

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

1 CHAIR: Thank you for joining us in Maryborough for the
2 10th day of our public hearings. I am Penny Armytage, the
3 Chair of the Royal Commission into Victoria's Mental Health
4 System. I am joined by my fellow Commissioners, Professor
5 Allan Fels, Alex Cockram and Professor Bernadette McSherry.
6

7 On behalf of the Commission, I acknowledge the
8 traditional owners of the land on which we meet, the
9 Dja Dja Wurrung people. I also pay respect to their Elders
10 past, present and emerging, and I also extend my welcome to
11 those Elders joining us here today.
12

13 We are delighted to be back in rural Victoria and
14 before proceedings resume I want to speak briefly about
15 what we have heard and our aspirations. By the end of
16 this year around 20 per cent of Victorians, more than
17 1.2 million people, will have experienced a mental health
18 problem. Indeed, nearly half of us will have experienced a
19 mental health challenge in our lifetime. Think for a
20 moment what those numbers actually mean.
21

22 When it comes to our loved ones, this is a 50/50
23 chance they will have a mental health problem of some kind
24 during their life, and nearly half of the people living in
25 towns just like this one will experience difficulties with
26 their mental health.
27

28 We know that there is enormous variation in people's
29 experiences of mental health, the causes of mental health
30 problems, the cultures of communities and the delivery of
31 services and support. Nevertheless we are all entitled to
32 live fulfilling lives, contributing in our communities and
33 having access to the support services we want and need.
34

35 No matter who you are and where you live, this
36 aspiration is something my fellow Commissioners and I hold
37 a deep commitment to achieving for all Victorians.
38

39 Listening to people in rural communities is central to
40 this vision. Rural Victorians are a significant part of
41 our state's identity and contribute to who we are and our
42 way of life. One in four Victorians live in rural and
43 regional Victoria, on farms and in small towns and big
44 cities. Each of these communities have their own identity,
45 their own view about what's important, what challenges they
46 face and their own aspirations for the future.
47

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

8
9 We have seen the formidable power of rural communities
10 to effect change and withstand hardship through local ideas
11 and actions. Participation in community groups has been
12 shown to be a key factor in establishing and maintaining
13 healthy and resilient communities.

14
15 To provide just one important example, in the
16 aftermath of Black Saturday bushfires, research suggests
17 that close friends and family, social networks and
18 community groups were important influences on resilience
19 and recovery.

20
21 We have all a lot to learn from the strength and
22 generosity displayed by rural communities in times of
23 crisis but also over generations as communities connect and
24 demonstrate resilience.

25
26 During our work for this Royal Commission we have been
27 told of some truly inspiring examples of community
28 connectedness. We have heard from farmers that use phone
29 trees and regular catch-ups to check in on each other - how
30 something as simple as a phone call is providing much
31 needed support and how, as one person put it, "The grape
32 vine works in wonderful ways."

33
34 We have also heard how volunteers in remote parts of
35 the state have established local support groups to help
36 each other through difficult times, giving people a sense
37 of hope and reassurance about the future.

38
39 Yesterday here in Maryborough at the local health
40 service we heard how the community comes together to drive
41 local solutions for people living with mental health
42 conditions by pulling together, be it at the school, the
43 police, the council, rotary, the health service, there is
44 an acknowledgment that individuals and communities will
45 always do better when we work together.

46
47 And, despite the immediacy of some of the challenges

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

5
6 It has been our privilege to meet with people from
7 this community and to be welcomed in many other areas
8 across the state. So far, we have spoken with more than
9 1,600 people in 21 locations, the majority of those in
10 Rural and Regional Victoria.

11
12 We have heard from 45 out of our 90 witnesses at our
13 public hearings, many of whom travelled to be there. We
14 have received thousands of informal comments and
15 submissions from every corner of the state.

16
17 The community's interest in the Royal Commission is
18 extraordinary. The level of public discourse about mental
19 health issues in recent weeks is indicative of the palpable
20 desire our community has for change. We are hopeful that
21 this interest will continue to gain momentum in recognition
22 that a collective effort involving every Victorian will be
23 required to address stigma and champion reform.

24
25 In our interactions with the community, the
26 Commissioners and I have been deeply affected by people's
27 courage and their willingness to share their experiences.
28 We have seen their strength as they've shared often painful
29 stories so that others might avoid treading a similar path.

30
31 We have also witnessed the selflessness of families
32 and carers and the passion of the workers doing their best
33 in an overwhelmed system.

34
35 But on numerous occasions people have described tragic
36 and difficult events that bring along what many people
37 referred to as "a broken mental health system".

38
39 When it comes to rural areas in particular, people
40 have spoken about the tyranny of distance and the myriad
41 inequities they face when trying to gain access to mental
42 health services.

43
44 One person characterised the disparities in access as
45 "a lottery of rural communities", others spoke of different
46 realities. To name a few, we heard last week at our
47 hearings of a mother's desperate desperation to receive

1 care for her daughter. She packed up half her home, quit
2 her job and moved to Melbourne for an extended period in an
3 attempt to receive care.
4

5 The impacts of having to travel great distances to
6 receive care and the isolation that comes from being away
7 from family, friends and support networks. The high cost
8 of waiting for care, waiting to be transferred to another
9 health service and how this exacerbates a crisis.
10

11 About the vastly different experiences people have had
12 in the public and private systems and how access to a range
13 of services was possible, if you could afford it, or if you
14 could afford to travel to Melbourne.
15

16 How natural disasters in the farming environment can
17 take their toll and how services and supports are often out
18 of reach because farmers can't be away from their land.
19

20 The challenges people in the border towns face falling
21 in between three different service areas: the difficulties
22 Aboriginal Victorians living in rural communities
23 experience when seeking inclusive and culturally safe
24 services; far too many people taking their lives often
25 after unsuccessful attempts to gain help. These are the
26 realities that we must confront.
27

28 Although the evidence suggests that the prevalence of
29 mental health conditions is much the same in urban and
30 rural Victoria, the same can not be said of the prevalence
31 of suicide. Australia-wide the suicide rates in rural
32 areas is almost twice that in metropolitan areas. Too
33 often it is farmers, young men, older people and Aboriginal
34 and Torres Strait Islander people who are taking their
35 lives, and they make up a high proportion of our rural
36 populations.
37

38 Every suicide is devastating and impactful, however,
39 the fact that people living in rural areas are experiencing
40 such distress that it is culminating in suicide, is
41 something we have to grapple with.
42

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

1 outdated and misplaced expectations of culture.

2

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

5

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

11

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

18

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

25

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

32

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

36

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

42

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

1 privilege to have the opportunity to hear about your
2 experience and ideas for the future. I'm so pleased that
3 you are all with us today.
4

5 With those brief remarks, I now ask Senior Counsel
6 Assisting, Ms Lisa Nichols, to say more about the structure
7 and content of today's hearings.
8

9 MS NICHOLS: Thank you, Chair. Today we'll be hearing
10 from six witnesses, three of whom are community witnesses.
11 Maryborough has and is well served by the Maryborough
12 District Health Service, and so our first witness will be
13 the CEO of that service, Mr Terry Welch. He will discuss,
14 among other things, the factors that are challenging in
15 relation to mental well-being and mental ill-health in this
16 community, the multi-faceted services that are delivered
17 through the Maryborough District Health Service, and the
18 challenge of caring for mentally unwell patients,
19 particularly those with serious mental illness.
20

21 The second witness will be Mr Alastair Gabb.
22 Mr Gabb's a farmer, and he will tell the Commission of the
23 difficulties that he faced in trying to get help. He will
24 also speak about the particular strength of rural
25 communities.
26

27 The Commission will next hear from Trevor and
28 Christine Thomas. Tragically, there have been a number of
29 deaths by suicide in Trevor's Family. Mr Thomas himself
30 has battled against suicide and will speak of his
31 experience with the mental health system.
32

33 Mrs Thomas cares for Trevor and she will explain the
34 difficulties of managing the system from a carer's
35 perspective.
36

37 Dr Ravi Bhat is the Clinical Director of the Goulburn
38 Valley Area Mental Health Service. He will speak about the
39 services provided in that service, the capacity building
40 that has happened over recent years, the complexity of
41 meeting mental health needs in rural communities, an
42 historical perspective on the mental health system, and
43 what is needed to change and how we can make lasting change
44 that responds to evolving needs.
45

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

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

5
6 Dr Kennedy will explain current learnings on suicide
7 prevention strategies.

8
9 Finally, the Commission will hear from Dr Gerard
10 Ingham, who has been practising as a rural GP for about
11 30 years. He will explain his experience of caring for
12 people with mental health issues and the role of a GP in
13 the mental health system in a rural context.

14
15 We'll ask a number of questions today through
16 witnesses and we're seeking to explore some of the
17 following themes: what's the prevalence of mental illness
18 in rural communities? Is the risk of mental illness higher
19 in rural communities and, if so, why is that? What are the
20 challenges of delivering high quality mental health care in
21 rural areas? What can be done to better meet the needs of
22 people in relation to mental health care in rural
23 communities? And, in that context, what particular
24 strength of rural communities ought to be paid attention to
25 and incorporated into the systems so that the whole system
26 can be strengthened?

27
28 Of course, there are many issues that won't be covered
29 in this session but will feed into later themes in the
30 Commission's work, which include workforce and comorbidity
31 of drug and alcohol issues.

32
33 With that, may I call the first witness, Mr Terry
34 Welch.

35
36 **<TERRY MICHAEL WELCH, sworn: [10.15am]**

37
38 MS NICHOLS: Q. Mr Welch, are you the Chief Executive
39 Officer at the Maryborough District Health Service?

40 A. I am.

41
42 Q. In that role, do you have responsibility for managing
43 the equivalent of 256 equivalent full-time staff?

44 A. I do.

45
46 Q. And a budget of \$42.5 million per annum?

47 A. Rounded up, yes.

1
2 Q. The role encompasses all operational and strategic
3 management including of a 128 bed facility which includes a
4 Community Health Centre?

5 A. That's right, yes.
6

7 Q. Can I ask you to describe briefly the kinds of
8 services that the Maryborough District Health Service
9 provides?

10 A. Sure. So, we're, if you like, a traditional health
11 service from acute perspective, so we have a medical ward,
12 we have a surgical component to that, we have operating
13 theatres, renal dialysis; the broad spectrum of acute-based
14 services. We have a very large aged care service across
15 three campuses, so we have the Avoca campus, the Dunolly
16 campus, and the main Maryborough campus, and then we have a
17 breadth of services within our Community Health Centre as
18 well, including allied health, including social support
19 programs, including District Nursing, so some traditional
20 and non-traditional community health programs running out
21 of there.
22

23 Q. In relation to your dealings with patients requiring
24 help with mental illness, do you have about 15 patients
25 every month presenting to your urgent care centre?

26 A. We have, on average, 15 patients who present with a
27 presenting symptom of mental health.
28

29 Q. Of those, are quite a number of them requiring urgent
30 care?

31 A. Yes.
32

33 Q. And so, there are about 6,000 presentations of that
34 kind every year?

35 A. There's 6,000 presentations to our urgent care centre,
36 yes, absolutely.
37

38 Q. Can I ask you about how it is that urgent
39 presentations are dealt with. Can we start by describing
40 what your Urgent Care Centre is and how it works?

41 A. Sure, the Urgent Care Centre, if you like, is an
42 extension of a private practice, that we provide resources
43 for the medical offices in town to be able to provide
44 emergency care and support, so it's not a traditional
45 funded Emergency Department such as a regional or
46 metropolitan centre has.
47

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

5
6 Q. That's a staffed 24 hours a day, 7 days a week?

7 A. With nursing staff, yes.

8
9 Q. When patients present, that is, patients regardless of
10 what their presenting issue is, are they first triaged?

11 A. Yes. Every patient who presents is triaged in
12 accordance with the Australasian triage scale which is used
13 universally.

14
15 Q. Do you find that the vast majority of needs can be
16 dealt with at the clinic?

17 A. So, in the Urgent Care Centre we can certainly provide
18 primary care level support. We can do intermediate
19 emergency care, if you like, but anything of high
20 complexity, certainly we need to refer out, yes.

21
22 Q. When it comes to people presenting with mental health
23 issues, particularly the more severe presentations, what
24 happens?

25 A. So, just as every other patient, they are triaged and
26 assessed by one of our registered nurses and, dependent on
27 the triage level, obviously that then instigates a level of
28 response in accordance with their needs.

29
30 Q. Those that your staff deem need further assistance,
31 who provides that?

32 A. So, the nursing staff will and then obviously we can
33 call in the support of our general practitioners should we
34 need. Again, it's dependent on their presentation and
35 their requirements, or the nurse practitioners can manage
36 the lower end presentations, but anything of high
37 complexity, we are then very reliant on our outreach
38 program through Bendigo.

39
40 Q. What's the outreach program provided by Bendigo, and
41 is it Bendigo Health?

42 A. Bendigo Health, yes.

43
44 Q. What do they provide?

45 A. So, they are our immediate service provider for mental
46 health services, we don't provide any specialist mental
47 health services. So, we contact them with any mental

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

5
6 Q. Do they perform triage by video?

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

12
13 Q. Can you tell the Commissioners what are the challenges
14 that you face in the Urgent Care Centre where you have
15 someone who is in acute need and they can't be seen
16 immediately, including being triaged immediately by someone
17 from Bendigo?

18 A. Sure. So, the challenge comes for us in our Urgent
19 Care Centre as we were able to display yesterday, is that
20 we have no ability to securely care for someone with mental
21 health illness. So, if they are exhibiting behaviours
22 which are disruptive, they are disruptive within the entire
23 unit and they can move around. Obviously, if they are
24 disruptive to the point of concern, we call the police. We
25 don't have on site security, so we will often need police
26 support to manage the behaviours for the safety of the
27 patient themselves and the staff up until the point of
28 triage assessment and often referral.

29
30 The triage process can delay the ability for us to, I
31 think, efficiently manage patients who are suffering severe
32 mental health. The triage basis from how the mental health
33 system works is very different to everything else that we
34 work with.

35
36 Q. Can you explain how it works for mental health
37 patients who are in acute need?

38 A. So, again, our clinicians will contact the Bendigo
39 Health in this instance, but any gazetted provider, and
40 they provide clearly the examination and their thoughts and
41 primary diagnosis in terms of the patient's presenting
42 complaint and behaviours and so forth. At which point then
43 Bendigo Health will provide the triage and assessment and
44 it's that triage and assessment which determines the
45 ongoing management of the patient.

46
47 That may mean that the patient can wait with us

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

11
12 In extreme instances obviously patients may be
13 transferred to Bendigo Health and then there's
14 consideration about how we safely do that, do they need to
15 go via police or do they need to go via ambulance with
16 appropriate sedation and support, and again that's always a
17 difficult discussion and a very individual discussion based
18 on the presentation.

19
20 Q. What are the options for transferring someone to
21 Bendigo who is in acute need?

22 A. Well, the options are really that: that, if someone is
23 exhibiting behaviours which are extremely dangerous, the
24 clinicians will work with the police to assist
25 transportation and that may be the police go in the
26 ambulance or it may be that the patient is okay to go by
27 ambulance, or I think in the worst case scenario, the
28 patient will go in a police vehicle in a way which can be
29 safely done.

30
31 Q. How do the options for transferring quite mentally
32 unwell patients compare with what's available for generally
33 medically unwell patients?

34 A. I think the system over the years has done a terrific
35 job in making sure we get the right care at the right time
36 at the right place for medical patients. So, what that
37 means is, if we have a complex medical patient right now at
38 Maryborough, we have the ability to ring one number, called
39 Adult Retrieval Victoria, and they will support and
40 facilitate the overarching care, transportation and
41 location of that patient moving forward.

42
43 Because the difficulty with the mental health process,
44 is we have no oversight of bed capacity, bed availability,
45 and I'm sure Bendigo Health are under extreme pressure and
46 then we're contacting them escalating that pressure even
47 further.

1
2 With the medical process, with Adult Retrieval
3 Victoria, they have oversight over the system: they know
4 bed capacity, they know resource availability, so they
5 support our clinicians with the care, at the same time
6 arranging transportation and the location for where the
7 patient will go. It's a very efficient process, it's a
8 very safe process, it supports our clinicians.

9
10 If you think overnight we have two nurses on and we
11 might have one general practitioner within our Urgent Care
12 Centre, so that support provided by the Adult Retrieval
13 process is very good. It's the same with obstetrics, it's
14 the same with paediatrics and neonatal, we call one number
15 and everything is facilitated.

16
17 Q. How do the wait times, if you like, for mentally
18 unwell patients at your Urgent Care Centre compare with the
19 wait times for people who have general health issues?

20 A. I'll just talk on the average, if you like, because
21 there are outliers always.

22
23 Q. On average, of course.

24 A. But certainly the clinicians would indicate to me that
25 we have much longer wait for mental health patients than we
26 do for medically unwell patients.

27
28 Q. In relation to patients whose behaviour becomes
29 uncontained, what sort of safety issues does that present
30 to your staff at the centre?

31 A. It's an enormous challenge because overnight - if I
32 can use the overnight example?

33
34 Q. Yes.

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

40
41 So often, if the scenario escalates, and that often is
42 an escalation before we will call police, for example.
43 And, if you think about that scenario, a mental health
44 patient overnight who has these challenging behaviours and
45 needs all the support, the nursing staff will have a GP
46 available with them and the only road crew in town from the
47 police in our Urgent Care Centre.

1
2 The issue with that is, as I mentioned before, we have
3 no way to seclude the patients, so they are free to move
4 around the unit and they do. As we saw yesterday, our room
5 is set up as well as it can be; it is literally a bland
6 white wall room with no risks in it. By that there's no
7 sink, there's no hanging points, we've done the full safety
8 assessment of it, but there are doors that the person can
9 walk out. There's no outside access to fresh air without
10 going back through the department, so the design of the
11 unit is inhibitive but also the resource availability
12 overnight is certainly a concern.
13

14 Q. Can I get you to explain what you've been discussing
15 by reference to one of the diagrams you've prepared. Can
16 we have the Current State Real Life diagram, please.
17 Excuse me, Commissioners.
18

19 Beg your pardon, Commissioners, I misunderstood the
20 logistics of the room. I thought it would be displayed
21 where everybody could see it.
22

23 COMMISSIONER COCKRAM: I think they can see it.
24

25 MS NICHOLS: Yes, but you can't, unfortunately. We have
26 copies for you, I'm sorry about that.
27

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

29 A. I do.
30

31 Q. Apologies for that?

32 A. Yes.
33

34 Q. Do we have the diagram entitled, Current State Real
35 Life Experience?
36

37 CHAIR: Yes.
38

39 MS NICHOLS: Excellent. Mr Welch, can I get you to
40 explain what's illustrated in the two tracks on that
41 document?
42

43 A. Sure. Please be clear that this is an example
44 provided to me by clinicians. So, the psychiatric patient
45 who presents to our Urgent Care Centre in this instance
46 presented following an overdose, came in at 2200 hours, so
47 10 o'clock at night. Not an uncommon time for a
presentation, was rightly assessed as a triage category 2,

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

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

10
11 At 9 in the morning the patient was then allocated to
12 the community-based team I mentioned to come and commence
13 the assessment from a mental health perspective. At
14 11 o'clock that team attended our site, but the patient was
15 still drowsy so had to return. At 3 o'clock the patient
16 was assessed again and deemed to need admission and they
17 were transferred at 1800 hours to Bendigo.

18
19 Q. From your assessment, based on the information you've
20 received from the clinicians, do you regard that as a
21 significantly delayed period of time over which the patient
22 was dealt with?

23 A. I would suggest there are examples of this quite
24 common.

25
26 Q. And that compares to the journey on the right-hand
27 side which is more straightforward?

28 A. Yes. It's just an example again of a medical patient
29 and, as I mentioned before, the streamlined response,
30 particularly the support of Adult Retrieval Victoria, or
31 the like agency, to be able to facilitate a very prompt
32 transfer.

33
34 Q. Thank you very much. I'm finished with that diagram
35 now, thank you. Can I ask you about the factors in this
36 community and the surrounding areas that are likely to
37 contribute to difficulties accessing help for mental health
38 issues?

39 A. Sure. There's a number of challenges for the
40 community, and I think, as I've written in my statement,
41 the community here faces a whole range of challenges to do
42 with socio-demographic matters. So, the ability to afford
43 transportation to access services is an inhibitor. The
44 ability to --

45
46 Q. Can I stop you there. Can you say a little bit more
47 about the transport problem, what's involved in it and how

1 inhibiting is it?

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

9

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

16

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

20

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

24 A. Yes.

25

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

30 A. Yes, I do.

31

32 Q. Great. We'll just wait till it comes up on the
33 display. Mr Welch, can you take us through what you're
34 depicting there in that description of pathways for a
35 mental health presentation?

36 A. Sure. We were able to have some detailed discussions
37 with our general practitioners in town to really try and
38 get some real life learnings about the process. What this
39 outlines for you is, once the assessment is done and there
40 is identification that there is services and support and
41 specialist support needed, there are multiple potential
42 referral points, and clearly we've just demonstrated some
43 for an example, but there are up to a dozen or more
44 potential options for a general practitioner or a clinician
45 to decide where they may send someone.

46

47 What happens in that scenario is, the general

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

5
6 The person then goes into a system where there is no
7 identification or wait list, so the general practitioner
8 may be referring someone who needs some psychiatric support
9 to a psychiatrist with no understanding of the length of
10 the wait or their wait times or their availability. The
11 issue then of course is the GP in this scenario loses sight
12 of that patient. So, they've done the referral, they're
13 assuming there's an appointment happening and the process
14 is working.

15
16 And, if it's not the appropriate referral point, so
17 they may go and see someone and the patient may be told,
18 "No, you need to see someone else", which happens. The
19 patient has to go back to the general practitioner, wait to
20 see the general practitioner, then have another referral,
21 so the GP has to do another referral to a different
22 specialist again. So, if you like, the patient can be
23 bouncing backwards and forwards during lengthy waits, all
24 reliant on the referral program without knowledge of wait
25 lists and availability.

26
27 Q. Is that what you mean when you say "patients become
28 lost in the system"?

29 A. Absolutely. Yep, absolutely.

30
31 Q. Is one of the features, lack of visibility for the
32 general practitioner to know what is available and when?

33 A. I think that, if you think of the social state, we
34 need to be able to almost hand-hold patients through this
35 journey. The stress alone is so difficult for patients and
36 families, yet alone being given a referral to try and
37 navigate to somewhere, and they are definitely getting
38 lost. If you think of that urgent care presentation, that
39 is the cycle.

40
41 Q. I see, thank you. You said in your statement, which I
42 will tender in due course, that:

43
44 "The Maryborough region leads every social
45 indicator at the wrong end and the
46 community is institutionalised in the sense
47 that it does not know what good looks like

1 in the health context."

2

3 Can you say a little bit more about that?

4 A. So three years ago, or approximately three years ago,
5 we did our service plan and there was a whole raft of
6 detailed review of the community and its perception of
7 health. It was recognised that the health status of this
8 community is poor. The community said they were happy with
9 that. So, there's no understanding about what good health
10 looks like for a lot of people because it's
11 institutionalised, it's multi-generational as I mentioned
12 before.

13

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

19

20 Q. Is social isolation a barrier to help-seeking?

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

30

31 Q. Once they end up in aged care, are there further
32 challenges in treating people with mental health
33 difficulties?

34 A. There is, and I haven't touched on that too much
35 because of the Royal Commission into aged care obviously,
36 but certainly the challenges that we describe in terms of
37 accessing specialist support is again challenging, although
38 there are some modalities which are improving in that
39 space.

40

41 Q. What about the stigma that is associated both with
42 mental ill-health and with help-seeking for mental
43 ill-health?

44 A. It's an interesting discussion because recently we've
45 done a massive body of work around women's health and we
46 utilised the expertise of the Health Issues Centre to
47 conduct a survey of women in our community to understand

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

5
6 Because small communities, clearly everyone can know
7 and see each other, so it is a challenge and that certainly
8 prohibits people from accessing timely and effective care.

9
10 Q. Did this relate to women in particular?

11 A. Well, that did, yes.

12
13 Q. Have you advocated the use of what's called, the
14 Orange Door Model to help overcome this issue?

15 A. Well, I've written it in there, yes.

16
17 Q. You need to explain to us what it is.

18 A. Well, it's still in development but it is the program
19 being developed to support people within family violence
20 and domestic violence. So, the rationale is, the Orange
21 Door is a one entry point and you enter through the Orange
22 Door and you are then receiving of a wrap-around service.

23
24 So it's still being developed, Maryborough needs one
25 because of the issues that we have. But if you think about
26 the stigma and the concerns of the community, the ability
27 to walk through one door which is, you could be going there
28 for anything, but the reality is you walk in and the
29 service will wrap-around, in this case the women, but of
30 course it needs to be a fully holistic model, The Orange
31 Door.

32
33 Q. So you need both holistic and interconnected service
34 delivery and you need a presentation which doesn't say
35 mental health?

36 A. Correct.

37
38 Q. Rather, it says health more generally?

39 A. Correct. And our thoughts are, we need a wellness
40 centre model which is all encompassing whereby you could be
41 entering there for some allied health support or you're
42 entering there for very detailed counselling and support
43 for a significant issue and no-one will know.

44
45 Q. Can I ask you about stigma and young people. Do you
46 have a nurse practitioner and a doctor at the public
47 secondary school each week?

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

2

3 Q. Do they particularly attend to mental health issues or
4 are they more general?

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

14

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

21

22 Q. How is it funded?

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

28

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

32

33 Q. When you say it's underwhelming, if you had further
34 funding, what sorts of services would actually meet the
35 need that's being seen in that clinic?

36 A. I would say to you it's not only that clinic, there
37 are other schools in this community right now with zero
38 service provision for a doctor and a nurse practitioner.
39 So, I think we need to consider how we encapsulate other
40 schools and support those children just like we're doing at
41 MEC.

42

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

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

5
6 Q. We've asked you about how things can be done better, I
7 think you've alluded to some of those things already. Can
8 we have a look at your preferred model of primary care.
9 Can we have the Preferred Primary Care Model slide
10 displayed, please. [MDH.0018.0001.0012] Commissioners, do
11 you have this document?

12
13 Mr Welch, do you have the document?

14 A. I do.

15
16 Q. Excellent. Can you please talk us through how your
17 preferred model for primary care works?

18 A. Sure. I just want to put a clause on this that none
19 of us consider ourselves scholars in developing a system
20 and a model. This was a roundtable discussion with our
21 clinicians at the health service about what may or may not
22 work for us. So, what we are saying here is that, we need
23 the ability to be able to refer to one central point. So
24 in this case in a primary care scenario the GP is able to
25 do one referral which then enters a mental health intake
26 service, that is, the referral goes to an expert group or
27 an expert body who then determines the care requirements
28 for that person through additional triage, through an
29 additional assessment, a holistic assessment, and then they
30 can allocate accordingly the care requirements. So, rather
31 than a scenario of the general practitioner right now
32 trying to determine where to send somebody without any
33 knowledge of the wait list, or is that specialist
34 appropriate, this expert group would be able to do a
35 holistic review and be able to refer appropriately.

36
37 The other key thing here is, it would take into
38 account care for the carers and the families which we hear
39 often is missed, and it would also make sure that the GP,
40 who is the primary caregiver is, if you like, kept in the
41 loop, there's feedback back. This is the journey that
42 their patient's on, this is the step they're at, so at all
43 times we would have knowledge and some lens of the patient
44 who, without such a model, developed however it would be,
45 is currently lost.

46
47 Q. Is visibility across the whole spectrum of care and

1 coordination, are they two of the features of your model?
2 A. Absolutely. Coordination to us is paramount. I
3 mentioned before and I don't say it flippantly, that hand
4 holding, to be able to help patients or their families and
5 their carers and the patients navigate the system is
6 critically important.
7
8 Q. In this context, what would you say about
9 transportation arrangements and how they should change?
10 A. The eutopic world would be services in Maryborough, so
11 that would be a very selfish approach, to say everything
12 should be here at our fingertips. But there's a reality.
13 I think there are two answers to that: priority must be
14 given to rural areas that have evidence of high stress and
15 high need, and we're clearly one of those, so there's my
16 lobby. The second point is that transportation could be
17 facilitated by a number of means, and also the fact that we
18 are completely under-utilising telehealth. We are
19 under-utilising telehealth still and I think the fact that
20 it is always often in the car to somewhere for an
21 appointment, when there must be in 2019 some really good
22 models available to reduce the barrier and the stress on
23 the families and the patients from travel.
24
25 Q. Can you elaborate, please, on the under-utilisation of
26 telehealth: firstly, what potential does telehealth hold -
27 we'll get to the barriers shortly - but what potential do
28 you think it holds for this community?
29 A. My belief is that it brings services that currently
30 are not available and in reality will never be available.
31 Because recruitment of specialists to smaller communities,
32 as we know, is very difficult, but access to specialists is
33 very easy via telehealth.
34
35 It's been discussed for decades, telehealth, but a
36 system that was well coordinated and set up and structured
37 could easily bring services and system response locally
38 that currently we don't have and some I don't think we'll
39 ever have.
40
41 Q. What would be the practical measures you would need to
42 implement to have telehealth well set up, observing at the
43 moment that you use a video which you wheel into a room at
44 the Urgent Care Centre for triage?
45 A. So, some of it is appropriate equipment in an
46 inappropriate setting. For example, I firmly believe that
47 the rooms that we have available for the care of the

1 mentally unwell in our Urgent Care Centres should be
2 equipped with fixed cameras and fixed telehealth equipment,
3 safely away, that can assist with a really prompt triage
4 and response from our - whichever service we're accessing.
5

6 The current scenario, we have to wheel a cart into a
7 sometimes hostile environment if we can - has all the
8 barriers that you can appreciate. So, some of this is
9 simple equipment and set up, and then of course the biggest
10 challenge with telehealth is that co-ordination and
11 administration, to make sure that there is someone on the
12 other end, that it works properly, and all those
13 challenges. But I don't see one barrier that can't be
14 overcome with telehealth.
15

16 Q. That's very encouraging, I should say. You've also
17 talked about the importance of a lack of accessible social
18 housing. Can you say a little bit more about that?

19 A. Yeah, I can, and I'm going to use the Dunolly example
20 if I may. We've been working very closely with the
21 hospital axillary out at Dunolly, and they've done an
22 enormous report into the community and the state of the
23 community from a housing point of view, and the reality is
24 that smaller communities - there is no equity. To buy into
25 something is very difficult because equity in housing's
26 very low. The fact that there is none is an issue.
27

28 The housing scenario out at Dunolly, as I mentioned
29 before, you may be in your unit, you may be on a farm, you
30 may be at risk, there is no public housing available or, if
31 there is, it is oversubscribed in communities like ours.
32 So, I think social housing and supported arrangements that
33 are available in some of the bigger regional centres and
34 they are absolutely brilliant facilities; in smaller
35 communities, clearly in smaller models will bring that
36 social connectedness, will bring that social support, and
37 relevant care that's needed for those people, and it will
38 certainly stop the deterioration of health which I believe
39 occurs.
40

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

42 "We don't need our own mental health
43 service workers. What we need is access to
44 a system as efficient and as effective as
45 the system described for medical and other
46 patients."
47

1
2 You've addressed that at some length. Is there
3 anything else you'd like to say about that?

4 A. What I would say is, I think the system has done a
5 terrific job for medical patients, for surgical patients,
6 overall, for medical patients, surgical patients, obstetric
7 emergencies, paediatric neonatal emergencies, and I think
8 it's time for us to really be able to drill into the
9 challenges, and I'm not the person to be able to explain
10 all the challenges of the mental health system, but we must
11 be able to set up a way whereby the fail-safe is not
12 someone sitting in our Urgent Care Centre. The fail-safe
13 must be, there is no wrong door.
14

15 So, we can send someone to Ballarat today with a
16 medical issue and they may have nothing wrong with them.
17 So, we might send them across concerned they've got chest
18 pain and we're thinking there's something really wrong with
19 this person. Naturally they go across, they have all their
20 assessment. If there's nothing wrong with them they come
21 home, and there's no criticism of that system; that is
22 fail-safe.
23

24 The current mental health model of people sitting in
25 our Urgent Care Centres is just exposing such great risk,
26 and I would hate to be a family member or a patient in the
27 scenario which we have here of the room with white walls.
28 So, I think we need to be able to work through a system
29 that responds quicker and accept that some people will be
30 transferred who didn't need to be transferred, but it's
31 safer and it's a better outcome. We do it with all other
32 elements of health and I think it's time to do it for
33 mental health.
34

35 MS NICHOLS: Thank you, Mr Welch. Chair, do the
36 Commissioners have any questions?
37

38 CHAIR: Professor Fels.
39

40 COMMISSIONER FELS: Q. I would be interested to see the
41 housing study that you mentioned, if you are able to get
42 that to us?

43 A. I can get you a copy, yes.
44

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

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

5

6 Is the length of time that's waiting, and I think you
7 describe many hours that people will wait in acute mental
8 health crisis before being transferred, increased the
9 issues and risks that you've identified?

10 A. I have absolutely no doubt it does. There is no
11 question, if you look at the environment that people are
12 placed in, if you look at the - and I'm sure patients will
13 describe the sense of what is happening in an Urgent Care
14 Centre - they can be a very busy facility and someone's in
15 there with a mental health concern who needs care and
16 attention and we have two nursing staff on, no security
17 available to sit with them and support them, often leads to
18 escalation and often frustration for those patients and
19 families.

20

21 Q. Do you have any sense of how often people are then
22 transferred when they need a transfer by ambulance or
23 alternatively in a divi van, the percentage of the times
24 that occurs?

25 A. No, I don't know.

26

27 Q. There might be some data that would be helpful?

28 A. Certainly, I agree and I can provide that.

29

30 MS NICHOLS: May Mr Welch be excused.

31

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

34

35 MS NICHOLS: The next witness is Mr Al Gabb.

36

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

38

39 MS BATTEN: Q. Al, we'll just get you to sit so the
40 microphone's alright and you can speak into the microphone.

41 A. Is that good?

42

43 Q. Thank you very much. Have you, with the assistance of
44 the Royal Commission team, made a statement to the Royal
45 Commission, a witness statement?

46 A. Yes, I have.

47

1 Q. I tender that statement. [WIT.0001.0001.0001] Al, you
2 grew up in country Victoria in Skipton?
3 A. That's correct.
4
5 Q. Which is about 45 minutes west of Ballarat?
6 A. That's correct, an hour south of here.
7
8 Q. During school you experienced some bullying?
9 A. Yes, through both my primary and secondary.
10
11 Q. You feel that had a lasting influence on you as a
12 person?
13 A. I have no doubt that has had an influence on my life
14 today.
15
16 Q. If we move to your 20s and early 30s, can you describe
17 how your life was during that period.
18 A. So, my 20s and early 30s, I spent much of my 20s
19 working in the ski industry as well as getting a trade and
20 some university in there. I travelled the world, life was
21 pretty good, living the dream so to speak. Saw lots of
22 Australia and lots of different countries around the world,
23 and I didn't have too many worries, so I thought. Now I'm
24 a little lost.
25
26 Q. So you were overseas at that time and then it got to a
27 point where you decided you needed to come home and so six
28 or seven years ago you decided you needed to move back to
29 the country farm?
30 A. Yeah, that's correct. In my late 20s I decided to
31 study some agribusiness degree, and then in my early 30s,
32 six or seven years ago, I came home to the family farm
33 which I'm fifth generation on through my mother's side, and
34 decided to make a go of farming and reinstate the business
35 that had been leased out for a number of years.
36
37 Q. And you said that that's when your problems first
38 started. So about that time, six or seven years ago, can
39 you tell us some of the factors that were happening in your
40 life that contributed to the problems?
41 A. When I came home I decided there was a farm down the
42 road that was for sale and I decided it would be a good
43 idea to purchase that farm. And, unbeknownst to me, I
44 allegedly sprayed out some native grasses and received
45 quite a threatening letter in the mail from one of the
46 Federal Departments under the EPBC Act, and combining that
47 with a relationship breakdown at the time, it sort of

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

6
7 Q. You said that you had some behavioural issues and also
8 you became a bit of a recluse from your family and friends;
9 is that right?

10 A. That's correct.

11
12 Q. So, being a farmer, living alone on the farm in one of
13 the houses, and it would be not uncommon for me to not see
14 anybody for weeks and sometimes more than that at a time,
15 other than going to the supermarket and doing daily chores,
16 you know, the likes thereof. So, I started to recluse as a
17 person. Naturally, I sit somewhere between an extrovert
18 and an introvert so depending on which day of the week it
19 is.

20
21 I did become reclusive, I stopped talking to my
22 friends, stopped talking to my family who - mum and dad
23 only live literally 100 metres away and would shut
24 everybody out and that really made me spiral downhill as a
25 person. It made my existence - the walls started to cave
26 in around me and I was making it worse for myself with my
27 behavioural patterns, and that was a result of obviously a
28 mental health condition which I refused to acknowledge at
29 the time.

30
31 Q. But you did go and see a GP?

32 A. That is correct, yes.

33
34 Q. Did the GP help you?

35 A. The GP did help me. This is sort of a very long story
36 of GPs, psychologists, psychiatrists, mental health care
37 plans through the public system, seeing private
38 psychologists.

39
40 Q. We will come to those parts of the story, but with the
41 GP, the GP put you on some medication and you said it took
42 four to six weeks to have any effect and that was a long
43 period for you?

44 A. That is right. So, from my understanding most
45 psychological medications are sort of a four to six week
46 introduction to your body. So, by the time you're at
47 week 6 it's meant to be there and, if it doesn't work,

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

3
4 I've been on a few medications, all of which except
5 for one was a failure for myself but I have and still do
6 every day take a drug called lithium.

7
8 Q. The GP put you on a mental health plan and that
9 allowed you to have 10 sessions with a psychologist. In
10 your view was that enough, the 10 sessions?

11 A. So, the time I was put on that mental health care plan
12 I was in crisis. I had had attempts at my own life, three
13 of which, and that extended pre and post seeing this GP
14 over a period of time. Sorry, can you repeat the question?

15
16 Q. We were talking about whether the 10 sessions with the
17 psychologist was enough and you're saying you're in crisis,
18 so is 10 sessions enough for someone who's in crisis?

19 A. So, for me it was not enough. I used up those 10
20 sessions rapidly, it may have been 10 weeks, it may have
21 been shorter, it may have been longer, I cannot give you a
22 hard timeframe.

23
24 When you're in crisis as a person and your life is in
25 the balance, 10 sessions does not fix everything, it
26 doesn't even start to fix. It gets the ball rolling, yes.
27 I rapidly adapted to the fact that I had some mental health
28 issues and acknowledged it really quickly but, had I not
29 acknowledged it, those 10 sessions would be just lost time,
30 you know, a bit of a lost target, I guess.

31
32 I am of the belief, and I do stand to be corrected if
33 somebody else in the room knows better, but I think once
34 you've used those 10 sessions, you have to wait maybe
35 another 12 months or until the 12 months rolls. I do stand
36 to be corrected on that; that is my belief.

37
38 Q. That's my understanding as well, that it's the next 12
39 months.

40 A. So, 12 months is a long time when it comes to
41 anything, especially your mental health, someone's mental
42 health.

43
44 Q. You've said that you went and saw the psychologist but
45 then you were able to access a private psychiatrist in
46 Melbourne. Can you tell us about, first, the experience
47 with the private psychiatrist?

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

9
10 Q. Why did it take a day? How did it take a day?

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

20
21 He didn't come cheaply and I have no issues with that,
22 but I'm very lucky that I had the financial capacity myself
23 and through help from my family to use external help
24 outside of the public system, and I'm very fortunate for
25 that and I'm very aware that a lot of people don't have
26 that ability and that would be something that's quite dear
27 to me, is to try. Everybody should have access to the best
28 help.

29
30 Q. Even with that access and the financial means, is it
31 correct that you stopped going to him because it just
32 wasn't practical with your commitments on the farm and the
33 travel time.

34 A. That is correct.

35
36 Q. So you didn't continue seeing the private
37 psychiatrist?

38 A. No. The time out of my week - weeks - was starting to
39 add up to too much for me.

40
41 Q. So you stopped seeing him?

42 A. That is correct, yes.

43
44 Q. You touched on this before, but in your statement you
45 said:

46
47 "I was living by myself and could sometimes

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

7
8 Can you just expand on that and just tell us a bit
9 more about the nature of the work and the social isolation,
10 please?

11 A. So, as a farmer, where I farm in Skipton, which is
12 45 minutes west of Ballarat, I would not consider it
13 isolated in the scheme of Victoria or Australia as a whole,
14 but compared to people that have access to cities, whether
15 it be Ballarat, Bendigo, Melbourne, it is.

16
17 So, as a farmer, and a young farmer, the demands of
18 running a farm are significant: you are responsible for
19 livestock, you're responsible for your business, you're
20 responsible for - you know, you're the accountant, you're
21 everything. So, the hours worked can really quite stretch
22 right out, and especially in seasonal times.

23
24 At harvest time it is not uncommon to be living on
25 three, four hours a night's sleep and for days if not weeks
26 on end just to get the job done because we have that
27 window; and, most farmers acknowledge that and most farmers
28 have those windows in their businesses.

29
30 But it's when you start to get reclusive as I was and
31 not be social with my friends and family is when it
32 started, this is one of the issues I see.

33
34 Q. You referred before about attempts on your life.

35 A. Yes.

36
37 Q. Without detailing what you did, can you tell us about
38 that experience and particularly the paramedic who was
39 involved?

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

46
47 Q. That's okay.

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

7
8 So, for him to have to pick me up, you know, in my
9 state, he was just doing what he does. He does it for
10 everybody, but you know, there was also another neighbour
11 who's a great friend of my family's, and a friend of mine
12 as well all there helping me get in the ambulance. So, on
13 the side of the road, just the side of the country road.
14 It's those things that rural communities have that can be
15 tough on others as well.

16
17 Because, you know, for the guy in the ambulance, we
18 know each other really well, he's not much older than me,
19 we've grown up together, farmed almost side-by-side, so
20 that has an effect on him to see that. So, the flow-on
21 effects in those rural communities are greater than what
22 people, I guess, see from the outside. That's just a small
23 example, I guess.

24
25 Q. You've also said though that the community provides a
26 lot of support.

27 A. Absolutely.

28
29 Q. Can you tell us about that side of it as well?

30 A. Yes. I can give you a few examples of that. I've had
31 comments made to me by members of the community who you
32 would least suspect. You know, they've come up to me and
33 said, "Good on you, Al" because I've been quite vocal in my
34 campaigning for mental health.

35
36 I've had one person come up to me and openly said that
37 he'd had similar thoughts himself, and yet, me being vocal
38 had given him the courage to talk to his wife about it.
39 And this guy's not young, you know, he's my parent's age.

40
41 There's also other channels and people I talk to in
42 the community, my close friends, who also champion for
43 mental health in their own ways, whether it be politically
44 or giving through their own time into different areas: it's
45 been quite a good experience for that, I guess.

46
47 Q. Just coming back to your experience with the system:

1 you've also had to go to the Emergency Department a couple
2 of times.
3 A. Yes.
4
5 Q. Can you tell us about the experience of going to the
6 Emergency Department.
7 A. Yes. Well, to the [REDACTED] Hospital?
8
9 Q. M'hmm.
10 A. I was very interested in what Terry was saying before.
11 It was a horrible experience, to be honest with you,
12 because here I am, I'm like I am now, you know, I'm
13 perfectly okay from the outside. And when you go to the
14 triage nurse, that's one way to get to emergency really
15 quickly, is to say that you're suicidal. And you go in the
16 back and there's people in obvious distress for medical
17 conditions.
18
19 Q. You mean physical medical conditions, is that what you
20 mean?
21 A. Yes, you know, they might have broken their arm or
22 something along those lines. And here I am sitting on the
23 bed sort of crying, but I'm alright, I'm not dying; so that
24 made me feel pretty bad of taking up their resources
25 because I wasn't right with my mental health.
26
27 And they didn't really know what to do, so they asked
28 [REDACTED] Psych Services to come, which I believe was at
29 [REDACTED] Hospital and they sent one of their
30 counsellors, I believe - this is about 1 in the morning at
31 this stage - and he sat down and we went to a room out the
32 back and we sort of chatted for a bit.
33
34 Then he made me sign a piece of paper saying that I
35 would not attempt self-harm, and basically on that
36 discharged me and said, "Go and see your GP." So that was
37 a fairly muddy picture, I guess, of how it happened but -
38 yeah.
39
40 Q. You've also had experience with the public psychiatric
41 services, and you've said, "It felt fairly stereotypical of
42 a public psychiatric hospital." What do you mean by that,
43 what's a fairly stereotypical public psychiatric hospital
44 and what was your experience that confirmed that
45 stereotype?
46 A. Well, [REDACTED] Psych Services, for those that know, is
47 the old [REDACTED] Hospital which is right on [REDACTED]

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

5
6 Q. You might just have to explain a bit more to us what
7 you mean. I think I know but it would be helpful if you
8 explain.

9 A. You sort of expect someone in a movie to come out,
10 like one of those - anyway, we're getting a bit lost.

11
12 So you walk in, there's big tall white ceilings,
13 there's not a lot of decor that's warming, makes you feel
14 okay, it's all very quite cold and sterile.

15
16 There's a waiting room and I remember very clearly in
17 the waiting room, and it wasn't a very big waiting room,
18 might have been half a dozen chairs, there was a lady
19 there, and she was obviously in a very bad way and she had
20 her head between her knees and she could not - she was
21 rocking backwards and forwards and was obviously in dire
22 need of some help. When you combine that with the tall
23 concrete corridors and very white fixtures, it's not a
24 welcoming environment, it's not a calming, soothing
25 environment which, when you're in mental health issues,
26 it's a good thing if it's calming and soothing.

27
28 Q. In your statement you've said:

29
30 "For me it's all about saying, it is okay
31 to have been there."

32
33 Can you expand a bit more on why you choose to speak
34 out about mental health?

35 A. Well, it is okay to have mental health issues, and
36 somebody mentioned some facts before and it's staggering
37 how many people are going to experience it in their
38 lifetime. So, for me speaking out and openly talking about
39 it - and I'll talk about it to anybody that asks - it's
40 about helping. If I can help one person, that's a win,
41 that's all that matters to me, is to give back.

42
43 And, people helped me, I'm great these days, I manage
44 myself, but if I can help one person make a choice to go
45 and see their GP and get some help; or even better, one
46 person preventing self-harm, to me that's a win.

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

7
8 MS BATTEN: Thanks very much, Al. Commissioners, are there
9 any further questions for Mr Gabb?

10
11 CHAIR: Q. Thank you very much, Mr Gabb, for your
12 evidence today and for being so frank with us about your
13 experiences. I noticed in your witness statement you did
14 say of that experience when you were in [REDACTED] and I just
15 want to make sure I understand that. When you were in the
16 psychiatric ward, it was in the old part of the hospital,
17 and the things that you describe about it not being warm
18 and welcoming were in stark contrast to what you saw in the
19 new part of the hospital that was immediately next door.

20
21 So, how did that comparison, when you reflect upon
22 that, about the place of mental health in our health
23 system, leave you feeling?

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

28
29 It's intimidating when you're in there in a way,
30 because you're not thinking clearly yourself, so you know,
31 everybody's got their own version of it. But when you're
32 in there it's not comforting and calming, and the example
33 of the lady that was sitting right there more or less, and
34 she was rocking backwards and forwards and obviously needed
35 a lot of help. So, to be next to her. And I had no
36 problems with that but I have vivid images in my head in
37 these stark environments, is probably not the best.

38
39 Q. The other issue I just wanted to touch on is the fact
40 that you talked quite graphically about the life on the
41 farm and the fact that you've got very intense periods. I
42 think it was the point you made about sometimes travelling
43 to Melbourne ultimately became too long away from your job.

44
45 You might have heard Mr Welch talk earlier about the
46 potential there is for telehealth. Do you think accessing
47 mental health support through new technology would be

1 something that's important in the future or would have
2 helped you in those circumstances?

3 A. I'm assuming you're meaning telehealth, as in iPad,
4 computer screen-type scenarios?

5

6 Q. Yes.

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

11

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

19

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

22

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

24

25 CHAIR: Has the witness statement also been formally
26 produced?

27

28 MS BATTEN: Yes, it has.

29

30 **<THE WITNESS WITHDREW**

31

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

35

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

42

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

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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.

1
2 Q. You've said that your experience with the mental
3 health system really began in about 2013 when you met a
4 social worker who led you to engage with the system. Can
5 you tell the Commissioners what the social worker said that
6 made you first engage with the system in 2013?
7 A. My job was shift work and I'd come home and the
8 support worker would be with my wife, supporting her with
9 some stuff that was helping and I used to just sit there
10 and talk. One day she said to me "You're struggling a bit
11 I reckon", so she advised me to go to the GP, which I did,
12 and set the ball rolling as far as getting help, yes.
13
14 Q. So, you went to the GP. Did the GP put you on some
15 antidepressants?
16 A. The GP put me on antidepressants and watched me over
17 the next three weeks that he said that it would take for it
18 to happen.
19
20 Q. This was about October 2013 when you saw the GP?
21 A. Yes.
22
23 Q. Did you try and get an appointment with a
24 psychiatrist?
25 A. Yes, we did, and it was going to be when he came back
26 from holidays, the first week of February I think was the
27 appointment.
28
29 Q. This is October 2013, the first appointment you could
30 get was not until February 2014?
31 A. Yeah.
32
33 Q. How were you travelling at that time?
34 A. Not good, not good.
35
36 Q. You said that you had an Employee Assistance Program
37 at your work, so did you try and use that instead?
38 A. On work's - I was talking to them one day and they
39 said, why don't you try the EAP, which I did, and I spoke
40 to a fellow on that for about half an hour, told him what
41 was going on. Within a few hours we had a phone call and I
42 could see a female psychologist, I don't know whether it
43 was that day or the next day, which I saw her two or three
44 times, yeah.
45
46 Q. If we go forward a bit more to September 2014, at that
47 point you had a leadership role at work, but you said you

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

3 A. Yep.

4
5 Q. At about that point you asked Chris, your wife, to
6 take you to hospital?

7 A. That's correct.

8
9 Q. Can you tell us about that, what happened that you
10 wanted to go to the hospital?

11 A. Well, yeah, I just didn't wanna live any more. I
12 always had pride in how - all my work experience, I'd
13 always had pride in. I'd felt I'd failed and I just didn't
14 wanna live any more. I asked her, I said, "I need to go",
15 and she took me down because we have no - where we are
16 there's no - oh, we didn't even have a hospital then, it
17 had been washed away by the floods, so we had to go down to
18 the major one 30-odd kilometres away.

19
20 Probably 6 o'clock at night we got there into
21 Emergency. Sat, and sat, and sat, and there was no-one
22 there to really deal with me, with what I was saying. My
23 wife, when she gets up, will probably be able to speak more
24 clearly on that; by this time I was just wanting something
25 to happen.

26
27 Q. And so, you sat and sat and sat, and eventually did
28 Chris leave? She left you there?

29 A. Chris got up. When they said, "Yes, you need
30 admitting but we don't have a bed", and Chris being a
31 little bit feisty, got up and left me there. She said,
32 "I'm not taking him home" - her words were, "I'm not taking
33 him home to die" and I just - I didn't know what was
34 happening. I was scared then, I was.

35
36 Q. So Chris left the hospital?

37 A. Yes.

38
39 Q. And did you get a bed?

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

44
45 Q. And you were in the psych ward for about three or four
46 days?

47 A. Three or four days. I didn't like it in there at all.

1 I was fortunate that I was just not far off turning 60, so
2 they allowed me to go into the senior wing, which was a
3 little bit more - I felt more comfortable in there.
4
5 Q. What about it was making you feel uncomfortable?
6 A. Just, there was people - young people in there that
7 were highly visibly mentally ill. Like, they were prancing
8 and I just wasn't used to that environment basically.
9
10 Q. You mentioned you were almost 60. You've said in your
11 statement that you had in your head you wanted to make 60.
12 Why was getting to 60 so important for you?
13 A. My two uncles, which were my dad's brothers, and my
14 dad, were all 58, 59 when they died, and I just had it in
15 my stupid brain that I wanted to beat that and get to - it
16 was important to me.
17
18 Q. You've also said, because of the history in your
19 family of a number of people dying by suicide, that you're
20 worried that there's something in your genetics?
21 A. Yep.
22
23 Q. So, you were in the psychiatric ward for three or four
24 days, and then you went to a PARC?
25 A. I went to PARC.
26
27 Q. What was it like at PARC?
28 A. I liked PARC. It was, like, self-contained, cook your
29 own meals and everything, which was just - yeah. But
30 everyone was caring, they'd come and walk around all day
31 and make stuff for me to do. I think I made their vege
32 garden for them for the spring and stuff like that. They'd
33 come fishing with you if you wanted to go down the river
34 fishing, which was only a kilometre away. It was good,
35 just nice, relaxed - yeah.
36
37 Q. What about the clinical treatment, did you get access
38 to the --
39 A. I think I only saw a psychiatrist once at PARC. I
40 think by that time I was seeing my psychologist?
41
42 Q. That's okay.
43 A. My memory's not that - yeah.
44
45 Q. That's okay, you're doing really well. Did you get
46 the medical support that you felt you needed?
47 A. Well, I had my pills and I was attending the - I was

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

4
5 Q. At PARC you've said that you started meditating?

6 A. Yes.

7
8 Q. Can you tell us how meditating's helped you?

9 A. Meditating is - I say to people now, anyone that
10 enquires with me - as far as I'm concerned meditating
11 probably in that period, where I wasn't getting a lot of
12 help from the system, I say to people, "Meditating has gone
13 a really long way to save my life."

14
15 Q. If we move forward, there was a point at which you
16 were due back at work and you got some forms that were
17 trying to ask you if you were well enough to go back to
18 work. Did those forms relate to what you were feeling?

19 A. No. The forms turned up and my doctor just wouldn't
20 fill them in because it was all about - I work in food
21 processing where we were lifting stuff and standing all
22 day, and all the forms were about, can I stand all day, can
23 I carry 20 kilograms, can I do this, can I push - nothing
24 to do with my head at all, nothing, so they had to redesign
25 the form I think. That was the insurance company's form.

26
27 Q. And then you had another period where you were off
28 work and you had a bit of an episode in 2015 where you had
29 your medication changed, you went and saw a psychiatrist.
30 Can you tell us about the impact on changing the medication
31 and how it made you physically sick?

32 A. That was, yeah, I ended up in our hospital for - our
33 new hospital - for a few days and I was sent down to a
34 psychiatrist in [REDACTED] who, when I got there I didn't
35 have an appointment with him, I had an appointment with the
36 registrar I think it was at another venue. So, we went
37 round there, talked to him. He put me on lithium. On top
38 of what I was on he put me on lithium because I was having
39 ups and downs. To me, the lithium just made me sick in the
40 stomach most of the time and I was on that - I've only just
41 gone off it in the last month.

42
43 Q. If we move forward to February of this year, you
44 haven't been at work since February this year and you tried
45 to see a psychiatrist again and there was another
46 three-month wait; is that right?

47 A. Another three-month wait.

1
2 Q. But you have seen the psychiatrist through telehealth?
3 A. Telehealth - my GP said, if we can't get in quick
4 here, we will get you a telehealth. I think it was about a
5 week and I had an appointment, but then they'd
6 inadvertently - someone had double booked on the day so it
7 had to be put off until the next week. But I was there. I
8 went and had probably nearly an hour there. Once again,
9 off one lot of drugs, back on to a new lot of drugs to try.
10 But, yeah, I had telehealth that was there. That was a
11 good experience for me, I could talk to him good.
12
13 Q. It worked for you?
14 A. Yeah, definitely worked for me.
15
16 Q. Just finally, Trevor, is there anything that you would
17 like to say about what you think should change in the
18 system?
19 A. Like Al, the 10 visits to the psychs. The
20 psychologist I'm with now, I can see that he's trying to
21 make them last till the end of the year with me. Whereas,
22 the way I've been in the last few weeks since this change
23 of drugs, I probably need to be, you know, using those 10
24 up fairly shortly. Just, my whole demeanour - my wife will
25 tell you soon - my whole demeanour has changed since I've
26 come off what I was on.
27
28 Like, the Emergency Department, when we went to
29 [REDACTED]: you sit there and it's like, this bloke looks
30 alright. There's kids coughing and sick, and people
31 injured, and you seem to be, "We'll get to him when we get
32 to him"; when, I was in serious trouble. Just, yeah, I
33 don't know whether it's the shortage of mental health
34 professionals and aid, I don't know what it is. Not much
35 help.
36
37 Q. One final thing you mentioned is that you got an NDIS
38 package of quite a lot of money, \$53,000, but there's no
39 services that you can access; is that right?
40 A. Well, there's stuff there for, like, spiritual, like
41 my meditation and all. They're little groups where I go
42 that, you know, there's no invoice - how do you claim?
43 There's no invoices. It's just, the people that organise
44 it rent a - one of them's an old church and then we've
45 moved around to another place. I go three times a week,
46 and there's no paperwork to say that I paid me \$10 donation
47 to pay the morning's use on the building. And there's a

1 lot of money in there that I don't need. I was a bit
2 embarrassed when they told me how much money they'd given
3 me actually, it's - yeah.
4

5 MS BATTEN: Thank you very much, Trevor. Chair, are there
6 any further questions for Trevor?
7

8 CHAIR: Q. I just have one. Thank you very much for
9 your evidence today. You talked in your statement about
10 the fact that you'd said you thought you'd probably had
11 depression since the age of 18 to 19 but you didn't finally
12 reach out and get that help until you were 58, so a long
13 time in your adult life.
14

15 Can you think about what would have been helpful and
16 what do you think this Royal Commission could do to try and
17 assist people such as yourself to seek help earlier in
18 their journey?

19 A. Well, I was brought up in a family of blokes who were
20 blokes and didn't talk about that sort of stuff, which has
21 been a big problem for a long, long time. You know, had
22 different people say, "Come on, you gotta harden up."
23

24 We've changed GPs in the last few years because our
25 old original ones are slowly all retiring. The ones we're
26 with now I think are a lot more in tune to this. Instead
27 of just saying, take these pills and go home, they'll get
28 you back every week and see how you are progressing, yeah.
29

30 Q. More responsive to you?

31 A. More responsive, yeah, that part of it is. I think
32 it's like that, what do they call them, first responders,
33 like when I get to the hospital in trouble, there's nothing
34 there to help, and you sit and sit, yeah. And I just
35 nearly freaked when my wife walked out and left me there, I
36 just ...
37

38 Q. I think we're going to hear from her about that too,
39 so thank you very much for your evidence today, Mr Thomas.
40

41 MS BATTEN: Thank you, may Trevor be excused? I was
42 proposing to call Ms Christine Thomas and then have a break
43 after Mrs Thomas's evidence.
44

45 CHAIR: Yes. Thank you, Mr Thomas.
46

47 <THE WITNESS WITHDREW

1
2 MS BATTEN: Thank you. I now call Christine Thomas.

3
4 <CHRISTINE MARGARET THOMAS, affirmed and examined: [11.38am]

5
6 MS BATTEN: Q. Thank you, Chris. Have you, with the
7 assistance of the legal team, prepared a witness statement
8 for this Royal Commission?

9 A. Yes, I have.

10
11 Q. I tender that statement. [WIT.0001.0037.0001] You're
12 Trevor's wife?

13 A. Yes.

14
15 Q. We've just heard Trevor's story and we'd like to hear
16 it from your perspective. Can we start with the support
17 worker and what she told you and how to help Trevor?

18 A. We had a family support worker visiting home and she'd
19 observed Trevor and said, "He's depressed, we need to get
20 him to a doctor." And he went to the doctor, but over a
21 course of months, we're observing him, and she said, "You
22 can't push him to go to hospital, we've got to wait
23 hopefully for him to make that decision. And, when you do,
24 this is what is gonna happen and this is what you need to
25 do."

26
27 Q. And what did she say was going to happen?

28 A. She said, "You'll go to the Emergency Department, and
29 you'll wait, and you'll wait, and you'll wait. Eventually
30 someone will come across, a psychiatric nurse, whatever,
31 and assess him and they'll say, "Yes, you are very
32 suicidal. Yes, we need to admit you. But we don't have a
33 bed, so go home and come back tomorrow."

34
35 Q. And, did you have to take Trevor to hospital?

36 A. I did.

37
38 Q. And what happened when you got to hospital?

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

46
47 And she said, "Yeah, he needs a bed, he's highly

1 suicidal, yep, he needs a bed. But we don't have a bed, so
2 take him home and bring him back tomorrow." And I looked
3 at her and I said, "You have admitted a duty of care to
4 him. I'm leaving now", and I got up and I walked out of
5 that room, and he'd been my husband for 20-plus years,
6 we're pretty close. Nobody should ever, ever have to do
7 that to someone they love, and he shouldn't have to have
8 that done to him. And I walked out. But this worker told
9 me, "When you walk out, don't leave the carpark, because
10 they're probably going to put him in a taxi and send him
11 home."
12

13 So I hid in the bushes, I felt like a bit of a
14 pervert, but I'm hiding in the bushes in case. Then the
15 phone rings, "Oh, we've found him a bed. Could you bring
16 his clothes in please?"
17

18 Q. So he got a bed in the hospital?

19 A. He got a bed in the hospital. Mind you, by this stage
20 I think it was well after midnight some time. They took
21 him to the psychiatric hospital and I went home.
22

23 Q. After the hospital we've heard he had a time in PARC.
24 What was Trevor's experience in PARC like, from your
25 perspective?

26 A. He was happier there, he found the psychiatric ward
27 distressing, it was very busy and seeing a lot of things
28 he'd never seen or had to deal with.
29

30 PARC, there's units with a central kitchen, office,
31 table tennis room, you know, sort of facility there, and
32 one bedroom, you look after yourself. There are seriously
33 ill people there, we're talking schizophrenia, bipolar, and
34 other issues. And I thought, well, this is good, he's
35 gonna be safe, because I felt I couldn't keep him safe at
36 home any more. I thought, they'll watch him, he's gonna be
37 safe.
38

39 Then I realised that, no, they're not clinical nurses,
40 they're, like - what do you call them, I'm lost for words?
41

42 Q. Support workers?

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

1 dilemma, do I leave him here? Do I take him home? I'm
2 struggling to keep him safe at home. When he got up during
3 the night to go to toilet, I'm sneaking behind him to make
4 sure, yes, he's going to the toilet, he's not going out to
5 hang himself in the shed, he hasn't found the spare keys
6 and gonna wrap the car around a tree. Um, it was hard.
7

8 Q. So, did you feel like Trevor was getting the support
9 that he needed at the PARC?

10 A. No, because it was: you had to fight for him to see a
11 psychiatrist. I was told that there'd be clinical nurses
12 down every day to give him medication and talk with him,
13 he'd see the psychiatrist every week. No. There was a
14 meeting - you know, there's meetings, the psychiatrist
15 comes in or the different workers will have a meeting.
16

17 I got a phone call about an hour before that meeting,
18 you know, "Have you been told there's a meeting that you
19 should be at?" "No." "You'd better get down here." And
20 you just needed to know the system.
21

22 Trevor and I have been really lucky, we had a support
23 worker prepared to put her job on the line by telling me
24 stuff that I didn't know, I didn't know about the duty of
25 care. Then, when they were going to release him from PARC,
26 and he wasn't even established on medication, he wasn't
27 well - not much better than when he went in - that I
28 learnt, if he's homeless they can't release him.
29

30 So then I had the pain and the anguish again of
31 looking Trevor in the face after 20 years of marriage and
32 saying, "You can't come home. I'm going to change the
33 locks on the door. I'm sorry, you're homeless", and once
34 again walking out the door, but that was the only way I
35 could keep him getting some help.
36

37 And, if you didn't have somebody in the system who
38 could say, hey, this is what's going to happen, and sure
39 enough, these things happen, Trevor would be dead today.
40 So, this person, I owe them his life.
41

42 Q. Moving forward from there, you tried to find a
43 psychiatrist for Trevor, and you said that you found it
44 difficult to get him the help that he needs ?

45 A. Yes, there was such a wait, even though he was in PARC
46 and in the hospital. To see the psychiatrist was just
47 incredibly hard. And then, if you wanted to be present or

1 speak to the psychiatrist, that was impossible nearly.
2 That took promises of media and legal, solicitors coming in
3 on the act on Trevor's behalf to get that help.
4

5 At one point when I did get to speak to the
6 psychiatrist, he didn't know how many suicides were in
7 Trevor's family, he didn't know half the pressures Trevor
8 had been living on, because Trevor didn't tell him because
9 he was too busy wanting to die.
10

11 Q. You've said since January this year you've not sought
12 help from the hospital in relation to the mental health of
13 Trevor?

14 A. No.
15

16 Q. Or the mental health services. Why haven't you sought
17 help from them again?

18 A. I think I was so disillusioned last time: you know,
19 things have not improved, and I just didn't have the
20 strength or the fight, to fight with a broken system, and
21 this time it's been different and worse, his breakdown, and
22 I didn't think the system would keep him safe.
23

24 Q. Finally, Chris, what in your view needs to change to
25 the mental health system to look after people like Trevor
26 properly?

27 A. I think that, when someone presents at an Emergency
28 Department, or at a GP, there should be a system - bang.
29 This person looks fine; they're not fine, they're mentally
30 unwell, highly unpredictable. A lot of the time they're
31 incoherent and unable to speak, they need immediate
32 treatment, and I think the carers need to be taken on
33 board. We all understand about confidentiality, but I
34 think in cases of mental illness that needs to be set aside
35 and listen to the carers, listen to the husband, wives,
36 mothers, fathers, that know the patient.
37

38 I think we need more psychiatrists. I think we need
39 more trained mental health workers. And, probably one more
40 thing, I have a question - I'm not sure if someone can
41 answer it - how many children's inpatient units do we have?
42 Mental health for anyone under 18, that is even more scary
43 than mental health for adults. Once again, I've lived
44 experience.
45

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

1
2 CHAIR: No. Thank you very much for, again, taking the
3 time to come and share with us those reflections and your
4 very helpful suggestions for change. So, thank you very
5 much for your time.

6
7 MS BATTEN: May Mrs Thomas please be excused?
8

9 CHAIR: Yes, thank you.
10

11 **<THE WITNESS WITHDREW**
12

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

15
16 CHAIR: Yes.
17

18 **SHORT ADJOURNMENT**
19

20 MS NICHOLS: Chair, before I call the next witness, may I
21 tender the statement of Terry Welch that I omitted to
22 tender this morning?
23

24 CHAIR: Thank you. [WIT.0002.0018.0001]
25

26 MS NICHOLS: The next witness is Associate Professor Ravi
27 Bhat, I call him now to give evidence.
28

29 **<RAVI BHAT, affirmed and examined:** [12.09pm]
30

31 MS NICHOLS: Q. Associate Professor Bhat, are you the
32 Divisional Clinical Director of the Goulburn Valley Area
33 Mental Health Service?

34 A. Yes, I am.
35

36 Q. Are you an Associate Professor of Psychiatry in the
37 Department of Rural Health at the University of Melbourne?

38 A. Yes, that's right.
39

40 Q. Have you prepared a statement which details your
41 experiences in relation to the mental health system and
42 answers the questions that the Royal Commission has posed
43 to you?

44 A. Yes, I have.
45

46 Q. I tender that statement. [WIT.0002.0011.0001]
47

Dr Bhat, can I ask you firstly about the catchment area

1 served by the Goulburn Valley Area Mental Health Service.
2 You've described it in your witness statement as possessing
3 geographical and cultural diversity. Can you elaborate on
4 that, please?

5 A. Sure. So, the catchment area for Goulburn Valley Area
6 Mental Health Service covers about 19,000
7 square kilometres, it stretches from the Murray in the
8 north down to Wallan, Kinglake and Ealen in the south, so
9 the geographical diversity is both from a plains
10 perspective and the fact that there is considerable hilly
11 terrain, a big proportion of it which was affected by the
12 Black Saturday bushfires in 2009.

13
14 And culturally also, it is extraordinarily diverse.
15 There are people from all over the world settled in the
16 Goulburn Valley.

17
18 Q. Does Greater Shepparton have the highest population of
19 Aboriginal and Torres Strait Islander peoples outside of
20 Metropolitan Melbourne?

21 A. That's how I understand it, yes.

22
23 Q. Does Murray, which is the area covered by the public
24 health care network, have 28 per cent of the total number
25 of Victoria's Aboriginal and Torres Strait Islander
26 population?

27 A. I believe so, that's right.

28
29 Q. Was there a needs analysis performed by the
30 Commonwealth in relation to this area in 2017 and 2018
31 which showed, among others things, that Aboriginal and
32 Torres Strait Islander people experience Emergency
33 Department presentations for psychiatric illness at a rate
34 of 76 per cent higher than for non-Aboriginal people?

35 A. I understand that's what the report showed.

36
37 Q. In your area, are there a significant number of
38 resettled refugee groups, including from Iraq, Afghanistan,
39 the Congo and the Sudan?

40 A. That is right.

41
42 Q. Does the catchment area include considerable areas of
43 socioeconomic disadvantage?

44 A. That is right.

45
46 Q. In the needs analysis that I've just referred to, was
47 it shown that in the general population across your

1 catchment area, there were 44 per cent more people who were
2 registered mental health clients than there are in the
3 Victorian average?

4 A. Yes, that's one way of putting it, yes.

5

6 Q. Do you want to say anything else about the
7 characteristics of your catchment area?

8 A. No, I think you've covered most of the details.

9

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

14 A. That is right.

15

16 Q. Were more than one-third of those categorised as
17 requiring an emergency, high urgency, urgent or semi urgent
18 response?

19 A. That is right.

20

21 Q. Can I ask you about the different services that your
22 mental health service provides. In relation to bed-based
23 services, what are they?

24 A. The bed-based services are basically for adults and
25 older people. For adults, there is an inpatient unit that
26 has 15 beds. There is a prevention and recovery care
27 service, which is a step-up/step-down service, that has 10
28 units.

29

30 Q. While we're there, can I just ask you, does that in
31 practice function both as a step-up and step-down service?

32 A. Yes, it does; more so in the last few years, yes.

33

34 Q. What other services do you have?

35 A. There is a 10 bed Specialist Rehabilitation Program,
36 which is essentially a community care unit.

37

38 Q. While you're there, I want to ask you about that one.
39 Is that one that's run in partnership with Wellways?

40 A. That's right. So, both the PARC and the Specialist
41 Residential Rehab Program are run conjointly with Wellways.

42

43 Q. The Specialist Residential Rehabilitation Program, was
44 that the first of its kind in Victoria and Australia in
45 fact?

46 A. Both were actually, PARC and Specialist Residential
47 Rehab Program, but Victoria has always had community care

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

7
8 Q. What, in your assessment, is the importance of having
9 a mix of both of those kinds of staff?

10 A. I think it depends on the phase of care that we
11 provide. In the end, it is vital that, for all of us, that
12 we live lives that are flourishing and that, you know, the
13 idea of recovery, that we have a roof over our head, that
14 we learn, that we work, that we are loved and so on, and to
15 achieve those ends doesn't mean that you have to, you know,
16 have complete symptomatic remission.

17
18 I think what having a mix of clinical and non-clinical
19 staff does, is that, you get both perspectives: you get the
20 perspectives of a clinical staff member that's focusing on
21 symptomatology, distress and risk and so on and so forth,
22 and the treatment of all those.

23
24 Whereas from the non-clinical staff, you are
25 essentially seeing the perspective of someone who's
26 thinking that, here in this trajectory of life this person
27 who is suffering now has moved away for a lot of reasons
28 and how to help that person come back into that trajectory
29 that they wanted to live. I think these are very important
30 perspectives to have.

31
32 Q. The Specialist Residential Rehabilitation Program has
33 been evaluated, has it not?

34 A. That is right, yes.

35
36 Q. What did that evaluation find?

37 A. What the evaluation found was that, over nearly a
38 13-year period - I might be mistaken on some of the details
39 here - over a 13-year period of the people who engaged in
40 the program, they had an average length of stay of about
41 215 days, and at entry there is an evaluation by which the
42 participants, as they are known, they set their goals as to
43 what they want to achieve while they're in the program.
44 Their needs are also assessed in a systematic manner, and
45 at the end of the program about 90 per cent, from memory,
46 had gone into their own accommodation. About two-thirds of
47 people had either gone into an educational program of their

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

4
5 Q. What's the level of acuity of the patients who enter
6 into the Specialist Residential Rehabilitation Program?

7 A. Most people are severely unwell; they tend to have one
8 of the following diagnoses: they're suffering from either
9 schizophrenia, bipolar disorder or very severe depressions
10 often, or sometimes very severe personality disorders.
11 Their level of disability is typically very high in being
12 able to manage every day affairs. About two-thirds, from
13 memory, had a comorbid alcohol and drugs problem, so in
14 that sense these are people with the severe and complex end
15 of psychiatric problems.

16
17 Q. Can I ask you about community treatment more
18 generally. You say in your statement that you, yourself,
19 treated people over long periods of time and up to
20 15 years.

21 A. Yep.

22
23 Q. Can I ask you what's facilitated that and how
24 important is it to have longevity of relationship between
25 the clinician and the patient?

26 A. Look, I think it's extraordinarily important, and in
27 this particular case, as I said in my statement, I think
28 some of it is simply because I've, for a variety of
29 reasons, ended up staying in one place. I mean,
30 this October I would have worked in the same place for
31 20 years.

32
33 But a lot of it is because of the fact that you
34 develop trust with people, that the person learns to trust
35 you, and you get then this privilege of getting to know
36 them over a long period of time, which I think, it's not
37 easy to build those relationships in the first few
38 assessments, or maybe in an inpatient facility when people
39 are admitted; you can certainly develop a therapeutic
40 relationship.

41
42 But when you get to know people over a much longer
43 period of time, you have a much more nuanced understanding
44 of their lives and what's affecting them, and this
45 relationship then becomes the bedrock on which discussion
46 can be had about how to prevent future episodes of mental
47 illnesses, or even if there is a relapse, how to mitigate

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

3
4 Very importantly I think to focus on what flourishing
5 might look for that person. Certainly, my clinical work
6 mostly has been with older people and, you know, older
7 people can flourish too and they get better and they get to
8 do things and that's quite important.

9
10 Q. You've engaged in some activities that you describe as
11 capacity building in your region?

12 A. Yes.

13
14 Q. One of which is to have had the appointment of
15 Professor Ogden in addiction medicine which, among other
16 things, has allowed you to accept trainees in this area.
17 Can you talk about the importance of adding that capacity
18 to what you do in this region?

19 A. Sure. I'll have to probably step back a little bit
20 before I introduce Ed into the discussion there. I think
21 one of the best things that we can do in regional mental
22 health services is to train locally in all disciplines.
23 Often what happens is that there are significant, what I
24 may term as training steps, in getting people to train
25 locally and having such facilities available.

26
27 We have now successfully run a Graduate Mental Health
28 Nurse Program in Goulburn Valley Health for more than a
29 decade, and much under that we have now run a training
30 program in specialist training in psychiatry.

31
32 Now, for regional services across Australia, for
33 specialist training in psychiatry, for example, that's my,
34 I suppose, disciplinary area, is that often there's not
35 enough child psychiatry capacity, there's often not enough
36 what's known as consultation liaison psychiatry, both of
37 which are termed as core requirements of training by the
38 Royal Australia and New Zealand College of Psychiatrists.
39 And that has taken considerable time to build at GV Health,
40 which then allowed us to become accredited by the RANZCP to
41 provide training programs.

42
43 In the RANZCP training, your trainees are required to
44 get some addiction medicine experience or addiction
45 psychiatry experience, and that might be either through
46 seeing a finite number of people with those problems or it
47 may be through experiencing, you know, under supervision of

1 somebody who specialises in addiction psychiatry or
2 addiction medicine. Again, it's very uncommon to have that
3 type of dedicated experience.
4

5 So we were quite fortunate where GV Health decided to
6 employ an addiction specialist, and Professor Ed Ogden came
7 that way and the next logical step seemed to be, let's work
8 together, develop what we can, because the comorbid
9 presence of psychiatric illnesses and alcohol and substance
10 abuse problems is so common that it's now almost
11 meaningless to talk of them separately and not give
12 trainees of tomorrow, or the psychiatrists of tomorrow,
13 experience in that.
14

15 Q. Can you say a little bit more just on that subject
16 about what system capacity is needed in order to have those
17 comorbidities addressed in a practical way?

18 A. So Victoria since the de-institutionalisation has had
19 these two elements of health provision separate: mental
20 health services and services for people affected by alcohol
21 and drug problems. It's not the case everywhere, it
22 certainly seems to be the case in most parts of the western
23 world, and that may well have been the case back then. But
24 when you look at the proportion of people who, say, have
25 alcohol dependence, the number of people with psychiatric
26 disorders is quite high; the number of people with
27 traumatic experiences is even higher.
28

29 Likewise, from the other side, if you look at people
30 who are primarily presenting with psychiatric problems,
31 depending upon which setting you look at, the rates of
32 alcohol and drug problems can range from about two-thirds
33 to nearly three-fourths, or sometimes even a bit more than
34 that.
35

36 Alcohol and drugs, you could almost say that in many
37 instances is a kind of self-treatment of the distress that
38 a person finds themselves in, and then it spirals out of
39 control and people end up having these complex sets of
40 problems.
41

42 Q. Can I ask you about a couple of other capacity
43 building projects. One is that you partnered with
44 Rumbalara Aboriginal Co-operative to establish a spiritual
45 wellbeing clinic. Briefly, what is that?

46 A. So, a little more than a decade ago we had Rumbalara
47 Aboriginal Co-operative, which is the local health service,

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

7
8 So we had a discussion, we said fine, we'll rotate
9 these psychiatrists on a three-monthly basis to run a
10 clinic, and at the end of one year, because we had four
11 psychiatrists, very neatly for one year, we said that you
12 then decide which psychiatrist you want, and that's how it
13 started, that we run a clinic and then we put in some
14 additional senior psychiatric nurse time.

15
16 But over time we have had to, because of resource
17 constraints, we have had to limit the frequency of
18 psychiatrist review, and we also haven't been able to
19 expand it into child and adolescent psychiatry.

20
21 Q. It's a spiritual wellbeing clinic: what does it
22 actually do and what services does it provide?

23 A. It's very important, I think, to provide a service
24 that's both culturally safe and culturally sensitive.
25 Tagging on names such as mental health and all that, as
26 we've heard before, can be quite stigmatising, can be quite
27 difficult for people to even approach. So, in some ways
28 the clinic is about mental wellbeing. It is about the
29 connection that people feel to the land and improving their
30 wellbeing.

31
32 The psychiatrists in the clinic provide for
33 traditionally diagnostic assessment and treatment service.
34 The nurse provides a much more broader approach than that.

35
36 Q. I see. Do you have workers other than psychiatrists
37 and nurses in that clinic?

38 A. Not from the GV Health side, no.

39
40 Q. I see. You've also, since 2012, separately from that,
41 run a series of consultant psychiatric-led clinics into
42 general practitioners?

43 A. Yeah.

44
45 Q. Briefly, what is that service and why is it important?

46 A. So, one of the things that we realised was that, often
47 when general practitioners referred people to us, that they

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

10
11 So, we developed a series of clinics that would be
12 provided in the general practice, either face-to-face or
13 through telehealth, and those set of clinics now sees
14 anywhere between 500 to 700 people a year.

15
16 Q. What proportion of your area is that able to service?

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

27
28 Q. So, its funding isn't secure?

29 A. Its funding is very insecure, yes.

30
31 Q. But, in your assessment, is it an initiative that
32 provides real assistance to GPs and therefore their
33 patients?

34 A. I think so, and the independent evaluation that the
35 Department of Rural Health and City of Melbourne did showed
36 that that's the perception by the general practitioners and
37 patients who attended the clinic, yes.

38
39 Q. Can I ask you now about the prevalence of mental
40 ill-health in rural communities, and I want to direct my
41 questions generally to rural communities.

42 A. Sure.

43
44 Q. Firstly, in interpreting prevalence data, do we have
45 to be mindful of terminology and definition? And, can you
46 say what we should understand by the expression "rural" in
47 connection with this data?

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

5
6 So, if you go by the UN, United Nations definition,
7 it's any urban centre that's 20,000 people or more, and of
8 course we have the Australian classifications as well which
9 classify through metropolitan, to inner regional and outer
10 regional and remote and so on.

11
12 What studies from overseas show is that - again, it
13 also depends on the mental illness - so we often talk in
14 terms of a serious or severe mental illnesses, which are
15 often conditions such as schizophrenia, bipolar disorder,
16 severe depressions and so on. Then we talk about common
17 mental disorders or high prevalence disorders which include
18 mild-to-moderate depressions, mild-to-moderate anxiety
19 disorders and the like.

20
21 The evidence would suggest that severe mental
22 illnesses are probably the same or may even be more in
23 urban centres, perhaps even more in metropolitan centres.

24
25 The high prevalence disorders, the prevalence is more
26 contentious, it depends upon the study and how it was done.
27 I suppose the general agreement is probably there are no
28 significant differences between urban and rural. But
29 psychological distress may well be higher in rural areas.

30
31 Q. Can I ask you for some clarification there. The
32 studies you've referred to, we won't discuss the actual
33 studies, but do you say they're applicable to Australia?

34 A. I think they're mostly applicable, in the sense that,
35 once you nuance them and understand what they relate to, I
36 think in that sense they're applicable. Of course, there
37 are significant differences in population and so on.

38
39 Q. Of course, and what's a good working definition of
40 rural community for our purposes, do you think?

41 A. I would probably go with the Australian
42 classifications.

43
44 Q. Which is?

45 A. Which is, that goes from remoteness to metropolitan.

46
47 Q. So, a rural community would be, what, under that

1 classification?

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

5

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

11 A. Maybe higher, yes.

12

13 Q. By psychological distress, what do you mean?

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

21

22 Q. So regardless of diagnosis, there's an experience in
23 the person of psychological distress?

24 A. That's right.

25

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

30 A. Yes.

31

32 Q. One of the things you point out in your statement is
33 that there can be particular barriers for particular groups
34 of people in rural locations in seeking help for mental
35 health issues, and is one group of those, young people from
36 refugee backgrounds?

37 A. That is right, and we have done a study locally and we
38 found that to be the case.

39

40 Q. Did you find that there was a real concern about those
41 young people seeking assistance, particularly for early
42 psychosis, and that the longer the symptoms went on
43 untreated, there was a correlation with more complex and
44 severe presentations later on?

45 A. That is the understanding, yes.

46

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

1 in your study?

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

12
13 Q. What conclusions did you draw about the steps that
14 might need to be taken to improve that situation for young
15 people from refugee backgrounds who need to seek help for
16 mental distress and illness?

17 A. A few things, and one of the first things was to have
18 greater engagement with the refugee community, with greater
19 opportunities for mental health literacy, improving mental
20 health literacy, and also showing what services are
21 available, so it's not just about talking about them, it's
22 actually taking people through the services to give them a
23 sense of what's available.

24
25 Q. Can I ask you what you know about the rates of suicide
26 in rural communities, as opposed to the metropolitan areas?

27 A. So, suicide rates in Australia in rural communities is
28 higher: anywhere from 1.5 to 2.5 times higher, if my memory
29 serves me right, and it increases, the rate of completed
30 suicide increases with the remoteness. Most of the
31 increase is accounted by the fact that it's an increase in
32 suicide in men as compared to women.

33
34 Q. And young men in particular?

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

39
40 Q. Can I ask you about the issues relating to access to
41 mental health services in rural communities. What
42 difference does rurality and remoteness make in accessing
43 services? Can I ask you firstly in relation to the tyranny
44 of distance?

45 A. You know, it's a well quoted phrase, Geoffrey
46 Blainey's phrase of tyranny of distance. It's a huge
47 problem, as we've heard before from Mr Welch and community

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

5
6 Then there is the problem that, while car ownership is
7 generally pretty high in Australia, we know that as the car
8 ownership rates decrease with further remoteness, we also
9 know that, especially given the fact that rural areas are
10 more likely to have areas of relative socioeconomic
11 disadvantage, that you can expect more poor people to be
12 living.

13
14 So, while some people may be able to own a car, they
15 might find it extraordinarily difficult to actually
16 maintain a car, or even if they're able to maintain a car,
17 just to pay for fuel to travel long distances then becomes
18 extraordinarily difficult.

19
20 As we heard from Mr Gabb before, it takes a day by the
21 time you do things and go out to see somebody, and you've
22 effectively lost one full working day for one appointment.
23 So, all these are very important barriers, let alone other
24 issues such as mental health literacy and stigma and so on.

25
26 Q. I was going to ask you about those two things
27 actually. We've heard a bit about that today already, and
28 in your experience, to what extent are these barriers to
29 help-seeking?

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

40
41 Studies have shown that mental health literacy per se
42 may not be that lower as increasing by remoteness, but
43 stigma and self-stigma may play a very important role.

44
45 Q. Can I ask you about the availability of services in
46 rural communities as opposed to non-rural communities,
47 concentrating on the state-funded services.

1 A. Yes.

2

3 Q. In your assessment, are there significant disparities
4 in the availability of services and, if so, what are they?

5 A. There are huge disparities in the availability of
6 services. When we de-institutionalised in Victoria in the
7 mid-90s, the character of services, the types of services
8 that were developed, and which I thought was
9 extraordinarily thoughtful coming in as an outsider back in
10 1999, is not something that's necessarily ideally suited to
11 Regional Victoria.

12

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

20

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

29

30 Q. So, apart from the availability of CAT or similar
31 teams, and more limited availability of Community Mental
32 Health Teams, are there other disparities, for example
33 acute inpatient beds; is the availability less in rural
34 areas?

35 A. I believe so, and I can certainly speak probably more
36 in relation to GV Health. According to a letter to the
37 editor published by Stephen Ellison and colleagues, at the
38 moment Victoria has 22 beds per 100,000 population. By
39 that count, in Goulburn Valley Health we should be having
40 33 beds, this is including aged care beds.

41

42 Q. And how many do you have?

43 A. 20, so 15 adult and five beds for older adults.

44

45 Q. Over what period of time has your bed count been less
46 than you think it should be?

47 A. For the better part of the last decade, I would say,

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

6
7 And also, the geographical distances are such that
8 it's not possible, the way it might be let's say if you
9 were in the metropolitan service, where people can access
10 other inpatient services.

11
12 Q. Can you say a little bit more about the throughput
13 pressure?

14 A. So, the Victorian Mental Health Triage Scale, I'll
15 start there, is based primarily on risk, which means that,
16 if a person is especially presenting with a serious risk of
17 either harm to one's self or harm to others, then often the
18 first thing that we need to do is to try and provide an
19 environment where that risk can be mitigated, which means
20 that you have to admit people, or at least provide a safe
21 environment.

22
23 Some of the metropolitan services, for example, have
24 psychiatric assessment and planning units which are
25 attached to Emergency Departments where you could
26 potentially keep people for a shorter period of time, less
27 than 24-48 hours at least, and then decide what you could
28 do next. So, with a very limited bed capacity, that's 15
29 adult beds in the face of demand and with no access to a
30 psychiatric assessment and planning unit bed and other
31 sorts of facilities like that, which means that you have to
32 make decisions quite rapidly as to how long you are going
33 to keep somebody there, which I think is hugely problematic
34 in providing care.

35
36 Q. Is one of the problems that people can be discharged
37 before they're ready to be discharged?

38 A. Yes, that may be the case.

39
40 Q. There again, there are - it's not just about
41 discharge, it's also about providing care that's
42 appropriate to the type of condition that a person is
43 presenting with. So, what we have noticed is that often
44 people with more severe mental illnesses, like
45 schizophrenia, bipolar disorder and the like, the duration
46 of admission rests on the time it takes to start a
47 medication and the medication to start affecting them.

1
2 But a number of other people with very complex
3 problems where there is a mix of alcohol and substance
4 problems and deliberate self-harm or suicide and other
5 depression and anxiety symptoms, it's not just about
6 inpatient care, it's also providing the care after
7 discharge.
8

9 Q. Are the demand pressures on the system in your area
10 such that you can't always provide the level of care post
11 discharge that you would like to provide?

12 A. It's the type of care that I think is very important.
13 I think that, with how demand and services have evolved, I
14 think state-funded mental health services are reasonably
15 good at providing a good assessment and managing the
16 immediate risks, but many people with complex problems -
17 not the severe mental illnesses that I have talked about
18 earlier on - need psychotherapies for ongoing treatment and
19 often that capacity simply doesn't exist.
20

21 Q. What are the particular pressure points for demand in
22 your area?

23 A. One of the pressure points is the capacity to provide
24 intensive follow-up across the entire catchment area; not
25 just limited to, let's say the local government area of
26 Greater Shepparton.
27

28 The other touch points are the fact that there are
29 limitations in how many inpatient beds that we have.
30

31 Q. Are there particular workforce issues in providing the
32 extent of care that you would like to provide?

33 A. One of the things I think we all have to appreciate is
34 that the problems that mental health services face are
35 hugely amplified in rural areas. So, probably what I
36 should do in terms of workplace is just to go back in time
37 a bit and just provide that historical context, if I may.
38

39 Q. Yes.

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

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

4
5 In these institutions there were clear roles of not
6 just doctors and nurses but also for allied health staff
7 such as psychologists and occupational therapists and
8 social workers and the like.

9
10 And, while I think de-institutionalisation was a
11 radical reform in many ways, and especially in the fact
12 that it brought into focus the fundamental human rights of
13 people with mental illnesses, I think one of the effects
14 that it's had is that the focus became on providing what's
15 known as case management, which is mostly coordination of
16 care. This, in my opinion, left out a highly specific
17 discipline skill set, such as psychology and occupational
18 therapy and so on, which has affected Victoria-wide in my
19 view, but has affected rural services even more.

20
21 So, from a workplace perspective, it's how we grow as
22 human beings: we go to universities in metropolitan areas,
23 we graduate, we fall in love, we start families, and the
24 pull to come back to rural areas is quite limited, which
25 means that the staffing levels required to attract people
26 to come back into rural areas is, again, quite limited and
27 often regional mental health services don't have the same
28 buffer that metropolitan services have, which means that
29 you get one person leaving the service that has a huge
30 impact because you're already so tight - I have to use a
31 very technical term - the redundancies in the system hardly
32 exist.

33
34 Q. Are there other ways, too, in which there is less
35 redundancy built into the system in rural mental health
36 services?

37 A. Yeah, I think so, and I think the capacity for rural
38 training is quite important and, as many rural clinical
39 schools have shown, you can train medical students in rural
40 areas, you can show that people stay back and work in rural
41 areas. I think the same things can be done for mental
42 health professional workforce as well.

43
44 In the last decade we have had about 49 graduate
45 nurses go through our program; 41 stayed on the first year.
46 I think, if they hadn't stayed on, we would have collapsed
47 long ago. So, it is possible to do these things, it is

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

7
8 Q. On that point can we segue slightly to the role that
9 you think technology can usefully play in the delivery of
10 mental health services rurally, and can I particularly ask
11 you to address the issue of the need for a face-to-face,
12 human-to-human contact and the extent to which you say
13 telehealth can assist in that?

14 A. Sure. I don't think I can put it more eloquently than
15 what Mr Gabb did earlier on. I don't see public transport
16 improving in Regional Victoria in my lifetime, so really
17 what we have to then do is try and address issues the best
18 way we can with the technological capacity that we do
19 obviously have now, and in that sense I think telehealth is
20 extraordinarily important, as we have ourselves shown that
21 it is possible to actually provide much better access,
22 though we are limited at the moment by providing only
23 diagnostic access.

24
25 I think that there has to be investment made in
26 technological infrastructure that connects the large
27 regional hospitals to these smaller rural hospitals. It's
28 something that we're trying to do in Goulburn Valley Health
29 now, which means that what we could do is, as we've heard
30 before, we can not only look to provide urgent video
31 triaging but also video assessments, but this then has to
32 be done with somebody at both ends so that the person,
33 let's say sitting in Seymour or Kilmore is not alone, they
34 actually have somebody that they know, that they're in the
35 process of assessment, or at least they're there at the
36 start or towards the end, just to make sure that things
37 have gone well.

38
39 Q. You might have been going to answer my next question,
40 which is, by way of example how would that work and what
41 kind of staff person would you have sitting with the person
42 who is receiving the assessment by remote?

43 A. Look, I think to some extent it would depend - again,
44 this is speculation on my part, I don't have any evidence
45 to show that this works, because the only evidence we have
46 is from a non-emergency situation, which is in a general
47 practice clinic, and there what has worked really well is

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

5
6 I think in at least urgent situations it is still
7 possible to replicate this, but that will require much
8 greater collaboration between the large regional hospitals
9 and the smaller rural hospitals so that you have staff at
10 both ends and you can actually build capacity.

11
12 What we will need to perhaps do this is to layer this
13 with other models of capacity building, and one of the
14 models that I have quoted in my statement is the so-called
15 Project Echo which started in the United States and it's
16 really focused on people with severe hepatitis and hepatic
17 failure in the context of hep C infections. That's now a
18 major model and Professor Ed Ogden has now introduced that
19 to the mental health service as well, so we have a
20 connection with St Vincent's Hospital and we participate in
21 this model.

22
23 It's a highly structured way of learning, and everyone
24 learns, everyone teaches, and that's the motto of the
25 program. So, if you layered a clinical service degree with
26 an educational model, you are much more likely to get
27 synergies much more likely for capacity building, for
28 fine-tuning the service so that at least people then don't
29 have to travel all the way from, say, Broadford or Wallan
30 to Shepparton, they could go to Kilmore or the nearest
31 smaller rural hospital and have that linkage.

32
33 It will take time but I do believe that the technology
34 exists, the understanding of capacity building exists that
35 can make it possible, yes.

36
37 Q. We've asked you to reflect on the development of the
38 system as it was in the 1990s and you referred to that a
39 bit earlier.

40 A. Yes.

41
42 Q. What is your opinion about the way the population
43 needs have changed, and I'm speaking now about Victoria
44 more generally - - -

45 A. Indeed.

46
47 Q. -- since de-institutionalisation in the 1990s.

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

7
8 What has also changed is the types of problems that
9 people are presenting with. So, the structure of services
10 that was designed was designed keeping in mind people,
11 let's say somebody suffering from schizophrenia, and one
12 might reasonably expect that this person will have
13 difficulty in adjusting to a life, that they might have a
14 crisis and so on, so you had Crisis Assessment Teams, you
15 had Case Management Teams, you had Mobile Support Teams for
16 those who were very unwell and who were not taking their
17 medications and needed a lot of support.

18
19 But in the two references that I've given of
20 presentations to emergency departments, what we have seen
21 is a complete change in the type of presentations that
22 people come with. So, there is this extensive study,
23 Victoria-wide study that looked at so-called paediatric
24 presentations, that is 0-19 years, as well as a study from
25 four Emergency Departments, three or four in Melbourne, and
26 both effectively showed that mental health presentations
27 for mental and behavioural disorders due to drug and
28 alcohol and so-called stress and anxiety disorders, along
29 with suicidal ideation and suicide attempts, now account
30 for well more than 50 per cent of all presentations.

31
32 Q. What does that tell you about the needs that the
33 system has to now serve and how it should be different?

34 A. We know from work done outside of Australia that what
35 clinicians are telling us is not inaccurate. It takes
36 anywhere from one to two and a half hours to do an
37 assessment, a psychiatric assessment in, let's say, the
38 Emergency Department.

39
40 So, what this has done is that, when the rate of
41 presentation for these complex mental health problems has
42 increased, a lot of effort goes into doing an assessment,
43 documenting the assessment and having a treatment plan, or
44 at least the risk management plan.

45
46 In this time the core mental health services, which
47 are the crisis teams and so on, the funding has not

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

7
8 Q. So, what is the gist of the limitation you're now
9 discussing? Is it the assessment teams not having adequate
10 time to do what they have to do or something different?

11 A. It's both. So, we have services that have - what has
12 happened over time is that - I'll probably step back to
13 nuances a bit. I think my senior colleague, Dr Ruth Vine,
14 about a week ago showed this graph about the number of
15 reform items and things that have happened. I think one of
16 the points I make in the statement is that there has been
17 no whole-of-system review which has meant that, whenever
18 there have been problems or whenever there have been ideas
19 which may have been very good ideas at the time, they have
20 been picked up and addressed without necessarily
21 understanding the whole-of-system impact.

22
23 Q. Yes.

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

34
35 So I believe this has affected the services in this
36 way, that you have very finite time, it's being divided
37 into work that is much more than what was anticipated at
38 the time of the institutionalisation, and the type of work
39 that was anticipated at the institutionalisation.

40
41 Q. Are you saying that at a system level there needs to
42 be a more sophisticated understanding of the types of
43 demands on the system, not just numbers, but the types of
44 problems that people have and the way in which the parts of
45 the system work together?

46 A. That's it, you've put it better than I have, thank
47 you.

1
2 Q. No, I don't think so, Dr Bhat. But, are you also
3 saying that, since de-institutionalisation, when particular
4 parts of the system have been examined, they've been
5 examined for improvement in a piecemeal way?

6 A. Yep.

7
8 Q. And the consequences of that have been?

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

15
16 The other thing ironically that's happened is, loss of
17 specialisation of what I would call an integration, I
18 suppose. So, many of the services that used to exist, for
19 example, Mobile Support Teams and so on, I am told in
20 Metropolitan Melbourne they no longer exist because there's
21 been such pressure to get the work done, so to speak, that
22 services have cut down what they have to offer.

23
24 But what it does really is that it affects the people
25 who are the most vulnerable, who don't necessarily have a
26 voice.

27
28 Q. One of the things you mentioned earlier in your
29 evidence today was the interaction between alcohol and
30 other drug problems and mental ill-health. You've said in
31 your statement that:

32
33 "Area mental health service programs were
34 well designed but the overall design didn't
35 adequately consider the needs of people
36 with both serious mental illness and
37 alcohol and drug use disorders. Decisive
38 action needs to be taken to cease the
39 separation of those two streams."

40
41 What are the fundamental points about ceasing the
42 separation of those two streams? What needs to happen in
43 your view?

44 A. At one level it's very simple, these services need to
45 be brought together, and that of course is easier said than
46 done. There are complexities in terms of how services have
47 evolved, but I think that's the start, that's the

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

6
7 Q. It should occur. You've also made some observations
8 about funding.

9 A. Yes.

10
11 Q. And you've said fairly directly that funding should be
12 activity-based. Why is that?

13 A. I think we have to move somewhere. As previous
14 witnesses have indicated over the last week or so, the
15 funding for mental health services was so-called input or
16 block-based. Looking at the framework documents from 1994,
17 it was very thoughtful for the time and very thoughtfully
18 considered, and adjustments were made for socioeconomic
19 disadvantage and rurality and so on.

20
21 But the fact remains that mental health services
22 continue to remain the so-called Cinderella of services,
23 they don't get funded to the same extent as acute medical
24 health or health services are, and the problem with block
25 funding also is that it may not necessarily match activity,
26 which increases over time, which is what has happened with
27 acute health services, that as activity has increased,
28 funding has at least kept somewhat in step with the
29 increase in activity.

30
31 So, I think that it's vital, and also what happens is
32 that block funding services does not necessarily mean that
33 it's transparent over a long period of time. It would have
34 been very transparent at the start, but as time progresses
35 it's no longer transparent because things change.

36
37 So I think that it is vital to move towards some sort
38 of an activity-based funding with some kind of loading
39 but --

40
41 Q. When you say "loading", is that what you mean by
42 locale-based funding?

43 A. Indeed, indeed. You know, we have to be informed,
44 just as the people who went through the
45 de-institutionalisation process had some idea of social
46 economic disadvantage. I think we need to do that.

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

10
11 I think that, if we are to go with the spirit of the
12 Mental Health Act and where we are going with the Charter
13 of Human Rights and the function of this Commission, and if
14 we're saying, no, what matters to us is outcomes as to what
15 people become: do they flourish in their lives? Do they
16 have a roof over their head? You know, are they working,
17 the kind of work they want to do? Do they have an intimate
18 relationship? If these things matter, then we can't keep
19 on doing activity-based funding. Ultimately we have to
20 say, hey, what matters to us is outcomes of people, are
21 they living healthy lives?

22
23 I think if they're going to get measured with that
24 metric, you will also develop individuals within the system
25 who will not just count the money, who will not just count
26 whether the processes are being followed, they will
27 actually see how many people are getting better, and are
28 they leading productive, flourishing lives?

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

31 A. Yes.

32
33 Q. -- but real consideration needs to be given to moving
34 towards outcome-based funding?

35 A. Eventually, yes.

36
37 Q. Can I finally ask you this: you have made an
38 interesting observation in your statement that you:

39
40 "... doubt that any change will bring about
41 lasting improvements."

42
43 Which I think is a response to our question?

44 A. Yep.

45
46 Q.

47 "... simply due to our limited human

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

7
8 And you've said that:

9
10 "We need to be agile in implementing our
11 changes."

12
13 Can you say what you mean by that?

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

22
23 So, I think that we should be careful about saying
24 things like lasting changes and so on. I think that we
25 should design a system for the realities that we know
26 today, but I think that we should develop a system that is
27 reflective, that is adaptive, that is responsive, that is
28 data-informed.

29
30 We have an antiquated so-called patient administration
31 system in mental health. We don't have a common electronic
32 medical record for example. Now, they come with a lot of
33 problems, but, for example, in rural areas I think
34 electronic medical records are critically important.

35
36 Now, if you have these things, and if you have a
37 system that does not wait for another two and a half
38 decades before having another Commission, another review,
39 and that says that, let's say every five years or every
40 10 years, we are going to do a system check and we're going
41 to see what that reality looks like for that point in time,
42 and then adjust systems so that it's not addressing one
43 problem, it's actually - it may still address one problem,
44 but it says this is what the system-wide impact is going to
45 be.

46
47 One methodology for doing that is what I have quoted

1 in my evidence, is this implementation program called Agile
2 Implementation, unsurprisingly developed by a geriatrician
3 who are much more used to complexity than people in other
4 parts of medicine - I shouldn't deride my colleagues, but
5 geriatricians are comfortable with complexity.
6

7 So I think systems should be designed so that they're
8 capable of checking at regular points in time. I think we
9 would fail in future if we didn't do that. I think that,
10 depending upon what we do, we should account for it. So,
11 for example, it may be services for the complex mental
12 health problems that people, we all suffer from today, but
13 it can also be about preventing.
14

15 One of the things that I have talked about in my
16 statement, is that, a lot of the complex problems have
17 their root in childhood, and we now have very good evidence
18 that adverse childhood experiences that can range from
19 neglect and bullying, to horrendous abuse, all lie at the
20 root of problems that we see in youth and much beyond that.
21 I think we also need to develop systems that look to
22 mitigate, because the evidence for mitigation in the
23 earliest years, that is, from the time of pregnancy to the
24 first five years, we have good evidence now to show that we
25 can make a difference.
26

27 So, I think it's designing based on the evidence we
28 have today. It's a system that I would say has scientific
29 temperament. By science, one doesn't have to mean that
30 it's all very cold; science means that we are capable of
31 critically examining what we're doing and we make funding
32 decisions based on that. So, if something is not working
33 we should also have the courage in a future system to say,
34 we will stop funding this, which we don't do these days,
35 and we rely on services to close some of their programs
36 based on funding pressures.
37

38 So, I think we need an adaptive, responsive system
39 designed for current realities but will check on itself
40 over time.
41

42 Q. So, the adaptive responsive system needs to have an
43 inbuilt capacity for self-review across the entire system
44 on a regular basis?

45 A. Exactly right, yes.
46

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

1 any questions?

2

3 CHAIR: Professor McSherry.

4

5 COMMISSIONER McSHERRY: Q. Dr Bhat, thank you very much
6 particularly for your statement with all the references in
7 it, we're working through all that. Can I take up that
8 last point about the clear statement of expected outcomes
9 in changing the system which has an end date. What would
10 you envisage in terms of an end date, you've spoken about a
11 self-review every 5 or 10 years, is that what you're
12 picturing?

13 A. In a manner of speaking. I mean, what I mean is that,
14 if we are to go by, say, evidence-based services for which
15 we have evidence at the complex level, then we should be
16 able to specify what outcomes we are hoping to achieve, and
17 we would also have a sense to say how long it might take to
18 actually achieve those outcomes. And I'm not saying that
19 outcomes necessarily have to be achieved in a year, it
20 might take 5 years.

21

22 I think we should have a system that says that, if we
23 provide this service, then we expect these outcomes of the
24 service providers, say in 5 years' time, or maybe in
25 10 years' time. And, if those outcomes are not achieved,
26 then we should have the courage to say, maybe we were
27 wrong; maybe we were wrong to think that worked and we
28 change our plans. That way, at least we are proactive in
29 thinking about what we want rather than being reactive to
30 problems.

31

32 COMMISSIONER McSHERRY: Thank you very much.

33

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

40

41 Can you make a comment about some of the barriers and
42 what you think might be some of the solutions?

43 A. I think barriers exist across the system, to start
44 with, again trying to take a historical context, is that
45 Child and Adolescent Mental Health Services, they did not
46 receive the same type of thoughtful planning that the adult
47 mental health services, or even the aged mental health

1 services received at the time of de-institutionalisation,
2 because I think there were no institutional reference
3 points for that, and some of the reference points that did
4 come, came from child guidance clinics, and the CAMHS
5 services as they're called, they adopted a model of care
6 which was suited to certain groups of people, and I think
7 in the first decade it became quite clear that it actually
8 didn't help people, help kids who had the most severe
9 needs, and I'm specifically talking about children in
10 out-of-home care, which I think resulted historically in a
11 fragmentation of CAMHS services.
12

13 So, as you might know as Commissioners, that take two
14 was created really as a therapeutic arm for children in
15 out-of-home care, and what that meant was that there was a
16 further depletion of CAMHS services. Now, again, as has
17 happened with other services, you take metropolitan
18 services, all those problems amplify in rural areas. So,
19 you have services that have depleted, now in many services
20 there was simply no capacity to provide adequate care.
21

22 The second barrier I think that has shaped CAMHS is
23 that, it's not easy to have child psychiatrists available
24 for rural CAMHS services, and this is not just about
25 Victoria, it's been a problem throughout Australia, which
26 has meant that, without having an adequate number of child
27 psychiatrists it's not possible to develop a local training
28 program; and, if you don't have a local training program,
29 then you can't provide that multi-tiered services that you
30 could provide.
31

32 The third big issue is that, the way it was designed
33 originally, that none of the rural and even ultimate
34 reporting services would have child and adolescent mental
35 health beds. which again, there is a problem there in the
36 sense that, you know, you can't have large inpatient units
37 because you may not have the capacity to even run them.
38

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

1
2 So, I think it's, across the spectrum all these
3 problems get amplified in rural services. What's then
4 happened is that, while in recent times there has been some
5 effort to improve capacity through CAMHS and early action
6 in schools, for example, focusing on very young children in
7 the school system, it's not for the entire age group.
8

9 My colleague, Dr Vibhay Raykar, who used to be the
10 Clinical Director of our CAMHS, has recently come back from
11 a sabbatical at Tulane University where they have the
12 Tulane early childhood collaborative program and a number
13 of other programs. Now, what they have done to address
14 this problem is that, you see, by the time a 13-year-old or
15 a 15-year-old comes with a severe enough problem, as per
16 the Victorian mental health triage scale, it's already too
17 late in many ways.
18

19 What they have done in Tulane is that, instead of
20 having this stepped care or tiered approach, they have
21 actually brought services together. So, you have the equal
22 end of CAMHS services, that's the child psychiatrist and
23 mental health clinicians, actually sit in regularly with
24 paediatricians and mental health nurse and child health
25 nurses, what they call as kerbside consultations: they
26 provide support, they provide secondary consultations, they
27 actually see people so that you don't actually wait for a
28 triaging system to pick them up; they pick up children
29 early and then they provide treatment and care. So, I
30 think we need to rethink all these things so that we can
31 actually make a difference.
32

33 We have heard a little about this issue about the
34 intergenerational problems as well. One of the other
35 things that the Tulane collaborative does really well is
36 that often, especially for children in out-of-home care,
37 their parents may not know how to parent, or they
38 themselves may not have had models of how to parent, and
39 they have something that sounds deceptively simple, like
40 parenting programs, and these seem to have a big effect as
41 well. These are the kind of mitigating factors I think
42 which - well, we have models that seem to work. The Tulane
43 model has now been adapted in many ways in at least a
44 couple of sites in the UK, for example, so we know that
45 these things are possible that can mitigate effects and
46 improve care.
47

1 COMMISSIONER McSHERRY: Thank you.

2

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

14

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

21

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

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

36

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

43

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

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

7
8 After that we can provide the full five-year training
9 in psychiatry at Shepparton but not other disciplines. Not
10 everyone wants to do psychiatry, so then the issue is that,
11 what do we do in terms of providing training opportunities
12 in regional areas so that people train there?

13
14 We know that if people train there the chances that
15 they stay back in those communities is much higher, okay.
16 So, I think if we think about the system broadly and see,
17 this is the workforce that we need, I think we can get
18 people there.

19
20 Simultaneously, if we build these linkages between
21 health services and we provide opportunities for people to
22 do the type of work they would want to do; now, what I mean
23 by that is that when we had de-institutionalisation the
24 idea was to have these so-called case manager loads.

25
26 The thing with case managers was that they were not
27 necessarily there to provide therapeutic work, they were
28 there to make sure that people got the work: the question
29 is, where from? Because then you do not have many teams,
30 and in rural areas this was a particular problem, that
31 don't necessarily have psychologists, there is no way of
32 attracting psychology because of a whole range of issues.

33
34 And so, if you created a system where you would have
35 capacity for people to do what they were trained to do and
36 you encourage that, again you're providing incentives for
37 people to work, which is why I come back to the idea that
38 what we should be expecting from people is, these are the
39 outcomes we want from you and from your work; not whether
40 you've ticked off on all 100,000 processes, whether you've
41 done that or not. So, I think we have to have a system
42 enablers that allow people to do the work that they're
43 trained for and we support them.

44
45 Rural areas in particular have problems of
46 professional isolation as well, and again, technology can
47 be provided. So, as I indicated in my statement, I am now

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

5
6 So, we already have the enablers that reduce
7 professional isolation, but we need to think about all
8 these things, which means that we will have to have a
9 collection of people who will think about all these things.
10 Sorry if I've wandered off.

11
12 CHAIR: Thank you very much. Thank you.

13
14 MS NICHOLS: May Dr Bhat be excused, please.

15
16 CHAIR: Yes. Thank you very much for your evidence today,
17 Dr Bhat, and for your comprehensive witness statement.

18
19 **<THE WITNESS WITHDREW**

20
21 MS NICHOLS: Chair, is it convenient now to break for
22 lunch until 2 o'clock?

23
24 CHAIR: Yes, thank you.

25
26 **LUNCHEON ADJOURNMENT**

27
28 **UPON RESUMING AFTER LUNCH:**

29
30 MS NICHOLS: Commissioners, the next witness is Dr Alison
31 Kennedy, I call her now to give evidence.

32
33 **<ALISON KENNEDY, sworn:** [2.05pm]

34
35 MS NICHOLS: Q. Dr Kennedy, are you a Research Fellow at
36 Deakin University's Department of Health and also at the
37 National Centre for Farmer Health?

38 A. So, it's actually the School of Health, School of
39 Medicine in the Faculty of Health at the National Centre
40 for Farmer Health.

41
42 Q. Thank you. Did you earn your PhD from the University
43 of New England in 2016 studying the impact of bereavement
44 following suicidal accidental death on farming families?

45 A. Yes.

46
47 Q. With the assistance of the Commission's lawyers, have

1 you prepared a witness statement in relation to the
2 questions on which we've asked for your opinion?

3 A. Yes, I have.

4
5 Q. I tender the statement. [WIT.0001.0044.0001]

6
7 CHAIR: Thank you.

8
9 MS NICHOLS: Q. Dr Kennedy, can I ask you firstly to
10 tell the Commissioners, what is the National Centre for
11 Farmer Health?

12 A. So, the National Centre for Farmer Health is a
13 partnership between Deakin University and the Western
14 District Health Service and our role is to support the
15 health, wellbeing and safety of farmers, farm workers,
16 farming families and the farming community.

17
18 Q. What sorts of programs does it deliver?

19 A. So we do that through a combination of research,
20 service delivery and education and information provision
21 through our Farmer Health website.

22
23 Q. Can I ask you about the prevalence of mental illness
24 in rural communities as compared to metropolitan areas.
25 Generally speaking, what can you say about that?

26 A. So, the current evidence suggests that there isn't any
27 great difference between metropolitan and rural areas in
28 terms of diagnosed rates of mental illness.

29
30 Q. Is there anything to suggest that, nevertheless, there
31 are high levels of psychological distress in rural
32 communities?

33 A. Yes. So, evidence would suggest that there are
34 particular things in rural and farming communities that may
35 contribute to levels of psychological distress.

36
37 Q. Is it also the case that there is a higher rate of
38 suicide in rural and farming populations as compared with
39 metropolitan populations?

40 A. Yes, that's true. Rural suicide rates are estimated
41 around about twice that of metropolitan areas. The
42 evidence around farmer suicide rates is a little bit
43 uncertain and variable.

44
45 Q. Is there anything sufficiently positive that you can
46 say about that?

47 A. So, the evidence currently that we are relying on

1 really comes from Queensland and it's the most recent
2 evidence. So, that suggests that there's up to twice the
3 rate of suicide in farming populations compared to the
4 general population; however, that is very variable
5 according to different regions.
6

7 Q. That data's from Queensland and you've relied on that
8 because there's no Victorian data presently available?

9 A. Correct. We are currently working with the Victorian
10 Coroners Court to help gain a better understanding of
11 farming-related suicide in Victoria.
12

13 Q. Thank you. Can I ask you about what is known about
14 the risk factors for increased mental illness in rural
15 communities, starting with the lack of access to
16 appropriate services.

17 A. Yes. So, in rural communities obviously there are
18 less services available and that's sort of across the board
19 when it comes to mental health: so, from psychiatrists,
20 psychologists, GPs, mental health nurses, all of those are
21 less in rural areas.
22

23 Where services are available, they're not always
24 appropriate services. Particularly, there may be service
25 providers who don't have an understanding of work and life
26 within a rural farming community, and that's often very
27 important to build rapport with a client, is to have that
28 understanding of the situation that they're in, so when
29 that's not available, the services aren't always
30 appropriate for that individual.
31

32 Q. Have you done any research on the means by which
33 better understanding of farming life can be gained by
34 health practitioners?

35 A. Can you repeat that question?
36

37 Q. Yes. Does your research say anything about the means
38 by which health practitioners can gain a better
39 understanding of farming life and its relationship with
40 mental health factors?

41 A. Yeah, definitely. So, one of the programs that we
42 offer at the National Centre for Farmer Health is
43 agricultural health and medicine training, and that
44 actually is a means by which we're able to provide health
45 practitioners with cultural competence and knowledge of the
46 risk factors that people face in farming communities when
47 it does come to health, wellbeing and safety.

1
2 Q. To what extent has that program been rolled out across
3 Victoria or taken up in Victoria?

4 A. So, I couldn't give you the exact numbers, but the
5 education program is now in its 10th year and there's a
6 couple of different units that we run as part of that
7 graduate certificate. So, there's an intake of around
8 about between sort of 15 and 25 people per year in those
9 units.

10
11 Q. Is that education program directed to general
12 practitioners or other clinicians as well?

13 A. It's a range of health practitioners; so, a lot of
14 nurses, allied health specialists, GPs, but also people
15 working in agriculture, so vets, agronomists, those sorts
16 of people as well.

17
18 Q. Are there what you call environmental and situational
19 factors that present themselves to people in farming
20 communities that present risks for mental ill-health?

21 A. Absolutely. So, there are I think a range of
22 situational factors. We know that rural communities on the
23 whole are shrinking, so there is less social contact.
24 Farms are getting larger, they're getting more mechanised
25 so there's less labour in a farming business, which again
26 affects that social contact.

27
28 Exposure to environmental extremes, so bushfires,
29 droughts, those kinds of things can have psychological
30 distress factors associated with them. People moving away
31 from the rural community: so, not only do we think of
32 relationship breakdowns as affecting psychological
33 distress, but when children, for example, move away from
34 the farm for work or education elsewhere, also that lack of
35 connection can have a psychological impact as well.

36
37 Q. There's a factor that you've referred to in your
38 statement called "Acclimatisation to Risk", can you explain
39 what is meant by that?

40 A. Yes, certainly. So, in farming families, particularly
41 from a very young age people are exposed to risk-taking
42 behaviour. So, we see children helping out on the farm,
43 being involved in machinery, livestock, riding motorbikes,
44 horses, so those sort of everyday factors in farming just
45 become part of everyday farming life. So, while they are
46 inevitably risky activities, people no longer sort of see
47 them as risk-taking, it's just part of everyday life in

1 farming work.

2

3 Q. Those factors and others are risk factors for the
4 development of mental ill-health. How do they relate to
5 the rates of suicide in rural communities, if you can say?

6 A. There's some theory around acclimatisation to
7 risk-taking as a precursor to suicide. So, it makes that
8 journey - once somebody is in a place where they are
9 considering taking their life, it actually makes that
10 journey that little bit easier when people are acclimatised
11 to risk-taking, particularly in farming communities where
12 there is also access to means, so an accumulation of
13 factors can lead to suicide.

14

15 Q. In the study of the contributing factors to suicide,
16 is an accumulation of factors particularly important?

17 A. Absolutely. I think, suicide is always incredibly
18 complex and it's never just one single factor that leads
19 somebody to take their own lives.

20

21 Q. Can I ask you about the role that stigma plays in
22 help-seeking for mental illness in rural communities.

23 A. Yes. So, stigma is definitely a factor that's not
24 only been found to increase the risk of suicide, but it
25 also decreases help-seeking behaviour. Stigma can lead to
26 feelings of shame, feelings of guilt, and we know that in
27 small rural communities where anonymity is often quite low,
28 the stigma that's associated with poor mental health can
29 inhibit people from seeking help. They may find that the
30 only mental health professional they have access to is also
31 a parent at the local primary school with their own child,
32 so that fear of lack of confidentiality perhaps and lack of
33 anonymity is an issue.

34

35 Q. In the context of research on suicide, how is stigma
36 understood to play a role in suicide itself?

37 A. Well, stigma, as I said, it socially isolates people,
38 it stops people from seeking help when they feel that they
39 need help. I can draw on an example of somebody that was
40 part of my research and he explained to me that, even
41 though he felt that he really needed assistance from a
42 mental health professional, he felt that if he put up his
43 hand and said that he wasn't coping and he did need some
44 help, he had a fear that he would actually lose the trust
45 of the people hiring him in his agricultural contracting
46 business and he would actually lose his business because of
47 that, so he remained silent and in incredible emotional

1 pain.

2

3 Q. So, with that background, what do stigma reduction
4 programs aim to achieve in relation to reducing rates of
5 suicide?

6 A. So there isn't a whole lot of evidence around stigma
7 reduction in relation to suicide specifically, so we're
8 really drawing on evidence that comes from mental health
9 stigma at this stage and trying to understand that better
10 in relation to suicide. Sorry, can you ask the question
11 again?

12

13 Q. I'm asking you about the role that stigma reduction is
14 understood, or at least theorised, to play in reducing
15 rates of suicide.

16 A. So, in reducing stigma, we're really aiming to
17 encourage people to speak openly about their experiences
18 and to seek help, and to I guess make sure that people
19 realise that they are not the only people experiencing
20 these feelings, that there is help out there, and it's
21 appropriate and acceptable for them to actually ask for
22 that assistance and seek that assistance.

23

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

26

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

30 A. Absolutely.

31

32 Q. You've used a concept in your witness statement of
33 "suicide literacy", can you explain what that is?

34 A. So, suicide literacy is knowing about both the risk
35 and the protective factors around suicide and suicidality.

36

37 Q. What do you mean by "protective factors" in this
38 context?

39 A. I guess one of the examples, if we think of a Suicide
40 Literacy Scale, that's a series of 12 statements that are
41 either true or false, and so, if we think of some of the
42 items on that scale one of them is that people can change
43 their mind rapidly when they are considering suicide.

44

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

1 change their mind.

2

3 Q. Can you just go back a step. What is the suicide
4 scale to which you're referring?

5 A. So, that's the Literacy of Suicide Scale, so that's a
6 validated tool that's been developed to measure suicide
7 literacy.

8

9 Q. So, is suicide literacy something that is understood
10 in relation to people who may be contemplating or
11 attempting suicide, or is it more of a population health
12 measure?

13 A. Yes, it's much more broad, so it's more of a general
14 assessment tool.

15

16 Q. If we can zero in on the more individual level, how is
17 it that having better suicide literacy is understood to
18 help people who may be at risk of attempting suicide?

19 A. So, I guess it helps them identify the risk factors,
20 but also perhaps enables them to identify the pathways to
21 support.

22

23 Q. I see. Could I ask you about the projects that the
24 National Centre for Farmers Health has undertaken.
25 Firstly, the Ripple Effect, and that was a digital
26 intervention project. How did it work and what was it
27 intended to achieve?

28 A. So, it was a project that was initially aimed at males
29 in the farming community aged between 30-64 years who had
30 been touched by suicide in some way. So, that may be that
31 they had thoughts of taking their own life, that they've
32 attempted to take their own life, that they were bereaved
33 by suicide, they may have been a carer for somebody who had
34 attempted suicide, or felt that they had been touched by
35 suicide in some other way. The intervention was designed
36 to try to reduce the stigma that was associated with that
37 suicide experience.

38

39 Q. Did that work in two ways: firstly, by asking
40 participants to complete a survey about their own situation
41 and their own beliefs, and then presenting them with
42 material tailored to their specific circumstances?

43 A. Yes, that's correct.

44

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

1 they have in common that they were messages from people
2 about their own life experiences?

3 A. Correct.

4
5 Q. What's important about that aspect of the material?

6 A. So, that aspect of the material gave people an
7 opportunity to share their own experiences and also
8 identify some of the strengths that they had drawn on or
9 the positive messages that they could share with others in
10 an effort to reduce further suicide risk in the community.

11
12 Q. You also presented videos of health professionals and
13 stigma experts.

14 A. Correct.

15
16 Q. In short, what was the substance of that material?

17 A. So, that material was really I guess presenting
18 information about stigma, about help-seeking, about
19 self-care and wellbeing, but was presented very much from a
20 farming perspective, so these were professionals who had
21 knowledge of farming work and life.

22
23 Q. You also presented material about topics such as
24 having safe conversations. What does the expression "safe
25 conversations" mean in this arena?

26 A. So, we want to encourage people to speak about their
27 experiences but, in what we call a safe way. So, not to
28 talk about method, not to be sensational in the way that
29 they speak about suicide, but to make the conversation
30 about suicide real and approachable in people's lives.

31
32 Q. There was a very significant uptake for this project
33 in rural communities; is that right?

34 A. Yes. There is an amazing passion in rural communities
35 for improving mental health. I think, given that
36 communities are small, social networks are quite tightly
37 entwined, we generally find that there's very few people in
38 rural communities who haven't been touched by suicide or
39 poor mental health in some way, so there is a real passion
40 for improving that and reducing suicide risk.

41
42 And so, as part of The Ripple Effect we called for
43 expressions of interest for a steering group, and we had 15
44 places to fill, but we ended up with a lot more people than
45 that applying and expressing interest in the project, so we
46 ended up creating community champion roles in addition to
47 the steering group, so we had around about 60 people who

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

6
7 Q. The evaluation of this project showed that, of itself,
8 it didn't reduce stigma and, why was that?

9 A. So, we measured stigma reduction. As you were saying
10 earlier, people did a survey at the beginning of their
11 involvement and also once they'd completed their
12 involvement, and so, we measured, using the Stigma of
13 Suicide Scale, we measured stigma at the beginning and at
14 the end of their involvement.

15
16 And so, by using that tool, we weren't able to show
17 that there was a significant reduction in suicide stigma.
18 However, when we looked more closely at the postcards and
19 the outcomes of the digital storytelling workshop, and also
20 in the personal goals that people set as part of their
21 involvement in The Ripple Effect, we were able to see
22 behavioural indicators of stigma reduction through that
23 process.

24
25 Q. What do you mean by "behavioural indicators of stigma
26 reduction "?

27 A. So, things like increased willingness to seek help,
28 willingness to have conversations, difficult conversations
29 around emotional issues and mental well-being: yeah, those
30 kinds of things which are indicative of stigma reduction.

31
32 Q. What were the key features of that program that, in
33 your assessment, contributed to that outcome?

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

45
46 Q. So, is the essential idea that the person who tells
47 the story will have their own stigma reduction, and it will

1 help them as well as helping the recipients of the personal
2 story?

3 A. That's absolutely right. We found that, through the
4 storytelling process, it was quite cathartic for people on
5 the whole.

6

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

13

14 Q. That is a digital intervention. Is it part of the
15 Beyond Blue's STRIDE initiative?

16 A. Correct, and funded --

17

18 Q. And was it funded by Beyond Blue?

19 A. Funded by Beyond Blue through donations from the
20 Movember campaign.

21

22 Q. The digital aspect of it: what are the positives of it
23 being a digital intervention?

24 A. The biggest positive of being a digital intervention
25 is the potential reach that it can have. We know that,
26 particularly in rural areas, often people don't have
27 exposure to these kinds of things on a face-to-face basis,
28 but having it in a digital mode meant that potentially a
29 lot more people could reach that.

30

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

35

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

41

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

46

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

1 Gate campaign, that's a funded series of social events.
2 What's the idea behind that project?

3 A. So, it has a couple of different components, but Look
4 Over the Farm Gate, by its very name I guess, is designed
5 to encourage farming communities to look after their own
6 wellbeing but also to keep an eye on their neighbours and
7 support the wellbeing of others in their community.
8

9 Q. What aspects of that program were important, do you
10 think?

11 A. I think the whole of the program has been really
12 important. There was two significant components of Look
13 Over the Farm Gate: so, one is social gatherings. So,
14 small grants were available to community groups to run
15 social gatherings with a mental health aspect to those.
16 So, that could have been having somebody come and speak
17 about mental health or providing resources, but very much
18 focusing on bringing people together and to socially
19 connect people.
20

21 The other aspect was, there's been a series of
22 community workshops, so they're interactive workshops, to
23 raise awareness and to encourage people to develop skills
24 and confidence to support their own mental health but also
25 to support the mental health of other people in their
26 community.
27

28 Q. What kind of feedback have you had about the Look Over
29 the Farm Gate program?

30 A. So, the part of the program that the National Centre
31 for Farmer Health has been mainly focused on are the
32 workshops, and we've had really strong feedback. So, we've
33 done evaluations of those workshops to, I guess, establish
34 increased knowledge, how appropriate the material was for
35 people's roles in their community, the nature of the
36 delivery of the workshops, how appropriate that was, all of
37 those sorts of things and we have had very positive
38 feedback from participants.
39

40 Q. There's another program which is entitled, "The Great
41 South Coast Leadership Program", the aim of which was to
42 identify and document the stories and needs of carers in
43 the Great South Coast region. What did that study find?

44 A. So, I participated in the Great South Coast Community
45 Leadership Program. As part of that we were involved in a
46 community project, so the community project that I was
47 involved in was the needs assessment of mental health

1 carers.

2

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

15

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

21

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

30

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

36

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

42

43 Can you talk to us about both of those things:
44 firstly, what you mean by "a rapid decision-making pathway"
45 and what kinds of interventions might assist with that?

46 A. Yeah, so I think that relates back to what we spoke
47 about earlier about that acclimatisation to risk and access

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

6
7 Q. You've given in your statement an example of a program
8 that you say is a good community intervention and it's the
9 Rural Alive and Well Program in Tasmania. What do you know
10 about that?

11 A. I think we can learn a lot, and whether that's a
12 program that can be implemented in Victoria - I mean, I
13 think we need to still look into that and see exactly what
14 is it that's working in that program.

15
16 But it's a real community-based, it's an outreach
17 program and they have a number of outreach workers who are
18 not actually mental health workers, they are members of the
19 community often with a background in farming, and they are
20 supported to make direct contact with people in rural
21 farming communities and to support them and to help them
22 through - you know, they may refer them to services that
23 are available, but it is often around somebody being there
24 to have a conversation and to nut out some of those issues
25 in order to be able to work out the best resource pathways
26 for them.

27
28 Q. You have said in your statement:

29
30 "They have support workers who are not
31 mental health professionals but are people
32 in the community that cold-call people for
33 a chat."

34
35 Do you know anything more about the cold-calling
36 element of that?

37 A. Yes. So, it's not only self-referral, but if you
38 think somebody is going through a really tough time, you
39 can actually request that somebody be called upon and
40 contact is made with that person.

41
42 MS NICHOLS: Thank you, Dr Kennedy. Commissioners, are
43 there any questions.

44
45 CHAIR: Q. I just have a few, thank you very much,
46 Dr Kennedy. You talked earlier in your statement about the
47 changing demographics of farmers and farms per se, and also

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

6
7 How do you address that in terms of the work that
8 you're doing and also the role that women might be playing
9 as women farmers as well and how you've tailored your
10 advice and support to their needs?

11 A. Yeah. I think particularly with younger farmers they
12 have such a future ahead of them, and there is so much
13 uncertainty now in farming.

14
15 If we just take climate change as an example of that.
16 For a long time there has been a lot of inherited knowledge
17 that has assisted people to learn how to farm and to be
18 successful in farming. A lot of that knowledge now is
19 obsolete because there is so much uncertainty as to what
20 the future is going to bring, whether that be in terms of
21 weather or whether it be in terms of global markets,
22 there's just so much that's out of people's control, and
23 so, I think a lot of that knowledge is lost which raises
24 that anxiety level when something happens.

25
26 Q. And, for women farmers?

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

40
41 Q. You gave us an example of a pamphlet, I think you
42 said, that had been designed about managing stress on the
43 farm. What's the primary area of focus of that sort of
44 tool that you've made available?

45 A. It's a very practically-based booklet. So, it
46 complements the community-based workshops that I was
47 talking about as part of Look Over the Farm Gate and it

1 really builds the learning that is part of that workshop,
2 it builds it into sort of practical approaches to reducing
3 stress and allowing people to understand and manage that
4 stress in a context that they can really relate to. It's
5 very much based around farming and that understanding that
6 they need.
7
8 CHAIR: Thank you.
9
10 MS NICHOLS: May Dr Kennedy be excused please?
11
12 CHAIR: Yes. Thank you very much for your evidence this
13 afternoon, Dr Kennedy.
14
15 <THE WITNESS WITHDREW
16
17 MS BATTEN: Commissioners, the final witness for today is
18 Dr Gerald Ingham. I call Dr Ingham.
19
20 <GERALD PATRICK INGHAM, affirmed and examined: [2.40pm]
21
22 MS BATTEN: Q. Thank you, Dr Ingham. Have you, with the
23 assistance of the Royal Commission's legal team, prepared a
24 witness statement for the Commission?
25 A. I have.
26
27 Q. I tender that statement. [WIT.0001.0033.0001]
28
29 CHAIR: Thank you.
30
31 MS BATTEN: Could you start by briefly outlining for us
32 your current role and responsibilities, please?
33 A. Well, I'm a rural GP in Daylesford, about 50 minutes
34 from here, and I work as a GP there three days a week and
35 provide on-call care and attend patients in the local
36 hospital and in the aged care facilities, and I also have
37 other roles pretty much as a GP academic, I suppose, as an
38 academic and researcher with particular interest in the
39 training of GPs, the Australian General Practice Program.
40
41 Q. Could you tell us a little bit more about the clinic
42 that you work at?
43 A. The clinic that I work in is a large multidisciplinary
44 clinic. It has 17 GPs, it has three psychologists who work
45 there. We have physiotherapists, podiatrists,
46 audiologists, lots of practice nurses. It's a very
47 multidisciplinary clinic. It's the only clinic in town and

1 so we service the community.

2

3 Q. You stated that you believe in the four Cs of general
4 practice. What are the four Cs and why do you believe in
5 them?

6 A. Well, they really define/explain what a GP's role is.
7 So that, the first C is that we're the point of contact,
8 and I think it's in my witness statement that GPs are the
9 most accessed health practitioner by the community. So,
10 we're the point of first contact.

11

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

17

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

29

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

32

33 MS BATTEN: I'll try and help you.

34

35 CHAIR: Coordinated context?

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

40

41 MS BATTEN: Q. Just very briefly, can you explain to us
42 where you see rural GPs fitting within the mental health
43 system?

44 A. Well, I think we have a very big role in the mental
45 health system, again, because we are the first point of
46 contact and people come to us often with a mental health
47 problem and they want to know how severe that problem is or

1 what that problem is, so they're looking for a diagnosis or
2 a definition to explain where to go. But we're also the
3 person - GPs are the people who detect that a problem that
4 a person didn't realise was a mental health problem, is a
5 mental health problem. You know, that headache that they
6 had or the pain in their jaw from clenching their teeth all
7 the time; we're able to say, well, actually that might be
8 related to other things going on in your life or to your
9 anxiety and able to identify that. And often through that,
10 in fact able to remedy many of the common mental ailments
11 quite quickly.
12

13 So, we have that role, I suppose, in identifying and
14 then, as I say, actually referring off, but also a very big
15 point I'd like to make is, we do a lot of mental health
16 care, we care for a lot of people. We care for people who
17 are not able to be cared for within our system, so we end
18 up filling the gaps quite significantly.
19

20 Q. I wanted to ask you about that. You refer in your
21 statement to GPs being both the gap fillers and the glue.
22 So, first dealing with being a gap filler, how do you see
23 rural GPs as a gap filler?

24 A. We're gap fillers because often there isn't a service
25 available. Sometimes it's just not available at that time,
26 so, if a person has an acute mental health issue or crisis
27 and they need to be seen, where available they can get an
28 appointment with us today, they can't see their
29 psychologist for another week or their psychiatrist for
30 another month so we will end up filling because we're
31 available there at that time.
32

33 Then there are services where there appears to be a
34 lack of other services available, or other services tend to
35 not keep seeing people, so I'm thinking of people
36 classically with personality disorder, I'm thinking of
37 people who have both a drug and alcohol issue as well as a
38 mental health problem and so they won't be seen by the
39 mental health service, they will tend to only want to see
40 people who have solely a mental health problem, and so, we
41 will end up trying to fill the gap in that circumstance.
42

43 Q. And then, how are you the glue?

44 A. Well, we're the glue by trying to - which is a hard
45 job - we're trying to coordinate the services and bring
46 things together, but we're also trying to build things over
47 time, so we will remember or have written down the problem

1 the person had previously and how it got better in the
2 past, and hopefully be able to try the same solution that
3 worked previously again.
4

5 But also, just connecting services: are you aware that
6 there's a financial counsellor at the Community Health
7 Centre that you can go and see? Are you aware that, if
8 you've suffered from sexual assault, that we do have a
9 sexual assault service available in Ballarat and would you
10 like to go and see that? And, when those services write
11 back and communicate to us, ideally we can then coordinate
12 the action of those services.
13

14 Q. What proportion of patients to your service seek help
15 for mental health-related conditions?

16 A. I've estimated in my witness statement that my own
17 practice is around 20 per cent of encounters that I have,
18 would be about a mental health problem, and that's pretty
19 much in keeping with what GPs see.
20

21 It's often quite surprising, people come up to me in
22 the street and say, it must be busy, there's a flu or
23 something going around. I usually just say, "Yes", but
24 when a patient comes in through the door to see me about a
25 cough or a cold I feel like shaking their hand and, "Thank
26 you", because that's a relatively simple thing to see and
27 look after. Whereas, we see a lot of mental health
28 problems. It's estimated, when GPs were surveyed - and
29 it's again in my reference I gave - and asked what did they
30 think was the most common problem they dealt with, mental
31 health was the most common problem identified by general
32 practitioners.
33

34 I think we heard the previous witness saying that
35 mental health problems are no less common in rural areas
36 than they are elsewhere and, given that there are less
37 services available in rural areas, it's a very big role
38 that we have to fill that gap and we're seeing a lot of
39 people with mental health problems.
40

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

45 A. Yes.
46

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

1 us, please?

2 A. Yes. The first group would be patients who have, I
3 suppose, mild-to-moderate mental illness, problems such as
4 anxiety and depression; they're very frequent problems.
5 The sort of example I gave before of a person who perhaps
6 has some anxiety presenting as a physical symptom: they
7 will attend, sometimes they can be dealt with quite briefly
8 by me or maybe I might need a number of visits to look
9 after them, or I might refer them on to a psychologist
10 often within our practice, or I might prescribe, if their
11 depression for example was moderate, that might be an
12 indication to prescribe. So, that's the first group.
13

14 The second group is the patients with severe mental
15 illness, the patients who have had major depression perhaps
16 in the past, had suicide attempts, or needed ECT therapy or
17 admission to hospital, so very severe depression, patients
18 with very severe anxiety disorder such as obsessive
19 compulsive disorder where their lives are really being
20 dominated by their illness, and then of course we have
21 patients with schizophrenia and bipolar disorder where at
22 times their beliefs about the world are different from us,
23 and it's been called a psychosis, so those patients I often
24 need to manage ideally with the assistance of a
25 psychiatrist or mental health team. They will generally
26 need medication as part of their management.
27

28 Often when they're at their most severe, I'll be
29 handing over their care to a psychiatrist or usually to the
30 local regional mental health team, and then once things
31 have stabilised and settled down I will continue to see
32 them, and I'll be seeing them in between, both to continue
33 their care but to have an eye out for relapse prevention.
34

35 That's only a small proportion of the work that I do,
36 perhaps 5-10 per cent of the mental health problems that I
37 see.
38

39 The third group which has been described by a
40 colleague of mine, Dr Louise Stone, as the swamp of general
41 practice, which is the so-called missing middle. So, the
42 patients I mentioned before who have a drug and alcohol
43 problem plus a mental health problem, the patient who has
44 borderline personality disorder, the patient who has
45 chronic pain, where you can't have chronic pain without
46 also having depression as a consequence of that.
47

1 And also, there's a group of patients who have what we
2 call medically unexplained symptoms: they have physical
3 symptoms which we're unable to explain by pathology testing
4 or imaging but they continue to suffer, and so, they also
5 belong in this so-called missing middle.
6

7 I've spent a lot of time caring for those patients,
8 and they're often the hardest work, I suppose, because
9 there's no clear pathway to treatment and they're complex:
10 maybe there's poverty or lower socio-economic class;
11 there's maybe past history of abuse, and very ongoing sort
12 of complex personal circumstances to add in to their
13 complex mental health issues.
14

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

18 A. Yes.
19

20 Q. Can you explain why you hold that view?

21 A. Well, I think it was said before - I heard Professor
22 Bhat say that the complexity - GPs are used to working in
23 complexity, because we are generalists. We call the other
24 doctors, we call them partialists, we're generalists. So,
25 we're used to looking after, if you've got diabetes and
26 you've got a mental health problem and you're on
27 medications that's causing you to gain weight which is
28 making your diabetes worse, we're used to looking after
29 that and considering the relative merits of each of those
30 problems and how important each of those are in terms of
31 making a decision, so we're used to dealing with
32 complexity, and we see people over time and we see people
33 in their context and so we know other family members. The
34 other family members may also be patients, their carers,
35 where we are embedded in complexity in our day-to-day work.
36

37 Q. In terms of diabetes, you've referred to the
38 multidisciplinary coordinated care for other complex health
39 issues, but you've said that we don't seem to have that in
40 the same way for mental health; is that right?

41 A. That's right. It strikes me, I was involved early on
42 in a program called the National Primary Care
43 Collaboratives that looked at trying to improve the care of
44 patients with diabetes, and it involved basically measures
45 of diabetes outcomes but also working collaboratively as a
46 team.
47

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

11
12 I'm sure we will do a lot better if we were able to
13 work better in teams in primary care, and we would have the
14 capacity to look after those patients with complex
15 problems, I'm sure.

16
17 Q. In terms of the system, you've said:

18
19 "From my perspective, for patients with
20 severe mental health problems, the main
21 issue is obtaining access to the system and
22 obtaining an opinion from a psychiatrist,
23 particularly when a patient is seen to be
24 from the middle group."

25
26 Can you just explain to us some of the issues with
27 obtaining that access?

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

36
37 I understand they work as a team, they would discuss
38 this patient and decide whether this patient was one that
39 they could take on and, to be honest, I've done this so
40 often now that I know when I needn't even bother to refer,
41 so I wouldn't bother referring a patient with borderline
42 personality disorder who was having frequent suicidal
43 ideation. I wouldn't bother referring a patient who had a
44 significant drug and alcohol issue as well as their mental
45 health issue because they're not going to take them on.

46
47 I know they will take on patients who have

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

8
9 Q. You've said similar things in terms of access to a
10 community psychologist. You've said:

11
12 "For access to a bulk billing or community
13 psychologist the waiting time fluctuates
14 but is typically around two to
15 three months. My view is that the referral
16 process is labyrinthine and bureaucratic."

17
18 Just very briefly, what's the process and why is it so
19 bureaucratic?

20 A. Well, I refer through the Primary Health Network, I
21 complete a Mental Health Assessment and Plan. I refer that
22 off to the Primary Health Network, who then find the
23 psychologist for the patient. I have to complete a
24 questionnaire as part of it. A common questionnaire we use
25 is a questionnaire called K10. If I fail to fill out one
26 of the questions it comes back to me, they won't assess it
27 further.

28
29 One of the questions for example on that is, "How
30 often do you feel hopeless?" And so, I have to ask the
31 patient that question, then I have to tick it on the form,
32 send it off to the Primary Health Network: if I don't fill
33 that question out correctly they send it back to me. I
34 find it inappropriate and, you know, I don't like asking my
35 patients those questions. I feel like I should just be
36 able to say, "I've got a patient here who needs a
37 psychologist, can you get me one?" But that's not how it
38 works.

39
40 Q. You also highlighted earlier the importance of
41 continuity of care.

42 A. Yes.

43
44 Q. You've said that the continuing relationship between
45 the clinician and the patient is key to success of
46 treatment.

47 A. Yes.

1
2 Q. Can you elaborate on why you think that relationship
3 is so important?

4 A. Even more in mental health than in any other area that
5 we work; I mean, getting to know someone over time and the
6 relationship that you have just - that's just healing. So,
7 it's one of the lines that is said, "the doctor is the
8 drug", so often me just knowing someone and understanding
9 them and spending time listening and understanding them and
10 being able to say to them, that sounds really tough at the
11 moment, is very useful.

12
13 Plus also, if I know that, hold on, when you stop
14 sleeping, that's usually a sign that things are going to go
15 off. Or I've found in the past when your husband's away on
16 a fly in, fly out working job, during that time you're
17 likely to go off, I might schedule to book you in.

18
19 Or the pregnant woman who I ask about during her
20 pregnancy about what's she got arranged at home for when
21 this baby comes, who's going to help her. Just knowing
22 people over time and having an ear out or looking out for
23 them, that's the role that we have, that's a preventive
24 role as well as a - it's both useful in prevention and it's
25 useful in treatment in terms of knowing how a person is
26 when they're ill.

27
28 Q. What about barriers to GPs performing that role? So,
29 from a systematic perspective what are some of the barriers
30 to GPs practising in mental health?

31 A. First of all, training, so gaining experience in that
32 area is difficult. My own personal experiences coming
33 through is, what we do as GPs - when I started out there
34 wasn't a textbook of general practice for a start, and in
35 terms of knowing what we did in mental health, what GPs do
36 in mental health is different from what psychiatrists do
37 and from what psychologists do, and so, it was hard to
38 learn those skills or learn how to look after the missing
39 middle.

40
41 So, the training of our undergraduates and even in the
42 vocational training in general practice, it still has been
43 historically largely done by psychiatrists and not done by
44 GPs, and so, hasn't necessarily prepared people well for
45 the nature of general practice and the mental health care
46 that we provide there.

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

7
8 Q. Can you just explain that further for us. How are you
9 less remunerated when you're dealing with a patient with a
10 mental health issue as opposed to a physical issue?

11 A. Well, mental health problems generally take longer,
12 take time, counselling takes time. Many GPs will work on
13 somewhere between four and six patients an hour. So, a GP
14 who's seeing six patients per hour will be able to bill for
15 six instances, whereas if I'm a GP with an interest in
16 mental health, I might book two patients in for that same
17 hour. Although the fee is larger for the longer
18 consultation, it doesn't make up for it.

19
20 In my witness statement I gave an example of one GP
21 who was seeing six patients an hour and the other was
22 seeing two per hour, and there was a \$70 difference, even
23 though the GP who was seeing the patient for half an hour
24 may have been dealing with a very complex patient with
25 personality disorder and suicide intent, and the other GP
26 who was seeing six in a row of maybe relatively simple
27 problems would be - it doesn't appear appropriate on face
28 value that there should be this difference in reward for
29 that kind of work.

30
31 Q. Is one aspect of it the length of the consultation,
32 but is it also the nature of the consultation?

33 A. Yes, so there is a higher reward. Definitely the
34 length of the consultation, so the so-called six-minute
35 medicine. We know that the longer a GP spends with a
36 patient the less money they earn, that's the nature of the
37 MBS fee-for-service system.

38
39 The other part though is that there's a higher reward
40 on procedural medicine than there is on consultation
41 medicine. So, if I spend half an hour removing a skin
42 cancer, my Medicare fee might be \$250, whereas if I spend
43 my half an hour consulting it might be \$70.

44
45 I think I gave an example in my witness statement that
46 if you go down to Melbourne or the regional centres here,
47 you'll see lots of GPs' skin clinics where they're removing

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

3
4 The other thing I want to point out with mental health
5 consults is, of course, a lot of the patients from this
6 messy missing middle also fail to attend their
7 appointments, so you cross off a half an hour appointment
8 for them and then they don't show and you earn nothing for
9 that time for showing the care that you're making your time
10 available for them. So, there's a lot of disincentives in
11 a fee-for-service system for GPs doing mental health work.
12

13 Q. So that Medicare payment structure, you've said, does
14 not reflect the care and value that you bring in treating
15 someone with mental health issues?

16 A. Yes. The other thing is that we are not paid - if I
17 take a call from a psychiatric nurse from that Regional
18 Health Service, or that call that I make to them to do the
19 refer over, none of that is funded.
20

21 Q. You've touched on this briefly before but I'd like you
22 to expand on it, this issue of working as a GP with an
23 interest in mental health is also hard work. Can you
24 expand for us about the cognitive and emotional toll of
25 working with patients with mental health issues?

26 A. Yes, I think there's a river of emotion beneath all
27 human interactions and often we're working above that, but
28 it's still flowing underneath and often at the end of the
29 day you're aware, that is. I mean, I've consulted this
30 morning before coming over. I've had two patients cry in
31 my consulting room this morning: one of them in extreme
32 distress, and there's no way you'll walk away. I mean,
33 I've learnt, when I come home at the end of the day, I need
34 to - I've actually got a shorter drive home than I used to
35 and I recognise that's not so good, because you need time
36 to drive home and to recover a bit from doing that work.
37

38 And I used to have a - well, he's no longer working
39 with me, but a colleague who I would debrief with on a
40 Friday night and we'd sit around and have a chat and talk
41 about things we'd seen and the experience we have.
42

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

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

4
5 Q. You compared the GP system with psychologists for
6 example where there's support structures in place for
7 psychologists, but there doesn't seem to be the same sort
8 of support around GPs?

9 A. Yeah, my understanding is that psychologists have a
10 supervisor or mentor and that they're asked periodically to
11 check in, whereas I think for most GPs if we have a network
12 it's an informal network that we develop.

13
14 Q. Can we return to the issue of training for GPs, so
15 first could you explain what training exists for GPs in
16 relation to mental health?

17 A. Of course we have our broad training that we go
18 through as an undergraduate or postgraduate, but in terms
19 of further specific training, there's a level 1 training
20 which is about six or eight hours of training, which is
21 really just to enable you to access those Medicare item
22 numbers, so to be able to access a Medicare item number to
23 complete a mental health plan. There's a slightly higher
24 rebate if you're a trained GP versus an untrained GP in
25 that area. I really think it makes no difference, it's not
26 significant training.

27
28 There is further training for GPs who have an interest
29 who would like to, for example, use cognitive behavioural
30 therapy or other forms of what we call focused
31 psychological strategies and they go through level 2
32 training, and that enables them to access a different
33 series of item numbers which gives them a slightly higher
34 award for long consultations where they employ those
35 focused psychological strategies.

36
37 Sorry, I think there is another level of training
38 available. I understand that GPs can train, there are
39 courses to do training in GP psychiatry, but there is no
40 funding available for people who undertake that training.
41 It doesn't translate into higher rebate fees.

42
43 I was a GP obstetrician, I did 6-12 months worth of
44 training in obstetric care, learning how to deliver babies
45 and forceps and vacuum extractions, and from doing that
46 training I was able to - then when I saw women and help
47 them with their birthing I was able to build the same item

1 number as an obstetrician. Whereas there is no equivalent
2 for a GP. A GP who undertakes further training or did
3 another six months or a Masters degree in mental health
4 cannot access the item numbers which are used by
5 psychiatrists.
6

7 Q. You said most of what you've learned about helping
8 patients in the missing middle has been learned by doing.
9 Given the training limitations, do you have ideas on how it
10 could be improved?

11 A. I do think learning by doing is a large part of
12 learning how to look after complexity. Well, learning by
13 doing and reflecting is probably what I would like to say,
14 and reflecting with a peer would be a great way of doing
15 that, because patients with complex - it's not like you can
16 go to a guideline or a textbook and say, look, this patient
17 with diabetes who's also on medication to help with their
18 mental health problem, which one's more important? You're
19 not going to be able to find that in a guidebook, that's an
20 ethical and a complex decision based upon experience and
21 knowledge, and that sort of mastery is acquired by
22 reflection with a peer and discussion, unpacking the
23 reasoning behind decisions, and also, as I mentioned, I
24 think there's a value in the emotional support which GPs
25 would give each other if we were able to do that.
26

27 So I see groups of GPs sitting down to talk about
28 their challenging patients. There has been similar work
29 done in the UK, something called Balint Groups,
30 B-A-L-I-N-T, similar work where GPs spend time
31 understanding their complex patients and reflecting upon
32 that and hopefully obviously looking after them better.
33

34 Q. I want to ask you a couple of system-focused
35 questions. When we asked, "Is supply keeping up with
36 demand? What gaps have you observed?" You said, "There is
37 an enormous unmet demand." Can you just explain for us the
38 demand that you are seeing as unmet?

39 A. Well, repeatedly patients come in and, you know, where
40 are we now? We're in July and patients say, well, I've
41 done my 10 psychologist visits for the year, and I've
42 recently been uncovering the story of some very complex
43 problems in my family, maybe past abuse, but now I have no
44 psychologist visits for the rest of the year. That's quite
45 a typical circumstance of demand.
46

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

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

5
6 Psychiatrists, well, I hardly ever refer to a
7 psychiatrist because, to a private psychiatrist, because
8 the availability of a quality psychiatrist who my patients
9 can afford, it pretty much doesn't exist, so there's a huge
10 unmet demand there in terms of psychiatric services.

11
12 Q. In terms of helping your patients navigate the system,
13 you said the complexity occurs when other services are
14 needed. For example, patients with mental health illnesses
15 often need drug and alcohol counselling, housing support,
16 social support. Can you tell us how that becomes more
17 complicated for you?

18 A. In my circumstance the Drug and Alcohol Services and
19 the Social Work Services are available in the Community
20 Health Centre, so they're not within my centre. So, I
21 refer off to those services, but because I don't see those
22 notes, I don't see what they're doing, they don't
23 communicate back to me, or very infrequently communicate
24 back to me. There is no funding for me to speak to them or
25 spend time with them. So, if I spend a 10 or 15 minute
26 consultation with a drug and alcohol worker, that's
27 unfunded. Even if I spoke to them for half an hour it's
28 completely unfunded. So, we're already geographically
29 separated, we don't spend any time together as clinicians
30 where you get to understand how other clinicians work, and
31 then there's no funding, and of course that's a
32 state-based, state-funded service; I'm a Federally-Funded
33 service, communication between them is poor.

34
35 Q. Finally, I want to ask you three questions about
36 reform. The first one relates to telehealth and
37 teleconferences. You've said:

38
39 "Surely in the days of web conferencing a
40 statewide telehealth service could operate
41 after hours for urgent mental health
42 problems when a clinician needs support."

43
44 How do you see telehealth working in the future in
45 overcoming some of the barriers?

46 A. I don't - I still think you're better off to see a
47 clinician face-to-face if you can, and I would like to

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

8
9 So if someone comes into my urgent care currently and
10 they have come off their motorbike and they're unconscious
11 and I'm needing some help with their emergency care, I just
12 pull up the little mobile video screen which we have in our
13 acute care system, I hit the phone, I end up speaking to
14 someone, an emergency specialist right there on the video.
15 That specialist can see the patient, we can talk and
16 discuss; that happens immediately for emergency care, we
17 can all arrange transport, arrange services, what needs to
18 be done. I think that sort of service should happen for
19 acute mental health problems as well.

20
21 Q. Sorry, where's the emergency specialist from in that
22 scenario you're talking to?

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

35
36 The disparity between those two examples is quite
37 stunning.

38
39 Q. So the first example is for the physical health
40 scenario, and what hours is that available to you?

41 A. All the time.

42
43 Q. 24/7?

44 A. 24/7.

45
46 Q. So you can call someone and get access to an emergency
47 specialist for whatever physical problem you're dealing

1 with; is that right?

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

9

10 Q. What's the situation when you have someone in a crisis
11 mental health situation?

12 A. My most recent example was that I rang, I was on the
13 phone, and I waited for an hour and a half for an answer,
14 "You're first in queue, you're first in queue." I ended up
15 handing it over - the phone over to the nurse because I
16 needed to see some other patients. I had a patient who was
17 trashing a house, smashing things up, she was having a
18 manic episode. She wasn't in immediate - she had a family
19 with her who were caring for her extraordinarily well.

20

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

30

31 Q. Two final questions about the system. You've referred
32 to Lewin's 3-stage Model in Developing and Maintaining
33 Change. Just very briefly, can you tell us what that is
34 and how you think that could be helpful for reforming the
35 mental health system?

36 A. I'm aware and I listened with interest to Professor
37 Bhat's evidence before, saying how there's a long history
38 of what seems like a good idea, another small idea, another
39 small idea, another little change and not appreciating the
40 complexity of the system and that implementing change in
41 major - you really need to be thinking about that and
42 constantly reviewing and updating it.

43

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

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

7
8 Q. From your perspective what changes do you think would
9 make lasting improvements to help people affected by mental
10 health?

11 A. Well, I think I've mentioned, I think a GP
12 psychiatrist qualification and enabling GPs to access the
13 Medicare item number for psychiatry and that they are given
14 an equivalent recognition by the Commonwealth. It amazes
15 me that whenever I see a patient for a disability support
16 pension and I'm writing their diagnosis down, my diagnosis
17 as a GP is not accepted. So, at least if we had GP
18 psychiatrists that might be accepted.

19
20 I talked about that statewide mental health after
21 hours service. Telehealth I think would be good. I think
22 we need to fund the provision of mental health services by
23 GPs more appropriately, and by that I mean the appropriate
24 funding of longer mental health consultations.

25
26 I think we need to fund primary health, mental,
27 primary care mental health care teams, and by that I mean
28 teams that involve GPs with drug and alcohol workers,
29 social workers, psychologists, even physiotherapists,
30 occupational therapists within the general practice to help
31 care for these complex patients, and I think the funding of
32 communication between health professionals relating to
33 mental health issues.

34
35 So, if I want to pick up the phone, or more typically
36 if the other mental health clinician wants to ring up and
37 speak to me and we want to discuss this patient and that
38 conversation is going to go for 10 or 15 minutes, it's not
39 an issue that, look, I can't be doing this because this is
40 non-financial for me to be doing that. So those sorts of
41 interactions in my mind need to be funded.

42
43 MS BATTEN: Thank you very much, Dr Ingham. Chair, are
44 there any further questions for Dr Ingham?

45
46 COMMISSIONER FELS: Q. I just had a rather small
47 question about your quite good comprehensive discussion of

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

3

4 I just want to compare that with the situation of a GP
5 who has to have a long consultation but not on a mental
6 health matter and its not a procedural aspect. Would that
7 happen very much, or is that somewhat rare for a GP to need
8 to have a long consultation on a non-mental health matter
9 and not involving a procedure?

10 A. No, those consultations happen frequently as well,
11 particularly ageing patients who have got many, many health
12 problems. So, any time there's some complexity, the
13 consultation will take longer, so I don't think that a long
14 consult necessarily designates that it's a mental health
15 issue.

16

17 COMMISSIONER FELS: Thank you.

18

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

28

29 How are you able to do that in your practice?

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

43

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

1
2 I know when I first started out in practice and it was
3 a two doctor practice, names would just get written in in
4 pencil in the appointment book. My colleague, the one who
5 I referred to, Greg Malker(?), who used to help me, he'd
6 say we have to jump over that wall of graphite today, we've
7 just got to see everyone that needs to be seen.
8

9 But we actually run a triage system, and again, no-one
10 pays us for doing this, but we employ nurses to field all
11 calls and to determine whether that needs to be seen today
12 or can wait till tomorrow. So, if someone needs to be seen
13 today and they say to the receptionist, I need to be seen
14 today, it goes to the nurse who then does that triage and
15 makes that decision or discusses that with the patient.
16 But in the end if the patient says, "No, I want to be seen
17 today", they're seen today.
18

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

22 A. Yes.
23

24 Q. But I presume that funding is no longer available and
25 something's happened. Could you explain what happened with
26 that? Because you indicated it was highly valuable in
27 managing mental health?

28 A. I don't understand the reasons for why the funding
29 changed, but we did for a while, I think it was about
30 18 months, have a nurse who was located in our practice
31 whose primary role was to help us with patients who were at
32 risk of admission to hospital or who had severe mental
33 health problems. So, I'm talking about patients who
34 previously had depression, who needed ECT, or patients with
35 schizophrenia, or very complex difficult to manage
36 patients, and she would be conducting - it was like my
37 experience of looking after my patients with diabetes: I
38 would open up the notes and see her - be able to read her
39 notes. She'd be able to fill me in with what was going on
40 socially, her assessment of what was going on. She'd have
41 some ideas about what she thought I might do, but she was
42 also keeping contact in between times, and that's just the
43 nature of working in a team.
44

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

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

7
8 Even today I saw one of the patients this morning
9 who's seeing that nurse and I said, "Oh, when are you
10 seeing this patient?" She said, "Oh, I'm seeing her on
11 Friday." She said, "I haven't managed to coordinate your
12 two appointments yet." She knows that she needs for
13 prevention, for monitoring of her mental health, she's had
14 severe depression in the past, she knows she needs to be
15 seeing a clinician about once a month. But because we're
16 not coordinated she's going to see us both in the same
17 week, it doesn't make sense.

18
19 CHAIR: Thank you very much.

20
21 MS BATTEN: Thank you, Commissioners, may Dr Ingham please
22 be excused?

23
24 CHAIR: Yes, thank you very much for your evidence today.

25
26 MS BATTEN: That concludes the evidence for today. May we
27 adjourn till tomorrow?

28
29 CHAIR: Thank you.

30
31 **AT 3.30PM THE ARBITRATION WAS ADJOURNED TO**
32 **TUESDAY, 16 JULY 2019 AT 10.00AM**
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