ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Maryborough Community Hub,
48 Burns Street, Maryborough,
Victoria

On Monday, 15 July 2019 at 10.00am

(Day 10)

Before: Ms Penny Armytage (Chair)
Professor Allan Fels AO
Dr Alex Cockram
Professor Bernadette McSherry

Counsel Assisting:
Ms Lisa Nichols QC
Ms Georgina Coghlan
Ms Fiona Batten

CHAIR: Thank you for joining us in Maryborough for the 10th day of our public hearings. I am Penny Armytage, the Chair of the Royal Commission into Victoria's Mental Health System. I am joined by my fellow Commissioners, Professor Allan Fels, Alex Cockram and Professor Bernadette McSherry.

On behalf of the Commission, I acknowledge the traditional owners of the land on which we meet, the Dja Dja Wurrung people. I also pay respect to their Elders past, present and emerging, and I also extend my welcome to those Elders joining us here today.

We are delighted to be back in rural Victoria and before proceedings resume I want to speak briefly about what we have heard and our aspirations. By the end of this year around 20 per cent of Victorians, more than 1.2 million people, will have experienced a mental health problem. Indeed, nearly half of us will have experienced a mental health challenge in our lifetime. Think for a moment what those numbers actually mean.

When it comes to our loved ones, this is a 50/50 chance they will have a mental health problem of some kind during their life, and nearly half of the people living in towns just like this one will experience difficulties with their mental health.

We know that there is enormous variation in people's experiences of mental health, the causes of mental health problems, the cultures of communities and the delivery of services and support. Nevertheless we are all entitled to live fulfilling lives, contributing in our communities and having access to the support services we want and need.

No matter who you are and where you live, this aspiration is something my fellow Commissioners and I hold a deep commitment to achieving for all Victorians.

Listening to people in rural communities is central to this vision. Rural Victorians are a significant part of our state's identity and contribute to who we are and our way of life. One in four Victorians live in rural and regional Victoria, on farms and in small towns and big cities. Each of these communities have their own identity, their own view about what's important, what challenges they face and their own aspirations for the future.

A commonality that we do see running through rural towns is a commitment to community participation and leadership. Whether it's volunteering through Rotary clubs, the SES, or CFA, assisting people to join in community events or participating in community groups, community spirit continues to be a hallmark of rural Victoria.

We have seen the formidable power of rural communities to effect change and withstand hardship through local ideas and actions. Participation in community groups has been shown to be a key factor in establishing and maintaining healthy and resilient communities.

To provide just one important example, in the aftermath of Black Saturday bushfires, research suggests that close friends and family, social networks and community groups were important influences on resilience and recovery.

We have all a lot to learn from the strength and generosity displayed by rural communities in times of crisis but also over generations as communities connect and demonstrate resilience.

During our work for this Royal Commission we have been told of some truly inspiring examples of community connectedness. We have heard from farmers that use phone trees and regular catch-ups to check in on each other - how something as simple as a phone call is providing much needed support and how, as one person put it, "The grape vine works in wonderful ways."

We have also heard how volunteers in remote parts of the state have established local support groups to help each other through difficult times, giving people a sense of hope and reassurance about the future.

Yesterday here in Maryborough at the local health service we heard how the community comes together to drive local solutions for people living with mental health conditions by pulling together, be it at the school, the police, the council, rotary, the health service, there is an acknowledgment that individuals and communities will always do better when we work together.

And, despite the immediacy of some of the challenges

and the joint focus required to support people in a crisis, this is a town that has created the space to reach out to the Royal Commission with its vision for a better mental health system.

It has been our privilege to meet with people from this community and to be welcomed in many other areas across the state. So far, we have spoken with more than 1,600 people in 21 locations, the majority of those in Rural and Regional Victoria.

We have heard from 45 out of our 90 witnesses at our public hearings, many of whom travelled to be there. We have received thousands of informal comments and submissions from every corner of the state.

The community's interest in the Royal Commission is extraordinary. The level of public discourse about mental health issues in recent weeks is indicative of the palpable desire our community has for change. We are hopeful that this interest will continue to gain momentum in recognition that a collective effort involving every Victorian will be required to address stigma and champion reform.

In our interactions with the community, the Commissioners and I have been deeply affected by people's courage and their willingness to share their experiences. We have seen their strength as they've shared often painful stories so that others might avoid treading a similar path.

We have also witnessed the selflessness of families and carers and the passion of the workers doing their best in an overwhelmed system.

But on numerous occasions people have described tragic and difficult events that bring along what many people referred to as "a broken mental health system".

When it comes to rural areas in particular, people have spoken about the tyranny of distance and the myriad inequities they face when trying to gain access to mental health services.

One person characterised the disparities in access as "a lottery of rural communities", others spoke of different realities. To name a few, we heard last week at our hearings of a mother's desperate desperation to receive

care for her daughter. She packed up half her home, quit her job and moved to Melbourne for an extended period in an attempt to receive care.

The impacts of having to travel great distances to receive care and the isolation that comes from being away from family, friends and support networks. The high cost of waiting for care, waiting to be transferred to another health service and how this exacerbates a crisis.

About the vastly different experiences people have had in the public and private systems and how access to a range of services was possible, if you could afford it, or if you could afford to travel to Melbourne.

How natural disasters in the farming environment can take their toll and how services and supports are often out of reach because farmers can't be away from their land.

The challenges people in the border towns face falling in between three different service areas: the difficulties Aboriginal Victorians living in rural communities experience when seeking inclusive and culturally safe services; far too many people taking their lives often after unsuccessful attempts to gain help. These are the realities that we must confront.

Although the evidence suggests that the prevalence of mental health conditions is much the same in urban and rural Victoria, the same can not be said of the prevalence of suicide. Australia-wide the suicide rates in rural areas is almost twice that in metropolitan areas. Too often it is farmers, young men, older people and Aboriginal and Torres Strait Islander people who are taking their lives, and they make up a high proportion of our rural populations.

Every suicide is devastating and impactful, however, the fact that people living in rural areas are experiencing such distress that it is culminating in suicide, is something we have to grapple with.

We are acutely aware that some people experience mental health problems in overwhelming isolation, feeling ashamed and helpless. Many have told stories of their reluctance to seek help stems from their embarrassment or fear of judgment. Farmers spoke about the impact of

outdated and misplaced expectations of culture.

One farmer put it eloquently: "Farmers are good at helping each other but we're not good at asking for help."

Too often we hear of mental health problems being associated with weakness. It is the kind of rhetoric that is detrimental to the wellbeing and mental health of our community. It contributes to a wall of stigma that stops many people asking for help.

We have also been told that what is described as the "tough it out" attitude amongst some rural people contributes to many staying quiet. While the culture of small towns, often built on self-sufficiency and self-reliance is a great asset, at times it can restrict frank and open discussion about mental health.

Looking forward, we must work together to harness the strength of close-knit communities and create places where people feel safe and where asking for help is common course, not an admission of failure. We need to explore what lies at the heart of individual experience and work out what can be done to bring about change.

Today the Commission has another opportunity to listen to people who have lived experience of mental health problems and to hear from those who work with them and offer support. It is a chance to reflect on new and innovative approaches and think ambitiously about our future.

We must seize the opportunity afforded by this Royal Commission. It is a once in a lifetime chance to reform mental health services and to realise the hopes of so many.

We are fortunate to have so many people in the community participating in our work. We are conscious of your goodwill and grateful to all who have shared their stories and contributed so generously to our thinking thus far.

We are thankful to all those people who have travelled to Melbourne to be part of our work and those that have travelled to be here today. In particular, on behalf of the Commission, I extend my gratitude and admiration to those who are appearing today as witnesses. It is a

privilege to have the opportunity to hear about your experience and ideas for the future. I'm so pleased that you are all with us today.

With those brief remarks, I now ask Senior Counsel Assisting, Ms Lisa Nichols, to say more about the structure and content of today's hearings.

MS NICHOLS: Thank you, Chair. Today we'll be hearing from six witnesses, three of whom are community witnesses. Maryborough has and is well served by the Maryborough District Health Service, and so our first witness will be the CEO of that service, Mr Terry Welch. He will discuss, among other things, the factors that are challenging in relation to mental well-being and mental ill-health in this community, the multi-faceted services that are delivered through the Maryborough District Health Service, and the challenge of caring for mentally unwell patients, particularly those with serious mental illness.

The second witness will be Mr Alastair Gabb. Mr Gabb's a farmer, and he will tell the Commission of the difficulties that he faced in trying to get help. He will also speak about the particular strength of rural communities.

The Commission will next hear from Trevor and Christine Thomas. Tragically, there have been a number of deaths by suicide in Trevor's Family. Mr Thomas himself has battled against suicide and will speak of his experience with the mental health system.

Mrs Thomas cares for Trevor and she will explain the difficulties of managing the system from a carer's perspective.

Dr Ravi Bhat is the Clinical Director of the Goulburn Valley Area Mental Health Service. He will speak about the services provided in that service, the capacity building that has happened over recent years, the complexity of meeting mental health needs in rural communities, an historical perspective on the mental health system, and what is needed to change and how we can make lasting change that responds to evolving needs.

Dr Alison Kennedy is a researcher at Deakin University and also at the National Centre For Farmer Health. She's

been involved in a number of projects which are intended to understand and reduce stigma, particularly as it is associated with suicide. The projects include The Ripple Effect, and Look Over the Farm Gate.

Dr Kennedy will explain current learnings on suicide prevention strategies.

Finally, the Commission will hear from Dr Gerard Ingham, who has been practising as a rural GP for about 30 years. He will explain his experience of caring for people with mental health issues and the role of a GP in the mental health system in a rural context.

We'll ask a number of questions today through witnesses and we're seeking to explore some of the following themes: what's the prevalence of mental illness in rural communities? Is the risk of mental illness higher in rural communities and, if so, why is that? What are the challenges of delivering high quality mental health care in rural areas? What can be done to better meet the needs of people in relation to mental health care in rural communities? And, in that context, what particular strength of rural communities ought to be paid attention to and incorporated into the systems so that the whole system can be strengthened?

Of course, there are many issues that won't be covered in this session but will feed into later themes in the Commission's work, which include workforce and comorbidity of drug and alcohol issues.

With that, may I call the first witness, Mr Terry Welch.

<**TERRY MICHAEL WELCH, sworn: [10.15am]**

MS NICHOLS: Q. Mr Welch, are you the Chief Executive Officer at the Maryborough District Health Service?
A. I am.

Q. In that role, do you have responsibility for managing the equivalent of 256 equivalent full-time staff?
A. I do.

Q. And a budget of $42.5 million per annum?
A. Rounded up, yes.

Q. The role encompasses all operational and strategic management including of a 128 bed facility which includes a Community Health Centre?
A. That's right, yes.

Q. Can I ask you to describe briefly the kinds of services that the Maryborough District Health Service provides?
A. Sure. So, we're, if you like, a traditional health service from acute perspective, so we have a medical ward, we have a surgical component to that, we have operating theatres, renal dialysis; the broad spectrum of acute-based services. We have a very large aged care service across three campuses, so we have the Avoca campus, the Dunolly campus, and the main Maryborough campus, and then we have a breadth of services within our Community Health Centre as well, including allied health, including social support programs, including District Nursing, so some traditional and non-traditional community health programs running out of there.

Q. In relation to your dealings with patients requiring help with mental illness, do you have about 15 patients every month presenting to your urgent care centre?
A. We have, on average, 15 patients who present with a presenting symptom of mental health.

Q. Of those, are quite a number of them requiring urgent care?
A. Yes.

Q. And so, there are about 6,000 presentations of that kind every year?
A. There's 6,000 presentations to our urgent care centre, yes, absolutely.

Q. Can I ask you about how it is that urgent presentations are dealt with. Can we start by describing what your Urgent Care Centre is and how it works?
A. Sure, the Urgent Care Centre, if you like, is an extension of a private practice, that we provide resources for the medical offices in town to be able to provide emergency care and support, so it's not a traditional funded Emergency Department such as a regional or metropolitan centre has.

We are funded to provide nurses and resources and then the facility is covered by an on-call roster of either our general practitioners in town with the support of nurse practitioners.

Q. That's a staffed 24 hours a day, 7 days a week?
A. With nursing staff, yes.

Q. When patients present, that is, patients regardless of what their presenting issue is, are they first triaged?
A. Yes. Every patient who presents is triaged in accordance with the Australasian triage scale which is used universally.

Q. Do you find that the vast majority of needs can be dealt with at the clinic?
A. So, in the Urgent Care Centre we can certainly provide primary care level support. We can do intermediate emergency care, if you like, but anything of high complexity, certainly we need to refer out, yes.

Q. When it comes to people presenting with mental health issues, particularly the more severe presentations, what happens?
A. So, just as every other patient, they are triaged and assessed by one of our registered nurses and, dependent on the triage level, obviously that then instigates a level of response in accordance with their needs.

Q. Those that your staff deem need further assistance, who provides that?
A. So, the nursing staff will and then obviously we can call in the support of our general practitioners should we need. Again, it's dependent on their presentation and their requirements, or the nurse practitioners can manage the lower end presentations, but anything of high complexity, we are then very reliant on our outreach program through Bendigo.

Q. What's the outreach program provided by Bendigo, and is it Bendigo Health?
A. Bendigo Health, yes.

Q. What do they provide?
A. So, they are our immediate service provider for mental health services, we don't provide any specialist mental health services. So, we contact them with any mental

health condition where we need that additional support or advice, be it, it may be a high level immediate need or it might be some advice for some ongoing care as an outpatient.

Q. Do they perform triage by video?
A. They perform triage by a number of means and it may be via video or it may be through the consultation with the practitioner who's talking to them in the assessment. They may know the patient as well, so it's all dependent on the presentation.

Q. Can you tell the Commissioners what are the challenges that you face in the Urgent Care Centre where you have someone who is in acute need and they can't be seen immediately, including being triaged immediately by someone from Bendigo?
A. Sure. So, the challenge comes for us in our Urgent Care Centre as we were able to display yesterday, is that we have no ability to securely care for someone with mental health illness. So, if they are exhibiting behaviours which are disruptive, they are disruptive within the entire unit and they can move around. Obviously, if they are disruptive to the point of concern, we call the police. We don't have on site security, so we will often need police support to manage the behaviours for the safety of the patient themselves and the staff up until the point of triage assessment and often referral.

The triage process can delay the ability for us to, I think, efficiently manage patients who are suffering severe mental health. The triage basis from how the mental health system works is very different to everything else that we work with.

Q. Can you explain how it works for mental health patients who are in acute need?
A. So, again, our clinicians will contact the Bendigo Health in this instance, but any gazetted provider, and they provide clearly the examination and their thoughts and primary diagnosis in terms of the patient's presenting complaint and behaviours and so forth. At which point then Bendigo Health will provide the triage and assessment and it's that triage and assessment which determines the ongoing management of the patient.

That may mean that the patient can wait with us

overnight until the Bendigo Health team is with us the next day. We're very fortunate to have the Bendigo Health team on site with us with their community outreach program. But it can mean that a patient - and we've got some examples, that if someone is seen at 10 o'clock at night, triaged and we're able to maintain them safely, they won't be assessed and seen again until the morning, or they're assessed by us and cared for by us, but from a mental health perspective, it's the morning when they are able to be seen by the community health team.

In extreme instances obviously patients may be transferred to Bendigo Health and then there's consideration about how we safely do that, do they need to go via police or do they need to go via ambulance with appropriate sedation and support, and again that's always a difficult discussion and a very individual discussion based on the presentation.

Q. What are the options for transferring someone to Bendigo who is in acute need?
A. Well, the options are really that: that, if someone is exhibiting behaviours which are extremely dangerous, the clinicians will work with the police to assist transportation and that may be the police go in the ambulance or it may be that the patient is okay to go by ambulance, or I think in the worst case scenario, the patient will go in a police vehicle in a way which can be safely done.

Q. How do the options for transferring quite mentally unwell patients compare with what's available for generally medically unwell patients?
A. I think the system over the years has done a terrific job in making sure we get the right care at the right time at the right place for medical patients. So, what that means is, if we have a complex medical patient right now at Maryborough, we have the ability to ring one number, called Adult Retrieval Victoria, and they will support and facilitate the overarching care, transportation and location of that patient moving forward.

Because the difficulty with the mental health process, is we have no oversight of bed capacity, bed availability, and I'm sure Bendigo Health are under extreme pressure and then we're contacting them escalating that pressure even further.

With the medical process, with Adult Retrieval Victoria, they have oversight over the system: they know bed capacity, they know resource availability, so they support our clinicians with the care, at the same time arranging transportation and the location for where the patient will go. It's a very efficient process, it's a very safe process, it supports our clinicians.

If you think overnight we have two nurses on and we might have one general practitioner within our Urgent Care Centre, so that support provided by the Adult Retrieval process is very good. It's the same with obstetrics, it's the same with paediatrics and neonatal, we call one number and everything is facilitated.

Q. How do the wait times, if you like, for mentally unwell patients at your Urgent Care Centre compare with the wait times for people who have general health issues?
A. I'll just talk on the average, if you like, because there are outliers always.

Q. On average, of course.
A. But certainly the clinicians would indicate to me that we have much longer wait for mental health patients than we do for medically unwell patients.

Q. In relation to patients whose behaviour becomes uncontained, what sort of safety issues does that present to your staff at the centre?
A. It's an enormous challenge because overnight - if I can use the overnight example?

Q. Yes.
A. We have two nursing staff on, we have an after hours coordinator who's supernumerary, who will move through and manage the facility on our behalf after hours, but that is the resource capacity. So, there are no security staff to help placate an issue.

So often, if the scenario escalates, and that often is an escalation before we will call police, for example. And, if you think about that scenario, a mental health patient overnight who has these challenging behaviours and needs all the support, the nursing staff will have a GP available with them and the only road crew in town from the police in our Urgent Care Centre.

The issue with that is, as I mentioned before, we have no way to seclude the patients, so they are free to move around the unit and they do. As we saw yesterday, our room is set up as well as it can be; it is literally a bland white wall room with no risks in it. By that there's no sink, there's no hanging points, we've done the full safety assessment of it, but there are doors that the person can walk out. There's no outside access to fresh air without going back through the department, so the design of the unit is inhibitive but also the resource availability overnight is certainly a concern.

Q. Can I get you to explain what you've been discussing by reference to one of the diagrams you've prepared. Can we have the Current State Real Life diagram, please. Excuse me, Commissioners.

Beg your pardon, Commissioners, I misunderstood the logistics of the room. I thought it would be displayed where everybody could see it.

COMMISSIONER COCKRAM: I think they can see it.

MS NICHOLS: Yes, but you can't, unfortunately. We have copies for you, I'm sorry about that.

Q. Most importantly, Mr Welch, do you have a copy of it?
A. I do.

Q. Apologies for that?
A. Yes.

Q. Do we have the diagram entitled, Current State Real Life Experience?

CHAIR: Yes.

MS NICHOLS: Excellent. Mr Welch, can I get you to explain what's illustrated in the two tracks on that document?
A. Sure. Please be clear that this is an example provided to me by clinicians. So, the psychiatric patient who presents to our Urgent Care Centre in this instance presented following an overdose, came in at 2200 hours, so 10 o'clock at night. Not an uncommon time for a presentation, was rightly assessed as a triage category 2,

meaning needs to be seen within 10 minutes and some prompt attention.

So there was some care provided there and you'll see the team contacted the Bendigo Health psychiatric triage and at that point you'll see the plan was made for monitoring overnight for the overdose and for care the next day. For some reason, I don't have the details obviously, but the patient was reviewed by the GP at 3 in the morning.

At 9 in the morning the patient was then allocated to the community-based team I mentioned to come and commence the assessment from a mental health perspective. At 11 o'clock that team attended our site, but the patient was still drowsy so had to return. At 3 o'clock the patient was assessed again and deemed to need admission and they were transferred at 1800 hours to Bendigo.

Q. From your assessment, based on the information you've received from the clinicians, do you regard that as a significantly delayed period of time over which the patient was dealt with?
A. I would suggest there are examples of this quite common.

Q. And that compares to the journey on the right-hand side which is more straightforward?
A. Yes. It's just an example again of a medical patient and, as I mentioned before, the streamlined response, particularly the support of Adult Retrieval Victoria, or the like agency, to be able to facilitate a very prompt transfer.

Q. Thank you very much. I'm finished with that diagram now, thank you. Can I ask you about the factors in this community and the surrounding areas that are likely to contribute to difficulties accessing help for mental health issues?
A. Sure. There's a number of challenges for the community, and I think, as I've written in my statement, the community here faces a whole range of challenges to do with socio-demographic matters. So, the ability to afford transportation to access services is an inhibitor. The ability to --

Q. Can I stop you there. Can you say a little bit more about the transport problem, what's involved in it and how

inhibiting is it?
A. So if I can give you an example of not a mental health patient, but recently we have heard that people have, for reasons of not being able to afford transport to a facility like Bendigo or Ballarat, have not had chemotherapy. So, the reality of the barriers of transport and cost are very significant to the community, and people are having to opt out of their care because they simply can't afford it.

The other challenge is health literacy, that is, knowing how to navigate the system, and I am in the system and sometimes I find it confusing to navigate. So, a consumer who has the stress of a mental health issue, having to try and navigate the system is extremely difficult and extremely difficult for this community.

There's well-known challenges of high unemployment, some really generational issues that we're trying to tackle.

Q. One of the things you draw attention to in your statement is the lack of a centralised intake and referral service.
A. Yes.

Q. I would like to have displayed, if I can, the current State Primary Care document. [MDH.0018.0001.0009] Commissioners, I hope you have that document. Do you have that one, Mr Welch?
A. Yes, I do.

Q. Great. We'll just wait till it comes up on the display. Mr Welch, can you take us through what you're depicting there in that description of pathways for a mental health presentation?
A. Sure. We were able to have some detailed discussions with our general practitioners in town to really try and get some real life learnings about the process. What this outlines for you is, once the assessment is done and there is identification that there is services and support and specialist support needed, there are multiple potential referral points, and clearly we've just demonstrated some for an example, but there are up to a dozen or more potential options for a general practitioner or a clinician to decide where they may send someone.

What happens in that scenario is, the general

practitioner, who is often the primary caregiver in a community like ours, will refer the person to where they think is the best option. That's a challenge in itself and I'm sure you'll hear later from your witness about that.

The person then goes into a system where there is no identification or wait list, so the general practitioner may be referring someone who needs some psychiatric support to a psychiatrist with no understanding of the length of the wait or their wait times or their availability. The issue then of course is the GP in this scenario loses sight of that patient. So, they've done the referral, they're assuming there's an appointment happening and the process is working.

And, if it's not the appropriate referral point, so they may go and see someone and the patient may be told, "No, you need to see someone else", which happens. The patient has to go back to the general practitioner, wait to see the general practitioner, then have another referral, so the GP has to do another referral to a different specialist again. So, if you like, the patient can be bouncing backwards and forwards during lengthy waits, all reliant on the referral program without knowledge of wait lists and availability.

Q. Is that what you mean when you say "patients become lost in the system"?
A. Absolutely. Yep, absolutely.

Q. Is one of the features, lack of visibility for the general practitioner to know what is available and when?
A. I think that, if you think of the social state, we need to be able to almost hand-hold patients through this journey. The stress alone is so difficult for patients and families, yet alone being given a referral to try and navigate to somewhere, and they are definitely getting lost. If you think of that urgent care presentation, that is the cycle.

Q. I see, thank you. You said in your statement, which I will tender in due course, that:

> "The Maryborough region leads every social indicator at the wrong end and the community is institutionalised in the sense that it does not know what good looks like

in the health context."

Can you say a little bit more about that?
A. So three years ago, or approximately three years ago, we did our service plan and there was a whole raft of detailed review of the community and its perception of health. It was recognised that the health status of this community is poor. The community said they were happy with that. So, there's no understanding about what good health looks like for a lot of people because it's institutionalised, it's multi-generational as I mentioned before.

So, unless we're able to support and show people what good health looks like, and in this case mental health, well, they are living in the unknown and I think there is a lot of people that we are not touching simply because of the unknown.

Q. Is social isolation a barrier to help-seeking?
A. I think, again, you're hearing from people who are isolated. We see in particular in our smaller communities, like Dunolly, that we have in the aged demographic often women who become isolated because their spouse passes away. There is no housing availability for them, there is no social network for them, and they often end up in aged care far too early or they end up at home in a depressive state and in a condition which, if they were in an optimised social support network, would be far enhanced.

Q. Once they end up in aged care, are there further challenges in treating people with mental health difficulties?
A. There is, and I haven't touched on that too much because of the Royal Commission into aged care obviously, but certainly the challenges that we describe in terms of accessing specialist support is again challenging, although there are some modalities which are improving in that space.

Q. What about the stigma that is associated both with mental ill-health and with help-seeking for mental ill-health?
A. It's an interesting discussion because recently we've done a massive body of work around women's health and we utilised the expertise of the Health Issues Centre to conduct a survey of women in our community to understand

their health. Over 500 people responded to a survey, which is an amazing return for a community of this size, and stigma to their health and privacy of their health were two of the very big concerns that they raised.

Because small communities, clearly everyone can know and see each other, so it is a challenge and that certainly prohibits people from accessing timely and effective care.

Q. Did this relate to women in particular?
A. Well, that did, yes.

Q. Have you advocated the use of what's called, the Orange Door Model to help overcome this issue?
A. Well, I've written it in there, yes.

Q. You need to explain to us what it is.
A. Well, it's still in development but it is the program being developed to support people within family violence and domestic violence. So, the rationale is, the Orange Door is a one entry point and you enter through the Orange Door and you are then receiving of a wrap-around service.

So it's still being developed, Maryborough needs one because of the issues that we have. But if you think about the stigma and the concerns of the community, the ability to walk through one door which is, you could be going there for anything, but the reality is you walk in and the service will wrap-around, in this case the women, but of course it needs to be a fully holistic model, The Orange Door.

Q. So you need both holistic and interconnected service delivery and you need a presentation which doesn't say mental health?
A. Correct.

Q. Rather, it says health more generally?
A. Correct. And our thoughts are, we need a wellness centre model which is all encompassing whereby you could be entering there for some allied health support or you're entering there for very detailed counselling and support for a significant issue and no-one will know.

Q. Can I ask you about stigma and young people. Do you have a nurse practitioner and a doctor at the public secondary school each week?

A. Yes, we do, at the Maryborough Education Centre.

Q. Do they particularly attend to mental health issues or are they more general?
A. The feedback has been that it's becoming more and more utilised for traditional teenage issues, but also certainly mental health is becoming more apparent. Yesterday at our roundtable the principal from MEC was able to describe how children will go the first time for a cut toe, the second time for something else, and the third time they'll really open up about their issues and a lot of underlying issues are associated with mental health. So, yeah, it's taken time.

It's heavily under-resourced, I would say, for a community like ours. There's no drop-in clinic in Maryborough for a teenage student to go to. So, we had to lobby very hard to get the Doctors in School Program. The nurse practitioner as well has been a great support, but it is underwhelmingly resourced for the need.

Q. How is it funded?
A. It's funded through the Department of Education and we had to lobby through various channels to be able to utilise that. We are the fundholder; they pay us and then we pay the program. That works fine now, there's no problems with that process.

To be honest, we don't care where the money comes from, we just want to have services on the ground and one day a week's a start, but it is underwhelming.

Q. When you say it's underwhelming, if you had further funding, what sorts of services would actually meet the need that's being seen in that clinic?
A. I would say to you it's not only that clinic, there are other schools in this community right now with zero service provision for a doctor and a nurse practitioner. So, I think we need to consider how we encapsulate other schools and support those children just like we're doing at MEC.

Then of course there's the social support requirements and the need for accessible support services within the community. Because, again, it's all very well to have a nurse practitioner and doctor there who identifies a mental health concern. That referral then needs that student,

plus or minus their parents if they know in some instances, to be able to get to an appointment or to find access to the ability to get to an appointment which again will often mean no appointment attended.

Q. We've asked you about how things can be done better, I think you've alluded to some of those things already. Can we have a look at your preferred model of primary care. Can we have the Preferred Primary Care Model slide displayed, please. [MDH.0018.0001.0012] Commissioners, do you have this document?

Mr Welch, do you have the document?
A. I do.

Q. Excellent. Can you please talk us through how your preferred model for primary care works?
A. Sure. I just want to put a clause on this that none of us consider ourselves scholars in developing a system and a model. This was a roundtable discussion with our clinicians at the health service about what may or may not work for us. So, what we are saying here is that, we need the ability to be able to refer to one central point. So in this case in a primary care scenario the GP is able to do one referral which then enters a mental health intake service, that is, the referral goes to an expert group or an expert body who then determines the care requirements for that person through additional triage, through an additional assessment, a holistic assessment, and then they can allocate accordingly the care requirements. So, rather than a scenario of the general practitioner right now trying to determine where to send somebody without any knowledge of the wait list, or is that specialist appropriate, this expert group would be able to do a holistic review and be able to refer appropriately.

The other key thing here is, it would take into account care for the carers and the families which we hear often is missed, and it would also make sure that the GP, who is the primary caregiver is, if you like, kept in the loop, there's feedback back. This is the journey that their patient's on, this is the step they're at, so at all times we would have knowledge and some lens of the patient who, without such a model, developed however it would be, is currently lost.

Q. Is visibility across the whole spectrum of care and

coordination, are they two of the features of your model?
A. Absolutely. Coordination to us is paramount. I mentioned before and I don't say it flippantly, that hand holding, to be able to help patients or their families and their carers and the patients navigate the system is critically important.

Q. In this context, what would you say about transportation arrangements and how they should change?
A. The eutopic world would be services in Maryborough, so that would be a very selfish approach, to say everything should be here at our fingertips. But there's a reality. I think there are two answers to that: priority must be given to rural areas that have evidence of high stress and high need, and we're clearly one of those, so there's my lobby. The second point is that transportation could be facilitated by a number of means, and also the fact that we are completely under-utilising telehealth. We are under-utilising telehealth still and I think the fact that it is always often in the car to somewhere for an appointment, when there must be in 2019 some really good models available to reduce the barrier and the stress on the families and the patients from travel.

Q. Can you elaborate, please, on the under-utilisation of telehealth: firstly, what potential does telehealth hold - we'll get to the barriers shortly - but what potential do you think it holds for this community?
A. My belief is that it brings services that currently are not available and in reality will never be available. Because recruitment of specialists to smaller communities, as we know, is very difficult, but access to specialists is very easy via telehealth.

It's been discussed for decades, telehealth, but a system that was well coordinated and set up and structured could easily bring services and system response locally that currently we don't have and some I don't think we'll ever have.

Q. What would be the practical measures you would need to implement to have telehealth well set up, observing at the moment that you use a video which you wheel into a room at the Urgent Care Centre for triage?
A. So, some of it is appropriate equipment in an inappropriate setting. For example, I firmly believe that the rooms that we have available for the care of the

mentally unwell in our Urgent Care Centres should be equipped with fixed cameras and fixed telehealth equipment, safely away, that can assist with a really prompt triage and response from our - whichever service we're accessing.

The current scenario, we have to wheel a cart into a sometimes hostile environment if we can - has all the barriers that you can appreciate. So, some of this is simple equipment and set up, and then of course the biggest challenge with telehealth is that co-ordination and administration, to make sure that there is someone on the other end, that it works properly, and all those challenges. But I don't see one barrier that can't be overcome with telehealth.

Q. That's very encouraging, I should say. You've also talked about the importance of a lack of accessible social housing. Can you say a little bit more about that?
A. Yeah, I can, and I'm going to use the Dunolly example if I may. We've been working very closely with the hospital axillary out at Dunolly, and they've done an enormous report into the community and the state of the community from a housing point of view, and the reality is that smaller communities - there is no equity. To buy into something is very difficult because equity in housing's very low. The fact that there is none is an issue.

The housing scenario out at Dunolly, as I mentioned before, you may be in your unit, you may be on a farm, you may be at risk, there is no public housing available or, if there is, it is oversubscribed in communities like ours. So, I think social housing and supported arrangements that are available in some of the bigger regional centres and they are absolutely brilliant facilities; in smaller communities, clearly in smaller models will bring that social connectedness, will bring that social support, and relevant care that's needed for those people, and it will certainly stop the deterioration of health which I believe occurs.

Q. Thank you. Finally, in your statement you have said:

> "We don't need our own mental health service workers. What we need is access to a system as efficient and as effective as the system described for medical and other patients."

You've addressed that at some length. Is there anything else you'd like to say about that?
A. What I would say is, I think the system has done a terrific job for medical patients, for surgical patients, overall, for medical patients, surgical patients, obstetric emergencies, paediatric neonatal emergencies, and I think it's time for us to really be able to drill into the challenges, and I'm not the person to be able to explain all the challenges of the mental health system, but we must be able to set up a way whereby the fail-safe is not someone sitting in our Urgent Care Centre. The fail-safe must be, there is no wrong door.

So, we can send someone to Ballarat today with a medical issue and they may have nothing wrong with them. So, we might send them across concerned they've got chest pain and we're thinking there's something really wrong with this person. Naturally they go across, they have all their assessment. If there's nothing wrong with them they come home, and there's no criticism of that system; that is fail-safe.

The current mental health model of people sitting in our Urgent Care Centres is just exposing such great risk, and I would hate to be a family member or a patient in the scenario which we have here of the room with white walls. So, I think we need to be able to work through a system that responds quicker and accept that some people will be transferred who didn't need to be transferred, but it's safer and it's a better outcome. We do it with all other elements of health and I think it's time to do it for mental health.

MS NICHOLS: Thank you, Mr Welch. Chair, do the Commissioners have any questions?

CHAIR: Professor Fels.

COMMISSIONER FELS: Q. I would be interested to see the housing study that you mentioned, if you are able to get that to us?
A. I can get you a copy, yes.

CHAIR: I've got one other thing, Mr Welch. You talked about the fact of that delay in having people in your emergency centre and awaiting transfer. I guess I'm trying

to understand, how much of their presenting issues are exacerbated by that? You did talk about the need to call in police which you've said is not the option you prefer in the instance.

Is the length of time that's waiting, and I think you describe many hours that people will wait in acute mental health crisis before being transferred, increased the issues and risks that you've identified?
A. I have absolutely no doubt it does. There is no question, if you look at the environment that people are placed in, if you look at the - and I'm sure patients will describe the sense of what is happening in an Urgent Care Centre - they can be a very busy facility and someone's in there with a mental health concern who needs care and attention and we have two nursing staff on, no security available to sit with them and support them, often leads to escalation and often frustration for those patients and families.

Q. Do you have any sense of how often people are then transferred when they need a transfer by ambulance or alternatively in a divi van, the percentage of the times that occurs?
A. No, I don't know.

Q. There might be some data that would be helpful?
A. Certainly, I agree and I can provide that.

MS NICHOLS: May Mr Welch be excused.

CHAIR: Thank you very much, Mr Welch, for your evidence today.

MS NICHOLS: The next witness is Mr Al Gabb.

<**ALASTAIR GABB, affirmed and examined: [10.54am]**

MS BATTEN: Q. Al, we'll just get you to sit so the microphone's alright and you can speak into the microphone.
A. Is that good?

Q. Thank you very much. Have you, with the assistance of the Royal Commission team, made a statement to the Royal Commission, a witness statement?
A. Yes, I have.

Q. I tender that statement. [WIT.0001.0001.0001] Al, you grew up in country Victoria in Skipton?
A. That's correct.

Q. Which is about 45 minutes west of Ballarat?
A. That's correct, an hour south of here.

Q. During school you experienced some bullying?
A. Yes, through both my primary and secondary.

Q. You feel that had a lasting influence on you as a person?
A. I have no doubt that has had an influence on my life today.

Q. If we move to your 20s and early 30s, can you describe how your life was during that period.
A. So, my 20s and early 30s, I spent much of my 20s working in the ski industry as well as getting a trade and some university in there. I travelled the world, life was pretty good, living the dream so to speak. Saw lots of Australia and lots of different countries around the world, and I didn't have too many worries, so I thought. Now I'm a little lost.

Q. So you were overseas at that time and then it got to a point where you decided you needed to come home and so six or seven years ago you decided you needed to move back to the country farm?
A. Yeah, that's correct. In my late 20s I decided to study some agribusiness degree, and then in my early 30s, six or seven years ago, I came home to the family farm which I'm fifth generation on through my mother's side, and decided to make a go of farming and reinstate the business that had been leased out for a number of years.

Q. And you said that that's when your problems first started. So about that time, six or seven years ago, can you tell us some of the factors that were happening in your life that contributed to the problems?
A. When I came home I decided there was a farm down the road that was for sale and I decided it would be a good idea to purchase that farm. And, unbeknownst to me, I allegedly sprayed out some native grasses and received quite a threatening letter in the mail from one of the Federal Departments under the EPBC Act, and combining that with a relationship breakdown at the time, it sort of

unravelled me as a person, the stressors of allegations against me. My life I guess wasn't coming together like I thought and it unravelled a lot of issues that I hadn't tackled as a person early on in my life and probably needed to have.

Q. You said that you had some behavioural issues and also you became a bit of a recluse from your family and friends; is that right?
A. That's correct.

Q. So, being a farmer, living alone on the farm in one of the houses, and it would be not uncommon for me to not see anybody for weeks and sometimes more than that at a time, other than going to the supermarket and doing daily chores, you know, the likes thereof. So, I started to recluse as a person. Naturally, I sit somewhere between an extrovert and an introvert so depending on which day of the week it is.

I did become reclusive, I stopped talking to my friends, stopped talking to my family who - mum and dad only live literally 100 metres away and would shut everybody out and that really made me spiral downhill as a person. It made my existence - the walls started to cave in around me and I was making it worse for myself with my behavioural patterns, and that was a result of obviously a mental health condition which I refused to acknowledge at the time.

Q. But you did go and see a GP?
A. That is correct, yes.

Q. Did the GP help you?
A. The GP did help me. This is sort of a very long story of GPs, psychologists, psychiatrists, mental health care plans through the public system, seeing private psychologists.

Q. We will come to those parts of the story, but with the GP, the GP put you on some medication and you said it took four to six weeks to have any effect and that was a long period for you?
A. That is right. So, from my understanding most psychological medications are sort of a four to six week introduction to your body. So, by the time you're at week 6 it's meant to be there and, if it doesn't work,

well, you've got that time, that lagging time, then you've got to get off it and try the next thing.

I've been on a few medications, all of which except for one was a failure for myself but I have and still do every day take a drug called lithium.

Q. The GP put you on a mental health plan and that allowed you to have 10 sessions with a psychologist. In your view was that enough, the 10 sessions?
A. So, the time I was put on that mental health care plan I was in crisis. I had had attempts at my own life, three of which, and that extended pre and post seeing this GP over a period of time. Sorry, can you repeat the question?

Q. We were talking about whether the 10 sessions with the psychologist was enough and you're saying you're in crisis, so is 10 sessions enough for someone who's in crisis?
A. So, for me it was not enough. I used up those 10 sessions rapidly, it may have been 10 weeks, it may have been shorter, it may have been longer, I cannot give you a hard timeframe.

When you're in crisis as a person and your life is in the balance, 10 sessions does not fix everything, it doesn't seven start to fix. It gets the ball rolling, yes. I rapidly adapted to the fact that I had some mental health issues and acknowledged it really quickly but, had I not acknowledged it, those 10 sessions would be just lost time, you know, a bit of a lost target, I guess.

I am of the belief, and I do stand to be corrected if somebody else in the room knows better, but I think once you've used those 10 sessions, you have to wait maybe another 12 months or until the 12 months rolls. I do stand to be corrected on that; that is my belief.

Q. That's my understanding as well, that it's the next 12 months.
A. So, 12 months is a long time when it comes to anything, especially your mental health, someone's mental health.

Q. You've said that you went and saw the psychologist but then you were able to access a private psychiatrist in Melbourne. Can you tell us about, first, the experience with the private psychiatrist?

A. That's correct. So, my father, he knew of a guy in Melbourne who had helped other family members, and dad recommended I go down and see this guy. He was great, you know, he called a spade a spade and he really helped me. The problem was, he was in Chapel Street and I was in Skipton, and by the time I got down to Chapel Street and go and see him for an hour, and then get all the way back to the farm, that's a day gone for me.

Q. Why did it take a day? How did it take a day?
A. Well, I'm two hours drive from Melbourne, and then it's - driving in Melbourne can be tricky, as I suggest a few people are aware, so I chose to take the train and the train station I get off at is South Yarra and it's spot on right there. By the time I see him it was the best day of a day gone, a day out of my work week, and a day out of running the farm, and I have responsibilities at the farm for animals and the likes thereof. So, it made it tricky as well as economically tough.

He didn't come cheaply and I have no issues with that, but I'm very lucky that I had the financial capacity myself and through help from my family to use external help outside of the public system, and I'm very fortunate for that and I'm very aware that a lot of people don't have that ability and that would be something that's quite dear to me, is to try. Everybody should have access to the best help.

Q. Even with that access and the financial means, is it correct that you stopped going to him because it just wasn't practical with your commitments on the farm and the travel time.
A. That is correct.

Q. So you didn't continue seeing the private psychiatrist?
A. No. The time out of my week - weeks - was starting to add up to too much for me.

Q. So you stopped seeing him?
A. That is correct, yes.

Q. You touched on this before, but in your statement you said:

"I was living by myself and could sometimes

go a month without speaking to someone other than my parents or the person at the checkout at the supermarket. In my experience farmers work too hard and can be socially isolated because of the demanding nature of the work."

Can you just expand on that and just tell us a bit more about the nature of the work and the social isolation, please?

A. So, as a farmer, where I farm in Skipton, which is 45 minutes west of Ballarat, I would not consider it isolated in the scheme of Victoria or Australia as a whole, but compared to people that have access to cities, whether it be Ballarat, Bendigo, Melbourne, it is.

So, as a farmer, and a young farmer, the demands of running a farm are significant: you are responsible for livestock, you're responsible for your business, you're responsible for - you know, you're the accountant, you're everything. So, the hours worked can really quite stretch right out, and especially in seasonal times.

At harvest time it is not uncommon to be living on three, four hours a night's sleep and for days if not weeks on end just to get the job done because we have that window; and, most farmers acknowledge that and most farmers have those windows in their businesses.

But it's when you start to get reclusive as I was and not be social with my friends and family is when it started, this is one of the issues I see.

Q. You referred before about attempts on your life.

A. Yes.

Q. Without detailing what you did, can you tell us about that experience and particularly the paramedic who was involved?

A. So, out of the attempts on my life, one I ended up in hospital with a trip in an ambulance. So, my hometown's Skipton and Skipton has an ambulance which is not manned by a paramedic but it is volunteer-run, and I don't know the proper word for those people who do it, it's somewhere between a paramedic and a volunteer.

Q. That's okay.

A. I met the ambulance at a major intersection not far from home with the help of my brother, and unbeknownst to me, because I wasn't quite in the state to remember, but the ambulance volunteer that day was a local farmer who I know really, really well, and I know he works on the ambulance service.

So, for him to have to pick me up, you know, in my state, he was just doing what he does. He does it for everybody, but you know, there was also another neighbour who's a great friend of my family's, and a friend of mine as well all there helping me get in the ambulance. So, on the side of the road, just the side of the country road. It's those things that rural communities have that can be tough on others as well.

Because, you know, for the guy in the ambulance, we know each other really well, he's not much older than me, we've grown up together, farmed almost side-by-side, so that has an effect on him to see that. So, the flow-on effects in those rural communities are greater than what people, I guess, see from the outside. That's just a small example, I guess.

Q. You've also said though that the community provides a lot of support.
A. Absolutely.

Q. Can you tell us about that side of it as well?
A. Yes. I can give you a few examples of that. I've had comments made to me by members of the community who you would least suspect. You know, they've come up to me and said, "Good on you, Al" because I've been quite vocal in my campaigning for mental health.

I've had one person come up to me and openly said that he'd had similar thoughts himself, and yet, me being vocal had given him the courage to talk to his wife about it. And this guy's not young, you know, he's my parent's age.

There's also other channels and people I talk to in the community, my close friends, who also champion for mental health in their own ways, whether it be politically or giving through their own time into different areas: it's been quite a good experience for that, I guess.

Q. Just coming back to your experience with the system:

you've also had to go to the Emergency Department a couple of times.
A. Yes.

Q. Can you tell us about the experience of going to the Emergency Department.
A. Yes. Well, to the [redacted] Hospital?

Q. M'hmm.
A. I was very interested in what Terry was saying before. It was a horrible experience, to be honest with you, because here I am, I'm like I am now, you know, I'm perfectly okay from the outside. And when you go to the triage nurse, that's one way to get to emergency really quickly, is to say that you're suicidal. And you go in the back and there's people in obvious distress for medical conditions.

Q. You mean physical medical conditions, is that what you mean?
A. Yes, you know, they might have broken their arm or something along those lines. And here I am sitting on the bed sort of crying, but I'm alright, I'm not dying; so that made me feel pretty bad of taking up their resources because I wasn't right with my mental health.

And they didn't really know what to do, so they asked [redacted] Psych Services to come, which I believe was at [redacted] Hospital and they sent one of their counsellors, I believe - this is about 1 in the morning at this stage - and he sat down and we went to a room out the back and we sort of chatted for a bit.

Then he made me sign a piece of paper saying that I would not attempt self-harm, and basically on that discharged me and said, "Go and see your GP." So that was a fairly muddy picture, I guess, of how it happened but - yeah.

Q. You've also had experience with the public psychiatric services, and you've said, "It felt fairly stereotypical of a public psychiatric hospital." What do you mean by that, what's a fairly stereotypical public psychiatric hospital and what was your experience that confirmed that stereotype?
A. Well, [redacted] Psych Services, for those that know, is the old [redacted] Hospital which is right on [redacted]

Street, and by nature the building's old, it's got tall ceilings, it's got concrete walls. You walk in and it's almost Hollywood-ised, if you want to put it that way, that's a really bad way of putting it.

Q. You might just have to explain a bit more to us what you mean. I think I know but it would be helpful if you explain.
A. You sort of expect someone in a movie to come out, like one of those - anyway, we're getting a bit lost.

So you walk in, there's big tall white ceilings, there's not a lot of decor that's warming, makes you feel okay, it's all very quite cold and sterile.

There's a waiting room and I remember very clearly in the waiting room, and it wasn't a very big waiting room, might have been half a dozen chairs, there was a lady there, and she was obviously in a very bad way and she had her head between her knees and she could not - she was rocking backwards and forwards and was obviously in dire need of some help. When you combine that with the tall concrete corridors and very white fixtures, it's not a welcoming environment, it's not a calming, soothing environment which, when you're in mental health issues, it's a good thing if it's calming and soothing.

Q. In your statement you've said:

"For me it's all about saying, it is okay to have been there."

Can you expand a bit more on why you choose to speak out about mental health?
A. Well, it is okay to have mental health issues, and somebody mentioned some facts before and it's staggering how many people are going to experience it in their lifetime. So, for me speaking out and openly talking about it - and I'll talk about it to anybody that asks - it's about helping. If I can help one person, that's a win, that's all that matters to me, is to give back.

And, people helped me, I'm great these days, I manage myself, but if I can help one person make a choice to go and see their GP and get some help; or even better, one person preventing self-harm, to me that's a win.

And as a farmer we are, as a young male farmer, we are one of the highest risk categories in the demographic for self-harm and suicide and, to me, I think to be seen to be vocal and: one, telling my story, and two, trying to help the system progress through avenues like the Commission, I think it's a great way of giving back to society.

MS BATTEN: Thanks very much, Al. Commissioners, are there any further questions for Mr Gabb?

CHAIR: Q. Thank you very much, Mr Gabb, for your evidence today and for being so frank with us about your experiences. I noticed in your witness statement you did say of that experience when you were in [redacted] and I just want to make sure I understand that. When you were in the psychiatric ward, it was in the old part of the hospital, and the things that you describe about it not being warm and welcoming were in stark contrast to what you saw in the new part of the hospital that was immediately next door.

So, how did that comparison, when you reflect upon that, about the place of mental health in our health system, leave you feeling?

A. So, that's correct, I was talking about the old [redacted] Hospital and directly right next to it is the modernised new part of it, and the mental health area is in the old part.

It's intimidating when you're in there in a way, because you're not thinking clearly yourself, so you know, everybody's got their own version of it. But when you're in there it's not comforting and calming, and the example of the lady that was sitting right there more or less, and she was rocking backwards and forwards and obviously needed a lot of help. So, to be next to her. And I had no problems with that but I have vivid images in my head in these stark environments, is probably not the best.

Q. The other issue I just wanted to touch on is the fact that you talked quite graphically about the life on the farm and the fact that you've got very intense periods. I think it was the point you made about sometimes travelling to Melbourne ultimately became too long away from your job.

You might have heard Mr Welch talk earlier about the potential there is for telehealth. Do you think accessing mental health support through new technology would be

something that's important in the future or would have helped you in those circumstances?
A. I'm assuming you're meaning telehealth, as in iPad, computer screen-type scenarios?

Q. Yes.
A. For me personally, I love one-on-one, I love to see somebody next to me: whether it's seeing my GP or, you know, if I was sitting here just doing this on a computer screen, it would be kind of a little bit weird.

I think it's definitely got merit. There's some people that live far more remote than I do, but I don't think it's the silver bullet. I think, you can't go past one-on-one contact as a human. We are social beings by nature, and mentally ill people, and myself in there, having that contact is good, is a good thing. But I'm not saying that telehealth is bad either.

CHAIR: Thank you very much, Mr Gabb, thank you for giving your evidence today.

MS BATTEN: Thank you, Chair. May Al please be excused.

CHAIR: Has the witness statement also been formally produced?

MS BATTEN: Yes, it has.

<**THE WITNESS WITHDREW**

I understand there's a restricted publication order for the next two witnesses. Would you like to read that out?

CHAIR: Yes, thank you very much. Pursuant to the Inquiries Act 2014, the Royal Commission has made an order prohibiting the publication of the name or the identity of any support worker who might have been inadvertently mentioned in the oral evidence of the next two witnesses, Trevor Thomas and Christine Thomas.

I would like to remind all persons present, including the media, that publication of the name of any support worker who might be mentioned in the evidence of Mr and Mrs Thomas cannot be published. A copy of that order has been placed on the door to the hearing room.

Thank you.

MS BATTEN: Our next witness is Mr Trevor Thomas. I call Mr Thomas.

<**TREVOR NOEL THOMAS, affirmed and examined: [11.21am]**

MS BATTEN: Q. Thanks very much, Trevor. Have you, with the assistance of the lawyers for the Royal Commission, prepared a witness statement for the Commission?
A. Yes, I have.

Q. I tender that statement. [WIT.0001.0038.0001]

THE CHAIR: Thank you.

MS BATTEN: Q. Trevor, you are 64 years old and you live in the country with your wife, Christine?
A. Yes, I do.

Q. You've said in your statement, looking back you've probably had depression since you were about 18 or 19; is that right?
A. I have, yes.

Q. In the 80s and 90s you said you really struggled; that's right?
A. Yeah.

Q. And you had a really difficult time where your mum got cancer and died, your first marriage fell apart and your dad died by suicide and also your uncle died by suicide?
A. (Witness nods.)

Q. Also in the late 1990s you had another uncle die by suicide?
A. Yes.

Q. And that really knocked you about on top of what else you had to contend with.
A. Yep.

Q. And you continued to battle away with your mental health as you had a business collapse, and then periods where you changed job and you were out of a job?
A. Correct.

Q. You've said that your experience with the mental health system really began in about 2013 when you met a social worker who led you to engage with the system. Can you tell the Commissioners what the social worker said that made you first engage with the system in 2013?
A. My job was shift work and I'd come home and the support worker would be with my wife, supporting her with some stuff that was helping and I used to just sit there and talk. One day she said to me "You're struggling a bit I reckon", so she advised me to go to the GP, which I did, and set the ball rolling as far as getting help, yes.

Q. So, you went to the GP. Did the GP put you on some antidepressants?
A. The GP put me on antidepressants and watched me over the next three weeks that he said that it would take for it to happen.

Q. This was about October 2013 when you saw the GP?
A. Yes.

Q. Did you try and get an appointment with a psychiatrist?
A. Yes, we did, and it was going to be when he came back from holidays, the first week of February I think was the appointment.

Q. This is October 2013, the first appointment you could get was not until February 2014?
A. Yeah.

Q. How were you travelling at that time?
A. Not good, not good.

Q. You said that you had an Employee Assistance Program at your work, so did you try and use that instead?
A. On work's - I was talking to them one day and they said, why don't you try the EAP, which I did, and I spoke to a fellow on that for about half an hour, told him what was going on. Within a few hours we had a phone call and I could see a female psychologist, I don't know whether it was that day or the next day, which I saw her two or three times, yeah.

Q. If we go forward a bit more to September 2014, at that point you had a leadership role at work, but you said you

weren't really travelling that well and you decided to hand in your leadership role.
A. Yep.

Q. At about that point you asked Chris, your wife, to take you to hospital?
A. That's correct.

Q. Can you tell us about that, what happened that you wanted to go to the hospital?
A. Well, yeah, I just didn't wanna live any more. I always had pride in how - all my work experience, I'd always had pride in. I'd felt I'd failed and I just didn't wanna live any more. I asked her, I said, "I need to go", and she took me down because we have no - where we are there's no - oh, we didn't even have a hospital then, it had been washed away by the floods, so we had to go down to the major one 30-odd kilometres away.

Probably 6 o'clock at night we got there into Emergency. Sat, and sat, and sat, and there was no-one there to really deal with me, with what I was saying. My wife, when she gets up, will probably be able to speak more clearly on that; by this time I was just wanting something to happen.

Q. And so, you sat and sat and sat, and eventually did Chris leave? She left you there?
A. Chris got up. When they said, "Yes, you need admitting but we don't have a bed", and Chris being a little bit feisty, got up and left me there. She said, "I'm not taking him home" - her words were, "I'm not taking him home to die" and I just - I didn't know what was happening. I was scared then, I was.

Q. So Chris left the hospital?
A. Yes.

Q. And did you get a bed?
A. Eventually a lady - I think she was a visiting, might have been a psych nurse or something, was running around backwards and forwards. She came out and she said, "We found you a bed in the psych ward."

Q. And you were in the psych ward for about three or four days?
A. Three or four days. I didn't like it in there at all.

I was fortunate that I was just not far off turning 60, so they allowed me to go into the senior wing, which was a little bit more - I felt more comfortable in there.

Q. What about it was making you feel uncomfortable?
A. Just, there was people - young people in there that were highly visibly mentally ill. Like, they were prancing and I just wasn't used to that environment basically.

Q. You mentioned you were almost 60. You've said in your statement that you had in your head you wanted to make 60. Why was getting to 60 so important for you?
A. My two uncles, which were my dad's brothers, and my dad, were all 58, 59 when they died, and I just had it in my stupid brain that I wanted to beat that and get to - it was important to me.

Q. You've also said, because of the history in your family of a number of people dying by suicide, that you're worried that there's something in your genetics?
A. Yep.

Q. So, you were in the psychiatric ward for three or four days, and then you went to a PARC?
A. I went to PARC.

Q. What was it like at PARC?
A. I liked PARC. It was, like, self-contained, cook your own meals and everything, which was just - yeah. But everyone was caring, they'd come and walk around all day and make stuff for me to do. I think I made their vege garden for them for the spring and stuff like that. They'd come fishing with you if you wanted to go down the river fishing, which was only a kilometre away. It was good, just nice, relaxed - yeah.

Q. What about the clinical treatment, did you get access to the --
A. I think I only saw a psychiatrist once at PARC. I think by that time I was seeing my psychologist?

Q. That's okay.
A. My memory's not that - yeah.

Q. That's okay, you're doing really well. Did you get the medical support that you felt you needed?
A. Well, I had my pills and I was attending the - I was

walking back up to the [redacted] Hospital once a week to attend to that, and I had bloods done a few times and different things, yeah.

Q. At PARC you've said that you started meditating?
A. Yes.

Q. Can you tell us how meditating's helped you?
A. Meditating is - I say to people now, anyone that enquires with me - as far as I'm concerned meditating probably in that period, where I wasn't getting a lot of help from the system, I say to people, "Meditating has gone a really long way to save my life."

Q. If we move forward, there was a point at which you were due back at work and you got some forms that were trying to ask you if you were well enough to go back to work. Did those forms relate to what you were feeling?
A. No. The forms turned up and my doctor just wouldn't fill them in because it was all about - I work in food processing where we were lifting stuff and standing all day, and all the forms were about, can I stand all day, can I carry 20 kilograms, can I do this, can I push - nothing to do with my head at all, nothing, so they had to redesign the form I think. That was the insurance company's form.

Q. And then you had another period where you were off work and you had a bit of an episode in 2015 where you had your medication changed, you went and saw a psychiatrist. Can you tell us about the impact on changing the medication and how it made you physically sick?
A. That was, yeah, I ended up in our hospital for - our new hospital - for a few days and I was sent down to a psychiatrist in [redacted] who, when I got there I didn't have an appointment with him, I had an appointment with the registrar I think it was at another venue. So, we went round there, talked to him. He put me on lithium. On top of what I was on he put me on lithium because I was having ups and downs. To me, the lithium just made me sick in the stomach most of the time and I was on that - I've only just gone off it in the last month.

Q. If we move forward to February of this year, you haven't been at work since February this year and you tried to see a psychiatrist again and there was another three-month wait; is that right?
A. Another three-month wait.

Q. But you have seen the psychiatrist through telehealth?
A. Telehealth - my GP said, if we can't get in quick here, we will get you a telehealth. I think it was about a week and I had an appointment, but then they'd inadvertently - someone had double booked on the day so it had to be put off until the next week. But I was there. I went and had probably nearly an hour there. Once again, off one lot of drugs, back on to a new lot of drugs to try. But, yeah, I had telehealth that was there. That was a good experience for me, I could talk to him good.

Q. It worked for you?
A. Yeah, definitely worked for me.

Q. Just finally, Trevor, is there anything that you would like to say about what you think should change in the system?
A. Like Al, the 10 visits to the psychs. The psychologist I'm with now, I can see that he's trying to make them last till the end of the year with me. Whereas, the way I've been in the last few weeks since this change of drugs, I probably need to be, you know, using those 10 up fairly shortly. Just, my whole demeanour - my wife will tell you soon - my whole demeanour has changed since I've come off what I was on.

Like, the Emergency Department, when we went to [redacted]: you sit there and it's like, this bloke looks alright. There's kids coughing and sick, and people injured, and you seem to be, "We'll get to him when we get to him"; when, I was in serious trouble. Just, yeah, I don't know whether it's the shortage of mental health professionals and aid, I don't know what it is. Not much help.

Q. One final thing you mentioned is that you got an NDIS package of quite a lot of money, $53,000, but there's no services that you can access; is that right?
A. Well, there's stuff there for, like, spiritual, like my meditation and all. They're little groups where I go that, you know, there's no invoice - how do you claim? There's no invoices. It's just, the people that organise it rent a - one of them's an old church and then we've moved around to another place. I go three times a week, and there's no paperwork to say that I paid me $10 donation to pay the morning's use on the building. And there's a

lot of money in there that I don't need. I was a bit embarrassed when they told me how much money they'd given me actually, it's - yeah.

MS BATTEN: Thank you very much, Trevor. Chair, are there any further questions for Trevor?

CHAIR: Q. I just have one. Thank you very much for your evidence today. You talked in your statement about the fact that you'd said you thought you'd probably had depression since the age of 18 to 19 but you didn't finally reach out and get that help until you were 58, so a long time in your adult life.

Can you think about what would have been helpful and what do you think this Royal Commission could do to try and assist people such as yourself to seek help earlier in their journey?
A. Well, I was brought up in a family of blokes who were blokes and didn't talk about that sort of stuff, which has been a big problem for a long, long time. You know, had different people say, "Come on, you gotta harden up."

We've changed GPs in the last few years because our old original ones are slowly all retiring. The ones we're with now I think are a lot more in tune to this. Instead of just saying, take these pills and go home, they'll get you back every week and see how you are progressing, yeah.

Q. More responsive to you?
A. More responsive, yeah, that part of it is. I think it's like that, what do they call them, first responders, like when I get to the hospital in trouble, there's nothing there to help, and you sit and sit, yeah. And I just nearly freaked when my wife walked out and left me there, I just ...

Q. I think we're going to hear from her about that too, so thank you very much for your evidence today, Mr Thomas.

MS BATTEN: Thank you, may Trevor be excused? I was proposing to call Ms Christine Thomas and then have a break after Mrs Thomas's evidence.

CHAIR: Yes. Thank you, Mr Thomas.

<**THE WITNESS WITHDREW**

MS BATTEN: Thank you. I now call Christine Thomas.

<**CHRISTINE MARGARET THOMAS, affirmed and examined: [11.38am]**

MS BATTEN: Q. Thank you, Chris. Have you, with the assistance of the legal team, prepared a witness statement for this Royal Commission?
A. Yes, I have.

Q. I tender that statement. [WIT.0001.0037.0001] You're Trevor's wife?
A. Yes.

Q. We've just heard Trevor's story and we'd like to hear it from your perspective. Can we start with the support worker and what she told you and how to help Trevor?
A. We had a family support worker visiting home and she'd observed Trevor and said, "He's depressed, we need to get him to a doctor." And he went to the doctor, but over a course of months, we're observing him, and she said, "You can't push him to go to hospital, we've got to wait hopefully for him to make that decision. And, when you do, this is what is gonna happen and this is what you need to do."

Q. And what did she say was going to happen?
A. She said, "You'll go to the Emergency Department, and you'll wait, and you'll wait, and you'll wait. Eventually someone will come across, a psychiatric nurse, whatever, and assess him and they'll say, "Yes, you are very suicidal. Yes, we need to admit you. But we don't have a bed, so go home and come back tomorrow."

Q. And, did you have to take Trevor to hospital?
A. I did.

Q. And what happened when you got to hospital?
A. Exactly as I was told: we got to the hospital, we waited for a long time in the public section, people coming and going. Then they moved us into a small room, and eventually a psychiatric nurse came across. She spoke with Trevor, and me, and he was highly suicidal at this time, he really wanted to die; he knew how he was going to do it, he just needed to get away from me to do it.

And she said, "Yeah, he needs a bed, he's highly

suicidal, yep, he needs a bed. But we don't have a bed, so take him home and bring him back tomorrow." And I looked at her and I said, "You have admitted a duty of care to him. I'm leaving now", and I got up and I walked out of that room, and he'd been my husband for 20-plus years, we're pretty close. Nobody should ever, ever have to do that to someone they love, and he shouldn't have to have that done to him. And I walked out. But this worker told me, "When you walk out, don't leave the carpark, because they're probably going to put him in a taxi and send him home."

So I hid in the bushes, I felt like a bit of a pervert, but I'm hiding in the bushes in case. Then the phone rings, "Oh, we've found him a bed. Could you bring his clothes in please?"

Q. So he got a bed in the hospital?
A. He got a bed in the hospital. Mind you, by this stage I think it was well after midnight some time. They took him to the psychiatric hospital and I went home.

Q. After the hospital we've heard he had a time in PARC. What was Trevor's experience in PARC like, from your perspective?
A. He was happier there, he found the psychiatric ward distressing, it was very busy and seeing a lot of things he'd never seen or had to deal with.

PARC, there's units with a central kitchen, office, table tennis room, you know, sort of facility there, and one bedroom, you look after yourself. There are seriously ill people there, we're talking schizophrenia, bipolar, and other issues. And I thought, well, this is good, he's gonna be safe, because I felt I couldn't keep him safe at home any more. I thought, they'll watch him, he's gonna be safe.

Then I realised that, no, they're not clinical nurses, they're, like - what do you call them, I'm lost for words?

Q. Support workers?
A. Support workers. Then I realised, it's not a locked facility. He's probably a couple of Kms from a major, major truck route. He's a kilometre from the river and there's the most magnificent oak trees all around the place, perfect to hang yourself from. So, I'm in this

dilemma, do I leave him here? Do I take him home? I'm struggling to keep him safe at home. When he got up during the night to go to toilet, I'm sneaking behind him to make sure, yes, he's going to the toilet, he's not going out to hang himself in the shed, he hasn't found the spare keys and gonna wrap the car around a tree. Um, it was hard.

Q. So, did you feel like Trevor was getting the support that he needed at the PARC?
A. No, because it was: you had to fight for him to see a psychiatrist. I was told that there'd be clinical nurses down every day to give him medication and talk with him, he'd see the psychiatrist every week. No. There was a meeting - you know, there's meetings, the psychiatrist comes in or the different workers will have a meeting.

I got a phone call about an hour before that meeting, you know, "Have you been told there's a meeting that you should be at?" "No." "You'd better get down here." And you just needed to know the system.

Trevor and I have been really lucky, we had a support worker prepared to put her job on the line by telling me stuff that I didn't know, I didn't know about the duty of care. Then, when they were going to release him from PARC, and he wasn't even established on medication, he wasn't well - not much better than when he went in - that I learnt, if he's homeless they can't release him.

So then I had the pain and the anguish again of looking Trevor in the face after 20 years of marriage and saying, "You can't come home. I'm going to change the locks on the door. I'm sorry, you're homeless", and once again walking out the door, but that was the only way I could keep him getting some help.

And, if you didn't have somebody in the system who could say, hey, this is what's going to happen, and sure enough, these things happen, Trevor would be dead today. So, this person, I owe them his life.

Q. Moving forward from there, you tried to find a psychiatrist for Trevor, and you said that you found it difficult to get him the help that he needs ?
A. Yes, there was such a wait, even though he was in PARC and in the hospital. To see the psychiatrist was just incredibly hard. And then, if you wanted to be present or

speak to the psychiatrist, that was impossible nearly. That took promises of media and legal, solicitors coming in on the act on Trevor's behalf to get that help.

At one point when I did get to speak to the psychiatrist, he didn't know how many suicides were in Trevor's family, he didn't know half the pressures Trevor had been living on, because Trevor didn't tell him because he was too busy wanting to die.

Q. You've said since January this year you've not sought help from the hospital in relation to the mental health of Trevor?
A. No.

Q. Or the mental health services. Why haven't you sought help from them again?
A. I think I was so disillusioned last time: you know, things have not improved, and I just didn't have the strength or the fight, to fight with a broken system, and this time it's been different and worse, his breakdown, and I didn't think the system would keep him safe.

Q. Finally, Chris, what in your view needs to change to the mental health system to look after people like Trevor properly?
A. I think that, when someone presents at an Emergency Department, or at a GP, there should be a system - bang. This person looks fine; they're not fine, they're mentally unwell, highly unpredictable. A lot of the time they're incoherent and unable to speak, they need immediate treatment, and I think the carers need to be taken on board. We all understand about confidentiality, but I think in cases of mental illness that needs to be set aside and listen to the carers, listen to the husband, wives, mothers, fathers, that know the patient.

I think we need more psychiatrists. I think we need more trained mental health workers. And, probably one more thing, I have a question - I'm not sure if someone can answer it - how many children's inpatient units do we have? Mental health for anyone under 18, that is even more scary than mental health for adults. Once again, I've lived experience.

MS BATTEN: Thank you very much, Chris. Chair, are there any further questions for Chris?

CHAIR: No. Thank you very much for, again, taking the time to come and share with us those reflections and your very helpful suggestions for change. So, thank you very much for your time.

MS BATTEN: May Mrs Thomas please be excused?

CHAIR: Yes, thank you.

<**THE WITNESS WITHDREW**

MS BATTEN: If now is a convenient time, we'll have a morning tea break.

CHAIR: Yes.

SHORT ADJOURNMENT

MS NICHOLS: Chair, before I call the next witness, may I tender the statement of Terry Welch that I omitted to tender this morning?

CHAIR: Thank you. [WIT.0002.0018.0001]

MS NICHOLS: The next witness is Associate Professor Ravi Bhat, I call him now to give evidence.

<**RAVI BHAT, affirmed and examined:** **[12.09pm]**

MS NICHOLS: Q. Associate Professor Bhat, are you the Divisional Clinical Director of the Goulburn Valley Area Mental Health Service?
A. Yes, I am.

Q. Are you an Associate Professor of Psychiatry in the Department of Rural Health at the University of Melbourne?
A. Yes, that's right.

Q. Have you prepared a statement which details your experiences in relation to the mental health system and answers the questions that the Royal Commission has posed to you?
A. Yes, I have.

Q. I tender that statement. [WIT.0002.0011.0001]
Dr Bhat, can I ask you firstly about the catchment area

served by the Goulburn Valley Area Mental Health Service. You've described it in your witness statement as possessing geographical and cultural diversity. Can you elaborate on that, please?
A. Sure. So, the catchment area for Goulburn Valley Area Mental Health Service covers about 19,000 square kilometres, it stretches from the Murray in the north down to Wallan, Kinglake and Ealen in the south, so the geographical diversity is both from a plains perspective and the fact that there is considerable hilly terrain, a big proportion of it which was affected by the Black Saturday bushfires in 2009.

And culturally also, it is extraordinarily diverse. There are people from all over the world settled in the Goulburn Valley.

Q. Does Greater Shepparton have the highest population of Aboriginal and Torres Strait Islander peoples outside of Metropolitan Melbourne?
A. That's how I understand it, yes.

Q. Does Murray, which is the area covered by the public health care network, have 28 per cent of the total number of Victoria's Aboriginal and Torres Strait Islander population?
A. I believe so, that's right.

Q. Was there a needs analysis performed by the Commonwealth in relation to this area in 2017 and 2018 which showed, among others things, that Aboriginal and Torres Strait Islander people experience Emergency Department presentations for psychiatric illness at a rate of 76 per cent higher than for non-Aboriginal people?
A. I understand that's what the report showed.

Q. In your area, are there a significant number of resettled refugee groups, including from Iraq, Afghanistan, the Congo and the Sudan?
A. That is right.

Q. Does the catchment area include considerable areas of socioeconomic disadvantage?
A. That is right.

Q. In the needs analysis that I've just referred to, was it shown that in the general population across your

catchment area, there were 44 per cent more people who were registered mental health clients than there are in the Victorian average?
A. Yes, that's one way of putting it, yes.

Q. Do you want to say anything else about the characteristics of your catchment area?
A. No, I think you've covered most of the details.

Q. Yes, alright. Can I ask you about the Goulburn Valley Area Mental Health Service. Did it have an average of just over 6,000 referrals each year calculated over the past five years?
A. That is right.

Q. Were more than one-third of those categorised as requiring an emergency, high urgency, urgent or semi urgent response?
A. That is right.

Q. Can I ask you about the different services that your mental health service provides. In relation to bed-based services, what are they?
A. The bed-based services are basically for adults and older people. For adults, there is an inpatient unit that has 15 beds. There is a prevention and recovery care service, which is a step-up/step-down service, that has 10 units.

Q. While we're there, can I just ask you, does that in practice function both as a step-up and step-down service?
A. Yes, it does; more so in the last few years, yes.

Q. What other services do you have?
A. There is a 10 bed Specialist Rehabilitation Program, which is essentially a community care unit.

Q. While you're there, I want to ask you about that one. Is that one that's run in partnership with Wellways?
A. That's right. So, both the PARC and the Specialist Residential Rehab Program are run conjointly with Wellways.

Q. The Specialist Residential Rehabilitation Program, was that the first of its kind in Victoria and Australia in fact?
A. Both were actually, PARC and Specialist Residential Rehab Program, but Victoria has always had community care

units, so CCUs. Elsewhere there are clinical CCUs, in the sense that they're manned by medical health professionals. Whereas Specialist Residential Rehab Program was different in the sense that it was developed in partnership with Wellways, so there was a mix of clinical and non-clinical staff.

Q. What, in your assessment, is the importance of having a mix of both of those kinds of staff?
A. I think it depends on the phase of care that we provide. In the end, it is vital that, for all of us, that we live lives that are flourishing and that, you know, the idea of recovery, that we have a roof over our head, that we learn, that we work, that we are loved and so on, and to achieve those ends doesn't mean that you have to, you know, have complete symptomatic remission.

I think what having a mix of clinical and non-clinical staff does, is that, you get both perspectives: you get the perspectives of a clinical staff member that's focusing on symptomatology, distress and risk and so on and so forth, and the treatment of all those.

Whereas from the non-clinical staff, you are essentially seeing the perspective of someone who's thinking that, here in this trajectory of life this person who is suffering now has moved away for a lot of reasons and how to help that person come back into that trajectory that they wanted to live. I think these are very important perspectives to have.

Q. The Specialist Residential Rehabilitation Program has been evaluated, has it not?
A. That is right, yes.

Q. What did that evaluation find?
A. What the evaluation found was that, over nearly a 13-year period - I might be mistaken on some of the details here - over a 13-year period of the people who engaged in the program, they had an average length of stay of about 215 days, and at entry there is an evaluation by which the participants, as they are known, they set their goals as to what they want to achieve while they're in the program. Their needs are also assessed in a systematic manner, and at the end of the program about 90 per cent, from memory, had gone into their own accommodation. About two-thirds of people had either gone into an educational program of their

choice or gone into some sort of supported work program, and about half the participants had either developed or got back into an intimate relationship.

Q. What's the level of acuity of the patients who enter into the Specialist Residential Rehabilitation Program?
A. Most people are severely unwell; they tend to have one of the following diagnoses: they're suffering from either schizophrenia, bipolar disorder or very severe depressions often, or sometimes very severe personality disorders. Their level of disability is typically very high in being able to manage every day affairs. About two-thirds, from memory, had a comorbid alcohol and drugs problem, so in that sense these are people with the severe and complex end of psychiatric problems.

Q. Can I ask you about community treatment more generally. You say in your statement that you, yourself, treated people over long periods of time and up to 15 years.
A. Yep.

Q. Can I ask you what's facilitated that and how important is it to have longevity of relationship between the clinician and the patient?
A. Look, I think it's extraordinarily important, and in this particular case, as I said in my statement, I think some of it is simply because I've, for a variety of reasons, ended up staying in one place. I mean, this October I would have worked in the same place for 20 years.

But a lot of it is because of the fact that you develop trust with people, that the person learns to trust you, and you get then this privilege of getting to know them over a long period of time, which I think, it's not easy to build those relationships in the first few assessments, or maybe in an inpatient facility when people are admitted; you can certainly develop a therapeutic relationship.

But when you get to know people over a much longer period of time, you have a much more nuanced understanding of their lives and what's affecting them, and this relationship then becomes the bedrock on which discussion can be had about how to prevent future episodes of mental illnesses, or even if there is a relapse, how to mitigate

that relapse so that things don't get out of hand for the person.

Very importantly I think to focus on what flourishing might look for that person. Certainly, my clinical work mostly has been with older people and, you know, older people can flourish too and they get better and they get to do things and that's quite important.

Q. You've engaged in some activities that you describe as capacity building in your region?
A. Yes.

Q. One of which is to have had the appointment of Professor Ogden in addiction medicine which, among other things, has allowed you to accept trainees in this area. Can you talk about the importance of adding that capacity to what you do in this region?
A. Sure. I'll have to probably step back a little bit before I introduce Ed into the discussion there. I think one of the best things that we can do in regional mental health services is to train locally in all disciplines. Often what happens is that there are significant, what I may term as training steps, in getting people to train locally and having such facilities available.

We have now successfully run a Graduate Mental Health Nurse Program in Goulburn Valley Health for more than a decade, and much under that we have now run a training program in specialist training in psychiatry.

Now, for regional services across Australia, for specialist training in psychiatry, for example, that's my, I suppose, disciplinary area, is that often there's not enough child psychiatry capacity, there's often not enough what's known as consultation liaison psychiatry, both of which are termed as core requirements of training by the Royal Australia and New Zealand College of Psychiatrists. And that has taken considerable time to build at GV Health, which then allowed us to become accredited by the RANZCP to provide training programs.

In the RANZCP training, your trainees are required to get some addiction medicine experience or addiction psychiatry experience, and that might be either through seeing a finite number of people with those problems or it may be through experiencing, you know, under supervision of

somebody who specialises in addiction psychiatry or addiction medicine. Again, it's very uncommon to have that type of dedicated experience.

So we were quite fortunate where GV Health decided to employ an addiction specialist, and Professor Ed Ogden came that way and the next logical step seemed to be, let's work together, develop what we can, because the comorbid presence of psychiatric illnesses and alcohol and substance abuse problems is so common that it's now almost meaningless to talk of them separately and not give trainees of tomorrow, or the psychiatrists of tomorrow, experience in that.

Q. Can you say a little bit more just on that subject about what system capacity is needed in order to have those comorbidities addressed in a practical way?
A. So Victoria since the de-institutionalisation has had these two elements of health provision separate: mental health services and services for people affected by alcohol and drug problems. It's not the case everywhere, it certainly seems to be the case in most parts of the western world, and that may well have been the case back then. But when you look at the proportion of people who, say, have alcohol dependence, the number of people with psychiatric disorders is quite high; the number of people with traumatic experiences is even higher.

Likewise, from the other side, if you look at people who are primarily presenting with psychiatric problems, depending upon which setting you look at, the rates of alcohol and drug problems can range from about two-thirds to nearly three-fourths, or sometimes even a bit more than that.

Alcohol and drugs, you could almost say that in many instances is a kind of self-treatment of the distress that a person finds themselves in, and then it spirals out of control and people end up having these complex sets of problems.

Q. Can I ask you about a couple of other capacity building projects. One is that you partnered with Rumbalara Aboriginal Co-operative to establish a spiritual wellbeing clinic. Briefly, what is that?
A. So, a little more than a decade ago we had Rumbalara Aboriginal Co-operative, which is the local health service,

had a visiting psychiatrist come there and he was planning to retire, Dr Michael Duke. And the Rumbalara Service approached us saying, do we have any capacity, and we had a number of overseas trained psychiatrists and the RANZCP required that they obtain what's termed as indigenous experience.

So we had a discussion, we said fine, we'll rotate these psychiatrists on a three-monthly basis to run a clinic, and at the end of one year, because we had four psychiatrists, very neatly for one year, we said that you then decide which psychiatrist you want, and that's how it started, that we run a clinic and then we put in some additional senior psychiatric nurse time.

But over time we have had to, because of resource constraints, we have had to limit the frequency of psychiatrist review, and we also haven't been able to expand it into child and adolescent psychiatry.

Q. It's a spiritual wellbeing clinic: what does it actually do and what services does it provide?
A. It's very important, I think, to provide a service that's both culturally safe and culturally sensitive. Tagging on names such as mental health and all that, as we've heard before, can be quite stigmatising, can be quite difficult for people to even approach. So, in some ways the clinic is about mental wellbeing. It is about the connection that people feel to the land and improving their wellbeing.

The psychiatrists in the clinic provide for traditionally diagnostic assessment and treatment service. The nurse provides a much more broader approach than that.

Q. I see. Do you have workers other than psychiatrists and nurses in that clinic?
A. Not from the GV Health side, no.

Q. I see. You've also, since 2012, separately from that, run a series of consultant psychiatric-led clinics into general practitioners?
A. Yeah.

Q. Briefly, what is that service and why is it important?
A. So, one of the things that we realised was that, often when general practitioners referred people to us, that they

were not necessarily seeking a transfer of care, so to speak, they really wanted an opinion as to what the problem was and to get a sense whether they were on the right track with the treatment or not. So we decided that one approach that we could do was to - and these are not people who would be traditionally taken up by a state-funded mental health service to provide care, because they might not necessarily meet the complexity and the risk that often predicates state-funded mental health services care.

So, we developed a series of clinics that would be provided in the general practice, either face-to-face or through telehealth, and those set of clinics now sees anywhere between 500 to 700 people a year.

Q. What proportion of your area is that able to service?
A. So, that accounts for - because all referrals are directed through our centralised triage, that accounts for about 10 per cent of our referrals now. So it's a considerable number. It has its limitations, even though it's been evaluated and found to be well accepted by general practitioners and patients, it has limitations in the sense that it's purely a diagnostic assessment service, and also that, as the EBA changes the funding that we get through Medicare reimbursements, they no longer meet how much we pay the psychiatrist to work there.

Q. So, its funding isn't secure?
A. Its funding is very insecure, yes.

Q. But, in your assessment, is it an initiative that provides real assistance to GPs and therefore their patients?
A. I think so, and the independent evaluation that the Department of Rural Health and City of Melbourne did showed that that's the perception by the general practitioners and patients who attended the clinic, yes.

Q. Can I ask you now about the prevalence of mental ill-health in rural communities, and I want to direct my questions generally to rural communities.
A. Sure.

Q. Firstly, in interpreting prevalence data, do we have to be mindful of terminology and definition? And, can you say what we should understand by the expression "rural" in connection with this data?

A. So, as you perhaps know, rurality has been variously defined, and when we interpret studies we have to be both mindful about definitions of rurality as well as definitions of mental illness and mental health problems.

So, if you go by the UN, United Nations definition, it's any urban centre that's 20,000 people or more, and of course we have the Australian classifications as well which classify through metropolitan, to inner regional and outer regional and remote and so on.

What studies from overseas show is that - again, it also depends on the mental illness - so we often talk in terms of a serious or severe mental illnesses, which are often conditions such as schizophrenia, bipolar disorder, severe depressions and so on. Then we talk about common mental disorders or high prevalence disorders which include mild-to-moderate depressions, mild-to-moderate anxiety disorders and the like.

The evidence would suggest that severe mental illnesses are probably the same or may even be more in urban centres, perhaps even more in metropolitan centres.

The high prevalence disorders, the prevalence is more contentious, it depends upon the study and how it was done. I suppose the general agreement is probably there are no significant differences between urban and rural. But psychological distress may well be higher in rural areas.

Q. Can I ask you for some clarification there. The studies you've referred to, we won't discuss the actual studies, but do you say they're applicable to Australia?
A. I think they're mostly applicable, in the sense that, once you nuance them and understand what they relate to, I think in that sense they're applicable. Of course, there are significant differences in population and so on.

Q. Of course, and what's a good working definition of rural community for our purposes, do you think?
A. I would probably go with the Australian classifications.

Q. Which is?
A. Which is, that goes from remoteness to metropolitan.

Q. So, a rural community would be, what, under that

classification?
A. I can't tell you off the top of my head what the definition there is, but the UN definition certainly would say that it's people under 20,000.

Q. You say that both the more severe and the so-called higher prevalence disorders are about the same in rural and metropolitan communities, but the level of psychological distress is thought to be higher in rural communities in Australia?
A. Maybe higher, yes.

Q. By psychological distress, what do you mean?
A. So, usually psychological distress is measured by scales that measure symptoms of anxiety or depression; there are a number of scales, call it K10 for example or PHQ9, and they don't necessarily lead to a diagnosis; they are indicative that a person is distressed in some way in their mind, and in those scales the rates appear to be higher in studies done from rural areas.

Q. So regardless of diagnosis, there's an experience in the person of psychological distress?
A. That's right.

Q. Do you say in your statement that, leaving to one side location by itself, factors such as socioeconomic disadvantage are relevant contributors to the prevalence of psychological distress?
A. Yes.

Q. One of the things you point out in your statement is that there can be particular barriers for particular groups of people in rural locations in seeking help for mental health issues, and is one group of those, young people from refugee backgrounds?
A. That is right, and we have done a study locally and we found that to be the case.

Q. Did you find that there was a real concern about those young people seeking assistance, particularly for early psychosis, and that the longer the symptoms went on untreated, there was a correlation with more complex and severe presentations later on?
A. That is the understanding, yes.

Q. What were the barriers to seeking help that you found

in your study?
A. So, in our study we specifically looked at young people from refugee backgrounds, and it mostly had to do with perceptions of what constitutes a mental illness, stigma against mental illnesses, especially severe mental illness which was often colloquially termed as "going crazy" and so on. And lack of accessible services for many people from their country of origin which quite significantly influenced how they viewed the world as to what access would be in, say, like in a country like Australia.

Q. What conclusions did you draw about the steps that might need to be taken to improve that situation for young people from refugee backgrounds who need to seek help for mental distress and illness?
A. A few things, and one of the first things was to have greater engagement with the refugee community, with greater opportunities for mental health literacy, improving mental health literacy, and also showing what services are available, so it's not just about talking about them, it's actually taking people through the services to give them a sense of what's available.

Q. Can I ask you what you know about the rates of suicide in rural communities, as opposed to the metropolitan areas?
A. So, suicide rates in Australia in rural communities is higher: anywhere from 1.5 to 2.5 times higher, if my memory serves me right, and it increases, the rate of completed suicide increases with the remoteness. Most of the increase is accounted by the fact that it's an increase in suicide in men as compared to women.

Q. And young men in particular?
A. Young men but, as we have heard before, even men in the middle - you know, from 35 to 45, that's an age group that is particularly at higher risk of suicide, and also older men, who are much older than that age group.

Q. Can I ask you about the issues relating to access to mental health services in rural communities. What difference does rurality and remoteness make in accessing services? Can I ask you firstly in relation to the tyranny of distance?
A. You know, it's a well quoted phrase, Geoffrey Blainey's phrase of tyranny of distance. It's a huge problem, as we've heard before from Mr Welch and community

witnesses earlier on, that people in rural areas face multiple problems. There is little or no public transport in some or many areas in Regional Victoria to access long distances.

Then there is the problem that, while car ownership is generally pretty high in Australia, we know that as the car ownership rates decrease with further remoteness, we also know that, especially given the fact that rural areas are more likely to have areas of relative socioeconomic disadvantage, that you can expect more poor people to be living.

So, while some people may be able to own a car, they might find it extraordinarily difficult to actually maintain a car, or even if they're able to maintain a car, just to pay for fuel to travel long distances then becomes extraordinarily difficult.

As we heard from Mr Gabb before, it takes a day by the time you do things and go out to see somebody, and you've effectively lost one full working day for one appointment. So, all these are very important barriers, let alone other issues such as mental health literacy and stigma and so on.

Q. I was going to ask you about those two things actually. We've heard a bit about that today already, and in your experience, to what extent are these barriers to help-seeking?

A. It's mixed. As we heard before, rural communities can also be sources of strength, they can also be sources of where people can encourage each other to seek help, but the very fact that I know a number of people in my own community can also mean that I am less likely to talk about the fact that I have a problem, as to how I might be perceived by other people, so perceptions of stigma, perceptions and something that's known as self-stigma where I stigmatise myself for having a problem, can be a much bigger problem in Rural Australia.

Studies have shown that mental health literacy per se may not be that lower as increasing by remoteness, but stigma and self-stigma may play a very important role.

Q. Can I ask you about the availability of services in rural communities as opposed to non-rural communities, concentrating on the state-funded services.

A. Yes.

Q. In your assessment, are there significant disparities in the availability of services and, if so, what are they?
A. There are huge disparities in the availability of services. When we de-institutionalised in Victoria in the mid-90s, the character of services, the types of services that were developed, and which I thought was extraordinarily thoughtful coming in as an outsider back in 1999, is not something that's necessarily ideally suited to Regional Victoria.

One such service would be, for example, the Crisis Assessment and Treatment teams. Now, they are supposed to respond quickly in the community, not just emergency-based, but given the large distances, it makes it almost impossible for CAT-like services to move away from wherever they're based to beyond the 50 kilometre areas and that is a huge problem.

So, I think most regional services have had some version of availability of Community Mental Health Teams; these are often teams that work during working days; they don't have a presence after hours, which means that at least metropolitan services, even though we don't necessarily offer 24/7 services, we have some services available still over the weekend, and that is hugely restricted in rural and regional areas.

Q. So, apart from the availability of CAT or similar teams, and more limited availability of Community Mental Health Teams, are there other disparities, for example acute inpatient beds; is the availability less in rural areas?
A. I believe so, and I can certainly speak probably more in relation to GV Health. According to a letter to the editor published by Stephen Ellison and colleagues, at the moment Victoria has 22 beds per 100,000 population. By that count, in Goulburn Valley Health we should be having 33 beds, this is including aged care beds.

Q. And how many do you have?
A. 20, so 15 adult and five beds for older adults.

Q. Over what period of time has your bed count been less than you think it should be?
A. For the better part of the last decade, I would say,

that it's been lower, and as the demand for services has increased which has meant that there's considerable pressure on admitting people and having a throughput, getting people out, which then is made purely on the basis of how risky a person is.

And also, the geographical distances are such that it's not possible, the way it might be let's say if you were in the metropolitan service, where people can access other inpatient services.

Q. Can you say a little bit more about the throughput pressure?
A. So, the Victorian Mental Health Triage Scale, I'll start there, is based primarily on risk, which means that, if a person is especially presenting with a serious risk of either harm to one's self or harm to others, then often the first thing that we need to do is to try and provide an environment where that risk can be mitigated, which means that you have to admit people, or at least provide a safe environment.

Some of the metropolitan services, for example, have psychiatric assessment and planning units which are attached to Emergency Departments where you could potentially keep people for a shorter period of time, less than 24-48 hours at least, and then decide what you could do next. So, with a very limited bed capacity, that's 15 adult beds in the face of demand and with no access to a psychiatric assessment and planning unit bed and other sorts of facilities like that, which means that you have to make decisions quite rapidly as to how long you are going to keep somebody there, which I think is hugely problematic in providing care.

Q. Is one of the problems that people can be discharged before they're ready to be discharged?
A. Yes, that may be the case.

Q. There again, there are - it's not just about discharge, it's also about providing care that's appropriate to the type of condition that a person is presenting with. So, what we have noticed is that often people with more severe mental illnesses, like schizophrenia, bipolar disorder and the like, the duration of admission rests on the time it takes to start a medication and the medication to start affecting them.

But a number of other people with very complex problems where there is a mix of alcohol and substance problems and deliberate self-harm or suicide and other depression and anxiety symptoms, it's not just about inpatient care, it's also providing the care after discharge.

Q. Are the demand pressures on the system in your area such that you can't always provide the level of care post discharge that you would like to provide?
A. It's the type of care that I think is very important. I think that, with how demand and services have evolved, I think state-funded mental health services are reasonably good at providing a good assessment and managing the immediate risks, but many people with complex problems - not the severe mental illnesses that I have talked about earlier on - need psychotherapies for ongoing treatment and often that capacity simply doesn't exist.

Q. What are the particular pressure points for demand in your area?
A. One of the pressure points is the capacity to provide intensive follow-up across the entire catchment area; not just limited to, let's say the local government area of Greater Shepparton.

The other touch points are the fact that there are limitations in how many inpatient beds that we have.

Q. Are there particular workforce issues in providing the extent of care that you would like to provide?
A. One of the things I think we all have to appreciate is that the problems that mental health services face are hugely amplified in rural areas. So, probably what I should do in terms of workplace is just to go back in time a bit and just provide that historical context, if I may.

Q. Yes.
A. So, I think we've heard over the time of this Royal Commission that the system is broken. The idea of being broken implies that it's not working the way it was intended, and when we look at how the system was established, it was really established for caring for people in a de-institutionalised environment. It was really built for people who had been institutionalised, who had been discharged from there and who might have been

institutionalised had those institutions continued to exist, and these are people with very severe mental illnesses.

In these institutions there were clear roles of not just doctors and nurses but also for allied health staff such as psychologists and occupational therapists and social workers and the like.

And, while I think de-institutionalisation was a radical reform in many ways, and especially in the fact that it brought into focus the fundamental human rights of people with mental illnesses, I think one of the effects that it's had is that the focus became on providing what's known as case management, which is mostly coordination of care. This, in my opinion, left out a highly specific discipline skill set, such as psychology and occupational therapy and so on, which has affected Victoria-wide in my view, but has affected rural services even more.

So, from a workplace perspective, it's how we grow as human beings: we go to universities in metropolitan areas, we graduate, we fall in love, we start families, and the pull to come back to rural areas is quite limited, which means that the staffing levels required to attract people to come back into rural areas is, again, quite limited and often regional mental health services don't have the same buffer that metropolitan services have, which means that you get one person leaving the service that has a huge impact because you're already so tight - I have to use a very technical term - the redundancies in the system hardly exist.

Q. Are there other ways, too, in which there is less redundancy built into the system in rural mental health services?
A. Yeah, I think so, and I think the capacity for rural training is quite important and, as many rural clinical schools have shown, you can train medical students in rural areas, you can show that people stay back and work in rural areas. I think the same things can be done for mental health professional workforce as well.

In the last decade we have had about 49 graduate nurses go through our program; 41 stayed on the first year. I think, if they hadn't stayed on, we would have collapsed long ago. So, it is possible to do these things, it is

possible to train psychiatrists. We have this year employed a first psychiatrist who was also a trainee at the service. So, these things are possible, but they need a lot of attention, they need localised capacity building, not something that is distant and we can't always assume that Metropolitan Melbourne knows the best.

Q. On that point can we segue slightly to the role that you think technology can usefully play in the delivery of mental health services rurally, and can I particularly ask you to address the issue of the need for a face-to-face, human-to-human contact and the extent to which you say telehealth can assist in that?
A. Sure. I don't think I can put it more eloquently than what Mr Gabb did earlier on. I don't see public transport improving in Regional Victoria in my lifetime, so really what we have to then do is try and address issues the best way we can with the technological capacity that we do obviously have now, and in that sense I think telehealth is extraordinarily important, as we have ourselves shown that it is possible to actually provide much better access, though we are limited at the moment by providing only diagnostic access.

I think that there has to be investment made in technological infrastructure that connects the large regional hospitals to these smaller rural hospitals. It's something that we're trying to do in Goulburn Valley Health now, which means that what we could do is, as we've heard before, we can not only look to provide urgent video triaging but also video assessments, but this then has to be done with somebody at both ends so that the person, let's say sitting in Seymour or Kilmore is not alone, they actually have somebody that they know, that they're in the process of assessment, or at least they're there at the start or towards the end, just to make sure that things have gone well.

Q. You might have been going to answer my next question, which is, by way of example how would that work and what kind of staff person would you have sitting with the person who is receiving the assessment by remote?
A. Look, I think to some extent it would depend - again, this is speculation on my part, I don't have any evidence to show that this works, because the only evidence we have is from a non-emergency situation, which is in a general practice clinic, and there what has worked really well is

for the general practitioner to come in with the patient at the start, to introduce the patient, to have that initial discussion, then leave so that the psychiatrist and the patient can have a discussion and decide on where to go.

I think in at least urgent situations it is still possible to replicate this, but that will require much greater collaboration between the large regional hospitals and the smaller rural hospitals so that you have staff at both ends and you can actually build capacity.

What we will need to perhaps do this is to layer this with other models of capacity building, and one of the models that I have quoted in my statement is the so-called Project Echo which started in the United States and it's really focused on people with severe hepatitis and hepatic failure in the context of hep C infections. That's now a major model and Professor Ed Ogden has now introduced that to the mental health service as well, so we have a connection with St Vincent's Hospital and we participate in this model.

It's a highly structured way of learning, and everyone learns, everyone teaches, and that's the motto of the program. So, if you layered a clinical service degree with an educational model, you are much more likely to get synergies much more likely for capacity building, for fine-tuning the service so that at least people then don't have to travel all the way from, say, Broadford or Wallan to Shepparton, they could go to Kilmore or the nearest smaller rural hospital and have that linkage.

It will take time but I do believe that the technology exists, the understanding of capacity building exists that can make it possible, yes.

Q. We've asked you to reflect on the development of the system as it was in the 1990s and you referred to that a bit earlier.
A. Yes.

Q. What is your opinion about the way the population needs have changed, and I'm speaking now about Victoria more generally - - -
A. Indeed.

Q. -- since de-institutionalisation in the 1990s.

A. As I said earlier, the system that we have today was something that was designed for de-institutionalisation. It was designed for effectively the care of people with serious mental illnesses, and since 1994 a lot has changed, we have added nearly 2 million more people in Victoria, so the population itself has expanded considerably.

What has also changed is the types of problems that people are presenting with. So, the structure of services that was designed was designed keeping in mind people, let's say somebody suffering from schizophrenia, and one might reasonably expect that this person will have difficulty in adjusting to a life, that they might have a crisis and so on, so you had Crisis Assessment Teams, you had Case Management Teams, you had Mobile Support Teams for those who were very unwell and who were not taking their medications and needed a lot of support.

But in the two references that I've given of presentations to emergency departments, what we have seen is a compete change in the type of presentations that people come with. So, there is this extensive study, Victoria-wide study that looked at so-called paediatric presentations, that is 0-19 years, as well as a study from four Emergency Departments, three or four in Melbourne, and both effectively showed that mental health presentations for mental and behavioural disorders due to drug and alcohol and so-called stress and anxiety disorders, along with suicidal ideation and suicide attempts, now account for well more than 50 per cent of all presentations.

Q. What does that tell you about the needs that the system has to now serve and how it should be different?
A. We know from work done outside of Australia that what clinicians are telling us is not inaccurate. It takes anywhere from one to two and a half hours to do an assessment, a psychiatric assessment in, let's say, the Emergency Department.

So, what this has done is that, when the rate of presentation for these complex mental health problems has increased, a lot of effort goes into doing an assessment, documenting the assessment and having a treatment plan, or at least the risk management plan.

In this time the core mental health services, which are the crisis teams and so on, the funding has not

necessarily increased, both human and financial resources haven't really increased. Which means that now they're dividing their time between the new demands and they, in my view, have less time available to do what they were designed to do, and this then creates this difficulty in providing ongoing care to a whole lot of people.

Q. So, what is the gist of the limitation you're now discussing? Is it the assessment teams not having adequate time to do what they have to do or something different?
A. It's both. So, we have services that have - what has happened over time is that - I'll probably step back to nuances a bit. I think my senior colleague, Dr Ruth Vine, about a week ago showed this graph about the number of reform items and things that have happened. I think one of the points I make in the statement is that there has been no whole-of-system review which has meant that, whenever there have been problems or whenever there have been ideas which may have been very good ideas at the time, they have been picked up and addressed without necessarily understanding the whole-of-system impact.

Q. Yes.
A. So, when we say assessment teams, now often in rural areas, for example, assessment teams are typically also done by rosters, which means that you have people who do their regular ongoing work, they're rostered into the assessment teams as well, and there are limitations in how long people can work and what safe working hours are and so on. So, when people work and a lot of attention is paid to assessments, then often there is no workforce extra left that could do other work as well, which is follow-up of people and providing ongoing care.

So I believe this has affected the services in this way, that you have very finite time, it's being divided into work that is much more than what was anticipated at the time of the institutionalisation, and the type of work that was anticipated at the institutionalisation.

Q. Are you saying that at a system level there needs to be a more sophisticated understanding of the types of demands on the system, not just numbers, but the types of problems that people have and the way in which the parts of the system work together?
A. That's it, you've put it better than I have, thank you.

Q. No, I don't think so, Dr Bhat. But, are you also saying that, since de-institutionalisation, when particular parts of the system have been examined, they've been examined for improvement in a piecemeal way?
A. Yep.

Q. And the consequences of that have been?
A. The consequences I think have been twofold: oddly enough and ironically enough, one has been a fragmentation of services which has meant there are smaller services or issues that have been funded for that address a particular problem, and I think, if you look at that problem alone, many of those services do indeed do that.

The other thing ironically that's happened is, loss of specialisation of what I would call an integration, I suppose. So, many of the services that used to exist, for example, Mobile Support Teams and so on, I am told in Metropolitan Melbourne they no longer exist because there's been such pressure to get the work done, so to speak, that services have cut down what they have to offer.

But what it does really is that it affects the people who are the most vulnerable, who don't necessarily have a voice.

Q. One of the things you mentioned earlier in your evidence today was the interaction between alcohol and other drug problems and mental ill-health. You've said in your statement that:

> "Area mental health service programs were well designed but the overall design didn't adequately consider the needs of people with both serious mental illness and alcohol and drug use disorders. Decisive action needs to be taken to cease the separation of those two streams."

What are the fundamental points about ceasing the separation of those two streams? What needs to happen in your view?
A. At one level it's very simple, these services need to be brought together, and that of course is easier said than done. There are complexities in terms of how services have evolved, but I think that's the start, that's the

discussion that I feel we should be having: to say, these two so-called separate problems are so intimately related that we need to look at how to bring them back. So, I don't really have an answer of how to do that, but I think we should be having those discussions.

Q. It should occur. You've also made some observations about funding.
A. Yes.

Q. And you've said fairly directly that funding should be activity-based. Why is that?
A. I think we have to move somewhere. As previous witnesses have indicated over the last week or so, the funding for mental health services was so-called input or block-based. Looking at the framework documents from 1994, it was very thoughtful for the time and very thoughtfully considered, and adjustments were made for socioeconomic disadvantage and rurality and so on.

But the fact remains that mental health services continue to remain the so-called Cinderella of services, they don't get funded to the same extent as acute medical health or health services are, and the problem with block funding also is that it may not necessarily match activity, which increases over time, which is what has happened with acute health services, that as activity has increased, funding has at least kept somewhat in step with the increase in activity.

So, I think that it's vital, and also what happens is that block funding services does not necessarily mean that it's transparent over a long period of time. It would have been very transparent at the start, but as time progresses it's no longer transparent because things change.

So I think that it is vital to move towards some sort of an activity-based funding with some kind of loading but --

Q. When you say "loading", is that what you mean by locale-based funding?
A. Indeed, indeed. You know, we have to be informed, just as the people who went through the de-institutionalisation process had some idea of social economic disadvantage. I think we need to do that.

But ultimately, I would say this: that the system will develop people by the metrics that it's been measured against. So, for example, if you're going to measure against a system's cost efficiency, then you will get people, managers and whatnot, who will be highly developed in their cost management skills. You evaluate a service on the basis of processes and process indicators, you will get quality and safety people who will develop from that perspective.

I think that, if we are to go with the spirit of the Mental Health Act and where we are going with the Charter of Human Rights and the function of this Commission, and if we're saying, no, what matters to us is outcomes as to what people become: do they flourish in their lives? Do they have a roof over their head? You know, are they working, the kind of work they want to do? Do they have an intimate relationship? If these things matter, then we can't keep on doing activity-based funding. Ultimately we have to say, hey, what matters to us is outcomes of people, are they living healthy lives?

I think if they're going to get measured with that metric, you will also develop individuals within the system who will not just count the money, who will not just count whether the processes are being followed, they will actually see how many people are getting better, and are they leading productive, flourishing lives?

Q. So, you would say, at least funding in mental health should be activity-based whether loading for locale --

A. Yes.

Q. -- but real consideration needs to be given to moving towards outcome-based funding?

A. Eventually, yes.

Q. Can I finally ask you this: you have made an interesting observation in your statement that you:

"... doubt that any change will bring about lasting improvements."

Which I think is a response to our question?

A. Yep.

Q.

"... simply due to our limited human

capacity to apprehend complexity and predict the future, but we can shape the future by ensuring that any change to the system is undertaken with a clear statement of expected outcomes which has an end date."

And you've said that:

"We need to be agile in implementing our changes."

Can you say what you mean by that?

A. Look, I think we can think that we are in the midst of a Royal Commission, that we've got all these people, we've got so many submissions, we can easily fall into the trap of thinking that we have all the answers. I think we should not. I think that the future is inherently uncertain. It's not like a roulette machine where the odds are known and we can predict what's going to happen, it's inherently uncertain.

So, I think that we should be careful about saying things like lasting changes and so on. I think that we should design a system for the realities that we know today, but I think that we should develop a system that is reflective, that is adaptive, that is responsive, that is data-informed.

We have an antiquated so-called patient administration system in mental health. We don't have a common electronic medical record for example. Now, they come with a lot of problems, but, for example, in rural areas I think electronic medical records are critically important.

Now, if you have these things, and if you have a system that does not wait for another two and a half decades before having another Commission, another review, and that says that, let's say every five years or every 10 years, we are going to do a system check and we're going to see what that reality looks like for that point in time, and then adjust systems so that it's not addressing one problem, it's actually - it may still address one problem, but it says this is what the system-wide impact is going to be.

One methodology for doing that is what I have quoted

in my evidence, is this implementation program called Agile Implementation, unsurprisingly developed by a geriatrician who are much more used to complexity than people in other parts of medicine - I shouldn't deride my colleagues, but geriatricians are comfortable with complexity.

So I think systems should be designed so that they're capable of checking at regular points in time. I think we would fail in future if we didn't do that. I think that, depending upon what we do, we should account for it. So, for example, it may be services for the complex mental health problems that people, we all suffer from today, but it can also be about preventing.

One of the things that I have talked about in my statement, is that, a lot of the complex problems have their root in childhood, and we now have very good evidence that adverse childhood experiences that can range from neglect and bullying, to horrendous abuse, all lie at the root of problems that we see in youth and much beyond that. I think we also need to develop systems that look to mitigate, because the evidence for mitigation in the earliest years, that is, from the time of pregnancy to the first five years, we have good evidence now to show that we can make a difference.

So, I think it's designing based on the evidence we have today. It's a system that I would say has scientific temperament. By science, one doesn't have to mean that it's all very cold; science means that we are capable of critically examining what we're doing and we make funding decisions based on that. So, if something is not working we should also have the courage in a future system to say, we will stop funding this, which we don't do these days, and we rely on services to close some of their programs based on funding pressures.

So, I think we need an adaptive, responsive system designed for current realities but will check on itself over time.

Q. So, the adaptive responsive system needs to have an inbuilt capacity for self-review across the entire system on a regular basis?
A. Exactly right, yes.

MS NICHOLS: Thank you, Dr Bhat. Commissioners, are there

any questions?

CHAIR: Professor McSherry.

COMMISSIONER McSHERRY: Q. Dr Bhat, thank you very much particularly for your statement with all the references in it, we're working through all that. Can I take up that last point about the clear statement of expected outcomes in changing the system which has an end date. What would you envisage in terms of an end date, you've spoken about a self-review every 5 or 10 years, is that what you're picturing?
A. In a manner of speaking. I mean, what I mean is that, if we are to go by, say, evidence-based services for which we have evidence at the complex level, then we should be able to specify what outcomes we are hoping to achieve, and we would also have a sense to say how long it might take to actually achieve those outcomes. And I'm not saying that outcomes necessarily have to be achieved in a year, it might take 5 years.

I think we should have a system that says that, if we provide this service, then we expect these outcomes of the service providers, say in 5 years' time, or maybe in 10 years' time. And, if those outcomes are not achieved, then we should have the courage to say, maybe we were wrong; maybe we were wrong to think that worked and we change our plans. That way, at least we are proactive in thinking about what we want rather than being reactive to problems.

COMMISSIONER McSHERRY: Thank you very much.

COMMISSIONER COCKRAM: Q. Thanks, Dr Bhat. You mentioned it as you were coming to a close in your statement today, but in our consultations and in our previous hearings, we've heard a lot about the capacity of rural systems to access Child and Adolescent Services and Youth Services for young people in these communities.

Can you make a comment about some of the barriers and what you think might be some of the solutions?
A. I think barriers exist across the system, to start with, again trying to take a historical context, is that Child and Adolescent Mental Health Services, they did not receive the same type of thoughtful planning that the adult mental health services, or even the aged mental health

services received at the time of de-institutionalisation, because I think there were no institutional reference points for that, and some of the reference points that did come, came from child guidance clinics, and the CAMHS services as they're called, they adopted a model of care which was suited to certain groups of people, and I think in the first decade it became quite clear that it actually didn't help people, help kids who had the most severe needs, and I'm specifically talking about children in out-of-home care, which I think resulted historically in a fragmentation of CAMHS services.

So, as you might know as Commissioners, that take two was created really as a therapeutic arm for children in out-of-home care, and what that meant was that there was a further depletion of CAMHS services. Now, again, as has happened with other services, you take metropolitan services, all those problems amplify in rural areas. So, you have services that have depleted, now in many services there was simply no capacity to provide adequate care.

The second barrier I think that has shaped CAMHS is that, it's not easy to have child psychiatrists available for rural CAMHS services, and this is not just about Victoria, it's been a problem throughout Australia, which has meant that, without having an adequate number of child psychiatrists it's not possible to develop a local training program; and, if you don't have a local training program, then you can't provide that multi-tiered services that you could provide.

The third big issue is that, the way it was designed originally, that none of the rural and even ultimate reporting services would have child and adolescent mental health beds. which again, there is a problem there in the sense that, you know, you can't have large inpatient units because you may not have the capacity to even run them.

But at the moment the difficulty is that, say, for example, if a 15-year-old presents to the Emergency Department of many rural services, they may not be able to be put into the metropolitan services that they link into that night, which means this 15-year-old kid has to now spend time in an Emergency Department until a bed becomes available, or even end up in the paediatric unit where there is no dedicated capacity to manage the types of problems that this 15-year-old might present with.

So, I think it's, across the spectrum all these problems get amplified in rural services. What's then happened is that, while in recent times there has been some effort to improve capacity through CAMHS and early action in schools, for example, focusing on very young children in the school system, it's not for the entire age group.

My colleague, Dr Vibhay Raykar, who used to be the Clinical Director of our CAMHS, has recently come back from a sabbatical at Tulane University where they have the Tulane early childhood collaborative program and a number of other programs. Now, what they have done to address this problem is that, you see, by the time a 13-year-old or a 15-year-old comes with a severe enough problem, as per the Victorian mental health triage scale, it's already too late in many ways.

What they have done in Tulane is that, instead of having this stepped care or tiered approach, they have actually brought services together. So, you have the equal end of CAMHS services, that's the child psychiatrist and mental health clinicians, actually sit in regularly with paediatricians and mental health nurse and child health nurses, what they call as kerbside consultations: they provide support, they provide secondary consultations, they actually see people so that you don't actually wait for a triaging system to pick them up; they pick up children early and then they provide treatment and care. So, I think we need to rethink all these things so that we can actually make a difference.

We have heard a little about this issue about the intergenerational problems as well. One of the other things that the Tulane collaborative does really well is that often, especially for children in out-of-home care, their parents may not know how to parent, or they themselves may not have had models of how to parent, and they have something that sounds deceptively simple, like parenting programs, and these seem to have a big effect as well. These are the kind of mitigating factors I think which - well, we have models that seem to work. The Tulane model has now been adapted in many ways in at least a couple of sites in the UK, for example, so we know that these things are possible that can mitigate effects and improve care.

COMMISSIONER McSHERRY: Thank you.

CHAIR: Thank you, Dr Bhat, for your comprehensive evidence. There's just one issue I wanted to follow up a bit on that. We've heard in the course of today's hearings but also in other hearings and consultations we've done, that sometimes people in Rural Victoria have this really difficult choice: either stay in the community with the supports around them of family and friends in their own home and especially for younger people, or transferred to Melbourne to get access to specialist treatment and support, and I think we also even heard this morning about the challenge.

So, even in a redesigned future, you can conceive that there may well be people in Rural Victoria who will elect to stay in their community, get help from their local services and their GPs, prefer for example to be in a general paediatric ward or a general hospital rather than transfer.

How do you think, in this redesigned system, we can provide better support to those carers who consumers are electing to have provide their ongoing care rather than move away or have to travel great distances to get that support?

A. I don't have a simple answer; I can't even think of an answer, to be honest. But I think, if we develop capacities within the large regional hospitals in Rural Victoria, and if we develop capacity of very strong linkages and relationships between large regional hospitals and smaller rural hospitals, and if we capacity build at each level, and if we use things such as telehealth as an add-on capacity to this, I think that it is possible to make a difference.

Now, I know that, while rural services have historically faced considerable challenges in recruiting psychiatrists, for example, to their services, I know it is possible to do that. I know it is possible to provide an environment where people do want to come. I know it is possible to develop a training program.

But, to use a phrase, it's all on the edge of failure. It needs one person to lead, it needs one thing to go wrong that it collapses. Just to give you one example in raising capacity: so, Shepparton is home to the Department of Rural

Health of the University of Melbourne, which means that we train medical students there. When medical students finish their training they need to do an internship. Now, there is obviously some capacity for an internship, both at GB Health and at another program called the Murray to Malvern program. So, we can get people there.

After that we can provide the full five-year training in psychiatry at Shepparton but not other disciplines. Not everyone wants to do psychiatry, so then the issue is that, what do we do in terms of providing training opportunities in regional areas so that people train there?

We know that if people train there the chances that they stay back in those communities is much higher, okay. So, I think if we think about the system broadly and see, this is the workforce that we need, I think we can get people there.

Simultaneously, if we build these linkages between health services and we provide opportunities for people to do the type of work they would want to do; now, what I mean by that is that when we had de-institutionalisation the idea was to have these so-called case manager loads.

The thing with case managers was that they were not necessarily there to provide therapeutic work, they were there to make sure that people got the work: the question is, where from? Because then you do not have many teams, and in rural areas this was a particular problem, that don't necessarily have psychologists, there is no way of attracting psychology because of a whole range of issues.

And so, if you created a system where you would have capacity for people to do what they were trained to do and you encourage that, again you're providing incentives for people to work, which is why I come back to the idea that what we should be expecting from people is, these are the outcomes we want from you and from your work; not whether you've ticked off on all 100,000 processes, whether you've done that or not. So, I think we have to have a system enablers that allow people to do the work that they're trained for and we support them.

Rural areas in particular have problems of professional isolation as well, and again, technology can be provided. So, as I indicated in my statement, I am now

back to being a student, I am a PhD candidate, and my supervisor is from Melbourne and she had gone off overseas and she supervised me over an iPad from tens of thousands of kilometres away, so it's possible to do that.

So, we already have the enablers that reduce professional isolation, but we need to think about all these things, which means that we will have to have a collection of people who will think about all these things. Sorry if I've wandered off.

CHAIR: Thank you very much. Thank you.

MS NICHOLS: May Dr Bhat be excused, please.

CHAIR: Yes. Thank you very much for your evidence today, Dr Bhat, and for your comprehensive witness statement.

<**THE WITNESS WITHDREW**

MS NICHOLS: Chair, is it convenient now to break for lunch until 2 o'clock?

CHAIR: Yes, thank you.

LUNCHEON ADJOURNMENT

UPON RESUMING AFTER LUNCH:

MS NICHOLS: Commissioners, the next witness is Dr Alison Kennedy, I call her now to give evidence.

<**ALISON KENNEDY, sworn:** **[2.05pm]**

MS NICHOLS: Q. Dr Kennedy, are you a Research Fellow at Deakin University's Department of Health and also at the National Centre for Farmer Health?
A. So, it's actually the School of Health, School of Medicine in the Faculty of Health at the National Centre for Farmer Health.

Q. Thank you. Did you earn your PhD from the University of New England in 2016 studying the impact of bereavement following suicidal accidental death on farming families?
A. Yes.

Q. With the assistance of the Commission's lawyers, have

you prepared a witness statement in relation to the questions on which we've asked for your opinion?
A. Yes, I have.

Q. I tender the statement. [WIT.0001.0044.0001]

CHAIR: Thank you.

MS NICHOLS: Q. Dr Kennedy, can I ask you firstly to tell the Commissioners, what is the National Centre for Farmer Health?
A. So, the National Centre for Farmer Health is a partnership between Deakin University and the Western District Health Service and our role is to support the health, wellbeing and safety of farmers, farm workers, farming families and the farming community.

Q. What sorts of programs does it deliver?
A. So we do that through a combination of research, service delivery and education and information provision through our Farmer Health website.

Q. Can I ask you about the prevalence of mental illness in rural communities as compared to metropolitan areas. Generally speaking, what can you say about that?
A. So, the current evidence suggests that there isn't any great difference between metropolitan and rural areas in terms of diagnosed rates of mental illness.

Q. Is there anything to suggest that, nevertheless, there are high levels of psychological distress in rural communities?
A. Yes. So, evidence would suggest that there are particular things in rural and farming communities that may contribute to levels of psychological distress.

Q. Is it also the case that there is a higher rate of suicide in rural and farming populations as compared with metropolitan populations?
A. Yes, that's true. Rural suicide rates are estimated around about twice that of metropolitan areas. The evidence around farmer suicide rates is a little bit uncertain and variable.

Q. Is there anything sufficiently positive that you can say about that?
A. So, the evidence currently that we are relying on

really comes from Queensland and it's the most recent evidence. So, that suggests that there's up to twice the rate of suicide in farming populations compared to the general population; however, that is very variable according to different regions.

Q. That data's from Queensland and you've relied on that because there's no Victorian data presently available?
A. Correct. We are currently working with the Victorian Coroners Court to help gain a better understanding of farming-related suicide in Victoria.

Q. Thank you. Can I ask you about what is known about the risk factors for increased mental illness in rural communities, starting with the lack of access to appropriate services.
A. Yes. So, in rural communities obviously there are less services available and that's sort of across the board when it comes to mental health: so, from psychiatrists, psychologists, GPs, mental health nurses, all of those are less in rural areas.

Where services are available, they're not always appropriate services. Particularly, there may be service providers who don't have an understanding of work and life within a rural farming community, and that's often very important to build rapport with a client, is to have that understanding of the situation that they're in, so when that's not available, the services aren't always appropriate for that individual.

Q. Have you done any research on the means by which better understanding of farming life can be gained by health practitioners?
A. Can you repeat that question?

Q. Yes. Does your research say anything about the means by which health practitioners can gain a better understanding of farming life and its relationship with mental health factors?
A. Yeah, definitely. So, one of the programs that we offer at the National Centre for Farmer Health is agricultural health and medicine training, and that actually is a means by which we're able to provide health practitioners with cultural competence and knowledge of the risk factors that people face in farming communities when it does come to health, wellbeing and safety.

Q. To what extent has that program been rolled out across Victoria or taken up in Victoria?
A. So, I couldn't give you the exact numbers, but the education program is now in its 10th year and there's a couple of different units that we run as part of that graduate certificate. So, there's an intake of around about between sort of 15 and 25 people per year in those units.

Q. Is that education program directed to general practitioners or other clinicians as well?
A. It's a range of health practitioners; so, a lot of nurses, allied health specialists, GPs, but also people working in agriculture, so vets, agronomists, those sorts of people as well.

Q. Are there what you call environmental and situational factors that present themselves to people in farming communities that present risks for mental ill-health?
A. Absolutely. So, there are I think a range of situational factors. We know that rural communities on the whole are shrinking, so there is less social contact. Farms are getting larger, they're getting more mechanised so there's less labour in a farming business, which again affects that social contact.

Exposure to environmental extremes, so bushfires, droughts, those kinds of things can have psychological distress factors associated with them. People moving away from the rural community: so, not only do we think of relationship breakdowns as affecting psychological distress, but when children, for example, move away from the farm for work or education elsewhere, also that lack of connection can have a psychological impact as well.

Q. There's a factor that you've referred to in your statement called "Acclimatisation to Risk", can you explain what is meant by that?
A. Yes, certainly. So, in farming families, particularly from a very young age people are exposed to risk-taking behaviour. So, we see children helping out on the farm, being involved in machinery, livestock, riding motorbikes, horses, so those sort of everyday factors in farming just become part of everyday farming life. So, while they are inevitably risky activities, people no longer sort of see them as risk-taking, it's just part of everyday life in

farming work.

Q. Those factors and others are risk factors for the development of mental ill-health. How do they relate to the rates of suicide in rural communities, if you can say?
A. There's some theory around acclimatisation to risk-taking as a precursor to suicide. So, it makes that journey - once somebody is in a place where they are considering taking their life, it actually makes that journey that little bit easier when people are acclimatised to risk-taking, particularly in farming communities where there is also access to means, so an accumulation of factors can lead to suicide.

Q. In the study of the contributing factors to suicide, is an accumulation of factors particularly important?
A. Absolutely. I think, suicide is always incredibly complex and it's never just one single factor that leads somebody to take their own lives.

Q. Can I ask you about the role that stigma plays in help-seeking for mental illness in rural communities.
A. Yes. So, stigma is definitely a factor that's not only been found to increase the risk of suicide, but it also decreases help-seeking behaviour. Stigma can lead to feelings of shame, feelings of guilt, and we know that in small rural communities where anonymity is often quite low, the stigma that's associated with poor mental health can inhibit people from seeking help. They may find that the only mental health professional they have access to is also a parent at the local primary school with their own child, so that fear of lack of confidentiality perhaps and lack of anonymity is an issue.

Q. In the context of research on suicide, how is stigma understood to play a role in suicide itself?
A. Well, stigma, as I said, it socially isolates people, it stops people from seeking help when they feel that they need help. I can draw on an example of somebody that was part of my research and he explained to me that, even though he felt that he really needed assistance from a mental health professional, he felt that if he put up his hand and said that he wasn't coping and he did need some help, he had a fear that he would actually lose the trust of the people hiring him in his agricultural contracting business and he would actually lose his business because of that, so he remained silent and in incredible emotional

pain.

Q. So, with that background, what do stigma reduction programs aim to achieve in relation to reducing rates of suicide?
A. So there isn't a whole lot of evidence around stigma reduction in relation to suicide specifically, so we're really drawing on evidence that comes from mental health stigma at this stage and trying to understand that better in relation to suicide. Sorry, can you ask the question again?

Q. I'm asking you about the role that stigma reduction is understood, or at least theorised, to play in reducing rates of suicide.
A. So, in reducing stigma, we're really aiming to encourage people to speak openly about their experiences and to seek help, and to I guess make sure that people realise that they are not the only people experiencing these feelings, that there is help out there, and it's appropriate and acceptable for them to actually ask for that assistance and seek that assistance.

So really, not to normalise, but to really validate, I guess, people's experience by reducing that stigma.

Q. Is the essential premise that, if stigma is broken down, people will be in a better position to seek help when they need it?
A. Absolutely.

Q. You've used a concept in your witness statement of "suicide literacy", can you explain what that is?
A. So, suicide literacy is knowing about both the risk and the protective factors around suicide and suicidality.

Q. What do you mean by "protective factors" in this context?
A. I guess one of the examples, if we think of a Suicide Literacy Scale, that's a series of 12 statements that are either true or false, and so, if we think of some of the items on that scale one of them is that people can change their mind rapidly when they are considering suicide.

So, the fact that, you know, having a conversation, being able to provide people with support, can actually allow them that space and that time and that support to

change their mind.

Q. Can you just go back a step. What is the suicide scale to which you're referring?
A. So, that's the Literacy of Suicide Scale, so that's a validated tool that's been developed to measure suicide literacy.

Q. So, is suicide literacy something that is understood in relation to people who may be contemplating or attempting suicide, or is it more of a population health measure?
A. Yes, it's much more broad, so it's more of a general assessment tool.

Q. If we can zero in on the more individual level, how is it that having better suicide literacy is understood to help people who may be at risk of attempting suicide?
A. So, I guess it helps them identify the risk factors, but also perhaps enables them to identify the pathways to support.

Q. I see. Could I ask you about the projects that the National Centre for Farmers Health has undertaken. Firstly, the Ripple Effect, and that was a digital intervention project. How did it work and what was it intended to achieve?
A. So, it was a project that was initially aimed at males in the farming community aged between 30-64 years who had been touched by suicide in some way. So, that may be that they had thoughts of taking their own life, that they've attempted to take their own life, that they were bereaved by suicide, they may have been a carer for somebody who had attempted suicide, or felt that they had been touched by suicide in some other way. The intervention was designed to try to reduce the stigma that was associated with that suicide experience.

Q. Did that work in two ways: firstly, by asking participants to complete a survey about their own situation and their own beliefs, and then presenting them with material tailored to their specific circumstances?
A. Yes, that's correct.

Q. You described the material as including postcards, videos of people talking about their lived experiences, and I'll just stop there. The postcards and the videos, did

they have in common that they were messages from people about their own life experiences?
A. Correct.

Q. What's important about that aspect of the material?
A. So, that aspect of the material gave people an opportunity to share their own experiences and also identify some of the strengths that they had drawn on or the positive messages that they could share with others in an effort to reduce further suicide risk in the community.

Q. You also presented videos of health professionals and stigma experts.
A. Correct.

Q. In short, what was the substance of that material?
A. So, that material was really I guess presenting information about stigma, about help-seeking, about self-care and wellbeing, but was presented very much from a farming perspective, so these were professionals who had knowledge of farming work and life.

Q. You also presented material about topics such as having safe conversations. What does the expression "safe conversations" mean in this arena?
A. So, we want to encourage people to speak about their experiences but, in what we call a safe way. So, not to talk about method, not to be sensational in the way that they speak about suicide, but to make the conversation about suicide real and approachable in people's lives.

Q. There was a very significant uptake for this project in rural communities; is that right?
A. Yes. There is an amazing passion in rural communities for improving mental health. I think, given that communities are small, social networks are quite tightly entwined, we generally find that there's very few people in rural communities who haven't been touched by suicide or poor mental health in some way, so there is a real passion for improving that and reducing suicide risk.

And so, as part of The Ripple Effect we called for expressions of interest for a steering group, and we had 15 places to fill, but we ended up with a lot more people than that applying and expressing interest in the project, so we ended up creating community champion roles in addition to the steering group, so we had around about 60 people who

came on board as community champions, so we were able to provide - to offer them some education around The Ripple Effect project, provide them with communications materials and support them to bring that to their community and share the information about The Ripple Effect project.

Q. The evaluation of this project showed that, of itself, it didn't reduce stigma and, why was that?
A. So, we measured stigma reduction. As you were saying earlier, people did a survey at the beginning of their involvement and also once they'd completed their involvement, and so, we measured, using the Stigma of Suicide Scale, we measured stigma at the beginning and at the end of their involvement.

And so, by using that tool, we weren't able to show that there was a significant reduction in suicide stigma. However, when we looked more closely at the postcards and the outcomes of the digital storytelling workshop, and also in the personal goals that people set as part of their involvement in The Ripple Effect, we were able to see behavioural indicators of stigma reduction through that process.

Q. What do you mean by "behavioural indicators of stigma reduction "?
A. So, things like increased willingness to seek help, willingness to have conversations, difficult conversations around emotional issues and mental well-being: yeah, those kinds of things which are indicative of stigma reduction.

Q. What were the key features of that program that, in your assessment, contributed to that outcome?
A. I think it's probably a combination of a range of different features as part of that intervention, but certainly the digital stories were incredibly powerful in conveying that, and we've gone on to use digital stories in more of our work because they've been a really great tool, not only for the person creating their own story - we've seen measured stigma reduction just by the creation of your own story - but also being able to share that with the broader community and increase awareness and empathy towards others; as well as, I guess, encourage action in people watching the stories.

Q. So, is the essential idea that the person who tells the story will have their own stigma reduction, and it will

help them as well as helping the recipients of the personal story?
A. That's absolutely right. We found that, through the storytelling process, it was quite cathartic for people on the whole.

I remember, one woman was telling me at the end of the storytelling workshop, she said, "It feels like a weight has been lifted off my shoulders. I've had this sense of guilt about my husband's suicide death and I've realised through this process of telling the story that it wasn't actually my fault."

Q. That is a digital intervention. Is it part of the Beyond Blue's STRIDE initiative?
A. Correct, and funded --

Q. And was it funded by Beyond Blue?
A. Funded by Beyond Blue through donations from the Movember campaign.

Q. The digital aspect of it: what are the positives of it being a digital intervention?
A. The biggest positive of being a digital intervention is the potential reach that it can have. We know that, particularly in rural areas, often people don't have exposure to these kinds of things on a face-to-face basis, but having it in a digital mode meant that potentially a lot more people could reach that.

Also the way that it was designed was so that people could access it from their telephone - sorry, a smartphone, on a tablet or on their laptop and be presented with just as good an image.

It was also adaptable in terms of the quality of people's internet connection. So, for example, if people were looking at one of the videos but they didn't have a great connection, they were still able to watch the video but it would have been in a lower resolution.

Several of the videos, not the digital stories, but the expert videos also had text. So, if people were unable to watch the videos, then they could at least read the text there.

Q. Thank you. Can I ask you about the Look Over the Farm

Gate campaign, that's a funded series of social events. What's the idea behind that project?
A. So, it has a couple of different components, but Look Over the Farm Gate, by its very name I guess, is designed to encourage farming communities to look after their own wellbeing but also to keep an eye on their neighbours and support the wellbeing of others in their community.

Q. What aspects of that program were important, do you think?
A. I think the whole of the program has been really important. There was two significant components of Look Over the Farm Gate: so, one is social gatherings. So, small grants were available to community groups to run social gatherings with a mental health aspect to those. So, that could have been having somebody come and speak about mental health or providing resources, but very much focusing on bringing people together and to socially connect people.

The other aspect was, there's been a series of community workshops, so they're interactive workshops, to raise awareness and to encourage people to develop skills and confidence to support their own mental health but also to support the mental health of other people in their community.

Q. What kind of feedback have you had about the Look Over the Farm Gate program?
A. So, the part of the program that the National Centre for Farmer Health has been mainly focused on are the workshops, and we've had really strong feedback. So, we've done evaluations of those workshops to, I guess, establish increased knowledge, how appropriate the material was for people's roles in their community, the nature of the delivery of the workshops, how appropriate that was, all of those sorts of things and we have had very positive feedback from participants.

Q. There's another program which is entitled, "The Great South Coast Leadership Program", the aim of which was to identify and document the stories and needs of carers in the Great South Coast region. What did that study find?
A. So, I participated in the Great South Coast Community Leadership Program. As part of that we were involved in a community project, so the community project that I was involved in was the needs assessment of mental health

carers.

So, we invited carers to participate in a survey and we had a working group to help us develop that survey, and through that we were able to identify some of the important experiences and the needs of those carers. Some of the things that we found were that they were under pressure and incredibly time poor; that caring for somebody with a mental health condition took up an enormous part of their lives, and so, often they were giving up their own life goals in order to be able to be carers. They found it difficult often to navigate the system and to figure out what support was available out there, if there was support available.

But they found great value in being able to talk with other carers and to have those sort of peer support networks and just to have somebody that was willing to have a conversation and who understood what they were going through was incredibly important.

I really must say, I find that in a lot of mental health work that we do at the National Centre, the value of having a conversation. So, I don't think we can ever underestimate the value of having somebody that's willing to take the time out of their very busy lives to be interested in what you're experiencing and to be able to have that opportunity to share that event is really important.

Q. In a slightly different connection, we've asked you about what more successful suicide prevention strategies might look like and, apart from discussing the findings of The Ripple Effect which we've already talked about, you say that:

> "It appears from [your] research that the decision-making pathway to suicide for farmers can in some cases be quite rapid and there needs to be interventions that can intervene in a rapid way."

Can you talk to us about both of those things: firstly, what you mean by "a rapid decision-making pathway" and what kinds of interventions might assist with that?
A. Yeah, so I think that relates back to what we spoke about earlier about that acclimatisation to risk and access

to means. So, if somebody is in a really dark place where they are considering suicide, the pathway to dying by suicide can be quite rapid: they have the means generally at their disposal and, without intervention at that moment, can be fatal.

Q. You've given in your statement an example of a program that you say is a good community intervention and it's the Rural Alive and Well Program in Tasmania. What do you know about that?
A. I think we can learn a lot, and whether that's a program that can be implemented in Victoria - I mean, I think we need to still look into that and see exactly what is it that's working in that program.

But it's a real community-based, it's an outreach program and they have a number of outreach workers who are not actually mental health workers, they are members of the community often with a background in farming, and they are supported to make direct contact with people in rural farming communities and to support them and to help them through - you know, they may refer them to services that are available, but it is often around somebody being there to have a conversation and to nut out some of those issues in order to be able to work out the best resource pathways for them.

Q. You have said in your statement:

> "They have support workers who are not mental health professionals but are people in the community that cold-call people for a chat."

Do you know anything more about the cold-calling element of that?
A. Yes. So, it's not only self-referral, but if you think somebody is going through a really tough time, you can actually request that somebody be called upon and contact is made with that person.

MS NICHOLS: Thank you, Dr Kennedy. Commissioners, are there any questions.

CHAIR: Q. I just have a few, thank you very much, Dr Kennedy. You talked earlier in your statement about the changing demographics of farmers and farms per se, and also

talked about the additional sense of obligation there might be for people on multigenerational farming communities and that capacity; the context of that farming and obligation, I guess, you've suggested some young farmers feel to carry on the family farm.

How do you address that in terms of the work that you're doing and also the role that women might be playing as women farmers as well and how you've tailored your advice and support to their needs?
A. Yeah. I think particularly with younger farmers they have such a future ahead of them, and there is so much uncertainty now in farming.

If we just take climate change as an example of that. For a long time there has been a lot of inherited knowledge that has assisted people to learn how to farm and to be successful in farming. A lot of that knowledge now is obsolete because there is so much uncertainty as to what the future is going to bring, whether that be in terms of weather or whether it be in terms of global markets, there's just so much that's out of people's control, and so, I think a lot of that knowledge is lost which raises that anxiety level when something happens.

Q. And, for women farmers?
A. Yeah, so I think women farmers may not even identify as farmers. Often they'll self-identify as farmers' wives or they will have some off-farm income, so they might be identifying themselves according to that role, but they make a huge contribution to the farming business. They not only play a big role in the caring of the farming family, but they'll often have a big role in running the farming business, so whether they're doing the books or that kind of thing, and they'll often help out as well in busy periods on the farm, so they're really an integral part of the farming family. Often I guess they de-prioritise their own health and wellbeing in order to be able to better support people in their family.

Q. You gave us an example of a pamphlet, I think you said, that had been designed about managing stress on the farm. What's the primary area of focus of that sort of tool that you've made available?
A. It's a very practically-based booklet. So, it complements the community-based workshops that I was talking about as part of Look Over the Farm Gate and it

really builds the learning that is part of that workshop, it builds it into sort of practical approaches to reducing stress and allowing people to understand and manage that stress in a context that they can really relate to. It's very much based around farming and that understanding that they need.

CHAIR: Thank you.

MS NICHOLS: May Dr Kennedy be excused please?

CHAIR: Yes. Thank you very much for your evidence this afternoon, Dr Kennedy.

<**THE WITNESS WITHDREW**

MS BATTEN: Commissioners, the final witness for today is Dr Gerald Ingham. I call Dr Ingham.

<**GERALD PATRICK INGHAM, affirmed and examined: [2.40pm]**

MS BATTEN: Q. Thank you, Dr Ingham. Have you, with the assistance of the Royal Commission's legal team, prepared a witness statement for the Commission?
A. I have.

Q. I tender that statement. [WIT.0001.0033.0001]

CHAIR: Thank you.

MS BATTEN: Could you start by briefly outlining for us your current role and responsibilities, please?
A. Well, I'm a rural GP in Daylesford, about 50 minutes from here, and I work as a GP there three days a week and provide on-call care and attend patients in the local hospital and in the aged care facilities, and I also have other roles pretty much as a GP academic, I suppose, as an academic and researcher with particular interest in the training of GPs, the Australian General Practice Program.

Q. Could you tell us a little bit more about the clinic that you work at?
A. The clinic that I work in is a large multidisciplinary clinic. It has 17 GPs, it has three psychologists who work there. We have physiotherapists, podiatrists, audiologists, lots of practice nurses. It's a very multidisciplinary clinic. It's the only clinic in town and

so we service the community.

Q. You stated that you believe in the four Cs of general practice. What are the four Cs and why do you believe in them?
A. Well, they really define/explain what a GP's role is. So that, the first C is that we're the point of contact, and I think it's in my witness statement that GPs are the most accessed health practitioner by the community. So, we're the point of first contact.

We provide continuity of care, so we care for people over their lifetime. I've been a GP for 30 years, the GP I took over from was a 70-year-old when I took over from him. I see patients who are 70 years of age and have only seen two GPs, so we have that continuity of care.

The other important part is we're always caring for people in their context, so we're not caring for just one part of them, we're understanding their biological issues, their physical health issues I suppose you could say. We're understanding them in the context of social contexts and also the psychological issues going on: if they have anxiety or depression or how that may be impacting on how they are. So looking after them completely, and we're not just looking after one illness, we're looking after all of their illnesses at the same time, and hopefully also looking after their health.

There you go, I've forgotten the final C, which is: continuity, context.

MS BATTEN: I'll try and help you.

CHAIR: Coordinated context?
A. And coordinated, thank you. We do try and coordinate the care and we link up services for our patients and I think that's sort of a definition of general practice which has come from the World Organisation of GPs.

MS BATTEN: Q. Just very briefly, can you explain to us where you see rural GPs fitting within the mental health system?
A. Well, I think we have a very big role in the mental health system, again, because we are the first point of contact and people come to us often with a mental health problem and they want to know how severe that problem is or

what that problem is, so they're looking for a diagnosis or a definition to explain where to go. But we're also the person - GPs are the people who detect that a problem that a person didn't realise was a mental health problem, is a mental health problem. You know, that headache that they had or the pain in their jaw from clenching their teeth all the time; we're able to say, well, actually that might be related to other things going on in your life or to your anxiety and able to identify that. And often through that, in fact able to remedy many of the common mental ailments quite quickly.

So, we have that role, I suppose, in identifying and then, as I say, actually referring off, but also a very big point I'd like to make is, we do a lot of mental health care, we care for a lot of people. We care for people who are not able to be cared for within our system, so we end up filling the gaps quite significantly.

Q. I wanted to ask you about that. You refer in your statement to GPs being both the gap fillers and the glue. So, first dealing with being a gap filler, how do you see rural GPs as a gap filler?
A. We're gap fillers because often there isn't a service available. Sometimes it's just not available at that time, so, if a person has an acute mental health issue or crisis and they need to be seen, where available they can get an appointment with us today, they can't see their psychologist for another week or their psychiatrist for another month so we will end up filling because we're available there at that time.

Then there are services where there appears to be a lack of other services available, or other services tend to not keep seeing people, so I'm thinking of people classically with personality disorder, I'm thinking of people who have both a drug and alcohol issue as well as a mental health problem and so they won't be seen by the mental health service, they will tend to only want to see people who have solely a mental health problem, and so, we will end up trying to fill the gap in that circumstance.

Q. And then, how are you the glue?
A. Well, we're the glue by trying to - which is a hard job - we're trying to coordinate the services and bring things together, but we're also trying to build things over time, so we will remember or have written down the problem

the person had previously and how it got better in the past, and hopefully be able to try the same solution that worked previously again.

But also, just connecting services: are you aware that there's a financial counsellor at the Community Health Centre that you can go and see? Are you aware that, if you've suffered from sexual assault, that we do have a sexual assault service available in Ballarat and would you like to go and see that? And, when those services write back and communicate to us, ideally we can then coordinate the action of those services.

Q. What proportion of patients to your service seek help for mental health-related conditions?
A. I've estimated in my witness statement that my own practice is around 20 per cent of encounters that I have, would be about a mental health problem, and that's pretty much in keeping with what GPs see.

It's often quite surprising, people come up to me in the street and say, it must be busy, there's a flu or something going around. I usually just say, "Yes", but when a patient comes in through the door to see me about a cough or a cold I feel like shaking their hand and, "Thank you", because that's a relatively simple thing to see and look after. Whereas, we see a lot of mental health problems. It's estimated, when GPs were surveyed - and it's again in my reference I gave - and asked what did they think was the most common problem they dealt with, mental health was the most common problem identified by general practitioners.

I think we heard the previous witness saying that mental health problems are no less common in rural areas than they are elsewhere and, given that there are less services available in rural areas, it's a very big role that we have to fill that gap and we're seeing a lot of people with mental health problems.

Q. You've said that you see patients affected by mental illness with all degrees of severity and complexities, and your experience is that patients fall into one of three groups.
A. Yes.

Q. Could you just explain each of the three groups for

us, please?
A. Yes. The first group would be patients who have, I suppose, mild-to-moderate mental illness, problems such as anxiety and depression; they're very frequent problems. The sort of example I gave before of a person who perhaps has some anxiety presenting as a physical symptom: they will attend, sometimes they can be dealt with quite briefly by me or maybe I might need a number of visits to look after them, or I might refer them on to a psychologist often within our practice, or I might prescribe, if their depression for example was moderate, that might be an indication to prescribe. So, that's the first group.

The second group is the patients with severe mental illness, the patients who have had major depression perhaps in the past, had suicide attempts, or needed ECT therapy or admission to hospital, so very severe depression, patients with very severe anxiety disorder such as obsessive compulsive disorder where their lives are really being dominated by their illness, and then of course we have patients with schizophrenia and bipolar disorder where at times their beliefs about the world are different from us, and it's been called a psychosis, so those patients I often need to manage ideally with the assistance of a psychiatrist or mental health team. They will generally need medication as part of their management.

Often when they're at their most severe, I'll be handing over their care to a psychiatrist or usually to the local regional mental health team, and then once things have stabilised and settled down I will continue to see them, and I'll be seeing them in between, both to continue their care but to have an eye out for relapse prevention.

That's only a small proportion of the work that I do, perhaps 5-10 per cent of the mental health problems that I see.

The third group which has been described by a colleague of mine, Dr Louise Stone, as the swamp of general practice, which is the so-called missing middle. So, the patients I mentioned before who have a drug and alcohol problem plus a mental health problem, the patient who has borderline personality disorder, the patient who has chronic pain, where you can't have chronic pain without also having depression as a consequence of that.

And also, there's a group of patients who have what we call medically unexplained symptoms: they have physical symptoms which we're unable to explain by pathology testing or imaging but they continue to suffer, and so, they also belong in this so-called missing middle.

I've spent a lot of time caring for those patients, and they're often the hardest work, I suppose, because there's no clear pathway to treatment and they're complex: maybe there's poverty or lower socio-economic class; there's maybe past history of abuse, and very ongoing sort of complex personal circumstances to add in to their complex mental health issues.

Q. You've said that you disagree that these people, this missing middle or missing swamp, are too sick or complex for the primary care system; is that right?
A. Yes.

Q. Can you explain why you hold that view?
A. Well, I think it was said before - I heard Professor Bhat say that the complexity - GPs are used to working in complexity, because we are generalists. We call the other doctors, we call them partialists, we're generalists. So, we're used to looking after, if you've got diabetes and you've got a mental health problem and you're on medications that's causing you to gain weight which is making your diabetes worse, we're used to looking after that and considering the relative merits of each of those problems and how important each of those are in terms of making a decision, so we're used to dealing with complexity, and we see people over time and we see people in their context and so we know other family members. The other family members may also be patients, their carers, where we are embedded in complexity in our day-to-day work.

Q. In terms of diabetes, you've referred to the multidisciplinary coordinated care for other complex health issues, but you've said that we don't seem to have that in the same way for mental health; is that right?
A. That's right. It strikes me, I was involved early on in a program called the National Primary Care Collaboratives that looked at trying to improve the care of patients with diabetes, and it involved basically measures of diabetes outcomes but also working collaboratively as a team.

I saw a patient with diabetes this morning and the patient saw a diabetes educator before they saw me. I was able to read her notes, she knows a lot about diabetes, I learn quite a lot from her, but then I was able to add in the context of some of his other health problems which were going on which were impacting upon his diabetes care, and this coordinated approach has achieved fantastic outcomes with other illnesses, whereas I think in the area of mental health we mostly as GPs, and particularly with this complex missing middle group, we end up working on our own.

I'm sure we will do a lot better if we were able to work better in teams in primary care, and we would have the capacity to look after those patients with complex problems, I'm sure.

Q. In terms of the system, you've said:

"From my perspective, for patients with severe mental health problems, the main issue is obtaining access to the system and obtaining an opinion from a psychiatrist, particularly when a patient is seen to be from the middle group."

Can you just explain to us some of the issues with obtaining that access?

A. Well, again, talking about obtaining access to a public psychiatrist: so, I would ring the Regional Psychiatric Service or Area Mental Health Service, which in my case is Grampians Area Mental Health Service. I would speak to an intake worker and explain the circumstance about a patient or why I would like this patient to be seen, or why for example I might like an opinion from a psychiatrist, and that gets filtered through a mechanism.

I understand they work as a team, they would discuss this patient and decide whether this patient was one that they could take on and, to be honest, I've done this so often now that I know when I needn't even bother to refer, so I wouldn't bother referring a patient with borderline personality disorder who was having frequent suicidal ideation. I wouldn't bother referring a patient who had a significant drug and alcohol issue as well as their mental health issue because they're not going to take them on.

I know they will take on patients who have

schizophrenia, bipolar disorder, bipolar disorder with an ongoing - providing they're ongoing unwell. Many people with bipolar disorder are quite well for extended periods between being unwell. So, in those circumstances I know I will get access and care, and often very, very good care, but outside of those circumstances there's no point referring, so I try and fill the gap myself.

Q. You've said similar things in terms of access to a community psychologist. You've said:

> "For access to a bulk billing or community psychologist the waiting time fluctuates but is typically around two to three months. My view is that the referral process is labyrinthine and bureaucratic."

Just very briefly, what's the process and why is it so bureaucratic?
A. Well, I refer through the Primary Health Network, I complete a Mental Health Assessment and Plan. I refer that off to the Primary Health Network, who then find the psychologist for the patient. I have to complete a questionnaire as part of it. A common questionnaire we use is a questionnaire called K10. If I fail to fill out one of the questions it comes back to me, they won't assess it further.

One of the questions for example on that is, "How often do you feel hopeless?" And so, I have to ask the patient that question, then I have to tick it on the form, send it off to the Primary Health Network: if I don't fill that question out correctly they send it back to me. I find it inappropriate and, you know, I don't like asking my patients those questions. I feel like I should just be able to say, "I've got a patient here who needs a psychologist, can you get me one?" But that's not how it works.

Q. You also highlighted earlier the importance of continuity of care.
A. Yes.

Q. You've said that the continuing relationship between the clinician and the patient is key to success of treatment.
A. Yes.

Q. Can you elaborate on why you think that relationship is so important?
A. Even more in mental health than in any other area that we work; I mean, getting to know someone over time and the relationship that you have just - that's just healing. So, it's one of the lines that is said, "the doctor is the drug", so often me just knowing someone and understanding them and spending time listening and understanding them and being able to say to them, that sounds really tough at the moment, is very useful.

Plus also, if I know that, hold on, when you stop sleeping, that's usually a sign that things are going to go off. Or I've found in the past when your husband's away on a fly in, fly out working job, during that time you're likely to go off, I might schedule to book you in.

Or the pregnant woman who I ask about during her pregnancy about what's she got arranged at home for when this baby comes, who's going to help her. Just knowing people over time and having an ear out or looking out for them, that's the role that we have, that's a preventive role as well as a - it's both useful in prevention and it's useful in treatment in terms of knowing how a person is when they're ill.

Q. What about barriers to GPs performing that role? So, from a systematic perspective what are some of the barriers to GPs practising in mental health?
A. First of all, training, so gaining experience in that area is difficult. My own personal experiences coming through is, what we do as GPs - when I started out there wasn't a textbook of general practice for a start, and in terms of knowing what we did in mental health, what GPs do in mental health is different from what psychiatrists do and from what psychologists do, and so, it was hard to learn those skills or learn how to look after the missing middle.

So, the training of our undergraduates and even in the vocational training in general practice, it still has been historically largely done by psychiatrists and not done by GPs, and so, hasn't necessarily prepared people well for the nature of general practice and the mental health care that we provide there.

I think the other issue which I've alluded to in my statement is the issue of funding. If you're a GP with an interest in mental health, you will earn a lot less money than another GP. That's not the reason we do the work, but it does provide an incentive clearly for GPs to do other work which is better remunerated than mental health.

Q. Can you just explain that further for us. How are you less remunerated when you're dealing with a patient with a mental health issue as opposed to a physical issue?
A. Well, mental health problems generally take longer, take time, counselling takes time. Many GPs will work on somewhere between four and six patients an hour. So, a GP who's seeing six patients per hour will be able to bill for six instances, whereas if I'm a GP with an interest in mental health, I might book two patients in for that same hour. Although the fee is larger for the longer consultation, it doesn't make up for it.

In my witness statement I gave an example of one GP who was seeing six patients an hour and the other was seeing two per hour, and there was a $70 difference, even though the GP who was seeing the patient for half an hour may have been dealing with a very complex patient with personality disorder and suicide intent, and the other GP who was seeing six in a row of maybe relatively simple problems would be - it doesn't appear appropriate on face value that there should be this difference in reward for that kind of work.

Q. Is one aspect of it the length of the consultation, but is it also the nature of the consultation?
A. Yes, so there is a higher reward. Definitely the length of the consultation, so the so-called six-minute medicine. We know that the longer a GP spends with a patient the less money they earn, that's the nature of the MBS fee-for-service system.

The other part though is that there's a higher reward on procedural medicine than there is on consultation medicine. So, if I spend half an hour removing a skin cancer, my Medicare fee might be $250, whereas if I spend my half an hour consulting it might be $70.

I think I gave an example in my witness statement that if you go down to Melbourne or the regional centres here, you'll see lots of GPs' skin clinics where they're removing

procedures, you won't see any GP mental health clinics because it's not rewarded.

The other thing I want to point out with mental health consults is, of course, a lot of the patients from this messy missing middle also fail to attend their appointments, so you cross off a half an hour appointment for them and then they don't show and you earn nothing for that time for showing the care that you're making your time available for them. So, there's a lot of disincentives in a fee-for-service system for GPs doing mental health work.

Q. So that Medicare payment structure, you've said, does not reflect the care and value that you bring in treating someone with mental health issues?
A. Yes. The other thing is that we are not paid - if I take a call from a psychiatric nurse from that Regional Health Service, or that call that I make to them to do the refer over, none of that is funded.

Q. You've touched on this briefly before but I'd like you to expand on it, this issue of working as a GP with an interest in mental health is also hard work. Can you expand for us about the cognitive and emotional toll of working with patients with mental health issues?
A. Yes, I think there's a river of emotion beneath all human interactions and often we're working above that, but it's still flowing underneath and often at the end of the day you're aware, that is. I mean, I've consulted this morning before coming over. I've had two patients cry in my consulting room this morning: one of them in extreme distress, and there's no way you'll walk away. I mean, I've learnt, when I come home at the end of the day, I need to - I've actually got a shorter drive home than I used to and I recognise that's not so good, because you need time to drive home and to recover a bit from doing that work.

And I used to have a - well, he's no longer working with me, but a colleague who I would debrief with on a Friday night and we'd sit around and have a chat and talk about things we'd seen and the experience we have.

We're very privileged, GPs, we have the front row seat on life. We get to see and hear about some amazing things and watch people - the amazing strength and resilience of people, but we also do get to hear some very sad stories. If someone tells you their story of abuse or that they're

feeling that their life is not worth living, that's a very hard thing to hear and not to feel something when you hear that.

Q. You compared the GP system with psychologists for example where there's support structures in place for psychologists, but there doesn't seem to be the same sort of support around GPs?
A. Yeah, my understanding is that psychologists have a supervisor or mentor and that they're asked periodically to check in, whereas I think for most GPs if we have a network it's an informal network that we develop.

Q. Can we return to the issue of training for GPs, so first could you explain what training exists for GPs in relation to mental health?
A. Of course we have our broad training that we go through as an undergraduate or postgraduate, but in terms of further specific training, there's a level 1 training which is about six or eight hours of training, which is really just to enable you to access those Medicare item numbers, so to be able to access a Medicare item number to complete a mental health plan. There's a slightly higher rebate if you're a trained GP versus an untrained GP in that area. I really think it makes no difference, it's not significant training.

There is further training for GPs who have an interest who would like to, for example, use cognitive behavioural therapy or other forms of what we call focused psychological strategies and they go through level 2 training, and that enables them to access a different series of item numbers which gives them a slightly higher award for long consultations where they employ those focused psychological strategies.

Sorry, I think there is another level of training available. I understand that GPs can train, there are courses to do training in GP psychiatry, but there is no funding available for people who undertake that training. It doesn't translate into higher rebate fees.

I was a GP obstetrician, I did 6-12 months worth of training in obstetric care, learning how to deliver babies and forceps and vacuum extractions, and from doing that training I was able to - then when I saw women and help them with their birthing I was able to build the same item

number as an obstetrician. Whereas there is no equivalent for a GP. A GP who undertakes further training or did another six months or a Masters degree in mental health cannot access the item numbers which are used by psychiatrists.

Q. You said most of what you've learned about helping patients in the missing middle has been learned by doing. Given the training limitations, do you have ideas on how it could be improved?
A. I do think learning by doing is a large part of learning how to look after complexity. Well, learning by doing and reflecting is probably what I would like to say, and reflecting with a peer would be a great way of doing that, because patients with complex - it's not like you can go to a guideline or a textbook and say, look, this patient with diabetes who's also on medication to help with their mental health problem, which one's more important? You're not going to be able to find that in a guidebook, that's an ethical and a complex decision based upon experience and knowledge, and that sort of mastery is acquired by reflection with a peer and discussion, unpacking the reasoning behind decisions, and also, as I mentioned, I think there's a value in the emotional support which GPs would give each other if we were able to do that.

So I see groups of GPs sitting down to talk about their challenging patients. There has been similar work done in the UK, something called Balint Groups, B-A-L-I-N-T, similar work where GPs spend time understanding their complex patients and reflecting upon that and hopefully obviously looking after them better.

Q. I want to ask you a couple of system-focused questions. When we asked, "Is supply keeping up with demand? What gaps have you observed?" You said, "There is an enormous unmet demand." Can you just explain for us the demand that you are seeing as unmet?
A. Well, repeatedly patients come in and, you know, where are we now? We're in July and patients say, well, I've done my 10 psychologist visits for the year, and I've recently been uncovering the story of some very complex problems in my family, maybe past abuse, but now I have no psychologist visits for the rest of the year. That's quite a typical circumstance of demand.

I also feel that patients, where I'm primarily their

caregiver, I feel like if I had someone else to help me with that, that - there's a lot of demand for some - if I had a mental health nurse to help me look after the patients, there's a lot of demand for that.

Psychiatrists, well, I hardly ever refer to a psychiatrist because, to a private psychiatrist, because the availability of a quality psychiatrist who my patients can afford, it pretty much doesn't exist, so there's a huge unmet demand there in terms of psychiatric services.

Q. In terms of helping your patients navigate the system, you said the complexity occurs when other services are needed. For example, patients with mental health illnesses often need drug and alcohol counselling, housing support, social support. Can you tell us how that becomes more complicated for you?
A. In my circumstance the Drug and Alcohol Services and the Social Work Services are available in the Community Health Centre, so they're not within my centre. So, I refer off to those services, but because I don't see those notes, I don't see what they're doing, they don't communicate back to me, or very infrequently communicate back to me. There is no funding for me to speak to them or spend time with them. So, if I spend a 10 or 15 minute consultation with a drug and alcohol worker, that's unfunded. Even if I spoke to them for half an hour it's completely unfunded. So, we're already geographically separated, we don't spend any time together as clinicians where you get to understand how other clinicians work, and then there's no funding, and of course that's a state-based, state-funded service; I'm a Federally-Funded service, communication between them is poor.

Q. Finally, I want to ask you three questions about reform. The first one relates to telehealth and teleconferences. You've said:

> "Surely in the days of web conferencing a statewide telehealth service could operate after hours for urgent mental health problems when a clinician needs support."

How do you see telehealth working in the future in overcoming some of the barriers?
A. I don't - I still think you're better off to see a clinician face-to-face if you can, and I would like to

think that we wouldn't choose telehealth as the answer, but in terms of after hours services, I think there's a big role for telehealth which would be that, when a patient presented and needed urgent care after hours, that they were able to perhaps go into our hospital, which is the acute care centre in our hospital which is where people are sent after hours. We have video links.

So if someone comes into my urgent care currently and they have come off their motorbike and they're unconscious and I'm needing some help with their emergency care, I just pull up the little mobile video screen which we have in our acute care system, I hit the phone, I end up speaking to someone, an emergency specialist right there on the video. That specialist can see the patient, we can talk and discuss; that happens immediately for emergency care, we can all arrange transport, arrange services, what needs to be done. I think that sort of service should happen for acute mental health problems as well.

Q. Sorry, where's the emergency specialist from in that scenario you're talking to?
A. I don't know exactly where they are, but they're in Melbourne. We have a statewide emergency response system, okay. So, if there's an emergency health problem - and they will coordinate the ambulance, the transport, they will give me clinical advice about how to manage, administer medications, help assess the patient, help make decisions. I can access that easily, no problem at all. Whereas, if I wanted to access a mental health support after hours, I have to get on the phone, ring the CAT Team, and hope that - I think there's only one clinician available there - will answer the phone and provide services.

The disparity between those two examples is quite stunning.

Q. So the first example is for the physical health scenario, and what hours is that available to you?
A. All the time.

Q. 24/7?
A. 24/7.

Q. So you can call someone and get access to an emergency specialist for whatever physical problem you're dealing

with; is that right?
A. Absolutely. They will provide access, will provide treatment advice, will actually assist me. Actually be watching on the video screen while I'm providing the treatment. They'll organise the ambulance, I won't have to organise the ambulance if the person needs to go on further, or the helicopter or whatever it is. It's a wonderful service we have.

Q. What's the situation when you have someone in a crisis mental health situation?
A. My most recent example was that I rang, I was on the phone, and I waited for an hour and a half for an answer, "You're first in queue, you're first in queue." I ended up handing it over - the phone over to the nurse because I needed to see some other patients. I had a patient who was trashing a house, smashing things up, she was having a manic episode. She wasn't in immediate - she had a family with her who were caring for her extraordinarily well.

I knew that she was acutely unwell and she needed mental health support and treatment, you know, right now, and yet I had to wait an hour and a half on the phone. And then, when I got on the phone they say, oh, we'll ring her back in a little while and they'll conduct a telephone assessment of her, which again, when you can compare that to a video - when you've got this video camera that's sitting there, I just find it hard to understand how we could allow that to continue.

Q. Two final questions about the system. You've referred to Lewin's 3-stage Model in Developing and Maintaining Change. Just very briefly, can you tell us what that is and how you think that could be helpful for reforming the mental health system?
A. I'm aware and I listened with interest to Professor Bhat's evidence before, saying how there's a long history of what seems like a good idea, another small idea, another small idea, another little change and not appreciating the complexity of the system and that implementing change in major - you really need to be thinking about that and constantly reviewing and updating it.

The Lewin's system is saying - first of all looking at, if you decide the change that you want, what you would like, what are the attitudes of people towards it, or what are the issues which are stopping you achieving that change

and then you need to unfreeze them - that's the first stage, so unfreezing. The next stage is the movement stage, so then you need to have that movement stage conducted with the people who are involved, and then the re-freezing which is solidifying the change once it's happened.

Q. From your perspective what changes do you think would make lasting improvements to help people affected by mental health?
A. Well, I think I've mentioned, I think a GP psychiatrist qualification and enabling GPs to access the Medicare item number for psychiatry and that they are given an equivalent recognition by the Commonwealth. It amazes me that whenever I see a patient for a disability support pension and I'm writing their diagnosis down, my diagnosis as a GP is not accepted. So, at least if we had GP psychiatrists that might be accepted.

I talked about that statewide mental health after hours service. Telehealth I think would be good. I think we need to fund the provision of mental health services by GPs more appropriately, and by that I mean the appropriate funding of longer mental health consultations.

I think we need to fund primary health, mental, primary care mental health care teams, and by that I mean teams that involve GPs with drug and alcohol workers, social workers, psychologists, even physiotherapists, occupational therapists within the general practice to help care for these complex patients, and I think the funding of communication between health professionals relating to mental health issues.

So, if I want to pick up the phone, or more typically if the other mental health clinician wants to ring up and speak to me and we want to discuss this patient and that conversation is going to go for 10 or 15 minutes, it's not an issue that, look, I can't be doing this because this is non-financial for me to be doing that. So those sorts of interactions in my mind need to be funded.

MS BATTEN: Thank you very much, Dr Ingham. Chair, are there any further questions for Dr Ingham?

COMMISSIONER FELS: Q. I just had a rather small question about your quite good comprehensive discussion of

the length of consultations and the relatively unremunerative aspect to them.

I just want to compare that with the situation of a GP who has to have a long consultation but not on a mental health matter and its not a procedural aspect. Would that happen very much, or is that somewhat rare for a GP to need to have a long consultation on a non-mental health matter and not involving a procedure?
A. No, those consultations happen frequently as well, particularly ageing patients who have got many, many health problems. So, any time there's some complexity, the consultation will take longer, so I don't think that a long consult necessarily designates that it's a mental health issue.

COMMISSIONER FELS: Thank you.

CHAIR: Q. I just have one other question, thank you very much for your evidence. I noted in your witness statement you say at your particular practice - and recognising we've heard a lot in the course of this Royal Commission about how difficult it is often for people to get access to care when they need it. You say that, from your practice, "if a patient needs to be seen today our practice will see them today. We turn nobody away in an emergency and we provided a 24/7 service."

How are you able to do that in your practice?
A. We've been fortunate. I mean, I suppose there could be an argument here I am the rural GP, and people say, well, you're a rural GP and you're in Daylesford and Daylesford's - I mean, it is a rural practice and it is a rural environment so it's probably a little bit easier to attract clinicians to come and work in Daylesford than it is to - well, I'm not going to mention another country town by comparison. We're within what might be called the latte line, you know, people can get a nice cup of coffee and have a lovely meal. But all jokes aside, the sort of professional isolation and the way that a person lives their life is an important factor in terms of attracting doctors, so we have that.

Plus also, it's probably still true, I would imagine every country GP would be trying to see every patient that they could that day, but for some of them will just get to the point where they couldn't.

I know when I first started out in practice and it was a two doctor practice, names would just get written in in pencil in the appointment book. My colleague, the one who I referred to, Greg Malker(?), who used to help me, he'd say we have to jump over that wall of graphite today, we've just got to see everyone that needs to be seen.

But we actually run a triage system, and again, no-one pays us for doing this, but we employ nurses to field all calls and to determine whether that needs to be seen today or can wait till tomorrow. So, if someone needs to be seen today and they say to the receptionist, I need to be seen today, it goes to the nurse who then does that triage and makes that decision or discusses that with the patient. But in the end if the patient says, "No, I want to be seen today", they're seen today.

Q. There was one other point you made. You said in your witness statement at one stage you had a mental health nurse based in your practice who was funded?
A. Yes.

Q. But I presume that funding is no longer available and something's happened. Could you explain what happened with that? Because you indicated it was highly valuable in managing mental health?
A. I don't understand the reasons for why the funding changed, but we did for a while, I think it was about 18 months, have a nurse who was located in our practice whose primary role was to help us with patients who were at risk of admission to hospital or who had severe mental health problems. So, I'm talking about patients who previously had depression, who needed ECT, or patients with schizophrenia, or very complex difficult to manage patients, and she would be conducting - it was like my experience of looking after my patients with diabetes: I would open up the notes and see her - be able to read her notes. She'd be able to fill me in with what was going on socially, her assessment of what was going on. She'd have some ideas about what she thought I might do, but she was also keeping contact in between times, and that's just the nature of working in a team.

We'd also be able to have a chat, oh, so and so is going along quite well, isn't that great, or they're not going along so well. So, just when the funding was

withdrawn, it went to a different funded - through the Primary Health Network, it's now a nurse, who I'm sure is trying to do a great job over at the Community Health Centre, but I don't get to see her notes, I don't get to speak to her, and so, I don't really know what she's doing with my patient.

Even today I saw one of the patients this morning who's seeing that nurse and I said, "Oh, when are you seeing this patient?" She said, "Oh, I'm seeing her on Friday." She said, "I haven't managed to coordinate your two appointments yet." She knows that she needs for prevention, for monitoring of her mental health, she's had severe depression in the past, she knows she needs to be seeing a clinician about once a month. But because we're not coordinated she's going to see us both in the same week, it doesn't make sense.

CHAIR: Thank you very much.

MS BATTEN: Thank you, Commissioners, may Dr Ingham please be excused?

CHAIR: Yes, thank you very much for your evidence today.

MS BATTEN: That concludes the evidence for today. May we adjourn till tomorrow?

CHAIR: Thank you.

AT 3.30PM THE ARBITRATION WAS ADJOURNED TO TUESDAY, 16 JULY 2019 AT 10.00AM

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