Ingrid Ozols AM
B.Sc, MMHS, M(Suicidology)
[redacted]

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Victoria's Royal Commission into Mental Health

***Altruism comes with a price**.*

I welcome the Victorian Government's commitment to promoting the health and wellbeing of Victorian's at all stages of life, and thereby appreciate the opportunity to make an individual submission.

My submission is based on the challenges of **voluntary and paid participation of the lived experience workforce for nearly 2 decades.**

I respectfully request that the inquiry takes into consideration **the importance of demonstrating the value of lived experience knowledge, skills, time, and commitment being offered to the health and wellbeing of Victorian's as this workforce grows.**

Attention to more equitable remuneration is long overdue, all the more as this perspective is becoming an important complimentary health service, a professional and vocational opportunity.

Volunteering versus Paid Participation

Wanting to give back to community using the lived experience of managing life with mental illness and surviving suicide is deeply rewarding. Endeavouring to alleviate one person's pain who maybe travelling on a similar path, gives the lived experience meaning, helps recovery through connectedness. Finding "common ground" with " someone who "gets it." (NESTA, 2013)

Giving of oneself, sharing vulnerability and offering support, gives others permission to share their lived experience, to feel hope and that recovery and rebuilding is possible.

Often this "giving" comes at a high cost.

Over 19 years, I have used my lived experience of recovery, managing bipolar disorder and surviving several suicide attempts through various roles and activities in the hope of reforming Australia's mental health system and how we as a society manage suicidal behaviour. In doing "advocacy" work, and sharing my lived experience loudly and publicly, I very quickly became estranged from a parent and some family members due to the power of stigma and shame. It has been nearly two decades *that I love them from a distance. No, I wasn't going to give up what became a personal crusade and my calling just because it was viewed as "morbid, negative, attention seeking"*

Mental health and suicide prevention faces a major workforce shortage. We can never meet demand, so services need to be innovative.

Consumer participation has been enshrined in our national mental health policies since 1992. As part of a now rapidly growing global social movement, the lived experience as a workforce of peers, peer support, consumer and carer advocates offers diverse vocational and professional career employment opportunities (Australian Health Ministers, 1992., Gordon, & Bradstreet, 2015., Meagher, Stratford, Jackson & Fong, 2018, Australian Government, National Mental Health Commission, 2018) .

There is also tension between service providers and the lived experience. The former are feeling threatened, perhaps their roles will no longer be needed? There isn't clear understanding of what peer support, peer support workers do, their roles are not always clarified, how they can enhance and compliment the work of other health professionals in case managing an unwell person? How are peer workers to be accepted and integrated into services? Programs? (Byrne, L. Stratford, & Davidson, 2018, St George, O' Hagan, Bradstreet & Burge, 2017).

There is strong evidence that peer support/lived experience helps people with wellness and recovery from a range of health issues, including helping individuals to cope with stress or emotional and psychological challenges, engaging with communities that are difficult to reach, and reduce admissions to hospital. Generally being a cost-effective and cost-saving complimentary option that presents an opportunity for health care planning and management (Peers for Progress, 2015).

A major challenge exists in how best to acknowledge the value these perspectives, experiences, knowledge and skills contribute to the mental wellness of our community, and in suicide prevention. How do we acknowledge innovation, the giving ideas, sharing, designing, developing, implementing, delivering, monitoring, evaluating of programs and services for the human condition, time to read and comprehend and review complex materials and concepts?

There is has been and still is to a large degree, an expectation that these contributions and services are pro bono. Volunteering suits many people, but doesn't work for everyone. Others try a combination of employment for salary and volunteering for causes of personal meaning and pleasure. Generally though, volunteering can only go for so long, unless the individual has economic circumstances allowing them to.

In some organisations across the mental health and suicide prevention sectors, remuneration or recompense is a given, but this is not consistent across the entire industry (Bennetts, Pinches, Paluch, & Fossey, 2013, Burge, & Child, 2011, St George, O' Hagan, Bradstreet & Burge, 2017).

So when is asking and receiving something or a service for free unfair or even unethical (Payne, C. 2018)?

Those who work in this way daily, spanning years and decades and who may not have wealthy circumstances some how continue volunteering. Pain, anger, passion, love can be powerful fuel to try to make something better, even under adversity and perhaps not always in one's best personal interests. Money is rarely the motivator, but we all have financial obligations. Caring too much finds day to day (and future) economic realities stressful for the volunteer and their families.

Participation comes in many forms; voluntarily, as mentioned, but also via (inadequate and devaluing) tokens of appreciation, such as vouchers, honorariums, or sitting fees - that don't always take into account extra work and time, or skills required to participate or complexity of work, consulting and/or salaries via employment. Some dedicated advocates who are employed use all their annual leave to do extra advocacy and/or educational activities

An example of inequity;

Every few years only 60 consumers and carers are selected onto the National Mental Health Consumer and Carer Register auspiced by Mental Health Australia and linked to the National Mental Health Consumer and Carer Forum. Government bodies, whether state or national, NGO's, and others who know of this register use this to appoint lived experience voices, consumer and carer advocates, or representatives to their table or project. These are mostly national paid roles with payments established by The Australian Government rates set by the Commonwealth Remuneration Tribunal (as at 2013) for reimbursement of consumer and carer participation. A policy as used by National Mental Health Commission, and other government agencies.

This register has a mix of people, some with years of experience mentoring upcoming future leading registrants. A positive initiative, this was established to provide wider opportunities for more consumers and carers to participate in advocacy and leadership roles at a national level. In the early days, when the movement was smaller, there was a sense that advocates where not being fairly selected, but rather tapped on the shoulder. Ironically, this model perpetuates similar practices, excluding many. Why is this not open to all consumers and carers? Why not have such a service in Victoria?

There are more discriminatory practices….

Our higher profile mental health and suicide prevention colleagues/charities have government funding to establish extensive "lived experience databases." Whilst doing admirable work, the practice of recruiting people to speak about their lived experience, their pain and vulnerability. It is expected predominantly pro-bono. Remuneration is far from adequate, if at all and are required to request donations from the audiences. This of course gives the organisation marketing, branding opportunities at no cost!

The lived experience voices enjoy their work and opportunity to bring change but they may be uncomfortable to say anything about payment as they love what they do and enjoy being able to represent a well-recognised mental health and/or suicide prevention organisation.

Yet, paradoxically, these very voices will complain in whispers outside the offices, but don't say anything to management as they don't wish to be viewed negatively (and also not lose out on possibly paid work that we all are hanging out for).

It is very hard to say no.

But this is taking advantage of generosity of spirit and exploiting people who wish to make a genuine difference. Those who do find the courage to say something, to decline doing something for nothing or raise fair questions diplomatically and assertively are considered to be troublesome and divisive, and are excluded from participating, ignored. Often they are bullied.

What message does this send to community and the lived experience contributors and workers coming up behind us that will be our leaders tomorrow? **This sets a terrible backward precedent**. Society pays for what it values.

Not remunerating lived experience for their contributions is also demoralising. We all talk of the importance of volunteering to mental healthiness, but it can also hinder and hurt our self-worth.

Giving "us" our "messages and skills" away not only devalues the individual but it devalues and demeans us all, what we do and are striving to do. Giving things away constantly though important and admirable, comes at a cost.

Add in the stress at seeing the same wealthy charities appearing to be spending excessively on expensive, "glossy" resources, clever mass marketing, savvy social media advertising all through government funding to hold "fundraising parties" for community members to keep donating, and something doesn't seem fair.

With unknown numbers of people within this sector providing pro bono work, or at very little recompense, the value of the contribution to society now and in future generations is difficult to quantify financially.

The lived experience workforce, as with the entire health sector, all need support and resourcing to continue our loving painful life and death work. We are putting ourselves and our mental health at risk of burning out, experiencing or potentially experiencing vicarious trauma every day we give ourselves, to try to make something better.

We are also struggling to contribute to our financial future adequately, e.g superannuation and therefore paradoxically some of us will probably need a pension.

This is also an industrial relations issue that will eventually flare up.

The very real alternative is for many gifted skilled, sometimes even tertiary qualified experienced people to walk away with rich sector and lived experience knowledge that can and does help countless people to stay safe and work towards recovery.

If many of us do this, on top of those retiring as we are an aging population, the loses will be incalculable.

Recommendation;

Lived experience to be offered choices of remuneration, either voluntary or not.

Government committee membership, advisory board, as with many, payment to equal for all members, irrespective of title, slightly more for the chairperson e.g. Better Access – GPMHSC (General Practice Mental Health Standards Collaboration) pays/paid all committee members the same amount, whether psychiatrist, psychologist, GP, consumer and carer and take into account extra reading time and complexity).

Remuneration that is equitable with other stakeholders at the decision making table

For organisations who wish consumers and carers to be speakers, presenting their lived experience to be paid a speakers fee appropriately, including preparation and delivery time, plus any transport expenses.

This raises the issue of evaluating all our charities financial records very carefully, including advertising and marketing expenses, salaries of employees and board member expenses. Awareness is important, but it is time to move on to education and service provision. The monies being used on these activities, plus the donations and government funding received might be an opportunity to call out our wealthier colleagues to remunerate the lived experience peer support workers that they call upon regularly.

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Formal submission to The Royal Commission into Victoria's mental health system

The connection between obesity and mental health

I welcome the Victorian Government's commitment to promoting the health and wellbeing of Victorians at all stages of life, thereby appreciating the opportunity to make an individual submission.

My submission is based on 49 years (from the age of 7) living with the combined impact of bipolar depression, obesity, binge eating disorder, body shaming, trauma, childhood abuse, and surviving several suicide attempts.

I respectfully request that the Commission takes into consideration the connection for many people, including very young children, between mental illness, being overweight and obesity.

The causes of the rise in overweight and obesity in Australia.

Key points of connection between obesity and mental health

Weight is never simply a matter of food or self-discipline. It is the visible outcome of a complex interaction between biology, nutrition, mental health, life experience, and social and environmental influences. Short-term diets fail to address the underlying causes of obesity. Mental illnesses are described as bio-psychosocial problems and obesity is a biopsychosocial problem as well. The social drivers of depression have much in common with the social drivers of obesity.

About a quarter of Australian adolescents have experience of mental illness and levels of psychological distress are increasing. One in five people who are obese will also have a comorbid eating disorder (NEDC, 2017). The trigger for eating disorders is dietary restriction. Standard nutritional and exercise advise are not safe or sufficient to address the mental health problems of people with eating disorders and can place people at increased risk of mental illness and suicidality. There is substantial evidence that obesity prevention initiatives increase the risk for eating disorders (NEDC, 2017). The rate of eating disorders in the Australian population is increasing in parallel with the increase in childhood obesity (NEDC, 2012).

The annual economic burden of treating obesity-related diseases is estimated to cost Australia $21billion by 2025 (World Obesity Federation, WOF). The financial ramifications of mental illness and suicide are also enormously high (Productivity Commission's issues paper, 2019). These figures need to be considered together as well as independently for the reasons that follow.

The extreme dieting and weight loss strategies used by people with disordered eating perpetuate obesity (Urquhart & Mihalynuk, 2011) and vice versa, the nutritional deficits of extreme dieting perpetuate binge eating. Few obesity prevention studies assess the interaction between mental health, nutrition and weight gain, or the possible harm obesity prevention initiatives cause to people already affected by mental illness or at risk of eating disorders.

My experience is that mental illness, binge eating and dieting are intertwined.

The impact of fat-shaming on mental health and long-term weight gain

Obesity prevention campaigns inadvertently contribute to “fat shaming” and social isolation of people who are probably already struggling with the isolation of depression and disordered eating. “Fat shaming” is not effective in motivating people for sustained weight loss and places people at increased risk of cardiovascular disease, mental illness and suicidality.

Being overweight is reviled by society. The self-shame and swinging moods with weight loss and then gaining the weight back, is embarrassing. What is wrong with me? The words “I have no willpower” echo in my mind. At one point I was so distressed about my weight and appearance that I physically could not eat in front of anybody else.

Population health messages are interpreted, over-simplified and distorted in popular dialogue and the good intentions are lost in misinformation, shame, stigma and social exclusion. Health messages targeting individuals are unlikely to be effective if they leave the person feeling stigmatised and rejected by society. People who believe these messages that their self-worth is directly related to their weight are at greater risk of obesity related disease and premature mortality.

I have personally been the recipient of harmful commentary from sales assistants when shopping for clothes and from prospective employers who have said I am “too fat” to work for them. This only serves to reinforce and exacerbate my feelings of self-loathing and push me into a retreat from life and contributes to deterioration of my mental health. This is a vicious cycle that many obese people cannot escape; when we try to do the right things for our health, like gaining employment and joining in social activities, we are abused and become further isolated. This triggers the urge to binge eat and our mental and physical health deteriorates further.

Effectiveness of existing policies and programs introduced by Australian Governments to improve diets and prevent childhood and reduce adult obesity.

Evidence can be interpreted in many ways but the reality is that there is no single approach which can be consistently identified as effective in reducing levels of childhood and adult obesity. Adopting one approach will not achieve Government’s aims.

Learning from practices that do not work

School educational programs have shown mixed results with some researchers finding success (Bauman, Bellew, Boylan et al., 2016) where others find failure (e.g. Adab, Pallan, Lancashire et al., 2018; Hung, Tidwell, Hall et al., 2015). Much depends on the measures used, and on the timing of those measures. Self-weighing, and the community messages which promote regular weight measurement, have been shown to be ineffective for adolescents, contributing to poor self-esteem and disordered eating rather than healthy nutrition (Pacanowski, Loth, Hannan et al., 2015).

In contrast, therapy and counselling have been linked to improvements in diet and levels of exercise (Hadley, Hair and Dreisbach, 2010). Clinically supervised weight-loss, and psychological interventions have been shown to consistently improve symptoms of binge eating disorder as well as contributing to modest weight loss (NEDC, 2017). A key is ensuring that the people who administer weight loss interventions are adequately trained in mental health and in the risks associated with unhealthy dieting behaviours.

Training the people who administer obesity prevention and intervention strategies

The people relied on to implement prevention initiatives, particularly in children and adolescents are not qualified in nutritional science, psychology or medicine. A teacher commenting on the nutritional value of a child’s lunch, or weighing a child in front of their peers, is not expected to have the knowledge and skills to understand how this impacts on mental health and motivation for change. **Despite popular representation of GPs as experts in health, most medical professionals are not experts in nutrition and psychology and are influenced by the wider social dialogue about nutrition and weight.**

Targeting strategies to specific populations

People who are overweight and people who are obese are not a single homogenous group. There are identifiable sub-groups distinguished by biomarkers, psychological profile and social environmental influences. People need strategies that are right for them with their physical and mental health needs and in their social contexts (Rizk, 2013). Models of intervention are required that take into consideration the measurable differences both within and between groups of people who are overweight and those who are obese.

There isn’t one way of eating well that will work for everyone. There are many health conditions which require dietary modification; there are many different cultural, social and religious expectations that may affect dietary behaviours. When you promote one way of doing things (e.g. 5 portions of grains a day) you invite people to ignore the advice or misinterpret it with devastating consequences for themselves and their children.

My relationship with food has been disordered since I was a child, growing up with very confused messages about “good and bad food, my appearance, and health. On one hand my mother either took meals away from me or wouldn’t allow me to leave the table until I finished everything. As I grew older I was placed on very low “calorie” diets and medications. In the background, my grandparents indulged me with the heavy food traditional in my culture and chocolates. During this time, with further family turmoil, I turned to "secret binge eating" as my head filled with growing self-loathing and regular suicidal thoughts – all at 7 years of age.

Regulating the non-medical weight loss industry

The lack of regulation of the weight loss industry, particularly in regard to the promotion of 'quick fix' diet products and diet plans raises considerable concern. Unlike pharmaceuticals, diet products do not have to prove their effectiveness. Failure to lose weight leads product users to blame themselves rather than the product leading to low self-esteem and the potential for increased health risks (NEDC, 2012). Regardless of the strategy adopted, stigmatisation does not work and should be avoided.

For decades I have restricted my food intake and exercised in the belief that this is what I needed to do to be well and to be socially acceptable. I have been seesawing from great weight loss only to gain greater weight later. It's a cycle I can't get off. The daily invisible psychological struggle is hidden in plain sight behind the mask of being overweight. The diets that I followed were not right for my physical or psychological health needs but provision is made for individual need and no-one made the connection between mental and physical health.

Solutions

When choosing strategies to reduce obesity it is just as important to ensure that they do no harm as to ensure that they achieve their narrowly defined purpose of short-term weight loss. The long-term consequences of mental illness are no better for the individual or the costs of health-care than the long-term consequences of obesity.

It is always more effective to deal with the systemic issues sustaining behaviours rather than focussing on the individual's responsibility to change. Without systemic change, the factors that influence behaviour will remain the same and the outcomes – in this case obesity – will remain the same as well.

- Include safe guards into all obesity prevention interventions and measure unintended consequences (Bauman, Bellew, Boylan et al., 2016).

- Integrate mental health and obesity prevention strategies, addressing the shared risk factors of body dissatisfaction, depression and disordered eating. I agree with the National Eating Disorder Collaboration that "there is an urgent need to develop integrated prevention initiatives which encourage body esteem, healthy eating and lifestyle behaviours without prompting engagement in fad diets, weight loss attempts and the diet-binge cycle"**.** (NEDC, 2012)

- Train the people responsible for delivery of obesity related messages in mental health, trauma informed care, supported decision making and suicide prevention.

Whether they are school teachers, doctors or weight loss coaches, it is essential that these professionals are skilled and supported to carry out prevention initiatives without placing young lives at risk.

- Make sure that when young people go to the internet for dietary advice the information they find is safe and evidence-based and includes ways to seek help not only for weight loss but for any underlying mental health contributors to weight gain.

- Make sure that all community messages around dieting and weight are safe and effective. Obesity prevention initiatives should avoid:
- Emphasising weight as the only measure of health. Good health is as a state of physical, social, and mental well-being and absence of disease. Emphasising weight promotes weight stigmatisation, body dissatisfaction, and disordered eating, and may increase the risk of weight gain, depression and eating disorders in adult life.

- Labelling foods as ‘good’, ‘bad’, ‘junk’, and food choices as ‘right’ or ‘wrong’. This detracts from the development of a healthy and relaxed relationship with food, increases feelings of guilt and shame and the risk of disordered eating.

- Cues to engage in any type of dieting, including fad dieting. Sensible healthy eating is quite different to the diets promoted through popular media. These are unsuitable for growing children.

(Source: Evaluating the Risk of Harm of Weight-Related Public Messages, Watson, 2010)

My binge eating disorder was finally diagnosed early 2018 when I had the opportunity to participate in an inpatient Binge Eating Disorder program with The Melbourne Clinic, the only one of its kind in Australia. I was fortunate to be able to afford this unique type of private health care. Many others do not have access to this basic essential evidence-based treatment.

Treatment was not what I expected. This initiative was based on my relationship with food, mood and sleep. No-one put me on a diet or shamed me. I am not calorie counting or weighing myself, but rather have acclimatized to a new way of being. Eating regularly, in a balanced way and walking. My “set-point” has still not settled, it may take a year or 18 months (Bacon, 2008).

It has been a life-changing program. Though traumaticizing and confronting in many ways, I have learnt strategies to curb my urges to binge and haven’t binged since. I am eating and moving in a way I could not a year ago and feel the healthiest I ever have. I want to make sure that the roughly 25% of people who are overweight who also have binge eating disorder have access to successful treatment. If as a country we care about health, productive and *participating lives, and reducing health care costs long-term, then we need to provide access to the right type of treatment when it is needed, early in illness.*

I want to make sure that children are not exposed to the conflicting diet messages, weight shaming, social isolation and profound psychological distress that I had to endure from the age of 7. No child or adult should want to take their life because of their weight.

Ingrid Ozols AM

Date 24TH June 2019

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2019 Submission - Royal Commission into Victoria's Mental Health System

Organisation Name
N/A

Name
Ms Ingrid Ozols

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
" I believe that the Victorian community needs to go beyond awareness to actions, to commence demonstrating change and/or the willingness to commence changing attitudes & behaviours. Instilling the promotion, prevention, and early intervention, and pro-activity in a whole of health and wellbeing approach throughout all of life-span. Being more proactive with programs that teach skills from earliest of ages throughout all of lifespan around safe supportive communication not only through ngo free programs (which is a problematic in itself, as this devalues the work of what we do and deliver, this isnt sustainable, small consultancies cannot continue to compete with pro-bono or subsidized work. To encourage support beyond MHFA and sector programs, but embrace all of health programs that maybe provided by private organisations demonstrating an evidence based approach To encourage community to embrace peer support across all areas, schools, educational institutions, workplaces e.g. in workplaces for specific employment, recruitment, (particularly of long term unemployed, many of whom have a mental illness), retention of someone with a mental illness, and supporting someone in the workplace, using models that are already working to demonstrate the benefits of employing people with a mental illness Language used regarding mental illness, suicidal behaviours, shaming, blaming - to be trauma informed care approaches as per above in every part of society (this may include promotional activities that increase awareness of trauma and complicated trauma and its impact on people) more skills based training, particularly via paid and trained lived experience consumers and carers Introduce mandatory education at undergraduate and post grad levels of medical/dental/business/economics/arts + other faculties, in mental health promotion, prevention and early intervention and suicide prevention in a person-centred, strengths based trauma informed approach, using lived experience in co-production to design, develop, implement, deliver and evaluate such programs/initiatives, e.g, Prof David Castle at Melbourne University has a recovery based module co-delivered/co-facilitated by lived experience in Masters of Psychiatry qualification Investment to establish co- operated peer and clinical drop in/safe centres, which encompasses quality assurance, evaluation e.g. Australian Institute of Suicide Research and Prevention at Griffith University (AISRAP) Lifehouse model please contact Jacinta Hawgood clinical psychologist Penalties for cyberbullying, harassment on social media to be picked up immediately or as soon as possible "

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?
"We have a plethora of information and awareness too much now that people are overwhelmed with information, which has been done well. However information states help and support is immediately available which we know is not that case, and sets up false hope, and increases distresses of person in crisis and their families and supports when the find the reality very different Use of digital technology via service providers that are working collaboratively with universities and

industry. E.g. Innowell Pty Ltd (Sydney University, Brain and Mind Institute and PWC). More research to provide what are evidence-based applications. Making technology accessible to all Victorians. In Chicago, homeless people are provided with recycled or new phones and given $25 per month for emergency/connectedness to services/family Expanding peer support workforce appropriately paid and appropriately trained in recovery, trauma informed care, suicide prevention, mental health act. Cannot continue to exploit the voice of lived experience generosity of spirit when they are most marginalised and vulnerable. Too much and too long volunteering can also contribute to mental ill health. Resentment grows as some people are paid but the lived voice isnt which sends a devaluing message. More more more educated community support, drop in centres around the city, regional and rural areas More housing variety of models now available to build small cabins, provide more shelter and safety, dignity to growing homelessness. In each of the above examples to provide free health checks for disadvantaged people Actively addressing social determinants of health. "

What is already working well and what can be done better to prevent suicide?
"'+ As above.... Sadly not much is working well in to prevent suicide as demonstrated by statistics indicating rates have increased over the last 10 years, and mental health problems are growing. As above in Q2. More documentaries, podcasts, stories of people with lived experience of surviving suicide (by paid and appropriately paid lived experience voices). We have large high profile wealthy tax payer funded organisations that have ambassador/volunteer lived experience people on a data base where speakers are invited to events NOT PAID, yet expected to ask for donations for the charity they are representing. A practice that has continued for too long. Yet high profile speakers, and senior executives are paid highly for their public presentations either as a part of their job or extra speakers fees. A most distressing and unfair ethical and emotive issue. Establishing more recovery colleges. Introducing community hubs with every primary health network (phn), and linking crisis drop-in centres here, as a short term triage approach as well as consumer/carer consultants, case managers at every phn both paid and short term volunteered. Introducing outpatient services in each hospital for crisis support Cross community training in supported decision making practices "

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.
"Stigma, fear, lack of confidence, confusion, know how to navigate the system (not that we have a system), not knowing what to do or where to go Confusion, what is a psychologist versus a psychiatrist? What is a clinical psychologist versus an organisational psychologist versus someone with a basic degree in psychology? Can the later practice psychology? Do they all have the same level and understanding of mental health, trauma informed care, recovery/strengths-base models of care, suicide prevention?"

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
" Social determinants of health!!! As above response using primary health networks to have consumer/carer hubs that help link lived experience, peer support with people with mental health problems. Basic societal needs (maslows theory of hierarchy) providing housing, employment, income, connectedness. More supported services such as orange sky, increase essentials from community as when there is a natural disaster, for those who are

homeless. There needs to be more proactive community awareness that homelessness can happen to anyone. The justice system needs total re-design, to enable more people who have been released are able to reintegrate into society without stigma, eg police checks for employment is increasing. This serves as an instant rejection in most cases if a person has a previous recorded offence. The youth and adult systems are the poor cousins of mental health and are breeding grounds for increased mental health problems. Include more peer support and rehabilitation programs. "

What are the needs of family members and carers and what can be done better to support them?
"They need to be included more into the whole of life skills person centred recovery approach. They dont need to know patient details, but have more inclusion and education around what they can do to compliment and encourage self-agency and self-determination, be informed where medications are involved, especially if patient is a minor and family dont have any understanding of what they are giving their children and what potential side effects may be experienced. They require separate care and check-ins to see how they are coping, before their health starts to decline. Be provided with support/network systems and places to go to for assistance. They often do not know where to turn or go to as not many people offer them anything as the focus is on the patient which it should be. However, many people do not live in silos, they are part of a system, their families also need support to help with the persons lifestyle change which is all too often a part of recovery. "

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
" Genuine embracing of peer support workers Appropriate remuneration of peer support workers Consistent mandatory training/education of anyone working in this sector with others who maybe vulnerable - facilitated by experienced peer support workers Financial/time assistance for ongoing training as per any profession Peer support for the peer support worker Provide clear roles and responsibilities, goals and objectives of what the peer support worker is expected to do and ensure colleagues also know and understand what their role is and how each role can support the other person. This is to also reduce a sense of threat that peer support workers are to replace rather than compliment the current workforce. Education and integration of peer support workers in service provider organisations Promote the positives of working in this sector more widely, this in turn will help general workplaces to role-model and employ people with lived experience During recruitment phase, include someone with lived experience in process, encourage interaction Zero tolerance of excluding, discriminating, bullying, using power differentials over lived experienced/peer support workers "

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?
"An embracing, non-stigmatising family, community, workplace, school that links into areas for improving the above. Having a combination of centralised information eg via hubs connected to the primary health networks, case managers/peer support workers, gps, allied health professionals, All of community to be educated as to what to do and where to go to for maintaining ones health and wellbeing. Helping Victorians navigate what they need, when they need it wherever they are located. Many are very confused with the overwhelming level of

awareness information, which is flooding the state. It is time to move on from reading fact sheets (there are something like 155 depression fact sheets?????) this money could be better invested in other ways. Using surplus monies that our high profile wealthy organisations have to fund more front line services, such as for the homeless, lifeline, paying for lived experience work, peer support workers at a reasonable level as per any professional role. Perhaps undertaking a gap analysis and consolidating what current services Victoria has and does not have. Increasing workforce across all domains/professions Providing longer stay places for severely ill patients. Reducing coercion, restraint and seclusion. Having discharge plans for people leaving hospitals/emergency departments "

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?

"Acute services[redacted] NO HELP. Must change how, where, when services are available as people don't just get into crisis between 9-5pm Mon-Fri. Workforce shortage increasing quotes at tertiary levels for admission in to medical fields. Workforce support high suicide rates, eg gps, physicians, anaesthetists, vicarious trauma of staff, burning out, leaving sector, expectations too high, not resourced enough to do the job properly, stigma stigma stigma. Inadequate training in mental health, supported decision making, trauma informed care, role of peers, suicide prevention. Education system inadequate careers counselling for the sector, current focus is still on year 12 result, no interviews with tertiary institutions or always relevant /diverse work experience. Many young people do not know much about mental health etc. Admission to higher education, especially medical, psychology or other relevant degrees based on quota (which can be very high to only allow a few placements) and not based on a persons social interpersonal skills or motivations. As per previous responses, not all such degrees have mandatory training in mh/sp/trauma informed care/recovery/lived experience/stigma etc "

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?

"Review Mental Health Act, Establish a Victorian MH Commission Update/implement a state survey of wellbeing and health have made similar recommendations at PC for update of National Health and Wellbeing survey as last one was done more than a decade ago old stats (2007). Challenge is that the sector is siloed, and collaboration/clicks is with a few select organisations. This requires the whole sector and all the infrastructure to codesign a modern approach using the lived experience rather than driven by a few high profile large organisations. There is a sense that there is empire building within the sector at the cost of services, duplication and reinvention of resources, lack of parity and equity with lived experience/peer support workers/consumer/carer consultants Review funding of all ngos (review to include financial records and where monies are being or not being spent) and consolidate some services depending on what they do, outcomes and independent evaluations, and reuse funding for frontline services. Supporting, funding, upscaling, expanding non-medical model community networks that embrace those vulnerable and disadvantaged. E.g. Wild at Heart, promoting arts, music, dance as part of whole of life approach to health and wellbeing. Improving the NDIS for people with mental illnesses to be able to access services as intended for other people with physical challenges and vulnerabilities "

Is there anything else you would like to share with the Royal Commission?

"Thank you for the work that you will be doing in reading so many submissions, opening yourselves to reading and hearing many many many painful and traumatic human stories of heart ache and despair of where services have failed people in crisis, causing in many instances, preventable tragedy."