

Mental Health in the Age of Pharmacology; Medicine and Pharmacy as a Panacea to Treating Mental Illness

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Abstract:

Mental health service delivery in many parts of North America and the United Kingdom is maintained by organized medicine, pharmaceutical manufacturers, and the insurance industry, each advocating a quick fix treatment mentality that continues to be spoon-fed unscrupulously to the masses. As a result, there has been a wholesale brainwash by the new drug culture within contemporary society that has been received with open arms by a passive public in search of a fast cure. These propagandizing efforts have paid off, for the public shows little interest to change. They are discontent but manipulated by persuasive medical professionals to take drugs rather than face their suffering more directly and effectively. They pine for help but are offered few alternatives. As a result, psychotherapy has been underutilized and diminished in value for what it genuinely has to offer the public; and when publicly funded, it has devolved into a manualized, prescriptive step-by-step recipe that caricaturizes authentic therapeutic intervention. Psychoanalytic paradigms are simply marginalized. Mainstream medicine advocates for chemicals, and this appeal to authority is hard to resist due to the medicalization of mental healthcare, especially in Canada. This is further due to a collective identification based on the wishful fantasy to have problems magically disappear. The tablet unconsciously symbolizes this fantasy.

Keywords: Mental Health, Crisis, Pharmacology, Quick-Fix Models, Psychotherapy

Introduction: Why Medication is no Panacea for Treating Mental Illness

In Greek antiquity, *pharmakon* refers to a remedy that is also a poison. This contradiction of signification (Derrida, 1972) points toward something that can potentially heal and harm the body (and soul) at the same time. Here we may observe contradictory attitudes toward the pharmacy in contemporary society. Like Plato (*Protagoras*, 354a-c), I am suspicious of the *pharmakon* and its promise of remedy, moreover cure, especially when it comes to mental health issues. Despite the fact that drugs can be effectively used for therapeutic interventions, they often come with a price. In modern parlance, we call them 'side-effects' that can be more debilitating than beneficial, its own malady. The new drug culture has become its own disease, often conditioned by the political hegemonies of medical ideology motivated by arrogance and economic self-interest. Talking, engaging in conversation, having a dialogue is more instinctive than ingesting a foreign substance. That which goes against its own natural process, its own organic development, is in need of remedy. *Pharmakon* is society's new poison.

Therapies and Mental Health

There are many different types and viable forms of talk therapy that help people, but many capitalist countries in the English speaking world are driven by profit motives that favor fostering the illusion that medicine and pharmacy serve as a panacea to treating mental illness. Here psychiatry epitomizes this myth. This fantasy goes against our true human tendencies to want to talk about things that bother us, which are either sociologically supported or discouraged, especially when stigma is attached to admitting having psychological or emotional difficulties. The pill has become socially conventional, particularly when it remains confidential and is part of

patient-doctor privilege, as well as more convenient, including conveniently reinforcing patients' resistances or defences whereby acknowledging mental health concerns is not an easy psychological attitude to bear (nor pill to swallow), especially when the doctor is quick to reduce one's suffering to biology or a brain state that can be remedied by taking psychotropic medication. Here the *pharmakon* is the new drug dealer that is perfectly acceptable to the masses gobbling up prescriptions like candy.

We cannot deny sombre statistics. Mental illness has been attributed to one of the main causes of disease worldwide (Vos *et al.*, 2013). The World Health Organization (2017)

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conservatively estimates that over 500 million people are affected by depression and anxiety, but when you include alcoholism and addictions, over 100 million of the world population is affected by mental disorders²². According to the National Institute of Mental Health, more Americans suffer from mental illness than any other people in the world (Walton, 2011), while the populations of Canada and the United Kingdom are estimated to be 1 in 5 adults. In this essay, I will specifically address the Canadian mental health crisis, as it tends to be on par with the UK, and offer reflections on ameliorative strategies to improve access to healthcare.

The Mental Health Crisis

In a sober revelation on "The Erosion of our Profession," Kenneth Eisold (2007) alerts us to how psychoanalytic psychology is dogged by social, political, and economic pressures to conform to the mainstream medicalized expectations of expedient cure, marketplace demands for economic utility and efficiency, and the loss of autonomy and control we once enjoyed in providing treatment based upon our own professional sensibilities and training. I would like to contribute to his insights by alerting others to the plight of mental healthcare in Canada.

By way of introduction, a word about the Canadian healthcare system is in order. As in the UK, but unlike the United States, healthcare is part of every resident's right based on social-democratic principles that govern this country's political-humanistic commitments to its citizenry. As a result, patients do not have to pay directly out of pocket for medical needs since a large percentage of their taxes go to sustain egalitarian healthcare delivery for all people. This is socially conditioned and an expected legislative right. However virtuous this system is, it also tends to produce a sense of entitlement: people are frugal, and in some cases chintzy, when it comes to paying for what they believe should be 'free' by virtue of their right to healthcare. This equally applies to mental healthcare. Those from lower economic strata have it worse, because they often get little to no help, and they are amongst the largest population groups that suffer.

The mental healthcare industry in Canada is dominated by medicine. Psychologists,

psychotherapists, Master's level counsellors, and social workers in private practice are not covered by the healthcare system: only physicians are directly paid by the government. This becomes problematic when patients need therapy but have no free service to turn to. Because Canada is domineered by a pharmacological model of mental health treatment, people will most often be given medication for their difficulties, which is inculcated by medical authority. By and large, individual psychotherapy is very rarely delivered by the medical community including psychiatry. Moreover, there is a dearth of government funded psychotherapeutic resources in the community because they have been largely displaced by biochemical interventions. Because individual therapy is not promoted as widely as psychopharmacology, people often end up suffering rather than seeking out talk therapy through direct expense. When they do, they are often prescribed cognitive behavioural therapy (CBT) by their family doctors because that is the current model adopted by Canadian practitioners instilled by academic empirically-based training institutions and endorsed by the Canadian Psychological Association. Psychoanalytic psychologists are vilified by mainstream practitioners and are often discriminated against by insurance providers, allied mental health professionals, as well as the profession of psychology itself.

Quick Fix Ideologies

What I wish to argue is that the politics of mental illness dominated by medicine, pharmaceutical companies, and insurance corporations is creating a crisis for Canadian mental healthcare. This crisis is largely the result of a quick fix model that is economically driven to create profit for those providers who participate in this truncated, deficient, and politically institutionalized method of service delivery. The public is not only being manipulated, they are also dissuaded from seeking out what could be more beneficial because the healthcare monopoly devalues the viability of alternative and better modes of psychological practice. The biologicalization of medicine and psychiatry has collapsed the human being into physical reduction, hence claiming that mind is nothing but brain. The main solution they profess is in the form of a chemical. From this standpoint, the complexities of human emotion,

²². JM: '...but when you include alcoholism, addictions, and other mental disorders, nearly a billion people in the world population could be affected by mental illness...'

thought, perception, consciousness, and unconscious experience are nothing but material states in the brain that can be controlled by pharmacology. This viewpoint has palpable philosophical and logical limitations (Mills, 2002), ignores the quality of lived experience or what it means for each individual who suffers, negates the phenomenological, existential, and humanistic commitments to treatment, is amoral at best and unethical at worst. Furthermore, the new drug culture politically and economically oppresses alternative healthcare providers, and privileges one modality of therapy contra empirical evidence produced from the behavioral sciences that challenge the primacy of psychopharmacology. Medicine and pharmacology see any competing discipline who espouses an opposing viewpoint as an unwelcome trespass that is swiftly marginalized. The medical establishment often does whatever it can to discourage the presence of trespassers and ensures that they only have a minimal say because of cherished group narcissism, political loyalties, competition, and perceived dangers to its level of influence and power over popular culture; not to mention a most important detail, they hold the purse.

In my over 25 years of practice as a clinical psychologist and psychoanalyst, working in both the public and private sectors, I have observed with increasing dismay the egregious inadequacy of mental health service delivery in Canada. As a general rule, most of my patients who seek me out for therapy have already been put on psychotropics, many of them several different types, and they are not happy with the results. Even those who are functional on medication still feel it is inadequate because they are not entirely free from their suffering, something a pill cannot take away. They will often concede that drugs merely mask the real issues or numb a person from dwelling on inner anguish they would rather avoid and not think about—not to mention they produce troubling side-effects that in some cases are detrimental to physical health. Based upon my direct professional observations working in public healthcare environments as well as the *prima facie* testimonials of my patients, I offer the following reflections.

Legitimate arguments can be made that (a) organized psychiatry and psychopharmacology are more expensive in the long-run than psychological treatment modalities, are (b) unethical when they are systematically abused by the establishment, (c) show inferior treatment efficacy, (d) have poorer long-term

outcomes, and (e) politically subjugate the role of psychology and psychotherapy paradigms though they prove to be at least equally but often more useful and ameliorative. Organized medicine opposes alternative healthcare providers from joining national and provincial Medicare programs due to direct threat and economic self-interest, and perpetuates the mythology of fast and expeditious cures, which collectively deceives, indoctrinates, and gives false hope to an uneducated public who are vulnerable, helpless, and wishful for brief and immediate treatment interventions that produce rapid results. Canada needs a wake-up call, as they don't exist.

Mental healthcare in Canada today is alarmingly inadequate. Statistics on prevalence rates of mental illness are astoundingly high and little is being done except medicating the masses who moan for instant relief. The second main reason for all visits to family physicians are for depression, and 33% of all hospitalizations in Canada are due to mental illness as either a primary or secondary diagnosis (Mood Disorders Society of Canada, 2009). The cost of keeping someone with serious mental illness in the hospital is estimated to be \$170,820 per year. Furthermore, 37% of mental health patients are readmitted to the hospital within one year of their discharge (Canadian Institute for Health Information, 2006).

There is a paucity of government funded outpatient, community, and rural mental health facilities that provide direct clinical consultation, assessment, and individual therapy to adults, children, adolescents, and their families, and psychology is hardly utilized in hospital environments. Similar to the National Health Service in Britain, where wait lists are long and restrictive, government funded clinics in much of Canada have an average wait list of 1 year, and child and youth assessments can take as long as 3 years to be seen. And when the public finally gets into see a counsellor, they are often minimally trained and constrained by a short-term treatment model under pressure to see as many people as possible due to organizational mandates (and to improve optics to the government) and usher them out the door before any therapeutic benefits have been achieved.

The medical profession and pharmaceutical industry heavily influence governmental policy, public opinion, and healthcare decision making instituted by these politically and economically powerful groups who are largely responsible for fostering the illusion of the quick fix. And the

public buys it, which is unreflectively reinforced by the media who turn to the medical establishment as those in authority, rather than psychologists or mental health therapists of all types. There are many reasons for this phenomenon including the voice of medical consensus, public ignorance, financial limitations, media misinformation, and mass fear, anxiety, and avoidance of truly facing the cause of one's suffering. This defensiveness perpetuates the unconscious fantasy that psychological problems and personal woes will mystically vanish if we deceive ourselves long enough. The truth is, they don't, and they won't simply go away. Although psychopharmacology is of immense benefit for chronic forms of mental illness such as schizophrenia, bipolar disorder, and severe depression, medications are being routinely and unjustly over-prescribed for the slightest degree of emotional discomfort or ordinary unhappiness. Prescription abuse is rampant among general practitioners and psychiatrists who choose to see no other avenue to mental health service delivery than the pill. Perhaps there is some symptom relief for some patients, which is of practical value, but a pill doesn't solve the problems let alone address the reasons why one suffers to being with. The big scam is getting people to believe that all mental experience—one's thoughts, feelings, attitudes, perceptions, and desires—boils down to a chemical in the brain. And the corporate drug peddlers, insurance bean-counters, and majority of doctors exploit this belief by gratifying the hopes and vulnerabilities of an uneducated public who rely on the dictums of medical science to deliver them from psychic pain.

The New Drug Dealers

The first line of defence against mental illness in the US, Canada and the UK, is pharmacology. We are medicating our children for displaying the slightest degree of overstimulation, inattention, failure to listen, follow directions, or mind their parents—all passed off as Attention-Deficit-Hyperactivity-Disorder (ADHD). We label young children and adolescents as oppositionally defiant and conduct disordered when they act out their anger or challenge adult authority, and dispense mood stabilizers when they express intense emotions that threaten their parents' or school personnel control over them. And we prescribe adults anti-depressants, anti-anxiety agents, sleeping pills, pain killers, and muscle relaxants the minute they complain to their family doctor of normal stress, adjustment difficulty, loss, or emotional anguish rather than

encouraging them to seek professional therapy and work-through their struggles verbally. The over-prescription of medication is part of a false social consciousness seduced by the fallacy of the quick fix institutionalized by our healthcare systems. As the first course of action, most citizens are conditioned to talk to their family doctor who has no training in psychiatry or psychology, yet who often acts as an expert in the behavioral and social sciences, experiments with medication, oversteps professional competence by pretending to know how to intervene with emotional conflict, or simply gives pep-talks and offers false reassurances rather than referring patients to professionals who are appropriately trained in psychotherapy. And when therapy is encouraged, it is often only after patients become extremely distressed or are in crisis.

A very small minority of physicians in Canada, minuscule in fact, actually practice psychotherapy or psychoanalysis and bill the Medicare system for this service. To make matters worse, there are no formal requirements or proof of adequate training in order to bill for this service, and it is the case that doctors, such as family practitioners on the front lines of primary care, conduct so-called therapy or counselling who have conceivably never cracked the cover of a technique book let alone took appropriate graduate-level courses or received ongoing clinical supervision and training. It is simply obscene that medicine is able to misrepresent its area of competency to government officials and policy makers who dole out budgetary approval and pay for psychological services for those not trained to deliver, and that there is no accountability for requiring formal training. As a result, therapeutic incompetence runs rampant with no adequate watchtower or enforceable consequences. Moreover, doctors have the right to terminate their involvement with any patient at anytime the patient does not follow the doctors' professional advice. Not only is this an unrestricted monopoly, it is also a palpable abuse of power. For example, I had one patient who was terminated by his life-long family doctor because he no longer wanted to continue his anti-depressant medication because he believed his therapy with me was more effective. Because there is a shortage of family physicians, whereby many citizens go without personalized healthcare, patients may feel that they have no other choice than to follow their doctor's orders or be left out in the cold.

Psychiatrists can be just as bad because the large majority of psychiatrists in Canada

become pimps for the pharmaceutical industry that give them financial incentives, perks, and free gifts to peddle the latest experimental drug on the market that promises better efficacy and fewer side-effects than previous ones. The Medicare system only encourages doctors to see people as quickly as possible out of fiscal restrictions and demand. These doctors consequently focus on symptoms rather than on the true causes of their conflict, attach a psychiatric label with the word 'disorder' behind it, and give them a prescription to hand to the pharmacist. Most psychiatrists in Canada do not perform therapy nor are they properly trained to do so, yet they pretend to be. In most cases they only assess, diagnose, and dispense drugs. People are herded in and out like cattle. Patients are lucky to get a thirty-minute interview during an initial consultation, and may be put on a 3-6 month waiting-list for a follow-up appointment. There is often no real human connection made or continuity in seeing a psychiatrist—no real relationship is formed; the patient is viewed as an object that is broken and needs to be fixed. Patients are no longer seen as experiential beings who are mired in conflict and emotional turmoil and who crave human comfort, as the Latin term *patiens*, derived from the Greek word *pathos* (πάθος) signifies, namely, those who suffer. Instead the suffering becomes clinically objectified as biological anomalies whereby people become things to be rebuilt rather than human subjects with their own unique intrapsychic organizations and interpersonal struggles. Through this impersonal mode of treatment, people don't feel felt—they don't truly feel understood or validated, yet they are reassured by their doctor that a pill will help.

Ineptitude in the Academy and Lack of Professional Psychology

Contemporaneously, the field of psychology and the competing modes of psychotherapy and counselling services being promulgated can be equally limiting. Psychologists in Canada are largely trained by academics whom by and large do not practice clinically. They are researchers whom care more about publishing and establishing a research reputation. There is no Doctor of Psychology (PsyD) training models in Canada that mirror the solid practitioner-based training that structures the curriculum of most professional schools in the United States, which place a high premium on clinical training, service delivery, field experience, and supervision. And there are absolutely no clinical psychology departments in Canada that train students in psychoanalytic practice. As a result, psychology graduate

students are often not even exposed to psychoanalytic or psychodynamic principles, which tend to be viewed as antiquated and unscientific. Instead, trainees are mainly taught a circumscribed view of clinical practice. As in the US and UK, psychoanalytic psychology is immersed in the 'evidence-based' turf wars that divide and polarize psychological and psychotherapeutic training programs, and what seems to be 'empirically-supported' and advocated for these days are recipe, cookie-cutter, manualized treatment approaches that range from four to eight sessions in length, if one is lucky to get that. Moreover, they are often delivered by neophytes or those with the most minimal of training, particularly in any government funded community or hospital clinic who pay counsellors a meager salary. Here the adage goes, you get what you pay for.

Contemporary academic psychologists are so over-identified with providing a scientifically-based model of practice, that they have become pawns of organized healthcare that thrive on a quick fix philosophy. They either prostitute themselves out by offering brief treatments because most insurance policies offer little coverage, misrepresent themselves, as Eisold (2007) also confesses, mainly to appease the political pressures to conform to the medical and short-term treatment regimes dictated by insurance policies, stand idly by and let psychiatry roll over them passively without protest, or adopt the current fad of therapeutic modalities based on what academics who do not practice clinically tell them what they should be doing. For the most part, Canadian academics know very little about what really goes on in the consulting room because they conduct manufactured research studies far removed from clinical reality rather than provide direct service delivery (see Christie *et al.*, 2015, for example). This is such an endemic problem in the clinical training of psychologists it is no wonder why so many people find psychology to be an inflated form of common sense with little value.

An Anti-Therapy Culture

There is an anti-therapy culture in Canada. This is not because Canadians are unwilling to profit from what therapy has to offer, but rather it is due to a lack of knowledge, discouragement from medicine, economic prohibition, entitlement to free healthcare, social stigma, and the limited impression psychotherapies make on the Canadian public. What is rather ironic is that while it is okay to take medication for a psychiatric condition that is labeled a 'mental disorder' by a doctor, it is not deemed

helpful by the same doctor to talk with a specialist about it. Why is this so? Perhaps it is because medicine is not so impressed with what psychology has to offer. Psychology in Canada is an academic and research enterprise with a fine reputation, yet it lacks adequate professional preparation for those who will embark on direct clinical and counselling work. Consequently, psychologists are largely ill-trained to practice because they are trained by academics who teach but do not do, hence they lack practical skills in psychotherapy, largely offer brief treatment models that cater to the quick fix mentality or the recent research fad rather than what truly works in the consulting room, and are biased against competing psychotherapeutic paradigms that do not conform to vogue empirical and political pressures. What I have in mind are the evidence-based treatment wars that have transpired within mental health disciplines whereby one politically dominant research group attempts to discredit the theory and methods of others because they do not engage in the same form of research or practice. This has amounted to ridiculous splitting on the part of many similar fields in order to find a leverage to legitimate its practice to medicine, the drug companies, and insurance providers who are not likely to deviate from what medical authorities tell them.

Because the acceptable mainstream treatment modality is medication maintenance, so-called evidence-based approaches have jumped on the medical-model bandwagon and have adopted a sterile, manualized step-by-step approach to therapy that is often time-limited in duration, stilted, regimented, and focuses on very select short-term goals that often gloss over the real problems and their aetiology. Moreover, this follows a business model of service delivery that is motivated to keep costs low at the expense of any real lasting benefit to the client. In the end, this adhesive bandage approach to treatment ultimately hurts the health of the consumer and the economy in the long haul, especially when you look at lost productivity, increased physical health problems, lack of employment, hospitalizations, and suicide rates. As a result, therapy has disgracefully devolved into telling people what to think and how to behave, turning them into a virtual Pavlovian dog programmed by a robot—to the point that online techno-therapy is delivered by computer conversational software (see Martinovich, 2017). Insurance companies and HR departments love anything simple and cheap because they promise a quick fix. In reality, however, the patient gets a little better

but there is very little long-term change. They simply come back into mental health treatment at a later date once the bandage falls off and the cycle starts all over again. The buck gets passed and passed with no permanent solution in sight. Here psychiatry and mainstream academic psychology are equally limited.

In a large majority of cases, quick fix approaches are theoretically naive, methodologically superficial, lack treatment efficacy, defy logical coherency, fail to account for the overdetermined complexity that informs mental health and illness, lack holistic approaches to wellness, and are embarrassingly shallow. Moreover, they're unethical. By perpetuating the quick fix mentality to a public hungry for symptom relief, we keep them ignorant, collude with their denial and avoidance of dealing with real problems honestly and directly, and rob them of having exposure to legitimate and viable alternative approaches to mental healthcare that the Medicare system does not practice nor endorse. Instead, the medical model of treatment is firmly wed to preserving the status quo by sustaining fruitless solutions that are palpably ineffectual, futile, and cosmetic dressing tactics that do no more than suture up an infected wound.

People deep down desire not to know anything about what truly afflicts them or what torments them, and they will spend their whole life running away from facing inner demons if they can (Mills 2005). Psychoanalysts have always known this, but they are often discredited by other mental health providers because they puncture our illusions and take away our security blankets that jeopardize the wishful hopes and fantasies that are part of people's unconscious defences. And no one is immune. Professionals such as doctors and psychologists equally find their own introspection and self-examination just as painful to bear as the masses; so they deceive themselves into thinking that they can heal others through simplistically naive treatment strategies. They too are human, and opt for the fantasy that there are easier solutions to the afflictions life bestows. Here enters the pill.

The Commoditization of Mental Healthcare

The quick fix mentality is promulgated by the healthcare industry and reinforced by the conditioned illusions that govern popular culture based on ignorance and the desire not to know. Pharmacies and many mental health workers also promote this line of treatment for emotional problems, and there are big bucks in this

deliberately calculated and sustained commoditization of healthcare. An insidiously obscene form of dependency on the medical profession for the verity and pursuit of psychological normalcy is a dangerous practice based on the mythology of the doctor as omnipotent healer—the transference unto God. I am not denying the fact that medications help. They most certainly do in many cases of severe mental illness. What I am opposed to is the narcissistic arrogance of medical authoritarianism; the ostensive passivity and unquestioning attitude of the masses who are slaves to social conditioning; the institutionalization of rote prescription writing; the brazen conceit of claims to objective certainty based on dogmatic adherence to a scientific epistemology when science is neither certain nor purely objective; the intellectual lassitude of not considering other avenues of healing; and the lazy unreflectiveness borne from a biased, myopic and uncritical way of thinking that pharmacology should be the first line of action against mental discomfort—when this is in fact the very thing that keeps people from getting better. Albeit palliative, promoting dependency on prescription medication for psychological comfort is not ameliorating the underlying discomfort, it is only masking it. And doctors know but ignore this fact because they are overburdened by the healthcare system. They simply want patients to go away. The pill expedites this process. The pill has become the concrete symbolic surrogate for all the inner laborious work and unavoidable suffering that comes with overcoming painful life tribulations inevitably encountered in the process of psychic healing that most people are not willing to deal with nor are brave enough to face head on.

But when it comes right down to it, the main endemic issue fuelling the crisis in Canadian mental healthcare is the dominance of organized medicine that is not likely to change its practices nor relinquish its governance. And when the public does nothing to challenge the supremacy of medical authority, they merely become sheep in the meadow herded toward a pill factory. Canadian medicine oppresses many viable approaches to mental health treatment that are indisputably recognized and justified in other countries but are omitted from society's repertoire and Medicare dollars. There is very limited attention to the role psychology or mental health interventions can play in childhood, adolescent, and family prevention, education, health and behavioural medicine, rehabilitation, forensics, and outpatient services that are not available to the

public under the Medicare system. The doctors and drug companies are taking all the resource dollars away from community outpatient and rural mental health programs when they are potentially more effective in keeping people functional, adaptive, adjusted, and employed.

Toward Political Activism in Rehabilitating Mental Healthcare Service Policy

As in other parts of the world, Canadians are disturbingly underserved when it comes to receiving quality mental healthcare services, but they do not have the resources nor do they know where to turn to for help. Medical authorities, pharmaceutical manufacturers, and insurance companies offer no viable alternatives except for quick fix solutions and band-aid style remedies. The media, which relies on the expertise of medical professionals, only perpetuates public ignorance about what is the best standard of mental health treatment available. Because there is such an entrenched medical model bias that saturates the whole mental healthcare system, little is being done to investigate the long-term efficacy rates of psychopharmacology let alone contest its monopoly. And all the public policy makers do is back medicine or throw money toward funding worthless 'research' rather than 'intervention' with little critical reflection on what may be a better course of action or investment on the dollar.

Canadian citizens have the right to adequate mental healthcare and need advocates who are willing to challenge the status quo. Medication is not the only answer nor should it be the first line of defence in the majority of cases, but we are led to believe otherwise. The public is misguided because it does not have all the facts. We are duped into believing that drugs are the best way and the cheapest form of treatment for the mentally ill, when they are more expensive and in the majority of cases less ameliorative in the long-run. There is a large cost to mental illness including the economic loss of work time and potential productivity, but more importantly, the loss of quality of life. If the pill only masks but does not cure, then is it worth fooling ourselves any longer, even if it offers us some hope? As Freud (1913) reminds us, nothing in life is more costly than illness or stupidity. Because statistics tell us that the proportion of disabilities due to mental illness has increased exponentially and dramatically in the last two decades, current mainstream approaches are obviously not working.

What are possible solutions?

Although an adequate response to this question cannot be fully addressed in this brief article, suffice it to say that I do not believe in easy fixes (*cf.* Anderssen, 2015); yet the following reflections may be considered:

- Demystify medicine;
- Expose the pharmaceutical companies for spreading false hopes through the newspeak of medication;
- Ban propaganda that brainwashes the public to desire pills over facing their problems honestly;
- Educate the public on the value of talk therapy;
- Establish more Medicare funded outpatient, community, and rural mental health centers that are non-medically oriented and governed;
- Emphasize early prevention and intervention including child, youth, and family education;
- Tighten regulation of mental health service delivery;
- Expand the option for regulated health professionals such as psychologists and psychotherapists to participate in the national Medicare system;
- Grant prescriptive privileges to psychologists for those who are adequately trained and can exercise more discretion when medication is needed;
- Penalize and remove opportunities for boundary violations of claims to legitimate practice;
- Ban therapy offered by non-trained medical practitioners who bleed the Medicare system and abuse public trust;
- Provide better holistic education and training to physicians, psychologists, social workers, nurses, and therapists of all kinds;
- Ensure better clinical training for psychiatry, psychology, and mental health programs in all graduate and postgraduate institutions based on a clinical-practitioner model, especially in the public sectors, rather than perpetuating the dominance of a scientist-research model that is not directly related to applied intervention; and
- Mandate universities and training centers to hire and tenure faculty who actually practice clinically rather than employ those who teach but do not do.

These are but a few of the solutions on my wish-list we may entertain in order to lift the plight of mental healthcare in this country.

But what would be a more forceful approach is for national and provincial psychological, psychotherapeutic, and counselling organizations to consider and press into service proposed changes and demand that the government allow psychologists, psychotherapists, mental health therapists,

counsellors, and social workers, to join the national Medicare system. These mental health professionals should be allowed the choice to become service providers under each provincial health insurance plan. This would shift the healthcare monopoly and provide the Canadian public more options in their mental healthcare treatment needs. The Canadian Psychological Association (CPA), perhaps in unison with the certifying boards of the various psychotherapy, counselling, and social work colleges of each province and territory that grant licenses to practice, could follow the precedence set by the American Psychological Association's lawsuit against the American Psychoanalytic Association for discrimination against and refusal to train non-medical mental health professionals in psychoanalysis, by not admitting them to their training institutes. The CPA and other organizations could make a viable case for the necessity of making psychological treatment regimes available to the public under the national Medicare system that are delivered by registered providers and not by untrained or mediocre practitioners. If appealing to politicians, social media, and the general public fail, then perhaps a lawsuit against the government may be the most effective route that would introduce national attention and debate and perhaps issue a sea-change in mental healthcare service delivery. This would also ensure that psychotherapeutic practitioners will not have to continue to be discriminated against by the medical profession, allied mental health professionals, the insurance industry, and its own kind scurrying for reactionary legitimization among its rival schools.

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