Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF ROB GORDON

I, Rob Gordon, clinical psychologist, of 921 Station Street, Box Hill North, Victoria 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 my employers or organisations that I am a member.

3 Attached to this statement and marked 'RG-1 is a list of references that I have referred to within this statement.

Background

4 I am a clinical psychologist with over 35 years of experience in the areas of trauma, emergencies and disasters. I have a Bachelor of Arts with Honours in Psychology from Adelaide University and a Doctor or Philosophy from Melbourne University. I am a Fellow of the Clinical College of the Australian Psychological Society.

5 I first became involved in disaster recovery in 1983 in response to the Ash Wednesday fires, where I was part of the Royal Children's Hospital team working in the Macedon area. Since then, I have worked with children and adults in over 50 large scale disasters including the Ash Wednesday fires, Queen Street and Port Arthur massacres, Bali bombings, the Canberra firestorm, Black Saturday bushfires, the Manawatu and Bay of Plenty floods, the Christchurch earthquake in New Zealand, the Dunalley and 2019 Tasmanian bushfires, the Fort McMurray wildfire in Canada and most recently the Kangaroo Island and Adelaide Hills fires in South Australia and the East Gippsland and north-eastern Victoria fires of 2020.

6 I am currently the President of the Australasian Confederation of Psychoanalytic Psychotherapies (**ACPP**), which is an umbrella organisation representing more than 450 psychanalytic psychotherapists throughout Australasia. I have held this position since 11 April, 2018. Where I express opinions on behalf of ACPP, I have identified that to be the case.

7 I am also:

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

(a) a consultant to the Victorian Department of Health and Human Service for disaster recovery, since 1989. In this role, I have advised on how to assist individuals and whole communities as they rebuild and recover from disasters; and

(b) a consultant to the Red Cross, since 1992. In this role, I have advised on emergency recovery programs and provided services as part of recovery programs offered by the Red Cross. These activities included design and implementation of community recovery programs, training of recovery workers from various agencies and leading community meetings to inform affected community members about the nature of stress and trauma during recovery and advise on therapeutic strategies.

8 I have conducted a private psychotherapy practice in Box Hill North, Victoria for forty years in which I have treated children, adolescents and adults suffering a wide variety of psychological disorders. This has always included a significant proportion of those suffering from the effects of both recent and childhood trauma. Many of the clients have had longstanding histories of neglect, abuse and deprivation prior to their presentation for treatment.

9 I have specialised in group psychotherapy of children, adolescents and young adults, usually those with long standing social problems and often those who have no peer relations. I have been a member of the Australian Association of Group Psychotherapists for thirty years and president on two occasions. I have been Director of Training for eight years. My interest in group process has given me a particular interest in the social process in disasters.

10 Earlier roles in my career included:

(a) the Clinical Director of the Department of Health and Human Services Critical Incident Stress Management Service between 1989 and 2008. This involved the design, development and management of a service for managing trauma associated with their staff, as well as, supporting people on the day of a traumatic event and conducting debriefings, workplace sessions and follow-ups in the aftermath; and

(b) a consultant psychologist at the Royal Children's Hospital between 1976 to 1995. My work involved assessment and treating children and families referred to the Department of Psychiatry, consulting to medical wards and as psychologist to the Psychiatric inpatient assessment ward. When I started there, there was no State Child Protection Service and many children who had been physically abused came into the hospital for psychosocial admissions, assessment and treatment for their significant trauma.

Impact of trauma and treatment for trauma

11 Trauma is something that happens to a person in the context of their life that already has a variety of issues. People therefore respond differently to traumatic experiences. In my experience, people who develop chronic post-traumatic stress disorders are often people who have been carrying a significant amount of psychopathology or disturbed development or have a background of severe emotional and social depravation. In some instances, they have been managing their lives successfully undertaking education, working in professional jobs and so forth. For example, I have seen professionals who are very high functioning, and no one would know that they carry a tremendous body of painful experiences. Then they experience a traumatic event and it destabilises the adjustment that they've made so that they seem to move from being a functional, successful person to suddenly having this complex intractable problem that is difficult to manage.

12 On the other hand, people that recover quickly, tend to be those fortunate enough to have had a secure environment, stable circumstances and good support systems. They seem to recover well and I've seen people who have experienced a terribly traumatic event and they just need one or two sessions of treatment to deal with it.

13 Treatment for trauma involves consideration of the ways in which the traumatic experience engages with, and activates, other complex problems in a person's life. In my opinion, there is a tendency for treating practitioners who specialise in trauma to look only at the traumatic experience and often neglect the context of the broader complexities of a person's life. In these circumstances, a person might have their trauma symptoms attended to but still not know how to get on with their lives and not understand what it all means. Therefore, in my view, it is important for treatment for trauma to be embedded as a part of a broader clinical perspective.

Supporting recovery from trauma in workplaces

14 In my opinion, work related trauma is an important area for reform. There is a great need for policies that provide early care, particularly for emergency service and high risk workforces. This involves a package where management need to be educated, and peer supporters and others trained, so that they can provide early intervention, and the whole system needs to be backed up with competent clinicians. Competence in this context involves not only an understanding of the clinical requirements of trauma but also an understanding of the social system of the workplace and the relationships that provide support. These relationships are the basis for recovery even when the traumatic experience and its problems are resolved. Effective clinicians will be those with a good grounding in general clinical practice and the ability to follow how the trauma may have activated other life history of conflicts and issues.

15 I conceptualise an improved approach in the form of a tripod: the first leg involves correcting distortions caused by the high arousal associated with the threat of the trauma, the second leg requires careful management by the workplace and its representatives, and the third leg is the social support provided by the peers in the workplace.

Correcting distortions caused by high arousal

16 If a person has a dangerous, unusual, stressful or disturbing experience in a workplace, they go into a state of heightened arousal in order to survive the experience. The biology and psychology of that state involves adrenalin which brings about a narrowing of focus onto those details that a person needs to focus on in order to get through the event successfully. It is inevitable with this specialised perspective, that the person only focuses on those features that seem most prominent and talk about the sequence of events leading up to the most stressful event. These memories form a loop in their minds that picks up and processes all the threatening information and because of the narrow focus is very likely to ignore the reassuring information of the context.

17 Take the example of a person being threatened with violence by a client. In this circumstance, the person focuses on what they need to say, how they need to say it and what they need to do. It may be that they successfully manage the situation; however, if they don't, and get injured, they go into the medical system and get cared for straight away. But if they avoid injury, the risk is that they go straight home and there is no care. What happens then is that the memory system of the event circulates up to the moment of highest threat and then goes into a loop of emotion without including the memory of how they kept themselves safe. The loop then closes on anything in that sequence and as soon as something reminds them of that, they go around that loop again ending up with the threat of what might have happened. It's very important that as soon as possible after the event that a person can be helped to get a coherent narrative of the event and link together what they did and why, the context in which they acted and the outcome so that they can restore their sense of competence and confidence.

18 In my experience, the people who move into complex post-traumatic stress are frequently those who don't get support to manage what's going on in their mind in the early hours, days, weeks and months after the event. They have fragments of threatening memory associated with high emotion and go in loops around it - that's what the fragmented loops are - they become intrusive recollections. There are some people who have very traumatic experiences but have significant past vulnerabilities who can't do that early work and need careful clinical assessment and care early on but I believe most people benefit enormously from sensitive help to reconstruct events.

Careful management

19 Where a traumatic experience occurs in the workplace, it is imperative that the workplace sensitively manages the emotional impact of the traumatic experience as well as the organisational priorities. A failure to carefully manage an employee's needs leaves them feeling devalued and exploited.

20 An important support to recovery is the organisation showing it acknowledges that what occurred was a significant event, that they care about the person, that they are putting arrangements in place to help them restore confidence in the work and giving them space to recover. They should provide pathways for the person to contact their manager/team leader to let them know what they need. There's a whole organisational context for recovery. It is necessary for the organisation to communicate to the affected person that they are respected and will be assisted to recover.

Social support

21 Once the affected person has had the opportunity to clarify the experience, regain a more realistic context which includes the otherwise neglected information, and the workplace has shown them respect and care for their recovery, they need to take the experience into their network of colleagues, friends and family and that's where they process it. This means they need to compare it with what has happened to others, know how others would have handled it, receive encouragement, empathy and perhaps advice from their colleagues. This all enables them to place the experience into the wider context of the work and make it less unique. There needs to be careful attention to ensuring work colleagues understand something has happened so that supportive communication is facilitated.

22 The issue of confidentiality may need to be managed by the organisation, otherwise some people feel they can't say anything about what's happened because they can't reveal anything about their clients. They feel they have to hold the whole experience inside themselves. They need to be shown that they don't reveal anything about the client, when they tell their colleagues, "*I've had a terrible experience, I thought a client was going to assault me*" and then the colleagues can say "*oh that's terrible, it happened to me too, come and have a coffee*".

23 The organisation needs to coordinate the peer support because in my experience if this does not occur, then support from colleagues does not necessary follow.

Impact of trauma in workplaces

24 In my experience, the most reliable indicator of whether a person will develop complex or severe post-traumatic stress disorder (**PTSD**) following a traumatic event in the workplace

is whether the person was able to remain in their work role during the incident. The role is the pattern of behaviour, skills, knowledge and values that belongs to the function they perform for the organisation. It is determined by the organisation, the job description, professional training and knowledge base and as such is not determined by the person. Preserving the role in the incident is continuing to act out of the professional knowledge and priorities. For example, if a social worker continued to do their job in a dangerous situation by using their skills and knowledge to talk down somebody who was threatening them and so successfully evaded the situation, their role provided the skills to show them how to behave and what to do to succeed. It depersonalises the event in that it suggests that any competent well-trained social worker is likely to have done much the same things. Contrast this with a social worker who is so threatened that they fail to use their skills in that situation, and rather than doing their job in that moment, they feel they're a human being facing imminent injury. They have lost the role of being a professional social worker and revert to being a person about to be hurt. That person may never be able to do social work again because the role ceases to provide them with the confidence they can manage the threatening situations. Anything that pushes them out of their professional role exposes them in a very intimate way and increases the likelihood they will suffer a lasting posttraumatic injury.

The community experience of emergencies and disasters

25 In a disaster, the social system and normal fabric of social life is broken down. People might do some preparation, but when the fire, flood, earthquake or cyclone approaches, everyone goes into a high emotional and arousal state. If they haven't been well trained to go into well practiced routines, they start to dither and get disorganised which makes the threat and the arousal worse.

26 When the event hits, everyone moves into survival mode. It's as though the social fabric momentarily evaporates because what determines people's actions are the immediate physical circumstances associated with the danger. Most people do much the same if they're with their nearest and dearest or with people they've never met before, if they have a physical opportunity to rescue someone, most people will help out. This shows that fundamental, basic human values are guiding their actions, not the complex relationships that we have in normal life. People act in the moment according to the momentary priorities regardless of the previous social structure. I call this the moment of de-bonding.

27 When the danger passes, and they come out of the event, people feel it untenable to be in the situation of de-bonding. There is then a massive rebound where everyone reconnects into what I call a state of fusion. This involves actions like volunteering, setting aside previous scruples, having people at the house, running around doing things, putting your life at risk and helping people. This state of fusion may exist even for those who have

lost their loved ones where they are involved with multiple people and agencies and there is so much to do, there is little time to feel.

28 While the fusion state is a time of high energy and often results in positive actions to help the community, it is a time when people's own recovery can get derailed. Some people throw themselves into the recovery process, exhaust themselves and neglect their families. I've had referrals three and four years down the track of families who are in difficulties, because even though they did not lose their house, Mum or Dad spent most of the next three years overworking for the recovery because they felt guilty that their house was not lost. Those who did lose their house have to be active in finding alternative accommodation and sorting out all the issues that arise. In this way the fusion period prevents the all important step of re-establishing a stable, supportive family life, a social structure where the various members of the family step back into their roles and the relationships return to what is familiar and secure. It is easy for the fusion period to compound the difficulties, creating a new set of problems that are added to the problems of the impact.

Impacts on mental health

29 From a mental health perspective, research shows that after a disaster around 5% to 15% of people will have evidence of having developed a diagnosable mental health condition. If the event involves the death of many people or if it's a criminal event (like a shooting) it's more likely to be around 40% to 60% of people that have developed diagnosable conditions (North, 2007; Norris and Wind, 2009). The main conditions from the literature are post-traumatic stress disorder, anxiety disorders, depressive disorders, substance abuse and unexplained medical symptoms and from these domestic violence, child protection issues and other social issues arise (North, 2007). These people need to be identified as soon as possible and provided with treatment.

Help seeking behaviour

30 A proportion of people are reluctant to seek help for mental health following a disaster or emergency, which is a significant problem. Some people have never engaged with services before, and probably never would; for these people, seeking mental health help is completely foreign. The theme of "help seeking" has become an important area of research and policy (Yates, Axsom and Tiedeman, 1999). In my view, it's very important that the social role of being a health seeker and a health user is promoted. There is a lot of learning to do about how to encourage this, whether that be about messaging, networking, social processes or figure heads saying, "*I've used the service*".

31 Some people affected by the severity of an emergency or disaster will seek help for the first time years later. For example, after Black Saturday mental health workers providing

services for men reported that there was an influx of people seeking help three or four years later, saying "*I thought I could do this myself and I can't go on*". It would have been much better if they had sought help earlier. Black Dog Institute and Beyond Blue are doing much necessary work to make help seeking more acceptable.

32 There is also a group of people who have some, but not all, of the symptoms required to qualify for a diagnosis of PTSD. Recent studies show that for every person who qualifies for a diagnosis of PTSD, two to three times as many fall into this partial category ("sub-clinical PTSD"), (Benedek, 2007). Experiencing any of those symptoms makes life worse, and while they may not have serious depression or anxiety, a constant background of instability and unhappiness gives them what I call a "*degraded quality of life*". They no longer feel happy, no longer have time to enjoy time with their family and friends because they are building fences all the time; all the things that give life quality are put aside.

33 Bringing attention to this and its effects on family and friendship is so important. How people will recover 10 years down the track doesn't depend primarily on how much they lost, it's how they cope over the two years following a disaster or emergency. That will probably determine whether their marriage survives, whether they stay close to their children, whether they keep their friendships, or whether they want to stay in the community or go somewhere else - and all of that determines their long term quality of life.

34 My experience is that this group will make very good use of minimal mental health information about the nature of stress, how to look after themselves, how to manage their sleep problems, and understanding why they're so irritable.

Supporting recovery following emergencies and disasters

35 In my view, it is extremely important that representatives of recovery agencies and local governments are in communities early to help people start to restore order, predictability, roles, relationships, encourage people to reconstruct their family life and preserve the boundaries of intimacy. This is not intuitively obvious to focus on the structure of normal life when everyone is in the mode of helping each other out. It is not that emergency mutual aid shouldn't happen - there should be communal support, but it needs to be balanced with the central re-emergence of encouraging people to take care of their families and themselves.

36 In my opinion, what is needed is a communal environment that makes this information available and helps people to stop, reflect and take stock. As time passes it gradually becomes apparent that contrary to what people felt at first, which was "*we've all been through the same event,*" there is realisation that no-one had the same event because everyone's circumstances are different. Some were at greater risk, some are eligible for

one thing, some are eligible for multiple things, some aren't eligible at all and some are insured whilst others are not. As these differences start to emerge, they create tensions. Under normal circumstances nobody knows about each other's financial circumstances as it's private, but after the disaster or emergency that privacy is ripped away and everyone thinks they know what everyone has got. For example, in the bushfire areas one of the things that goes around is opinions about who was entitled to what in terms of relief. It is therefore important to manage the psychosocial environment, otherwise there are a whole lot of secondary stressors, social *angst* and conflict.

37 A very important strategy is to mobilise a constructive recovery process at the earliest possible moment. (But it's often very hard to get the attention of the overwhelmed response managers to do this.) It's necessary to do this early because as time passes divisions between differently affected subgroups in the community form. I liken them to the *cleavage planes* in a diamond where there are planes of weakened molecular bond in the crystal so that it can be cut. In disaster affected communities, they take the form of breakdowns or splits which may focus around any of the differentials in the disaster environment that can emerge. They are arbitrary and will keep emerging for some time as different issues arise.

38 So the first supportive process, and the most lasting supportive process, is the community itself. But if there is a lack of a perspective that tries to identify these tensions and hold them together with a common view, then the community splits the very relationships that need to be the basis for support and recovery.

39 There needs to be community organisation with a focus around the formation of community recovery committees, advocacy processes and social organisation so people can let their needs be known and communicated. Outreach programs and programs to help bring the community together should be adopted. Helping the community form their own "*community led recovery process*" where community advocates communicate with government has enormous mental health payoffs because it gives people what makes them resilient - confidence, trust, optimism and security.

40 There is growing awareness and research going back to the 1980s which shows that formalised mental health services tend to be underutilised (Drabek, 1986; Watson, 2007; Elhai and Ford 2009). Immediately following a disaster or emergency, there tends to be a great rush of clinicians to the field thinking everyone is traumatised, but at this time not all those affected are ready to deal with their trauma and the services tend to be withdrawn for not being used. In fact simpler interventions are often most effective including personal support and psychological first aid (Watson, 2007). There is often a peak of crisis around six months as people tire from being under high levels of stress and demand for many months. Not only do they have their normal lives and responsibilities to maintain but now they have all the problems of the disaster to deal with on top. They are effectively

functioning in overdrive. This makes them unavailable for targeted mental health services since they feel their focus to be on their practical problems for as long as they can. It is only when their exhaustion begins to develop and they feel unable to manage their tasks and their mood drops, and they wonder how they will ever get through it all. My observation is that about six months is how long a reasonably healthy person can maintain an abnormally high level of activity before they begin to exhibit physical, psychological or social problems, which is about the time that many of the services are winding down. In Ash Wednesday, it was initially said that the recovery time frame would be six months and then it had to be extended. Each time the end of a period approached, people would feel they were going to be abandoned and so they didn't come out of that emergency mode. There is another predictable peak of distress leading up to the first anniversary of the event. Then there is another trough of morale in the next six months, subsequent anniversaries and seasonal difficult times such as cold, wet weather in winter. Mental health support, therefore, needs to be ongoing.

41 I advocate for early stage, very broad generic community support processes, information transmission, opportunities for people to get together and share their experience, messages of support and messages of confidence in ongoing services, whose representatives attend meetings, mix with the community and make themselves known. It's also very helpful that the community is provided a clear and confident recovery timeframe, which is often two to three years for bushfires.

Generic community health processes

42 It is very important that generic community health processes are prioritised. An example of a low key process is the provision of initial and informal support by mental health professionals at community meetings. By just attending and spending time out at a community meeting and giving a little talk about some aspect of mental health maintenance, people came up and talked to me, sometimes they queued up for five or ten minutes. Then I met them two years later and they said "*you know that conversation we had, that really got me on the right track and I feel my recovery started from that point*". This sort of process enrols people through communicating with a mental health professional (such as a psychologist or mental health nurse) which leads them to start thinking: "*you're okay, I might make an appointment with you*" or "*I'd never thought I'd do that – well he's not too bad that makes sense.*"

43 Another example of effective process involves outreach in the community as some people are very hard to engage. After Black Saturday, various agencies received funding to develop men's programs. Those with experience working in these programs went out to communities and started to network with men. They slowly built up connections and started to run thoughtfully designed activities to bring men together. I remember one worker ran a program in the fourth year after the fires, where he took a group of men

away for a weekend fishing expedition. The way he described it was that they just had a great time fishing, they didn't talk about the fire at all until the last evening when they were sitting around the campfire, they'd eaten their fish, they'd had a couple of beers and then they had this big long conversation about the day of the fire. He said that for most of them, this was the first time they'd ever talked about it. Similar programs were conducted for women based on artistic and social activities.

44 In my opinion, experienced mental health workers are needed to act as supervisors and consultants to community programs, recovery activities and decision making. It is important that someone with that kind of training and experience is sitting in the room when decisions are being made to advise on psychosocial implications. For instance, anything perceived as an authoritarian decision, such as road blocks, can really upset people. Research shows that if people get very upset and angry they can also get distressed and can't go on with their recovery, sometimes for weeks. For example, in Wye River after the bushfires it was suddenly decided that a new retaining wall was needed and so a simple concrete retaining wall was put in. The community was very upset querying why they were not asked or consulted, and that they could have had input into an attractive design. All of this is unnecessary emotional noise which overrides people processing the disaster's effects on their lives.

45 Disaster creates an opportunity to do very efficient community work because the community members are all starting from a similar experience although they've got different responses. Emphasising their common interest and engaging them in advocating for their needs and allowing all the differently impacted groups to be represented provides a basis for community cohesion. Simple programs for generic community health have an effect on morale, cohesion and development of social support networks that can continue to evolve for several years and will have high cost benefit in terms of creating social recovery resources.

Digital mental health services

46 In my opinion digital mental health services, while not a replacement for in person services, can be very helpful and useful. Once a person has built a relationship with a mental health professional, it is much easier to go digital but it may be hard to just log in and start talking to someone without that initial relationship. To an extent, though, this problem can be overcome if there is care to introduce the services and personnel providing assistance in the communities with photographs and descriptions of their experience. Then community members can feel they are making contact with people they know something about. There are studies being undertaken on group consultations by digital means and I think we need to explore its use.

47 We may have to pursue digital services in particular areas which cannot attract enough people to work there, such as Mallacoota. Digital services could be adjunct to visits. Mental health professionals could first visit the affected area, meet the local people by attending things like community meetings and get their face known. This would be a good basis for then building on the relationship with the use of digital services.

48 It is important that assumptions are not made about how digitally literate a community is. To support access, it might be appropriate for IT and digital teams to attend the communities and set up hubs where people can tune into digital services. For example, I've heard stories of information saying, "*grants are available, this is the link to apply*" and people don't have a computer.

Supporting mental health during COVID-19

49 In my opinion, there are going to be two pandemics: one is the virus, the other is the anxiety. If you take a psychoanalytic approach to the anxiety, what you see is that the source of the anxiety, unlike a bushfire, is nebulous and indeterminate. There are feelings of "*I don't know if it's there, I don't know how to defend myself, you can tell me all this stuff about washing my hands but how do I know that they're clean*".

50 There are two responses that will happen if you control the anxiety and acknowledge it. One is to go into denial and minimising. For example, somebody has recently said to me "*I think there's a lot of hype about this, it's just the flu*" and I said "*but a lot of people will die*" and they said "*but they're only old people*" and this person was retired themselves, so they have not actually put it together. The other response, which is a natural defence mechanism to managing anxiety, is to displace it from something that can't be controlled to something that can be controlled. In this case, it's toilet paper. People feel a lot better if they stockpile, but my prediction is that the people that are stockpiling must be anxious to be doing that as it doesn't actually make sense. When they have stockpiled enough toilet paper, they're still going to feel anxious, so they're going to displace onto something else. This has a community wide effect because everyone has to rush and buy what's being lost.

51 In these circumstances, a broad community based mental health management process that tackles the need for education and self awareness about anxiety and its management is important.

52 In my view, if you want quarantine to hold, support needs to be provided. If you want people not to panic buy, then there needs to be reassurance that there is a number you can ring for assistance for essential supplies and they won't go without. The community is going into fusion and fusion creates tensions and conflicts because we don't all fit together so closely.

53 The Red Cross in Queensland has an arrangement with the State Government for a program where each day they ring elderly people and people who are in quarantine. The Red Cross has reported a variety of issues arising. Some people will talk for 45 minutes about their anxieties and problems, which must be very helpful for those people. It is my hope that this develops across Australia, particularly if we go into lock down.

54 The model of the community support processes I have detailed earlier in this statement could be utilised, although they can't be done face to face, the principles are there - about how we support people in grief and also support them in anxiety.

Emerging changes in mental health service delivery as a consequence of COVID-19

55 My observations about the impact of COVID-19 isolation have been drawn from participation in national and state level forums of practitioners discussing these issues, and from consultation and supervision sessions with a variety of organisations and agencies ranging from school counsellors, private psychotherapists and counsellors to public mental health and welfare providers.

56 Since late March 2020 most of the mental health profession seems to have adopted online work either by teleconference or telephone. Although some practitioners have continued to see some clients face to face, my impression is that most work is being done remotely. Clinicians also generally seem to be working from home or spending limited time in their workplace. There have been considerable stresses in making this transition, but the consensus is that they continue to undertake effective treatment through electronic media. There are difficulties such as increased emotionality in some patients, difficulty in managing anger and anxiety when they are strongly expressed in telehealth sessions and more difficulty getting to know some clients remotely. For those who already have a relationship with the client, the work is much easier.

57 There are a number of changes in mental health service delivery that I have observed. There is increased flexibility and availability of sessions as service providers are not so constrained by organisational requirements and travel. Productivity has improved, however many clinicians observe greater difficulty in gaining access to colleagues for informal support, advice and debriefing since they have to make a phone call rather than see the person in the corridor. They also observe a particular quality of fatigue associated with online work that is different to that associated with face to face work. I believe this will be reduced as people become more familiar with working in this way.

58 Perhaps the most important change in mental health service delivery is greater accessibility to clients who can have telehealth consultations regardless of their location. I believe this will greatly assist in accessibility for some people once the technical issues of telehealth are understood and practiced.

59 These changes could emerge into longer term opportunities for new approaches to service delivery. While the lack of face to face contact is felt to be a loss to the depth of contact between clinician and client, in my view, the availability of telehealth will allow consumers a greater choice of treating clinician, provide access to more experienced and skilled clinicians regardless of location and increase opportunities for consultation and supervision among clinicians. This will be especially valuable for rural clinicians and consumers of mental health services.

The impact of prolonged quarantine and social distancing measures on wellbeing and mental illness

60 I have not been in a position to investigate the research into prolonged quarantine or social distancing. However I am aware of a recently published Rapid Review paper which considers the impact of quarantine by drawing on previous quarantines for a variety of conditions (Brooks, S., Webster, R., Smith, L., Woodland, L., Wesseley, S., Greenberg, N., and Rubin G., 2020).

61 In this paper, the various studies reviewed showed high psychological distress in people quarantined (34%), with symptoms lasting up to three years after the quarantine for a small percentage of persons. A much higher percentage reported "subclinical" distress and negative feelings and exhaustion (up to 73%). Disturbed behaviour was also reported including avoidance, minimising patient contact and absenteeism. Some of these behaviour changes were long term (three years). The financial consequences are a major stressor for those on lower incomes and greatly increase the risk of psychological disorders. The paper concludes that "the psychological impact of quarantine is wide-ranging, substantial, and can be long lasting." The threat is mitigated by keeping quarantine as short as possible; providing adequate and timely information; providing adequate and timely supplies; reducing boredom and promoting communication; providing special attention to the needs of health workers who are more vulnerable to the effects; gain voluntary cooperation rather than coercion.

62 It is likely that those already suffering from mental health conditions will be at higher risk in quarantine or during social distancing unless there are intensified supports.

63 This paper does not consider community social distancing. However, I am aware of the following research in relation to this problem and specifically the negative impacts of social isolation:

(a) Julianne Holt-Lunstad, a professor of psychology and neuroscience, and her colleagues concluded on the basis of a meta-analysis that social isolation increases health risks as much as smoking 15 cigarettes a day or having an alcohol use disorder. They also found that loneliness and social isolation are

twice as harmful to physical and mental health as obesity (Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D., 2015).

(b) A more recent study analysing data from more than 580,000 adults found that social isolation increases the risk of premature death from every cause. According to this study, increased risk of early death associated with social isolation ranged from 60 to 100 percent, depending on other circumstances (Alcaraz K., Eddens K., Blase J.L., Diver R.W., Patel A.V., Teras T.R., Stevens V.L., Jacobs E.J., Gapstur S.M., 2019).

64 Also of concern is the impact of the economic crisis on the accessibility of mental health services. Many psychoanalytic psychotherapists have a group of patients with longstanding developmental and trauma-related difficulties who are significantly affected by losing their jobs at short notice. These patients have been paying for ongoing therapy as a means of maintaining work and family lives and not requiring public mental health support while carrying high levels of mental health difficulties. Having lost their jobs, some are now no longer able to pay for their therapy which generally has been the only service they required. In their case, no financial assistance is available. It is the view of the ACPP that this limited group of patients would benefit from some form of assistance to help them maintain their therapy during this difficult time until they are able to return to work. Continuation of their therapy should enable them to avoid making demands on other mental health services and we do not believe this will be a great impost on the public resources since they are likely to return to work as soon as they can.

Mitigation of the negative impacts of prolonged quarantine and social distancing measures

65 In my view, the mitigation of the negative impacts of prolonged quarantine and social distancing is not complex but requires authorities to focus on the personal experience and social context of the situation.

66 The first consideration is to recognise that during prolonged quarantine there is a loss of assumptions and expectations of normal everyday life which are the basis for security and confidence. Lack of information and supplies will exaggerate the insecurity and then provoke anxiety or other reactions. Regular contact with someone representing the public health authority and a program to give people ideas and opportunities to be constructive in their isolation will be important.

67 The second consideration is to recognise that the immersion into the social world is one of the assumptions that everyone relies on for healthy adjustment. Loss of social contact is potentially debilitating for many and can be alleviated by helping people use social media and other opportunities to communicate and if they do not have family and friends

then other networks can be facilitated. Psychological isolation is a function of lack of communication not physical isolation.

68 Community information and education into the effects and reasons for the reactions to isolation helps people understand and take a problem solving approach to the problem.

69 I believe it is likely that as in any protracted stress situation, there is some form of adaptation achieved by most people. When that happens coming out of the stress – in this case isolation – leads to considerable discomfort and delayed emotional impacts which are likely to manifest as social and interpersonal conflicts and changed behaviours (withdrawal, isolation, substance use, exercise and eating habits). If this is expected and there are strategies to mitigate it there will be less impact.

70 One final observation I have made is that many people describe a diminished or eroded sense of identity in the confined situation. Identity is formed and maintained by the routine feedback people get from their surroundings – mainly social – and when this is curtailed or changed, their sense of their own self and its value are impaired. Some seem to rise to the challenge and compensate with various constructive activities while others seem to suffer and withdraw. Discussion of these processes are likely to help a proportion of those affected.

71 There will be much to learn about this in the coming months.

Psychoanalytic psychotherapy

72 ACPP is of the view that psychoanalytic psychotherapy should be more broadly utilised. In my opinion, this is an important area because the public system is not very good at dealing with people with serious psychopathology - they bounce in and out of hospitals and crises.

73 The psychoanalytic psychotherapies are methods of treatment which explore not only conscious but also unconscious layers of the mind. Unconscious processes, which are not readily accessible, are understood to be the source of much of what we think and experience and are considered largely responsible for maintaining a person's internal suffering, and unsatisfactory relationships. They are formed and evolve during the early and later developmental processes and relationships.

74 Practitioners of these therapies are drawn from the various disciplines of psychoanalysis, analytical psychology, psychoanalytic individual and group psychotherapy. Such practitioners complete theoretical and experiential post-graduate training and intensive case supervision, usually in addition to a basic professional qualification. This training consists of three parts; a minimum of three years' (at least 250 hours) of theoretical seminars; supervision of at least two long-term clinical cases or therapeutic groups; and

personal intensive psychoanalysis/psychoanalytical psychotherapy for the duration of the training.

75 Their training enables practitioners to understand the many complex factors arising from early developmental experiences, and a range of personal relationships and life events, which shape a person's internal world. Their characteristic tripartite psychoanalytic training also enables them to understand distress and symptoms, uninfluenced, as far as possible, by personal bias.

76 Practitioners apply theoretical and clinical knowledge that is constantly developing and evolving through current research and practice with individuals (children and adults), couples, families, or groups. The therapeutic relationship established to conduct such work requires commitment and responsibility from both analyst/therapist and patient or client. The work makes links between present and past as well as emphasising the here-and-now experience within the therapeutic relationship. Exploration of the conscious and unconscious nature of this relationship makes this work different from other therapies or talking to a friend. The overall aim of the treatment is to make sense of the patient's ways of functioning and emotional life. Through non-judgemental understanding and interpretative work within the therapeutic relationship, a patient can recognise the underlying meaning of dreams, conflicts and fantasies and the way in which thoughts and feelings are expressed and resisted. This process enables long lasting changes in the personality, increased freedom to make new and creative life choices, and the fulfilment of the unique potential of the person.

77 There is a substantial body of evidence that psychoanalytic training equips clinicians to treat complex disorders that are expensive and protracted such as borderline personality disorder, psychosis, longstanding trauma and other disorders of similar severity Recent research in Australia has demonstrated that very successful treatment can be conducted on a twice weekly basis and that the cost of a year's twice weekly sessions is about the same as an average mental health admission to a hospital. (eg. Caleo, J.S., Stevenson, J. & Meares, R. 2011; Doidge, N. 1997; Leichsenring, F & Rabung, S., 2008; Meares R., Stevenson J., Comerford, A., 1999; Shedler J. 2010; Stevenson, J. & Meares, R., 1999).

78 Many ACPP psychotherapists see people over long periods of time and keep them out of hospital, manage suicidal ideation and other crises and generally assist to stabilise people so that they are not reliant on the use of other health services.

79 Psychoanalytic psychotherapies are very effective in the forensic space. A number of people working in New South Wales and London have worked on forensic populations. There is a growing evidence base, including from randomised control trial studies in the US and Germany, that people who've had complex inpatient treatment do very well from two years of psychoanalytical psychotherapy and after two years following their discharge

they continue to do better. Rather than relapsing they're set on a road where they start to recover (Keller, W., Westhoff, G., Dilg, R., Rohner, R., Studt H.H. and the study group on empirical psychotherapy research in analytical psychology, 2006b; Leuzinger-Bohleber M, Target M, 2002; Richardson P, Kächele H, Renlund C., 2004).

80 The ACPP is of the opinion that there is a body of experience and skills that are underutilised because most psychoanalytic psychotherapy work is practiced privately. There are only a small number of psychoanalytical psychotherapy clinics available. One example is the psychoanalytic clinic at Spectrum in Victoria, where psychoanalytically trained people, treat people diagnosed with borderline personality disorder. Another example is a psychoanalytically based clinic for mother-infant treatment at the Royal Children's Hospital. ACPP believes it would be helpful to open a conversation as to the valuable contribution that clinicians with psychoanalytical training can make for what are otherwise intractable problems.

81 In my view, it would be possible to embed psychoanalytic psychotherapy into the community mental health system in two ways:

(a) By placing psychoanalytically trained people in supervisory roles in order to understand, oversee and manage client/clinician relationships and assist to preserve the therapeutic basis; and

(b) By supporting trained psychoanalytic psychotherapists to work with some otherwise complex and difficult to manage cases.

82 The long-term aim of ACPP would be for psychoanalytic psychotherapy to be a specialised mode of treatment for people with otherwise very longstanding and intractable conditions that is recognised by Medicare.

sign here ► Rob Gordon

print name Rob Gordon

Date 20 May 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RG-1

This is the attachment marked 'RG-1' referred to in the witness statement of Rob Gordon dated 20 May 2020.

References:

Alcaraz K., Eddens K., Blase J.L., Diver R.W., Patel A.V., Teras T.R., Stevens V.L., Jacobs E.J., Gapstur S.M. (2019) Social Isolation and Mortality in U.S. Black and White Men and Women. *Am. J. Epidemiol.*188:102–109.

Benedek, D. (2007) Acute stress disorder and post-traumatic stress disorder in the disaster environment. In In Ursano, R., Fullerton, C., Weisaeth, L and Raphael, B (2007) Textbook of Disaster Psychiatry. Cambridge, Cambridge University Press. Pp. 140-163.

Brooks, S., Webster, R., Smith, L., Woodland, L., Wesseley, S., Greenberg, N., and Rubin G. (2020) "The psychological ilmpact of quarantine and how to reduce it: rapid review of the evidence". *The Lancet*. Vol 395, March 2020. 912-919.

Caleo, J.S., Stevenson, J. & Meares, R. (2011) An economic analysis of psychotherapy for borderline personality disorder patients. *The Journal of Mental Health Policy & Exonomics. Vol 4(1), 3-8.*

Drabek, T. (1986) Human System Response to Disaster: An inventory of findings. London, Springer Verlag.

Doidge, N. (1997) Empirical evidence for the efficacy of psychoanalytic psychotherapies and psychoanalysis: An overview. *Psychoanalytic Inquiry. (Suppl),* 102-150.

Elhai, J and Ford, J. (2009) Utilization of mental health services after disasters. In Neria, Y., Galea, S. and Norris, F. (2009) Mental health and Disasters. Cambridge, Cambridge University Press. Pp. 366-384. Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and socialisolation as risk factors for mortality: A meta-analytic review. *Perspectives on Psychological Science*,10, 227-237.

Keller, W., Westhoff, G., Dilg, R., Rohner, R., Studt H.H. and the study group on empirical psychotherapy research in analytical psychology (2006b). Efficacy and cost effectiveness aspects of outpatient (Jungian) psychoanalysis and psychotherapy - a catamnestic study. Department of Psychosomatics and Psychotherapy, University Medical Center Benjamin Franklin, Free University of Berlin.

Leichsenring, F & Rabung, S (2008) Effectiveness of Long-term Psychodynamic Psychotherapy: A Meta-analysis . *JAMA.* 300(13):1551-1565.

Leuzinger-Bohleber M, Target M, editors. The outcomes of psychoanalytic treatment. London: Whurr; 2002.

Meares R., Stevenson J., Comerford, A. (1999), Psychotherapy with borderline patients: I. A comparison between treated and untreated cohorts. *ANZ J Psychiatry* 33(4), 467-472.

Norris, F. and Wind, L. (2009) The experience of disaster: Trauma loss, adversities, and community effects. In Neria, Y., Galea, S. and Norris, F. (2009) Mental health and Disasters. Cambridge, Cambridge University Press. Pp. 29-44.

North, C (2007) Epidemiology of disaster mental health. In Ursano, R., Fullerton, C., Weisaeth, L and Raphael, B (2007) Textbook of Disaster Psychiatry. Cambridge, Cambridge University Press. Pp. 29-47.

Richardson P, Kächele H, Renlund C (eds) (2004). Research on psychoanalytic psychotherapy with adults. London: Karnac.

Shedler J. (2010) The Efficacy of Psychodynamic Psychotherapy. *American Psychologist. Vol 65; 98-109.*

Stevenson, J. & Meares, R. (1999) Psychotherapy with borderline patients: II. A preliminary cost benefit study. *Australian and New Zealand Journal of Psychiatry.* 33:473–477.

Watson, P. (2007) Early intervention for trauma-related problems following mass trauma. In Ursano, R., Fullerton, C., Weisaeth, L and Raphael, B (2007) Textbook of Disaster Psychiatry. Cambridge, Cambridge University Press. Pp. 121-139.

Yates, S., Axsom, D. and Tiedeman, K (1999) The help-seeking process for distress after disasters. In Gist, R and Lubin, B. (1999) Response to Disaster: Psychosocial, community and ecological approaches. Philadelphia, Brunner/Mazel. Pp. 1