National Summit on Physical and Mental Health: Addressing the Premature Death of People with Mental Illness

Response to the Pre-Summit Consultation Paper

Submitted 15th May 2013
Consumers of Mental Health WA (Inc)

ABN: 95581286940
Business Address: 13 Plaistowe Mews West Perth WA 6005
Postal Address: PO Box 1078 West Perth WA 6872
Ph: (08) 9321 4994 or admin@comhwa.org.au
Web: www.comhwa.org.au

For further enquiries about our submission, please contact
Executive Summary

CoMHWA recommends that the term “severe” be removed from the title, goals and principles of this forum in recognition that diagnostic category and severity is not the relevant concern mental health consumers are seeking to address on the issue of unequal physical health outcomes. It is the prevalence, significance and impact of physical health conditions that mental health consumers face, and their access to affordable and appropriate physical health care for these conditions that should be the focus of political concern, research funding and evidence-based practice. As such, while CoMHWA recognises and supports the need for adequate funding and targeted intervention to address clear physical health inequity in consumers with a “severe” or “serious” prognosis, the issue must be treated much more broadly and carefully. A restrictive focus on “severe mental illness” as the basis of intervention and concern narrows reform towards acute clinical care settings and interventions. Yet people with mental health issues are frequently and significantly affected by lower physical health outcomes and higher risks of preventable physical disease across clinical and community contexts, and supports and solutions should be identified to improve their physical health outcomes across these contexts. A current slippage is also occurring in rhetoric on co-morbidity between clinical severity and diagnostic type (e.g. schizophrenia as severe), that risks
counteracting national stigma reduction, and recovery promotion, efforts to date among these groups.

CoMHWA recommends minor changes to some principles and the addition of three principles focused on:

- equal patient care and rights;
- addressing the underlying determinants of poor physical health outcomes; and
- incorporating health equity considerations to ensure particularly disadvantaged mental health consumers receive appropriate levels, and well-designed, support for physical health outcomes

Contextually, we agree with the factors contributing to lower than average physical health outcomes. We see as the following four challenges as priorities for policy, funding and leadership: sub-standard clinical treatment, which has several contributing causes; limited investment in patient self-advocacy and rights; socio-economic disadvantage; and the need for new paradigms of risk-informed decision-making. Socio-economic disadvantages consumers face are a major contributor to poor physical wellbeing and these need to be addressed through national reforms towards greater social equity and opportunity such as basic housing affordability and liveable income. We further suggest a range of recommended funding initiatives and examples that share a focus on:

- Substantive patients’ rights and care partnerships with consumers and carers in treatment settings;
- Affordable and accessible physical health care;
- Widely available, locally accessible, low-cost programs and initiatives that are empowering and helpful to consumers, which aim to improve lifestyle and physical health management and provide opportunities for peer support;
- Holistic, longitudinal, recovery-focused approaches to risk management in partnership with consumers.

Introduction

CoMHWA was approached by the Mental Health Commission to respond to this consultation paper from a WA consumer perspective and welcomes the opportunity to present our perspectives on challenges and opportunities for co-enhancing our mental and physical wellbeing. Consumers of Mental Health WA is a systemic advocacy organization run for and by consumers in Western Australia, whose core purpose is to coordinate, promote and support the consumer voice within services and the wider community. We do so through member consultation and information services, systemic advocacy, collaborative partnerships and relationships, education, training and awareness raising. We have 265 member and we are well respected and supported for our comprehensive and informed perspectives on consumer inclusion and empowerment, peer led approaches, and recovery and wellbeing.

Summit Goal
A strong research evidence base exists linking severe and serious mental illness to poorer physical health outcomes, and which warrants adequate funding and targeted intervention. At the same time, much research is clinically focused and establishes an evidence-base more strongly linked to consumer cohorts in clinical practice settings. As such full epidemiological data for Australian mental health consumers as a whole, that identifies morbidity and premature mortality characteristics in terms of prevalence, etiology, vulnerability factors and at risk groups, and which links physical health outcomes to a broader range of causal factors than psychiatric diagnosis, needs to be established. Until such information is available, policy makers need to ensure that an evidence gap for broader mental health consumer populations does not lead to under-attention to their physical health needs.

Consistent with this position, CoMHWA disagrees with the framing of the Summit in terms of 'severe' mental illness for several reasons:

1. Severity is a clinical assessment and judgment of consumer’s mental health experiences and used as an indicator for acute, inpatient and intensive interventions. As such, there is a risk that the Summit’s attention will be clinically framed with the following negative implications: (i) a misplaced concern for mental health severity, rather than physical health priorities, with subsequent allocation or resources on the basis of mental health diagnosis rather than priority physical healthcare needs; (ii) Attention to clinical contexts, scenarios and solutions, when there should be balanced attention to a range of clinical and community contexts, scenarios and solutions (iii) exclusive attention to consumers involved in clinical settings, when a range of mental health consumers across different settings may co-experience physical health issues and be unable to afford or effectively source treatment; (iv) treatment of existing physical health issues, in place of a balanced mix of health promotion, prevention, early intervention and treatment approaches. Many consumers experience premature death and preventable illness due to system failures in provision of prevention and early

\[1\] Mental Illness Fellowship of Australia's, 2011, *Literature Review: The Physical Health of People Living with Mental Illness*
intervention supports, which should not be historically repeated into the future. (v) The significance of ‘severity’ of mental health issues as a predictor of low physical health outcomes – and mental health – is heavily mediated by a range of other factors that challenge ‘severity’ as the most significant predictor of poor physical health outcomes among mental health consumers. Examples of factors that mediate mental health and physical health outcomes are: personal recovery outcomes, irrespective of clinical outcomes, through which people may make improvements to their physical health; socio-economic circumstances (housing, income and food affordability) that affect health and longevity; and the presence or absence of additional social, cultural, geographic or economic disadvantage (e.g. Aboriginal and remote communities) that may compound poor physical health outcomes.

We note that the provision of examples of “severe mental illness” provided in the paper may mislead people in the consultation process to believe that “schizophrenia, bipolar disorder, schizoaffective disorder and major depressive disorder” are severe, in contrast to other diagnoses not listed. We are concerned that doing so publicly misrepresents consumers who have received this diagnosis, as warranting more assertive clinical scrutiny and intervention. It also misrepresents clinical assessment processes, in which ‘severity’ is assessed not on the basis of diagnosis but on the basis of distressing symptoms, functioning and risk with which a person with any diagnosis presents. This type of semantic shorthanding, if paralleled in physical health care, would see patients treated on the basis of, say, having diabetes, over those with heart conditions, irrespective of how individuals with those diagnoses were affected, and adds support to our concern in this submission that a focus on specific diagnoses and prognoses may lead to failure to appropriately prioritise on the basis of greatest physical health care need.

CoMHWA also recommends the substitution of “mental illness” with “mental health issues” as desirable to promote a more inclusive perspective that would see the physical health needs of people identifying with lived experience of mental health issues responded to effectively, before and irrespective of a formal diagnosis of “mental illness” from a health service.
CoMHWA is in principle accepting of a focus on physical health outcomes, provided that there is a broad awareness retained in the Summit that:

1. Consumers also seek holistic wellbeing and quality-of-life, in which physical health outcomes are desired in the context of overall psychological, emotional, social, political, cultural, spiritual and physical wellbeing, and that

2. Morbidity and mortality are a result of “too little, too late” approaches that may be clearly contrasted with early, collaborative mechanisms for consumers to be informed about, self-direct and actively improve their physical health care and physical health outcomes, in partnership with their supports and services.

In Summary, CoMHWA therefore recommends:

(i) that the goal of the Summit be changed from:

“Enable people with severe mental illness to have the same life expectancy and health outcomes as the general population”

to:

“Enable people affected by mental health issues to have the same life expectancy and health outcomes as the general population.”

And further that the Summit be critically informed by our response to the framing of physical health needs in terms of psychiatric diagnosis, and to actively strive to minimise the risks associated with that framing through the alternative framing presented above, namely through an approach informed by:

- Effective prioritisation on the basis of prevalence, significance and impact of physical health concerns and of barriers to met need, irrespective of diagnosis and prognosis;
- Diverse contexts, scenarios and solutions for addressing physical health outcomes;
- Diverse contexts within which consumers experience and present with physical health concerns;
• Balanced approaches across promotion, prevention, early identification, early intervention, sound treatment and management;
• Attention to resilience and vulnerability factors that are determinants of, and mediate the relationship between, mental health and physical health outcomes;
• Framing physical health priorities in terms of our broader aim for overall wellbeing, and our aim for increased choice, information and control over our lives and our services.

Summit Principles

The Consultation paper lists the following key principles to guide development of Summit outcomes:

1. People with severe mental illness should have the same access to health promotion, prevention, early detection and intervention as the general population.
2. Solutions need to be informed by the experiences and knowledge of consumers and carers and a sound evidence base.
3. All mental health professionals should have a responsibility for the physical health of their mental health patients.
4. Improving the physical health of severe mental illness can only be achieved through engagement with the primary health care sector.
5. Effort should be directed to building on successes and/or evidence of what works as well as on better coordination of available resources.

CoMHWA responds with the following list of principles, with comments:

1. People with severe mental illness mental health issues should have the same access to health promotion, prevention, early detection and intervention as the general population.

Comment 1: As per Summit Goal discussion above.
2. Solutions need to be appropriately informed by the experiences and knowledge of consumers and carers. and a sound evidence base.

Comment 2: Evidence base already listed section 5- inclusion here may be read as consumers and carers experiences and knowledge not being part of, but existing in tension with, an evidence base. In contrast, CoMHWA’s perspectives is that consumer and carer experiences and knowledge are integral to sound clinical decision-making, and that consumer and carer perspectives in research are an important contribution to evidence based practice on matters affecting consumers and carers.

3. All mental health professionals, including the primary health care sector, have an active role to play in ensuring people with mental illness can experience good physical health outcomes equal to that of the general population.

Comment 3: While acknowledging political drivers for explicit reference to primary health care in Principle 5, we believe principle 4 overstates the case for primary health care involvement – against important additional principles of multi-stakeholder involvement beyond direct health care providers- and so instead recommend reference is made to the primary health care sector in principle 3.

4. Improving the physical health of people with mental health issues can only be achieved through active efforts to ensure consumers and carers are engaged as partners in care, supported in their self-management, and have information, education, rights, choices and responsibilities equal to that experienced by the general population in healthcare settings.

Comment: Replacing principle 4 on primary health as discussed comment 3, we believe that major challenges of unequal physical health outcomes can be principally attributed to low consumer engagement, involvement, choice and self-direction and so state it here. This focus on patient rights and involvement is a separate but complementary principle to the strategic involvement of consumers and carers in principle 2. If the original Principle 4 is retained in addition to our recommended principle, reference to “severe mental illness” should be replaced with “people with mental health issues”
5. Effort should be directed to building on successes and/or evidence of what works as well as on better coordination of available resources.

Comment: While accepting principle 5, CoMHWA recommends greater attention to options for funding evidence-based successes on this issue. Funding of inter-service coordination and partnerships need to be wisely measured against the promise of direct investment in mental health consumers and local communities for direct, significant and immediate outcomes. Under the Response Section on challenges and solutions, CoMHWA encourages attention to widely available, smaller scale, individual and local community physical health programs, focused on groups and individuals with socio-economic disadvantage, mental health and physical health difficulties and which provide opportunities for individuals and communities to develop locally appropriate, effective and empowering solutions to improve physical wellbeing. In particular see MHCA's (2006) Weaving the Net Report, for a promising approach to community resilience and wellbeing development.

6. Effort should be directed to research and solutions that address a range of social, economic and cultural determinants of lower physical health outcomes for people with mental illness, in order to improve physical health in conjunction with, and in the context of, overall wellbeing and quality of life of mental health consumers.

Comment: CoMHWA recommends adding this principle to ensure that clinical physical health care interventions for existing physical health conditions are balanced with a deep concern for, and a strong political commitment to address, these key determinants of morbidity and mortality in solution building efforts.

7. Efforts need to be informed by the principle of health care equity, which recognises that people with mental health issues are unevenly affected, and solutions need to equitably consider the specific and additional needs and perspectives of disadvantaged groups (e.g. Aboriginal, migrant, elderly, rural, regional and remote populations).
Comment: CoMHWA recommends adding this principle to ensure that solutions developed by the Summit are guided by awareness that some consumers may be especially disadvantaged, affecting mental health and physical health outcomes, and that solutions need to equitably consider specific and additional perspectives and needs of these groups.

Context for the Summit

In this section, we comment on the Summits’ explicit context and list our perspectives on the challenges, ways forward and positive examples, to support the Summit’s intention to improve the physical health outcomes for people with mental health issues.

CoMHWA agrees with the contextual evidence the Summit Consultation Paper provider, which cites, as significant factors accounting for unequal physical health outcomes, the following factors:

- Higher rates of substance misuse and smoking;
- Higher rates of chronic, preventable diseases (e.g. cardiovascular and ischemic heart disease, obesity and diabetes);
- Lifestyle factors;
- Socio-economic disadvantage.

While agreeing that the use of atypical psychotics is associated with weight gain, we assert that consumers experience a range of significant side-effects not limited to weight gain; which are associated with a range of medications, not limited to atypical anti-psychotics; and which may affect physical health, mental health and/or quality of life, depending on the individual.

What are the challenges in getting the right care for people with mental illness and physical health problems?
Based on our broad experience of mental health consumer perspectives, complaints and advocacy requests, we suggest four major factors contributing to low physical health outcomes that need to be addressed:

1. Socio-economic disadvantage;
2. Sub-standard clinical treatment, which has several contributing causes;
3. Limited investment in patient self-advocacy and rights;
4. Clinical risk frameworks that overlook individual needs for, and concerns about, about long-term health, wellbeing and quality of life.

1. **Socio-Economic Disadvantage**

12.8% of people live below the poverty line, after taking account of housing costs, with rates being 52% and 42% for those on Newstart Allowance and the Disability Support Pension respectively, which clearly indicate a major societal problem of socio-economic inequality. Statistics reported in the National Mental Health Commission’s 2012 National Scorecard range from slightly elevated risks of poverty for those experiencing mental health issues (20% of people in the lowest income households, compared with 16%) to greatly elevated risk of poverty (85% of people with a psychotic illness have social benefits as their primary income). There is a need for more consistent research to support the wide, empirical evidence that people with mental health issues who experience these issues over longer periods of time, are socio-economically disadvantaged, and to demonstrate the impact of this disadvantage on access to health care and healthy lifestyles.

2. **Sub-Standard Clinical Care for Physical Health issues**

We note sub-standard clinical responses to physical health concerns of people with mental health issues, relative to general patients, as *significant and preventable problems* contributing to poor physical health outcomes. These are also listed as factors by the
consultation paper. Sub-Standard Clinical Responses include: misdiagnoses; failures of
timely investigation, and under-investigation, of physical health concerns. We note this
problem has several contributing factors which are attitudinal and structural in nature.

People with mental health issues are assumed to have, and treated as if, they have
significant impairments in decision-making and judgment. CoMHWA does not dispute that
decision-making and judgment may be affected under some circumstances, nor that some
services and practitioners deliver quality supports. However, there is a systemic issue
whereby this evaluation can lead to negative practitioner attitudes in which consumer’s
needs, interests and concerns are not adequately listened to, respected and responded to.
Thus, a consumer may report a physical health concern, and these are assumed to be
mental health related, rather than potential physical health concerns to be adequately and
promptly investigated. This attitude, which is ultimately a failure to take consumer self-
reports as seriously as general patients commonly experience, is discriminatory and leads
to poor physical and mental health care assessment practice. This sub-standard response
to physical health concerns is particularly concerning within acute inpatient settings where
consumers, on account of periods of able to effectively self-advocate in relation to physical
health issues as these arise. While under clinical care and monitoring, professional
diligence in physical health screening, assessment, investigation and treatment is a patient
right, not an expectation.

In addition to attitudinal barriers, we note that structural, and sometimes service political,
barriers exist that lead to ‘either/or’ approaches, with a trend of under-communication
between ongoing primary health care practitioners and public inpatient treating teams
while under hospital-based treatment and in relation to transition arrangements (admission,
discharge and follow up). In consequence, discontinuity of care can adversely affect
appropriate and timely treatment and management of physical health issues. Medical care
quality can also be challenged where mental health specialised nurses and psychiatrists do not continuously apply general medical skills.

We believe three strong, consistent, programmatically delivered messages need to be delivered to providers, and efforts taken to ensure these are substantively reflected in practice:

*Equal patient rights & rights-informed partnerships:* Effective partnerships based on genuine respect, information sharing, treatment planning and decision-making between a consumer, their nominated supports and service providers, based on the principles of consumer-centred and self-directed care and in accordance with the Australian Charter of Healthcare Rights;

*Partnership for Co-Addressed Needs:* Mental health care providers and physical health care providers need to overcome silo approaches and work collaboratively as part of these rights-informed partnerships;

*Precautionary Approaches:* Precautionary approaches should be adopted in the context of health care provision, which specify that if a physical health concern can be reasonably attributed to either a mental health or physical health issue is presenting, health care practitioners must proceed as if both are equally credible explanations, and attentive to the risks to mental health consumers neglecting either factor.

3. **Limited Investment in Patient Self-Advocacy and Rights Education**

We note that our members offer frequent accounts where physical health concerns have been raised but not addressed, and that only successful advocacy by the consumer, carer or supporter to change a mental health provider has resulted in physical health needs being met. Unfortunately, we also hear frequent accounts where the treatment delays involved in these scenarios have resulted in preventable, adverse events (e.g. bowel obstructions, stroke, complications from alcohol misuse, and deep vein thrombosis
emergencies). This suggests that patient advocacy programs that help consumers, carers and supporters to recognise unusual physical health signs and symptoms, and to advocate for these to be addressed in an appropriate ways, including recourse to second opinions and changes in provider, will enable consumers to have their rights to good physical health care and advice substantively advanced.

4. *Clinical Risk Frameworks that Overlook Long-Term Quality of Life Factors and Decisions*

A focus on clinical acuity risks (active risks with major consequences of harm to self or others) in acute settings can eclipse a broader, recovery-focused risk assessment paradigm across service approaches that also addresses: longitudinal risks to physical, social, emotional, and spiritual wellbeing and opportunities for personal recovery through positive risk taking. In practice this can lead to the omission of these broader risk factors in the course of patient education and informed consent arrangements, such as in relation to medication side-effects, and reduced attention to a range of interventions aimed at supporting positive recovery risks and minimising negative, longitudinal wellbeing risks. Examples of the latter practices include: enabling consumer choice and control; supporting community-based living trials for long-stay inpatients; lifestyle improvement programs; and programs that support social inclusion and vocational recovery. These activities may be directly or indirectly related to positive physical health outcomes but through improving overall wellbeing are likely to greatly contribute to closing the gap between consumer physical health outcomes and those of the general population.

For this reason, CoMHWA believes that the recovery-focused risk paradigm needs to be developed, supported and led in the mental health sector and services, with a joint focus on provider education and consumer education about how to understand and self-advocate in treatment consistent with this paradigm.
What are the areas that you think need to be improved to help people with severe mental illness get their physical health needs better addressed?

1) **Solutions to Address Socio-Economic Disadvantage**

- Addressing basic lifestyle affordability in relation to: social benefits and minimum wage conditions; housing availability and affordability, food and utility hardship;
- At a local level, improve access to low-cost, nutritional food options (e.g. food relief, food vouchers, co-operatives) and other forms of relief and subsidy that ensure access to basic utilities, transportation, nutrition, medical care, and exercise.

2) **Improve Clinical Care Practice**

- Cultural change programs to ensure mental health consumer's rights, information and expectations are understood, that mental health consumers are respected and listened to, so that when they discuss physical health symptoms with medical professionals these are taken seriously. This entails consistent delivery and implementation of messages of: *Equal Partnership & Rights-Informed Partnership; Clinical Partnerships for Co-Addressed Needs; Precautionary Approaches* as discussed above. In support of this:
  - Health care excellence awards for providers that *are* effectively addressing physical health issues
  - Mechanisms for consumers to identify and access providers with appropriate joint qualifications (e.g. mental health specialist GPs); partnerships with carers and family members;
  - Practical Guidelines for Mental Health Professionals, developed in consultation with consumers and carers, on ensuring physical health concerns and conditions are promoted, identified and addressed in partnership with consumers and carers;
- Promotion and availability of health screenings and vaccinations within psychiatric inpatient settings, as part of a general culture of good physical health care;
- Community mental health services that connect people with, and help maintain their connections with, services to address their physical health needs (e.g. Personal Helpers and Mentors program)

3) **Investment in Patient Self-Advocacy and Patient Rights**

- Independent, funded, individual advocacy services that can assist consumers to have unmet needs, including their physical health care needs, addressed and resolved earlier to reduce risks of adverse health events and improve general physical health outcomes;
- Education and training for consumers, carers, families and supporters on awareness of, and action to address, physical health symptoms and signs early;
- Personalised service and funding options for consumers to choose and self-direct their supports, including their physical health care treatment and services;
- Education and training on consumer rights and self-advocacy skills for consumers, carers and supporters, to improve prompt and successful resolution of physical health concerns.

4) **Holistic, patient informed approaches to risk assessment and risk management**

- Transparent disclosure of, and close monitoring of medication side-effects, in recognition that medication effects vary between people but can lead to risks and harm that warrant informed consent to treatment;
• Ensuring subjective and objective quality of life considerations are understood and considered in inform, active, treatment decision making in partnership with consumers and carers;
• Local, free, community-based programs aimed at positive, sustained lifestyle improvement to reduce prevalence and impact of chronic, lifestyle related diseases
• Longer-term and short-term risk factors are considered in decision-making.
• The recovery-focused risk paradigm is actively developed, supported and led in the mental health sector and services, with a joint focus on provider education and consumer education about how to understand and self-advocate in treatment consistent with this paradigm.

5) Use of Peer Support and mentoring, and Specialist Peers On Specific Mental Health Initiatives

• In recognition of the low effectiveness of public anti-smoking campaigns for people with mental health issues relative to the general population, investing in more effective interventions focused on consumers’ experiences, needs and supports to quit smoking successfully;
• Peer Mentoring and Support programs, as a valuable approach to community-based programs, that focus on empowering people with mental health issues to improve their physical health, and to self-manage chronic health conditions effectively.
• Specialist peer programs, such as Aboriginal peer-led chronic health programs are also important to working with mental health consumers who have a diversity of additional and specific perspectives, needs and solutions

Do you have any good examples of services or programs or local activity where care has been provided well?
CoMHWA is aware of, and recommends the following services, programs and local activities, be considered:

**Health and Recovery Peer (HARP) Program:** US Peer-led chronic disease management pilot program for mental health consumers with chronic physical illness (www.ncbi.nlm.nih.gov/pubmed/20185272)

**Get Healthy Service- Health Coaching Program:** Free phone-based, 6 month health coaching program delivered in NSW, ACT and TAS (for everyone over 18 years) www.gethealthyact.gov.au/get-health-coaching.html

**YMCA Brightside Program:** Offers a 60 day free fitness training programs for groups of people with mental health issues over 16 years www.ymcansw.org.au/activity/brightside-mental-health-and-wellbeing

**Access All Areas:** The City of Swan, Western Australia, subsidises individuals with barriers to participation to access recreation and cultural activities. www.swan.wa.gov.au/Our_City/Grants_and_Funding/Subsidies

**StreetDoctor:** This important program based in Western Australia, provides primary medical care via a mobile van to people who are homeless or otherwise unable to fund or access medical health treatment in other clinical settings (www.ppcn.org.au/street-doctor/)


**Act Belong Commit:** Comprehensive health promotion campaign for protecting and promoting mental wellbeing. While not exclusively focused on physical health improvements, good nutrition, sleep, stress reduction and exercise are promoted as part of ABC strategies, and local groups are directory listed and promoted;
**HealthRight Project**: Developed at the University of Western Australia, this was the first program involving peer support in Western Australia, and provided peer support that aimed at helping consumers to set goals and have effective, empowering partnerships with their health care providers and supporters to improve their physical health;

**General Practice Mental Health Standards Collaboration** RACGP accredited mental health training activities for GP providers. “Mental health friendly GP” accreditation programs and directories (e.g. BeyondBlue) benefit consumers who seek to have their mental health and physical health needs co-addressed, and primarily managed by a GP. Additionally, various publicly funded chronic disease self-management programs are available for low income earners with physical health issues, but consumers are not always aware of these programs, and medical referrals are required. These programs are therefore only successful if consumers have a relationship with GPs who they can afford, access and trust, and who are aware of, and supportive of, their physical health goals and who know and refer to available programs.

**Additional Comment: Consultative Process towards the Summit**

CoMHWA notes that the time allocated for consultation was short. Members who may have sought to contribute their individual perspectives to CoMHWA’s submission, rather than writing individual submissions, were likely to have been disadvantaged by this process. We request that future MHC consultation papers are released with adequate time to enable a collective and informed voice to be raised by, and on behalf of, our members in support of our consumer empowerment and wellbeing.