Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF DR SARA RENWICK-LAU

I, Dr Sara Renwick-Lau, general practitioner, of 21-23 Maurice Avenue, Mallacoota, in the state of 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 making this statement in my personal capacity and based on my experience as a general practitioner, and as the practice principal of the Mallacoota Medical Centre (**Medical Centre**).

Background and experience

3. A copy of my CV is attached at Attachment SRL-1.

4. I am currently a general practitioner at the Medical Centre. I have been the practice principal of the Medical Centre since 2008 and its sole owner since 2017.

5. I have been working as a doctor for about 20 years. I completed my junior doctor training in the Northern Territory at the Royal Darwin Hospital and all of my GP training in remote communities - communities that are separated from other places and usually a long distance from a hospital and other medical services. Since 2005, I have worked in remote communities.

6. Between 2005 and 2008 I was a General Practice Registrar and GP locum in Aboriginal Medical Services at Ngalkanbuy Health, Kakadu Health and Miwatj Health. In these roles, I advocated for improved community health services.

7. I was a board member of the Top End Division between 2005 to 2007 and East Gippsland Divisions of General Practice from 2009 to 2014.

8. I hold a:

   (a) Bachelor of Medicine and a Bachelor of Surgery from the University of Melbourne (2001); and

   (b) Fellowship of the Royal Australian College of General Practitioners (2008).

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

9. I also educate doctors in the Australian General Practice Training Program and the Remote Vocational Training Scheme as well as teach medical students as part of the John Flynn Scholarship Program.

Primary Care in small rural communities

The Medical Centre

10. Since I became the sole owner of the Medical Centre in 2017, it has expanded from a small single GP and single practice nurse practice to employing nine clinical staff members.

11. The Medical Centre provides the full breadth of GP services including health care, mental health care, chronic disease care, acute care, palliative care and emergency medicine and immunisations. It also provides services such as outpatient drug and alcohol detox, which are usually delivered in the home environment because we are a long way from a hospital. The Medical Centre also provides other public health measures. For example, we will provide advice about infection outbreaks to local organisations. We are presently taking an active role in preparing and educating Mallacoota about the novel coronavirus (**COVID-19**). This includes coordinating the supply of hand sanitiser stations to commercial and public areas within the town, providing education to health care workers in town, assisting with coronavirus testing and providing advice to local employers in managing their staff.

12. General practitioners in Mallacoota and other rural and remote communities assist with ‘gap-filling’ in first response to medical emergencies, emergency care, palliative care, after-hours nursing, and child and infant health. I have assisted with first responses in the past as Mallacoota only has community ambulance officers and does not have a full-time paramedic. Further, Mallacoota has limited access to state-funded postnatal care which means that women have no access to midwives after they leave the hospital. This places them at increased risk of post-natal depression, poor infant health outcomes and domestic violence as they are not receiving the monitoring and intervention of a midwife. The Medical Centre is left to try to fill that gap by providing a service akin to that usually provided by Child and Maternal Health Services. These are just two examples of general practitioners providing a broad scope of clinical care in an area that lacks many services normally accessible in most other parts of Victoria.

Caring for community members who do not present at the Medical Centre

13. I recognise that there may be a need for services even though patients do not present at the Medical Centre. Over the last 15 years, I have developed a way of working that does not just involve treating the patient in front of me, but also those in the community who have not accessed, or cannot access, care.

14. By way of example, our practice recently adopted a model developed by a local GP practice on the New South Wales south coast in response to a cluster of youth suicides within the area. The model is such that adolescent health is embedded within small town general practice. practices. This is done by upskilling practice nurses to provide immediate advice and treatment for significant adolescent presentations, such as depression, suicidality and sexual health (including contraception). The nurses are available for walk in presentations at set times and are a “soft” or “easy” entry for teenagers. As the service is embedded in the usual GP practice, the nurses are generally always available while the practice is open. The nurses are supported by GPs who are always available and on-site and local psychologists working from the practice who maintain an emergency appointment system. The program works closely with referral sources and a good relationship with the local school is essential.

15. All services are provided for free to the young person and are funded through a combination of MBS billing and other funding. In Mallacoota for example, the Primary Health Network funds staff training and a 0.2 FTE practice nurse in the teen clinic role and the on-site psychology is funded by the Foundation for Regional and Remote Renewal.

16. The logic behind the model is that young people in small towns do not have the ability to easily travel to centrally located youth services such as CAMHS, headspace and family planning clinics. By providing support to the already available, trusted and motivated local health services, it is possible to improve teenagers’ access to all of their health care needs.

17. In this way, at risk adolescents are provided with a safe, confidential and high quality wraparound health service by nurses who advocate for young people within the pre-existing mainstream local health service. This model has been hugely successful in providing access to young people with emerging and serious mental health illness since it was implemented at the Medical Centre 12 months ago. There are increased adolescent presentations at the Medical Centre for all causes, but particularly mental health, which indicates improved access.

18. Another example is our case management support program for people with chronic diseases and disabilities. These people are managed by an allied health assistant who will make home visits with the goal of gradually improving the mobility and fitness of a patient so that they are able to leave their home. The benefits of exercise are well known and there is a strong evidence base for the program as getting people moving and exercising increases their life span. We have found this program to be successful with vulnerable people in the community in particular, who do not have much self-efficacy or the ability to take on and implement health information.

Challenges when practicing in rural and remote communities

19. In my experience, service delivery in Victoria is metro-centric and not designed for remote areas. The issues in remote areas - such as the lack of some essential services, the provision of after-hours care, the lack of robust local mental health services and workforce difficulties - aren't difficult to fix. I think we get forgotten about because there is a sense that it might be difficult or expensive, or perhaps there is not the will within wider health services to provide base levels of service to our community.

20. Part of the issue may be because Victoria is unique in that it has such a small percentage of its population living in remote areas. The Modified Monash Model defines whether a location is city, rural, remote or very remote for the purposes of healthcare.[1] According to the model, MMM 1 is a major city and MMM 7 is very remote. Mallacoota is in one of the two most remote parts of Victoria, with a rating of remote - MMM 6. We find that the Department of Health and Human Services does not have any mechanism to work with GPs in remote areas. The other main organisation, the Primary Health Network, also prefers to commission outside General Practice, with the issue being that in Mallacoota the Medical Centre has always been the main provider of the majority of health care.

21. Our biggest challenge in Mallacoota is our limited access to hospital resources and allied health. Our closest main regional hospital is two hours away in Bega, New South Wales and our closest Victorian hospital is small and two hours away in Orbost. We find allied health difficult to access and we do not have access to radiology.

22. This distance also makes it difficult for us to manage the interface with larger distant services. This is a particular issue with Gippsland: when I worked in the Northern Territory, there was only one tertiary institution and they understood that they were mandated to provide services throughout the whole of the Top End. Comparatively, in Victoria there are a number of tertiary hospitals and we don't belong to any particular one. As a result, it is up to the patient's doctor to call the service and ask if they will accept the responsibility for the care of patients from Mallacoota. For example, if the closest specialist is in Melbourne, I find often they do not understand why I am calling them from seven hours away.

23. Our closest tertiary service is actually in Canberra, but this can be difficult to access as it is across two state borders. For example, we have had recent cases where ACT Health have refused to provide tertiary level hospital care to Mallacoota and Cann River patients, creating a delay in care for those patients. The refusal to provide care is usually associated with sub-specialty consultation for complex problems, for example, joint revision surgery or urogynaecology. Ultimately, our access to tertiary services is

[1] Department of Health, Commonwealth Government, 'Modified Monash Model' <https://www.health.gov.au/health-workforce/health-workforce-classifications/modified-monash-model>/.

dependent on the goodwill or a motivation by those services to provide access to rural patients. We are really at the mercy of those services as to whether or not they feel it is necessary to support rural patients.

24. Applying models of care is, naturally, more difficult across a greater distance. In Gippsland, we find that once you get to the other side of Bairnsdale, providers decide it is not feasible to extend the reach of services and Mallacoota will often end up without services. These challenges also apply to mental health care. For example, there was a period of time where we had Primary Health Network funded visiting psychology service. When we lost that funding, there were no qualified mental health professionals coming into town except for the acute services case manager, who was travelling from Orbost to see his long term chronic and severely unwell patients. Without any clinicians on the ground, a large portion of the population in Mallacoota lost access to mental health services. Instead, this function fell solely to the sole local GP and meant that access psychology for those who required increased intervention was almost non-existent.

Mental health issues and service needs of rural and remote communities compared to metropolitan areas

25. I think people in Mallacoota are, in general, more engaged with their local health service. This is because people have a familiar, trusted, point of access that has provided health care in town for more than 20 years. Many people will seek help for themselves or their family and friends through their GP.

26. As we have a smaller population, Mallacoota probably has relatively fewer cases of and fewer issues with managing acute psychosis and problematic drug and alcohol use compared to other parts of Victoria. For example, we have been relatively spared from widespread problems with ice and opiates. As we have a smaller population, problematic drug use can be well controlled by local policing and doctor shopping is easier to manage.

27. Even though Mallacoota has smaller incidence of problematic drug and alcohol use, it is still important to provide specialist care and intervention. There may be less need for services in Mallacoota compared to other parts of Victoria, but these services still need to be available on occasion and support from services in larger areas needs to be accessible.

28. The more common mental health issues that we see are similar to that of the general population, such as generalised anxiety, depression and alcohol use. As a result of the recent bushfires, there has been increased PTSD presentations and presentations of exacerbations of pre-existing mental illness. This is discussed in greater depth from paragraph 69.

Unique pressures on the viability of remote and rural GP practices

29. A lot happens in rural General Practice to ensure access to the full breadth of health services that rural and remote patients need, including acute, preventative and emergency general and mental health care. Having the right balance of locally available clinicians, with the coordinated support of distant specialist services, ensures that even complex problems can be managed well within rural General Practice. As stated above, GPs in this area are often required to gap fill and provide the kind of specialised health care that in bigger centres would be the role of other services, for example managing a heart attack, trauma, complex medical issues or an acute psychosis.

30. However, providing coordinated (non-siloed) care to the vulnerable and in particular those with mental illness, can be detrimental to the viability of GP practices. This is because GPs are limited to either MBS rebate funding or out of pocket private patient fees to fund the provision of essential services. Many vulnerable people will be prohibited from accessing care if they are required to pay private fees. In larger centres, with this understanding, emergency department and public mental health services are available. In rural and remote areas, however, GPs provide the same services at either at no or low cost to the patient - but that is well below the income that is sustainable for their practice. This is where the provision of robust GP services, which underpin access to mental health care in small communities, is subject to market failure.

31. There are health agencies with federal government funding whose role may be assumed to be to ensure access to primary health care for example, Primary Health Networks and Rural Workforce Agencies. However, they do not always recognise that this market failure creates strain on rural GP Practices, which in turn puts strain on the longevity of rural practice and workforce. This in turn decreases access to GPs in rural areas, and the breadth of care that they can provide.

32. There is significant international and local evidence that improved access to primary health care and GPs results in improved health outcomes. In this way, rather than supporting rural GPs to work within their broad breadth of scope, many Primary Health Networks and Rural Workforce Agencies, perhaps driven by their reporting requirements to their federal funders, prefer a "one size fits all" solutions to gaps in services. This leads them to support larger central organisations, which goes against available evidence for development of particularly mental health services and best practice models of care and is often in competition with local GP Practices.

33. The final difficulty is that there appears to be no review of the how the actions of these agencies impact on the provision of services at a local level. That the procurement and commissioning processes can worsen market failure and create gaps in services in small rural towns without any examination is a significant concern for access to mental health

services in particular. This has been a significant challenge to the provision of primary health care in our small community.

34. One difference between remote communities and metropolitan communities is in responses to market failure. Where there is market failure and there are vulnerable people unable to afford medical care, metropolitan areas often rely on standalone solutions to gap-fill, such as Headspace and other larger organisations. We find that these solutions do not have any impact in remote areas, largely because of distance. Our closest Headspace, for example, is three hours away, which is why we developed our local Teen Clinic model.

Commissioning of mental health services by Primary Health Networks in remote communities

35. In particular, I think that the Primary Health Network commissioning process does not work well for remote communities. Commissioning is a way of procuring and purchasing services based on the needs of particular regions. However, where the commissioning and procurement processes are not robust and do not have good clinical governance, this can result in unqualified practitioners and unsafe care being provided.

36. One example of the failure of the procurement and commissioning processes of health agencies is that four years ago the local Primary Health Network commissioned the Mallacoota Medical Centre to provide a mental health service. This service provided a free, face to face psychologist to low income people. The GP Practice was able to engage a visiting psychologist, at a time where recruiting any health professionals to rural and remote areas was (and still is) challenging. This was important as the Medical Centre was struggling at the time with viability and workforce issues. Whilst we could provide good evidence that the service was well utilised – fully booked with a waiting list – the Primary Health Network made a decision to put the program to tender. The tender was given to a large corporate service in Melbourne to provide a telehealth service. As a result of the re-tender, the town lost the ability to maintain our only face to face mental health worker.

37. When the visiting psychologist was replaced with the telehealth service, we found that the majority of people who were referred to the telehealth service did not access it. We also found that a lot of patients could not manage video by themselves at home so ended up having phone conversations instead. Patients needed help from the Medical Centre to access the psychologist, however the telehealth service would not allow GPs to provide a clinical handover of patients to a known psychologist. Instead, patients were asked to self-refer and arrange their own appointments.

38. It can be difficult for GPs to communicate with many mental health services as many services prefer to manage their intake in a central way and usually prefer systems

whereby the patient arranges their own appointment. This makes it difficult for the referring GP to provide clinical handover at the time of referral, particularly as a verbal handover is often more appropriate with mental illness as it can deal with sensitive or complex topics. Larger organisations with centralised administrative processes in place sometimes fail to recognise the importance of this communication and view GPs performing merely an administrative function, for example, by providing a Mental Health Care Plan for the patient so that the psychologist seeing the patient has access to MBS rebates. Medicare has this process in place to direct clinical handover for patients with mental illness. There seems to be a trend within commissioned services to prefer to waive the need for mental health care plans or clinical handover and allow patients self-refer so as to avoid the trouble of communicating with the GP.

39. Self-referral to specific services is important to ensure access to those people who are not comfortable with talking to their GP. However encouraging self-referral when the patient has an established and often longer term relationship with a GP only seeks to silo and fracture a patients care.

40. The commissioning model also reduces accountability for any issues that the service may have. The Primary Health Network has no responsibility for the quality or standard of care because they have outsourced it to a third party. Similarly, the commissioned organisation is usually on a large contract, providing services to many different communities, so are not concerned if the service is not well accessed in one particular community.

Provision of mental health services in Mallacoota

41. After we lost our visiting psychologist due to commissioning, the Medical Centre made efforts to bring on the ground, mental health professionals back into Mallacoota. I started taking a list of people who needed or requested services, or who I believed had a diagnosis or were in need of psychological intervention. This is best practice for mental illness. I have also kept this kind of list since the bushfires in early 2020.

42. We now have a local health charity that was formed out of our need to improve the viability of the general practice which was suffering market failure and the ongoing challenges presented by the Primary Health Network. It took us two years, but we managed to gain a grant with philanthropic funds from the Foundation of Regional and Remote Renewal through our local charity and we used that funding to engage two mental health professionals who now visit Mallacoota and work closely with GPs. We started that service 18 months ago and it has been the single biggest intervention in mental health during my time here, and has seen improvement in the mental health of our community, especially in the prevention of recurrent presentation of partially treated mental illness. Following the bushfires we were able to double this service to immediately meet the need for increased presentations by employing a third visiting psychologist.

43. However, funding runs out in September for our local mental health service. This means that there is a risk that the service ends in September as we are dependent on philanthropy to keep it running.

44. In my view, if you want to provide any sort of primary health care, you need to actually have clinicians on the ground to do it. If you don't have a clinician visiting in the town, you don't have the service; it simply doesn't exist as far as our community is concerned.

Application of the stepped care model in remote areas

45. Stepped care is not a solution that works for remote areas. Sometimes, the primary health network may get funding for stepped care and use that funding to roll out a program that involves group services across the board. This program may or may not make its way out to Mallacoota, because we are a small town. In other areas, stepped care might be effective to reduce costs, as the provider can reduce the amount of time a psychologist is in the area and then try to bring in a visiting service, but that doesn't work in remote areas like Mallacoota. You need to put the clinicians on the ground, let them build relationships in the community and then at that point, they can provide stepped care within the community.

46. For example, once the clinician has a relationship with the community, you can use that clinician psychologist to see one person an hour or you can get them to see five people an hour, but you still need the psychologist in the first place to do that. Our psychologists, however, are already over-subscribed. Whilst they still have a waiting list stepped care will not be an effective solution.

Supports needed to sustain small or sole GP practices

47. To provide appropriate support, commissioned services have to focus on an overarching good clinical government structure. In my experience, Primary Health Networks often try to use substitution as a means to provide services in remote towns; for example, where they cannot recruit doctors they fill the position with a nurse. This approach does not come from a framework of strong clinical governance. It is looking at easy, quick solutions and substitutions for services. However, asking a person to work outside the scope of their practice is not effective and can be unsafe for patients.

48. I think the important thing for health agencies to understand is that if you support GPs and doctors with a broad scope of practice, and you support the viability of private general practices in small communities, then you are supporting a breadth of treatments in the community. As mentioned above, GPs are gap-fillers and can be podiatrists, paramedics and psychologists.

49. Another advantage to supporting private general practices is that the practice will have strong clinical governance. Clinicians have within their professional ethos the need to ensure that people have access to services as well as ensuring that those people are safe. A practice will generally be run by a clinician who is invested in the service and has high levels of qualifications, such as a post graduate qualification in rural general practice.

Supporting GPs to deliver mental health care

50. We currently have access to mental health webinars, training and remote training. However, in my experience, the most benefit to GPs comes through working alongside mental health professionals.

51. One way to up-skill remote GPs is by sharing or case managing patients, or working closely with skilled clinicians. In my own career, I have experienced the most benefit when I have a particular health professional who is willing to let me call them and ask questions, share patients with me, communicate carefully and provide some clinical handover. Clinical handover is the communication of a patient's care needs from one clinician to another and can be in the form of a phone call, a confidential letter or a discharge summary. Each one of those clinical handovers is a learning opportunity that then improves your confidence in your ability to provide that particular service.

52. Clinical handover is also important in supporting GPs. If I refer a patient to a psychologist or psychiatrist then I need them to provide a clinical handover which is usually in the form of a phone call or a referral letter. Clinical feedback is a two-way street and I also need to receive a handover back from the psychologist or psychiatrist. The letter or communication that we receive helps to improve our understanding and helps us to learn for the next patient we see. Handover is part of our clinical duty and is something that will be done by good clinicians. Having clinicians providing services in close contact with their referring GP and who are willing to develop continuity of care with me, makes a significant difference to the care I am able to provide, and ultimately the patient's outcomes.

53. If you have someone working outside of their scope because there is no one else to fill their position, they are less likely to provide good handover as they're not working as confidently in their field. I am fortunate because I have a good relationship with our case manager in Orbost. He makes sure if he is involved with a patient and psychiatrist, he will send me their notes (even if they're handwritten) or will get me some information.

54. I have noticed on-the-spot learning opportunities now that we have a clinical psychologist who visits and we can have discussions about patients. This kind of connection, when clinicians are providing services in close contact with referral agencies and GPs, improves the quality of service. A GP's understanding is also improved by contact with case

managers and specialists, because general practice is very much behind a door and one on one.

55. I was recently on a panel for a webinar in the Black Dog Institute.[2] The webinar was clear that the role of the GP in providing mental health care is to ensure effective collaboration between everybody. For example, a GP should be monitoring patients and following up to ensure that they get their effective support and assessment and treatment, but that role in remote communities is very difficult. The best support for us is in having referral pathways, having access to clinicians and having somewhere for our patients with mental illness to get support and treatment. There is a huge psychological strain on local service providers because they presently have nowhere to send patients that need support.

Consumer experiences

Improving the ability of consumers to identify and navigate to appropriate mental health services

56. I personally find it impossible to navigate mental health services. I am a health professional with an interest in mental health - I cannot imagine what it is like for a consumer. I currently have 6 to 12 patients who I can't link in with an appropriate mental health service. For example, I currently have a patient with complex PTSD who has just been through a bushfire. How do I identify a good provider who is willing to provide long term care, who has trauma experience and who will keep my patient safe? Where do I start? If I do not have a relationship with an appropriate clinician with that skillset then I have limited options. As a GP, it is not enough for me to just tell my client to make some phone calls.

57. A locally focused pathway closely linked to a GP Practice is the best mechanism to help develop a navigable mental health system. It is incumbent on each service provider to make available to local GPs information about their services, the cost, wait times, details of practitioners. In a small community, the GP practice is generally the first port of call. People come here when they're a baby and they have an ear infection, when they're a teenager and when they're an adult. I often find that consumers come to us at the GP clinic and ask us to navigate the mental health system for them. They say something like "I need some help and I need a trusted person to help me get started".

58. For patients with low grade problems, websites can be useful. However, if a patient takes an online cognitive behavioural therapy course, they need to be supervised and followed up with to determine whether they are stable, improved or need increased treatment.

[2] The panel also consisted of Dr Jan Orman, Jane Nursey, Nicole Sadler and Janette Cook and a recording can be accessed at: https://medcast.com.au/courses/305.

59. Patients also need to be supported in accessing telehealth. For example, our usual psychologists are currently doing more telehealth with their clients that they have already met and spoken to face to face. However, we have terrible internet in Mallacoota, so we have to make sure that we provide IT platforms for our clients. We are constantly looking for solutions within the practice so that we can maintain our telehealth services.

Unmet, rather than unnecessary demand for mental health services in remote communities

60. We do not have an issue with unnecessary demand in Mallacoota and remote communities; there is more likely to be unmet need rather than unnecessary demand. In remote communities, if you are not sick, you do not come to the doctor as there is not a culture of “worried well” accessing health services. When we started providing a mental health service, we discovered that the depth and severity of mental health issues in the community were greater than even I anticipated, even after working closely with the community for a decade.

61. Specifically, we realised that there was a whole section of the community who had suffered significant trauma and who had not been treated because there had been limited services in town. It may be the case that Mallacoota attracts people with a history of trauma because it is remote and peaceful. Often people present to us with anxiety or personality issues, but actually what they’re dealing with is a significant trauma they have suffered previously. In those circumstances, the only people that can provide adequate mental health care are long term face to face mental health care providers of care for the community – trauma cannot be resolved in the short term. Care does not necessarily need to be regular for years, but to be available at times when patients are in crisis or at a point where they are able to engage in treatment.

Nature and impact of trauma following the bushfires in Mallacoota in early 2020

Responding to people in crisis

62. The best way to respond to crisis is to bolster current, local services.[3] This is the best practice recommendation for post natural-disaster care. In an early response to crisis, there should be an environmental scan of what services are already available on the ground. From this, we can educate all the local service providers in what they may need to provide appropriate services and then ask them how we can support their services. Of course, there are strengths and weaknesses in every community in the way that health is

[3] See Phoenix Australia, Centre for Posttraumatic Mental Health, *Australian Guidelines for the Treatment of Acute Stress Disorder & Posttraumatic Stress Disorder* (2013) 163-4.

provided. However, if you have a service already provided in town, the problem is solved if you support that service as you are building on a service that already works well.

63. For example, in the first six weeks after the bushfires, I kept the name and requirements of every person who had presented to the practice with trauma or anxiety or increased alcohol use or emerging PTSD to make sure that they could gain access to an appropriate service. If any agency wanted to make sure that people were accessing services they could provide funding to the Medical Centre and I could get the right clinician or service to meet the needs of the presenting patients. I was able to do that to a small degree with donated funds, but they will run out.

64. The most important part of responding to crisis is getting clinicians on the ground. In our experience with the bushfires, we found that the most useful people in this crisis, in terms of mental health services, were qualified clinicians. Case managers were very useful as they could do psychological first aid to ensure a person's basic needs were met so they could be helped with their mental health. But the most useful people were qualified clinicians because they have the skills to recognise normal or abnormal responses to trauma, practice a range of psychological modalities, and ensure adequate follow up.

65. In regards to the bushfire response, the majority of bushfire relief funding for mental health went to the Primary Health Network. The Primary Health Network took the view that they had to commission funds to cover the whole of East Gippsland. They commissioned Relationships Australia to provide mental health services into Mallacoota for the past three months. They also gave some money to headspace, but headspace is three hours' drive away from Mallacoota.

66. Relationships Australia was able to find a psychologist full-time to support Mallacoota, but they do not work out of our location. As a GP, if someone comes in to see me with a mental health issue, they walk out with a plan and if needed, an appointment time with a mental health professional. If an appointment is not immediately available, we have their details and we keep them on our waiting list until we can make them an appointment.

67. However, after gaining access to this full time psychologist, at first we were told that we could not make appointments for patients and were instead told to give them a phone number for a triage service in Traralgon. It took a while to convince them that we were the ones who needed to make the call. Otherwise, they were simply taking all the triage information that I had already taken in my role. If you have a local psychologist who people call all the time saying "*I need this service*", you're best placed to do the triage and then you just need to give that person the detail of the referral pathways.

68. I wrote a proposal for what mental health services would be needed in Mallacoota following the bushfires and how it would bolster local services and interact with what is

currently available. The proposal was based on my experience and knowledge of the current and emerging health needs in Mallacoota. As part of it, I recommended that we increase the local psychology workforce by 2 FTE for two to three years to manage the projected healthcare needs of the community. This would require the recruitment of clinical psychologists with trauma experience, either on a permanent or fly in fly out basis. I also recommended that the teen clinic (as discussed at paragraph 14) nurse availability be increased to 1 FTE. We had the capacity to increase this immediately, depending on funding. I also recommended that we commence a permanent local social work service and permanent youth worker service in Mallacoota. A copy of this proposal is attached at Attachment SRL-2.

The experience of trauma for people who have experienced emergencies or disasters

69. I can only provide a snapshot of the community's experience because we are in the early days in terms of the trauma from the bushfires, and the impact of COVID-19 will also be felt by the community.

70. From my research and speaking to other people, the experience of trauma in Mallacoota has not been different to other big traumatic events. There is evidence that if you traumatise 1000 people in a big traumatic event, the rates of significant PTSD are going to be between 15 to 25%.[4] Approximately 120 people will need interventions to prevent them from developing longer standing PTSD. We know that 50 to 60% of people will suffer from nightmares and hypervigilance and cognitive problems, all common symptoms of trauma in the first four to six weeks. That was evident in Mallacoota. Anger, irritability, an increase in domestic violence and an increase with alcohol abuse are also all recognised to have a greater incidence following traumatic events in the community. Again, this has not been any different in Mallacoota.

Progression of mental health issues following a traumatic event

71. One thing that I did notice in the wake of the bushfire crisis is that people with treated mental illness actually did quite well. They did not come to the clinic straight away; I suspect because they had an understanding and a previous relationship with a mental health provider so could easily check in with their psychologist and make sure they were developing appropriate strategies.

72. We also found that people with untreated mental illness – who were not engaged in treatment, or had not wanted treatment even though it had been suggested to them – came forward quickly requesting services. A lot of those people had been self-managing

[4] See Phoenix Australia, Centre for Posttraumatic Mental Health, *Australian Guidelines for the Treatment of Acute Stress Disorder & Posttraumatic Stress Disorder* (2013) 27.

anxiety and depression and found themselves unable to do so in the wake of the bushfires.

73. In my experience, four to six weeks after the event is when nightmares and ongoing effects of trauma can become pathological, and those people do begin to need intervention. At that point, we found that we needed to ramp up our long-term psychology service. I believe that someone with emerging PTSD symptoms needs access to long-term support, at least for six months or longer. This is necessary to continue over the next six months to bring the number of 25% of people in the community with PTSD following traumatic events down to 10%. This requires a clinician who can see them regularly and develop strategies for them. For that to happen, the clinician has to be somebody they know and trust and are willing to go and see, with skills in psychological first aid and long-term trauma. We anticipate that we will need to increase our local psychology work force for two to three years to appropriately manage the long-term trauma experienced in our community.

74. In Mallacoota, we are beginning to see more serious mental health issues come to the fore. I am now seeing people with reactivated serious mental illness; for example, people with previous psychosis or long histories of PTSD who are now re-traumatised. Three months after the bushfires, these people are requiring services. We also anticipate that depression will present six to 12 months after a traumatic event.

75. We are also dealing with the issue of disruption and displacement, I have patients all over the place, that is, they are not in Mallacoota. I have one woman who is psychotic who has fled to NSW. Another man with severe PTSD has gone to live with his son in Sydney. It is obviously harder to manage patients when they are not in town.

76. One particular issue is that I have patients who are not unwell enough to be admitted into an acute psychiatric hospital. Hospital admissions should be a last resort as they are incredibly traumatic. However, the only way I can get someone into the acute system so they have a mental health case manager and access to a publicly funded psychiatrist is through psych triage and an acute admission. I can’t make referrals directly to the case manager, even if I have someone who is escalating and who I think will end up in hospital if something is not done now.

Workforce capabilities and skills needed to respond to trauma

77. Providing education early after a disaster is really important, to ensure that the people on the ground who are responding to services have appropriate skills and knowledge. Educating people where they are providing services is very effective, as well as giving those people access to clinicians who know their stuff, like psychiatrists and psychologists, and even mental health trained social workers. In-house, high quality

training in workplaces makes a big difference: it's a six hour round trip to Bairnsdale to access training otherwise and most of the health practitioners in town are already tight on time and commitments.

78. In Mallacoota, we contacted Rob Gordon, an expert in disaster psychology. Luckily for us, our bushfire recovery people funded him to come to town. He came twice, once for 24 to 48 hours and then again for about two or three days. That was great because he was really knowledgeable and provided education to the community. I did a couple of webinars and group education with psychologists for my staff. He gave talks to the school community, teachers, health professionals, the community health service up the road; everyone got a couple of hours of his time. He also led community discussions which were useful.

79. Importantly, I think that support to communities who have experienced crisis needs to be ongoing. Whilst we were still in disaster area, we were inundated with people flying in, wanting to find out how they could provide services. All the different agencies bought people in, so I would have met a different psychologist every two days in January. But during that time, we were too busy working and providing services to tell them what to do and we did not fully utilise them. Instead, the most important thing when providing a health service in a remote community, particularly any visiting health service, is to be regular and always turn up. For example, if a service says that it will come on every second Wednesday of the month, people will turn up. Providing a service regularly is far more effective than providing a service twice.

80. Training people in psychological first aid should also be a priority. For example, rather than bringing Red Cross volunteers into Mallacoota, we could train people on the ground who already have some base levels of skills in mental health care or general health care and teach them psychological first aid. This will help to build confidence so that those people can then provide psychological first aid without feeling terrified. After the fires, the first thing that happened was everyone looked at each other and said "*We're not prepared, how do we deal with other people's distress*".

81. I would also suggest ensuring that local people providing services have access to supervision and someone who will follow up with them over the long term. Most psychologists are required to have some sort of supervision which ensures that the psychologist is getting some sort of psychological care themselves. When responding to crisis, I think access to supervision should be extended to whoever is providing psychological first aid: GPs, local nurses, emergency health services, and even to the school principal and leaders within the school. Supporting these people by educating them about their own needs and mental health and trauma helps them to provide better services within the community. It also helps to protect the wellbeing and safety of persons operating in disaster-response roles. This is particularly important when the person

providing psychological first aid is in a position of authority, as they are less likely to access help for themselves.

82. We need to cast a wide net to ensure that everyone who is being trained in and providing psychological first aid has access to supervision. There needs to be clinical governance over who provides services to the community to ensure that services that are being provided are safe.

sign here ►

print name Dr Sara Renwick-Lau

date 19/05/2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT SRL-1

This is the attachment marked 'SRL-1' referred to in the witness statement of Dr Sara Renwick-Lau dated 19/05/2020.

Dr Sara Renwick-Lau (MBBS, FRACGP) CV

Clinical work experience

May 2008 to present *Mallacoota, Vic*

General Practice and Practice Principle, Mallacoota Medical Centre

- General remote GP duties
- Practice management and duties associated with practice ownership
- AGPAL accreditation and quality improvement
- Ultrasound use registration
- Mixture of primary health care and emergency medicin
- Education and training - GP Registrars and Medical Students (John Flynn Program)
- Clinical governance role for Mallacoota Community Health Infrastructure and Resilience (registered local not-for-profit charity)

Jan 2015 to present *Melbourne, Vic*

Field Emergency Medical Officer, St Vincent's Hospital

- State Health funded disaster response position as part of the FEMO program
- Respond to local disaster in co-ordination with State Health Emergency Response Plan

Dec 2007 to 2014 *Various locations Vic and NT*

General Practice Locum

- Provided locum relief to rural and remote general practices in Victoria and Northern Territory
- Clinical experience in working as a VMO in a small rural hospital.
- General rural and remote GP duties

Jan 2006 to April 2007 *Jabiru, NT*

General Practice Registrar, Kakadu Health Service

- General Practice training Advanced Rural Skills Post in Aboriginal Health and Small Town General Practice
- Disaster management planning for Kakadu and Jabiru Health Services, including planning of and participation in disaster scenarios, in collaboration with local emergency services, following cyclone and flooding natural disasters.
- Mixture of primary health care and emergency medicine
- Occupational health experience at Ranger Uranium Mine
- Team environment supporting RNs, Aboriginal Health Workers and Allied Health Workers
- Teaching at regular staff in services

Jan 2005 to Jan 2006 *Galiwin'ku, NT*

General Practice Registrar, Ngalkanbuy Health Service

- Advanced and Subsequent GP Registrar training terms
- Working as solo GP in remote indigenous community
- Full breadth of primary health care, emergency medicine including aeromedical evacuation of patients requiring hospitalisation
- Some public health duties

- Involvement in conducting staff in services
- Working alongside RNs and Aboriginal Health Workers

July 2004 to Jan 2005 *Darwin, NT*

Resident Medical Officer, Royal Darwin Hospital

- Emergency Department resident duties
- Intensive Care Unit resident duties

Jan 2004 to Jul 2004 *Humpty Doo, NT*

General Practice Registrar, Fred's Pass Medical Centre

- General Practice training basic term
- Rural General Practice

Jan 2002 to Jan 2004 *Darwin, NT*

Resident Medical Officer, Royal Darwin Hospital

- Resident duties in Surgery, Medicine, Paediatrics, Emergency Medicine and Obstetrics and Gynaecology
- Member of emergency medical staff for triage and stabilisation of all "Bali bombing" victims received at the Royal Darwin Hospital Sep 2003

Medical Educator Work Experience

Jan 2006 to Apr 2007 *Darwin, NT*

Medical Educator, Northern Territory General Practice Education

- Medical educator for Pre-vocational GP Program
- Mentoring and teaching junior doctors placed in rural and remote general practice in the Northern Territory
- Developing curriculum for junior doctors

Education

Jan 2009 *Various locations, NT*

Fellowship Royal College General Practitioners, Northern Territory General Practice Education

- Examination passed 2008
- GP training in rural and remote general practice

2001 *Melbourne, Vic*

Bachelor of Medicine, Bachelor of Surgery, University of Melbourne

- Studied at Royal Melbourne Hospital Clinical school
- Clinical attachment in General Practice in rural victoria, Orbost and Wonthaggi

Extracurricular activities

Clinical Training Committee, Royal Darwin Hospital
Attendance at National Prevocational Training Forum 2003, 2004 and 2006

Plenary speaker
RACGP Annual Scientific Convention 2005

Plenary speaker
National Prevocational Education Forum 2006

Board Director Top End Division of General Practice
GP Registrar Director Sep 2005 to Sep 2007

Board Director East Gippsland Division of General Practice
Director Jun 2009 to 2014

Paper presentations at ACRRM and Rural Health Network annual conferences
"Community engagement in rural health services"

Lecturer Monash University
Annual lecture - Introduction to rural health for 1st year Medical Students

Radio Health Presentation
Weekly program on local 3MGB radio "Doctors hour"

Courses

- Implanon insertion Training 2002
- Yolngu Culture and Society – Charles Darwin University, Yolngu language subject semesters 1 and 2 2002
- Various GP training and CPD events held in Darwin over 2003 to 2007
- Advanced Life Support – accredited course Jan 2005
- Program in Experience of Palliative Approach – 1 week Palliative Care placement Oct 2005
- Star Board Training - 2 day workshop to improve skills as board director Jul 2006
- RATE – Remote Area Trauma and Emergency course – 1 day in service Aug 2006
- Clinical emergency Management Program (intermediate)– run by RACGP in Melbourne 2009, 2011
- REST – Rural Emergency Skills Training Program – run by RWAV in Melbourne 2009
- Radiography Training Course – Monash University in Melbourne 2009
- EM Core – Cardiology Training – Sydney 2012
- East Victorian GP Training, Supervisor Modules 2018
- Culture, Indigeneity and the Determinants of Health - Menzies School of Health Research, 3 day course in public health subject
- Building Capacity in Indigenous Communities – Aboriginal Resource Development Service, 2 day course

Conferences

- EM Core, Emergency training conference, Melbourne 2013
- High Risk Emergency Medicine Conference, University of California, Hawaii 2014

ATTACHMENT SRL-2

This is the attachment marked 'SRL-2' referred to in the witness statement of Dr Sara Renwick-Lau dated 19/05/2020.

Mental Health Services for Mallacoota District and Cann River affected by Bushfire

Dr Sara Renwick-Lau MBBS, FRACGP
Practice Principal
Mallacoota Medical Centre
Mallacoota, Victoria

Background

On December 31st 2019, a bushfire so large that it moved as a large pyrocumulus firestorm with a 30km firefront, descended on the town of Mallacoota during the tourist town's busiest week of the year. After daybreak, the morning sky turned to blackest night and the sky glowed red as the fire front reached the town. At this time, over 1500 residents and 3000+ visitors experienced direct threat to their property and to their lives. Some residents sheltered and/or defended their homes, the majority sought shelter in the crowded and stifling community hall or outdoors at the edge of the lake or on the beach.

Over 120 properties in the town were lost in the fire and a further 50 were damaged, the devastation became evident at the same time as thick smoke blanketed the town. This prompted hundreds of people to present for medical attention at the Mallacoota Medical Centre. Urgent medical needs, evacuation triage and acute exacerbations of mental health conditions became the mainstay of presentations to the practice.

In the coming week, the majority of the thousands were then slowly evacuated by the Australian Defence Force ships, planes and helicopters. Local residents who had evacuated before and after the fires were displaced from Mallacoota for over 3 weeks.

Meanwhile in Cann River and surrounding areas, there was protracted direct fire threat to life and property. As fires moved through the area, all resources were severely limited, due to poor road access to the town and its surrounding locales, which increased the threat to this remote population.

Following the Mallacoota fire event, normal reactions to trauma, loss and disruption are evident within the community, anecdotally and within medical center presentations.

Long-term formal mental health services are immediately required to meet the needs of those people whose symptoms are progressing beyond these normal responses.

Failure to respond to the current and emerging mental health needs of the Mallacoota and Cann River communities following this major bushfire event will have long term implications on the town's ability to recover. The ramifications of poor mental health outcomes in these small isolated communities, are the degradation of personal and social lives and loss of productivity and ability to work and other social problems. There is significant evidence gathered already as to the economic impacts of mental illness in Australian communities.

The Mallacoota Medical Centre Mental Health Program

Psychology services

The Mallacoota Medical Centre established a Mental Health Program at the end of 2018. It operates under the clinical governance of the Mallacoota Medical Centre GP principal and is auspiced by the registered charity Mallacoota Community Health Resilience Infrastructure Fund (CHIRF) and with the assistance of the Foundation for Regional Remote Renewal (FRRR).

The General Practitioners at the Mallacoota Medical Centre have completed Mental Health Care training and can provide counselling, diagnosis and treatment for mental health conditions and use the presentation of patients for acute and chronic conditions for opportunistic mental health screening and referral to services.

Income to the service is generated through MBS mental health item billing. All bulk-billing eligible services are provided to the patient with no out of pocket cost and at the end of available MBS services care is provided pro-bono on an as needs basis for vulnerable individuals.

FRRR funding provides a salary to the psychologist/mental health worker, tax effectively through the local health charity CHIRF – this funds travel, accommodation and administration costs of the program. The program runs in a very cost efficient manner which results in a 12% administration fee (as a percentage of health professional salaries).

Teen Clinic is an adolescent, general and mental health service that is embedded within the Mallacoota Medical Centre. It is a free, nurse-led service that is supported by the Medical Centre GPs and the Mental Health Program. Gippsland Primary Health Network (GPHN) funds training and employment of (0.2 FTE) Teen Clinic nurses.

The Mallacoota Medical Centre Mental Health Program and Teen Clinic, provide a referral pathway for mental health services and education to the Mallacoota P-12 College through an established relationship with the school leadership and health/wellbeing staff. It is well accessed by young people in Mallacoota.

Shared Care

- The GPs and psychologist at MMC provide shared care with a nearby regional health service.
- MMC also facilitate telehealth services with distant private and public specialist psychiatric services and private, commissioned and non-commissioned psychology services.

Current Staffing

- 2 resident GPs with mental health skills training 2 FTE
- Clinical psychologist with broad experience including trauma 0.15 FTE (travel time 2 hours from Bega region)

- Social worker with mental health training and child and adolescent experience
- 0.2 FTE (travel time 2 hours from Bega region)
- 2 resident practice nurses with basic mental health skills (Teen Clinic) at 0.2 FTE

Current External Mental Health Care Services

- Nearby regional health service – case management is provided through a fortnightly visiting service from Orbost (travel time 2 hours) for patients following acute psychiatric admissions (currently 3 to 4 clients). Ongoing psychiatry is accessed via telehealth as needed and arranged by LRH service and facilitated by the Mallacoota Medical Centre
- Mental health for aged persons – case management provided through a fortnightly visiting service to Cann River from Bairnsdale (travel time 2 hours) and Mallacoota service provided mainly via telehealth. (Currently 1-2 clients)
- Distant private psychologists in Canberra or Melbourne (4 and 6 hrs travel respectively) – about 10 referrals/year to distant psychologists, utilising a combination of face-to-face and telehealth, about half of these telehealth appointments are facilitated by the Mallacoota Medical Centre.
- A private mental health service are commissioned by the GPHN to provide telehealth psychological services to patients in Mallacoota. No data held by MMC as it is a self-referred service. Despite the longevity of this commissioning, the service has limited acceptability by patients and low uptake. It is not suitable for patients with moderate to severe mental illness.
- A local health service are commissioned by the GPHN to provide a counsellor. No data held by MMC as it is a self-referred service.

Prior to the bushfire event there were no other visiting or resident mental health care providers in Mallacoota, including mental health social workers, relationship counselling services, child and youth counsellors and other counsellors. There is occasional sporadic brief, visiting education from various government and non-government organisations focusing on mild mental health problems.

Despite having the population to maintain greater (partially) supported services, the lack of service infrastructure in the town has resulted in the inability for funding models to adapt to the needs of these remote communities. Many people travel 4 to 6 hour round trips by road to access services not available, unless a local service is resourced and motivated to provide it.

Pre-bushfire Mental Health Service need

- Psychological services provided in the 12 months prior - 40 GP referred adult patients and a further 12 adolescents.
- As of 31st December 2019 there were 50 patients with a current mental health care plan

- 20 patients were on the waiting list for access to psychological services at 31 December 2019
- Active patient population of the Mallacoota Medical Centre is 1200-2000

The Victorian population average for distribution of psychologist is 100 per 100K population. The current access to local psychology services is 0.35 FTE well below the required level for this patient population. This is reflected in the waiting list for those in immediate need of psychological services.

Patient preference for psychological care is face-to-face with a familiar local service provider. The current model has a 95% uptake of referrals with minimal no-shows due to no out of pocket expenses and careful follow up of patients. The expectation is of careful clinical handover with resident and distant mental health services for all patients of the service. The GP practice that runs the program has a role in coordinating and following up all mental health presentations which increases the safety and accessibility of the service and is the expected role of GPs for mental health care.

Post bushfire

Projected mental health care needs

General patient population

Current active/treated mental health illness (pre-bushfire see above)	50	
Current active mental health illness Cann River		50
50% mental illness undiagnosed/untreated (ref. Black Dog Institute)	50	
Rates of PTSD following a life-threatening event – 10-30%	240	
Population projected that will meet the criteria for (and require)		
intensive psychological intervention	390	

Children and families

In regards to psychological care of children for those children present during the fire threat 95% will develop symptoms and signs of PTSD (reference Rob Gordon).

Child and family statistics in regards to homes lost and those children who experienced or perceived a direct threat to their life in the Mallacoota event, gives an estimate that at least **50 local families** are affected.

Timing of presentations

- There are currently 30 patients on a waiting list for psychology services who require immediate access to medium or long term care.
- The Medical Centre is generating 2 referrals every day (as of 26/1/20) - mostly patients with pre-existing untreated mental illness who meet criteria for intensive psychological intervention and will likely require medium-long term care.
- Post-Traumatic Stress Disorder – diagnoses will begin to present and require treatment from 4 weeks post event (ie from 1/2/20).
- Depression – typically presents 6 to 12 months following a traumatic event (reference Rob Gordon).

RECOMMENDATIONS

Support expansion of current Mental Health Program

1. **Increase local psychology workforce by 2 FTE (for 2 to 3 years)**
    - **Requires recruitment of clinical psychologists with trauma experience to the town to provide focused psychological strategies, immediate and long-term funding**
    - **Fly in fly out will be more expensive but easier to source workforce, local permanent position is more cost effective but more difficult to source**
    - **At least 1 male clinical psychologist to meet needs in the community**
2. **Increase Teen Clinic nurse availability to 1 FTE**
    - **There is local workforce capacity to increase this immediately, pending funding**
3. **Commence a permanent local social work service in Mallacoota.**
4. **Commence a permanent youth worker service in Mallacoota.**

Other future complimentary services

- *ThisWayUp* – patients of the Mallacoota Medical Centre Mental Health Program are eligible for free access to this online program – Mallacoota Medical Centre GPs are able to refer patients who would prefer to access online CBT, to access this service for free (usually $60)
- Education and group treatments – these can be provided by the mental health program to the community and the school as required
- Stepped care - group and education can be provided by visiting/permanent psychology workforce

<u>Service Delivery planning</u>

The Medical Centre has demonstrated its ability to capture mental health presentations that require more intensive intervention and assist with active follow-up and logistics to

ensure patients can navigate and access local and distant mental health care. The current Program aims to provide education and group sessions for lower level mental health care of residents and support to the local school. The question is whether health funding agencies can recognise and support a small, local, but successful service for commissioning or joint funding.

The Mallacoota Medical Centre and the Community Health Infrastructure and Resilience Fund are actively recruiting two full time psychologists for a two year contract. This will be an extension of the currently existing Mental Health Program which is currently funded by the FRRR. Seed funding will be provided by donations to CHIRF, and ongoing funding will be sought from all health agencies and philanthropic organisations.

The Mallacoota Doctor Search have demonstrated their ability to recruit permanent health professionals to Mallacoota and may be utilised to ensure recruitment of appropriate mental health professionals. CHIRF auspiced programs have increased local Mallacoota health workforce over the past 12 months to include a further 3 registered nurses, an allied health assistant and a dietician. Prior to this, in 2018 the Mallacoota Doctor Search was able to source a second permanent GP to the town in a very competitive recruitment environment.

NB - this document was produced in Feb 2020. At April 2020 - based on current presentations and anecdotal evidence from locals these predicted numbers are likely to be an under-estimation of need.

Lack of communication and coordination of mental health services from government funded online/web based counselling, phone counselling services and commissioned services has hampered a local and coordinated approach and the biggest risk currently is an “overload” of various non face-to-face services. COVID-19 is limiting access to local face-to-face services now and also likely increasing the demand for mental health services, while decreasing access.

Patients still prefer to be referred via their trusted GP source and the in-house mental health service allows for careful handover and follow up.