Submission to

The Commissioners

Victorian Royal Commission into Mental Health

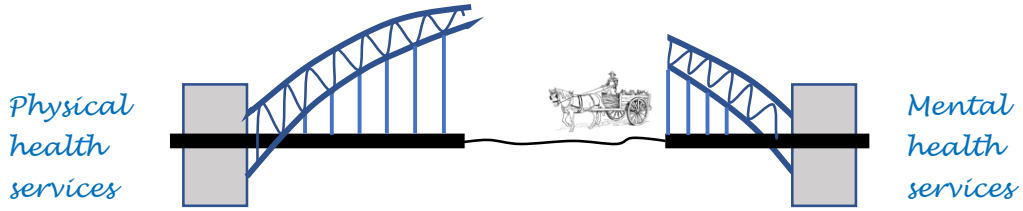
This submission relates to:

The Commission's terms of reference Section 4.2

> "How to improve mental health outcomes, taking account of best practice …. for people:
>
> - living with a mental illness and other co-occurring illnesses, disabilities, multiple diagnoses or dual disabilities"

Prologue

Whilst early intervention is important for people with emerging mental illness, so too is treatment for people of all ages, with all levels of illness. This paper concentrates on **those with greatest need**: people with severe mental illness *and* substantive comorbid issues. Frequently, there are associations or interactions between the physical and mental issues; yet the treatments (mostly) are disparate.



The real need for such people is to improve both physical *and* mental health outcomes because both cause pain, suffering and damage to those so afflicted.

Research indicates that up to 80% of people with severe mental illness are overweight or obese; and that they not infrequently have comorbid physical illnesses as a result. This paper proposes a new, integrated approach to treat both the physical and mental health issues of such people. There is potential here to invoke an approach that would be a 'first' for Australia, with potential to achieve real outcomes for such people.

Peter T Kent PhD
July 2019
[redacted]

Executive summary

This submission focuses in particular on people with **severe mental illness**, which include schizophrenia spectrum disorders, servere bipolar disorders and major depression.

ABS reports indicate that by 2014-15, 64% of Australians were overweight or obese (36% being overweight and 28% obese)[1].

For those with severe mental illness, up to 80% of people are overweight or obese. This leads to a substantial increase in comorbid illnesses including, but not limited to: heart disease and stroke; high blood pressure; diabetes; some cancers; gallbladder diseases; and osteoarthritis. This leads to a foreshortening of life for such people, estimated to be in the range 5 – 25 years.

There are relationships between physical and mental illnesses, for example:

- antipsychotic medications used to treat many severe mental illnesses cause weight gain;
- weight gain disposes to lethargy, poor self-image, and lack of exercise;
- lack of exercise predisposes to physical illnesses;
- physical and mental illness, and poor self-image can lead to social isolation which not only exacerbates the problem, but can lead to a negative world view, and/or depression.

Treatment of both of these, conjointly, will achieve better outcomes than treatment of either separately; in essence, a person-centred approach treating the whole person.

The causes of obesity are not just intrinsic to the person. They are a function of the obesogenic environment in which such people live. They are a function of the typically low incomes of such people and propensity thereby to purchase cheap junk food such as burgers and 'fries'. And, frequently, they are a function of the person's lack of understanding of both good dietary practice, and cooking skills.

A fragmented approach to addressing these matters is not sufficient. There needs to be an integrated approach, where, for a period of time, such people are moved out of their current obesogenic environment to a residential facility where all of the above needs can be addressed.

This paper proposes the establishment of a specialised, Victorian, residential, rural based facility, purpose built to address both the physical and mental health needs of persons with severe mental illness and overweight/obesity. Such a facility would be a 'first' in Australia. It would go a long way to bridging the void between mental and physical health services, and could become a model for similar facilities in other states. The proposal is referred to herein as 'Sanitas Villa' (**Latin** Sanitas: *health, sanity*; Villa: *farm, villa, village*) .

Recommendation

The proposed residential health farm for people with severe mental illness and comorbid overweight/obesity may be set up as a charity, or government owned establishment.

Regardless of how it is set up, it must operate with good governance, according to its charter, with focus on patient/client outcomes.

Subject to that, it is recommended that:

1 The Victorian government support the establishment of the facility

2 The Victorian government provides funding for operating expenses of the facility indicatively as follows:

Year	Funding $ million
1	1.5
2	1.5
3	2.0
4	2.5
5	3.0
6	3.0
7	3.0
8	3.2
9	3.2
10	3.2

Subject to the Victorian government agreeing to meet the operating costs of the facility for 10 years, the writer would be willing to take active steps to set up a charity for this purpose and get the facility established as soon as sufficient capital was raised. Engagement would begin forthwith with Victorian Shires to identify a suitable location.

Sanitas Villa[2]

Proposal for a

Physical and Psychosocial Health Farm Program,
deployable throughout Australia,
for those with, or recovering from,
severe mental illness
with comorbid overweight/obesity

Stage 1

Establishment of the Initial Farm in Victoria
to set up procedures, processes and methodologies,
measure outcomes, and evaluate the program.
This is a not-for-profit proposal.

The concept

Severe mental illness includes schizophrenia, other psychotic illnesses, and severe mood disorders.

Overweight/obesity is common in this group, along with smoking, leading to a range of comorbidities including insulin resistance, high blood pressure, atherosclerosis, stroke, cardiovascular disease, type 2 diabetes, gall bladder disease and some cancers. Various reports indicate that life expectancy for this group is reduced by 5-25 years.

In many cases, the primary mental illnesses here are difficult to treat, and sometimes, are chronic. However, in the right circumstances, with weight loss, and cessation of smoking, the physical comorbidities are, to a significant extent, treatable. Additionally, progress can be made in the mitigation of isolation and psycho-social problems, and the enhancement of living skills for such people.

Most Australians live in an obesogenic environment; that is, one in which there are readily available and strongly advertised products including confectionery, high sugar breakfast cereals, burgers, 'fries', and high sugar soft drinks. People with the above mental illnesses not only tend to do too little exercise, and often, are on anti-psychotic medications; they typically have low incomes, and thereby, a penchant for cheap junk food. It is not surprising that most of these folk are overweight or obese.

Programs to date have failed to address this problem, and new thinking is required.

The solution proposed here is to move groups of these people totally out of the obesogenic environment in which they live; and offer them accommodation on a psychosocial health farm for up to 12 months where, out of reach of 'easy-grab' foods, they can be on a program of weight reduction, psychosocial support, and treatment of both mental and physical illnesses. The farm would be built on a foundation of respect and mutual support for all involved. An exercise program would be built in for all participants, tailored to their needs and capabilities. Additionally, this would be a working farm to the extent that it would produce most of its own fruit, vegetables, eggs etc. Participants would be required to spend part of their day working under supervision on the farm, and an a roster basis, on laundry duty or assisting in the kitchen. As such, they would develop skills in these areas. Throughout the program there would be strong indoctrination and training on healthy cooking and eating practices. It is intended that on departure, every participant should have reached a BMI (basic metabolic index) within the normal range of 19-25. Prior to departure participants would begin a transition program back to normal life, with training on how to avoid obesogens[3], and continue their healthy practices back home. Follow up would be part of the program.

Contents

Incidence of severe mental illness in Victoria

Current population levels are, approximately:

Australia	25 million
Victoria	6.5 "

The Briefing Paper for the Productivity Commission's review into mental health provided figures for the incidence of severe mental illness in Australia. These figures, and the pro-rata figures for Victoria, are shown in the following table:

Persons with severe mental illness

	Australia	Victoria
Persistent	200,000	52,000
Episodic	500,000	130,000
Complex needs	100,000	26,000
Total	800,000	208,000

Thus, it can be seen that in Victoria, there are currently of the order of 200,000 persons who could be classified as having severe mental illness.

Obesogenic environment and its impact

Australians live in an obesogenic environment, i.e., an environment with ready availability of:

- manufactured and fast foods with high levels of fat, sugar and salt;
- confectionery;
- soft drinks with high levels of sugar, caffeine, colouring agents etc.

Superimposed on this, there is extensive advertising of such products, including advertisements targeted at children; and marketing tactics of product upsizing, and selling "2 for the price of 1.5", thereby encouraging over-purchasing.

This situation has emerged over the last 3-4 decades. ABS reports indicate that by 2014-15 64% of Australians were overweight or obese (36% being overweight and 28% obese)[4].

Over and beyond this: people with severe mental illness have tendencies towards poor diet, insufficient exercise; and in many cases the taking of medication which increases appetite. One recent scientific study investigated this and reported:

"About 80% of people with serious mental illness are overweight or obese".[5]

This same study investigated the effect of a weight loss/exercise intervention program on people with severe mental illness and achieved small weight losses (5% of body weight) over an 18 month period. However, in this study participants remained in their regular (obesogenic) environment throughout. Interventions were intermittent, not continuous. For effective outcomes, this underpins the need to move participants from their regular environment to a supervised environment, free from obesogens, and with a continuous health program. Hence the 'farm' approach.

Comorbidities

Severe mental illness and excess weight/obesity

Whilst a high proportion of Australians generally are overweight or obese, diagram 1 illustrates the particularly high correlation between severe mental illness and excess weight/obesity.

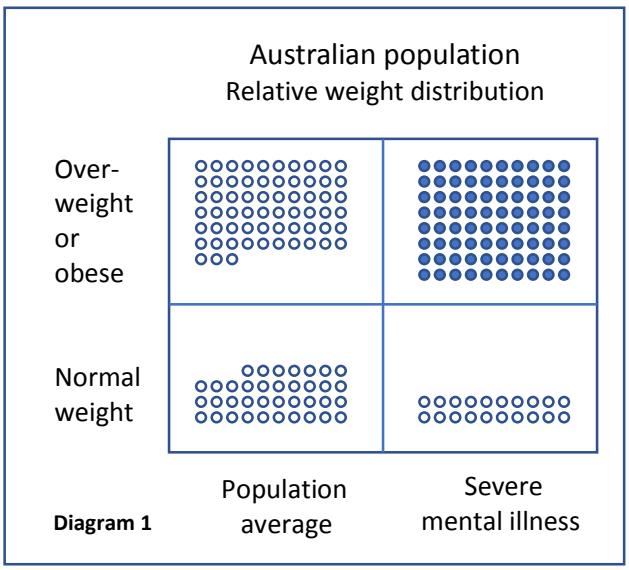


Diagram 1

Severe mental illness and smoking

SANE Australia reports[6]:

- Smokers in the Australian population 18%
- People with mental illness who are smokers 32%

The incidence of smoking is higher amongst those with severe mental illness.

The Cancer Council Victoria website:

"Tobacco in Australia"

reports that amongst people living with psychotic disorders:

- Men who are smokers 70%
- Women who are smokers 60%

The NSW Mental Health Commission Report "Physical health and mental well-being" quotes the following information:[7]

Issue	Frequency of occurrence %	
	General population	People with psychosis
Heart or circulatory conditions	16	27
Diabetes	6	21
Metabolic syndrome		50

It is likely that the higher levels of occurrence of these issues in people with psychosis are due to the comorbidity with overweight and smoking rather that the psychosis itself.

In general: there are strong links between physical and mental health. A common problem for people with severe mental illness is the associated stigma. This, and the impact of the illness itself not infrequently leads to social isolation. Being overweight or obese contributes to poor self-image which also contributes to social isolation.

Some mental illnesses have physical effects, for example: many persons with schizophrenia have negative symptoms of 'lethargy' or lack of 'get-up-and-go'. Similarly, those with severe depression may also suffer from lethargy. Lethargy contributes to lack of exercise, which contributes medical issues and to the patient being overweight or obese. Similarly, people who are overweight or obese find exercise challenging, and accordingly, do less. As such, they miss out on the cardiovascular benefits and the 'endorphin hit' that can come from vigorous physical exercise. As a consequence, their mood level, or affect, may drop. There is clearly a close relationship between mental and physical health. These comments are supported in the literature with evidence based research.[7,8]

In an ideal world one would apply effective treatments to both the mental illness and obesity (and conditions that flow from it).

However, with our present state of knowledge, it is difficult to 'cure' severe mental illness. In many cases, it is necessary to control the symptoms, and assist patients to live as full a lifestyle as possible. However, in this situation:

i) in the first instance, there is scope to treat the physical aspects of the illness. For example if an obese person can reduce his/her weight from 105 Kg to 80 Kg, not only will that person feel much better about themselves; it is quite possible that they may be able to reduce their medication dose by 20-30% without loss of clinical effect, but with reduced risk of side effects. Additionally, if such gains can be maintained, their ongoing healthcare costs are likely to be substantially reduced.

ii) A person achieving such weight loss undoubtedly would have improved self-esteem, with all the benefits that flow from that. Furthermore, there is (as a minimum) significant potential for secondary mental health and life skill gains by participants of the program which could include improved outlook/world view; increased sense of hope; reduced isolation; improved social skills; improved dietary knowledge, cooking practices and general living skills.

Why a farm

A farm offers the potential to build a supportive, recovery oriented community in a relaxed, outdoor environment away from the pressures of metropolitan life.

In addition, in treating obesity, it is particularly important that residents are in an environment ***away*** from the ready availability of fast food, confectionery, soft drinks and cigarettes.

A farm located at least 10km from the nearest town offers exactly that potential. Based on a farm of (say) 40 ha (100 acres), it is envisaged that:

- the farm would be a working farm in the sense of growing its own fruit and vege-tables, having chickens etc, thus being partially self-sufficient;

- residents, according to capability and under supervision, would spend some of their time engaged in farming activities; and in so doing, learn useful skills;

- on a roster basis, under supervision, residents would spend some time working in the farm kitchen preparing meals for all residents; and in so doing, learn to cook healthy meals. They would also be engaged in laundry, cleaning and other activities.
- there would be space on the farm for recreational and sporting activities;
- residents could stay for up to 12 months, and in some cases, up to two years;

- residents' access to mobile phones and internet would be restricted to facilitate community interaction.
- the farm would operate on an organised basis whereby residents had a mix of structured activities, exercise, and recreational time.

One of the problems of people with severe mental illness is isolation and, in some cases, lack of social skills. The farm is intended to be designed and operated in such a way as to facilitate residents engaging with each other (and staff) in a constructive, purposeful community, and in so doing, develop not only community values, but social skills and useful life skills. To be successful, the farm would need to operate as a mix of: training farm, holiday farm, boot camp and rehabilitation facility. It's culture would be based on respect and support, working, and having fun. It would, of necessity, have an element of 'tough love'.

Program activities

Programs would be tailored to individual needs, and may include:

- farm work and vegetable growing
- living skills including healthy cooking and eating; cleaning, washing
- daily exercise and fitness program
- weight loss program
- group counselling; individual counselling and personal development
- skills training, e.g. using a PC, learning Microsoft Office, learning Android etc
- excursions
- yoga, meditation, mindfulness training
- music / choir
- group fun and entertainment
- farm based sporting activities such as rope climbing, tug-of-war and wheel-barrow races.

The onset of residents' mental illness may have been caused by both genetic and environmental factors, where the latter may have included adverse experiences during childhood and adolescence. Whilst the farm cannot change residents' genetics, it can, over a period of time, give them a stable, supportive environment in which they may be able to re-establish their personal identities, heal childhood trauma (where it has occurred) and prepare for life ahead on a new footing.

What the farm is not:

The farm is not intended to be a hospital, nor to deal with people in the acute stages of a mental illness. It is not intended to be a drug or alcohol rehabilitation facility. It is not intended for weight loss alone. A prior condition is mental illness. If, on the farm, a resident has an acute psychotic relapse, that person would be looked after and arrangements made for their transfer to an external hospital. Once they had recovered, they would be eligible to return to the farm.

Resident access and admission criteria

It is envisaged that:

a) minimum age of access is 18 years.

b) eligibility for access is based on comorbidity of mental illness and overweight/obesity;

c) for places available on the farm, priority would be given to those in greatest need.

- at lease 30% of places would be reserved for people aged 18-30 years provided they meet the illness severity criteria;
- 10% would be reserved (with priority access) for people in the immediate catchment area, i.e., within 50km of the farm

d) admission procedure would include screening of applicants by a psychologist, social worker or medical practitioner. Whilst the intention would be to offer places to as many needy people as possible, the farm would reserve the right to refuse entry if the applicant was assessed at that time as clinically unstable, or likely to be excessively disruptive to the farm and its residents. People refused entry would have the right to reapply at a later stage.

e) the farm would be a non-smoking farm. (Cigarette butts can start bush fires.) People who are smokers and seeking entry would be asked first to engage in a Quit program. The farm would accept people who, as part of a quit program, were using nicotine withdrawal aids such as gums and patches. e-cigarettes would not be allowed.

f) applicants may be referred by medical practitioners, social workers, local councils, hospitals or health departments; or by family members; or via self-referral.

Mandatory referral: There may be situations where a person does not want to attend the farm; but where their medical practitioner sees it as a vital for their health. In such cases, medical practitioners may seek to have the power of mandatory referral, as they can do for mandatory referral of such people to a hospital. This is a matter for further discussion.

Notwithstanding any mandatory referral, it is not envisaged that the farm would be a prison.

It would have a strong culture of 'stay and persist', 'give it a go'. But if people were determined to leave, and became highly disruptive, in the interest of other residents, they would be let go.

Some residents may lose weight easily simply by switching from an obesogenic diet to a healthy diet. For others, weight loss may be a challenge, where, under the supervision of a dietician, targets may be set for weight loss (for example) of 1 Kg per week or fortnight. Recognition would be offered for achievement of goals. It is hoped that as people saw the progress they were making, they would commit even more fully to the program. As a consequence, it is hoped the reputation of the farm would build strongly, and it be seen as a place desirable to attend.

Physical health considerations

Good physical health contributes to a person's overall well-being. It is intended that the farm be run on lines that are not only healthy, but train or indoctrinate residents into healthy practices that they may take with them in their life beyond the farm. Whilst being sensitive to individual client needs, it is envisaged that the farm will have firm policies designed to achieve optimal outcomes over a client's period of residence. To this end:

a) the farm would be alcohol-free;
b) the farm would be soft drink free other than mineral waters or soda water;
c) other than prescribed medication, drugs would not be allowed;
d) food would be vegetarian oriented to facilitate health and weight loss.
e) the farm would be wholly or substantially sugar free to allow residents to break any sugar addiction they may have.

Vegetarian orientation Diet, and food preparation would be based on healthy guidelines, coordinated by dieticians.

Within this context, there are a large number of studies and publications worldwide, from the World Health Organisation down, promoting the benefits of a vegetarian oriented diet. These benefits include: reduced risk of diabetes, cardiovascular disease, some cancers; and less weight gain.[9]

It is envisaged that the kitchen would produce vegetarian meals seven days a week, and offer chicken, fish and meat dishes 2-4 days per week. If individuals have special dietary requirements, such as vegan or gluten-free, where possible these would be catered for.

Exercise All farm residents would be required to engage in a daily exercise program. This would be individually tailored, according to a person's health, fitness and personal goals. The program would be conservative, starting at what is a relatively low level for each individual and allowed to build up as the person progresses.

Weight loss program

Persons with a healthy weight usually have a BMI (Body Mass Index) in the range 19-25. A BMI in the range 25-30 is considered overweight, and over 30, obese. The specific goals of the weight loss program would be:

a) for all residents to enter a weight loss program, and leave the farm not only when they were psychologically ready, but their weight had stabilised within a normal BMI range;

b) that after leaving the farm, notwithstanding a return to the obesogenic environment, they were able to maintain their weight within the normal BMI range.

A key design parameter of the farm, under the supervision of a dietician, would be to offer residents healthy food, and keep the obesogens 'out of reach'. Over time it is hoped that residents would adapt to the healthy diet and their palate would normalise to this.

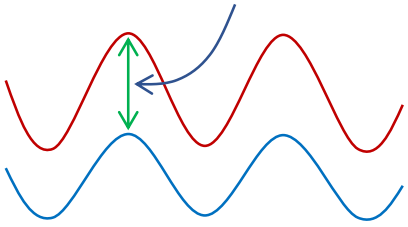
It is expected that some who were overweigh/obese would lose weight naturally by being on a heathy diet with plenty of leafy green vegetables. Others may need to kick start their weight loss program with a total meal replacement program; or by being placed on a tailored program which may include intermittent fasting[10].

Regardless of initial approach, it is intended that all would transition to a healthy, vegetarian oriented diet. It is hoped that they not only come to prefer this food by taste, but on seeing their weight loss and health gains, would consciously choose this diet, so that on leaving, they were strongly motivated to retain these eating habits.

Some medications, particularly the anti-psychotics, induce weight gain (see diagram). For persons on such medications the hunger pangs are greater, and the satiation points higher, than normal.

With all clients, psychological considerations, and in particular, 'psychological training in hunger management' would be important.

Medication induced hunger fluctuations



Normal hunger fluctuations

Clients on such medications would have to learn, inter alia, that their 'experience' of hunger was not a true, biological experience, but an unnatural and extreme hunger experience over and above their normal hunger requirements. Training for such clients could teach them that, on a scale of 10, a hunger experience of '3' was in fact 'zero' on a normal basis. They could learn that feeling hungry to 'level 3' was for them the new norm… In other words, they could learn that feeling slightly hungry all the time was normal, and should not be acted on in the form of eating. (If their hunger level was '6', then they would need to eat.)

There are parallels here with pain management. Some people have chronic pain. A range of non-medication based practices have been developed to help people to accommodate to such pain. These same approaches may also be applicable to hunger management in this situation.

Resident exit strategy and follow up

A central goal of the farm would be to assist residents:

a) in regard to mental health: become more stable, self-aware with enhanced, lasting life and social skills;

b) with regard to weight (where required): reduce this to a normal BMI range, and train the resident in healthy cooking and eating practices that may be carried forward in life.

However, when a resident leaves the farm they move from a supportive, health farm culture:

a) in regard to mental health: to their original settings, or new settings, and the need to deal with potential new stresses, and the hurly burly of life. The question is 'could they maintain their stability, equilibrium and life skills in this environment?'

b) in regard to weight: to an obesogenic environment. The question is 'could they maintain healthy eating practices and weight control in such an environment?'

If we imagine, for example, that without an exit strategy or client follow up, 50% of residents relapsed on either physical or mental health grounds; but with a well planned exit strategy, and a substantial follow up program, relapse could be reduce to 10-15%, then that would be a huge improvement. The key goal, after all, is to achieve lasting change.

It is envisaged, therefore, that for any resident attending the farm, 5-20% of the resources spent on that resident would be in exit programs and ongoing support. Such programs may include:

i) training for transition back to the external world;
ii) a period of time spend in a half-way house with support and further exit training
iii) telephone support for residents in their home environment
iv) transition for case worker support to residents in their home environment

v) provision for former residents to return to the farm for a revision week on up to two occasions: for example, six months and two years after departure

There may also be the possibility of a resident alumni arrangement to allow former members to keep in touch or offer peer support.

Farm development, safety and environment

It is envisaged the farm would be developed in three stages:

Stage 1	20 residents
Stage 2	40 "
Stage 3	60 "

Some of the infrastructure would be set up from the outset for 60 residents, such as office, kitchen, lounge/recreation room and laundry. Other infrastructure, such as accommodation units, would be constructed in stages. Whilst allowing quiet space and time for individuals, the farm's overall layout would be designed to facilitate social interaction and a sense of community.

One feature of the farm would be a free-standing hall of sufficient size that it could accommodate a basketball court. This would include a gymnasium in one section; and allow plenty of space for multiple activities, including exercise classes, farm community meetings, music and social activities in all weather conditions. In addition, as far as possible, the farm would need to provide an enjoyable environment for residents. Thus, it is envisaged that recreational facilities would include table tennis and billiard tables. At a later stage, if funds permitted, consideration would be given to adding a solar (or heat-pump) heated swimming pool and a tennis court. The recreational side is a vital part of the overall farm package.

Safety would be a prime consideration. Risks would need to be identified where such risks could include snake bite, accidents, bushfire; and resident risk of self-harm or suicide.

Safety policies would be developed whereby safety awareness and practices were incorporated into all aspects of daily activities. The facility may include a fireproof bunker in which, in the event of a bush fire, all residents could be protected for a period of up to (say) six hours.

Environment Environmental considerations would be central to the design and operation of the facility. It is envisaged that, building on the natural environment, the surrounds of the living areas would include small trees and shrubs, and areas of lawn – all of which create a relaxing and healing setting. Larger trees would be located further away from the buildings to reduce risk of bush fire.

Buildings would be designed to be fire resistant, with many having North facing roofs suitable for deploying solar panels. Indeed, with the incorporation of batteries, the facility might generate enough electricity to become self-sufficient and go off-grid. Roofs would be designed to capture rainwater and save this in tanks where such water could be used for irrigation, washing and, in the event of a bush fire, a backup supply of water to be deployed through roof based sprinklers.

Record keeping

Records would be kept on all residents from the time they arrived at the farm until they left. Such records would include their medical records, progress towards their goals, and psychosocial achievements. Where possible, residents would be followed up annually after they left. Over time, in this way, the effectiveness of the program could be evaluated, and program adjustments made if/as necessary. De-identified data could be available for research and policy development purposes.

Governance

The facility would be under the governance of a Board of Management

Staffing

Details are yet to be developed. However, from the outset, it is envisaged that the facility could need:

Full time staff:

- a general manager (resident at the facility)
- a chef
- a lead farm hand or agronomist to supervise farm activities
- an activities and exercise coordinator
- a psychiatric nurse (resident at the facility)
- welfare aides (2) (resident at the facility)

Visiting/part time staff:

- psychologist for entry assessments and to provide counselling/therapy services
- nurse to attend to minor health matters in the onsite surgery
- administration officer to handle enquiries, bookings, record keeping, and supplies
- bookkeeper/accountant
- maintenance person to attend to maintenance of equipment, buildings etc.

- visits from a GP and a psychiatrist

Over and beyond this there could be voluntary staff consisting of students on placement, for example: medical students, psychology students, or those training to be social workers or psychiatric nurses. Such volunteers could play ancillary roles in most activities of the farm, and in the process, gain valuable experience in dealing with people with mental illness. There may also be roles for volunteers from the local community.

Legal structure

It is intended that the farm be set up as a not-for-profit entity. The facility could be publicly owned; or, subject to legal advice, be incorporated as a company limited by guarantee. The assets of the farm may be held by the company, or in a trust for which the company is trustee. The entity may register as a charity and apply for status as a Deductible Gift Recipient so that donations to the facility were tax deductible.

Financial structure

Detailed capital and operating costs are not yet known. However as a starting point, the following rough estimates may be considered:

Capital costs $:	Farm purchase and initial setup	5 million
	Full development of the facility rising to	8-10 million
Initial operating costs: $ p.a.:	Staffing	1,190,000
	Food (not home grown)	60,000
	Supplies non food	60.000
	Vehicles, plant and equipment	30,000
	Telecommunications, insurance, utilities etc	60,000
	Sundries	50,000
	Contingencies	50,000
		1,500,000

As the farm expanded to (say) 60 residents, operating costs would increase, indicatively to $2-3 million per year. Beyond this, as the farm will require staffing 24/7, at full capacity operating expenses are likely to be of the order of $3 million per year.

Revenue Commercial health farms charge $2,000 per week or more for clients who generally are pampered. That is totally out of the range of our envisaged client group.

Whilst clients would be expected to make a financial contribution, no-one should be excluded through lack of ability to pay. Residents receiving a Centrelink payment would be asked to pay a fee, indicatively 80% of the Centrelink benefit that they receive[11]. Thus, a person on a disability pension of (say) $450 per week would pay $360 per week.

If we assume that on average, the amount residents can pay is $300 per week ($15,000 p.a.) then the annual revenue contribution from respectively 20, 40, 60 residents would be $300,000, $600,000, $900,000. The balance of operating costs would need to come from government funding. If residents can pay nil, the external contribution would need to be higher. It is possible that the facility could register as an NDIS provider, enabling some residents to be funded through the NDIS.

It is apparent that there are likely to be significant economies of scale to be achieved by developing the facility to hold 50-80 residents.

That is why the proposed farm is of a size 40 ha (100 acres). It needs to be large enough to provide plenty of space for the physical amenities, farming activities, exercise and recreation. It may also need to be large enough to provide a vegetation free zone around the facility as a fire break.

Naming rights

For consideration: if this is set up as a charity, the first philanthropist to donate $1 million or more to the facility would have naming rights, for example: "The John Smith Recovery and Rehabilitation Centre".

Conclusion

There are in Victoria of the order of 200,000 people with severe mental illness. Evidence indicates that at least 150,000 of such people will be overweight or obese. These people will be at risk of, or actually have, comorbid physical illness including cardiovascular disease, diabetes, stroke, gall bladder disease, some cancers and osteoarthritis. In this condition, their quality of life is degraded, and their life expectancy is reduced by 5-25 years.

This paper proposes the establishment of a residential, rural, farm based facility to offer treatment and support to such people, where the approach is person-centered, addressing the client's physical, mental and psychosocial needs, along with training in healthy eating, cooking practices, and life skills.

The benefits of the 'farm' approach include:

- it can be a medium to large facility which becomes a community in its own right;
- there is space and scope for a wide range of support activities and outdoor exercise;
- residents on the farm are removed from the temptation of going 'down the street' to buy junk food, soft drinks, cigarettes and confectionery;
- on entering the farm, residents would have severe mental illness, be overweight or obese, and may have other psychosocial and life skill problems. On leaving, in most cases, it would be expected that their weight was within a normal BMI range; their primary mental illness was (as far as possible) contained or reduced; they had acquired a range of life skills and healthy cooking/eating practices; and that their outlook on life, sense of well-being, and social skills were all enhanced;
- because the farm would be partially self-sufficient, costs would be kept down. This benefit is unique to farm based facilities, not available in metropolitan areas;
- the farm has the potential for creating rural or regional employment and economic activity;
- the farm could offer experience and training to students of medicine, psychology and social work;
- the farm would provide an information base for research into comorbidity rehabilitation and recovery.

If the majority of residents who left the farm were able to retain all or most of their weight loss, healthy eating habits, and psychosocial gains, not only would this be of great benefit to them personally in that it would increase their health, length of life, self-esteem, and potential for employment; it would significantly save on health costs to the nation in years to come. As far as I am aware, there is no facility like this anywhere else in the world. This project has the potential not only to succeed, but to become a model for world's best practice.

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[1] https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.001~2014-15~Main%20Features~Overweight%20and%20obesity~22

[2] This is a working title for the project. Latin. Sanitas: *health, sanity;* Villa: *farm, villa, village*.

[3] Obesogen: a manufactured product, usually containing high levels of fat, sugar, salt, or combinations thereof, engineered to appeal to the palate with the intention of engendering maximum, repeated consumption.

[4] https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.001~2014-15~Main%20Features~Overweight%20and%20obesity~22

[5] Daumit GL, Dickerson FB, Wang N-Y, Dalcin A, Jerome GJ, Anderson CAM, Young DR, Frick KD, Yu A, Gennusa III JV, Oefinger M, Crum RM, Charleston J, Casagrande SS, Guallar E, Goldberg RW, Campbell LM, Appel LJ. A behavioral weight-loss intervention in persons with serious mental illness. *New England Journal of Medicine*. 2013;368(17):1594-602.

[6] https://www.sane.org/mental-health-and-illness/facts-and-guides/smoking-and-mental-illness

[7] Mental Health Commission of NSW, 2016: Physical health and mental wellbeing: evidence guide.

[8] Mental Health Foundation UK https://www.mentalhealth.org.uk/a-to-z/p/physical-health-and-mental-health

[9] https://www.eurekalert.org/pub_releases/2018-06/n2-nrr053118.php

[10] See for example: https://www.healthline.com/nutrition/intermittent-fasting-guide

[11] A standard used by other residential accommodation services.

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

Organisation Name
N/A

Name
Dr Peter Kent

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
Publicity

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?
N/A

What is already working well and what can be done better to prevent suicide?
"Introduction of active anti-bullying and discrimination programs in schools. Educating students that disability, in its various forms, is a normal part of our society. "

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.
Excess stress in our competitive environment is a contributing factor.

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
N/A

What are the needs of family members and carers and what can be done better to support them?
More respite facilities. More supported accommodation for people with severe mental illness.

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
N/A

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?
See my submission.

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?
There is substantial opportunity to improve support and outcomes for people with severe mental

illness. See my submission.

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
"Greater integration between physical and mental health support systems. In regard to how this applies to people with severe mental illness, see my submission. "

Is there anything else you would like to share with the Royal Commission?
"Whilst young people are important, there needs to be good support for people of all ages with mental illness. They are all suffering. "