Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF DAVE PETERS

I, Dave Peters, say as follows:

1   I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

2   I am giving evidence to the Royal Commission in my personal capacity, and not on behalf of any of my employers.

Background

3   I have lived experience of severe mental illness and severe persistent pain, but it is my experiences dealing with our health and mental health services which have provided me with unique and valuable insights that allow me to contribute broadly to local, State and national projects and services. I enjoy working in close contact with other service users and aspire to work to improve the experience of seeking support for anyone in need.

4   I have extensive experience in advocating for improvement in the mental health sector. With a prominent social media presence, I have a wide following and network in the mental health and National Disability and Insurance Scheme (**NDIS**) sectors. I have experience in conducting focus groups, workshops, interviews, public speaking, delivering lectures and presentations at conferences or events. I was unable to work for several years, but have developed a new set of skills and experience working within the mental health sector in various Lived Experience roles. These opportunities highlighted the benefits of being able to contribute to service development, research and evaluation, service evaluation and improvement, teaching and training, recruitment and much more; they led to me returning to the workforce after over a decade of being unable to work in more traditional areas.

5   Until June 2020, my main role was at the Brotherhood of St Lawrence in their Research and Policy Centre as a Lived Experience worker. Unfortunately due to funding cuts primarily attributed to the COVID-19 pandemic, my role was recently made redundant.

6   I am Co-Chair of the Equally Well Alliance, where I chair meetings with representatives from professional associations, the Department of Health and others. I have been part of several projects and collaborations between Equally Well, the National Mental Health Commission, the Chronic Disease Prevention Alliance, the Mitchell Institute for Education

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

and Health Policy at Victoria University and others. I am also the Consumer Ambassador for Equally Well, where my activities, particularly using social media, are geared towards promoting improved physical health outcomes for people living with mental illness.

7   I also work as a Lived Experience Consultant at the Australian Catholic University, Monash University, Swinburne University and the University of Melbourne. At these universities, I variously act as a guest speaker, provide feedback to students on their Oral Presentations of simulated case conferences, form part of course advisory groups, and collaborate to create educational videos.

8   In addition, I contribute to the curriculum design of the mental health units within the Occupational Therapy courses at the Australian Catholic University, Monash University and Swinburne University. This work enables me to keep up with current practice and service development, and to offer the insights I have gained from living with chronic pain and severe mental illness to the next generation of practitioners.

9   I have also contributed to many other frameworks and research projects as a Lived Experience Consultant and as a member of advisory groups, steering committees, and in similar roles. Examples include my roles as Consumer Co-Chair of Neami National's Research and Evaluation Committee, and as a Member of the Lifeline Australia Lived Experience Advisory Panel. I worked on the development and re-write of Lifeline Australia's service model, which is primarily involved in suicide prevention and crisis intervention. I also contributed to the Lived Experience voice for the training and national rollout of this model for Lifeline Australia.

10   Attached to this statement and marked '**DP-1**' is a copy of my CV.

The physical health of people with a mental illness

The importance of understanding and treating the physical health needs of people with a mental illness

11   There is a longstanding tradition and practice in the medical profession of the separation of mind and body. However, best practice is to treat people in a holistic way, where you see the person as a whole. Being mentally unwell can impact a person's physical health, just as being physically unwell can impact a person's mental health. For example, the physical health of people with mental illness can be affected by the medications they take for their mental illness. In addition to the significant impacts on physical health and life expectancy discussed at paragraph 13 below, certain medications can have a terrible impact on oral health. In addition, the sedation effects of some medications can cause the people taking them to suffer from apathy and disengagement from life. That is something that I still struggle with.

12   The onset of a chronic physical condition can lead to mental distress and/or illness – for me it was chronic pain, but for other people it may be other chronic physical conditions, such as a diagnosis of diabetes or cancer, or an acquired physical disability. Understanding and treating physical health needs can also open the door for discussions and treatment of mental health needs. I live with chronic pain, which has a devastating impact on my mental and emotional wellbeing. For me, it was through discussions about the mental and emotional impacts of my pain that I first spoke to a clinician about mental health issues.

13   In addition, it is common for people with mental illness to suffer the sort of physical health effects and detriments that shorten life span. In fact, mental illness leads to a shortened life expectancy of about 20 years. The early mortality is caused partly by physical diseases that can be managed or prevented with the right interventions, like cardiovascular disease, diabetes, stroke, prostate cancer or breast cancer. Even though these diseases are manageable or even preventable, in people with mental illness they often lead to a shortened life expectancy or early death. That is because either people are not aware of the diseases, or they are taking medications that have a devastating impact on their bodies.[1]

14   When I first started getting support for mental illness, I was not aware of the poor physical health outcomes for people with chronic mental illnesses. The first time I heard about the early mortality or reduced life expectancy associated with the physical impacts related to living with mental illness, it was terrifying. At that point, I had already been on many of the medications that can be associated with those physical changes for around six or seven years – long past the point when those changes had started to happen. But I have learnt from my work with Equally Well that it's important to acknowledge and talk about these outcomes.

The Equally Well Program and its goals

15   Equally Well is a national program that I became involved with in early 2018. The program commenced in 2016, and was initially funded by the National Mental Health Commission.[2]

16   The core goal of Equally Well is to improve the physical health of people living with mental illness. It is a program, but I would also call it a movement. The program was initially a mirror of the work being done in New Zealand, in that it was inspired by a similar program

[1] Roberts, R. *The physical health of people living with mental illness: A narrative literature review.* NSW: Charles Sturt University; 2019. ISBN: 978-1-86-467344-9. <https://www.equallywell.org.au/wp-content/uploads/2019/06/Literature-review-EquallyWell.pdf> [accessed 3 July 2020]. For further information about the link between physical health and mental health, see generally Equally Well, <https://www.equallywell.org.au/> [accessed 3 July 2020].
[2] For a brief overview of the history relating to Equally Well in Australia, see Equally Well, 'Our Journey' <https://www.equallywell.org.au/our-journey/> [accessed 3 July 2020].

in New Zealand which had at that time already been running for a number of years.[3] Equally Well has a national consensus statement which was launched in July 2017.[4] A wide range of stakeholders around the country have signed up to the consensus statement, including state governments, Primary Health Networks, local health districts, hospitals and non-clinical services. They have all agreed to address physical health as a priority for their organisations. That means that in the normal course of business supporting a person with a mental health difficulty, the stakeholders will also make sure to address the person's physical health.

17   The national consensus statement was developed by a large and diverse working group of experts, from consumers to psychiatrists and academics. The working group spent about a year drafting the national consensus statement, and Equally Well subsequently became a key part of the Fifth National Mental Health and Suicide Prevention Plan for 2017–2022 (**the National Plan**). One of the eight steps in the National Plan is aimed at addressing and managing the physical health and wellbeing of people with chronic mental illness. Specifically, the fifth targeted priority area in the National Plan is: "improving the physical health of people living with mental illness and reducing early mortality".

18   The Equally Well consensus statement lists a number of actions and essential elements and the signatories to the consensus statement are asked to report back on work they are doing to address mental health in line with the statement.

19   There is some fantastic work being done both on a federal level and by the states to prioritise the agreed actions in the Equally Well consensus statement. Victoria has been leading the way in Australia and, indeed, around the world, as Victoria is farthest along in having policy and procedures in place to implement this work. The Victorian Office of the Chief Psychiatrist and the Victorian Office of the Chief Mental Health Nurse have worked together with a co-design group of consumers with lived experience and carer coordinators to develop a Victorian implementation framework, *Equally well in Victoria: Physical health framework for specialist mental health services*, which was launched at the National Equally Well Symposium in Melbourne in March 2019.[5]

---

[3] Te Pou o te Whakaaro Nui, 'Equally Well: Physical health' <https://www.tepou.co.nz/initiatives/equally-well-physical-health/37> [accessed 3 July 2020].
[4] National Mental Health Commission. *Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia.* Sydney NMHC, 2016. <https://www.equallywell.org.au/wp-content/uploads/2018/12/Equally-Well-National-Consensus-Booklet-47537.pdf> [accessed 14 July 2020].
[5] Department of Health and Human Services, 'Equally well in Victoria: Physical health framework for specialist mental health services' (March 2019) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/equally-well-in-victoria-physical-health-framework-for-specialist-mental-health-services> [accessed 3 July 2020].

20   Victoria has had another planning workshop with representatives from the clinical sector, along with Consumer and Carer representatives, to think about which of the areas of priority to focus on first, and how to implement them. At the workshop, a number of services came and spoke about the progress that they had made in implementing changes to their practices. It was great to see that this work had already started to happen, even though the framework had only been released a short time earlier. In my view, one stand out presentation was from Peninsula Health, where they demonstrated how they had started a community Wellness Clinic. I discuss this program further below.

Best practice examples that could be scaled system-wide

The Wellness Clinic

21   An example of a best practice program that could be scaled system wide is an initiative called the Wellness Clinic, which is run by Peninsula Health. Anyone who is using Peninsula Health's mental health services, on either an inpatient or outpatient basis, can access the Wellness Clinic. Clinicians, including Mental Health Nurses, Psychiatrists, Registrars and Allied Health practitioners, have a discussion with each patient who attends the Community Mental Health Clinic (Outpatient), and discuss the various impacts that many common medications can have on physical health. They then offer a referral to the Wellness Clinic, where further information can be provided along with the assistance of nurses, a dietician, an exercise physiologist and a music therapist, to offer a range of services designed to assist with the improvement of physical health. Peninsula Health also specifically recommends that certain people attend the clinic, for example people who have been prescribed anti-psychotic medications like clozapine or olanzapine.

22   The Wellness Clinic offers a range of supports for consumers, focusing on health matters such as exercise and diet. At the Wellness Clinic, a person's starting health measurements (such as blood pressure, weight, cholesterol level and blood sugar) are taken. The Wellness Clinic staff then explore ways in which the person can try to manage the effects of the medications they are taking, before those medications start to have a significant and detrimental impact on their physical health. If the consumer has already been on the medication for some time, then the discussion focuses on ways in which they can try to prevent the loss of years of their life. The aim is to try to mitigate the effects of medications before they have a physical impact, such as a slowing metabolism and weight gain.

23   Initially the Wellness Clinic was staffed by two nurses and a clozapine co-ordinator. It later expanded to three nurses, a dietician, an exercise physiologist and a music therapist. The Wellness Clinic is addressing the lack of awareness of the impact that medications can have on a person's physical health.

24   The Wellness Clinic's attitude to exercise is also important in light of what we now understand about the role that exercise plays in mental health. The recommended first step for managing symptoms of mild to moderate depression is exercise—not medication. We now know that exercise and food can impact your mood in a big way. For example, research conducted by Associate Professor Simon Rosenbaum and the Black Dog Institute has identified a positive link between exercise and improved mental health.[6] Initiatives like the Wellness Clinic are therefore useful not just for counteracting the impact of the medication, but also for creating a positive effect on our emotional wellbeing. In the UK, for example, practitioners are prescribing contact with nature in response to the first episode of mild and moderate depression.[7]

25   Social connectedness is another important part of maintaining good mental health. Isolation and loneliness can have a massive negative impact on a person's wellbeing. A positive side effect of programs like the Wellness Clinic is that they can offer a person connection with other people who are going through the same thing. I discuss social connectedness further from paragraph 56 below.

26   The Wellness Clinic also takes into account a person's readiness for change. If you are looking at addressing your wellbeing and recovery, you've got to be ready to do so. That is something I learned in my own pursuit of wellbeing and recovery: if you are not ready to make change, change cannot be forced upon you. At the Wellness Clinic, the initial session includes a discussion about readiness to take action. In my experience, people who are ready will enrol in the Clinic. People who are not yet ready will still have their initial health measurements taken, and then be advised to take those measurements to their own GP when they're ready. A person's level of readiness is considered and respected. I think that's amazing.

Neami National

27   Some community-based mental health services have their own psycho-educational programs that offer the same sorts of things as the Wellness Clinic. One such service is Neami National (**Neami**), which I was using for some years. Neami runs a program called the Optimal Health Program, which looks at health and wellbeing for the whole person

---

[6] See for example UNSW Sydney Newsroom, 'Exercise therapy for mental illness' <https://newsroom.unsw.edu.au/exercise-therapy-mental-illness> [accessed 22 July 2020]; ACT Government Healthier Work, 'COVID-19 Webinar Series | Physical activity and your mental health, featuring UNSW's Associate Professor Simon Rosenbaum' (and the references provided there) <https://www.healthierwork.act.gov.au/home/mentally-healthier-workplaces-pledge/covid-19-webinar-series/> [accessed 22 July 2020].

[7] See for example James Fullam, 'Developing a nature-on-prescription intervention for people with common mental health conditions' (Beyond Greenspace, 7 December 2018) <https://beyondgreenspace.net/2018/12/07/developing-nature-on-prescription-intervention/> [accessed 3 July 2020].

and discusses the role that food and exercise play in our lives. As the Neami website explains, the Optimal Health Program:

> "... is a group-based program that supports people to engage with, and self-manage, their health and wellbeing... The Optimal Health Program is the result of research to develop a self-management program promoting hope, growth and collaboration by Frameworks for Health at St Vincent's Health Melbourne. It is instilled with a collaborative therapy approach that supports the exploration of an individual's wellbeing; through reflection, setting of goals, self-managed strategies and health plans. The program is designed to support participants to manage stresses and vulnerabilities, and to address health behaviours that contribute to poor quality of life."[8]

28   Neami also has a tool called the Health Prompt, which is both a paper tool and a phone app. Many people who have chronic mental illness do not have a regular GP, especially if they are also experiencing homelessness. In such circumstances, it can be very difficult to maintain regular contact with anyone, but especially with a GP. The Health Prompt is a tool that poses a series of common questions around physical health, such as whether you get regular food and whether you have a regular GP and have a good relationship with them. The answers to the prompt can be taken into your GP appointment to set an agenda for that session, helping ensure that you can focus on the things you need without forgetting those little things you still need to address. You can access your previous answers to check progress and changes over time, and the data is de-identified and stored (with consent) for use in research and statistics. The questions are structured in a way that when someone answers "No", that indicates that there is something that needs to be addressed with your Doctor.[9]

Workforce quality

Stand-out experiences of professionals and teams who have been involved in my care and support

29   I have had help from some terrific people. While I've had both good and bad experiences, the stand-outs are the good experiences. I think the good experiences often come down to the service model of practice. The people at Neami who were involved in my care and support were all fantastic, but what was really important was that Neami recruited people on the basis of having shared values: Self-determination, Choice, Growth, Learning, Partnerships, Change, Respect, Wellbeing, Empowerment, Hope, Diversity and Quality.

---

[8] Neami National, 'The Optimal Health Program (OHP)' <https://www.neaminational.org.au/our-services/community-based-mental-health/community-programs/ohp/> [accessed 3 July 2020].
[9] For further information, see Neami National, 'Neami Health Prompt' <https://www.neaminational.org.au/what-we-do/social-innovation/neami-health-prompt/> [accessed 14 July 2020].

The people who were recruited shared Neami's values and could demonstrate that in their everyday work.

30   When I first sat down with Neami, we started with the fundamentals: what I did with my time, the routine of my week, whether I ate regularly, who else I had in my life. The aim was to put a safety plan in place, so that if I ever experienced a crisis, I would have already discussed what I wanted to happen. After completing a safety plan, we moved on to identifying and exploring my values and the things that are important to me in my life. We then worked on setting goals based on those values. For me, having something meaningful to do with my time was an important goal. Other value-based goals might have been pursuing a return to employment, or choosing a hobby to pursue. For me, my journey of recovery was about the pursuit of wellness through doing things that were important to me. I began to get involved in things that were important to me, and I was able to set goals and start achieving things again. While this may sound straightforward, it was an involved process that took years of support and work. I was invited to participate in Neami as someone with valued lived experience who could inform both their research and their service improvement.

31   I had come from a place of incredible disempowerment and disengagement. For the team at Neami to acknowledge that my lived experience has a role to play, that my voice was valuable and important, led me onto a new pathway to recovery. At one stage, I thought that recovery meant the absence of symptoms. I believed that to be "recovered" I had to be completely symptom-free and go back to my old life. But this consumer participation program, which invited me to have input and share my lived experience has opened up a whole new path for me. As I explained above, I have several jobs now, but they all involve me using my lived experience to inform research and service development. For example, my roles with universities allow me to use a bad period of my life to inform practice and talk to students about their future practice.

Integrated care

Achieving more 'integrated care' for people living with co-occurring mental illness and problematic alcohol and other drug use, or other support needs

32   As I said, the medical profession still has a preoccupation with the separation of mind and body. The alcohol and other drug (**AOD**) support sector is particularly problematic. A person in a mental health or suicidal crisis can attend a specialist facility or hospital, but if they also present with substance-abuse disorder, it has been my observation that they will often be turned away and told to go to a specialist AOD service. But substance abuse has an impact on mental health and vice versa. I think those services should be integrated.

33   I think the only way to integrate services is to have the workforce co-located within the same facilities. No matter a person's presentation, they should be in a facility that also houses services supporting other areas of health. If a person in a closed mental health ward has co-occurring conditions or complications that require specialist care or intervention, they should be able to receive that treatment in a sub-annex or a wing associated with the same unit. A person should be seen as a whole person. A health service should not address just one part of a person's problem, disregarding the fact that it's connected to every other part of their health.

34   I am aware of a current study that is looking to trial a dedicated mental health crisis space in emergency departments in a number of hospitals in Melbourne. As I understand it, this is an attempt to address the difficulty of caring for someone in crisis in a place like an emergency department which is not conducive to having lots of time and space for individual care and attention.

35   In an ideal world, one specialist could handle multiple presentations. But in reality there are many sub-specialities that have developed independently over decades. They might have developed in parallel, and with some peripheral integration, but mostly they are separate and distinct. We cannot now demand of clinicians that they be specialised and yet also be confident in practising across the spectrum. I think that the co-location of services means that a person who needs support can come to the one place and be sure of receiving the support they need.

Knowledge, skills and attitudes needed by a workforce to provide holistic, person-centred support

The importance of peer support

36   Peer support is vitally important, because it leads the way in providing people in crisis or distress with hope. If people with lived experience are sufficiently situated in their lives to be able to offer that support to others, and if they can learn the skills required to provide that support, then they are in an incredible position to offer their insight and support. The key skills that I think are required to provide that support include the ability to create a safe space for people to share their stories, being aware of vicarious trauma, knowing your own boundaries and engaging in self-care.

37   The sharing of similar experiences allows a level of compassion and empathy that people who have not had the experience themselves cannot demonstrate. When someone who is supporting you declares openly that they have gone through similar experiences, it makes a significant difference. They can act as a personal demonstration of recovery – an embodiment of hope for your own future recovery. It's incredibly powerful to hear

someone else articulate what it is that you're feeling, what it is that you've been going through. That is particularly important when you are struggling to express yourself.

38   In addition to compassion and empathy, people with lived experience may have the confidence to offer support where others might not. It's hard to be there to support a person in crisis, because you might not know what to say, and there's a common fear that you might make things worse or say the wrong thing. Many people lack the confidence to offer support to someone in crisis. That is where the peer workforce can offer something unique and of incredible value.

Challenges to the workforce's ability to provide holistic, person-centred support

39   I think there are some challenges to the workforce's ability to provide holistic, person-centred support, including that:

(a)   Peer workers are often in a difficult position in a clinical setting. They have a difficult role to play. They are expected to support the actions of the treating team, whether they agree with those actions or not. The peer worker may have conflicting loyalties between the treating team and the consumer, whose experiences the peer worker may identify more strongly with. Moreover, the treating team's attitudes towards the peer worker may be dismissive, not seeing the value or place for peer support, and that is a difficult culture to change.

(b)   In terms of attitudes amongst the workforce, I have heard that staff sometimes experience frustration and exasperation when people present with issues that the particular service cannot address. There is also some stigmatisation of drug users—the attitude that their problems are self-inflicted and that they should not be using up resources that could go to people in need. There are also highly prevalent occurrences of stigma towards people with Personality Disorders (who some staff see as manipulative or attention seeking), or people who have self-harmed (with some staff taking a view along the lines of: they've done it to themselves; they don't deserve my compassion or anaesthesia for the stitches).

(c)   I think that emotional burn-out is also a problem for the workforce. It can be very demanding for a staff member to be emotionally vulnerable and supportive to every single person they see, so they develop an emotional distance – it's part of their education to implement professional distance or clinical distance. But sometimes that sort of protection mechanism can become skewed. People risk losing their compassion and empathy. How do you care for the workforce in a way that enables them to show that care and empathy to each person, while balancing the risk of burn-out and compassion fatigue?

The role for digital technology in supporting integrated care across health, mental health, AOD services and other service systems

(a)   The use of shared care consumer records

40   Consumers may be interested in a shared care consumer record if it can help them avoid having to repeat their stories. In the current system, a consumer has to tell their story to one person, and then when they see someone else they have to tell it again. It's potentially re-traumatising and damaging each time. That is not constructive to a person's recovery or wellbeing.

41   A shared care consumer record could also help to facilitate integrated care. For people living with multiple or co-occurring conditions, a shared record like this could help cut down on duplication of testing and assist the specialist of the day with their diagnostic processes. If a clinician can view the shared information and maintain objectivity, there's a real opportunity to use the available information to benefit both the patient and the clinician by preventing repeated tests and helping prevent a need for the patient to tell their history again.

42   Unfortunately there is a risk that too much shared information could impair the diagnostic process due to the stigma related to mental illness. I have heard personal stories from people who have had a clinician refuse to engage when mental illness has been disclosed, essentially assuming that complaints of symptoms are an attempt to seek attention and are not genuine. This is also known as diagnostic overshadowing, an issue which I discuss further below.

(b)   Promoting trust in information sharing systems

43   I see two main issues with information sharing systems, which would need to be addressed to promote trust in the system: *first,* control over information, and *second,* diagnostic overshadowing.

44   The first issue is a consumer's lack of confidence in being able to control the information once it's out there. We would need strict controls around information sharing. Perhaps the only sharing should be between one mental health service and another. I can also see the benefits of information sharing between mental health services and allied health services, but I think it should be an opt-in system.

45   The only thing that would make me feel protected would be the existence of strict controls over information. The law should proscribe the sharing of a person's mental health record except in very limited, specified circumstances.

46   The information would need to be protected from data mining and profiling. I would hate to think that a person's medical information could be used for commercial purposes. A person's medical information must not be used to send them research requests or pharmaceutical advertisements based on their history of using a Medicare Benefits Scheme (**MBS**) item number or buying medicine under the Pharmaceutical Benefits Scheme.

Diagnostic overshadowing

47   The second issue with information sharing systems is the problem of diagnostic overshadowing. This is where a health professional makes an incorrect assumption that a person's physical symptoms are caused by that person's mental illness. I can see the real benefit of responders like ambulance services having access to a person's mental health record, but that access brings with it the risk of diagnostic overshadowing. Once the clinician hears about the mental illness diagnosis, they may disregard everything else and attribute either the reporting of the symptoms or the actual symptoms to that mental illness.

48   The problem is that a clinician, either consciously or subconsciously, may classify what a person is describing as part of their mental illness rather than as a symptom that needs exploring like any other. A condition might be overlooked, or an accurate diagnosis might be delayed. There are certain mental health diagnoses that are highly stigmatised, such as dissociative identity disorder (**DID**) and borderline personality disorder (**BPD**). In relation to DID, there is a whole cohort of people who believe it does not even exist. In relation to BPD, in my experience people with that diagnosis can be dismissed as manipulative attention seekers. That is a major oversimplification of a complex mental illness, and a generalisation that is both unfair and dangerous.

Recommendations

49   Some steps that could be taken to address these issues include specific mental health training for other practitioners and emergency responders. That training should include awareness training and situation training, and should be rolled out across the emergency services to better ensure that there are appropriately trained people working on every shift.

50   In addition, there is a need to carefully manage the risks associated with accessing patient history in non-clinical settings, such as the police force. Part of the risk is dedicating the appropriate resources to attend to the appropriate needs. I think it would be beneficial to have psychologists, social workers and mental health workers working in the call centres for emergency responders, and attending ambulance or police callouts for welfare checks

or in response to people in crisis or where the patient has a history of psychosis or other mental illness.

51   In the current system, where police respond to welfare checks, there are sometimes disastrous results,[10] when really what some people need most is empathy and care.

Service planning and mix

Strengths and weaknesses of approaches to reorganising services around the needs of consumers

52   I think it will take some time before the current status quo can be challenged enough to be open to the voice of Lived Experience. In my experience there seem to be many dominant voices from within the clinical/psychiatric field, and any involvement of consumers or people with lived experience is, however well intentioned, tokenistic in nature. For whatever reason, clinicians, most commonly Registrars and consulting Psychiatrists are firmly committed to the status quo and do not accept any challenge to their opinion or expertise. This is not always the case, as I have spoken to several consultant Psychiatrists who are open and welcoming of the voice of Lived Experience, but are frustrated or foiled by the weight of bureaucracy from the health services, making change an extremely difficult and lengthy proposition.

53   With the high caseload and general high demand for services, no-one I have spoken to has been able to commit the time and energy needed to create this kind of change. If such a change were facilitated, I can imagine services being modified to act similarly to other high demand services such as Oncology or Paediatrics, where the environment is welcoming and every effort is made to ensure that the patient's needs are accommodated and that patient feedback is acted upon as a matter of priority.

Organising mental health services around the needs of individual consumers

54   I think the only way we are going to change the paradigm to better meet the needs of consumers would be to have a joint governance of services where the voice of Lived Experience can have equal weight to the voice from the more traditional clinical disciplines. This would most likely take some time to get the balance right, but ultimately I see a co-designed and consumer led service system as the only way to ensure services are prioritising the needs of service users. The current system is too complex and governance is seemingly out of touch with service users, so I firmly believe that services should be governed by a mix of current system experts along with consumers who have

---

[10] See for example Nick McKenzie, 'Beaten, abused, humiliated and filmed by Victoria Police' (The Age, 2 April 2018) <https://www.theage.com.au/national/victoria/beaten-abused-humiliated-and-filmed-by-victoria-police-20180321-p4z5f2.html> [accessed 22 July 2020].

lived experience of crisis and distress, who can jointly govern the new and/or redesigned services.

Social connection

The contribution of social connection to good mental health

55   Living with a chronic mental illness can quickly become incredibly isolating. In an age of social media and COVID-19, I've become extremely isolated even with tele- or remote access supports. My family and friends are both maintaining the recommended distancing behaviours and I don't think I've experienced close contact with anyone but my physical therapists since February 2020. While I do have access to technology that facilitates remote connection through the use of social media and tele/remote supports, this is not a replacement for direct human contact, and gives the illusion of connection without any of the benefits such as oxytocin production which can come from close contact with friends and loved ones.

56   The other main contributor to social connectedness is being able to participate in meaningful activities such as employment or regular group leisure activities. In the digital age, recent studies have found that one in four Australians are experiencing loneliness which has a detrimental impact on their mental and emotional wellbeing.[11] As Dr Michelle Lim wrote in a recent article about loneliness in the time of COVID-19:

> "It is no surprise that higher levels of loneliness are related to clinical mental disorders. Large population studies indicate that loneliness increases the odds of all mental disorders, especially phobias, depression and obsessive-compulsive disorder (Meltzer et al., 2013). Worryingly, findings from longitudinal and cross-sectional studies have shown a positive association between feelings of loneliness and, suicidal behaviour and suicide risk, across older and younger age groups, even after controlling for demographic and other mental health

---

[11] Lim, M. H. (2020). Loneliness in the time of COVID-19. *InPsych,* 42(3), online at <https://www.psychology.org.au/for-members/publications/inpsych/2020/June-July-Issue-3/Loneliness-in-the-time-of-COVID-19/> [accessed 3 July 2020] and the references cited therein, particularly Lim, M. H. (2018). *Australian loneliness report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing.* <https://psychweek.org.au/wp/wp-content/uploads/2018/11/Psychology-Week-2018-Australian-Loneliness-Report.pdf> [accessed 3 July 2020]; Lim, M. H., Eres, R., & Peck, C. (2019). *The young Australian loneliness survey: understanding loneliness in adolescents and young adults.* <https://www.vichealth.vic.gov.au/loneliness-survey> [accessed 3 July 2020]; and Lim, M. H., Rodebaugh, T. L., Zyphur, M. J., & Gleeson, J. F. (2016). Loneliness over time: The crucial role of social anxiety. *Journal of Abnormal Psychology,* 125(5), 620-630. https://doi.org/10.1037/abn0000162.

variables (Bennardi et al., 2019; Chang et al., 2019; Niu et al., 2018; Solmi et al., 2020)."[12]

57   Numerous studies and reviews demonstrate associations between social interaction and mental wellbeing. For example, the Whitehall Study in the United Kingdom found that people without good social support were five times more likely to have a mental illness than those with good support.[13]

Community support of social connection for people living with mental illness, their families and carers

58   Being part of a community can have a positive effect on mental health and emotional wellbeing. Community involvement provides a sense of belonging and social connectedness. It can also offer extra meaning and purpose to everyday life. Communities can exist or be created from a shared location, hobbies, lived experiences and backgrounds, or a common cause. For many people, communicating with others – through online forums, social media, or in person – can help them to have a healthier mindset, improved self-worth, and greater enjoyment of life. In my experience, when consumers and carers talk about community-based services, they are looking for this broad spectrum of services.

59   In my view, the prevailing reality of 'community-based care' is limited and clinically focussed when compared with the needs and expectations of the community. Too many services are being co-located with hospitals or provided through hospitals, rather than in community settings. This was further exacerbated by the introduction and rollout of the NDIS. The NDIS has surprisingly provided opportunities for people participating in that Scheme to have choice and control over what supports they access and what activities they can participate in. Problematically, the NDIS was only ever designed to include people who are living with the most severe conditions that severely impair their ability to engage without funded supports. The National Disability Insurance Agency (**NDIA**) estimated that 64,000 people with primary psychosocial disability would be eligible for individual NDIS packages Australia-wide by the time of full rollout of the NDIS in 2019-20.[14]

---

[12] Lim, M. H. (2020). Loneliness in the time of COVID-19. *InPsych,* 42(3), online at <https://www.psychology.org.au/for-members/publications/inpsych/2020/June-July-Issue-3/Loneliness-in-the-time-of-COVID-19/> [accessed 3 July 2020].
[13] Marmot M. (1999). The Solid Facts: The Social Determinants of health. *Health Promotion Journal of Australia*, 9(2), 133-139.
[14] Productivity Commission (2017), National Disability Insurance Scheme (NDIS) Costs, Study Report, Canberra <https://www.pc.gov.au/inquiries/completed/ndis-costs/report/ndis-costs.pdf> [accessed 14 July 2020] at pages 31, 107 and 241, citing the NDIA Annual Report 2015-16 at page 26.

60   This is not necessarily problematic in itself, however my understanding is that a decision was made by the Victorian State Government to divert funding from the Mental Health Community Support Services (**MHCSS**) to meet their NDIS funding obligations. This, along with the transition of Commonwealth funded programs such as Day to Day Living (**D2DL**) and Personal Helpers and Mentors to NDIS, meant that the community-based services were only available to participants of the NDIS. This created a gap in service provision, meaning that tens of thousands of people relying upon support from those programs were left without support as most would not qualify for NDIS.

61   Unfortunately, as I understand it, most of the community-based mental health support services were primarily funded through the State-based MHCSS funding, and when this funding was ceased, the majority of these services were unable to continue their previous support services. This was most keenly felt by people participating in group and social activities previously funded through the D2DL program. D2DL was specifically designed to offer people living in crisis, distress or with mental illness opportunities to participate in group activities ranging from group exercise to skill building, psycho-education, art therapy, cooking classes, movie groups and more. The loss of these services was personally devastating and while I have access to NDIS funded supports, there is a scarcity of equivalent group based supports available for NDIS participants that are specifically designed for people with a psychosocial disability. The NDIS funding is individualised, so it would need a group of like-minded people to pool their funding and create a group activity or social program. Who would coordinate such an effort? How would it be managed?

62   The only similar offering I am aware of are those offered by Neighbourhood Houses, but these are not dedicated services related to mental illness – they are shared spaces designed for anyone in the community to participate in group activities.

Promoting and facilitating social connection

63   I would strongly recommend renewed funding for group social and psycho-education activities to replace the loss of the D2DL program, and provide a dedicated safe space for like-minded people with shared understanding of mental illness and distress. Rather than being run or administered by the hospital-based Community Mental Health services, this program would be co-designed and governed by people with lived experience and hosted and/or supported by community NGO mental health services such as Neami National, Mind Australia, Wellways or similar services. Such a service could theoretically offer a large range of group activities with facilitators from Community Mental Health services or peer based supports.

Digital technologies

Role of digital technology in enhancing face-to-face support

64   Digital technology can play a massive role in terms of enhancing face-to-face support. For example, it can act as a benchmarking tool to monitor progress, or as an activity diary to record exercise. I believe technology can play a huge role in supporting people to pursue their wellbeing. It is also useful for people in remote areas, where there may be a lack of face-to-face support and other options. It can also be useful for people experiencing domestic and family violence, where meeting face-to-face could be difficult, as well as for people who don't feel they can talk openly about these issues with or in front of their family – a text message or email can be done privately even in the same room as other family members. Alternatively you might leave the house for a walk and connect with supports via a smartphone in either a video or voice call.

65   New technology may also allow us to use artificial intelligence to enhance face-to-face support. For example, a person with a panic disorder might wear a device that monitors perspiration and heart rate, and which could pre-empt a panic attack and prompt the wearer to do something in response, such as relaxation exercises. Artificial intelligence could also be used in human interactions (such as telephone calls with help lines) to monitor and evaluate risk of self-harm or suicide, giving the help line service extra tools and mechanisms to enhance their responses.

Limitations of digital technology

66   The change to MBS billing items during the COVID-19 pandemic to allow for remote and tele-health options has been a really remarkable and beneficial change, particularly for people in remote and rural areas. I understand this has allowed some of these people to access supports for the first time.

67   Notwithstanding its potential benefits, digital technology cannot be a replacement for face-to-face support. I think we still need a human connection. We need to be able to build a rapport with someone. We lose so much non-verbal communication from remote or digital service delivery. Personally, I find it incredibly exhausting to have a conversation over video chat, and even worse by just telephone. I spend so much effort observing and trying to interpret non-verbal communication such as body language, that when it's missing I'm spending all my energy desperately trying to figure out what to say or if what I'm saying is okay – is it appropriate for this situation; am I explaining myself well enough? If we rely solely on technology, then we lose warmth and connection. Without that connection and rapport, how can we build trust and confidence in the person supporting us? Without that trust, there cannot be any therapeutic relationship or investment into the process of support or therapy. These technological tools can provide amazing access to

support, but I want to emphasise that technology will never be a replacement for human contact and connectedness with a real person.

sign here ▶

print name Dave Peters

date 22 July 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT DP-1

This is the attachment marked 'DP-1' referred to in the witness statement of Dave Peters dated 22 July 2020.

Dave Peters

Summary

I am a personable, social male with many years invested in my recovery, and what I have learnt, overwhelmingly, is that recovery is always going to be an ongoing process requiring constant attention and investment. I have a wonderful support network in place and enjoy spending lots of time with my friends and my family, as well as a range of activities to keep me enjoying my day to day life. I have a passion for Theatre, Music, Film and I enjoy the various film festivals every year. I also quite enjoy public speaking, and the sense of accomplishment I feel after any opportunities I get to do so.

Experience

June 2018 - June 2020

Research Assistant: RESEARCH & POLICY CENTRE, BROTHERHOOD OF ST LAURENCE

- Multi stage evaluation of Local Area Co-ordination Services for the National Disability Insurance Scheme
- Exploring alternative planning processes to improve participant outcomes
- Presenting at NDIS and Mental Health Conference 2018

May 2018 - Current

Co-Chair: EQUALLY WELL ALLIANCE

- Chair meeting with National Stakeholders from Mental Health Commission, RANZCP, RANZGP, SQPSC, PHN, Dept of Health and others

- Contribute to National forum to further awareness and promote change for quality of life and life expectancy for people living with chronic and severe mental illness

July 2018 - current

Member of LifeLine Lived Experience Advisory Panel LIFELINE AUSTRALIA

- bi-monthly meetings with input from highly regarded Lived Experience workers from around Australia with other members such as Ingrid Ozols, Leilani Darwin, Hailey Daisy and others

March 2016 – June 2017

Community Researcher UNIVERSITY OF MELBOURNE

- Participatory Action Research project exploring the experiences of Choice and Control with participants of the National Disability Insurance Scheme in the Pilot/Barwon Region

- Public speaking/presentation of findings/publicity for project

- Various stakeholder meetings: DHHS, Dept of Premier's Cabinet, Parliamentary Library presentation

November 2014 - current

Lived Experience Consultant/Lecturer   AUSTRALIAN CATHOLIC UNIVERSITY

- Oral Presentation marking and feedback OTHY 205 & 301

- Guest speaker (introduction to unit and example of lived experience of illness and recovery in line with Occupational Therapy principles)

- Collaborative project to write, film and appear in Person Centred Practice educational videos

March 2016 - current

Lived Experience Consultant   MONASH UNIVERSITY

- Guest speaker, Occupational Therapy Masters Program (Mental Health Unit)

- Case study scenario review panel

June 2017 - current

Lived Experience Consultant/lecturer: SWINBURNE UNIVERSITY

- Guest Speaker, Occupational Therapy Masters program (Mental Health Unit)

- Oral Presentation exam marking and feedback

- Course advisory group

- Co-Faciitator FOCUS program delivery (Recovery Oriented Practice by Mike Slade)

December 2017 - December 2018

Co-Facilitator NEVIL Program Psychologist Professional Development on Recovery Framework and Practice and WETS Cluster. (Now Centre for Mental Health Learning)

February 2017 - Current

Consumer Co-Chair Research & Evaluation Committee, NEAMI NATIONAL

- Chair alternate quarterly meetings

- Set Agenda in collaboration with co-chair and CEO

- Review Research papers and make suggestions for dissemination

- Strategy meetings to explore opportunities for engagement with Mental Health Sector

- Explore opportunities for Consumer and other Stakeholder engagement

February 2011 - current

Consumer Consultant   NEAMI NATIONAL

- Panels interviews for approximately 250 prospective new Staff for Neami

- Completed the Launching Pad training program in January 2014

- Member of Research Committee

- Have participated in multiple focus groups on Consumer Participation, Quality Control, Policies and Procedures etc

- Strong awareness of the Collaborative Recovery Model and the Flourish Program

- Self-aware and able to talk openly about issues I feel may obstruct my progress, either personally or professionally.

January 2015 – June 2016	**Lived Experience project consultant** Manningham Community Health Service Framework for Inclusion project, exploring ways to offer better service and to better include those clients who have a Mental Health condition.
March 2015 – April 2017	**Member of Steering Group** Monash University Supported Decision Making Project, researching the impact of allowing those with a Mental Health diagnosis make supported decisions regarding their treatment options
October 2004 - March 2006	**Sales Representative/2IC Victorian Branch**, AUSTAIN FASTENERS - Established a routine call pattern of over 400 clients across Metropolitan Melbourne and Country Victoria; - Cold Called/Visited New Businesses to promote the company and develop new contacts in the industry as well as to sign on new clients; - Supervision of Three staff in the office and warehouse - Developed new and alternative strategies to overcome barriers in enticing business away from competitors - Strong rapport building skills involved in developing close working relationships with clients ranging from factory floor to board room level - Engaging strongly with new and previously unknown clients to win contracts regularly valued at over $100k p.a.
2003 - 2004	**Sales Representative**, KEABLES PTY LTD (Nuts, Bolts, Custom Manufacturing)
2001 - 2003	**Sales/Customer Service**, STRAMIT INDUSTRIES (Structural Steel)
2000 - 2001	**Sales/Customer Service**, ITW BUILDEX (Fasteners)
1999 - 2000	**Sales/Customer Service**, OPTUS COMMUNICATIONS

Education

March 1997 – Nov 1998	**Bachelor of Performing Arts (Deferred)**, Monash University, Clayton

| Nov 1995 - Jan 1997 | **Advanced Diploma Hospitality & Management (Incomplete)**, William Angliss Institute of TAFE |

Referees

On request