a real and concerning risk that the patient will get trapped in "care" that is utterly useless to them and thus unable to move on to the care of a beneficial therapist.

Fourthly, we have to considder the impact that this low proportion of effective therapists has on the public image of the therapy industry, particularly amongst people who need help.

While the majority of people who have never been in therapy at all are quite naieve when it comes to poor odds of them striking a decent therapist, the more useless therapists a patient has had to endure, the more they will wake up to the true state of the system. Often it will be the very first useless therapist that drives a patient to an online therapy community to complain about their experience, at which point they will learn from others that long spells of useless therapy are all but routine.

Eventually, unhelped patients are bound to start wondering whether beneficial therapy will ultimately be worth the hassle, and/or the exorbitant costs of throwing money away on numerous useless therapists.

The Poor Quality of Care - Therapists
Only a Small Percentage of Therapists Are Effective

I once recounted a summary of my own awful therapy experience on an online mental health community. In what I assume was meant to be an encouragement to persevere, one of the other users responded that they had to go through **9** useless therapists before they found one that was any good. What immediately occurred to me was that it had taken me **7 years** to get out of the "care" of my last therapist. At that rate, a comparable run of 9 useless therapists meant I would be **nearly 80** before I even begun to receive beneficial therapy! Even if my therapy experience had simply been a waste of time, as opposed to being quite dammaging[34], I would've been very much deterred from persisting with therapy, knowing these shocking odds of it having any notable benefit in my lifetime.

So as a patient's therapy experience becomes increasingly bogged down by these time-wasters, patients start to grow weary of the process, and begin making risk vs. reward & cost vs. reward evaluations that typically do not produce favorable conclusions about the mental health system. Consequently, many of them will simply drop out, having decided that therapy simply isn't worth the trouble.

And fifthly, we need to considder the demoralizing effect that every round of ineffective treatment has upon a patient. Most every patient will go into therapy with some measure of doubt as to whether their problem(s) can indeed be adequately remedied. With every round of therapy that the patient goes through without any significantly positive outcome, the odds of their problems being fixable begin to seem slimmer and slimmer.

While demoralization can be a problem in a great many health issues, it is especially relevant to therapy scenarios, which often involve depression and suicidalness.

At the end of the day, the *"turn a blind eye and just soldier on"* attitude towards the lousy proportion of decent therapists in the system is one that we, as a country, cannot afford to maintain. It seems to have worked out well for many of the patients who eventually have ended up in the care of a beneficial therapist. But for a great many others, it just perpetuates too many pitfalls for their therapy experience to have a positive outcome.

[34] See "My Own Personal Experience" (pgs. 58 - 62)

Therapists Have a Disturbing Tendency to be Arrogant

Therapists have a disturbing tendency to be arrogant towards their patients. It is an offensive manner that I encountered countless times during my time in therapy, from all but the youngest, greenest of the therapists who's care I was under.

During my years of interacting with various online suicide/mental health communities, I have heard this matter being brought up over and over again, and I cannot recall ever encountering another patient who was any less offended by this behavior then I was whenever I noticed it during my own treatment. By all accounts, it is rife throughout the mental health industry; and patients are sick to death of it.

The following is some of the arrogant behavior that I personally experienced, and that I have also heard numerous other therapy patients state that they, too, have experienced:

- Therapist had no regard for my concerns that their treatment wasn't having any positive effect.[35]
- Therapist had his/her own mysterious measure for whether things were going better or worse for me; my opinion didn't matter.
- Therapist acted as if he/she had no obligation to explain what, precisely, their treatment was supposed to do. I was merely expected to obey without question.
- When questioned, therapist felt no obligation to justify perscribed treatment that, on the surface, seemed ill-advised or pointless. Again, I was simply expected to obey without question.
- Therapist had no regard for concerns I raised when they perscribed treatments that I'd already attempted previously, or that were extremely similar to things I'd previously attempted (sometimes with unfavorable consequences). Therapist did not care to explain why this repeat attempt should be expected to perform any better then previous attempts, nor showed any interest in minimizing the previously encountered consequences. Once again, I was expected to obey without question.
- Therapist presented a diagnosis that did not fit with the facts of my life/situation. When questioned about the elements in my situation that significantly contradicted with her diagnosis, she dismissed them as being all but irrelevant. Me/my life was expected to bend to fit her opinion, rather then her opinion bending to align with the facts of me and my life.

[35] These concerns were only raised after the treatment had been going on for several months, without any sign of improvement.

- Therapist showed no regard or remorse for the financial cost, time wasted, inconvienience or emotional distress caused by perscribed treatments that produced little or no positive outcome.

  One notable example of this was when I had completed a costly treatment run of medication, and the therapist admitted that he never expected the treatment to work in the first place - a detail he never once mentioned before or during the treatment run.
- Failed treatments were always my fault for being a bad patient (even though I would follow them to the best of my ability), never a case of the treatment being bad.
- My scepticism towards the things the therapist said and reccommended, which only surfaced after several months of ineffective treatment, and grew as the ineffective treatment persisted, were made out to be a case of me being a 'difficult patient'.
- My feelings towards elements of my life outside of therapy were of secondary importance to how he/she felt about those same elements. e.g. It didn't matter if an incident I'd experienced had been distressing/displeasing for me; it was good if she said it was good. Even if I clearly explained my position, her stance on the matter would not change and my grief was of no concern, or just plain and simply 'wrong'.

Additionally, I also experienced the following forms of arrogant treatment. Though I have not heard similar experiences being reported from other patients/former patients, I would not be surprised at all if it turned out that similar behavior occurs quite frequently in the mental health system:

- Therapist perscribed me medication without telling me what it was supposed to do, or informing me of any possible side effects or incompatabilities with other medications, alcohol, ect. The pharmacist who sold me the medication informed me of *some* of the possible side effects. When the therapist found out about this, he was annoyed and it became clear that he intended me to simply take the medication he'd perscribed without thought or question. He did not want me to make my own informed decision on the matter. I subsequently discovered that the medication had even more side effects that **nobody** had warned me about and that I unfortunately experienced.
- Therapist became irritated when he was told that my GP was concerned that the medication I'd been perscribed might be inadequate. The subject was only brought up with my GP because the therapist kept dismissing my observations that the medication was having no positive effect.

- While not violating doctor-patient privelage, therapist had little respect for it, and became very pushy about conducting therapy in a public environment. Therapist disregarded my discomfort about discussing uncomfortable/sensitive matters with no margin of privacy, and implied I was being a 'difficult patient'.
- Therapist refused to respect the inconvieniences her approach to therapy imposed upon me, such as with the scheduling of certain sessions. Despite my own willingness to reschedule those sessions at mutually-agreeable times, she would insist upon times she had been clearly informed were inconvienient for me.

Though the specifics obviously vary considderably from case to case, the general nature of the arrogance patients are often subjected to in therapy is virtually universal. It is a distinct impression the patient gets, that their feelings, problems, opinions and concerns regarding treatment are all of secondary importance to the ideas and intentions of the therapist. It is a sense of superiority conveyed by the therapist, in which the patient is expected to be unconditionally obediant to his/her 'superior'[36] and has little, if any, right to question or doubt the therapist's methods.

Some patients who have this experience may not be able to pinpoint a specific incident or behavior that conclusively demonstrates that their therapist is/was arrogant. Yet they will nonetheless report that the overall tone of their treatment reeked of the therapist's arrogance.

Even if you allow for the possibility that these patients may be misunderstanding their therapists' behavior, or are being overly critical of them[37], the mere fact that so many patients are taking away this impression of their treatment indicates a major flaw in the way the system handles it's patients.

This climate of arrogance, or percieved arrogance, undermines the potential for treatment to be beneficial in several ways.

Therapists who are unwilling to respect the input of their patients are far more likely to make misdiagnosises, based off inaccurate or incomplete assumptions made about the patient and/or their situation. They are also far more likely to ignore failures or consequences of the treatment as they occur, thus greatly increasing the chances that treatment will be useless, or even worse: dammaging.

Patients who don't feel respected are likely to not respect the therapist in response, thus making them more reluctant to follow the therapist's treatment plan.

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[36] i.e. The therapist.

[37] To clarify, I believe that the vast majority of patients who claim to have been treated arrogantly are gauging their situations accurately and fairly.

Ex-patients who have previously experienced this frustrating situation, and still need help, will be more reluctant to re-enter the mental health system as a result of their previous arrogant treatment.

Last but not least, people who think they might need therapy, but have not yet entered the mental health system, are likely to be discouraged when they hear about this commonplace attitude from therapists.

Causes

Why is therapist arrogance such a common problem? There is no single answer. Even when talking about any given therapist who exhibits an arrogant manner towards their patient, there are probably numerous causes as to why they act this way.

The following is a list of what I believe to be the most common causes, based upon my own personal experiences with therapists, and my extensive discussions with other patients, former patients, and other people with some form of history with the mental health system.

I must stress that the following vices will only be possessed by **some** therapists, and that this list is not meant to depict the mental health industry in it's entirety. Many therapists are not at all arrogant towards their patients, and carry none of the vices in this list:

Status

Very often, there will be a significant gap in social status or respectability between the therapist and the patient. Broadly speaking, the world views the therapist as a successful, model citizen, with an enviable string of letters attached to their name, boasting of their academic triumphs. Not to mention an office job that pays circa $200/hr.

By contrast, therapy patients are often what the world considders a 'loser'; either because they've always been one, or because their currant crisis has either caused or stemmed from a fall from grace. Even if a patient is outwardly successful, yet privately falling apart at the seams, it is easy to imagine how a therapist could come to considder them a sorry example of a human being.

Therapists accustom themselves to putting on a friendly, polite & seemingly respectful demeanor when addressing patients. But under the surface, many therapists considder such people to be 'beneath' them. They would never in a million years think about dating someone like the patient. They would have to suppress a sneer of disgust if their son or daughter ever brought someone like the patient home as their boyfriend/girlfriend. If they had a sibling or cousin like the patient, they would regard them as the family black sheep, and join in, or at least silently agree with all the disparaging innuendo that is spoken behind their backs.

The patient is one of society's defective or dammaged units; the very opposite of the successful, respectable, accomplished therapist.

So it becomes quite laughable to such a therapist when a patient starts to question their expertise in a field that the therapist has won a nice, fancy degree in. The fact that the world has given the therapist a considderably higher tally of 'thumbs ups' then it has to the patient essentially means that the therapist's word counts for much more then the patient's - to the point where the patient's ideas and doubts don't count **at all**, whenever they are at odds with the therapist's.

Education

A significant amount of the arrogance therapy patients are subjected to may be carry-over attitudes from the education that therapists are made to undergo.

I once read a story recounted, by a former student of a mental health therapy course, of a rather disturbing moment that occurred during one of their lectures.

"Do not think about the things that we tell you here," the teacher told the class, *"The thinking has been done for you."*[38] In context, he was talking about all the core elements of therapy: what constitutes a mental illness, how to diagnose such a mental illness, and the optimum treatments for such a mental illness.

Therapists are firmly discouraged, by the industry elders who instruct them, from thinking for themselves and questioning the legitimacy of the views and practices that the industry imposes upon them.

Thus, if it is culturally improper for a fully graduated therapist to question the formal stance of the mental health system on the matters related to their patient's case, then how can we possibly expect those same therapists to take the doubts and concerns of those same patients seriously?

"The system is always right!" That's what our therapists have had drummed in to them. So if a patient is doubtful, hesitant, or outright opposed to the stance of the system regarding their diagnosis, treatment, or any related matter, they **must** be in the wrong, and their concerns are to be politely dismissed, as they are inherently illegitimate.

The System hasn't Caught Up with the Age of Scepticism

Times have changed. As a society, we are much less willing to take the things our 'leaders', 'experts' and other 'pillars of our community' tell us at face value today, then we were 30 or 40 years ago.

[38] I cannot guarantee that those were the exact words, but they were words to that effect.

In times gone by, people would've almost always taken the word of a 'professional' or licensed doctor as gospel and blindly obeyed their instructions or reccommendations. However, in this day and age, people overall are less trusting and far more prone to ask questions about their treatment, and to personally double-check their therapist's mindset, to make sure they haven't overlooked anything relevant to their case.

This is fair. A patient has the right to fully understand how their therapist percieves their case, what their perscribed treatment is intended to accomplish, the success odds for their treatment, all the possible side-effects of their treatment, the other alternative treatments available, and any other information relevant to their case. It is the patient's life and future on the line, after all.

However, the culture of the mental health industry may be lingering back in the old days when their patients and surrounding society were much more inclined to be blindly obediant. This may filter out into individual therapy experiences as therapists, who are nurtured by that dated culture, approaching their duty to explain themselves as a trifle that is irrelevant to the therapy process and a chore they shouldn't have to bother with.

The Unreliable Patient

A certain portion of the patients that the mental health system treats lack the ability to think clearly (either as a permanent condition or in temporary 'episodes'). Unfortunately, due to the mental health system's tendency to misdiagnose real life crisises as 'mental illness'[39], pretty much every patient who walks in the therapist's door gets lumped into that basket, and will be percieved as having some form of brain defect or malfunction.

This creates an environment where the therapist feels like they have the only truly reliable brain in the room.

There are indeed cases where this mindset is justified. Sometimes patients contribute thoughts to the therapy process which are delusional, nonsensical, inaccurate, biased, or logically unsound.

However, this mindset can become a hinderance to beneficial therapy when the therapist gets used to feeling this way about her/his patients.

[39] See "The Misdiagnosing of Real World Problems as Mental Illness"(pgs. 30 - 35)

Even though, on the surface, a therapist might be able to tell the differance between a delusional objection or concern about their treatment, and a clearheaded one, their attitude towards them may merge to percieve **all** patient objections and concerns as the same brand of trivial nuisance. They don't need to respect these concerns as they always come from 'the unreliable brain in the room'. The task at hand therefore, is not to address, considder, or (god forbid) defer to these objections and concerns, but to pressure the patient into deferring to the therapist's 'clearheaded and reliable' judgement.

A Lack of Stake in the Game

The fact that a therapist has no real stake riding on a patient's treatment being successful makes it all too easy for them to harbor an arrogant attitude towards the treatments they perscribe.

Patients are the ones who have to do the majority of the work. Patients are the ones who have to endure the undesirable side-effects of treatment and bear the consequences if it fails. Patients are the ones who have to watch their lives ticking away as they waste time on useless, lengthy treatment runs; not to mention that they are the ones who have to endure the persisting, perhaps even worsening anguish of their problems, while they are tied up in an inneffective treatment.

So it is only natural that it is patients who will be most concerned about the cost (financial, emotional, effort, time, ect.), side-effects, ideal outcome, possible consequences and likelihood of success for any treatment that the therapist devises.

Therapists, by contrast, can easily dismiss such concerns, as they do not directly impact them at all. They are able to stubbornly press the position that they know best, because it doesn't matter at all to them if they are wrong. This breeds arrogance.

This was a dynamic that was very common during my treatment by one of my therapists. Concerns I raised about her poorly-considdered instructions were dismissed as being all but irrelevant or finnicky; even if my objection was that I'd tried her method several times before and found it only produced unfavorable results. Subsequently, when following her instructions resulted in very distressing, upsetting experiences, and with no success either, my resulting anguish was also dismissed as being trivial.

I quickly realized that my therapist would never respect the importance of perscribing me sound, well-considdered treatment that was tailored to meet my situation and needs, as she would never suffer the consequences of the treatment as I did.

Likewise, she would never respect the gravity of my problems, or the relevance of certain elements of them, as none of them effected her at all. This allowed her to pass her own judgements from a comfortable vantage point, with no repercussions if she ignored crucial details or gauged a situation poorly. Again, this position of 'invulnerability' is prone to breed arrogance.

I have had similar impressions of therapy recounted to me numerous times by other former patients. A great many of them were infuriated by their therapist's lack of concern about the effectiveness of their treatment, and otherwise dismissive behaviors. Behaviors which the therapist would almost certainly be unable to maintain if the consequences of inadequate treatment weighed upon them just as they weigh upon the patient.

What makes the therapist's lack of stake in their treatment seem almost criminal is the fact that they get paid the full price for their time either way, regardless of whether their treatment is a resounding success or a collosal failure.

A False Front

In certain cases, the arrogant manner of a therapist may simply be all an act.

Some therapists might be of the opinion that their patients will be more trusting of their abilities if they present themselves as infallable authorities on depression, suicidalness and mental illness, who's judgements and methods are beyond question.

However, such approaches will frequently be problematic as many patients will find their behavior disrespectful and subsequently harbor a negative attitude towards their treatment.

They Simply Don't Care

One very simple explaination for why a therapist might behave arrogantly towards their patients is that they simply don't care about their struggles. Naturally, someone who doesn't really care about your satisfaction will have very little interest in addressing your doubts and concerns regarding the treatment they perscribe.

For such therapists, the job becomes primarily about minimizing hassles, which means brisk dismissal of any roadblocks the patient might throw up in the path of the smoothest, easiest route of treatment that the therapist can perscribe without risking an accusation of malpractice.

Patients are thus made to feel that their input and concerns are trivialized and that the therapist is being overly pushy in trying to get the patient to follow their treatment agenda without any fuss.

Again, this is another very common impression patients take away from therapy, that I have heard recounted in online communities time and time again. The vast amount of claims of uncaring therapists may indeed paint an unfair and inaccurate picture of the actual scope of this problem. However, even if uncaring therapists only amount to a very small portion of the workforce, the mental health system has a severe problem in that so many patients **believe** the system to be dominated by these sorts of therapists.

Interestingly, a large amount of former patients I have spoken to carry the impression that their unsatisfactory therapist(s) were only in their job for the money. Again, regardless of whether this is true or not, the mere fact that this is what the patients believe presents a significant public image crisis for the mental health system, if nothing else.

Sociopaths in the Industry

A noteworthy contributing factor to the problem of therapists who don't care about their patients may be the proportion of sociopaths within the industry.

Last year, well-known American therapist Kati Morton conducted a widely-viewed interview[40] on the subject of sociopaths. Coinciding with the release of the interview, she also personally released a separate video[41] on the same subject, which offered additional information.

Ms. Morton revealed[42] that sociopaths are attracted to the profession of therapy[43]. This would suggest that the sociopath community is actually concentrated within the therapy industry and that the proportion of therapists who are sociopaths is significantly higher then the 4% presence[44] that sociopaths hold in the overall population. This in turn, means that vulnerable patients have significantly more then a 4% chance of stumbling into the "care" of a sociopath therapist.

Ms. Morton notes that sociopaths seek out the therapy profession not out of any regard for, or sincere desire to help people in need, but rather out of a deliberate desire to manipulate[45] 'easy prey' for their own selfish ends.

While 4%+ is certainly nowhere near a majority, this figure will still amount to a tragically high figure of treatments being conducted by uncaring, sociopath therapists, when one considders the sheer volume of patients who seek therapy every single year.

Bigotry

Hopefully a very rare source of therapist arrogance, but one worth mentioning nonetheless.

Prejudices harbored by a therapist can lead to them looking down upon their patient and thus behaving arrogantly towards them.

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[40] http://www.youtube.com/watch?v=vTLkSpY_aYg
[41] http://www.youtube.com/watch?v=gsjmefy3nHc
[42] http://www.youtube.com/watch?v=gsjmefy3nHc&t=4m11s
[43] Along with certain other, unrelated professions.
[44] http://www.youtube.com/watch?v=gsjmefy3nHc&t=5m7s
[45] http://www.youtube.com/watch?v=gsjmefy3nHc&t=3m44s

The closet white supremacist, who just happens to be a therapist by trade, doesn't stop being a white supremacist when they clock in to the office in the morning. They will have difficulty respecting any non-white patients who walk in their door and subsequently they may talk down to those patients, be dismissive of their concerns or input, or refuse to defer on relevant cultural issues.

Without being overtly abusive, the therapist can minimize the value of the patient's thoughts, feelings and plight, simply in response to their ethnicity.

Likewise, therapists can develop an arrogant stance towards a patient due to a prejudice against their gender, sexual orientation, religion, financial class, education level, age, fitness, physical (un)attractiveness, and likely many other traits.

It should be noted that, while prejudice unfortunately rears it's ugly head in all manner of interactions across our society, when it is directed at a patient from a therapist it should be especially concerning. Seeking therapy is a very sensitive undertaking, often with a great deal riding on it[46]. Compared to other everyday dealings, it is especially important that therapists are respectful toward their patients, and that their interactions are not clouded with prejudices.

[46] e.g. A patient's decision about whether they should prolong their life, or commit suicide.

Therapists Often Do Psychological Dammage

Unfortunately, there are many therapists in the mental health system who do much worse then merely waste their patients' time and money with useless, albeit harmless treatment. In fact, they actually make their patient's situation **significantly worse** - either by aggrivating the patient's existing problem(s), or by inflicting brand new problems upon the patient that they would never have had to deal with otherwise.

I have personal experience with this, in that I firmly believe that my time in therapy has caused me significant grief, demoralization and negativity in my world outlook; all of which are severe obstacles to my original goal of achieving a worthwhile life; obstacles I would not currantly be burdened with[47] if I'd never made the mistake of going in to therapy.

I have read statements by several patients who recount or imply that their mental state, personal situation, or both significantly deteriorated as a direct result of harmful therapy[48]. I have even read statements from **therapists** who say that they **often** have to try to undo the significant dammage done to their patients by a previous therapist.

I need to emphasize here that I am not talking about some minor setback on the road to recovery. The dammage done by therapists can often be far, far more debilitating for a patient then the situations that lead them to seek therapy in the first place.

Patient Undermining

The actual harmful elements of treatment are often extremely subtle. It doesn't need to be a case of a therapist being outright abusive to a patient (although this can occur). Dammage is often done via seemingly insignificant remarks, tidbits of selective information, or the general attitude presented by the therapist toward the patient.

For example, if a therapist were to mention a documented fact that: *"only 6% of* [people in the patient's situation] *go on to find meaningful long-term employment"*, this remark, in the long term, could be just as devastating to the patient as telling him: *"Your a pathetic loser! Why would anyone ever want to hire you?"*

[47] Or, which would not burden me to the high degree that they currantly do.

[48] A high proportion of these statements relate to mistreatment in psych wards, during involuntary treatment, or involving the usage of harsh drugs and/or techniques such as electroshock therapy. However, a significant proportion of these accounts of extreme harm in therapy relate to the seemingly more innocent "talking therapies" that occur in small clinics, much like the circumstances of my own harmful treatment.

While the second statement initially appears far more brutal, they both essentially carry the same message; that the patient's situation is more or less hopeless and that it is unrealistic for them to expect to ever achieve a satisfactory life of reliable employment. Consequently, they may be severely de-motivated to even attempt to achieve a better life, which will only make their odds of achieving that life even slimmer. Additionally, the 'official confirmation' that there's no hope for them may deepen the patient's state of depression and/or support the case for them committing suicide.

As another example, if a lesbian were to notice their therapist subtly cringing or sneering every time she mentions her girlfriend, that can ultimately have just as devastating an effect on her as if the therapist said to her straight out: *"What you are doing is wrong! Sleeping with a woman? It's perverse! It's unnatural!"*

Even when the therapist's disgust isn't overt, the patient is still able to recognize that they are disgusting the therapist, and this can lead to a mentality where the patient begins to wonder or suspect that she may be an inherently disgusting person. This can lead to devastating self-image issues and/or a personal identity crisis.

Often the true extent of a therapist's harm doesn't become evidant immediately, but can take weeks, months, or even years to develop to it's full scale.

What makes dammaging mental health treatment especially insidious is that therapists are widely promoted in the mainstream as being trustworthy allies a patient can turn to, who are committed to assisting them as best they can. Therapists are supposed to be 'the good guys'. So naieve patients go in to see them with their guard let down. This makes them especially vulnerable in the therapy environment.

Most therapy patients will be used to being called names, looked down upon, or otherwise exposed to negative or demoralizing thoughts by their community. In response, they tend to build up their own mental guard mechanisms to minimize the hurt and allow them to persevere.

However, when we go into therapy, we let these guards down - unless we are very wise, or experienced with the risks of the system. When we are in therapy, the hurtful remarks we hear aren't coming from "just some nasty asshole", they are coming from one of the "reliable good guys", and are therefore legitimate commentary that we ought to take to heart. If a therapist implies there is something severely defective with us, or that we have virtually no hope of ever achieving a worthwhile life, it's probably true.

Unwanted Character Conversion

Therapists who perform dammaging therapy often do so without any direct agenda.

However, in many cases, the dammaging gestures made by the therapist are part of a broader campaign to "correct" an aspect of the patient's personality and/or identity that the therapist views as being defective or otherwise 'wrong'.

In cases such as these, the dammaging elements of the therapy will typically go beyond mere remarks and gestures, and the therapist will actually tailor the treatment itself to reshape the patient's overall personality and/or behavior.

For example, if a therapist deems that a patient is too sentimental, they may instruct her to give many of her treasured keepsakes and heirlooms away to charity, or sell them on ebay.

As another example, a patient who is an enthusiastic MMA fighter and turns up to a session a bit battered and bruised might be instructed by their therapist to seek out a "more sensible" or "less dangerous" sport to participate in.

Either of these treatment measures might be appropriate, in cases where the patient actually wants the personality and/or behavior changes that the therapist is attempting to accomplish in them. However, when such personality changes are not wanted by the patient, the therapist's treatment can become extremely harmful.

The "overly sentimental" woman may be left heartbroken by the guilt of giving away her mother's precious engagement ring - an uncomfortable and out-of-character gesture she never would've done if she hadn't been pressured in to it by her therapist.

The MMA fighter may come to view himself as a coward for backing away from the physical punishment of a pastime he genuinely enjoyed, at the therapist's urging. He may lose treasured friendships in the MMA circle as a result of abandoning the sport; treasured friendships that may have been significant assets in helping the patient cope with the original problems that drove him to therapy. Even if the patient does eventually decide to return to the MMA fighting scene, the therapist's unwelcome interference will likely leave his relationship with MMA in shambles. Whereas once the patient simply enjoyed his MMA, now participating in MMA may provoke a complicated and confusing set of thoughts and feelings including lingering doubts[49] about the wisdom of participating in MMA, a sense of character weakness, upsetting reminders of their dammaging therapy experience, ect.

These examples are mainly intended to serve as very simplified demonstrations of the mechanics of a therapist's unwanted attempt at altering a patient's personality/behavior, and the repercussions such attempts can have on the patient's quality of life.

[49] i.e. Doubts that were seeded by the therapist's objection to the patient's participation in MMA.

In real life, therapists often target aspects of a patient's character that are far more significant then their hobbies or material goods. In worst case scenarios, a therapist may attack a patient's most treasured relationships, their dearest dream or passion in life, their most sacred personal values, or their religious or spiritual outlook. The more central the targeted aspects are to the patient's character, the more dammage the therapist will do when they attempt to "correct" or remove them.

The effects of such treatment, that is designed to remodel the patient's character, are much the same in general nature as the effects of the subtler remarks and gestures that attack the patient's character[50]. Except that 'character conversion' therapy's effects are far more devastating in scale, as the therapy actually seeks to strongarm the offending character aspects out of playing an active role in the patient's lifestyle, as opposed to merely criticizing them. In essence, this form of therapy shamelessly attempts to mangle a patient's personality, and force them into being someone they are not.

This can lead to **severe** depression (up to and including suicide), confusion, identity crisises, sense of shame, sense of rejection, sense of worthlessness, sense of hopelessness, anger, and/or unwillingness to trust others anymore, just to name a few possible outcomes.

So why does it happen? Quite simply because the therapist decides that some aspect of the patient is undesirable, or because they believe that the official stance of the mental health system is that that aspect is a defect to be corrected.

Quite often, these situations revolve around personal aspects that have little or nothing to do with the actual problem that the patient has sought therapy for. The patient walks in to the therapist's office seeking treatment for *Problem 'A'*, and the therapist just decides that they'd much rather focus on *Problem 'B'*, which, as far as the patient is concerned, has never really been a problem for them in the first place!

The Question of Consent

So, is this form of harmful treatment going on without the patient's consent? That is a complicated question and obviously the answer will vary on a case by case basis.

Perhaps the most accurate answer that covers the majority of these cases is that it happens with **coerced** consent.

What you have to remember is that many people come to therapists in a state of desperation. They are so desperate to fix their problem(s), and so desperate for the therapist to be their savior, that they become very easy to for the therapist persuade.

[50] See the previous subsection: "Patient Undermining" (pgs. 53 - 54)

If the therapist implies that the best (and perhaps only) route to fixing their problems is by altering themselves to the therapist's design, ultimately they are extremely motivated to agree. In less dire circumstances, most patients would be far more resistant to similar attempts to turn them into someone they are not, especially when the alteration is clearly designed to serve someone else's ends[51], not their own. But at the height of their crisis, most inexperienced patients are willing to surrender parts of themselves for the sake of a therapist's vague suggestions of a better future.

Alternatively, a therapist may get their patient to commit to a treatment program without fully disclosing what that program will involve, or what it's intended outcome is[52]. Once again, a naieve patient is extremely motivated to trust their therapist and they will likely agree to such a treatment if it has been implied that it will significantly remedy their problem(s).

By the time the patient finally begins to grow suspicious that the therapist is attempting to make unwanted personality/behavior changes to them, they may already be well into the stages of the treatment that are designed to bring about the changes.

Another reason why the question of consent becomes complicated is because of the 'baby steps' tactics therapists will use to manipulate a patient into following a treatment they don't want to follow.

A therapist will often tone down their instructions to a reluctant patient, until the request is so trivial, the patient can be made to seem stubborn and unreasonable by refusing to try it. Once again, a patient who is desperate for a therapist's help will be extremely motivated to compromise in this situation. He will agree to do this small, insignificant favor for her, in the hopes that the therapist will repay him by giving him some actual help with his problem(s).

Of course, the process repeats, over and over again. Each time, the request the therapist makes is just a small step further then the last favor the patient agreed to, making it seem like no big deal. Even though the therapist has done little (if anything) to repay the favors that the patient has already done for him/her, he keeps on agreeing to his/her requests, desperately hoping that if he can amass enough goodwill, the therapist will eventually agree to help him.

Until eventually, the patient discovers that this endless chain of 'small favors' has lead them to a point where the thoughts in their head and/or the way they carry themselves bears no resemblance to the person they've always been, nor the sort of person they want to be.

Therapists are masters at being able to lead a patient to a place they most definitely do not want to be, without the patient ever passing a point where they felt it was appropriate to say: "Stop! No more!"

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[51] i.e. The therapist's.
[52] i.e. To "correct" the personal aspect(s) of the patient that the therapist doesn't like.

Hence why I say that the issue of consent is complicated. The patients. buy and large. do not want to be psychologically mangled into an unrecognizable shadow of themselves, yet technically speaking, they will often agree to it.

My Own Personal Experience

In the interests of maintaining my anonymity and that of the therapist in question, I will not give an especially detailed account of my experience in this section. I apologize for any frustrations this vagueness might cause and I hope it does not make my case about the potential dangers of therapy seem weak. If the committee presiding over this inquiry requires more details, I will try to accommodate them with a confidential response. However, please respect the fact that this is very difficult for me to write about and be patient with me.

My years in therapy ultimately had a dammaging effect on me, which have left me with psychological problems that effect me to this day.

My time under the "care" of one particular therapist was dominated by obvious (and unwanted) efforts to try to alter defining aspects of what makes me me - such as my values, my tastes in many areas - including prospective romantic partners, my ambitions and the foundations of my world view.

A large part of this treatment was trying to persuade me that there was no place in the world for a person like me - hence, I would have to morph into someone the world did have a place for.

The therapist also tried to persuade me that the things I dreamed of most dearly (e.g. a loving marriage, treasured friendships, a fulfilling & noble career) simply weren't possible, so I would have to change my deepest dreams to something else. And of course, she was quite willing to supply these alternate leanings to me. Namely, she seemed committed to making sure I prioritized a lucrative career over fulfilling relationships; and that I forego any notions of love, happiness or devotion in my romantic/sexual pursuits, in favor of seeking a marriage of mutual financial benefit and domestic convienience, with love being an optional triviality.

While I don't mean to disparage people who fixate on having lucrative/prestigeous careers, nor those who marry for financial or other practical reasons; this is simply not who I am. It's not someone I can ever be.

All my therapist's efforts to *'reshape'* me in this manner accomplished was to make me much more bitter and cynical about life and the world around me. These are not helpful attributes, especially if you are expected to behave as if life is worth enduring.

In addition to her interest in reshaping the most defining aspects of my life (both present and future), smaller, day-to-day elements of my life were also addressed with a treatment approach that was likewise quite dammaging.

My therapist would often try to steer me in directions that had very negative effects on my quality of life and emotional endurance. She would pressure me to do various unhelpful things in my everyday life - like adopting certain habits, or performing 'baby step' gestures. Many of these things I had already done in the past and found to be unhelpful, if not downright self-defeating.

She encouraged me to nurture some toxic relationships I was caught up in at the time, as keeping company with these people, unpleasant as it might've been, seemed to fit better with the image of what she wanted me to be. Partially motivated by her urgings, I persisted with these relationships during the earlier stages of our therapy. My prolonged exposure to these toxic relationships has had many enduring negative effects on my image, life and mental state. They bolstered my depression and sense of hopelessness, made me increasingly bitter and impatient towards others and generally encouraged a negative perception of humanity as a whole.

Altogether, there were countless occasions where my therapist would push me to do something that made absolutely no sense in terms of progressing towards my life goals or otherwise achieving a more acceptable quality of life. It was almost always supported by nothing more then the arrogance I address in a previous section[53]. When I pushed her for an explaination as to what she hoped to accomplish with this treatment or to justify the risk/reward balance, her response was typically something akin to: "Just do it."

Her attitude was that she owed me no explainations about my treatment; that I had no right as a patient to understand the treatment I was being perscribed. My duty as the patient was simply to obey without question. My concerns were not only irrelevant to her, but they also seemed to be *beneath* her - like being a professional therapist made her too important to have to deal with such petty concerns.

My therapist was utterly unsympathetic to numerous upsetting ordeals that occurred in my life during my treatment, most of which she had advocated, or were in the spirit of things she had advocated. While I admit that, individually, almost none of these ordeals were particularly serious in the long-term sense, her attitude while the anguish and frustration were still raw speaks volumes about my treatment. It didn't seem like she considdered these ordeals to be gambles that had turned out poorly; nor was she trying to gloss over the negative in favor of promoting a "get back on the bike"-type of mentality. No, she was actually delighted that these events had played out the way they had. They made my life look more akin to the way **she** wanted it to look, as opposed to how I needed it to look. That was all that mattered to her.

[53] pgs. 43 - 46

Setbacks are, of course, inevitable. But good therapy ethics would've demanded that the therapist acknowledge that the experience was negative, so that we could've debriefed, explored the problem(s) and worked on developing strategies for avoiding or minimizing those negative elements in the future and more importantly, seek to introduce positive elements to similar situations in the future. In my case, **none** of that occurred, because the therapist was happy with things just the way they had played out!

While each of these lesser aspects of my therapy[54] were not really any big deal on their own, when taken all together, they demonstrate very clearly that my therapist was not committed to helping me during my treatment, she was pursuing some other, separate agenda.

Though I resisted her efforts to *'reshape'* me as much as I could, they nonetheless had a dammaging and enduring effect on me.

They cultivated a far more negative image of the world and humanity in my mind, greatly undermining the plausability of the idea that life is indeed worth prolonging.

The therapist all but robbed me of any hope I might've had that I could ever find happiness with a wife, or that I would ever be able to do any good with my life. It seems now as if I am incapable of doing anything to genuinely make the world a better place - even on a very small scale - and that therefore, my continued presence here can only possibly make the world bleaker and more unpleasant for the people I have to share it with.

Whereas my immediate surroundings were a bleak and ugly place when I'd first become her patient, she killed off any hope that there was a life worth living beyond the horizon. There are even several negative beliefs/prejudices I harbor now that I can directly attribute to this therapist - as these thoughts had never occurred to me until she suggested them!

She promoted a very bleak view of all humanity being materialistic beasts, with little to no capacity for nobility or making fulfilling spiritual connections. I suspect her agenda was to convince me: *"it's dog eat dog, so you'd better act like a dog and eat all the other dogs!"* - her point of view being that becoming top dog would be the best possible outcome a patient could achieve. Though I tried to resist it, I've unfortunately found that this bleak world view has taken root in my mind and I now find it incredibly difficult to entertain the idea that there is any uplifting decency in humanity, or that I will ever encounter such a thing. A potential wife who is not fixated upon material wealth, or who has the capacity to genuinely love someone, now feels like a fictional character.

[54] i.e. The aspects pertaining to more trivial day-to-day matters and minor one-off problems in my life, as opposed to her efforts to manipulate my defining characteristics, which I considder to be the far more harmful and insidious area of my treatement.

I find myself frequently troubled by this condition where anyone or anything that embody characteristics she tried to impose upon me feels like an enemy, or at the very least an unwelcome burden. For example, her habit of downplaying the social/political causes I was concerned with, in favor of promoting an interest in her own social causes, seems to have left me with a hostile gut reaction towards people/organizations who pursue these same (or similar) causes. To clarify, my social interests and theirs are not politically opposed; mere focussed on differant societal issues. It is, frankly, absurd that I should feel such baseless impatience with someone simply for promoting a passion that is differant, not antagonistic, to my own. But the role they unwillingly played in my harmful treatment has left a lingering resentment towards them, just as I resent the treatment itself.

Altogether, the therapy has had a sabotaging effect on any prospects I might have for fulfilling relationships. While I am able to maintain a polite outward manner very well, on the inside I am quick to assume the worst of people. Logically, I am well aware that this habit is doing me no favors, yet I find myself unable to subdue it. Previous to going in to therapy, I had a far more optimistic view of other people. Pretty much all social interactions I have today are far more difficult then they were for me before therapy and I am certain that my treatment bears a large portion of the blame for this awful change.

And beyond these more sinister ongoing symptoms, I just have to say that I feel thoroughly betrayed. The appalling nature of the treatment, in itself, serves as a very compelling piece of evidance that life is not worth prolonging. It's bad enough that, for many people, the only hope they have of getting any compassion and help from the world is to pay someone through the nose for it. But when people insist on beating you down even when you ***pay them*** to help you? Well, who in their right mind would ever want to live in a world so evil?

I went into therapy looking for help and guidance to achieve a life that was actually worth prolonging. But therapy all but convinced me that such a fair outcome was not possible. Even if, by some miracle, I did come to possess the means to pursue my dreams, I'm not sure I would have the spirit to do so anymore. It seems like nothing I could ever do would be able to overpower the ugliness I'm surrounded by. It seems like there is nobody in the real world who has sufficient virtue to make humanity, or life as a whole, worth bothering with.

My treatment left me in a state where now there is little left for me to do but run out the clock with the most unhealthy lifestyle I can, and pray that a natural death gives me peace sooner rather then later. I'd love to be free to commit suicide. But my impression has always been that suicide tends to provoke a more negative response from the people who talk or hear about it then other forms of death do. And I'll be damned if I give them ammunition to spread more depression and misery into the world. There's already far too much of that crap going around.

I try as best I can to respect the viewpoint of others that therapy can potentially be a valuable tool for those in crisis. But, for all the reasons I have just listed, I will never personally reccommend that someone in crisis seeks out help from the mental health system - at least not until it has undergone a **major** reform that creates measures that specifically protect patients from any attempts by therapists to *'remodel'* their personality or behavior against their wishes.

In the meantime, I will continue to call for far greater public awareness on the risks of therapy and the frequency with which both dammaging and useless therapy occurs within our mental health system.

The Poor Quality of Care - The System

Under this topic, it is my intention to address the deep-seated problems within the structure, ideology and methods of the overall mental health system, and the ways that it's governance of it's therapists lead to negative treatment experiences for far too many patients.

The System's Ideology is Poorly Supported

So much of the system's stance on various issues relating to mental illness/mental health, legitimate/illegitimate thought and legitimate/illegitimate behavior has little, if any basis in reason when scrutinized. The system tells the world that: *"such and such manner of thinking means a person is mentally disordered"*, but offers little if any publically accessable proof that such conclusions are indeed fair, balanced and grounded in well-considdered reasoning.

Many of these conclusions have strong counter-arguments which are self-evidant to many people in the community[55]. Yet because the system offers no clear basis for it's rulings on such matters, people who do encounter or deduce these compelling counter-arguments are left with very little reason to trust that the mental health system's ruling is well supported against these counter-arguments.

What the system considders to be 'mental illness', illegitimate thought, or illegitimate behavior amounts to a very broad field, and most of these stances have compelling counter-arguments against them. Hence, it would be impractical to try to detail all these unanswered counter-arguments in this single submission.

So, by way of example, I shall limit my discussion to the mental health system's poorly-based stance on the act or contemplation of suicide, as it is one of the questionable stances that effects the most lives.

The System's Attitude Towards Suicide

The mental health system opperates on an ideology that suicide is always, unquestionably wrong. In fact, it is so extraordinarily wrong that the system is well within it's rights to confine and/or restrain a person even suspected of being suicidal - essentially to imprison them without trial - until they no longer exhibit an intention to kill themselves.

Needless to say, this stance is at odds with that of the thousands of suicidal Australians, who have all drawn upon a lifetime of experience and come to the conclusion that suicide is, in at least some cases, a very warranted act.

[55] Especially those who follow the so-called 'mentally disordered' line of thought in question.

So, to the mental health system, we must ask: where is your proof? On what basis do you tell the suicidal person that, in spite of their inhumane anguish, their conclusion that they are better off dead is irrefutably wrong? On what basis do you so politely dismiss thousands of lifetimes of horrid experience to continue to make your classic proclaimation: *"Suicide is never the right answer"*?

Ask any suicidal person about why they want to end their life and, if they choose to dignify your question with an answer[56], most of them will paint you a very vivid and compelling picture of a life[57] defined by indecent suffering. But ask the mental health system as to why that person should be expected to keep enduring that awful life and they will answer only with the vaguest assurances or possibilities (e.g. *"You never know, things might get better tomorrow"*), or by cookie-cutter, one-size-fits-all anti-suicide arguments that are easily and routinely debunked by the suicidal community, due to their flimsy logic.

Two opposing views about the situation and yet, the person who can offer a clear, compelling, thoroughly considdered[58] justification for their stance is essentially regarded as a crank, while the system that counters that well-formulated case with vagueries is regarded as a trustworthy authority in such matters.

Perhaps the most disgraceful aspect of the system's stance on suicide is that, despite mental health system ideology *supposedly* being based on science[59], the notion that "suicide is wrong" has been settled upon in a manner that is an absolute insult to the scientific process!

The more you look into the ideology of the system, the more apparent it becomes that the system has started out with the determination that it would never come to any conclusion on the subject, other then: *"suicide is always wrong"*. Before it even began talking to suicidal people, and throughout it's long history of doing so, it has decided that it's conclusion on the appropriateness of suicide will never be altered. Throughout every study that it has ever conducted upon suicide and it's related issues, it has never been willing to alter this conclusion.

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[56] Which they may not. They don't owe strangers any explainations about how they conduct their personal affairs. And also keep in mind that they may well have been questioned about the legitimacy of their desire to end their lives countless times previously; often having their anguish, life experience, or ability to reason baselessly belittled once they have responded. Some people get tired of it. Others figure that there's no point trying to convince someone that your decision is sound and justified, when they've already decided that your decision is unquestionably wrong, and that they will never change their mind in that regard.

[57] Notably including the most realistic prospects for their long-term future.

[58] Admittedly, some people don't give their suicide thorough considderation before they attempt or commit it. However, I believe that the vast, vast majority of suicides are based on compelling and sound reasoning, and that the proportion of 'impulsive' suicides is very much exaggerated by anti-suicide groups, in a deliberate effort to undermine the legitimacy of suicidal people.

[59] Which it needs to be, in order for the mental health system to be recognized and supported by the government as a secular public service. If it were found to be opperating with a bias towards any given religion or particular political agenda, then it would fall upon the government to insure there were adequate alternatives provided for any and all patients who do not subscribe to the religion or political allegiance in question.

Not once, in it's long history of lackluster effectiveness in preventing suicides and healing the broken-spirited, has the mental health system ever stopped to question it's founding assumptions. Not once has it ever internally debated: *"Hang on! Maybe we got it wrong when we decided that suicide was always wrong. Maybe we need to go back, start exploring the subject without any preconceived notions, and see if we can actually prove that it is the correct conclusion!"*

There is nothing that suicidal people can ever say or do, no piece of evidance that can be presented to the mental health system, that might ever get them to admit that suicide might be an appropriate choice in some cases. Not because no evidance or arguments exist[60] that might undermine the mental health system's stance, but because the system has decided that it will never allow it's stance to be altered.

No self-respecting scientist would ever accept this as a being science! For a group to not merely hypothesize, but to **decide** what the results were going to be before any study was even commenced? For them to automatically decide that any and all contrary evidance and ideas 'must be' wrong, due to the fact that they are in conflict with the desired conclusion; and for them to subsequently seek to develop means to discredit this evidance, rather then to impartially explore the validity of it? For them to consistantly be searching for ways to bend testimony, evidance and facts to support their desired conclusion, rather then allowing new ideas and evidance to lead them to a differant, potentially more correct conclusion?

This is as gross a pervertion of the scientific method as you will ever see!

The suicidal community is well aware of this massive ethical shortfall, and the lack of integrity it demonstrates, not only in the system's conclusion that "suicide is wrong", but also in the mental health system as a whole.

This is why we are so sceptical of the idea that life is worth prolonging; because it is based upon such a questionable foundation.

Yet despite this appalling lack of integrity, the vast majority of suicidal people are willing to extend the mental health system far more respect then it is willing to extend to them. Suicidal people start out strongly suspecting that death is a better choice then life, but we approach the system willing to be swayed; in fact, we dearly hope that the system will be able to convince us that our initial assumption was wrong. We sit, we listen, we considder, we question, we listen again, and if we are biased at all, we are biased against own existing conclusions. Our minds are very much open to the possibility that we got it wrong.

The mental health system shows suicidal people no such courtesy. Nothing we can ever say or demonstrate will ever change it's predetermined conclusions. We really listen to the system. The system never really listens to us.

[60] There are plenty of both, which the suicidal community are well aware of and discuss frequently.

The average suicidal person in therapy is far more rational, balanced and scientific then the supposedly science-based system that treats them.

The Frail Arguments

I mentioned previously about the anti-suicide arguments that are dispensed by the mental health system to suicidal people, and that suicidal people routinely debunk. I won't clog up this submission with all of these arguments and their debunkings. I would be more then happy to provide an extensive list, if requested.

However, as an example, I will demonstrate here how one of the system's favorite arguments: *"You mustn't commit suicide because it would upset your friends/family and be selfish"*, is severely logically flawed.

First of all, it dismisses the suffering of the suicidal person themself. If it is selfish for the suicidal person to expect their friends/family to endure the anguish of the person's suicide for the sake of sparing themselves the prolonged misery of their unbearable life, isn't it likewise selfish for the friends/family of that person to expect him/her to endure that prolonged misery, so that they will be spared the grief from his/her suicide?

Secondly, it doesn't acknowledge the imbalance between the suicidal person's potential anguish and their friends/family's potential anguish. The anguish of the suicidal person is clearly of such magnitude that it has weighed them down past the limits of what constitutes an acceptable quality of life. So unless the grief that their friends/family will experience as a result of their suicide is likewise powerful enough to make their own lives undesirable (which it typically isn't), it would be fair to say that the suicidal person is carrying the heavier burden and that the outcome where he/she does commit suicide is, overall, the most humane of the two.

And thirdly, it instantly applies an obligation of servitude upon the suicidal person that has no defined limits. If we condemn them for upsetting their friends/family by committing suicide, should we also condemn them for upsetting their friends/family by embracing a sexual orientation their friends/family abhor? Or for choosing a career path that disappoints their friends/family? Or for following a differant religion to them? Or voting for a differant political party? Or for choosing a spouse that the friends/family don't care for[61]?

There are a great many ways to upset those around you - suicide is merely one of them.

[61] Perhaps due to the spouse's race, religion, refusal to adopt traditional gender roles, ect.

The fact is that once the very reason you exist is out of an obligation to please certain people, the entire nature of your existance - and every aspect within it - becomes bound by that same obligation. You cannot reasonably condone the *"you must live, for the good of your friends/family"* argument without likewise condoning a person's enslavement under those same people.

Who does a person's life belong to? Themself, or their family? That question cannot be dodged if the anti-suicide argument is to be taken seriously.

In numerous cases, this practice of advocating a life of servitude becomes **extremely** hypocritical, as at some other point in the therapy, the therapist will push the patient to adopt 'self confidance', with phrases like: *"What does it matter if other people are unhappy with what you do? Do what you want!"*, or even: *"You can't live just to please others"*. Only for them to rapidly push the **exact opposite** mentality when the patient implies they wish to end their life, with lines like: *"No! You mustn't kill yourself! Think about how it would upset your friends/family!"*!

How it All Effects Therapy

So, why is this all of concern? Well, it's of concern because this position that *"suicide is always wrong; it's the product of a malfunctioning mind"* dictates the way suicidal people are treated by the system. It leads the system to attempt unwanted alterations on some of the patient's most important values and beliefs[62]. This essentially means that the system (through it's minion, the therapist) is going to war with the patient's true character, which is a ripe situation for any number of undesirable therapy outcomes.

Of equal concern, the mental health system's infamous intollerance for suicidal thought deters many people from seeking out any help from them, because they know they won't get it; instead they will simply get a thorough browbeating about how suicide - not the horrendous circumstances that have made their life undesirable - is wrong.

[62] See "Unwanted Character Conversion" (pgs. 55 - 58)

Suicidalness comes about when a person holds the following beliefs all at the same time:

1. There is such thing as a fate worse then death.
2. The person's currant state of life[63] is such a fate.
3. It is not reasonable or realistic to assume that this situation will correct itself, or that a route to a quality of life that is worth prolonging will become available to them in the foreseeable future.
4. In a dire situation with real, heavy stakes, it is appropriate to take action to pursue the best available option[64], as opposed to merely analyzing the issue hyperthetically, without any intention of acting in accordance with your analysis.

Because the stance of the mental health system is that suicide is always the worst choice a person can make, it cannot abide belief #1, and secondarily, belief #4. By the system's standards, these are illegitimate notions; defective thinking.

So upon encountering a suicidal person, the mental health system's primary objective is to convert that patient's ideology so that they instead believe that: "There is **no** such thing as a fate worse then death." After all, it doesn't do to persuade a patient that they shouldn't commit suicide in response to today's crisis, only for them to commit suicide in response to next year's crisis.

The key problem that the therapist takes issue with isn't that this patient wants to die, rather then continue living in her currant nightmare; it's that this patient has the capacity to entertain the notion of committing suicide **at all**. That's something that mentally healthy people simply don't do. So, as a therapist, your primary job is to alter her values so that they no longer allow her to entertain the idea of suicide.

I have already discussed the very real potential for dammage that arises from attempting to alter a patient's personality against their will[65]. Overwriting a patient's spiritual beliefs or world view that allow for the possibility of a fate worse then death certainly qualifies as such a personality alteration.

But another major problem with the doctrine of attacking a patient's capacity to contemplate suicide is that it distracts therapists from addressing the actual problem(s) that are making the patient's life undesirable.

[63] Alternatively, sometimes it may not be their currant quality of life, but rather their immediate foreseeable future.
[64] i.e. In this case, death.
[65] "Unwanted Character Conversion" (pgs. 55 - 58)

It also tends to encourage a "mission accomplished" mentality in therapists, once they believe they have effectively stopped the patient from committing suicide. The therapist has little motivation beyond this point to help the patient with their actual problem. They essentially quit caring once the patient's problem ceases to be something that they might kill themself over. As a result, they become useless to the patient.

This culture effectively makes the mental health system another potential enemy for the suicidal person. While they are struggling to overcome their fate-worse-then-death problem, whatever it may be, the last thing they need is the mental health system to come along and break their one viable escape route[66] from their terrible predicament.

Many people whose lives are unbearable are well aware that the mental health system is more interested in destroying their belief that suicide is justified, then it is in actually tending to the problems that have made their lives less appealing then death. This is precisely why they refuse to disclose their need for help to the mental health system, or anyone else around them for that matter.

Have you ever heard someone say in the media: *"Why didn't they tell anybody how badly they needed help?"* in the wake of a suicide? Well, this is why! Suicidal people don't talk because they don't need to be browbeaten into believing that suicide is wrong! They need help with the problems that are making their life a living hell! And they know that if they reach out to the system, that unwelcome browbeating is the first and probably only so-called "help" they'll ever get!

This is why the weak basis of the mental health system's ideologies is such a massive problem. There is just so much riding on it.

The system performs drastic violations of patients' identities in it's pursuit of enforcing it's ideologies. It neglects patients' interests in deference to enforcing it's ideologies. It notoriously[67] tarnishes it's own public image, and therefore it's attractiveness to people who desperately need help, by obsessively pursuing it's ideologies.

Any ideology that has such significant and costly effects on the performance of the mental health system **needs** to be coherently and clearly justified by sound, balanced reason, so that those who scrutinize it will be able to have faith in the system. It needs to be able to stand toe-to-toe with the harsh realities of the lives of the patients it will be applied to. Because make no mistake, those harsh realities do call the legitimacy of those ideologies into question and, by extension, the trustworthiness of the mental health system that is governed by them.

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[66] i.e. Suicide.

[67] At least amongst patients, former patients, and people well exposed to patient views. The general public are largely oblivious to these issues, however.

To be clear: this applies to **all** of the mental health system's ideology, not just it's attitude towards suicide.

The System's Ideology is not Overseen by Any Independant Force

This is one of the main reasons why the mental health system's ideology has historically been, and continues to be one of it's biggest handicaps.

The mental health system is a law unto itself. Everyone, including the general public, the media and even governments defer to their judgement as to what is "right" thought and what is "wrong" thought. Very few people with the power to make a differance ever question their ideology.

Nobody, in any official capacity, is double-checking their ideological judgements to insure that they are balanced, thoroughly-considdered, fair and humane to all who are effected by them. Accounts I have heard from people more familiar with the inner workings of the system then I suggest that even the system's own workers are discouraged from scrutinizing the system's ideology [68].

Environments like this are ripe for corruption and I believe that is exactly what you will find throughout the mental health system. In too many ways, the system bears more resemblance to a dictatorship then the refuge of compassion, respect and assistance that it is supposed to be. The rules it lays down for what people are and aren't aloud to think; what they are and aren't aloud to do, seem to be less a product of careful, balanced compromise, much less due regard for the sacred rights of the individual, and more a product of people in power inflicting their will upon the masses, simply because they can.

Even if the ideology of the mental health system was 100% legitimate and reasonable[69], the lack of any independant oversight provides ample reason for people to question it's integrity. This makes it significantly less trustworthy for people in need, and will discourage them from approaching it for help.

Homosexuality as a Mental Illness

One of the most obvious reasons why it is so disturbing that the mental health system has such unchecked power is it's past history.

Up until about the mid-1970s, the mental health system considdered homosexuality to be a mental illness, and treated it as such. Of course, we now know that homosexuality is a perfectly legitimate and sane orientation.

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[68] See "Education" (pg. 47)

[69] Which I don't believe for a minute it is.

Even today, there are individual therapists who descriminate against gay patients due to their own personal homophobia, often to devastating effect[70]. One can only imagine how much harm must've been done to so many innocent gay patients back in the days when it was a therapist's official duty to diagnose their homosexuality as a mental illness and attempt to "cure" it.

Not to mention the degree to which the mental health system's official, "expert" ruling of homosexuality being a mental disorder fanned the flames of the harsh, and often violent cultural prejudice that the LGBT community had to endure back in those days.

Yet staggeringly, the modern world seems to have mostly forgotten this dark history. This is unfortunate, as even though the LGBT community has long been released from the mental health system's cruel and unfounded prejudices, many other people, with tastes, values, or mindsets that are well justified, still face poorly-supported condemnation from the mental health system.

Government and the general public still accept these proclaimations from the mental health system, about what is and what isn't a "mental illness", despite it's known history of getting these things disastrously wrong in the past! These rulings are **still** ruining lives, and **nobody** is double-checking them!

It's absurd that a system with such an appalling history is still aloud to exert such a powerful influence over our society and the lives of vulnerable people, with nobody checking that their stances are fair, humane and well-supported by impartial evidance and rationalization.

[70] I have read statements from therapists who say that they have treated LGBT patients who have suffered significant psychological harm from the treatment of a previous, homophobic therapist.

The Lack of Any Relevant Forum for People to Challenge the System's Ideology

People who find themselves at odds with the official stance of the mental health system on any matter relating to their plight, or the care that is available to them, find themselves in a powerless position, as there is no meaningful way for the people effected by the system's judgements to challenge their validity.

This is of particular concern when large sections of the mental health system's target market (for lack of a better term) find the stance of the system to be baseless, unbalanced, disrespectful, inaccurate, or otherwise problematic.

The labels that the system applies to members of these groups and the "care" it wishes to administer to them can have major undesirable consequences in their lives. Yet there is no effective means for them to air these grievances with the system's position, to compel the system to provide a coherent justification for it's stance, nor to seek to have these faults addressed and remedied.

How can we expect major ideological faults[71] in the system to be fixed if there is no proper system in place to recognize the negative impacts they have upon the people most effected by them, and to call upon the system to publically admit these faults and pledge to improve these situations as soon as possible?

How can we seriously regard the system as a fair, secular, science-based service when it is closed off from those who have contradictory viewpoints or evidance to present against it's governing ideology?

I should clarify that the absence of a proper forum to address these faults does not mean that they are not widely recognized. Online communities composed of people who need help, including the suicidal, often discuss and complain about these problems. The debates are going on, just not in any form that has the power to bring about meaningful, positive change.

For those among us who are aware of the system's broken ideology, the absence of any meaningful forum to challenge this ideology demonstrates a severe lack of integrity in the system. This only further discourages people from seeking help from it.

Whether it is by design or by accident, the system is currantly a law unto itself that cannot be trusted to care for us, because it is not answerable to us when it's treatment does us more harm then good. Even worse, it is not answerable to future patients who are in line for the same undesirable treatment with the same undesirable consequences.

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[71] See "The System's Ideology is Poorly Supported" (pgs. 63 - 70)

Beaurocratic Problems with Mental Healthcare

Under this topic, I will address a couple of concerns relating to the government's beaurocratic policies and procedures, regarding mental healthcare.

I should note that these concerns relate to how the system worked during my own stint in therapy, which was several years ago, and did not take place in Victoria. Due to the fact that I have not kept up-to-date with how the beaurocracy may have changed in the meantime, and also that I have no familiarity with the specific workings of Victorian government, it is entirely possible that some elements of this section may not be relevant to the currant state of the Victorian government's management of mental health.

Privacy Concerns Regarding Records of Receiving Therapy

While I was in therapy, I was signed up for a Medicare program that aloud me to receive a certain amount of discounted therapy sessions per year. Although this scheme helped with the significant cost of therapy, I was extremely reluctant to sign up for it, in part because it would mean that there would be a permanent record of me being a therapy patient in my Medicare file.

This was of concern for me at the time, due to the significant stigmata associated with being a therapy patient (especially the implication that such a patient is "mentally unhealthy"), and how this stigmata might negatively impact my career ambitions, as well as my general public reputation.

I recall reading something[72] at the time that stated that some doctors were actually advising patients **against** applying for the discount - particularly younger patients who had their futures to considder. These doctors apparently shared my concerns about the potential repercussions of having a Medicare record of mental health issues.

News that broke back in 2017 of peoples' Medicare information being up for grabs on the dark web certainly didn't ease my concerns in this regard; nor will it have eased them in the minds of other former, present and future patients of the mental health system.

As long as accessing a Medicare discount for therapy entails having your mental healthcare history recorded for posterity in a centralized database, there will always be an uncomfortable degree of risk in applying for these sorts of discount.

[72] I can't remember whether this was a news article or a statement of personal experience from someone associated with mental health care.

Although we, as a society, have made great strides in recent years regarding our attitudes towards mental illness, there will always be some degree of stigmata placed upon those who are "mentally questionable". As such, anyone who does feel the need to seek out mental healthcare - and who may need government financial assistance to be able to afford that care - needs to be confidant that they will be able to access this help with absolute privacy.

In every concievable sense, applying for the government discount should make it no easier for an outsider[73] to determine whether or not the person has been a mental health patient, then if they'd gone into therapy without applying for it.

[73] Including government, law enforcement, private investigators, major organizations, hiring firms, ect.

Surrendering of Doctor-Patient Privelage

The most disturbing and ultimately problematic aspect of the Medicare discounts I signed up for[74] was the fact that, in order to access the discounts, I had to sign away my doctor-patient privelage with my GP. Specifically, I could no longer trust that anything I said to my GP would not be repeated to my therapist.

While this was unsettling for several reasons[75], by far the worst was that I no longer had a legally-binding guarantee that anything unfavorable I said about my therapist would remain between my GP and myself. This essentially left me far more alone in facing my terrible therapy situation then I would have been if the Medicare discount scheme had left my doctor-patient privelage intact.

I could not, for example, lean on my GP for assistance, or even advice on how to get out of that therapy.

It also left me unable to use a medical excuse[76] to escape from therapy, as my therapist would be able to query my doctor directly to check the truth of these claims; medical information that would ordinarily be beyond her access.

Even if I was interested in going into therapy again (which I most certainly am not), I would not apply for the Medicare discounts again, assuming the system still requires patients to sign away their doctor-patient privelage. I have learned the hard way that doctor-patient privelage is an essential human right, and far too precious to sell off for just a few hundred dollars per year; especially considdering the hazards a patient exposes themselves to when they enter in to a therapy situation[77].

If asked, I would urge other patients considdering this discount system to not take the risk, either.

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[74] As discussed in the previous section (pgs. 74 - 75)
[75] Including offering my therapist potential extra insight into my life circumstances, which I may have wished to keep private from her.
[76] e.g. That I had had an accident, or fallen prey to some serious medical condition that required long-term hospitalization or home bed rest.
[77] See "The Poor Quality of Care - Therapists" (pgs. 40 - 62)

The Need to Involve a Patient's GP in their Mental Healthcare

During my therapy experience, I discovered that certain treatment options and associated support systems[78] were only available if I accessed them via my GP. I found this to be a very uncomfortable arrangement; so much so that it made me reluctant to access these services.

I was uncomfortable with the permanent impact this arrangement would have on my GP's perceptions of me. I did not want him to regard me as being "mentally abnormal", and I did not want this perception to make future medical appointments with him awkward.

There is a strong push at the moment for our society to drop the stigmata surrounding mental health issues. Part of this push being to reduce the likelihood of GPs thinking less of their patients who reveal they have such issues, and to likewise reduce patients' fears of this reaction occurring.

I am also aware that there is a strong case to be made for administering a patient's complete medical-mental care program as a united, coordinated effort, with free communication between all the professionals involved. Many people hold the well-supported view that this is the best possible route to a successful treatment.

Those points aside, I believe it needs to be remembered that the GP plays a unique and very important role in a patient's life and that trust and comfort are important elements in this relationship. A patient shouldn't be compelled or pressured by the government beaurocracy to take actions that they fear may make their GP think less or them, or which may otherwise make them feel uncomfortable or embarrassed around their GP.

GPs are encouraged to see their job in very broad terms. But for many patients, the GP's role in their life is strictly to tend to their medical problems. They are simply not comfortable with involving their GP in their *personal* problems, and view such actions as bringing unwelcome complications into their relationship with their GP.

There is no harm in informing the public of the merits of coordinating a GP's service with a patient's mental healthcare. But the government must understand that it cannot order people to be comfortable with involving their family GP in their personal problems.

Ultimately, I believe that there needs to be leeway for the beaurocracy and the mental health system to respect a patient's choice to not disclose their mental abnormalities to their GP; and that each mental health service/support must be accessable without a GP's involvement.

[78] e.g. The Medicare discounts described in the previous sections (pgs. 74 - 76).

Forcing people to complicate their relationship with their GP in these ways makes many patients reluctant to access such services, and may ultimately cause them to delay, or outright avoid accessing help they desperately need.

Calls to Increase the Amount of Medicare Discounts for Therapy

Over the past few months I have read numerous statements from various people and organizations calling upon the government to increase the amount of discounted therapy sessions they can get through Medicare.

While I won't disagree with these peoples' requests, I would like to point out that there's another side to the argument.

For people trapped in bad therapy situations, as I once was, 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 or tripled the amount of discounted sessions per year from 10 to 20, or 30 (as many people are currantly calling for), that would've been unbearable!

I understand and respect the calls people are making for more government-discounted therapy sessions - calls which are no doubt being made entirely from the point of view of therapists, and patients who have had beneficial therapy experiences. But the government must remain mindful that there is another side to this issue.

Before the government makes any increase to the amount of discounted therapy sessions it offers to patients, I strongly believe that the entire Medicare therapy discount program needs to be overhauled, so that it offers patients easy, convincing and secure escape routes from bad therapy situation.

BROADER SOCIETAL PROBLEMS

Australia's inadequate mental health system does not play the only role in the prolonged suffering and poor outcomes that befall many people who experience mental illness, or other severe personal crisises. The entire national community influences the outcomes of people who are in crisis.

Governments, media and the various mental health/anti-suicide organizations[79] across the country play especially significant roles in the modern experience of living with a mental illness or personal crisis.

To briefly summarize, there is much room for improvement in this area.

To a very significant extent, the widespread dissatisfaction with life, of which depression and suicidalness are the most recognizable symptoms, can largely be attributed to a lack of interest in our society in cultivating incentive to live. This is a noticeable shortfall in all levels of our society: government, media, companies, and even at the individual citizen level. Very seldom do any of these entities make deliberate efforts to make life more worthwhile for the community, or to demonstrate that life may indeed have redeeming value.

Instead, all of our priorities seem to lay elsewhere, while we bizarrely maintain this assumption[80] that people will carry themselves as if life is worth enduring, even though nobody[81] is doing anything to make that so.

Additionally, widely-held misconceptions about the mental health system, suicidalness, mental illness, severe real-world problems and other related matters cause the people who are effected by these issues no end of additional grief. Such misconceptions provoke and encourage many attitudes and behaviors throughout the community that ultimately make it more difficult for sufferers to get the help they need, or cause them additional problems. They often also support poor government policies[82] which have undesirable effects on these people's lives. In many cases, such policies may even be a contributing reason for why the person is in crisis in the first place.

The role that community and government, and the forces that influence them[83] play in the lives of mentally ill and anguished people is even more prominent and infinitely more complex then the role of our inadequate mental health system. It would be impractical for me to attempt to offer a complete listing of the many problems that exist in this area.

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[79] e.g. BeyondBlue, Headspace, Lifeline, RUOK, ect.
[80] As well as a culturally-inflicted expectation that it is highly taboo to violate.
[81] Or, to be more accurate, very, very few people. A terribly inadequate proportion of the national landscape.
[82] Often by handicapping, or oppressing opposition to these policies.
[83] e.g. Mental health/anti-suicide organizations, media, ect.

So it is my intention, with this section of the submission, to merely offer you some valuable insight into **some** of the most significant community failings, in regard to mental health & suicidalness.

No doubt other citizens impacted by the issues not addressed herein will be in contact with you as well. I hope you give their input all due considderation, just as I hope you considder the matters I raise in this section.

Many of the concerns I refer to ahead may present difficulties for you, in that they may seem like matters that are none of the government's business. Some may seem like matters that exist outside of this inquiry's scope of examination, which might prompt questions about whether or not this is the correct time and place to raise such concerns.

But I cannot stress enough how all of these matters **must** be addressed, if you have any serious interest in reducing the prevalence of depression, suicide, and similar fates.

For many of these issues, particularly the broad cultural trends and traditions, there is no particular organization, nor individual, who seems to be in a position to address the problem. So if the government won't address these matters, who will? If this inquiry isn't the right time to discuss these matters, when will be?

Some of the issues I will address under this topic apply to all areas of the community, whereas others apply to only certain groups, such as government or the media.

The Poor Recognition of Shortage as Motivation for Suicide

One of the biggest misconceptions clouding our society's modern interest in suicide and suicide prevention is that the relevant question surrounding a suicide or attempted suicide is: *"Why would they want to end their life?"*

For a large portion of these cases, the far more appropriate question is: *"Why wouldn't they?"*

Government, surviving relatives, the media, the mental health system and society in general - they always seem to be scouring for a 'big and bad' element in the person's life that they can deem to be the primary motivation for their suicide.

It is certainly true that often a particularly unpleasant element in a person's life will motivate them to commit (or attempt) suicide. It is also often true that more then one unpleasant element simultaneously serve as a person's motive to commit/attempt suicide. As I hope you will be aware, these unpleasantries come in a great variety of forms.

However, it is equally true that many people commit or attempt suicide not because of a presence of 'badness' in their life, but because of an absence of any 'goodness'.

As with any decision, the decision to continue living essentially rests on balancing the 'pros' against the 'cons'. If the 'cons' outweigh the 'pros', then it's only natural (and logical) that a person will decide against it; which, in this case, means deciding not to live anymore. There are two basic reasons why this might occur. The first being that the 'cons' side of the argument (i.e. bad things about being alive) is particularly heavily weighted. The second being that the 'pros' side of the argument (i.e. good things about life) is extremely light.

As I'm sure you would be aware, even the best lives come with their share petty nuisances. Things like heavy traffic, bills to pay, boring people, obnoxious people, selfish people, minor medical complaints[84], obligatory chores, appliance/vehicle/utility breakdowns, arguments, disapointments, ect.; these are just a handful of examples of the common, everyday factors that add subtle weight **against** the notion that life is worth prolonging.

I suspect that most people would find it mystifying that someone might considder committing suicide *"simply because they always have to pay off their phone bill",* or *"because they have to spend their weekend at a boring seminar"*; as these are minor complaints that most people would be expected to take in their stride. But when that person's life is composed **exclusively** (or practically exclusively) of negative elements - even if they are only minor, or routine negative elements - the case for ending that life becomes surprisingly strong.

Most of us have at least one appliance that requires some form of routine maintainance[85].

Imagine for a moment that you owned an appliance that required you to perform an extensive, tiresome cleaning procedure on it once a day; and yet performed absolutely no beneficial function for you whatsoever. Ask yourself honestly: would you keep such a device? Would you continue to tend to it's maintainance requirements? Or would you simply do away with it?

[84] e.g. Hayfever, arthritis, ect.
[85] e.g. A filter that needs to be routinely cleaned, a waste container that needs to be emptied, cartridges that need to be replaced, ect.

For many suicidal people, this is exactly what life is: a useless 'utility' that requires constant, mildly frustrating 'maintainance', for no redeeming benefit. Subsequently, is it any wonder they wish to be done with it?

I can speak to the truth of this side of suicidalness from personal experience. There is not, nor has there ever been, anything particularly 'bad' in my life. Any tale of woe I might be able to offer utterly pales in comparison to the stories of horrendous abuse or devastating trauma that I've discovered are tragically rife throughout the suicidal and mental illness/recovery communities. Nonetheless, I have long hoped for my life to end, because there has never been anything really **good** about it.

If an outsider wanted to try to understand my suicidal leanings, they would find that asking the question *"What reason does he have to die?"* would not be very enlightening. However, if they asked the question *"What reason does he have to live?"*, I would hope that they would find the silence they got in response to be very telling.

The badness in my life might be tame, all things considdered, but unfortunately, it is the **only** substance that makes up my life. Hence, my life as a whole is a bad ordeal and therefore an undesirable one. Positive outlooks are very difficult (if not impossible) to cultivate when a person has **only** negativity - even mild negativity - to draw upon.

My situation is not an unusual one amongst the suicidal community. Throughout the years I have spoken to many other suicidal people online and a lot of them express a strikingly similar plight to my own. It's not that they have a reason to die driving them to suicide, it's that they have **no reason to live**.

The failure, by **all** major groups who are interested in reducing suicides - government, the mental health system, mental health/anti-suicide organizations[86], major media and even the friends/families of suicidal people - to recognize the importance of the question *"Why would they want to live?"*, severely limits their ability to have a positive effect in this issue.

[86] e.g. [redacted] ect.

Public and Government are Largely Unaware of the Poor Quality of the Mental Health System

The mental health system's shortage of funding, shortage of staff and shortage of resources are all frequently referenced by the media and often addressed by members of our various governments.

However, the deeper flaws with the system's character, which I have addressed in the previous section[87], are largely unrecognized and unspoken of, except amongst the community of patients and former patients of the system who have experienced these flaws firsthand, along with a handful of sympathetic activists and therapists.

On the government level, this lack of awareness is concerning, since it means that our leaders are doing nothing about these major problems, because they are unaware of them. We need our government leaders to take the initiative in fixing these problems, since the system has proven itself unable - or more likely, unwilling[88] - to significantly amend it's attitudes and practices in favor of it's patients.

On the public level, this same lack of awareness is equally concerning, as it leaves Australians with a false sense of security that they have a system that can be relied upon to help themselves, or their friends and family, should they find themselves in a major life crisis. In fact, they are set up for a very rude shock when the time comes that they do need to lean upon that system, only to find that it is either utterly useless[89], or actually makes their problem(s) much, much worse[90].

People of modest means may well be concerned about the oft-reported underfunding of the system. However, I would suggest that they are not nearly concerned enough. They believe that, when in need, they will have to endure an uncomfortable wait of several months before they can get in to see a therapist and get the help they need. In actuality, they will have to endure a several month wait before they can get in to see a therapist who will do absolutely nothing for them. If they are lucky, they may be in for an ordeal of several years, bouncing around between numerous therapists before they might actually meet one who is any good. If they are **un**lucky, their lives may be devastated beyond recovery by a harmful therapist before they have the chance to meet a good one.

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[87] pgs. 30 - 73
[88] See "The System's Ideology is not Overseen by Any Independant Force" (pg. 71)
[89] See "The System's Unwillingness and Inability to Address Real World Problems" (pgs. 36 - 39); "Only a Small Percentage of Therapists Are Effective" (pgs. 40 - 42)
[90] See "Therapists Often Do Psychological Dammage" (pgs. 53 - 62)

People who are more well-off (financially speaking) will likely not be too concerned about the system's poor funding. But they don't realize that their position is not much better then poor people when it comes to mental health care. Even if they can afford to buy several hours of a therapist's time per week, all they will accomplish is to (very expensively) waste their own time, or be subjected to especially constant psychological torment, with only a small fraction of these patients getting any value for money.

This reality ought to scare the crap out of all Australians. But it doesn't, because most of them don't know about it until they, or their loved ones, are saddled with the anguish of severe life problems or mental illness; only to discover that the mental health system that they always assumed was there for them is, in fact, rubbish.

I believe that public vigilance is all but a requirement for a dependable mental health system. An indirect cause of why the system remains so poor in quality is that the public are so unaware of how bad it is, and therefore are not putting pressure on the right people to make it what it needs to be. Because when nobody knows, nobody cares; the people with the power to bring about change remain unmotivated and the system is aloud to linger in it's sorry, inadequate state.

The other major concern about the public's lack of awareness is that it can cause rifts and further grief between people in crisis and well-meaning friends, family members, coworkers, neighbors, ect. who keep pushing them to seek help from the mental health system, without properly understanding how unattractive the system can be to an experienced patient.

Public and Government Don't Respect Their Own Large Role in Mental Health Cases

The general public, and dare I say, probably most members of government, have an incredibly simplistic view of how a person recovers from mental illness or other crisis. They likewise have an incredibly simplistic view of how the world can drive someone to be depressed, anxious, suicidal, ect.

The general perception of how a person's recovery works is that they get fobbed off onto the mental health system and that the system (through it's therapists) and the patient work everything out together. End of problem. End of everybody else's role in the story.

For the sake of argument, let's assume we are talking about an optimal mental health system in this scenario.

Aside from cases of full-time residence in mental health care facilities, the presence of the mental health system in a patient's life is typically tiny compared to the presence of the patient's community - especially family, friends, coworkers and neighbors.

Making progress one hour per week in a therapy session is all well and good, but if the remaining 167 hours of their week are still lingering in a state that fuels the patient's misery, then the patient's chances of remedying their problems will be severely limited. The environment that the patient lives in is a huge factor in remedying major life crisises and mental illness. These environments are shaped by the people around them, and to a lesser extent, government and the media.

So it cannot fall on the mental health system alone to 'fix' the lives of these patients, when it is the friends, family, employers, and community around the patient who chiefly define how the patient's life looks and feels.

The ways in which community impacts a patient's recovery are far too numerous to list. But the most common themes that sour our currant culture in this matter are: lack of respect, lack of uplifting presence, unwillingness to help and exploitation.

Lack of Respect

This is probably the most well-recognized manner in which community attitudes and behaviors impact negatively upon mental health and crisis recovery. That being said, society's general level of understanding in this issue is still poor.

The blight of bullying (including cyber-bullying) has received a fantastic surge in media coverage in recent years, particularly with regard to it's ability to prompt suicide. There is still much work to be done in this area, but we are on the right track.

However, as a society, we must be cautious not to fall into the trap of thinking that the schoolyard or workplace bully, or the insensitive passer-by with her isolated, unkind remark, are the sole major perpertraitors of harmful disrespect.

All too often, it is the people closest to the person in question who are inflicting far more grief upon them with what many would considder to be far 'tamer' attacks. The parent who calmly grumbles that their kid should be *"ashamed"* of the B- grade for science on their report card can have far more devastating effect on the kid then the bully who loudly calls them a *"disgusting, fat tub of lard"* in the schoolyard. The outwardly polite boss, who never listens to the employee's ideas or input, or makes her feel like she's not even in the meeting, can have far more devastating long-term effect on her then the lone scumbag she passes on the street who screams at her to *"go back to whatever chinky country she came from!"*

We have become used to clicking our tongues and shaking our heads when we read the horrendous things that cyber-thugs tweet to the vulnerable, in the wake of a newsworthy suicide story. Yet, as a society, we are yet to stop and take serious notice of the fact that the subtle gestures of disrespect we exhibit are perhaps even more poisonous, and even more to blame for the serious life crisises or mental illnesses that often debilitate people and/or lead them to suicide.

These are just a handful of examples of the many ways in which a person's immediate community can be a major contributor to mental illness or other life crisises:

- Unconstructive, or overwhelmingly broad criticisms of any aspect of a person.
- Frequent subtle passive-aggressive jibes.
- Portraying someone as inadequate, or a 'lesser' person then everyone else.
- Unwillingness to listen to someone.
- Unwillingness to trust someone, or give them the same opportunities to prove themselves afforded to others.

When it comes to recovery, this type of treatment by the patient's community outside of therapy can counter-act the recovery process and minimize or significantly delay the prospects of a decent outcome. Instead of simply battling the patient's crisis or mental illness, the patient and therapist find themselves simultaneously battling the patient's crisis **and** the effects of their unkind peers. The combined load can often be too much to realistically overcome.

Often the nature of the disrespect that has bearing on life crisises or mental illness can't be pinned down to actual words or actions. It is often more of a subtle sense of disrespect that can be conveyed through glances, tone of voice, subtle innuendo or otherwise being treated differently from everyone else, in an unfavorable way. It is the unspoken knowledge that 'X' is the black sheep of the family, the 'loser' in the group, or the 'weird guy' over in the accounting department.

Even disrespect that takes place well away from the person in question will nonetheless have significant impact upon how that person is treated within the community. A person mightn't attend a Sunday brunch where her friends/family gossip about her being a 'trainwreck'. But when people start hearing disrespectful things about someone, they invariably begin to believe those things and before long those perceptions will effect how many elements of the broader community treat that person face-to-face.

All these things are, of course, commonplace aspects of our society. And therein lies the problem. We are all so used to petty family judgementalism and low-key social drama that we don't even think about it carrying as much weight in the suicide/mental illness issue as the explicitly vile tweets we hear about cyberbullies sending to their victims. But it does. And it is often made all the worse by the fact that, unlike bullying, it usually comes from people who are in positions of trust: family members, neighbors and supposed friends. The people we should ideally be able to count on to help us in our hours of need end up becoming more thorns in our side, at the worst possible times.

In order to properly address suicide, major life crisises and mental illness in our society, we need to acknowledge the role that community disrespect plays in holding people back from achieving a worthwhile quality of life.

Thought Shaming

A particular brand of disrespect that many people in crisis know all too well is 'thought shaming'. In essence, this is the practice of telling someone that they *"shouldn't think"* a certain way.

This is perhaps most clearly illustrated in cases of people contemplating suicide, though it is also experienced by people whose thoughts or feelings differ from the norm in many other ways, as well.

The person in question might make it known that they want to die, and may even provide detailed reasons for this desire. The responder will tell them: *"You shouldn't think like that"*, or words to that effect. This reaction only makes the suicidal person's dilemma worse, when the responder fails to provide any meaningful proof to back up their claim that the suicidal person's thinking is 'wrong'.

Far from being a compelling persuasion for the suicidal person to *'think the way they are supposed to'*, thought shaming comes off as an arbitrary attack on their thoughts. This is not merely a case of a civil differance of opinion; it is an attack on the suicidal person's **right** to have their own view, and by extension, the legitimacy of their own character and life experience which have formed this view.

For this reason, the thought shaming becomes a confused message in which the thought shamer simultaneously tells the suicidal person that they want them to remain alive, and that they also want them[91] eliminated.

On one hand, their literal words say: *"I don't want you to die"*, while on the other, their underlying message is: *"The capacity to entertain the notion of suicide is a defect of nature and it should not exist"*. Considdering that this capacity is a defining aspect of the suicidal person themself, you cannot wish to rid the world of the capacity for suicidal thought without wishing to be rid of the suicidal person as well.

Thought shamers likely intend to convey the message: *"I care about you"* when they attack a suicidal person's mindset.

However, more often then not, the message the suicidal person actually receives is: *"I don't care about you. Your too broken to genuinely respect. But I do care about your body; it's a valuable resource and I find it's features familiar and comforting. So what I would really like is to put a new, improved personality in that body. One that thinks and behaves in line with my values; a person who is incapable of seriously contemplating suicide. In other words, a person who isn't like you."*

Sometimes, thought shaming behavior extends beyond the initial responder, as more and more people in the suicidal person's community come to learn of their suicidal thoughts. This essentially magnifies the suicidal person's sense of persecution.

The way that individuals react to this knowledge will, of course, vary greatly from person to person. But regardless of whether people begin to give the suicidal person the cold shoulder, or whether they become aggressively coercive, the underlying climate of their relationship with others remains the same. In essence, the suicidal person is violating some social taboo by thinking the thoughts they do. They ought to feel 'wrong'[92] for having these thoughts (no matter how grounded in logic and thorough reasoning they may be), and the onus is on them to do away with these 'wrong' thoughts.

Under these circumstances, the person's community becomes less of a support network for the person in need, and more like their jailers.

Though it may be based in a seemingly honorable intention to *'show the suicidal person the error of their ways'*, thought shaming only adds to the suicidal person's troubles by giving them an enemy who wants to attack them and their ability to reason.

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[91] In the sense of the life experiences, values, way of thinking, ect. which makes them *'them'*.

[92] N.B. Though suicidal people are pressured to feel 'wrong' for having suicidal thoughts, it will often be emphasized to them that they shouldn't feel **guilty** about having those thoughts. Many anti-suicide organizations advocate against making suicide people feel guilty for their desires, as it is the stance of these organizations that the suicidal people are the innocent victims of a mental illness which they cannot help.

Lack of Uplifting Presence

As noted in a previous section[93], often the primary reason for a person's depression or suicidalness is the fact that they have nothing good in their life, or that the meager amount of goodness in their life does not balance out the ordinary negative elements, or 'cost' of living.

Most people's experience of life is primarily defined by the people in their life - their community - and especially their close community: made up of their friends, family, coworkers, sports teammates and anyone else they spend a significant amount of time with.

So when the people around someone buy and large do not contribute anything uplifting or enjoyable to that person's life, they become a significant factor in that person's risk of becoming depressed or suicidal due to an absence of goodness in their life.

We are all part of the landscape that the people in our community must look upon. We are each a part of life, as they percieve it. So it stands to reason that if we are to expect these people to prefer to continue experiencing life as opposed to ending that experience[94], then we each have some measure of duty to make life an enjoyable experience to behold.

Yet unfortunately, our society has a very strong culture of passing the buck when it comes to making life worthwhile. People often relate the attitude that *"It's not my job to make X happy"*, or *"...to make X's life worthwhile"*.

While on the individual level this attitude usually has very little impact on people's quality of life, when a person's environment is composed entirely of people holding this attitude, it becomes a serious problem.

We as a society are very quick to condemn the process of contemplating suicide. We profess extreme concern about the amount of depression in our country. Yet in spite of this, most Australians show little to no interest in making the lives of those around them more enjoyable. We do nothing to incentivise our neighbors to stay alive, then have the gall to defame them or belittle their sanity when they choose to end their lives, in order to escape the barren, joyless landscape that we helped to create.

Society and government **needs** to understand that, to suicidal people, this comes off as extreme hypocrasy - unintentional as it may be.

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[93] "The Poor Recognition of Shortage as Motivation for Suicide" (pgs. 81 - 83)
[94] i.e. By committing suicide.

For many suicidal people, while they feign 'normalcy', the people around them offer no substantial demonstration that life is worth prolonging. Yet the second they demonstrate a desire to end their own life, those very same people start protesting in the strongest terms that committing suicide is *"the wrong thing to do"* - typically without offering any actual evidance to support this position.

It is, frankly, absurd that people expect kneejerk statements like this to carry more weight in the eyes of a suicidal person, then the thousands upon thousands of hours they've spent observing those same people. If life really is worth prolonging, then why doesn't the suicidal person see any evidance of that in the countless hours they spend with these people, previous to making their suicidal intentions known?

An important distinction that must be made at this point is that there is a major differance between giving someone **a means** to survive (e.g. by serving them a meal) and giving someone **an incentive** to survive (e.g. by making them laugh or smile).

Our society is reasonably good at offering the first one to people who need it, but we tend to trivialize the second, or confuse it with the first. This oversight causes a lot of anguish and contributes to suicide. It is a mistake for well-wishers to believe that assuring someone has 3 square meals a day and a roof over their head will guarantee that they'll be alright, as the means to prolong their life may well be worthless to that person if that life is joyless and undesirable.

Another important thing to note is that when a community fails to provide uplifting life experiences to it's members, it not only leaves those people starved for personal joy, it also leaves them starved for **hope** that they will be able to do any good with their own lives.

A person's hope of achieving any given goal is directly proportionate to the amount of people they know who have achieved the same thing, or something similar. The fewer people who have accomplished something, the less feasable the task seems.[95] Thus, when a person knows few people, if anyone, who makes a significant positive contribution to life, the notion that they themselves will be able to make any significant contribution to their community seems less 'doable'. The challenge begins to seem overwhelming. As a result, they become less motivated to even attempt to make the world a better place.

This, in turn, makes the state of the overall community even worse, as there is now one less person striving to make it worth living in.

It also has the follow-on effect of making the person in question feel worthless, and therefore compounds their likelihood of being depressed or suicidal.

[95] In other words, seeing that someone else has accomplished a feat proves that that particular feat is indeed humanly possible; which is an immensely encouraging piece of knowledge for someone who wishes to attempt the same sort of feat.

The role that all levels of government play in this issue is particularly relevant. The law, which is set and maintained by government, defines the scope of what people are (legally) capable of doing, while less binding government initiatives and policy shapes what people will have a tendency to do. Government policy is a huge factor in defining the look and feel of the society we live in and therefore, in essence, what life itself is, for each and every Australian.

Unfortunately, our successive governments seem to be preoccupied with their financial economy, and making people smarter, at the expense of cultivating everyday happiness in the lives of their citizens. This agenda steers the country in a direction where the people all around us may have more money, and may talk and behave smart, but are not fun to be around - largely because they are too preoccupied with being consistantly profitable and smart to naturally do anything enjoyable. They are good at making money, good at racking up their tally of 'smart' decisions, and utterly hopeless at making the people who are aware of them laugh and smile with any meaningful frequency. Their 'accomplishments' are materialistically valuable, yet emotionally and spiritually worthless.

Every year, this effect becomes more and more apparent.

And while the government prides itself on the growing profit margin of it's workforce, or the 'educational prestige'/'brain power' of the same, it overlooks the growing crisis that all these people surrounded by smart, profitable coworkers, neighbors, friends and family members, have few people, if anybody, in their life who give them happiness. It utterly ignores the fact that financial gain and academic prestige is useless to such people, when their lives become so joyless they have no reason to prolong them.

What use is a stable paycheck that insures our capacity to survive, if we have **no reason** to survive? This supremely important question is central to a successful society, and the government ignores it in virtually every aspect of it's policymaking.

Perhaps most concerning of all is government policy regarding public services that have shown a tendency to be naturally depressing to their communities, such as emergency services and healthcare.

Governments seem to take frequent interest in addressing lack of resources in these departments, and in trying to make these workforces smarter/more extensively trained. However, it shows little if any interest in addressing the depressing/upsetting presence these departments have upon the broader community. Little, if any, noteworthy considderation seems to ever be given to the question of how the exploits of these departments can be made more enjoyable to the general community who witnesses them, or otherwise comes to know about them.

It is concerning that the capacity of these services to make the general public happier is so overlooked, considdering that, when they do become involved in people’s lives, their presence is typically a big deal for that person, and/or their friends, family, ect. In fact, it can often be a life-changing, if not life-defining event.

When an exploit of one of these departments becomes newsworthy, it often lingers in the forefront of the national consciousness and can have a massive effect on how all Australians percieve their society, and therefore how they feel about life itself.

In a nutshell, depressing public services make for a more depressed country.

Unwillingness to Help

Most Australians are well aware that most people in crisis, including those battling mental illness, can't overcome their difficulties all by themselves and therefore need help.

However, a major misconception amongst the general public is that it is the duty of the mental health system alone to provide this help. In actuality, there are many, many aspects of crisis recovery that our currant mental health system simply isn't set up to assist with[96]. For that reason, patients often need a great deal of help from **their community** and, in particular, those closest to them, in order to overcome their problems.

Unfortunately, a mixture of the classic Australian *"she'll be right, mate"* attitude and the mistaken belief that the mental health system will take care of these needs in the patient's life result in the average friend, family member, coworker, ect. being unwilling to step up and offer the assistance needed. Most are more inclined to just sit back, assuming that the situation will sort itself out one way or another.

These attitudes result in many patients missing out on crucial real-world support they need to make their lives worthwhile.

For example, patients may need help in finding and being set up with a potential romantic partner, or in making meaningful plutonic friendships. They may need help getting a job - or in particular, a job that can adequately offer them a quality of life[97] that is worth prolonging. Or they may need help in being relocated to a new permanent residence that offers a more agreeable environment for them to live in.

Currantly, the mental health system offers none of these important services for people desperately in need of them. So, unfortunately, people who need assistance such as this just have to take pot luck that their friends, family, neighbors, teachers or coworkers will be compassionate enough to offer it to them. In too many cases, they are not. Of course, in many other cases, the person in question has no family, friends, ect. to offer this assistance in the first place.

In addition to assisting someone with their major life issues, there are also often many opportunities to provide small-scale gestures of assistance to people in crisis, which frequently go overlooked. For example, a 'helper' might be able to publically support a person-in-need in a social situation by offering them support and solidarity in an interaction with others. Or they might be able to act as a buffer between the person in need and someone or something known to be distressing to them.

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[96] See "The System's Unwillingness and Inability to Address Real World Problems" (pgs. 36 - 39)

[97] Note: the effect of employment on quality of life is not limited to the amount of money it pays, though this is a factor. The nature of the work that the person does, the relationship they have with their coworkers and the social opportunities that the job offers the employee are just some examples of the other important ways that a person's job effects their quality of life.

With therapy typically being confined to the therapist’s office, the mental health system simply can’t provide real-time assistance to a patient when they encounter such difficulties in their daily lives. So it falls to noble members of the community - ideally those who know the patient well enough to understand their predicament and what outcome(s) they desire - to assist the patient when these small-scale problems arise.

It would be unfair to say that any one person or group are obligated to provide this much-needed help to their friends/family members, ect. Such tasks can indeed be quite a burden for the person who performs them.

That being said, I believe that the widespread misconceptions and attitudes about the community’s role in a person’s recovery from major crisises and mental illness are a significant handicap to their prospects for a successful recovery. In short, if the community were more inclined to be helpful, I believe that that much-needed help would come from somewhere or other, more often then not.

It often escapes the broader community that a few hours or days of their own personal inconvienience can make a lifetime of differance for a person in crisis. It can mean the difference between a life that isn’t worth prolonging and a life that is.

Exploitation

Unfortunately, while they are in the midst of battling a severe life crisis or mental illness, many people find themselves having to grapple with people who wish to exploit them in their time of greatest need. Sometimes, a person will recognize an attempt to exploit them quickly and be able to avoid it relatively smoothly. However, on other occasions, an instance of exploitation may have already done significant dammage to the victim's recovery before they 'wake up' to the fact that they are being manipulated against their own best interests.

What needs to be understood with this issue is that people who are in crisis: people who's lives are so abysmal that they would rather die then continue living in their present circumstances, are **absolutely desperate** to escape their plight. This makes them far more inclined to obey any directions that are implied to be a route to a better life for them, or earn favor with someone who may be able to help them, just on the off chance that things might work out to their benefit. Very often, even their own common sense or instincts will tell them that obeying the other person will ultimately be a disservice to themself; yet they will still follow through out of sheer desperation for a remedy.

People in crisis are very easy prey for those who want to use them.

Falling prey to exploitation can be especially harmful for people in crisis. In addition to the natural problems that the exploitation itself presents, it will also often undermine the victim's faith in their community, humanity and their prospects for a brighter future.

Many people in crisis already have trust issues, or difficulties connecting with the rest of the world. In fact, problems like this are often the reason they are depressed. So for a member of their community to exploit them in their time of great need, it is a huge setback for their prospects of being able to connect with other people and offer them their trust and genuine friendship.

This is all the more dammaging when the exploiter is someone close to the victim; someone the victim **should** have been able to trust to respect them and assist them in their hour of need.

Exploitation of people in crisis and the mentally ill can be divided into two general categories: self-serving and ideological.

Self-serving exploitation occurs when someone requests or demands that the mentally ill/person in crisis do a favor for them, with some implication that it will ultimately result in a significant improvement to the person's plight.

The implication may be that the deed itself[98] will deliver some benefit to the person performing it, or it may be that the 'reciever'[99] will repay the favor later on, by helping the person remedy their crisis. Of course, in cases of exploitation, this repayment is either never delivered, or is woefully less substantial then it was implied to be.

Ideological exploitation occurs when the person's crisis is blamed upon some aspect of themselves, such as their sexual orientation, religion or career path, by someone who disagrees with that element of their character and wishes to coerce the sufferer into changing their ways so that they are aligned with the exploiter's beliefs or preferences.

A common example is people of one religious persuasion being told by someone of a differant persuasion, that their woes are a product of them *"turning away from the righteous path"* of the second person's god(s). The implication being that if the sufferer converts to the exploiter's religion, their problems will be solved via 'devine intervention'.

Another common example is where LGBT people experiencing relationship difficulties have those difficulties blamed on their sexual orientation. The implication being that only straight sexual/romantic relationships are capable of succeeding, and that therefore the sufferer needs to 'convert' to heterosexuality, in order to have any hope of having a happy relationship.

Exploitative interactions are very often cloaked in vaguery, so that the victim is less likely to recognise the arrangement for what it is until they've already been preyed upon.

Very rarely will an exploiter clearly say: *"If you do 'A' for me, then I will do 'B' for you..."*, or *"So you want to accomplish 'A'? I know how you can do that! You do 'B', 'C' and 'D', and that causes 'A' to happen."*

Instead, the arrangements are usually made via vague, non-binding innuendos. A typical format of such interactions is: *"So you want to accomplish 'A'? You need to do 'B'."* Similarly: *"You'll never accomplish 'A' if you don't do 'B'."* Note how both of these statements imply that 'B' is a route to 'A', while failing to explicitly assure that accomplishing 'B' produces a reasonable increase in the likelihood of 'A' occurring.

In reality, the performance of 'B' usually never has any significant impact upon the likelihood of 'A' occurring. Taken literally, the exploiters' statements don't contradict this. However, it is reasonable to assume that they will be interpreted as suggesting that doing 'B' will lead to 'A'.

[98] i.e. The favor they are to perform.
[99] i.e. The exploiter.

This gap between implication and literal interpretation often causes conflict between exploiters and the victims when the victim discovers that their efforts towards the useless objective 'B' will not ultimately assist them in their struggle to accomplish 'A'.

A key identifier of exploitation that many people in crisis (including mentally ill) are all too familiar with is when a suspected exploiter is delighted that we have served the ends that they have layed out for us (i.e. objective 'B'), yet are utterly indifferant to the fact that we are no closer to our own goal (objective 'A') as a result of those efforts.

Obediance Through Duress

The consequences a person experiences when they refuse to submit to exploitation vary. Sometimes the only consequence for refusing to submit to the exploitation is that the person in crisis is left to linger in their plight. The exploiter(s) will often criticize the person in need and tell them that they are to blame for their plight, due to the fact that they have refused the exploiters' involvement in the situation.

Other times, exploiters may respond more aggressively. For example, they may take steps to make the person's crisis even more severe. Or they may socially 'blacklist' the person in crisis, e.g. by spreading an unflattering portrayal of their crisis/mental illness that is designed to make the person an outcast or 'creepy weirdo'.

Tactics like these are extremely persuasive, as the person in crisis is already struggling with their existing burdens and cannot afford to have their plight worsened, or their avenues of possible support sabotaged. Hence, it is no wonder that many people who wish to exploit those in need decide to use such tactics.

While exploitation of people in crisis is **never** justified, and is especially deplorable when it is enforced by threats or intimidation, there are especially tragic situations where an exploiter might deal out their punishments when the victim is incapable of serving the exploiter on a sustainable basis. The exploiters will 'lash their whips', so to speak, expecting that it will provoke the fallen victim to get back up and get back to work. However, when someone is paralyzed by sheer emotional exhaustion, pain can neither heal them nor motivate them, because they have nothing left to give.

The exploiters, carelessly assuming that their victims are merely being stubborn, will then proceed to punish them, when there is nothing agreeable to be gained, **for anybody**, out of this cruel behavior.

Gaps in the Public Forum for Discussion of Mental Illness, Suicide and Related Issues

As a society, we are now discussing mental illness, suicide and many related issues more then ever before. This is, of course, a good thing. Such discussions are an important first step towards amended government policies, public attitudes and other initiatives that will be beneficial to all.

However, the effectiveness of these discussions depends on the completeness of the input that is provided to them. If our community and our leaders aren't being fully enlightened to the plight of the suicidal, mentally ill and others experiencing major life crisises, how will they know what aid they need to provide, and where they need to provide it? If they are not fully informed about the state of our mental health system, how will they ever be able to address it's flaws?

Unfortunately, this discussion does not take place in a balanced arena. There are numerous factors that deter the 'smaller' voices from contributing to the discussion, and/or prevent them from being heard in any meaningful way. At the same time, influential presences - such as well funded mental health & anti-suicide groups[100], and prestigeous therapists & 'experts' - continue to push their own 'company lines'.

Whether by design or not, the national conversation is an environment where numerous important facts, ideas and testimonies are quietly buried because they are contrary to the reigning mindset. The people running the conversation seem to have preconceived notions about what they do and don't want the rest of the world to hear, and are doing their best to make sure the conversation sticks to this script.

Some of the more important, yet all too inconvienient ideas that apparently have no place in the conversation include:

- Seeking therapy comes with significant risk - due to the widespread uselessness of therapists (despite their universal expensiveness), not to mention the significant risk of them causing the patient severe dammage[101]. In fact, for many people, their best option may be to avoid therapy altogether.
- The numerous compelling, well-reasoned and thoroughly explored justifications for suicide, which suicidal people have extensive first-hand experience in. In short, the notion that suicide may indeed be the best course of action available to someone, depending on their circumstances and needs.
- Faults in the stance, reasoning, agenda, practices or priorities of the mental health system[102], or more broadly, our entire national interest in mental health and suicide prevention.

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[100] e.g. [redacted]
[101] See "The Poor Quality of Care - Therapists" (pgs. 40 - 62)
[102] See "The System's Ideology is Poorly Supported" (pgs. 63 - 70)

Not only does absence of these important matters in the national conversation prevent them from being explored and ultimately remedied, it also alienates the many people who are intimately familiar with one or more of these problems. It conveys a message that the world isn't really interested in helping them, or fixing the broken system that let them down; it is only really interested in maintaining it's existing framework and luring in as many people as possible to follow it's ideology.

A couple of points that need to be clarified before I go any further:

Firstly, pretty much every given issue and minority position is being discussed somewhere. There are even places where the legitimacy/rationality of suicide can be discussed openly and freely by, and amongst, suicidal people. The problem is that these issues and points of view aren't given a high enough profile to have a meaningful impact on our communities and government policy. In essence, the people effected by these issues are just talking amongst themselves, when what they really need is for the wider world to take notice of what they have to say, so these issues can be properly addressed.

Secondly, the state of the national mental health/suicide prevention conversation does seem to be improving.

In the past 12 months or so, many of the controversial issues and points-of-view seem to have gone from being dead silent to being quiet whispers in the breeze. However, the presence of these voices is still too obscure for the masses to recognize them. Any positive change that may be occurring seems to be happening far too slowly. People who are suffering under a poor mental health care framework today shouldn't have to wait a generation before it's leaders begin to admit that there *may* be major foundational problems with it.

The following sub-topics elaborate on the more notable stumbling blocks that prevent our national dialog from forming a complete and adequate picture of the currant state of affairs, with regard to mental health, suicide and related matters.

Commentary That Paints the Mental Health System in a Negative Light is Unwelcome

The prevailing trend in the national mental health conversation holds a view that the mental health system must be portrayed as the saving grace for people in crisis, and that such people must be bombarded with urgings to seek the system's help.

Unfortunately, patients who have been through the system and discovered it to be a hazard, rather then the invaluable assistance it is made out to be, become very inconvienient to the people who hold this attitude. Consequently, there is currantly no place at the table for them in the mental health conversation; there is no room for their input.

Exceptions are made, of course, for those who are critical of the system's shortcomings which can be attributed to poor funding or lack of resources. Their commentary and critical soundbytes aimed at the governments' budgetmasters are more then welcome.

However, viewpoints which suggest there are faults in the integrity, priorities, practices or ideology of the mental health system, are not.

If you say: *"The mental health system does good work. I just can't access it enough"*, or: *"...I can't access it when I need it"*, you are applauded and maybe even quoted on the homepage of this or that mental health/suicide prevention organization. If you say: *"The mental health system is terrible! I wish I'd never gone anywhere near it!"*, you will be diplomatically 'managed', as if you are a difficult customer causing a scene in a supermarket.

There is an abundance of compassion in the mental health conversation, so people who have been hurt or let down by the system won't be told outright that their alternative point of view is unwelcome.

However, far from rallying people to push for change, making a productive impact and helping to insure that no one else in the future has to suffer the same nightmare they've endured, a person who criticizes the system typically encounters a 'defuse and contain'-style of response. I have had it happen to me. I have seen it happen to many others who have reported that their dealings with the system left them much worse off.

Such responses virtually always begin with the phrase: *"I am/We are sorry to hear you found your treatment unhelpful."*

"Unhelpful" - that is the word they always use. When someone recounts an experience of a therapist compellingly demonstrating that life contains no significant goodness or hope[103], calling that therapy 'unhelpful' is the understatement of the millennium.

Yet this downplaying of the hazardous aspect of modern mental health treatment is deliberate and very characteristic of the way the system's critics are regarded. Nobody wants to make them feel rejected. But at the same time, the people/organizations[104] dominating the national conversation are desperate to prevent word getting out that the system may not be as wonderful as they make it out to be. They don't want naieve people who haven't personally experienced the system to know that there are significant risks associated with therapy, because discovering risks means having second thoughts, and second thoughts means the person might decide against turning to the mental health system. And the people guiding the national conversation on this subject are **fixated** on steering people in crisis to go into the system. It is the best place for them, as far as they are concerned; despite what a great many former patients may say.

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[103] e.g. See "My Own Personal Experience" (pgs. 58 - 62)
[104] e.g. [redacted]

To this end, further dialog with critics of the system tend to shift focus from the real negatives the critic has addressed to hyperthetical positives. A typical format is *"if you just keep going back to therapy over and over again, eventually you'll strike a therapist who will give you the help you need."*[105]

Problems with this advice, such as the significant financial, time and emotional cost of rolling through an indefinite series of therapists; the peril of enduring an untreated crisis while outwardly appearing to be treated by a therapist who is, in actuality, useless[106]; not to mention the very real risk of suffering psychological harm at the hands of a particularly bad therapist[107], tend to be ignored or trivialized. They are very deliberate efforts to shape the overall conversation so that other listeners will ultimately walk away only remembering the idealized picture of the mental health system, and scarcely be moved by the unpleasant aspects that were brought up.

Case in point: a video[108] uploaded in May last year, by a very popular Youtube personality, JackSepticEye.

The video is a recording of JackSepticEye playing through a small, independantly-made videogame called "You Left Me", which is intended to relate the experience of someone going through depression and suicidalness. The game is presented in a somewhat abstract style which leaves much of it's message open to interpretation.

There comes a point[109] where the protagonist of the game visits what appears to be a stylized representation of a mental health therapist. The encounter goes poorly, with the therapist implied to be useless and uncaring of the protagonist's plight.

Personally, I found the game's depiction of the mental health system in this segment to be refreshingly accurate. Much of what the protagonist experiences in that encounter was strikingly similar to experiences I myself had in therapy. It is also very much in line with accounts from countless other patients/former patients about their therapy experiences, which I have encountered in various online communities.

However, following this encounter, JackSepticEye's enthusiasm for the game is noticeably shaken and he soon after decides not to explore any more of it's numerous, branching storylines.

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[105] e.g. An example I personally experienced, recounted on pg. 42.
[106] See "Only a Small Percentage of Therapists Are Effective" (pgs. 40 - 42)
[107] See "Therapists Often Do Psychological Dammage" (pgs. 53 - 62)
[108] http://www.youtube.com/watch?v=lOcIb9GKQG8
[109] http://www.youtube.com/watch?v=lOcIb9GKQG8&t=12m48s

In a lengthy commentary he delivers at the end of the video, he specifically points to the therapist scene as a reason why he has chosen to stop playing the game, and is critical of the game's unflattering depiction of therapy[110]. He then goes on to gloss over the game's own message, with a speech about how therapy and medication are beneficial for many people.

While his commentary on the subject is, admittedly, a lot more fair and balanced then most other peoples' would be[111], his intention seems to be to bury the game's own message beneath the more mainstream stance that therapy is good. In other words, he doesn't seem to give both sides of the issue[112] equal weight.

He seems to imply that the game developer did something wrong by making an artistic statement about the dangerous inadequacies of therapy - a statement that accurately reflects the real life experience of many, many people.

This is quite typical of the community attitude towards therapy critics. While many people are aware of the existence of people who have been let down or hurt by their therapy experiences, they disapprove of these people speaking their piece. Apparently we are all expected to just sit in silence.

It should be noted that JackSepticEye does not pretend to be an authority on mental health matters. But due to his immense popularity, his voice carries a lot of weight and the sad truth is that people will generally take more notice of his input into mental health system issues then they will take of the input from someone who has actually suffered through an appalling treatment experience.

I suspect that far more of his subscribers will have developed an unfavourable view of people who dare to speak frank, legitimate, honest criticism of the system as a result of this video, then those who will have developed an interest/concern about the possibility of the mental health system being inadequate, in response to the game's suggestions to this effect.

Likewise, the game's apparent intended purpose - to offer the general community some insight into the plight of suicidal/depressed people - ended up getting lost in the politics. The fact that a suicidalness/depression crisis often entails dealing with frustratingly useless therapists is, apparently, too controversial to publically disclose. It would seem that we are apparently supposed to keep this to ourselves, so it can remain a mystery to our community, government and loved ones.

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[110] http://www.youtube.com/watch?v=lOcIb9GKQG8&t=21m18s
[111] e.g. He admits that medication can sometimes make patient's situations worse.
[112] i.e. That some people benefit from therapy and some people are hindered by it.

This culture of politely sweeping the system's critics under the rug at the ground-level of the national conversation[113] equates to an absolute silence regarding the potential hazardousness of the system and it's therapists, at the major media level.

Each and every major media segment/article that touches on any subject related to mental illness or suicide now ends with the standard footnote: *"If you are in crisis, seek professional help"*[114]. However **none** of the major media outlets acknowledge or explore the countless cases that raise the possibility that the professional 'help' that is currantly available may in fact be toxic for many, rather then beneficial.

Of course, few would expect the major media to condemn the entire industry, as many patients/former patients will testify that it does do some good work.

But the media's complete ignorance of the problems with the system, even if they were very small-scale problems, would seem to be an affront to good journalism. Problems with the mental health system are most definitely in the public interest.

In fact, the mental health system would have to be about the only industry for which the major media doesn't run investigations into it's bad eggs, toxic cultural issues and practices, or prevalence of it's clientelle suffering immense heartache through their dealings with them.

The typically bold, brazen media - who will take on prime ministers and presidants when they have cause to do so - are uncharacteristically timid when it comes to addressing the issue of hazardous mental health treatment. They have been so heavily conditioned to push this message that *"the mental health system is the saving grace for people in crisis, so go get help from them right now!"*, that they refuse to give the mental health system fair and balanced coverage. They keep silent regarding the severe flaws of the system, under the excuse that discussing the system in a negative light is "unhelpful" to the national mental health conversation.

Raising doubts in the minds of people in crisis about the quality of the system is "unhelpful", so these media outlets would claim, because without question, the best place for those people is in the mental health system. Yet how can the media maintain this position with such certainty, when they haven't actually investigated the extent and prevalence of harm done by the mental health system? How can you maintain that *"therapy is the best place for someone"*, when you have done no investigation whatsoever into the actual quality of modern therapy?

[113] i.e. Where average members of the public are just talking to average members of the public. Comment threads on facebook posts, pub conversations, ect.
[114] Or words to that effect.

This massive blind spot in the national media coverage of mental illness/suicide comes across as an injustice and a betrayal to those among us who have suffered at the hands of the mental health system. It robs the entire national conversation on these topics of it's integrity, because the conversation's leaders refuse to acknowledge the full story. We find that we can no longer trust the coverage we see on these issues, because the coverage is skewed to support only pre-approved viewpoints, rather then frank accounts from all sides. Australia's media is not the mentally ill Australian's media.

At this point, I would like to remind you that loneliness and isolation is a **huge** component of the distress that many mentally ill and people in crisis endure. What could be more lonely and isolating then living in a culture that refuses to listen to you when you want to speak about how you were terribly harmed when you reached out for help?

The lack of awareness of the potential hazards of therapy also prevents thousands of naieve first-time patients of the system from being adequately prepared to evade or defuse those hazards when they encounter them.

Patients hearing only the *"therapy will help you"* side of the argument wander in to therapy blindly expecting the best. They go in with no escape plan to get out of useless or harmful therapy, as they haven't even considdered they might need one. The end result being that they can find themselves stuck in these situations for months or years, because they have no way out.

This lack of awareness also increases the risks of therapy being harmful, as patients are poorly warned about the risks of lowering their defences. Patients in severe crisis tend to be desperate for a therapist to help them and blindly optimistic that they will do just that. This often leads them to be absolutely open and honest in the early stages of therapy, disclosing very intimate matters and points of vulnerability that they would normally keep shielded from a complete stranger. This often proves to be a disastrous gamble as, in cases of harmful therapy, the therapist will often use these intimate details against the patient.

Worst of all, though, the culture of enforced silence about the faults of the system means that our leaders - the people who actually have the power to correct the problems in question - are completely deaf to the grief that the system and it's therapists cause. They can't get to work fixing the problems that the patients have encountered because they can't hear the patients' statements!

The message *"Mental health treatment is often harmful"* has, for a long time, existed as thousands of obscure spot-fires in the mainstream mental health conversation, rather then as a single, massive, recognizable movement. Although I must admit that, over recent months, I have begun to get the impression that this is changing.

However, I am yet to see evidance that this stance is widely recognized by the general population, or being duely acknowledged by the key players in the conversation, including major media. I can't help but feel this is a deliberate stance from these organizations, who do not want awareness of harmful therapy to flourish and become a valued, respected element of the broader conversation.

It is essential that people who wish to address the appalling flaws with the mental health system be widely recognized as valid and valued contributors to the conversation, so that the severe problems they are so intimately familiar with can be brought out of the shadows and finally addressed by the people with the power to fix them.

The "Too Hard" Basket

Most mental health/anti-suicide organizations are aware of the many faults with the mental health system and the hazards it poses to it's patients. However, they abstain from seriously addressing the system's poor quality, apparently due to the fact that campaigning for an adequate (or better) system is too big a challenge.

While reforming the mental health system will indeed be an enormous challenge, it is not as if anyone expects any of these mental health organizations to fix the system all by themself, or even to do the lion's share of the work.

First and foremost, these organizations could at least use their already prominent platforms to simply raise awareness of the horrendous quality of care in our currant system. This alone would be an enormous step towards improving the system. The effort & financial cost it would require from these organizations would be minimal.

All the same, the organizations and their spokespeople have little interest in getting involved in this enormous task, even in a small role.

When they respond frankly to other people's commentary on the poor/hazardous quality of the system, their responses will often be something like: *"Yes, the system has problems. But it's what we have to work with. So rather then just sitting around complaining about it, we need to soldier on and make the most of what we have, broken as it may be."* I have personally encountered statements similar to this several times, in response to my mentioning of my own disastrous experience in therapy, on various mental health organization websites.

While I can appreciate the merit in encouraging a pro-active attitude towards recovery to a person in crisis, the "no point in complaining" message only strengthens the culture of silence which allows the system's horrendous flaws to continue unaddressed.

Raising awareness of the appalling quality of our treatment and pursuing our own recovery aren't mutually exclusive tasks. A patient may be capable of doing both. And if patients are capable of pursuing both these goals simultaneously, why can't the major organizations that are supposedly set up to advocate for them do the same?

The "Sacrificial Lamb" Philosophy

Another common justification used for the downplaying of criticism of the mental health system is a 'sacrificial lamb'-style philosophy.

Simply put, this philosophy suggests that the anguish suffered by patients who receive inadequate or harmful care from the mental health system is an acceptable price to pay for the benefit that **other** patients supposedly receive from the system.

This philosophy discourages the public discussion of therapy in a negative light, specifically to prevent potential future patients of the system from becoming hesitant to use the system. Privately, it acknowledges the harm done by the system's many failings, and therefore the risks posed to the future patients who it seeks to coax into therapy. However, it chooses to wilfully ignore these risks; having no regard for the portion of those patients who will be failed or harmed by the therapy they've been coaxed into, and instead justifying itself solely on the success stories that it produces.

A typical example of 'Sacrificial Lamb Philosophy' is a response like this to some testimony about the anguish a patient has suffered at the hands of the system: *"Yes, okay, sometimes people get hurt in therapy. But doesn't the good it does for others make it better to encourage people to seek help, rather then worry them with horror stories they mightn't even encounter?"*

Of course, although it's primary intention is to keep potential future patients in the dark as to the poor state of the mental health system, it also inadvertently keeps the community and the government in the dark about the exact same problems, by supporting the culture of silence regarding criticism of the system. Thus, this philosophy ultimately only helps to maintain the system's many problems.

But beyond the obstacles it poses to remedying the system's many flaws, this philosophy is morally appalling. It knowingly and heartlessly condemns numerous people to immense turmoil, by silencing all warnings to the danger ahead of them. What makes this so insultingly hypocritical is that this philosophy is usually practiced by people who outwardly advocate for compassion, listening and **help** for the mentally ill and people in crisis.

It shifts the heavy burden of misery from the many to an unlucky few. Even if this were a necessary evil, the lack of any apparent remorse for this sad state of affairs, and the absence of any apparent due process to thoroughly examine the issue and determine that, all things considdered, this is indeed the best, fairest possible practice, makes the legitimacy of this philosophy highly suspect. This lack of justification is an inexcusable disservice to the unfortunates who have to pay for this policy through unbearable emotional anguish.

Perhaps worst of all, this philosophy is completely indifferant to the cruel indignities it's 'sacrificial lambs' typically suffer as a direct result of performing their sacrifice.

When a soldier dies in combat *"for the good of the nation"*, at least he/she is typically shown respect and is honored by their countrymen and women for their noble sacrifice. When a patient commits suicide as a direct result of the mental health system's inadequacy or harmful practices; when a patient is crippled by unbearable sorrow and the judgmental community around them have no clue that the much-touted 'help' that is promised to this person is no help at all, those people are typically treated like 'lesser' human beings, who died because they themselves were broken or faulty.

The blood and tears they all shed for *"the good of the nation"* - or more accurately, for the good of a broken-down mental health system - does not even earn them the simple dignity of the common man, let alone the honor of a martyr.

'Sacrificial Lamb Philosophy' has no sympathy for the people who suffer these fates.

Suicidal People Are Not Aloud to Properly State Their Case or Explain Their Plight

At all levels of the national mental health conversation, productive dialog is severely hindered by the massive restrictions imposed upon the discussion of suicide; not so much by the law, but more by conventions established between the most influential presences in the discussion[115].

The lines of discussion which these dominant presences seek to limit or completely silence include, but are not limited to:

- Demonstrating falsities or logical failings in the currant arguments used to convince people not to commit suicide.
- Criticizing the use of non-binding vagueries[116] to coerce people into making major decisions with potential decades of repercussions[117].
- Presenting compelling arguments as to why another person's suicide was both rational and sensible.[118]
- Arguing that fates worse then death do exist/that many suicidal people may indeed be better off committing suicide rather then abstaining from it.
- Presenting clear, compelling, logically sound proof that your currant state of life and/or likely future is worse then death.[119]
- Questioning the validity and ethical integrity of the anti-suicide agenda, e.g. whether it is right for anti-suicide groups to inflict their ideology on others.
- Questioning the ethical integrity of modern anti-suicide practices, e.g. intruding upon a person's suicide attempt-in-progress and preventing them from completing it.
- Questioning the validity of the assumption that life is better then death; pressing for convincing, impartial proof of this idea.
- Presenting real cases (including personal stories) where abstaining from suicide, or surviving a suicide attempt did not work out well for the survivor.
- Debunking "things will get better/nothing bad lasts forever" statements with real cases of people for who things never got better, even over several decades.
- Criticizing the practice of people who oppose suicide assigning their own value to the emotional fixtures of suicidal people[120].
- Calling out logic holes or mistruths in a statement another person has made to discourage suicide.

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[115] e.g. [redacted]

[116] e.g. *"Things will get better", "There's always a better way"*, ect.

[117] i.e. The decision to abstain from suicide and commit to living out their natural lifespan; which typically amounts to several decades.

[118] Which, in some cases needs to be appreciated, as the community often fixates upon preventing suicides in the aftermath of such cases, at the expense of addressing the situation that drove the person to kill themself.

[119] Often a necessity in order to demonstrate your essential need for help. People will often be unwilling to give you meaningful help, for your actual problem, if they believe your quality of life is acceptable and your problem is trivial.

[120] e.g. By making statements like *"You'll move on", "You don't need it", "Other people manage to live without it"*, or *"It's not worth dying for"*, ect.

The given reason for these restrictions is to prevent other people from contemplating or attempting suicide. It is understandable why certain anti-suicide organizations would hold this viewpoint. The arguments they use to persuade suicidal people to abstain from suicide would likely be less persuasive if the flawed reasoning of those arguments was widely recognized. So it's easy to see how one might assume that restricting the criticism/debunking of anti-suicide doctrine will make suicide prevention efforts more effective and therefore ultimately result in less suicides.

However, this supposed increase in 'safety' comes with some severe costs that largely go unrecognized. Some of the more significant effects, and the negative impacts they have on the issues of suicide, depression, community disconnection and related matters are as follows:

Effect of the Restrictions:	Consequence
They deprive the community and government of a great deal of insight into the motivations behind suicide.	• Government policy and community initiatives geared towards reducing suicide perform poorly, as they are based on a poor understanding of the issues at hand. • Common and widespread issues that provide incentive for suicide go unrecognized and unaddressed by government, community and the media. • Well-meaning attempts to 'help' a depressed/suicidal person by friends/ family/coworkers/ect. are frustratingly ineffective or make things worse, because they do not understand the problem. • Survivors of people who have committed suicide remain mystified as to the reason why their friend/family member/ect. killed themself, which is apparently very distressing.

Effect of the Restrictions:	Consequence
They prevent suicidal people from clearly stating what their dilemma is[121], what specific help they need, and/or why certain forms of 'help' are inappropriate.[122]	• Person can't get access to help with the urgency they require, as the people in the position to help don't understand that their help means the differance between a life that is worth prolonging and a life that ought to be ended. • Person can't communicate their situation clearly to a would-be helper, hindering their ability to accomplish a beneficial outcome together and increasing the likelihood of the helper making numerous inappropriate 'helpful' gestures before stumbling upon a genuinely helpful strategy. • Person's inability to clarify what help they need, especially the **importance**[123] of the help they seek, reduces their likelihood of getting such help. • Person's inability to demonstrate why certain help that has been offered is inappropriate[124] increases the likelihood of the 'helper' bullying them into accepting it, and decreases the odds of the 'helper' offering an alternative, more appropriate form of help. • Person's overall inability to communicate clearly can give off a false impression that they are confused or unable to think clearly. This can lead others to assume they are suffering from some mental defect[125] that is muddling their thinking, which distracts them from the person's **actual** problems and further reducing the likelihood of recieving appropriate help.

[121] i.e. It is taboo to say: *"My situation is 'X', I'd be better off dead then living like this."*

[122] **Clarification:** These speech restrictions do not exist in the therapy environment. However, due to the typical uselessness of the therapy industry (covered in "The System's Unwillingness and Inability to Address Real World Problems", pgs. 36 - 39; and "Only a Small Percentage of Therapists Are Effective", pgs. 40 - 42), sufferers often find they have no option but to turn to the broader community for the help they need. This is where the speech restrictions begin to stifle clear communication and will severely hinder the person's prospects of getting adequate help.

[123] e.g. By stating: *"I need 'X'. A life without 'X' is a life that isn't worth living."*, which is once again regarded as a taboo statement. It is especially taboo to go on to make a compelling argument demonstrating the truth of that statement when it is challenged.

[124] e.g. By stating: *"There's no sense in doing 'X' because it'll just lead me to 'Y'. I'd still be better off dead then getting stuck with 'Y', so there's no point in doing 'X'!"*

[125] Cultural prejudices towards suicidalness mean that many people will automatically assume that the person in need has a mental defect as soon as they reveal that they've been contemplating suicide. Their inability to effectively communicate their situation and needs, due entirely to social constrictions and not muddled thinking, will only serve to reinforce these negative preconceptions about the person.

Effect of the Restrictions:	Consequence
They prevent the suicidal community from effectively disproving inaccuracies and misconceptions about suicide, themselves and other related subjects that are often repeated in the media and other levels of the national mental health conversation.	• The unchecked reinforcement of those inaccuracies and misconceptions cause countless difficulties in suicidal peoples' interactions with others who don't understand the truth. • Suicidal people hear those inaccuracies being repeated and know that many in their community will be swayed by them. This makes interacting with that community feel increasingly like an uphill battle, and subsequently a less desirable experience for the suicidal person. • Suicidal peoples' inability to guide the conversation makes them feel like they aren't truly a part of that conversation, nor the society hosting it. Their sense of loneliness/isolation grows.
They prevent suicidal people from effectively pointing out the inadequacies in the currantly used treatments and arguments against suicide.	• **Suicidal people continue to recognize that the treatments are logically or realistically invalid, even if they aren't aloud to demonstrate these flaws to others.** • Ineffective treatments persist, wasting suicidal peoples' time and undermining their faith in the community's ability or willingness to actually help them. • Suicidal people avoid contact with people who adhere to the classic, though actually invalid approaches towards suicidalness, knowing that they can neither help, nor be argued against[126]. • Hidden factors or counter-arguments which may, in fact, validate the anti-suicide treatments/arguments or effectively satisfy the concerns that the suicidal people have over them[127], remain hidden, as the need for them to justify the treatments is never publically disclosed.

[126] i.e. Any arguments they present won't actually be listened to, and therefore won't have any effect on their interactions and/or relationship with the people who follow these flawed approaches. Or alternatively, their arguments against the logic of anti-suicide doctrine might be outright forbidden in the environment in question, e.g. on certain mental health websites.

[127] Assuming, of course, that such factors or counter-arguments exist at all. Personally, I suspect that very few, if any, such factors exist, as if they did, they would likely have been presented to the suicidal community well before now.

Effect of the Restrictions:	Consequence
Suicidal people continue to be portrayed as irrational, impulsive, mentally disordered, or otherwise illegitimate in their contemplation of suicide. Though most of them are supported by thoroughly considdered, logical and balanced reasoning, and a significant amount of personal life experience and thorough observation of the world around them and other peoples' lives, all of which ultimately adds up to a compelling argument for suicide.	• Government, society, and the mental health system continue to base massive anti-suicide strategies around targeting perfectly rational minds, at the expense of ignoring actual problems. • Suicidal people face a heavy obstacle of prejudice towards them and their own cherished ideas, values, identities and needs, which hinders their efforts to get help. • Suicidal people come to see anyone who isn't likewise suicidal as *'the enemy'* - someone who is only interested in disparaging the integrity of their brain, rather then actually considdering what they have to say, or engaging with them[128] with regard and respect for their point of view. Engaging with the non-suicidal community becomes more trouble then it's worth. Suicidal people seek out the company of other suicidals, until they choose to end their lives - as suicidals can offer them respect, understanding and input that makes sense. • All the problems that stem from society's disregard of the suicidal person's point of view become cyclical, and even harder to dispel. The preconception of suicidal people being mentally defective makes people less inclined to **really** listen to what they have to say, thus making it extremely difficult for them to prove that they **aren't** mentally defective and that their input does indeed have significant merit.

The mechanisms for restricting the discussion of these topics varies amongst the differant areas of the national mental health conversation.

In the real life, or 'pub chat' area of the discussion, people who touch on the taboo subjects are quickly confronted with awkward silence, 'evil eyes', harsh abuse, or smothering close-minded insistances that they "shouldn't believe" that suicide can be a justified choice[129].

[128] i.e. Offering help.
[129] See "Thought Shaming" (pgs. 88 - 89)

In the Facebook community and online forum area of the discussion, users who touch on taboo subjects tend to be sensored. Their posts may either be edited by moderators, or deleted altogether. Typically these actions are performed with a standard apology/warning akin to: *"We can't allow users to encourage people to commit suicide"* - even when the user's input wasn't encouraging anyone to commit suicide at all, they were merely questioning the legitimacy or integrity of currant suicide prevention systems.

Repeated instances of the user tugging at the loose threads of the "suicide is bad" doctrine will often result in the moderators politely asking the user to leave the community, or perhaps kicking them out. However, it typically doesn't come to that; with most sceptical users recognizing that they cannot speak freely in that environment and quietly leaving of their own accord.

In the mass media area of the conversation, the taboo subjects aren't aloud to appear at all. Mass media, being probably the most choreographed portion of the national conversation on these topics, is practically impossible to be a part of unless it's masters want you to be a part of it. The people running our media have chosen to ally themselves with the anti-suicide campaigners 100%, and to that end, they see to it that, in the major media forum, questions about the validity or soundness of anti-suicide doctrine simply don't exist.

In the governmental policy area of the conversation, the taboo subjects have only slightly more presence then in the media. There are few, if any outright restrictions here, but the people who carry these concerns rarely venture in to this arena to voice them. Most don't have a sufficient interest in politics to explore their options for addressing these concerns. Many are probably too disenchanted with modern politics and government behavior to believe speaking their piece will have any relevant effect. Many are probably so used to their point of view being suppressed in the other areas of the conversation that they don't believe anyone in the public policy area would listen to them with an open mind, anyway.

Subsequently, this area of the conversation tends to be dominated by major organizations[130], academic institutions, "experts" in the field, and major ideological forces[131], who are all seasoned hands in political matters, and who all seem committed to pushing the unquestionable supremacy of anti-suicide doctrine.

[130] e.g. BeyondBlue, ect.
[131] e.g. The major religions.

What it all boils down to is this: there is no place in the conversation for the suicidal sceptic. There is no place for the man or woman who scrutinizes the anti-suicide statements they are told, rather then just takes them immediately as gospel truth. There is no place for the man/woman who checks that such statements are logically sound and morally balanced; that they don't distort probabilities to unreasonable degrees and that they respect the concepts of risk vs. reward and cost vs. reward. There is no place for the man or woman who holds a statement up to their own life experience; their lifetime of observations of all the people around them, to see if the statement's bold claims hold up in the real world. There is no place for the man or woman who is suspicious that the suicide naysayers who speak to them may in fact be more concerned with serving their own agenda[132], then actually giving due consideration to the suicidal person's plight.

This, in effect, means that there is no place in the **entire** national mental health & suicide prevention strategy for the suicidal sceptic.

It may be tempting to believe that the sceptics that can't be accommodated in the public dialog have their concerns adequately addressed behind closed doors in therapy. However, this is almost never the case.

Because the mental health system's treatment protocols are based off the same anti-suicide doctrine as the national conversation, it shares the exact same weaknesses[133].

The only differance is that when the conversation takes place in the privacy of the therapist's office, there is no public scrutiny over what the therapist tells the patient, nor public acknowledgement of the flaws in the therapist's stance, which the patient identifies.

Quarantining the suicidal sceptic in therapy does not serve the patient and certainly does not reduce the appeal of suicide for them. It is merely a disposal method to get the inconvienient 'lost cause' sceptics out of the public sight and mind.

Even if this major blindspot in our nation's policy on suicide does not seem like a cause for concern now, it is important to considder that the proportion of sceptics in the suicidal and mentally ill communities is only likely to grow.

Society as a whole is becoming more and more sceptical with every passing year. Once upon a time it was enough for the preacher on the pulpit to declare that: *"Anyone who commits suicide will burn in hell!"*, or for the surgeon general to make a national proclaimation that: *"Contemplating suicide is the result of a severe mental defect"*, to establish a near-unanimous public attitude.

[132] i.e. Reducing suicide statistics.
[133] See "The System's Attitude Towards Suicide - The Frail Arguments" (pgs. 66 - 67)

However, in this day and age, people are much more inclined to develop their own attitudes on critical issues, rather then blindly accepting the proclaimations of their leaders. Simply telling people what to believe is becoming less and less effective. It's now becoming increasingly essential to **convincingly demonstrate** one's case, if one expects to maintain public support for it, much less if they expect people to base their entire lives upon it.

Modern suicide prevention policy depends on the suicidal people it targets being unquestioningly obediant, when they are told: *"Don't kill yourself!"*. It depends on them not questioning the logic or reliability of the reasons that anti-suicide people provide to choose life over death. Very soon, this sort of unquestioning obediance will be all but extinct, and the policy that depends on it will have an equally meager success rate.

I feel I should also note at this point that the growth of scepticism towards anti-suicide doctrine is not merely confined to the suicidal community. I have personally noticed a growing trend across the internet, of people - who do not suggest that they themselves are suicidal - expressing sympathy and understanding for the suicidal, and acknowledging that suicidal people are often not well served by surviving. In other words, non-suicidal people seem to be starting to agree that many suicidal people are indeed better off dead.

Many people indicate a vague awareness that our currant anti-suicide arguments are inadequate or inappropriate. Many are aware that suicidal people can make a far more compelling and well-considdered case for their own suicide then our anti-suicide campaigners can make for their survival.

The vast majority of these statements, I believe, are genuine and non-malicious in nature[134].

My suspicion is that, despite the thorough efforts of our national mental health discussion's leaders to keep a lid on the point of view of suicidal people, these viewpoints are still managing to leak out into the general public. Everyday non-suicidal people are getting into discussions with suicidal people, are having explained to them the sound wisdom behind committing suicide and are witnessing the anti-suicide arguments they've always been taught to believe being dismantled before their eyes.

As is often the way with cover-ups, this one seems to be falling apart. I personally believe that it is folly to think that maintaining the currant restrictions on the discussion of suicide can be an effective long-term strategy for reducing suicides and maintaining near-unanimous public support for currant anti-suicide doctrine.

[134] i.e. They are not trying to "troll" suicidal people into committing suicide, nor being provocative just for the sake of being provocative

The only way to alleviate this scepticism is to confront it head on, and in full public view.

Sceptics need to know that every pertinant aspect of anti-suicide doctrine is open for criticism and examination. They need to know that the questions they have about the merits of survival are already being asked; they need to know that the answers being offered are frank and public record; they need to know that those answers are open to complete scrutiny and that the answers to any follow-on questions are open to complete scrutiny. They need to know that, if they have doubts that haven't yet been addressed, they have the right to interrogate the policy-masters who would press them to choose survival over death, and that those policy-masters will be compelled to answer frankly and publically, and be held to public scrutiny for their answers. They need to know that our suicide policy is as fair, balanced, compassionate, humane and as well-refined a piece of policy as humanity is capable of engineering - because whenever a problem is found with it, that problem is publically acknowleged, publically explored, and then addressed with a remedy that is publically debated and tested.

As a nation, we all need to know that a person who's life isn't worth prolonging can stand before the people who would urge them to live and state openly and frankly: *"My life is like this... I am better off dead then living like this! This is what needs to happen in order for my life to be worth prolonging..."*. They need to be able to plead their case openly and sincerely before the people with the power to make a difference. They need to be able to make it clear that they are not talking about a petty nuisance that can be ignored or put off, but the difference between a life worth living and a life that is best ended as soon as possible. They need to be able to state when a remedy that is suggested to them will likewise leave them in a situation that is worse then death. And they need to be able to do all this without being quietly ushered out the back door for making a scene, by daring to suggest that there is such a thing as a fate worse then death.

But before we can even talk about a day when our national suicide policy is trustworthy, we need to address it's massive and numerous flaws. For this to occur, these flaws need to be identified and acknowledged by everybody who has a hand in them, or who subscribes to the policy based upon them - in other words, each and every member of our society.

This means that we need to open up the discussion and allow suicidal people to explain to the rest of you why your arguments for survival simply don't work.

After extensive discussion with a great many suicidal and non-suicidal people, I am convinced that many of the flaws of anti-suicidal doctrine are only noticeable to suicidal people. People who haven't genuinely noticed that they find the idea of being dead more desirable then the idea of remaining alive don't seem to scrutinize the anti-suicide arguments; they just take it for granted that they make sense. Your suicide prevention agenda is targeted at people who find the idea of survival to be counter-intuitive. You need the analytical eyes of people who find survival counter-intuitive to understand why your prevention initiatives fail.

Just as importantly, the suicidal community needs to bear witness to you listening to the open criticism of your policy and practices, by suicidal people, so that we can all see hope of the future policy being far more trustworthy and useful then the one we have to deal with now.

Certainly, there are many, many people in this issue who simply aren't emotionally up to engaging in frank discussions about suicide and the flaws in suicide policy. Many such people can't even **listen** to such discussion without suffering severe distress. But the mentally ill and suicidal communities are remarkably good at gauging what topics they do and don't have the strength to confront at any given time. Providing clear and appropriate "trigger warnings" for all arenas of the conversation where suicide may be discussed openly and perhaps even in favorable terms, would do a great deal to limit the risks associated with open discussions of this nature.

Restricting the conversation surrounding suicide does reduce the difficulty in persuading certain members of the community to abstain from committing suicide, this is true. But **it also creates an immensely high risk that many other suicidal people will never be able to get help**, by maintaining a society that is hopelessly unaware of those people's actual plight.

If nothing else comes from this inquiry in regards to suicide, at the very least, the cost vs. reward of this code of silence really needs to be examined.

The Highest Levels of the Discussion are Dominated By "Experts"

At it's highest levels[135] our national discussion on mental illness, suicide, and related matters tends to be dominated by "experts", at the expense of the input of people who actually experience mental illness, suicidalness, or other related crisises.

This is particularly noticeable, and particularly frustrating for many members of the suicidal & mentally ill community, in terms of major media coverage of mental health and suicide-related issues.

We have become all too used to seeing segments where the hosts and "experts" will talk **about** us, but very rarely ones where anyone talks **to** us. We get to watch while these two teams talk back and forth about what our situations are and what they think we need, while almost never getting to explain in our own words to anyone what we are going through and what **we** think we need.

Often it feels like we are not even in the room; despite the fact that both the media figures and the "experts" they recruit for their segments must both be aware that thousands of mentally ill, suicidal and people in other crisises will be watching them. Other times, it feels like we are not really recognized as being actual human beings, but more an inanimate 'issue' to be managed - like a drought, or an oil spill.

Written articles about these subjects likewise tend to offer little space for the direct input of people who are currantly enduring mental illness, suicidalness or some other major life crisis. Instead, they lean almost entirely upon the testimony of one or more "experts".

The reason this style of media coverage is so concerning is that mentally ill and suicidal people often find that the "expert" testimony provided in the media is a very poor reflection of what we are enduring, if not an outright contradiction to our own viewpoints.

Their statements can be outright incorrect; they can deceptively overblow or minimize the importance of any given aspect of our situations[136]; they can outline aspirations for future policy which we know are ineffective or undesirable; and they can distract from the real issues of concern to us, by emphasizing issues that they themselves decide to place an elevated importance upon.

As an example, these "experts" will, from time to time, express concern that mentally ill people have increased risks of many life-threatening physical conditions[137].

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[135] i.e. The portions of the discussion that feature prominently in major media, or which directly form governmental policy.

[136] e.g. Statements that emphasize a theory that a bullying victim who committed suicide was mentally ill, while minimizing the relevance of the bullying she experienced and the immense anguish it caused her.

[137] e.g. Heart disease.

I once entered in to an online discussion about an article on this theme. Everyone in that discussion, including myself, were at an absolute loss at the "expert"'s cluelessness. For severely depressed and suicidal people, dying by heart disease is not a "tragedy" to be concerned about, as the "expert" was trying to make out; it is a welcome mercy! We have already suffered so much, and this person has the gall to stand up and, in effect, tell the nation: *"We really need to start thinking about how we can get these people to suffer for a couple decades more!"*[138]

Everyone in that discussion agreed that the "expert"'s spiel was an atrocious distraction from the **real** plight of the suicidal and mentally ill. Before we even begin to think about reducing our rates of heart disease, we first of all need to raise our quality of life to the point where avoiding heart disease - and the many years of life that will come as a result of that avoidance - is actually desirable to us.

For "experts" to try to pull focus onto our poor lifespans, over our poor quality of life is about as absurdly backwards as you can get.

Publicity such as this does not speak for mentally ill, depressed and suicidal Australians; nor does it serve them.

Yet to many bystander Australians, and likely many members of the government as well, these "experts" are percieved as being mouthpieces for the mentally ill and suicidal community. Most Australians make the mistake of assuming these people speak **for** us, when really, they are just someone speaking **about** us.

I am not suggesting that these "experts" shouldn't have the right to speak their view on national media platforms. Everyone is entitled to speak their opinion and be heard.

What I am suggesting is that the presence of these "experts" needs to be balanced with a significant presence of actual mentally ill, distressed and suicidal people. Real sufferers like this need to be included in the media's coverage, to give it balance, to make sure that inaccuracies and half-truths are properly clarified, and to accurately convey the diverse complexity of the important issues that effect them. Not to mention giving the mentally ill community a sense that they are respected and that their personal input regarding the issues that impact them worst of all, is greatly valued.

Adequate community awareness of our situations & needs, and proper policy formulation can't occur when the bulk of this information is being filtered and distorted by the interests of the "experts" chosen to make statements about them. The mentally ill and suicidal communities need a direct line of communication to their leaders and countrymen & women; we need the opportunity to state for ourselves: *"This is what we are going through, and this is what we need…"*, so that others may understand.

[138] i.e. By extending the 'mentally ill' peoples' natural life expectancy, thereby inflicting numerous more years of undesirable life upon them, in theory.

I should note that, at the moment, this shortfall in the mental health conversation seems to be gradually improving; I would say that there is definitely a stronger presence of people with a mental illness or other dire crisis in media materials relating to these matters, then there was, say, 5 years ago.

However, there is still a great deal of improvement needed in this area, as the voices of the mentally ill and suicidal are still very quiet on the national stage. This gentle trend of improvement needs to be strengthened and encouraged as much as possible in government and national media policy.

My Personal Grievance With "Expert" Statements on Suicide

My personal experience has been that "expert" leadership of the public mental health conversation is especially problematic when it comes to the issue of suicide and suicidalness. As a man who wishes he was dead, I find it makes it much more difficult trying to talk to people about the subject of suicide, and the shortcomings of life which make suicide desirable.

It can be particularly frustrating when I try to offer input on the subject of suicidalness before I identify myself as being suicidal[139], as advocates of the "expert" positions on this subject will often correct me and tell me what suicidal people believe, think and want[140]. As a suicidal man, I darn well know how **I** feel and what **I** want! I don't need to be told those things by "experts".

The misconceptions promoted by "experts" in this matter cause such grave confusion amongst the public and policymakers, I feel it is essential that they get to hear the input from people like myself. However, people are rarely interested in listening to what we have to say, especially when it is at odds with the "expert" testimony.

At this point, I feel I must acknowledge that I certainly do not speak for all suicidal people and many suicidal will indeed agree with the official "expert" position on their plight. However, many suicidal people I have spoken with over the years share my disagreements with the "expert" stance, and I believe that this diversity of viewpoints deserves to be acknowledged and addressed.

"They Just Want Their Pain To End"

One of the most problematic pieces of "expert" testimony, regarding suicide, that I regularly encounter these days is the statement that: *"Suicidal people don't want to die, they just want their pain to end."*

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[139] Which is a precarious thing to do and something I typically abstain from doing. Identifying yourself as being suicidal tends to attract aggressive bombardments of urgings to "seek help", or the traditional cliche anti-suicide slogans (e.g. *"What your going through is only temporary. Those feelings will pass."*), which most suicidal people have already heard a thousand times.

[140] Which are, without fail, wildly different from my own experience and point of view. To clarify, these experts make their statements as absolutes; not merely: *"Well, some suicidal people think this way..."*, but rather: *"Suicidal people think this way..."*. Basically implying via gross omission that suicidal people with stances like my own don't exist at all.

Speaking from my own point of view, this statement is not false as such, but I would deem it to be poorly phrased and highly misleading. A more accurate statement would be: *"Death is usually not a suicidal person's* ***most*** *preferred outcome, but it is more preferable to their currant circumstances and/or foreseeable future. It may also be more preferable then many of the options available to them."* Should the need arise to reduce it to a punchier slogan, I would suggest: *"Suicidal people just want the best outcome available to them, which, as it stands, is death."*

Many of the reasons why the *"...they just want to end their pain"* statement is inappropriate, have already been discussed in this document.

One reason is that quite often, suicidalness arises not out of pain, but of lack of incentive to survive[141]. Hence, 'pain' is a misleading word to use in describing the problem.

Another reason is that it can bolster preconceptions that the problem is in the patient's brain rather then their atrocious circumstances[142], as emphasis on the term "pain" can imply that the problem is within the patient themselves and not the life they endure. This is akin to describing a person who staggers into an ER with a bear trap latched onto their foot, as showing up at the ER because *"they want their pain to go away"*. While this mightn't technically be a lie, it is misleading, as presumably, their primary goal isn't to simply dull their pain with medication, but rather to get someone to remove the problem that is causing their pain and debilitating them, i.e. the bear trap.

This can be a problematic attitude for an acquaintance of a suicidal person to hold, as it may leave them to believe that the suicidal person simply needs that acquaintance to 'hold their hand' while they suffer, when in actuality, what the suicidal person really needs is for the acquaintance to provide them with some actual help with the problem(s) making their life unbearable.

Another problem with the statement is that it also bolsters preconceptions that suicides are based on impulsive emotions rather then well-thought-out evaluations of the suicidal person's circumstances. It's more inclined to conjure up the standard image of the distraught and agitated suicidal person standing on a tenth-story ledge in tears then it is to conjure up the image of a person calmly sitting at a table saying: *"I've considdered the case for living. I've considdered the case for dying. I've thought about it for a good long time. I've slept on it. I've mulled it over. I've given myself ample time to see if my feelings change significantly on these matters. But the case for dying is consistantly overwhelmingly stronger then the case for living."* This second scenario is a more accurate depiction of the suicidal decision making process in far more cases then the "experts" want the general public to realize.

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[141] See "The Poor Recognition of Shortage as Motivation for Suicide" (pgs. 81 - 83)
[142] See "The Misdiagnosing of Real World Problems as "Mental Illness" (pgs. 30 - 35)

The *"...they just want their pain to end"* statement fails to acknowledge that reason and logic are often defining elements in the decision to commit suicide.

This, in turn, supports the related misconception that all suicidal people have an arbitrarily varying level of attraction to suicide[143]. In many cases, this mis-characterizes the true problem as being an inconsistant emotion when it is in fact a consistant real-world circumstance.

In other words, it leads outsiders to believe that the proper course of action is either to leave the suicidal person be, until their 'pain' *"sorts itself out"*, or to attempt to dull that pain via medications. These approaches are gravely inappropriate when a person's suicidalness is the product of a clear-headed and sensible evaluation of their circumstances. 'Pain' may vary over time, or in response to medication, but logical conclusions will always remain consistant as long as the circumstances they pertain to remain consistant. Suicidal people who need **practical** help with their unbearable quality of life are greatly disserved by the *"they just want to end their pain"* statement.

Yet another problem with this statement is that it fails to acknowledge that there are numerous fates that are worse then death[144] - not merely the one that the suicidal person is suffering - and that lives that are worth prolonging are marked by certain essential conditions[145] being met.

This is a problem as it creates a mindset in the would-be helpers of suicidal people that all they need to do is address or alter the pain of their currant situation, without regard to the end result of their efforts. These would-be helpers may take it upon themselves to produce a radical change in the suicidal person's life, without listening to the suicidal person's protests that their new situation - though significantly different to their original situation - is nonetheless still a fate they do not wish to endure.

A simple example of this would be a person who wishes to die because their job makes them miserable, being transferred to another job which they hate even more. Their well-meaning boss might make the transfer believing that the essence of the problem was to eliminate the specific "pain" their employee felt in being stuck in their old job, while being unaware that there are many potential fates worse then death that might befall a person - and all he has done is move his employee from one such fate to another.

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[143] In fairness, many do. But it is most important that we remember that many others don't.
[144] As defined by the suicidal person.
[145] Which will be unique to each and every person. Everybody has their own idea about what a life worth prolonging consists of.

Another example would be a suicidally lonely person who is sent off by a would-be helper to spend time in the company of people he finds so unpleasant, he would much prefer to be alone. In trying to eliminate the pain of the suicidal person's isolation, they have fostered a new, even more toxic pain of resentment in that person, and thus done nothing to raise the suicidal person's interest in survival[146].

The 'Concert Hall' Metaphore

Perhaps a useful way of thinking about the whole problem would be to think of the suicidal person as a concert-goer looking to buy tickets to a concert. They would most prefer a front-row seat, but if the front row is booked out and unattainable, they would prefer a seat in row 2. If they can't get a seat in row 2, they would prefer a seat in row 3, and so on.

Each of these rows represents a fate which might befall the person. Though, in reality, there are usually countless fates which may possibly befall a person, for the purposes of this example, let's say there are 30 possible fates, or 30 rows in the concert hall. Let's also say that row 10 represents death/suicide.

Here, I hope it is evidant why the *"Suicidal people don't want to die..."* statement is woefully insufficient to guide the public discussion on suicide. If we were to say: *"The concert-goer doesn't want a seat in row 10"*, that is a statement that is neither entirely true nor entirely false, and is therefore overall confusing to people who wish to understand the situation. The concert-goer doesn't want a row 10 seat more then a row 1 seat, but they do want a row 10 seat more then a seat in rows 11 - 30.

Thus, if they are assigned a seat in, say, row 15, and they are able to renegotiate with the ticket agent for a seat in row 10, but not in any row closer to the stage, then in such circumstances, they do indeed want to sit in row 10 - the suicidal person does indeed *"want to die"*!

The efforts of "experts", whether by design or accident, misleadingly reduce the subject of suicide to a black-or-white question of life vs. death. The convienience of this, to anti-suicide activists, is that it also reduces the question to a simple matter of right vs. wrong, which allows them to promote the view that choosing life is **the** right choice and choosing death is **the** wrong choice.

In reality, suicide plays out on a table of numerous, rankable outcomes. Death is merely one of these outcomes, whereas life is represented by many different possible outcomes. Many of these will be more desirable then death, and many of these will be less desirable. It is not a question of right vs. wrong, but better vs. worse.

[146] In fact, they may have decreased it - in other words, made the person more likely to attempt suicide.

This reality **needs** to be appreciated by anyone who is expected to play a role in a suicidal person's recovery. Too many people are under the misconception that it is adequate to arbitrarily alter a suicidal person's circumstances, or offer an insignificant improvement, and expect that this will be enough to reasonably expect them to abstain from suicide.

But moving the concert-goer from seat 15-D to seat 15-Q, or to seat 17-J will not justify them abstaining from taking the seat available to them in row 10, as all the seats that have been offered to them are much poorer options then row 10.

It also needs to be noted that other concert-goers being assigned to seats further back then row 15 does not change the fact that row 10 is still better then row 15.
Many people will often try to remedy another person's depression or suicidalness by pointing out: *"Look at* [some misfortunate person or group of people]*! Their lives are much worse then yours! You should appreciate your life!"*[147] But this makes for a very poor argument for abstaining from suicide.

The concert-goer might be well aware that a person assigned to row 20 is in a much worse position then they are, being assigned to row 15. But that doesn't change the fact that they are much better off upgrading to row 10 then remaining where they are. They would probably also feel that the person assigned to row 20 would likewise be better off upgrading to row 10, but it isn't their business to tell other people where they should and shouldn't sit.

Just as importantly, we have to appreciate that upgrading the concert-goer from row 15 to row 12 does not justify them abstaining from taking the free seat in row 10. Yes, row 12 is an undeniable improvement over row 15, but that doesn't change the fact that row 10 is still a much better alternative to either of them.

Therapists are among the worst offenders, in terms of ignoring this ranking system, and indeed, in denying their patients' efforts to communicate how this is their reality.

They will often state that the goal of their treatment is: *"not to fix their patients' lives, but to get them to a place where they are 'better'"*[148]. The simplistic terms of: *"life vs. death = right vs. wrong"*, or indeed *"they wanted to die because they were in pain, but now they are 'better'."* tend to exaggerate the relevance of that word: "better". Namely, it tends to imply that making things "better" equates to curing suicidalness. Because when it comes down to a person either wanting to live or wanting to die, and wanting to die is the wrong choice, then making things "better" can only possibly mean that you now have them wanting to stay alive, as this is the only scenario that is "better" then them wanting to die.

[147] Or words to similar effect.
[148] Or words to similar effect.

Yet, from the concert hall metaphore, we can see that making things "better" for someone assigned to row 15 can potentially mean reassigning them to a row between 11 and 14. Any one of these situations will certainly be better then their existing seat in row 15, and yet even with such an improvement, the concert-goer will still be better off going to row 10 (death).

For this reason, therapists set the bar far too low when it is merely their goal to make things "better". In order to make meaningful and ethical contributions to suicide prevention, their duty must be explicitly defined as to do their very best to **make their patient's lives worth living**[149]. Simply aiming for "better" is one of the many reasons why the mental health system's performance is woefully inadequate in the field of suicide prevention.

By extension, this is one of many reasons why defining suicidalness simply in terms of 'pain' is a concept that is woefully unfit for purpose; and why "expert" testimony on what suicidal people think, feel and believe **must** defer to direct testimony from suicidal people themselves, about their own experiences and point-of-view.

How it Applies to Me

As a man who has consistantly and calmly yearned for a prompt death, for many, many years, I can say that *"Suicidal people don't want to die, they just want their pain to end."*, is a poor expression of my plight.

I wish to die, but I am not 'in pain'; I am without love and joy. My wish to die has remained consistant, it does not fade and return as my moods go up and down, or as I roll through my bad days and 'better' days. I have thought long and carefully about my plight; I have weighed the things that shall be parted from me if I should die and I have weighed the things I shall have to endure if I continue to live. I have questioned and tested my own conclusions over and over again and I have explored the limited arguments of the people who decry suicide many times over, as well. I have considdered every alternative that I understand to be available to me and I have consulted with professionals to determine if there were any other alternatives I did not know of.

My preferance for death is based on a sound, extensive and careful evaluation of my situation as it stands and as it is likely to play out; not on an irrational or impulsive response to 'pain'.

I would love to believe that one day soon, the circumstances of my life could be corrected, and my life made one that was actually worth prolonging. Obviously, if that were to occur, I would no longer be suicidal. I would be happy and willing to prolong my life for as long as those new circumstances could be maintained.

[149] And it is of crucial importance that the definition of "a life worth living" is established by the patient themself; not by the therapist, or the larger mental health system, and without any coercion from the therapist, mental health system, or other figures in the patient's life.

But I can't make that happen single-handedly. I need help. And in order to get that help, I need people to understand the nature of my crisis and, most importantly, what a life worth prolonging looks like to me.

Having to wrestle constantly with the widespread misconception that addressing suicidalness is about *"helping people cope with pain"* makes it so much more difficult for me, and other suicidal people like me, to open those essential lines of communication and be adequately understood.

The statement: *"Suicidal people don't want to die, they just want their pain to end."* does not help suicidal people like me; and neither do the "experts" when they push this idea.

The Narrow Scope of the Mentally Ill Input Contributed to the Highest Levels of the Discussion

Following on from the previous segment, the small amount of direct input from the mentally ill and suicidal community that does appear in major media seems to be hand-picked to reinforce certain existing preconceptions, rather then to provide fair and balanced coverage of these issues.

Buy and large, the candidates who are chosen to share their viewpoints on a major media platform only have testimony that reinforces the idea of the suicidal or immensely distressed citizen having a defect in their brain. They will give statements to the tune of:

- *"I was just plagued by these overwhelming thoughts of killing myself"*,
- *"Suddenly, I just couldn't concentrate in class anymore, I couldn't be bothered doing stuff and it just felt like there was no hope"*, or:
- *"I would suffer from these awful hallucinations and I just couldn't make them go away"*.

Of course, all of these contributions to the national conversation are important and valid. As suggested in the previous segment, we need more of them.

However, when the presence of sufferers in the conversation excludes or under-represents those who are suicidal, depressed, anxious, ect. due to **real world** circumstances (as opposed to a mental illness), it only widens the gap between these people and the help they so desperately need[150].

When the only testimony provided to the general public (not to mention government) suggests that suicidalness and depression come about due to mental defects, society is inclined to adopt an attitude that this is the one-size-fits-all explaination for these stances and behaviors. They don't even considder that other, completely differant causes can be equally as prevalent, because they haven't been told to considder such possibilities.

In other words, this manner of imbalanced media coverage encourages citizens to believe that any person they encounter in their lives who is depressed, suicidal, abnormally anxious, ect. **must** have a mental defect, as this is the only likely explaination for these manners and attitudes.

This misconception is especially nefarious, as once someone is branded as being "mentally defective", they are, in effect, guilty until proven innocent beyond a reasonable doubt.

[150] See "Real World Problems" (pgs. 30 - 39)

Because the sufferer is regarded as mentally defective, any statements they make are instantly unreliable - the distorted output of a broken mind. Therefore, any assertions they make that they are not "mentally defective", will almost certainly not be taken seriously, since these contradict the *"reliable"* information already issued to the public by the media, mental health system, and various other mental health organizations. Similarly, any attempts they make to demonstrate that the cause of their depression/suicidalness/ect. is due to some horrendous life circumstance(s), and not a mental defect, will likewise not be taken seriously.

Take, for example, a case of a man who has been constantly unemployed for many years and can recognize that there is no reasonable expectation that he might get a job offer any time in the foreseeable future. Say he can't bear the sense of uselessness, being treated as a 'loser', the poverty, the loneliness and the boredom any longer and has decided to commit suicide.

Say now that someone encounters him just as he is about to do it. The second person interrogates the suicidal man. The man tells them that he is going to kill himself because he can't stand being unemployed any longer.

Now, the second person's likely reaction to this will be: *"No! That's just your mental illness talking! You must be mentally ill if you are contemplating suicide, because suicidalness is caused by mental illness! A person in your position who wasn't mentally ill might still be long-term unemployed, but they would prefer living like that to being dead. The fact that you prefer death over life means you are mentally ill!"*

"Long-term unemployment doesn't make people wish they were dead. If it did, we would've heard about it in the media, or in the PSAs from the mental health organizations. Only mental illness makes people contemplate suicide."

Note: more then likely, the second person will **humor** whatever the suicidal man has to say, in order to talk him down from the ledge; but they won't **believe** what he has to say!

This distinction makes all the differance in the world, in terms of achieving the best possible outcome for the person in crisis. A person who is merely humored will be 'helped' by being sent to a therapist where they will be medicated, encouraged to speak at length about how horrible it is to be long-term unemployed, and eventually told (by someone with the benefit of a steady, prestigeous, ≈$200/hr job, no less) that *"It's okay to not have a job"* - despite how convincingly the harsh reality of his everyday life contradicts that statement.

On the other hand, a person who is **believed** may be helped with their actual problem: The person or people who want to help them may put feelers out that result in the unemployed man finally getting a job that offers him fulfilment, a sense of accomplishment, new co-worker friends and even a little extra spending money to tend to the material shortcomings in his life.

A person can only recieve help for their crisis once others acknowledge that crisis. And they will only acknowledge that crisis once they believe it is what it is, rather then what they've been told to assume it to be[151].

But so long as their surrounding culture remain inclined to insist that depression, sucidalness, ect. are mental illnesses, people suffering non-mental illness crisises will not feel safe to trust the people around them. They will remain more a probable hinderance then a potential asset.

And so long as the direct testimonies of suicidalness/depression experiences that appear in major media are almost entirely based in mental illness, the sufferers of other forms of major crisis have little reason to hope that the people around them might be willing to acknowledge that they have broken lives, not broken brains.

Hence, Australia needs a more balanced media coverage, particularly in terms of direct testimony from people in anguish. The coverage needs to adequately convey that conditions such as depression and suicidalness can just as likely arise from unacceptable real-life circumstances as they can from arbitrarily-occurring brain malfunctions.

Once again, it should be noted that this area is currantly seeing some gradual improvement. Though once again, there is still a long way to go before media coverage in this regard can be considdered adequate.

The currant presence of sufferers of real-life crisises in the major media-level of the national conversation is still far too small. But equally concerning is the fact that the only types of real-life crisis that are getting this sort of media exposure are the ones that are regarded as hot topics; leaving the more mundane forms of unbearable life lingering unaddressed in the shadows.

For example, we are now beginning to acknowledge that constant bullying, whether it be cyber or real-life, can indeed reduce a person's quality of life to the point that that life is not worth enduring anymore. Bullying - **not** severe defects within the brains of the victims - is now recognized[152] as a real-world cause of depression and suicide. And the media is rightly giving extensive coverage to this issue, and beginning to acknowledge it's gravity as a direct cause of depression and incentive for suicide.

[151] i.e. A mental illness.
[152] At least by the general public.

Several other real-life problems are similarly beginning to be recognized as motivations for rational minds to become depressed or choose suicide. For example, major media is starting to recognize that severe droughts can drive farmers to commit suicide, without needing to impose a mental malfunction upon said farmers, post-mortem, to explain their behavior. Likewise, descrimination and persecution are beginning to be recognized as causes for depression and suicide; with the impact of homophobic descrimination on suicide statistics within the LGBT community being widely reported during the postal vote on gay marriage in late 2017.

However, when it comes to accurately crediting other real-life crisises with noteworthy cases of depression, suicidalness, ect., I would considder the media to be far less dependable.

I must confess that, based off the last several months of media coverage into suicide, depression and related subjects, I find myself cautiously optimistic about the direction media coverage is headed in this regard. For instance, it seems that the media have recently begun to take the role loneliness plays in our depression and suicide epidemics more seriously. Of course, far more in-depth coverage of these sorts of real-life crisis is needed, but it does seem like mainstream media is generally going in the right direction.

Hopefully, in the near future, suicides that occur due primarily to things like loneliness, relationship breakdowns, career disappointment, or community incompatability[153] will be accurately reported in the media and not misreported as being chiefly caused by a ‘mental illness’.

Such a shift in media coverage on these issues is vital, if we as a country sincerely intend to alleviate depression and ethically, effectively prevent suicides from occurring. We can never hope to adequately address these problems until we stop presuming that they occur due to brain malfunctions and start recognizing their real-world causes for what they are. And in order for the nation to recognize those causes, and in particular, their gravity, they need to be adequately covered in the major media.

Reformed Suicidal People

A special example of the imbalance in the media coverage of suicide and severe depression is that of the ‘reformed’ former suicidal person. Or, to be more accurate, the fact that these people seem to be **the only** sources of direct testimony regarding suicidalness that appear in major media.

For the purposes of this submission, a ‘reformed suicidal person’ is a person who at one time in their life has been suicidal, but now is not; and additionally, now holds the view that they were in error for ever contemplating and/or attempting suicide.

[153] To name just a few of the real-life motivations for suicide.

Contrast this with a former suicidal person who now wishes to continue surviving rather then die; but acknowledges that their previous inclination towards suicide was appropriate for the time, given that their life circumstances at that time were indeed a fate worse then death and their prospects for improvement were realistically unlikely. Such a person may acknowledge that they intend to choose death should their life ever revert back to such unacceptable circumstances in the future, with a similar (or greater) level of unlikeliness of them being remedied.

Once again, reformed suicidal people have every right to share their story on a national platform. Their contribution is valuable and important.

However, it must be understood that the media's **exclusive** usage of these people widens the divide between much of the suicidal community and the general suicide prevention movement.

Most concerningly, when reformed suicidal people do appear in the media, the target audiences of these appearances doesn't seem to be the general public or government policymakers, but rather, the suicidal community.

Reformed suicidal people seem mostly inclined to use their media appearances to push the same old messages we've heard time and time again about suicide being *"the wrong choice"*. The only notable difference being that they can present this message with a sincere assurance of: *"Trust me. I've been where you are. I know what I'm talking about!"*

The problem for most suicidal people is that, regardless of whether or not they come from experienced lips, those messages remain immensely flawed in terms of logic, biased reasoning, dismissal of anguish and reliance on unrealistic probabilities. Frankly, suicidal people are much more likely to be guided by the stark realities they endure on an everyday basis, then the empty promises and vague assurances[154] offered by a formally-suicidal person.

While respecting the idea that formally-suicidal people have an important role to play in addressing the currantly-suicidal community, we have to recognize that this role isn't being well fulfilled.

Suicidal people need clear, compelling and sound demonstrations that there is indeed redeeming value in life, and that this redeeming quality is in fact so strong it outweighs all the negative aspects of life. They also need clear, effective directions on how to bring this supposed goodness into their life on a sustainable basis. If reformed suicidal people can offer any enlightenment to the suicidal community in these regards, then surely this is where their energy and time in the media spotlight would be best spent.

[154] e.g. *"Things do get better"*, *"There's always hope"*, *"There's always another way"*, ect.

In other words, don't vaguely promise me that life is worth prolonging; **prove** to me that it is.

And it's important to remember that these contributions need to respect the secular nature of the suicidal community[155], and not hinge upon exceptional twists of fate[156].

For many suicidal people, the mere fact that reformed suicidal don't offer any information of substance, in terms of making their life worth prolonging, reinforces their existing suspicions that the case for choosing to live is based on nothing but empty promises.

However, what is most concerning about the presence of reformed suicidal people in the media is not the inadequate messages they send to the suicidal community, but rather the problematic messages they send to everyone else in our society.

First and foremost, the fact that they scarcely make use of their media appearances to call attention to the major problems that suicidal people desperately need help with - such as the numerous failings of the mental health system - is a real missed opportunity. I, for one, always feel disappointed whenever I see/read/hear a formally-suicidal person in the media and notice that they've haven't called attention to any of the societal or government policy issues which contribute to peoples' decisions to commit suicide.

Suicidal people have a lot to say to the rest of the world about why death is so much more attractive then life for us. They are important and valid grievances which need to be heard, and which we desperately need community help in order to remedy. So it's a big problem when people with experience of suicidalness get media exposure and fail to use their time in the spotlight to open these lines of communication.

In fact, far from being an asset to the suicidal community, I am concerned that reformed suicidal people may be making it more difficult for the suicidal community to adequately communicate with the rest of society; particularly their immediate acquaintances and government leaders.

Non-suicidal people have already been well-conditioned to not respect the ideas of suicidal people. They've been told countless times that people can only contemplate suicide if they have some severe mental defect. *"Rational minds simply don't contemplate suicide!"* This is a major hurdle suicidal people have to overcome, if they ever wish to be taken seriously and respected by their community.

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[155] i.e. Whereas "finding God" might prove to be a compelling incentive to continue living for some, they need to be aware of, and respectful of the fact that many suicidal people will not be interested in such a belief system.
[156] e.g. *"I just happened to bump in to the girl of my dreams while crossing the road one day, therefore, it's reasonable to count on the same sort of thing happening to you."*

So when formally-suicidal people actually appear in major media and condemn suicidal mindsets as being illegitimate[157]; it merely reinforces this prejudice and makes it much more difficult for suicidal people to overcome. And tragically, the suicidal community **needs** to overcome this prejudice, so that we can communicate with the broader community and be taken seriously.

I respect the fact that most, if not all reformed suicidal people will be of the opinion that their own suicidalness was indeed caused by a mental illness or malfunction in their brains. Naturally, they have every right to share their story and their strong beliefs about what was behind their suicidalness, and what eventually made their lives worth living.

But I would hope that they will likewise respect the fact that their experience is not unanimous amongst the suicidal and formally-suicidal communities. Even if their suicidalness was the result of a brain malfunction and 'defective thinking', that does not mean that each and every case of suicidalness can be dismissed so neatly.

Many people, with perfectly rational minds, are suicidal based upon considderate evaluation of their circumstances and sound, sensible reasoning, and they are more then capable of demonstrating this. Their real-world crisises can't be invalidated by the significantly different ordeals endured by people who were once suicidal due to mental illness.

Which is why major media **must** find space to share the direct input of people who are, and who have been suicidal due to real-world hardship; people who maintain the belief that their suicidalness is (or was) an appropriate response to their unreasonable circumstances.

An adequate public understanding of the role that unbearable life circumstances plays in the suicide epidemic will be essential to remedying the many faults in the mental health system, and the broader societal problems that significantly contribute to suicide and depression statistics. And we cannot hope to have this level of general public understanding if we never get the chance to hear from an adequately broad range of the suicidal community.

[157] Commonly with labels like: *"mental illness", "distorted thinking", "impulsive behavior",* ect.

RECCOMMENDATIONS

1. Establish a Permanent, Impartial Overseer of the Mental Health System

Although this inquiry will likely provoke a meaningful reform of the system, it won't be able to offer vulnerable patients any guarantee that the system won't eventually slip back into it's old habits.

It also won't be able to assist patients with any problems that may arise from future declarations the system makes about mental health matters, as well as protocols, procedures and treatments which they are yet to develop.

For this reason, the government needs to insure that the mental health system will be permanently overseen by an impartial department, with no ties nor loyalties to traditional mental health system ideology, nor any such ties to any particular political, economic or religious ideology, or any organizations based upon such ideologies.

Such a department's duties would include:

- Making sure that all mental health system rulings on mental health matters[158] are fair, balanced, adequately justified, compassionate, humane and respectful of the individual human rights of the patients who the ruling effects.
- Scrutinizing all new rulings and treatment procedures, with the primary agenda of insuring patient satisfaction.
- Constantly monitoring the scope of treatment successes and failures and making sure that this data is made available freely to the public, and in plain english.
- Addressing incidents of therapists delivering useless, time-wasting therapy, and especially harmful therapy. Or, alternatively, keeping a constant eye on the mental health system's ability to adequately police itself in these matters.
- Advocating for patients and other people who are mentally ill, suicidal, or otherwise in crisis, by repeating their concerns and making sure these concerns are adequately addressed by the people who need to address them. Providing a prominent voice for the wretches who's voices are typically ignored.
- Providing government with impartial advice on mental health and suicide policy. Advice which duely considders mental health system ideology, but is not dictated by it. Advice which takes into account the patients' viewpoints without judgement or prejudice. Advice which is formulated without any initial preconceptions about what is 'right' and 'wrong'. Advice based upon due respect for individual rights[159], and demands adequate and fully-tested justification for any policy which would violate these rights.

[158] e.g. Which lines of thought are deemed to be legitimate and "sane" , and which ones are not.
[159] Including, but not limited to, an individual's rights to choose to end their own life, and to take action to bring about their death.

RECCOMMENDATION #1
Establish a Permanent, Impartial Overseer of the Mental Health System

I strongly believe that it would be impossible to insure quality mental health care in Victoria, or Australia as a whole, without the presence of such a department.

As I have watched the state of affairs regarding mental health care in this country over many years, it has become clear to me that our mental health system is plagued, at all levels, by members who are far more interested in exploiting patient desperation to promote their own ideology, then they are in assisting people in need with compassion and integrity.

This inquiry may well install safeguards that would undermine the ability of the system and it's therapists to put their own interests before their patients'. But the system's leaders and many individual therapists would immediately seek out ways to get around these safeguards, as such safeguards would be contrary to their own agendas.

For example, therapists and leaders of the system who firmly believe that suicidal people need to have their mindsets attacked and converted into a staunchly anti-suicidal belief system, will not respect any government-imposed safeguards designed to prevent them attempting an unwanted character conversion[160] upon such a patient. As such, if left unsupervised, they will seek out and likely find loopholes that allow them to circumnavigate such safeguards, so that they might continue to treat their patients in a manner that is in-line with their own ideology, and not the patient's interests.

This is a situation that is well-known to occur.

Despite the mental health system reversing it's official stance that homosexuality was a mental illness back in the 1970s[161], it's new stance contained a loophole[162] that aloud homophobic therapists to continue to treat their LGBT patients' sexual orientations as a mental illness. These therapists were able to use the very open-ended definition of *"otherwise unclassified sexual disorder"*[163] to label an LGBT patient's sexual desires or behaviors as being illegitimate and/or the symptoms of a mental illness.

I have been lead to believe that, only fairly recently, this loophole has been closed by the mental health system, so that therapists can no longer use it as a justification to persecute members of the LGBT community.

Nonetheless, this situation demonstrates that determined and resourceful workers in the mental health system will find a way to 'legitimately' continue to promote the ideology they personally subscribe to, even when the official stance of the system turns against that ideology.

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[160] As covered in the same-titled segment (pgs. 55 - 58)
[161] See "Homosexuality as a Mental Illness" (pgs. 71 - 72)
[162] Likely by accident.
[163] Or words to that effect.

RECCOMMENDATION #1
Establish a Permanent, Impartial Overseer of the Mental Health System

A permanent, impartial oversight department for the mental health system will be essential for insuring that the system tends to it's patients with compassion and integrity, by providing an active and vigilant safeguard mechanism for any attempts by various movements within the mental health community to exploit the system's patients for their own ends, and to insure that the system does not outgrow the reasonable boundaries of it's authority, to become the sole judge and jury over what people are and are not aloud to think.

VMIAC[164], is already doing fine work in many of these areas of concern: challenging the mental health system, creating awareness of it's failings, and advocating for patients in many other ways. However, it is my understanding that they have neither any direct authority over the mental health system, nor investigative powers to officially investigate incidents of abuse or harmful treatment. So obviously, this severely limits their potential to advocate for, and protect mental health patients as well as they might like.

I'm also unaware of what, if any, funding arrangements they might have with the government. However, I suspect that, if they do enjoy any government funding and/or resources, it would not be nearly enough to allow them to properly act as an overseer for the entire Victorian mental health system.

Nonetheless, VMIAC could provide an excellant base framework for a proper overseer of the mental health system. Their respect for, and support of the needs and rights of mental health patients sets an inspiring example of the sorts of attitudes we need to see enforced in the mental health system, and especially it's therapists.

At the very least, I believe VMIAC, and perhaps also it's interstate sister organizations like Being[165], deserve to be heavily consulted - **and listened to** - in the creation of an overseer department for the Victorian mental health system.

1-A. Establish an Official Forum Where People Can Openly Air Their Grievances With Mental Health System Policy

An essential element of any new system created to insure integrity within the mental health system must be an open forum where the people most effected by mental health system rulings and policy[166] can voice their dissatisfaction with these policies and testify to the negative effects these policies have upon their lives and their prospects for recovery.

After all, how can the mental health system be expected to properly serve and care for the mentally ill and those in crisis, if it is in no way answerable to them?

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[164] http://www.vmiac.org.au/
[165] http://being.org.au/
[166] That is: patients, the mentally ill, the depressed, the suicidal and others afflicted by major life crisises.

RECCOMMENDATION #1-A

Establish an Official Forum Where People Can Openly Air Their Grievances With M.H. System Policy

Many people in need of help have lost all faith in the mental health system precisely because it is answerable to no one, and continues to practice useless and counterproductive treatment completely unchecked.

Many people are disgusted that the system is able to maintain senseless, hurtful policies, and insist that such policies are "best practice", due to the fact that there is no official forum where the immensely compelling cases against such policies can be presented by their critics and victims. Many people despair that proclaimations made by the mental health system are rapidly promoted by government and the media, and accepted as gospel truth by the general public, who defer to the "experts"; whereas compelling contrary viewpoints go completely unheard, with there being no clear route through which they can establish widespread recognition.

There needs to be a forum of this nature where people effected by mental health system policy can call public attention to the policy's faults and where the system is compelled to either clearly and compellingly defend it's stance, or admit to the need for reform and commit to starting this process. This is essential not only to insure that the system provides a quality, tested service, but also to instill a much-needed sense of integrity in the system's public image, by insuring that it's policies are well-scrutinized and justified.

2. Abandon Suicide Prevention Policy; Focus on Making Peoples' Lives Worth Prolonging

A significant portion of the suicidal community do not trust those outside of that community, and will avoid turning to them for the help they desperately need to have any hope of making their lives worth prolonging.

This is because anti-suicide ideology makes the vast majority of people and organizations outside of the suicidal community a significant hazard to the suicidal person's prospects for their best possible outcome[167].

People and organizations (including the government) who adhere to an anti-suicide agenda are at odds with the suicidal person's agenda. Whereas the suicidal person seeks their happiest, or least-miserable, possible outcome; anti-suicide bystanders primarily concern themselves with making sure the sufferer remains **alive**. In simple terms, this separate agenda makes the anti-suicide community an enemy of the suicidal person.

The nature of the problem may best be illustrated by making a (simplified) list of the possible outcomes that might befall the sufferer, then comparing how both groups rank these outcomes in order of preference, side-by-side:

Possible Outcomes in Order of Preferance	
The Suicidal Sufferer	**Anti-suicide person/group[168]**
1. Sufferer achieves a happy life.	1. Sufferer achieves a happy life.
2. Sufferer dies.	2. Sufferer lingers in an unbearable life.
3. Sufferer lingers in an unbearable life.	3. Sufferer dies.

[167] For further discussion, see "The System's Attitude Towards Suicide" (pgs. 63 - 70); "Thought Shaming" (pgs. 88 - 89); pgs. 129 - 130, under "The Narrow Scope of the Mentally Ill Input Contributed to the Highest Levels of the Discussion".

[168] Note that most people adhere to anti-suicide ideology, even if they don't actively campaign on the issue. When in doubt, a suicidal person will assume that another person will treat them according to anti-suicide doctrine.

RECCOMMENDATION #2
Abandon Suicide Prevention Policy; Focus on Making Peoples' Lives Worth Prolonging

So long as both sides agree that a worthwhile standard of living[169] can be accomplished; and so long as the anti-suicide person/group share the sufferer's level of interest in helping them attain this standard of living[170], the anti-suicide person/group are indeed a potentially valuable ally.

However, once that worthwhile standard of living ceases to be a viable possibility, for either side, the anti-suicide group instantly become the sufferer's enemy, as they will actively conspire to sabotage[171] the sufferer's chances of achieving their second-best possible outcome[172]. In other words, at this point the anti-suicide group seeks to condemn the sufferer to the worst possible fate.

Many suicidal people take stock of this equation and decide that the risk[173] of reaching out to an anti-suicide person is not worth the potential reward[174], and will go to great lengths to avoid involving those people in their personal problems.

The consequences of this are all too familiar to us all: friends/family members/co-workers/ect. find themselves utterly shocked by a person's suicide and start saying: *"I had no idea their life was so bad! Why didn't they tell anyone? Why didn't they reach out for help?"*

Well, they didn't tell anyone because everybody they knew was a potential enemy maskerading as a friend. They didn't tell anyone because everybody they knew was more interested in suicide prevention then they were in making sure that the sufferer achieved the most agreeable outcome possible. They didn't tell anyone because the risk was far too great that doing so would only insure that their anguish was permanent.

In a nutshell, suicide prevention policy is a massive booby-trap, which makes seeking help or comfort from anyone who adheres to it a perilous choice for a suicidal person in crisis. The amount of reluctance to reach out that this policy generates is massive. For this reason, suicide prevention policy is it's own worst enemy.

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[169] As defined by the sufferer in question, not necessarily anyone else. It is not up to an outside observer - even a doctor - to decree what is 'worthwhile' for another person.

[170] An important distinction, as anti-suicide people may decide that the sufferer's self-stated needs aren't important, or aren't important enough to justify the effort/resources it would require to accomplish them. At this point, the anti-suicide peoples' focus will invariably shift from helping the sufferer satisfy these needs, to insuring that they can't/won't commit suicide in response to these needs being unfulfilled.

[171] e.g. By removing their access to possible suicide tools (e.g. drugs/medications/poisons, sharp implements, ect.), keeping a watchful eye over them with the intention of interrupting any suicide attempt, having them committed to a psychiatric ward, ect.

[172] i.e. Death.

[173] i.e. That the anti-suicide person will become a significant obstacle to them reaching the peace of the grave, and will therefore significantly and senselessly prolong their grief.

[174] i.e. That the assistance of the anti-suicide person may indeed allow them to achieve a worthwhile standard of living.

RECCOMMENDATION #2
Abandon Suicide Prevention Policy; Focus on Making Peoples' Lives Worth Prolonging

If we want to see a significant reduction in depression and suicide rates, there needs to be a massive improvement in the prospects of a suicidal person actually finding that seeking help is helpful; not adversarial. Society needs to stop being at war with the suicidal citizens who need it's help. It needs to stop butting heads with them over whether death is better then a long, miserable life, or vice-versa.

For this reason, society needs to dump it's focus on directly preventing suicides and focus instead upon making lives worth prolonging.

Government needs to take the lead in this momentous change, by officially dumping it's own anti-suicide policy, in favor of a firm and sincere commitment to aid it's citizens to achieve a worthwhile quality of life.

Suicidal people **need** to hear their government and communities say in complete honesty: *"We aren't going to badger you with lines like 'Suicide is wrong!'. We won't try to get in your way if you decide to take you own life. Nor will we defame you if you do so, or use your death to spread more misery in the world. We just want you to know that if there is a way your life can be made worth prolonging, we are willing to help you, as best we are able, to achieve that goal!"*

Our society needs to be a staunch ally for the person in crisis when a happy life is still in the cards, and nothing less then an impartial bystander when death becomes that person's best option. It needs to **consistantly** be a friend to the suicidal and stop being their potential enemy.

It may seem counter-intuitive, perhaps even negligent, in terms of reducing depression and suicide statistics. But I am certain that adopting this new policy, which is respectful of the experience and needs of people in crisis, will encourage help-seeking behavior on an unprecedented scale and ultimately result in more frequent happy outcomes for such cases. By extension, this means a significant decrease in suicides.

Suicide prevention **will** still occur without an explicit suicide prevention agenda. In fact, I believe it will occur at far more successful rates then it does now. But more importantly, it will occur not through heavy-handed tactics, but through willing consent of the people. People won't just stay alive, they will happily choose life.

2-A. Prevent Psychological Abuse by Laying Down Protected Rights for the Suicidal

As discussed in the previous sections, "Unwanted Character Conversion"[175], and "The System's Attitude Towards Suicide - How it All Effects Therapy"[176], many suicidal people suffer devastating psychological abuse at the hands of people who take a hard-line approach to suicide prevention. This is especially prevalent in the therapy environment, although it can also occur in interactions with others who claim to want to 'help' the suicidal person.

Unfortunately, it is unlikely that the government merely adopting a new policy towards suicide prevention will be enough to deter people from practicing this psychological abuse. Many of the people who use these cruel tactics are staunch believers that *"suicide is absolutely, unquestionably wrong and must be prevented at all costs"*, and will not easily change their views on this matter.

Therefore, it is necessary to lay down officially protected rights for the suicidal, to protect them from unwanted and potentially dammaging attempts to convert their mindsets to an anti-suicide ideology.

Specifically, I believe the government needs to recognize the following as a human being's fundamental rights:

1. A person has the right to believe that there is such thing as a fate worse then death.
2. A person has the right to choose for themselves what does amount to a fate worse then death, and what does not. However, **this freedom applies only to the matter of <u>personal preference</u>**; a person **does not** have the right to inflict these values on another, nor attempt to manipulate that person's actions or condition in accordance with these values[177].
3. A person has the right to recognize their currant, or probable future circumstances as a fate worse then death.
4. A person has the right to recognize any number (potentially all) of the alternative circumstances available to them as a fate worse then death.
5. A person has the right to respond to being stuck in circumstances where there is no avenue that is superior to death, by choosing death over these less desirable alternatives, and taking action to bring about their death.
6. A person has the right to exercise all the above listed rights without being harassed or otherwise pressured into waving them.

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[175] pgs. 55 - 58
[176] pgs. 67 - 70
[177] In other words, if person 'A' observes that person 'B's circumstances are what 'A' considders to be a fate worse then death, it does not justify 'A' murdering 'B', nor 'A' attempting to persuade 'B' to commit suicide.

RECCOMMENDATION #2-A
Lay Down Protected Rights for the Suicidal

The government must see to it that the mental health system is bound by law to respect these rights. The system should be forbidden from attempting to alter their patients' mindsets in an attempt to reduce their usage of these rights; unless the patient has made an explicit, sincere and uncoerced request for the system, or any therapist therein, to alter their personality in this fashion. I would anticipate such requests to be **extremely** rare, and would reccommend that therapists be required to obtain a written, audio, or video record of such requests, before they would be permitted to act on them.

Beyond the mental health system, I believe that the government should strongly encourage the other major players in Australia's mental health landscape[178] to adopt a respectful attitude towards these rights, and employ this respect in the way they approach suicide and suicidal people.

And, of course, the government itself should remain ever mindful of these rights in it's governance of the country; particularly when dealing with issues that impact strongly on mental health and/or suicide.

[178] Including major mental health/anti-suicide organizations like [redacted], ect.; religious and community organizations; the media; and ultimately, the general public.

3. Create a Service That Will Provide Respectful, Meaningful, Effective and Timely Assistance to People Suffering Real-World Crisises

As discussed in the previous section "Real World Problems"[179], a shocking amount of grief arises from the fact that the mental health system often misdiagnoses distress, caused by major life crisises, as a malfunction in the brain of the person experiencing that crisis and resulting distress. Even worse, the mental health system has a firm policy of refusing to assist people with their real-life woes, choosing instead to try to alter their brain chemistries and personalities, so that they can continue to endure those horrendous woes without acting out in response to them[180].

We are frequently told that we have a huge portion of our population who have mental illnesses, and need to be treated for them.

In actuality, a massive portion of those numbers are actually people who need help with major life problems that exist not in their brains, but in the real world! They are depressed and suicidal, not because their brains are broken, but because **their lives** are broken! Yet the system we have set up to help these poor, misfortunate people refuses to get involved in such dilemmas!

Quite obviously, Victoria, and indeed Australia as a whole, needs a service that is geared towards giving people practical assistance to remedy their major life problems.

This is a truth that is immensely simple to recognize, but will doubtlessly be incredibly complex to implement.

The life issues which can drive a person to depression, suicide, ect. are about as broad a collection as one could imagine. And the service would need to be able to provide **meaningful** assistance for each and every one of them. This would require the staff of this service to encompass an incredibly diverse range of capabilities, expertise and professional connections.

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[179] pgs. 30 - 39

[180] e.g. By committing suicide, or exhibiting other depressive behavior, such as being unmotivated, performing poorly at school/work, or behaving in a manner that is 'concerning' to those around them.

RECCOMMENDATION #3
Create a Service to Provide Assistance for Real-World Crisises

Some of the more common issues that such a service would need to be able to offer meaningful assistance with would be:

- Loneliness; lack of friends, family and/or romantic partner.
- Unemployment
- Unfulfilling Employment; needing a job that offers personal satisfaction.
- Poor/Unfair Reputation
- Financial Crisises
- Inappropriate Residancy Situation; living uncomfortably alone, living with incompatable people, or living in an incompatable neighbourhood, ect.
- Bullying/Harassment/ect. Situations - particularly ones that aren't menacing enough to warrant police intervention, in which police intervention has been ineffective in the long term, or schoolyard situations where school authorities have proven incapable of resolving the problem.
- Disaster Recovery/Management - including drought management.
- Beaurocracy-Related Grief
- Advocacy Against Hurtful Conduct by Government or Private Companies

This is by no means a complete list of what this service will need to be able to deal with. It is merely intended to serve as a very basic illustration of how diverse the service's capabilities will need to be to adequately perform it's duty.

Of course, it is unreasonable to expect that this service will be staffed by jacks-of-all-trades who can each solve any manner of problem a patient might present them with. The staff of this service will need to be a very diverse crew, each with their own strengths.

That being said, special care must be taken to minimize the amount of bouncing around a patient will need to do before finally being sent to a helper who actually has the capability to give them meaningful assistance in their issue. Remember that many of these people will be suffering terribly due to their problem; the service mustn't compound that suffering through poor case management at the system level.

Ideally, a patient of this service would merely need to consult with an evaluator before being referred on to a proper helper with the best capability to assist them.

Regardless of the diverse range of needs amongst the service's patients, one thing that must remain absolutely consistant is that the helpers must be compassionate, non-judgemental and thoroughly invested in their patient's cases. They must be committed to a principal of helping the patient achieve the patient's goals; not inflicting their own ambitions upon the patient.

And of course, all areas of this service must be bound by the same legally-binding rules of doctor-patient privelage that apply to the therapists in our existing mental health system.

RECCOMMENDATION #3
Create a Service to Provide Assistance for Real-World Crisises

Too many of us who have experience with the currant mental health system know all too well the disastrous outcomes that come from being treated by a therapist who doesn't care about his patient[181], or who is more interested in manipulating the patient into conforming to his own views then offering the patient meaningful help[182]. This atrocious culture of disrespect must not be aloud to become part of the new service.

Part of the creation of this new service will need to include an adequate public awareness campaign to make the public aware of the fact that there is now a service to help them with their real-life problems; so that the public know to turn to this service, rather then the existing mental health system, for help with their real-life crisises.

In the longer term, safeguards will need to be implemented within the mental health system, to insure that patients who turn to it because they are depressed, suicidal, ect. in whole or in part due to a real-life crisis (not a mental illness) will be appropriately directed to this "real life help" service, rather then be treated by the mental health system for a nonexistant mental illness.

I won't pretend that this service isn't a staggering engineering challenge. And I am well aware that the government's first instinct will probably be to reject this call for what will no doubt be a painfully expensive endeavor; especially in this modern economic climate.

But the cold, hard truth is that, expensive or not, difficult or not, this service is **needed** by a massive segment of the public.

Contrary to the commonly-held assumptions about our mental health system, there is no help mechanism at the moment for people suffering major real-life crisises. People are trapped in unspeakable misery because there is no one around to help them remedy the cause of it. People are killing themselves because there is no real help.

If you are sincerely interested in reducing suicides and the prevalence of depression, anxiety, ect. in Victoria, you need to build a system that will **actually** help the desperate Victorians who need it.

3-A. Develop a Strategy for Loneliness

I feel I must draw special attention to the problem of loneliness at this point because it is about to become a major crisis for this country, if it isn't already. I don't believe it is an exaggeration to say it is growing like a plague. And it is bringing with it large amounts of depression, suicidalness, and animosity & distrust towards our fellow man and woman.

[181] See "Therapists Have a Disturbing Tendency to be Arrogant" (pgs. 43 - 52)
[182] See "Therapists Often Do Psychological Dammage" (pgs. 53 - 62)

RECCOMMENDATION #3-A
Develop a Strategy for Loneliness

The situation is not helped by the fact that it is an appallingly understated crisis. The amount of people who will insist to a lonely person that *"it's okay to be lonely"*, is staggering. Most people seem to be of the mindset that food, water and air are absolute essentials, but meaningful connection with another human being is, apparently, a triviality.

Whilst I have, in recent months, noticed hints that the fedral government may be starting to take notice of this crisis, at the moment there still aren't any measures in place to seriously address it.

All round, there is very little respect for the fact that the absence of meaningful relationships in a person's life will often make the notion that life is worth prolonging quite implausable for that person. This in turn reduces the value of the money and the healthcare which they are expected to use to sustain that life - even if such resources are provided free of charge to the sufferer by the government. The longer the loneliness goes on, the more pronounced this effect becomes.

Thus, I would suggest that loneliness should be considdered at least as dire a crisis as widespread unemployment, poverty or a major medical epidemic. As, to a lonely population, secure employment, dole money and reliable healthcare are utterly worthless.

In addition to being understated, the nature of this crisis is also dreadfully over-simplified in many peoples' minds. What far too many people fail to appreciate is that remedying loneliness does not merely come about through placing a lonely person in proximity to other people. It comes about through fostering connections between a lonely person and someone who is compatable with them.

You can't just cure someone's loneliness by dropping them off at the doorway of a pub that is crowded with other people.

You need to ferret out specific people who you know to be of a similar character to the lonely person, you need to make sure these people encounter one another[183], and you need to cultivate circumstances to make sure they get to spend enough time together to forge a friendship.

The more significant the relationship the lonely person needs, the more refined this matching process needs to be[184].

Any strategy for combatting loneliness must appreciate that placing a person with people who they are incompatable with may not only fail to alleviate their loneliness, but may in fact make their sense of loneliness and depression much worse.

[183] e.g. By making a formal introduction.
[184] e.g. A person in need of a romantic partner/spouse will need an especially compatable match, as opposed to someone merely in need of a casual friendship, ect.

RECCOMMENDATION #3-A
Develop a Strategy for Loneliness

I believe that the nature of this loneliness crisis facing Australia is less a case of people not being in proximity to many other human beings, and more a case of people finding that the many human beings around them are collectively unpleasant and unfulfilling company. Thus, the strategy we devise to combat it must take care to avoid setting up encounters that re-inforce peoples' negative impressions of humanity as a whole. The aim of an anti-loneliness strategy is to support the idea that relationships with others and engagement with society can be beneficial, and worth investing time and effort in; not to disprove it.

Unfortunately, a fast-and-easy approach to dealing with the loneliness crisis simply won't work. In fact, it will more then likely be even more harmful then doing nothing at all.

An adequate anti-loneliness strategy will demand careful, considderate and individually-tailored handling of each and every case. It will demand thorough understanding of the character and needs of the lonely person who reaches out for help; and a careful evaluation of any potential candidates for a relationship with that person, to make sure that each of them can give the other what they need to forge a mutually-appreciated connection.

On top of all this, the strategy must also insure that the 'helpers' tasked with helping the lonely carry out their duties impartially and without judgement. The relationships they cultivate must tend to the needs and tastes of the people they are tasked with helping; not themselves, and certainly not a larger organization or ideological group.

A firm and committed strategy against loneliness, such as this, should be regarded as a cornerstone of the real-world help service; as I have no doubt that loneliness will make up a major portion of the real-world life crisises that the service will be called on to help with.

4. Promote Public Awareness of the Dangers of Therapy

There is a major need for far greater public awareness of the potential dangers of therapy[185]. This is important not only so that patients can be adequately prepared to encounter poor therapists, but also so that other people in their support network[186] may be informed of the gravity of poor therapy situations and may better understand what their friend/family member/ect. is going through.

Well before they go into therapy, patients should be aware that there is a significant chance that their therapy might well turn out to be ineffective. The existing assumption that signing up for treatment with a therapist will be a sure-fire cure for their problems[187] leads many naieve patients to silently endure long bouts of useless therapy, unaware that it is going nowhere. The thought doesn't even enter the patient's head that the therapist may be wasting their time and money until a great deal of both those things has been spent, with no significant reward to show for it.

So much of that wasted time could be spared if patients knew to be watchful for time-wasting, useless therapists. In many cases, minimizing this time wastage can make all the differance for a patient in need of prompt, **effective** assistance with a serious crisis. It can be the differance between recovering a life before it sinks below the limits of what is worth living for, or arriving too late.

But above all else, patients need to be warned about the serious and very real dangers of psychological harm by a therapist. In particular, they need to be cautioned about revealing too much of themselves before the therapist has thoroughly proven themself trustworthy enough to be trusted with the patient's intimate details. As previously discussed[188], a therapist who knows their patient's deepest vulnerabilities is especially capable of inflicting severe long-term psychological harm.

Patients should also be warned to be watchful for 'baby step' treatment which seems to be intended to bring about an end that is contrary to their own values or ambitions; even if it seems like this negative outcome will not be significant in scale. As previously discussed[189], perscribing undesirable treatment in unthreatening 'baby step' doses is a clever ploy that a therapist will often use to get a patient to cooperate with dammaging therapy. Patients should be informed to be especially wary if the 'baby step' perscribed is a scaled-down version of a more ambitious treatment that the patient refused to go along with.

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[185] See "The Misdiagnosis of Real-World Problems as Mental Illness" (pgs. 30 - 35), "The Poor Quality of Care - Therapists" (pgs. 40 - 62).
[186] i.e. Friends, family, coworkers, ect.
[187] Spurred on by emphatic promises by media, mental health organizations, ect. that "there **is** help available to you."
[188] pg. 54, under "Patient Undermining"; pg. 105, under "Commentary That Paints the Mental Health System in a Negative Light is Unwelcome"
[189] "The Question of Consent" (pgs. 56 - 58)

RECCOMMENDATION #4
Promote Public Awareness of the Dangers of Therapy

Patients need to be advised to have a well-considdered exit strategy for how they will get out of therapy should they find their therapist to be useless or dammaging. They should be advised to anticipate the most likely ways their therapist might attempt to pull apart their exit strategy and how they should best secure the strategy against such attempts.

Patients should be warned that **a therapist cannot be counted on to release them from therapy if they are unable to help them**.

I would suggest that all these warnings need to be emphasized, so that patients are truly made aware that these matters are all very real risks that they might be likely to encounter. Naieve incoming patients may be inclined to take such warnings as finicky disclaimers that are merely dealt out as a legal protection for the therapist and the system, and which describe issues that they, in reality, have virtually no chance of encountering.

This was my folly.

During the early days of my own stint in therapy, whenever I remarked about being in therapy to get help, I was cheerily corrected that my therapist would ***'try'*** to help me. At the time, I did not take this as a frank warning about a real risk that the therapy might amount to nothing. I certainly didn't take it as a warning that the therapy would actually darken my outlook on the world and life itself[190]. Instead, I assumed that she was merely making an over-cautious disclosure to cover herself, legally. I also likewise assumed that if she could not help me, she would promptly admit this and conclude my treatment.

The resoundingly pro-therapy media culture we currantly live in has cultivated an environment where everyone believes the mental health system to be the saving grace of the troubled. They believe that the worst thing about it is that it may take you forever to get an appointment, due to under-funding. This culture has set up already vulnerable people to be utterly blindsided by terrible therapists, who they were lead to believe would be their knights in shining armor.

The lucky ones will only have their time stolen. The unlucky ones will lose so much more.

Poor public awareness of bad therapy has also made it much more difficult for victims of bad therapy to get support from their friends, family, ect. during these times. Many people will tend to assume that, if there is a conflict between a respectable, fully-educated therapist, and their 'struggling' friend/family member/ect., then the fault most likely lies with the patient.

[190] See "My Own Personal Experience" (pgs. 58 - 62)

RECCOMMENDATION #4
Promote Public Awareness of the Dangers of Therapy

I reccommend that the government encourages adequate media scrutiny of failure rates of therapy - and **especially** rates of harmful therapy. I also reccommend that you establish a website geared towards informing the public of the risks of bad therapy and offering advice on how patients can protect themselves.

I reccommend that you encourage the major mental health & anti-suicide organizations[191] to devote prominent sections of their websites to informing visitors of the risks of therapy.

I would also like to suggest that you considder making a law that therapists must provide all new patients with a government-printed pamphlet detailing the risks of bad therapy, the warning signs, and tips on how to manage them when they occur; or a comparable law that insures that all new therapy patients are adequately informed of these matters.

[191] e.g. BeyondBlue, Lifeline, RUOK, ect.

5. Encourage the Media to Provide More Balanced Coverage of Suicide and Mental Health Issues

As detailed throughout the previous section, "Gaps in the Public Forum for Discussion of Mental Illness, Suicide and Related Issues"[192], there are many severe shortcomings in modern media's coverage of suicide and mental illness.

These problems reinforce major problems with the mental health system and society as a whole, by maintaining a culture of silence that keeps these problems unrecognized and undealt with.

They stifle many suffering peoples' ability to call out for help. And they widen the rifts between "normal" society and it's outliers, by depriving both of these groups of the clarity they need to relate to one another, and making the outliers feel like the rest of the world doesn't care about their side of the story.

At the heart of all these shortcomings is the fact that the media extends very little opportunity for currantly-mentally ill and suicidal people to provide direct input into the coverage of these issues. The media loves talking **about** mentally ill and suicidal people, but it seldom talks **to** them.

Case in point: In the lead-up to last year's "R U OK? Day", I noticed a large amount of comments on social media from depressed/suicidal/ect. people stating that they were going to take a sick day from school/work that day, because the general intrusiveness that the day encourages was extremely unpleasant for them. They truly dreaded a day-long bombardment of *"Are you okay?"*'s, being scrutinized like a lab sample in a petrie dish for any indications of 'struggling', or being repeatedly badgered to *"open up"* or *"talk to someone"*. So rather then enduring the hazards of "R U OK? Day" culture, they were opting to avoid human contact as much as possible for the entire day.

This phenomenon was very noticeable in social media, and was surprising even for myself. Yet as far as I could see, all the major media coverage around "R U OK? Day" was emphatically supportive of the movement and it's organizers; with no critique whatsoever of the noteworthy distress it may have been inadvertently causing. It was a day of extensive discussion **about** suicidal, depressed and other 'mentally ill' people. But the actual experience of people who were suicidal, depressed, or enduring some other major life crisis, was not factored into the media coverage at all.

This glaring absence of mentally ill/suicidal contribution in media coverage leaves the vast majority of Australia completely in the dark about issues that we are all supposed to be concerned about, but not aloud any insight into. We must all be concerned about what the mentally ill or suicidal person is experiencing, but we can't know precisely what that is; at least, not until the most pertinant elements have been sanitized out.

[192] pgs. 99 - 134

RECCOMMENDATION #5
Encourage the Media to Provide More Balanced Coverage of Suicide and M.H. Issues

So much of what is broken about Australia's approach to mental illness and suicide traces back to this culture of silence. People are suffering and dying, largely because everyone around them aren't aloud to be told why.

I implore you to use whatever influence you have over the media to encourage them to seek out a far more diverse range of input, for use in their stories, segments, articles, ect. on mental illness and suicide. In particular, please call on them to bring more currantly-suffering voices into the conversation, so that the nation can know what they are going through and, perhaps more importantly, so that their fellow sufferers can know that their voices are valued and being heard.

6. Insure Mentally Ill and Suicidal People Play a Central Role in Developing Policy on These Issues

Mentally ill and suicidal people need to play a bigger role in the development of official policy on these issues, in much the same way that their input needs to heard more often in media coverage. While it is of great importance that the general public be given insight into the plight of these people[193], it is equally important that the policymakers, who shape the lives and the recovery options for these people, have a thorough understanding of their suffering.

For how can such policymakers reasonably expect to alleviate the problem, if they have a poor grasp of what the problem is?

Much of the debate we currantly have over these issues seems to operate overwhelmingly on the input of various "experts", and organizations made out of such "experts".

Although many of the "experts" who testify on these matters would claim to base their statements on input they've taken from sufferers of mental illness and other crisises, I am concerned about the sanitizing effect that comes from having these "experts" act as proxies for the person in crisis. It is one thing for a committee to hear a rehearsed speech from a gentleman in a smart suit, who will state that he has spoken to suicidal people. It is another thing for the committee to have to look into the anguished eyes of someone trapped in their own living hell and hear firsthand: *"I wish I was dead. This is why..."*

Additionally, I must confess to having severe doubts about the ability of these "experts" to present their accounts of what mentally ill and suicidal people have told them, without bending that information to suit their own agenda. An "expert" who is convinced that the suicidal person is in error by preferring death over survival is highly unlikely to relate the suicidal person's compelling collection of evidance and reasoning that supports the idea that death is better then survival. They have an interest in maintaining the perception that suicidal people are unreasonable and that their viewpoints don't deserve to be considdered, much less indulged.

Also, we can't dismiss the amount of confusion and inaccuracy that can arise from blending numerous statements from numerous differant mentally ill, depressed & suicidal people, experiencing a diverse range of crisises, into a single, all-encompassing testimony.

[193] As discussed in the previous reccommendation **#5**: "Encourage the Media to Provide More Balanced Coverage of Suicide and Mental Health Issues" (pgs. 152 - 153)

RECCOMMENDATION #6
Insure Mentally Ill and Suicidal People Play a Central Role in Developing Policy

I must admit that I have noticed a recent significant uptick in the amount of direct input from currant and former sufferers of depression, suicidalness, or other major crisises. For example, I am encouraged by the notable presence they've established amongst the submissions to the fedral government's productivity commission inquiry into mental health[194]. I am also under the impression that they've already established a significant presence amongst the input to this inquiry, which is most encouraging.

It is yet to be seen what weight their input shall be given in the eventual conclusions of these policy debates, particularly in comparision to the input given by "experts", which remains substantial in quantity.

For the moment, we can only hope that the policymakers who have received our input will be attentive to it.

Although currant trends would seem to suggest that suicidal, depressed, mentally ill, ect. people are becoming a strong and established presence in the policy formulation process regarding these issues, I would nonetheless reccommend that the government remain ever mindful of the need to attract as much input as possible from these sorts of people, during each and every policy debate, with a special emphasis on attracting input from people **currantly** suffering these experiences.

For the sake of cultivating openness and trust in the process, I believe that the government should aspire to make as much of this testimony public record as possible. However, you must be ever mindful that a great many of such sufferers will desire to remain anonymous, and a great many more will not want their testimony to be made public in any way, shape or form. Above all else, the wishes of these people, regarding the privacy of their testimony, must be respected. The government must first and foremost aspire to attract these statements for it's own insight, with public enlightenment being a secondary priority.

I also believe that the government must make special efforts to insure that the role of suicidal and mentally ill people in this process goes beyond mere consultation. I believe that people in crisis must play an active role in the deliberations; they must be among the policymakers.

It is unrealistic to believe that policy that adequately and appropriately tends to the needs of people who are mentally ill, depressed, suicidal or otherwise in crisis can be engineered entirely by people who live outside of this turmoil. Even if they have talked at length with the sufferers of such crisises.

[194] http://www.pc.gov.au/inquiries/current/mental-health/submissions

RECCOMMENDATION #6
Insure Mentally Ill and Suicidal People Play a Central Role in Developing Policy

The mentality of people who have never seriously hoped for death over survival seems to opperate on a differant wavelength to those who have. Politicians will often times express shock that prepubescent children as young as 5 might be contemplating suicide[195], whereas a person with a thorough life experience in the undesirability of life will not be surprised at all. If anything, they are more staggered that the mainstream continues to make unsupported claims that life is worth enduring, and that they are able to do so with straight faces.

Take note: the problem in this scenario is not that the politician needs to be informed of the prevalence of youth suicidalness. The problem is that, even after being informed of the situation, they will still likely be quite mystified as to how a child's mind could entertain such ideas. They seem to be incapable of shaking the assumption that the merit of suicide is a complex construction that only an older, more elaborate mind can fathom, rather then a self-evidant truth that even a comparitively simple mind can notice by themself.

Policy concocted exclusively by such a separate mindset cannot possibly be adequately tailored to the needs and concerns of the people it will be applied to. And therefore, it will be prone to a significant degree of failure.

That's why suicidal, mentally ill, and other people in crisis need to be at the heart of deliberations. They need to be there, to tell the policymakers precisely when things stop making sense for people in their position, and to tell them when a measure is proposed that will clearly cause problems for people such as themselves. Because all indications are that most "mentally healthy", or non-suicidal people[196] can't recognize these milestones themselves.

They need to be there at the conference table, persistantly advocating for the key matters that people who don't understand dire life crisises always seem to forget about.

If you want policy that makes life worth living for those who are currantly better off dead, you need it to be engineered, at least in part, by people who truly understand why their lives are undesirable and who truly grasp what they need to change this situation.

I am not suggesting that the mentally ill, depressed, or suicidal be given absolute, unchecked power over these policies. But they do need to be involved at all levels of policy formation, including the highest.

For it is their lives, above all others, that these policies can either save, or betray.

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[195] *"Sixteen per cent (509 reports) of young people were having suicidal thoughts when they contacted yourtown's Kids Helpline last year, with 12 per cent of those aged just five to 12."* - http://www news.com.au/lifestyle/parenting/kids/kids-as-young-as-five-feeling-suicidal-over-bullying/news-story/eed8ac8471ea4eacf529070cf9d201cf

[196] Even amongst those who are regarded as "experts" in the field.

7. Recognize Happiness as an Essential Resource

So much of the grief and dysfunction that the government seeks to remedy, if not prevent, with it's policies on suicide and mental health stems from the shortage of happiness in our society[197]. It might seem absurdly obvious, but it needs stating, nonetheless: Many people are depressed and unmotivated because they lack happiness. Many people are **killing** themselves because they lack happiness.

While absence of happiness mightn't explain every case of personal crisis, mental illness or even suicide, every life that lacks a source of happiness will almost certainly sink into depression and/or suicidalness.

It therefore stands to reason that the government needs to start recognizing happiness as an essential requirement that it's citizens need; just as essential as food, water, heat and medicine. It needs to recognize that an absence of happiness, whether it be in just one household or across an entire community, is just as serious as an absence of any one of those other resources. It needs to recognize that just as surely as in a drought or famine, where there is an absence of happiness, sickness, ruin and death will surely follow.

This needs to be factored in to all future policy - across all areas - that the government develops. It also demands a reevaluation of all currant government policies, to determine which ones have a significantly negative effect on peoples' happiness and which ones have unutilized potential to generate a great deal of happiness, with the right modifications.

In particular, the policies which have the greatest impact on Australian lives must be tested for their impact on peoples' happiness, and explored to see if they can be improved to make people happier, in addition to serving their stated function.

For example, the government focusses a great deal of it's energy on making sure people are employed. But all indications are that this policy is chiefly fixated on insuring that the citizen is provided a financial income stream through their job, with no regard as to whether they are provided any happiness from it.

[197] See "The Poor Recognition of Shortage as Motivation for Suicide" (pgs. 81 - 83), and "Lack of Uplifting Presence" (pgs. 90 - 93)

RECCOMMENDATION #7
Recognize Happiness as an Essential Resource

It is my understanding that the government will often bounce it's citizens around through many different jobs in quick succession, because, as far as it is concerned, a paycheck is a paycheck is a paycheck. It has no regard whatsoever for the far more precious rewards that a job ought to provide, such as the potential to meet and bond with one's future spouse; cherished bonds of friendship with one's coworkers[198]; a sense of accomplishment in one's work exploits; a sense of pride in making world a better place; witnessing enjoyable workplace occurrances; and an overall enjoyment of the work itself. As a result, it may well be mindlessly demolishing precious assets such as these, as it carelessly moves the citizen from job to job.

And the whole time, it no doubt pats itself on the back and assures itself that it is doing right by that citizen. Because it's making sure that he has a decent income, and that's all that matters.

This tragedy becomes even more absurd when the citizen grows weary of working, well before the end of their productive lifespan, because the entirety of their diverse employment experience has shown them that work can reliably put food in their belly, but it has shown no capacity to make life worth prolonging; hence making the food worthless.

At this point, the government will likely either dub the citizen to be *"mentally ill"* or *"a lazy bludger"*. When in truth, the fault lies neither in the citizen's brain, nor their sense of fair play, but in the government's complete disregard for the citizen's need for happiness, in it's mad rush to insure that he/she was making money.

Employment policy **needs** to be corrected, to insure that citizens are not merely given jobs that will satisfy their financial needs, but also satisfy their need for happiness, as well. The government must abandon it's simplistic perceptions of jobs, based on how much money they pay, and begin evaluating each and every one of them based on their defining qualities. It must also stop viewing it's citizens as generic worker bees, and recognize their individual employment needs, so that they can be assigned the job that will best satisfy their personal needs.

Some workers might cherish working solo in remote, rural environments; whereas others desperately need the constant companionship of a workplace family. Some workers might need a reliable, punchclock job defined by routine, whereas others need the hustle and bustle of a job that is always throwing surprises at them in order to be content. Some workers will place supreme importance on safety, whereas others will emphasize the importance of getting a regular laugh out of their co-workers' mishaps. These are just simplified examples. But I hope they effectively demonstrate how the unique needs of a citizen and the unique qualities of the job need to be carefully matched when assigning the citizen their job. The government's failure to appreciate these subtleties causes an immense shortage of essential happiness.

[198] In best case scenarios, this is more like a family then a mere collection of friendships.

Employment policy is a particularly relevant example of government failure in regards to national happiness. But it most certainly isn't the only one. I won't even attempt to list them all[199], as there are far too many to address in this single submission.

By the way, there is a crucial truth that I feel I must emphasize at this point, because for some reason, it very often escapes people: Throwing money at people **does not** equate to throwing happiness at them!

If a government's policy began destroying the country's water or food supply, or if they failed to respond to a developing shortage of either of these resources, there would be an uproar. Yet this is precisely what the government is doing to the equally precious resource, happiness, all the time.

It has to stop, if the government has any sincere intentions of subduing the epidemic of depression and suicidalness that is growing in this country. We cannot continue to act shocked and surprised at the growing number of people who are judging life to be worthless, while at the same time, utterly disregarding our shortage of the very resource which would bring value to those lives.

7-A. Strive to Make Sure That Citizens are Placed Amongst Their Most Compatable Culture[200]

While reading through the previous section "Public and Government Don't Respect Their Own Large Role in Mental Health Cases"[201], you could be forgiven for thinking that it was placing an unfair obligation upon the wider community to accommodate the needs of people in crisis. You may even have gotten the impression that that section was suggesting that the general public ought to bend over backwards in order to satisfy the preferences and needs of this minority.

However, I don't believe that positive outcomes for people in crisis needs to come at the cost of significant inconvienience to others. I firmly believe that the community's burden of accommodating a person's needs can be greatly reduced by insuring that that person is placed within the culture that best reflects their own values, tastes and ambitions.

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[199] However, some particularly notable ones are the government's prioritizing of education over happiness, and the disregard of happiness in healthcare situations.

[200] n.b. For the purposes of this section, I use the word 'Culture' not in reference to a person's ethnic heritage or upbringing, but to the set of values, tastes, inclinations, spirituality and societal ambitions that they have personally accepted as their own, and as those of their ideal society. Often times these traits will indeed be inherited from ethnic background and/or upbringing. However, on many other occasions these traits will be separate from one's background/upbringing and will often even conflict with it.

[201] pgs. 86 - 98

RECCOMMENDATION #7-A
Relocate Citizens to Their Most Compatable Culture

Gathering people of common mindsets together, and allowing these cultures the freedom to shape their own environments makes massive strides towards not only alleviating a shortage of happiness, but also loneliness, too[202]. People of common core mindsets recognize each other's highest needs and will naturally orient their community towards tending to those needs. In other words, they create their own environment where happiness thrives; at least for people of their own culture.

Even better, members of these communities will often enjoy their roles in cultivating the community's sources of happiness, or at the very least, take sincere pride in them. This means that they will have a natural tendency to adopt the role of giving their community happiness, even without a sense of obligation or social pressure to do so.

Thus, by relocating an unhappy person into the a community that best matches his or her values, tastes and ambitions, you will virtually eliminate the degree of inconvienience their needs place upon their community, as the community naturally caters to those needs, without needing to go out of their way to accommodate their newest member.

That isn't to say that the need for compromise between the individual and the community will be completely eliminated. Very few people, if any, will be perfectly in-tune with the collective mindset of even the most compatable community. There will always be subtle points of contention. However, such points of contention are minor trivialities compared to the immense instances of dissatisfaction and reluctance to accommodate that arise when you try to remedy a person's absence of happiness amidst an incompatable culture.

An established community doesn't want to drastically alter their speech, behaviors and standards to raise the happiness of a handful of outliers, and nor should it have to.

A person who can't understand, nor relate to their surrounding community doesn't want to spend their life following values, speaking words and doing deeds that are contrary to themselves, and nor should they have to.

The only ethical and effective solution to a situation such as this is to relocate the outlier to their most compatable community.

Culture matching not is only very effective at tending to peoples' need for happiness, but it is also immensely helpful in tending to peoples' needs for cherished companionship.

[202] See the previous reccommendation **#3-A**: "Develop a Strategy for Loneliness" (pgs. 146 - 148)

RECCOMMENDATION #7-A
Relocate Citizens to Their Most Compatable Culture

As previously noted, there is far more to curing loneliness then simply placing a lonely person in proximity to other human beings. They must be able to relate to the people around them; they must be able to understand them and to feel they are understood. They must feel that their cherished values are not merely respected, but held equally as sacred by the people around them as they are held by themself. They must feel that the people around them hold the same social aspirations; that they are all part of the same team working towards the same ends.

The best remedy that can be applied to loneliness, on the national level, must surely be adopting a policy of seeking to match people with their own cultural communities. Not only will a successful execution of this policy reduce general loneliness immensely, but it will also have hugely beneficial effects in terms of citizens making close friends and even finding long term romantic partners; as citizens will find it immensely easier to find such deeply compatable people in an environment of their own culture.

I reccommend that the government adopt a long-term view of amending it's employment and residency policies to make sure that it's citizens don't merely have a steady paycheck and a roof over their heads, but are living and working amidst a culture that reflects who they truly are. At least in the most significant aspects. Such reforms ought to be a key considderation during the formation of the "Real World Help" service proposed in Reccommendation **#3**[203].

I don't pretend this will be an easy task: mapping out the character of each and every community pocket in Victoria; to say nothing of finding a way to condense scattered cultures into defined geographical areas. But ultimately, it is a task that the government needs to complete, if it hopes to have a future where Victorians feel a connection with and respect for the society around them, and therefore recognize value in human life.

Australia cannot possibly flourish if we remain a rabble where so many people are strangers to the environment around them; where our world is alien, incomprehensible and deeply at odds with our highest values and needs.

Just to clarify: I am not implying that culture matching is the best solution for everybody who is depressed. Nor am I suggesting that it will completely satisfy all the people who will benefit from it. There are many issues that drive a person to be depressed or to contemplate suicide and a lot of them will not be significantly remedied by relocating them to a community of like-minded souls. For this reason, adequate services that tend to mental illnesses and other personal crisises still need to be readily available to all communities.

[203] pgs. 144 - 148

RECCOMMENDATION #7-A
Relocate Citizens to Their Most Compatable Culture

Effective culture matching would significantly improve the lives of a great many people. But it is not the be-all end-all solution to Victoria's depression and suicide crisis.

8. Give Patients More Control Over the Involvement of Their GPs

As detailed in the previous sections, "Surrendering of Doctor-Patient Privelage"[204], and particularly "The Need to Involve a Patient's GP in their Mental Healthcare"[205], patients of the mental health system[206] need **complete** freedom to decide the involvement, or lack thereof, of their GPs in their mental health matters and personal issues.

This means that the mental health beaurocracy needs to be reformed so that there is no area of mental health treatment and no form of assistance which is difficult (or impossible) to access without a GP's involvement.

For example, Medicare discounts for mental health therapy, or real-world crisis assistance, should not need to be applied for through a GP. A patient ought to be able to apply for these directly through the therapist, or by making arrangements with Medicare directly.

Access to special psychiatric services shouldn't require a referral from a GP; there ought to be other ways of accessing them.

These are just examples of areas where the patient needs more control over the presence of their GP in their affairs.

The GP has a unique and crucial role in their patients' lives. Many patients are unwilling to dammage this relationship by disclosing mental or personal problems to their GP and this can prevent them from accessing help they desperately need.

The government's beaurocracy needs to stop forcing people to choose between maintaining a comfortable relationship with their GP, and getting the care they need. It needs to amend **all** it's policies to allow patients to keep their GP out of the process.

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[204] pg. 76
[205] pgs. 77 - 78
[206] Including the proposed future *"Real Life Assistance"* service detailed in the previous reccommendation: **#3** "Create a Service That Will Provide Respectful, Meaningful, Effective and Timely Assistance to People Suffering Real-World Crisises" (pgs. 144 - 148)

9. Apply Safeguards to the Medicare Therapy Discount System

As noted in "Calls to Increase the Amount of Medicare Discounts for Therapy"[207], the therapy discount system often plays an accidental role in prolonging bad therapy situations, and any increase to the amount of discounted sessions a patient can access per year poses a real risk of increasing the hardship that some therapy patients go through.

For that reason, I strongly reccommend that the government looks in to developing safeguards for the discount system, to insure that it gives patients all the freedom they need to ethically and compassionately escape from terrible therapy situations.

The most important step you can take in this regard is to **remove the requirement** that patients applying for the discount need to surrender their doctor-patient privelage with their GPs[208]. As I've previously noted, there are numerous reasons why this requirement is inappropriate. But one of the key benefits of removing it would be that it would allow patients to approach their GPs for reliably confidential assistance to escape from their bad therapy predicament.

I also have a couple of other ideas about how safeguards could be applied to the Medicare discounted therapy system.

The first is to convert the system from a strict set of discounts applied session-by-session to a patient's treatment, to an annual 'pool' of money offered to each patient to be spent as they please upon various 'mental health treatment' measures[209]. There are numerous benefits to such a system[210], and I have read proposals from several others for the discounted therapy system to be converted to such a format.

In terms of safeguarding the discount system against prolonging or aggravating a patient's bad therapy situation, such a reform would allow the patient to tell their (bad) therapist that they have already spent their annual 'pool' on other treatment measures, and thus they can't afford any more sessions with that therapist.

Note: for the safeguard to work this way, therapists must not be able to access the details of the patients' Medicare 'pools' to determine how much money is actually in them.

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[207] pg. 79
[208] As discussed on pg. 76.
[209] e.g. Meditation sessions, mental health retreats, alleviating the cost of mental health medication, ect.
[210] A major one being that it allows patients to tailor their treatment options to suit their specific needs, thus providing them with their best-possible treatment arrangement, and providing maximum value-for-money in terms of the government's spending.

RECCOMMENDATION #9
Apply Safeguards to the Medicare Therapy Discount System

Another option would be to give patients direct access to managing their discount scheme online, including the ability to disable their discount arrangement with that particular therapist, but without the therapist being able to determine that the arrangement was cancelled by the patient. The patient could then claim that their discounts had most likely been cancelled due to a beaurocratic snafu.

This would be plausable, as, in the wake of the ‘robodebt’ scandal and other similar government mistakes, the government beaurocracy has a less-then-stellar reputation. Also, as beaurocratic errors are notorious for taking very long times to sort out, this explaination would allow the patient to justifiably discontinue their treatment with that therapist indefinitely and, in reality, permanently.

These are only basic ideas that I hope will serve as food for thought. It is most likely that a much more effective mechanism could be devised for protecting users of the Medicare discount system from bad therapy situations. With that in mind, I urge you to thoroughly examine the problems associated with this system and seek to develop the best solution possible for them - **especially** if it becomes your intention to increase the amount of discounted sessions that therapy patients can access.

10. Decentralize Medicare Records of Mental Health Service Usage

As detailed in the previous section, "Privacy Concerns Regarding Records of Receiving Therapy"[211], many patients or would-be patients of the mental health system have severe concerns over the stigmata that records of their usage of mental health services can potentially attach to their identities. Particularly when such records are convieniently filed in a central database, such as Medicare's.

With medical histories becoming more and more accessable with every passing year - especially with the government's creation of the "My Health Record" database, the reputation risks attached to seeking mental health treatment are only growing.

While patients do, technically, have the option of keeping their therapy usage off of Medicare's radar, by not applying for the Medicare therapy discount[212], the high financial cost of this option makes it impractical for many.

I reccommend that the government conduct a detailed exploration of ways to minimize the paper trail/digital footprint that comes from seeking mental health assistance.

Each and every chink in the armor of patient privacy is another deterrant against seeking help for anyone who is concerned about their career prospects, or earning or maintaining the respect of their community; in other words, pretty much everybody.

In addition to reducing beaurocratic record-keeping to the bare minimum required, I would suggest that the government considder a system where records of therapy are recorded not in the **patient's** Medicare file or 'my health record', but exclusively in the therapist's file.

In other words, say you had an organization that was doing a background check upon 'Citizen A'. 'A' has a history of mental illness and undergoing therapy. Say also that this organization has the resources to access Medicare records. What I am proposing is a system where 'A's own Medicare file contains no reference or clues whatsoever to any therapy sessions. The only way the organization would possibly be able to discover that 'A' had been through therapy would be if they searched through the Medicare records of each and every therapist in the country, one by one, until they came upon one who has a record of treating a patient with 'A's Medicare number.

The resources required to perform such a cumbersome search would make violating patient privacy far less feasable for such an organization then it is now. Not to mention that it demands a far more extensive abuse of Medicare, which in turn increases the risk of them being caught.

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[211] pgs. 74 - 75

[212] In other words, paying the full cost of therapy themselves.

RECCOMMENDATION #10
Decentralize Medicare Records

We as a nation might be campaigning for a change in attitudes regarding mental health troubles. We might aspire to a future where nobody thinks any less of a person for having a mental illness and no organization behaves as if a mental illness lowers a person's worth.

But the fact is that, here and now, there is still a great deal of stigmata attached to usage of a mental health service. It **does** have negative implications for people's career prospects and general standing in their community.

And until those cultural prejudices are well and truly gone[213], across **every** aspect of life, the government has a duty to maximize the security of each and every citizen's mental health privacy.

[213] Which, realistically, may never happen.

11. Send Copies of Your Findings and Reccommendations to the Prime Minister and Every Interstate Premier

As I noted in my Introduction[214], it is my belief that the vast majority of dire problems that this inquiry will identify with the Victorian mental health system will be common to the entire national mental health system.

Those of us in other states are eagerly watching the progress of this inquiry, hoping it will finally bring to light the hidden atrocities of the mental health system, and the broader cultural attitudes towards depression, suicide and mental illness, which have afflicted us in the mental illness, suicidal & therapy patient communities for so long.

And yet, it is discouraging to think that while the Victorian government is bound to take notice of the findings of this inquiry, our own leaders have the luxury of ignoring these shocking truths and carrying on with business as usual. The instinct to bury their heads in the sand will no doubt be strong for them, as the reforms that will be required to remedy the problems this inquiry identifies will no doubt be extensive and challenging.

I am aware that, in terms of your specified duties, you hold no responsibility for anybody beyond the Victorian state border. But if I can appeal to you from a moral standpoint, please appreciate that our fates are in your hands.

Don't let the nation's other leaders get away with turning a blind eye to all this.

Please, send copies of all your findings to them all, especially the Prime Minister. Put them on notice. Hold a press conferance and state on public record that you've most definitely informed them about these dire crisises. And please take special care to point out to them all the issues that you can reasonably conclude are causing problems well beyond the boundaries of Victoria.

Let them know about what too many poor wretches in their own areas of governance are almost certainly suffering through in silence at this very moment. Let them know about the unspoken problems in their own mental health landscape that they finally need to start investigating and addressing themselves.

Let them know that their constituants are now well aware that they've been informed of all of these atrocities. And let them know that their voters will most definitely hold them to account if they fail to act.

[214] pgs. 5 - 8

2019 Submission - Royal Commission into Victoria's Mental Health System

SUB. 0002.0027.0030

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?

"In terms of the broad picture, we first and foremost need to do away with all the unwritten rules about discussion of these topics that stifle the sufferers' ability to speak freely about them. While this will probably be very difficult, if not impossible, to accomplish in the 'family dinner table' and 'pub chat'-type settings, I believe we can take steps to open up the more public arenas of the mental health & suicide discussion. We need to recommit to freedom of speech in the public discussion about these matters, to insure that sufferers are publically able to: * Talk openly and frankly about their issues; * Clarify pertinant aspects about their situations which may be taboo, or at odds with official mental health or anti-suicide policy; * Demonstrate, as compellingly as necessary, the wisdom for choosing death over life, as they see it, so that the essential point-of-view of suicidal people can be adequately factored into our discussions about their fates; * Compellingly defend attitudes, points-of-view, preferances, desires and values they hold, which the mental health system denounces as 'mental illness'. * Present frank and even scathing critique of the mental health system, including it's foundational philosophies; * Present and compellingly defend points-of-view that people in need might be better off avoiding the mental health system rather then turning to it; and: * Contradict popular statements and views presented to them, such as suicide being 'the wrong choice', or the mental health system being 'helpful', which significantly contradict with the person's life experience or cherished values. To this end, we need to insure that there are adequate internet facilities (e.g. forums) where this freedom to speak allows them to communicate not merely with one another, but with the broader community as well. In contrast to many currant mainstream internet forums where discussions are typically strongly restricted to prevent statements that discourage others from seeking 'help', or which legitimizes 'mentally ill' mindsets (including suicidalness), or paints them in a positive light. We need to make sure that all citizens can testify freely in these matters, without needing to fear being committed to a psychiatric ward for expressing ""mentally ill thought"" - including expressing a desire to kill themselves - or even being at risk of being pressured/coerced into entering into the mental health system. We also need to make sure that major media coverage of these issues features a much stronger presence of direct testimony from sufferers, and in particular, from currant sufferers. When the media decides to talk about mental illness or suicidalness, it ought to be an actual suicidal, depressed, or mentally ill person on camera, telling the public what the deal is - not some so-called ""expert"" on the subject talking about these situations from a sideliner perspective. And we need to massively reduce the restrictive 'guidelines' imposed upon the media by so-called ""experts"". These guidelines have the media running so confused and scared of putting one foot wrong that their coverage has become hollow and all but worthless to the depressed, suicidal and mentally ill communities. Modern media is so intimidated, they are scared to even mention the word ""suicide"" now - instead they tend to say: ""police do not considder the death suspicious"", which most readers now automatically assume means suicide. Adequate public awareness can never be achieved while our media are cowering in the corner. We need them to be bold, frank

and clear about these crisises. We need to be able to trust them to hold a corrupt and abusive mental health system to public account, instead of turning a blind eye for fear of creating ""an unhelpful attitude towards help-seeking"". We need them to convey an intact and adequate understanding of why people get depressed and why many come to prefer the idea of being dead to the idea of surviving. It is controversial but legitimate and important information that the public has a right to know, and needs to be informed on. And we need our media to be bold enough to report it. Currant guidelines are immensely sabotaging in this regard. For further information see: * ""Gaps in the Public Forum for Discussion of Mental Illness, Suicide and Related Issues"" (pgs. 99 - 135); * ""Unwillingness to Help"" (pgs. 94 - 95); * Reccommendation #4: ""Promote Public Awareness of the Dangers of Therapy"" (pgs. 149 - 151); and * Reccommendation #5: ""Encourage the Media to Provide More Balanced Coverage of Suicide and Mental Health Issues"" (pgs. 152 - 153), in the main submission document. Descrimination is a harder challenge to address. But I believe that it can be significantly addressed by making sure that people are directed into environments that are naturally more in-line with their mindsets, and will therefore be less discriminatory towards them. For further information see: * Reccommendation #7: ""Recognize Happiness as an Essential Resource"" (pgs. 157 - 162), in the main submission document."

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

"What is working well? Pretty much nothing. If you are fortunate enough to have friends/family/ect. who are genuinely respectful, supportive, and helpful, then they are usually a very valuable and effective asset. But for the rest of us, there is nothing that we can really say is ""working well"". For more information see: * ""PROBLEMS WITH THE MENTAL HEALTH SYSTEM"" (pgs. 30 - 79); * ""Lack of Uplifting Presence"" (pgs. 90 - 93); and * ""Unwillingness to Help"" (pgs. 94 - 95), in the main submission document. What can be done better to prevent mental illness? Most importantly, we need to raise overall quality of life in this country, to the point where life is well worth prolonging for as many people as possible. It is of crucial importance to understand that this does not mean simply throwing money at people. We need to thoroughly and effectively address loneliness, and come up with systems that unite lonely people with other kindred spirits; including, but not limited to, an effective system for uniting people with highly-compatable romantic partners. We need to redesign the positioning of our citizens, so that the jobs they are given and the schools/colleges they are sent to are places they will be highly compatable with. This is most important in terms of their coworkers & fellow students; every Australian should be able to say of the people they spend their day with: ""I love getting to share my life with these people!"" It is also highly important that they find the work itself meaningful and personally fulfilling, not merely a source of money. An important step towards achieving this will be to make all careers much more accessable to people, for example by reducing the educational and experience requirements imposed upon them as much as possible. We also need to devise a system for repositioning people, in the residential sense, into environments that are far more compatable with them. People should feel a genuine connection and appreciation to their neighborhood, and feel that the character, the values, the ideals and the ambitions of their local community strongly reflect themselves. All Australians should not merely feel truly at home within their own particular house, but throughout their entire town or suburb. We need to place an immense national focus on cultivating happiness and recognize that even more importantly then making a living for our community, we all have a duty to make life worth living for our community, as best we can. Australians need to have the freedom, and hopefully the willingness as well, to make others happy as much as possible as they go about their work and private lives. Community

and business management should not be oriented merely around smart decisions and profit, but also around outcomes that will make community members happier. For each and every service, industry and job, we need to ask: ""What opportunities are there to do this in a way that makes the community happier?"" And we need give those industries and individual workers the freedom they need to make those opportunities a reality. The less likely someone is to get trapped in a life that is lonely, meaningless, boring, joyless, and without accomplishments, the less likely they are to develop depression, suicidalness, or other anguish. For more information see: * ""The System's Unwillingness and Inability to Address Real World Problems"" (pgs. 36 - 39); * ""The Poor Recognition of Shortage as Motivation for Suicide"" (pgs. 81 - 83); * ""Lack of Uplifting Presence"" (pgs. 90 - 93); * ""Unwillingness to Help"" (pgs. 94 - 95); * Reccommendation #3: ""Create a Service That Will Provide Respectful, Meaningful, Effective and Timely Assistance to People Suffering Real-World Crisises"" (pgs. 144 - 148); and * Reccommendation #7: ""Recognize Happiness as an Essential Resource"" (pgs. 157 - 162), in the main submission document. What can be done to support people to get early treatment? It is of crucial importance that we insure that treatment is genuinely beneficial to patients, before we fixate on how to get them in to it. At the moment, a great many patients are much better served by avoiding treatment (including early treatment) as much as possible, because the quality of the system is so appalling. Today, ""early treatment"" mostly means expensive time wasting, masking of malignant crisises, and in too many cases, system-inflicted harm. For more information see: * ""PROBLEMS WITH THE MENTAL HEALTH SYSTEM"" (pgs. 30 - 79), in the main submission document."

What is already working well and what can be done better to prevent suicide?

"What is working well? Once again, pretty much nothing. And I believe this is supported by our currantly rising suicide statistics. The problem, unfortunately, is deeply rooted, in that our currant system is based primarily upon a confinement agenda. The strategy for keeping citizens imprisoned in life is based entirely upon sabotaging escape attempts, including by publically shaming any and all ambitions of escape, with depressing and disturbing labels like 'mental illness', 'impulsive action' and 'distorted thinking'. The true, nefarious intent of our modern suicide prevention strategy is well illustrated by the fact that one of the key tactics of that strategy is to deprive suicidal people of access to the tools they might use to accomplish their suicides. This is a very telling indication that the people who formulate this policy are not so averse to people deeply yearning for their lives to end, as they are to people actually acting on these desires. Comparitively speaking, it's fine to have someone wallowing so deeply in anguish that they constantly pray for the swift mercy of death; but it is not fine for that person to actually die. Suicidal people are not fools. They recognize that our suicide prevention policy is more geared towards appeasing those sections of the community that find suicide morally offensive then it is towards appeasing suicidal people themselves. And that is why so many of the suicidal community go to great lengths to avoid all anti-suicide groups and people - especially the mental health system - and likewise go to great lengths to conseal their own suicidalness, until they have actually committed suicide. Additionally, when more naieve or trusting suicidal people enter in to the mental health system seeking a non-fatal remedy for their unbearable quality of life, they are confronted by the fact that the system invariably will do nothing for them, and also that it's ideology towards suicide is, in truth, unbalanced, unreasonable and of highly questionable legitimacy. A person who goes in to the mental health system believing that: ""I ought to think and act as if life is worth prolonging, because that's the sane thing to believe"", will very often come out of their treatment with their faith in that principal severely shaken, if not destroyed. In putting mental health system doctrine on suicide to the test, patients discover, for the first time in their lives, that this doctrine fails woefully to support the idea that being alive is better then being dead. For more information see: * ""The

System's Attitude Towards Suicide"" (pgs. 63 - 69); * ""The System's Unwillingness and Inability to Address Real World Problems"" (pgs. 36 - 39); * ""Thought Shaming"" (pgs. 88 - 89); * ""My Personal Grievance With 'Expert' Statements on Suicide"" (pgs. 121 - 127); and * Reccommendation #2: ""Abandon Suicide Prevention Policy; Focus on Making Peoples' Lives Worth Prolonging"" (pgs. 139 - 143), in the main submission document. What can be done better? Listen to the suicidal, and stop trying to control them. Let them tell you where they need to go, and help them, as best you are able, to get there. Respect their values and respect their boundaries. Respect their stances on what amounts to a fate worse then death and commit to a helping strategy that will avoid those fates even more aggressively then it avoids that persons suicide. Stand side-by-side with the suicidal person and tell them sincerely: ""If you would rather be dead then be subjected to that fate, then *we* would rather you be dead then be subjected to that fate."" Stop being an ideological dictatorship, or a 'movement' with a cause, that fixates on reducing suicide statistics, regardless of whether or not the people whose suicides are prevented are actually happy to continue living. Stop fixating on preventing suicides and focus on making life worth living. Be a true ally to the suicidal. Abandon your own personal agendas (i.e. reducing suicide statistics) and join with them in seeking their best possible outcome, even if that outcome is death. Make yourselves worthy of suicidal peoples' trust and you will eventually receive it. And once you have their trust, you can truly work together as an effective team, to achieve the best outcomes possible. For more information see: * ""My Personal Grievance With 'Expert' Statements on Suicide"" (pgs. 121 - 127); and * Reccommendation #2: ""Abandon Suicide Prevention Policy; Focus on Making Peoples' Lives Worth Prolonging"" (pgs. 139 - 143), in the main submission document."

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

"What makes it hard for people to experience good mental health? * Loneliness * Community Incompatability (i.e. feeling like you aren't really a part of your family, company, school, neighborhood, town, church, ect.; Feeling like your values, ideas, preferances, ambitions, ect. are alien amongst your environment) * Nationwide Lack of Interest in Cultivating Community Happiness * Unemployment/Inappropriate Employment * Excessive Education * Constant Media Negativity * Bullying/Descrimination * Domestic Violence * History of Trauma * Bad Fortune (e.g. natural disasters, droughts) * Major Illness (e.g. cancer, MS, ect.) * Poverty/Homelessness * The Mental Health System itself (in far too many cases) Many of these problems already have measures in place to help correct them (e.g. illnesses, natural disasters). Many of such programs are, from what I've heard, horrendously unfit for purpose and need either a massive increase in government support, massive reform, or both (e.g. measures for addressing homelessness, bullying, the mental health system). Our approach towards unemployment needs serious re-evaluation from a mental health standpoint. My understanding is that government's approach towards unemployment is only interested in assigning people their jobs for the sake of getting them a paycheck. It utterly disregards the question of whether or not those people will get any happiness from the jobs they are assigned. The consequences this has upon national mental health are glaringly obvious, because what use is a job that provides a living, if it offers the worker no reason to live? Loneliness, and the closely-related issue of community incompatability, need bold new strategies, as they are not really being addressed at all at the moment. We need to create a nationwide matchmaking system that seeks out individuals, small friend clusters, or communities (whichever the patient is in need of) that is deeply compatable with the patient in question, then sets up and subsequently cultivates a relationship between that patient and the

person/people/community. Such a service will need to lean heavily upon a staff of people with strong social networks and a knack for tracking people and locales down, based upon the character traits that define them. The nationwide lack of interest in cultivating happiness also needs to be addressed, as I previously noted in my response to Question #2. For more information see: * ""The Poor Recognition of Shortage as Motivation for Suicide"" (pgs. 81 - 83); * ""Public and Government Don't Respect Their Own Large Role in Mental Health Cases"" (pgs. 86 - 98); * ""Therapists Often Do Psychological Dammage"" (pgs. 53 - 62); * Reccommendation #1: ""Establish a Permanent, Impartial Overseer of the Mental Health System"" (pgs. 135 - 138); * Reccommendation #3: ""Create a Service That Will Provide Respectful, Meaningful, Effective and Timely Assistance to People Suffering Major Real-World Crisises"" (pgs. 144 - 148); and * Reccommendation #7: ""Recognize Happiness as an Essential Resource"" (pgs. 157 - 162), in the main submission document."

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

"I think that one significant problem is the 'human livestock' culture that exists in this country. Basically, the attitude is that the primary, and perhaps only relevant factor in a person's life is whether they have the means to keep their bodies functioning optimally; do they have food, water, shelter, warmth and appropriate medical care? Essentially, it's about treating people like animals or livestock. Via my travels and through contacts I have across various types of regions, I have picked up the impression that this human livestock culture seems to be stronger in more agricultural communities. The massive problem with this culture is that it ignores the higher needs of a person, which don't fit in to any biology text book. Things like love, friendship, being part of a family, happiness, laughter, respect, sense of community, sense of purpose, motivation, sense of accomplishment, sense of being appreciated, ect. Because the culture has no regard for these needs, it makes little to no effort to satisfy them, and so they largely go unfulfilled. Subsequently, conditions like depression and suicidalness grow rife in these communities because, while citizens might have adequate food, ect. to sustain their survival, they begin to feel that their hollow, unsatisfying lives are not worth sustaining. They have the means to live, but they have no reason to live. You can't appreciate this dilemma when you look at a human being as just a piece of livestock - an animal that should just keep eating, drinking and breeding because that's what the laws of biology say it's supposed to do. So what's the solution? I think the main solution is to help people stuck in communities that don't satisfy their deeper needs to relocate to a community that is highly likely to meaningfully connect with them. Another approach would be to simply treat the individual untended needs of the citizen one by one. But I believe that in most cases, this approach would be less effective. Leaving the citizen lingering in a community that is unable to appreciate that they have higher needs, beyond their basic biology, will most likely result in a continuous series of difficulties and disappointment, for all concerned. For more information see: * ""The Poor Recognition of Shortage as Motivation for Suicide"" (pgs. 81 - 83); * ""Public and Government Don't Respect Their Own Large Role in Mental Health Cases"" (pgs. 86 - 98); * Reccommendation #3: ""Create a Service That Will Provide Respectful, Meaningful, Effective and Timely Assistance to People Suffering Major Real-World Crisises"" (pgs. 144 - 148); and * Reccommendation #7: ""Recognize Happiness as an Essential Resource"" (pgs. 157 - 162), in the main submission document. Another significant problem for many communities is the lack of employment opportunities. One major remedy to this problem, which often goes overlooked, is to minimize the requirements that make it difficult for people to get in to the jobs that would make them happiest; particularly in terms of education and experience. Of course, government initiatives to create new jobs in particular communities can also be extremely helpful - so long as

they are the right types of jobs for the people in the community and that they are filled via an employment policy that respects an employee's need to earn happiness/satisfaction from their job, not merely money. For more information see: * Reccommendation #7: ""Recognize Happiness as an Essential Resource"" (pgs. 157 - 162), in the main submission document. Finally, in many communities, widespread distress that is based in some common community issue can be dramatically compounded when the mental health system misdiagnoses peoples' suffering as mental illnesses, rather then a legitimate response to terrible circumstances. Misdiagnosis and subsequent mistreatment of real-world problems is a massive problem with the mental health system, and is the cornerstone of so much of the anguish that many patients and former patients endure. This dynamic is often amplified when a major real-world problem impacts a whole community or demographic. Though the mental health system often acknowledges the true crisis as a common 'factor' between all the cases of anguish, it tends to adopt the view that the main strategy for remedying this anguish is to treat the ""now-mentally ill"" brains of the sufferers. Addressing the actual source of the distress tends to be regarded as a lesser priority, and hence, is handled much less effectively then it ought to be. This problem is one of the countless reasons why the entire mental health system needs to be overhauled, right down to it's founding ideologies. We need to remake it so that it stops misdiagnosing legitimate anguish, distress or anxiety resulting from real-world problems as 'mental illnesses', and starts treating peoples' actual problems! For more information see: * ""Real World Problems"" (pgs. 30 - 39); * ""Unwanted Character Conversion"" (pgs. 55 - 58); * ""My Own Personal Experience"" (pgs. 58 - 62); * Reccommendation #1: ""Establish a Permanent, Impartial Overseer of the Mental Health System"" (pgs. 135 - 138); and * Reccommendation #3: ""Create a Service That Will Provide Respectful, Meaningful, Effective and Timely Assistance to People Suffering Major Real-World Crisises"" (pgs. 144 - 148), in the main submission document."

What are the needs of family members and carers and what can be done better to support them?

N/A

What can be done to attract, retain and better support the mental health workforce, including peer support workers?

"You need to stop gauging therapists' capacity to help by their amount of education, training, or 'work experience'. Personal life experience of mental illness, depression, suicidalness, and/or major life crisis is a valuable asset for therapists, managers and policy-makers to have, but it must also be recognized that a therapist/helper can still be very useful even without any personal experience of these things. The type of employees the mental health workforce desperately needs to recruit in large numbers are the ""Huggy-Bear""-type characters; those sorts of people who seem to know just about everybody in their community, who always know where to go locally to find whatever your looking for, and who have a wide array of contacts that allows them to deliver just about any manner of favor for a friend in need. The mental health system is in desperate need of staff that have the capabilities to offer their patients actual help for the problems making their lives miserable. So staff who have the contacts to set their lonely patients up with compatable partners & groups of friends; get their patients into the career path that will make them happy; get them into a better living/residancy situation; help them accomplish a currantly unattainable life goal; or help address any other real-world crisis, must be the focus of any recruitment campaign. For further information see: * ""The System's Unwillingness and Inability to Address Real World Problems"" (pgs. 36 - 39); and * Reccommendation #3: ""Create a Service

That Will Provide Respectful, Meaningful, Effective and Timely Assistance to People Suffering Real-World Crisises"" (pgs. 144 - 148), in the main submission document. So what can be done to recruit these types of people? Obviously a key component of the process must be informing whoever it is that hires therapists for the various hospitals/clinics/ect. of the mental health system that these are the types of people that they need to get a hold of. The government's employment system should be organized to chanel these sorts of people into the mental health system, provided, of course, that assigning them such a career path is absolutely agreeable for them, just as it must be agreeable for their future patients. The next time the government pledges to ""create X new jobs"", either as an election pitch, or just in the course of general economic management, it should make sure that a significant portion of these jobs are for these sorts of 'connected'-helper style therapists in the mental health system. As for supporting and retaining good workers: well, a major factor there is making sure that nobody gets overburdened with case load. So insuring adequate staff numbers is a must. Also, it will be essential to insure that therapists are given all the appropriate resources they need to provide their patients the assistance they are looking for. Obviously this will include adequate, well-maintained buildings/facilities. Beyond that, purpose-built IT resources are of immense importance, such as a network system that allows them to find and connect with the people who are most likely to be able to assist their patients with their problem(s); and which also allows them to share patient personality profiles (with their patients' consent, of course) with other therapists, for the purposes of matching and uniting compatable patients as prospective friends or romantic partners. They must also include access to an extensive database of information which is likely to be helpful to a patient's needs, such as information on the numerous communities & subcultures which the patient is likely to relate to, and how to enter such communities; religions which are likely to cater to the patient's self-stated unsatisfied spiritual needs; and geographical regions to which the patient - with respect to his/her values, tastes, needs and ambitions - would be a welcome addition. It goes without saying that securing patient privacy must remain the highest priority throughout the use of such digital resources. Resources such as these are essential not only for patient satisfaction, but by extension for therapists' own sense of accomplishment in being able to genuinely make a positive difference in their patients' lives. Their overall job satisfaction depends on them having the appropriate resources to be able to genuinely help their patients. Simply put, retaining good therapists requires that they are provided with the proper resources to do their job."

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

"I reccommend that this inquiry examine this issue from both directions. Certainly, many 'mentally ill' people are faced with limited opportunities for social and economic participation, as an ultimate consequence of their condition. However, it is also true that many cases of depression, anxiety, suicidalness, and many similar conditions commonly labelled as 'mental illnesses' arise due to the fact that the sufferer has found themselves with limited opportunities for social and/or economic participation, for reasons unrelated to their 'mental health'. For that reason, I suggest that the inquiry looks in to the many common factors of our society that have negative impacts on peoples' opportunities for social and economic participation, as being relevant to the issue of mental health in Victoria. In particular, I would suggest that you look at the laws, government policies and elements of workforce culture that create situations where it can be said that: ""Realistically, only certain types of people are usually given the opportunity"" to do a particular job or activity, with an ultimate aim of removing as many of these obstacles as possible. I would expect that educational barriers would feature highly on that list. For further information see: * ""Real World Problems""

(pgs. 30 - 39); * ""Lack of Respect"" (pgs. 86 - 88); * ""Lack of Uplifting Presence"" (pgs. 90 - 93); and * ""Unwillingness to Help"" (pgs. 94 - 95), in the main submission document. Regardless of whether a 'mentally ill' person's limited opportunities are a result of, or the cause of their 'mental illness', often the best opportunity to increase their social and economic participation is to insure that they are placed - socially, professionally, and residentially - amongst a community who they genuinely appreciate and who genuinely appreciates them. Social and economic participation becomes much, much more difficult to commit to when it is a lonely experience. This is especially true when such participation requires you to be around people who are unpleasant to be around; regardless of whether that unpleasantness is deliberate on their part, or unintentional. However, when social or economic participation involves being around people who are great company, these exercises become ones that the participant actually looks forward to. As a result, they will actively engage in them. Economic participation, in particular, can be greatly increased by partnering the person with a team who it is a genuine pleasure to work with, and with who the worker is consistantly 'on the same page' with. For further information see: * ""Lack of Uplifting Presence"" (pgs. 90 - 93); * Reccommendation #3-A: ""Develop a Strategy for Loneliness"" (pgs. 146 - 148); and * Reccommendation #7: ""Recognize Happiness as an Essential Resource"" (pgs. 157 - 162), in the main submission document. As discussed in my answer to the previous question (7), far too many people, especially amongst the 'mentally ill' and suicidal communities, are faced with limited opportunities due to the fact that they lack the contacts people need to 'make things happen'. They lack the contacts necessary to locate and enter in to the community or social group that could offer them an essential sense of connection to the world. They lack the contacts necessary to be able to access limited-vacancy or difficult-to-access services which they might be in dire need of. They lack the contacts necessary to get a decent job offer. Or they lack the contacts necessary to resolve some other serious practical problem with their life. In essence, all these opportunities: for meaningful relationships, meaningful employment, and an acceptable standard of living, technically *do* exist for the sufferer. The problem is that they are simply inaccessible because they lack a route to these opportunities - a contact who can connect the sufferer with these things. So once again, it is essential for the mental health system to be expanded to include a new system that places people in need in contact with these sorts of people; people who can build inroads and open doors for the sufferer, whether they be in a romantic, social, or professional context. For more information see: * ""The System's Unwillingness and Inability to Address Real World Problems"" (pgs. 36 - 39); * ""Unwillingness to Help"" (pgs. 94 - 95); and * Reccommendation #3: ""Create a Service That Will Provide Respectful, Meaningful, Effective and Timely Assistance to People Suffering Real-World Crisises"" (pgs. 144 - 148), in the main submission document. On the subject of economic, and particularly social participation, I would just like to emphasize that the absolute worst policy you can have in this matter is to coercively or forcefully push people into such participation against their will. And it doesn't matter if this policy is official, or if it just comes about due to the government and governors of the mental health system turning a blind eye to the widespread use of such tactics by individual therapists. Therapists are embassadors of society, as far as the patient is concerned. And when that embassador seeks to exploit the patient's troubles to bully or coerce that patient into increased social/economic participation, it reflects very poorly on the society that that therapist is advocating for. Ultimately, such approaches will make the patient far more reluctant to engage with their society, on both a professional and social level. People will not want to expose themselves to a culture that is characterized by a tendency to manipulate or bully them into serving it's own agenda. Nor will they want to play any role in economically sustaining such a cruel culture."

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
"1. Develop a system that provides genuine and significant assistance for patients' real-world problems, with a special emphasis on remedying loneliness. (See Reccommendations #3 & #3-A, pgs. 144 - 148 of the main submission document). 2. Investigate and put a stop to the numerous ideological and cultural issues within the mental health system that fuel disrespect towards patients and disregard for their wishes, needs and values within the treatment process. (See ""The Poor Quality of Care - Therapists"", pgs. 40 - 62; and ""The Poor Quality of Care - The System"", pgs. 63 - 73 of the main submission document). 3. Create an overseer department that holds complete authority over the mental health system, to insure that the system's ideology, conventions, practices, treatments, and therapists all serve their patients, rather then exploit, abuse, or neglect them. (See Reccommendation #1, pgs. 135 - 138 of the main submission document). 4. Do a complete reevaluation of official policy on suicide; beginning with a thoughtful questioning about whether suicides should be officially discouraged, or interfered with and prevented. Insure that there is thorough, unbiased, and tested justification for such interference, in all circumstances where it is deemed to be warranted. Thoroughly examine the question of whether it is always better to be alive then dead, and do not rest until your stance on this issue is compellingly, impartially justified, so that that justification can be shared with the suicidal community as persuasive proof that life is indeed worth prolonging. Hold your policy to a standard where you must prove anything you expect others to believe. (See Reccommendation #2, pgs. 139 - 143 of the main submission document)"

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
"You can begin by laying the groundwork for a system that offers real-world help to patients in need (see Reccommendation #3, pgs. 144 - 148 of the main submission document), and also for a permanent overseer department for the mental health system that has no ties to the therapist community, nor mental health system ideology (see Reccommendation #1, pgs. 135 - 138 of the main submission document). Consulting heavily with organizations who already advocate very well for patients and 'mentally ill' people, such as VMIAC, would be an excellent first step for this second undertaking. You should also get to work developing a recruitment strategy for hiring the sorts of connected, practical helper-therapists indicated in my answer to Question #7, as the mental health industry is in most dire need of such effective helpers. Last but certainly not least, you should look into developing a permanent forum - perhaps based upon a similar format to this inquiry - where people can openly discuss these issues, with the hard clarity necessary for government and communities to adequately understand and address these issues. For one thing, that means allowing suicidal people the freedom to publically present their sensible, compelling cases for why they are better off dying then facing their most probable living future, and also to publically debunk the flimsy and misleading arguments put to them for why they would be better off surviving. It has become painfully apparent that suicidal people need to clarify the situation for everybody in this fashion, in order to prove that the key elements that define a ""life worth living"", for them, cannot be dismissed. Only when the essential nature of these key elements is respected will suicidal people be able to reliably get the actual help they need from the community, to get to a place where they are sincerely willing to survive. It would also mean allowing people to publically criticize mental health system ideology, treatments, and therapist culture, even to the point of proclaiming that a sufferer is better off trying to solve things on their own, rather then subjecting themselves to the mental health system. Such a forum would need to be recognized as not merely a place for mental patients and other people in crisis to 'talk amongst themselves', but as a

purpose-built direct line of communication between sufferers and the people who shape their world; especially those governing the facilities that are intended to help them. While it would ultimately be important to incorporate a real-world side to such a forum, an online version is essential, and establishing such a web service could almost certainly be established by the government very promptly."

Is there anything else you would like to share with the Royal Commission?
"Please, please understand that people desperately need help. They don't need to be doped out of their gourds, they don't need to be branded as defective (or ""mentally ill"") units, they don't need to 'talk about' how terrible life is, and they don't need to be told to 'accept' that life is so devoid of appeal that it is less desirable then death. They. Need. Help! They need help to find love. They need help to get true friends. They need help to be inserted into a community that they can genuinely relate to and connect with. They need help to be inserted into an environment that is oriented towards nourishing the things that make them happy; and working against the things that make life ugly. They need help to be placed in a job where they can enjoy the company of their workmates, enjoy their working life, and take genuine satisfaction in their accomplishments. They need help to escape the bullies who make their lives a constant, living hell. They need help to cut through the unnavicable beaurocracies of government, banks, utility companies, and/or insurance companies that are inflict untold heartache upon them. And they need help with the countless other significant real-world shortcomings and crisises that make their lives an ordeal that is not worth prolonging. They also need freedom. They need freedom in their workplace and general societal laws and cultures to cultivate the outcomes that make them, and their kindred spirits, happiest. They need freedom to choose happiness over cold clinical intelligence, profit, productivity, efficiency, biological sustenance, safety, and yes, even survival itself. They need the freedom to devote themselves to happiness as the highest priority of both themselves, and that of their chosen community. They need the freedom to focus on making life worth prolonging first and foremost, so that any subsequent actions they take to maintain their survival will be made willingly, rather then behaviors that they are aggressively enforced to adopt. They need the freedom to know that living is something they do because they want to, not because they are made to, instructed to, or obliged to. At the end of this inquiry, please don't just cut a blank check to fund more of the grievously ineffective, and all too often harmful therapy services we've been saddled with for all these decades. Please don't just make a handful of token adjustments to the way the system works and market it as ""the much-needed reform that the patients called for"". And please don't palm off the difficult or low-key opperational decisions of the reform to ""experts"" who adhere to the traditional mental health ideologies that have been failing and harming us for all these years. Please don't subject the suffering and the suicidal to any more policies or ""professionals"" who are only interested in finding a way to explain away their anguish and dissatisfaction as a brain defect within the sufferer. Please see fit to recognize that so much of the crippling anguish and emptiness which has become epidemic in our society is the result of broken lives, not broken brains. The thousands upon thousands of Australians who are suffering these broken lives need help - real, effective, practical help. Please, for the love of god, hear their cries, and send it!"