Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF MARIAM TOKHI

I, Mariam Tokhi, General Practitioner, of 42/48 Coleraine Street, Broadmeadows, in the State of Victoria, say as follows:

1 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Background

2 I am a general practitioner (**GP**) at DPV Health, a community health centre in Broadmeadows, Victoria. I have worked at DPV Health for just over a year, and I currently work there two days a week. I have a general practice that crosses the spectrum of mental health, physical health and some procedural areas such as family planning procedures. Broadmeadows is a low socioeconomic area, and our clinic is geographically close to a large housing commission area, so we see many patients and families who are struggling. Because Melbourne Immigration Transit Accommodation (**MITA**) is close by, we also see a lot of new asylum seekers either in community detention or who are new refugees. I see many of my patients with an interpreter present.

3 I also teach medical students in a subject called Professional Practice at the University of Melbourne.

4 I have been a fellow of the Royal Australian College of General Practitioners (**RACGP**) since 2016.

5 I have previously worked as a general practice registrar at four different general practice clinics:

(a) Summit Medical Group;

(b) Gap Road Medical Centre;

(c) Victorian Aboriginal Health Service (**VAHS**); and

(d) PVH Medical.

6 I have also previously worked as a global health research officer at the Burnet Institute and Centre for International Child Health, and prior to general practice, I worked as a hospital medical officer at Monash Health (Victoria), Alice Springs Hospital and Alfred Health.

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

7 I hold a Bachelor of Medicine, Bachelor of Surgery from Monash University and a Master of Public Health from Johns Hopkins University.

8 I am giving evidence in my personal capacity, and not on behalf of my employer.

9 Attached to this statement and marked "MT-1" is a copy of my curriculum vitae.

Responding to diversity

Features of a service that is responsive to diversity

10 In my experience, there are a number of hallmarks of a health service that is responsive to diversity.

11 A service that is responsive to diversity has an underpinning mission to serve all people in its community. In order to do that, the service actively gathers information about the needs of community members and patients, so that it can recognise the challenges and understand better the barriers that vulnerable populations and outpatients face in accessing quality healthcare.

12 A service that is responsive to diversity has an ethos of treating all people with respect and warmth. It works in partnership with those people, rather than working hierarchically. It has flexible engagement with clients and referrers, recognising that people who are out of the mainstream face extra challenges with understanding and engagement, and so need that flexible engagement.

13 A service that is responsive to diversity has skilled staff across administration, program management and in clinic areas who are sensitive to the challenges that vulnerable patients face. Having sensitive staff is easier said than done because you really need to upskill staff across all kinds of perspectives in the service.

14 We need ready access to interpreting services and community liaison support. We need the ability to actively follow up clients who are difficult to engage. Follow-up might happen through community support workers, case support workers or liaison officers.

15 A team approach to healthcare provision is really important in order to understand diversity and to work through the challenges of meeting different people's needs. As part of that team approach, there needs to be support and linkages between clinicians, non-clinical support workers and patients, so that we can request and give help to people who need it.

16 We also need to understand the inter-play of social and economic challenges together with disease and disability. We need to be able to provide multi-disciplinary support services. For example, GPs need to be able to work with medical specialists, social

workers, allied health and mental health services. That interaction can sometimes be lacking in the model of GP care that is widespread in Australia. Healthcare can be quite segmented, but inter-professional communication is really important if we're going to be responsive to the diversity of our communities.

Providing responsive care to diverse populations

17 GPs are often the first port of call for both physical health and mental health issues. We work almost as care co-ordinators, and often we're described as gatekeepers to other services. In terms of my role as a GP, I need to be able to provide time, tact and sensitivity in that initial consultation and in subsequent consultations. But it is important that we recognise the importance of those initial encounters. The contact made at the initial consultation is important for providing patients with the feeling of being cared for, and for assisting them with navigating the health system.

18 GPs have a special role in our healthcare system because, unlike a lot of specialists, we get to see someone multiple times over a period of time, and we can bring people back more easily than a lot of specialist healthcare services can. We have reasons to engage from lots of different aspects. We can say, "Hey, I'm going to do your pap smear" to a young woman, and also "I'm going to support your mental health," and "I'm going to talk to you about smoking cessation," and "I'm going to talk to you about your risk of breast cancer, given that your mum has a history of breast cancer." A specialist might see a patient for one of those things, but because as a GP you're trying to provide whole-person care and understand health holistically, we have an ability to say, "Hey, how does your sexuality impact on your health?" and "How does your age impact on your health?" and "How is your mental health being impacted by these recent changes?" On our best days, GPs really do try and understand people. And because we build up trust over those various encounters, people open up.

19 You need longer consultations than average, and I think that is doubly true if you need an interpreter in the consultation. We need funding for those high quality interventions: funding for GP leadership, for education of doctors-in-training about diverse needs, and for targeted populations.

20 GPs want to help patients connect to important healthcare services, specialist services or mental health services and to navigate that system. I've often been referred patients from a mental health worker who says, "Oh, I know this really good GP and she'll look after you." Patients often try a few different GPs before being able to settle on one, and often in the meantime their mental health has deteriorated.

21 I am speaking from a GP's perspective, but the same applies to caseworkers or program managers who have made that initial contact with a vulnerable person from a diverse background.

Factors that hinder services from being responsive to diversity

22 I have already talked about the funding issues, but there are other things that hinder services from responding to diversity. I'll mention seven things:

(a) Medicare Benefits Scheme (**MBS**) requirements that are too stringent;

(b) referral requirements that are too complex;

(c) inflexible modes of engagement;

(d) the challenges posed by our increasing use of technology;

(e) the lack of spaces that feel culturally safe;

(f) the cost of services; and

(g) inadequate remuneration for GPs.

Stringent MBS requirements

23 The MBS requirements are overly stringent. For example, there are requirements that as a GP you can only bill for a mental health consult with a physical health consult if the physical health issue was discussed first. So if the mental health issue came up first, and then the patient tacks on a physical health issue, you can't bill for both of those consultations. It is really arbitrary, but I guess the Commonwealth Government is trying to get the most value for service. They're trying to say to GPs, "Look, don't just tack on an issue at the end of a consultation. Don't bill us for checking someone's blood pressure after you've done a mental health review."

24 But the problem with that type of thinking is that mental health issues are really strongly interlinked with physical health issues, and that having a mental health issue is a barrier to getting physical healthcare. So we should be doing everything that we can to encourage integrated, whole-person care.

Complex referral requirements

25 Sometimes referral requirements are overly complex or stringent. For example, I made a referral to an organisation recently, and I hand wrote the referral on the referral form that they sent me via email. They wrote back and said that I had to type out the referral. The referral was 10 pages long and needed detailed information, and I just don't have the time to be able to redo a referral. Sometimes referral requirements are far too stringent and far too complex, and don't recognise the time pressures that we're all facing.

Inflexible modes of engagement

26 Inflexibility of appointment times and modes of engagement is a real barrier for people, especially for people who are in unstable casual work, or are facing multiple situational crises. I know we have to be able to set boundaries, but we also need to be able to meet people where they're at. Most healthcare providers have moved from walk-in appointments into more rigidly timed, pre-booked appointments. We need to fund healthcare services that can provide some flexibility, to support people whose lives are chaotic and messy. But a model of care that incentivises a high volume of patient encounters doesn't build that flexibility in the system.

Challenges of increasing use of technology

27 People need to be able to communicate their need for an appointment. As we move to mostly online bookings, it can be really hard to communicate that need. For example, we're going to start doing a lot more telehealth consultations in the face of this COVID-19 pandemic, and it's a real challenge to be able to set up a face-to-face consultation via Skype with someone whose English isn't great, or who doesn't have a great internet connection on their phone, or even reliable phone credit. Both those technological issues—booking appointments online and having telehealth consultations—are obviously more apparent in vulnerable populations.

Lack of spaces that feel culturally safe

28 Healthcare spaces can be really important meeting spaces and support spaces for people on the margins. We need to make sure that there is overt welcome and cultural safety for people who are in minorities and who are struggling. For example, it can be really valuable to have an Aboriginal flag, a rainbow sticker or a "Refugees Welcome Here" sign in the waiting room. And for those things to be more than tokenism, there needs to be a reflection that people are invited to share their struggles and hopes for their health and wellbeing here. These tokens signal that there are trained medical professionals—and administrative and allied health staff here—who can demonstrate realness, respect and care for people from different cultures.

29 We know that medicine has a potted history of racism and exploitation. Australian hospitals, in many places, not long ago, were segregated by colour. We know that people from minority groups and poorer populations still receive inferior care, and have inferior health outcomes. So we have to actively combat this: to lift our standards for all people. The starting point is making sure that all people feel safe when they enter a health institution.

Cost of services

30 The cost of services is a huge issue. Lots of people from vulnerable communities are living on the breadline, and they can't meet the gaps for doctors, psychologists and other services. And when they do meet the gaps, they are going without in order to meet those gaps. For example, I had a patient who I'd referred for a bulk bill service recently, and then he organised a follow-up appointment which was going to have a gap of $150. He came in for me to sign a referral for him for the follow-up appointment, and I said to him, "Do you want to see a physician in the public hospital system rather than going to see this specialist privately?" And he said, "Oh, is that a possibility?" and I said, "Yeah. I mean, you'll have to wait longer, but it can happen that way." And he said, "Oh good, that means I'll be able to eat this week."

31 There is a real issue, especially in terms of psychiatric services, either using the public mental health system or the private mental health system. The public system is fraught with waiting lists, is overburdened and there are often barriers in terms of being able to engage flexibly. And then there's the private system, which is often much nicer, but which the majority of vulnerable patients can't access. Private psychiatrists can also put up a lot of limitations around who they will and won't see, which is also an issue.

32 Mental health care plans help substantially with the cost of accessing a psychologist. But many, perhaps most, psychologists still charge a hefty gap, which makes regular care too expensive reach. And some patients—particularly those who are quite unwell, or facing repeated crises—use up their ten funded sessions quite quickly.

Inadequate remuneration for GPs

33 Services need to be able to be able to attract highly skilled and motivated GPs. Providing high quality care for an acutely or chronically unwell person is complex and challenging. In the current model, to provide quality care, GPs who work in community health centres, or who work with larger proportions of vulnerable patients, typically earn substantially less than their colleagues who are working in privately billing centres or who see higher volumes of patients. The community health system relies on altruism; on the willingness of some GPs to do it for the love of it. But I can see that GPs who work in community health are just getting more and more squeezed, and people are moving out of that sector into more mixed-billing, private GP models.

34 Clinicians who are doing this work and serving highly vulnerable populations need to be accurately remunerated—and not just for the clinical work, but also for the administrative follow-up. That follow-up includes communication with other service providers, workers, patients and their families. At the moment, you don't get any funding for phone calls that you make, or phone calls that you receive, or emails or letters that you're trying to sort

out for patients. To be honest, patients who are navigating multiple systems at the same time often have a lot of that administrative burden, and that kind of engagement can be a bit off-putting for clinicians. A patient who needs help navigating those systems will bring you letters and ask you to make phone calls, and you do have to do a bit of the legwork. Whereas someone who speaks English really clearly and is well educated and has grown up in Australia doesn't need that extra assistance. GPs are often the first port of call for patients because we're trusted, and we've got a relationship with them, but that work we do is time consuming, and I am only paid for it if the patient is sitting in front of me.

Cultural and linguistic diversity

Overcoming the stigma about mental health that exists in some communities

35 From a GP perspective, it is really important to address stigma directly with individuals in consultation. It is important to seek to understand people's perception and understanding of mental healthcare. For example, I saw a patient who had severe obsessive-compulsive disorder, and her understanding around it was that it was a religious affliction. Being able to take the time to understand that from her perspective allows me to engage with it.

36 Overcoming stigma means normalising mental health, and we have the ability to normalise it in general practice. Providing healthcare and wellbeing care to whole families, where appropriate, and taking more of a whole-person, or even whole-family, approach is something that general practitioners can do well. As a GP, even if I don't see your partner, I can say, "Oh, how is your partner going? It sounds like he might be struggling too. Why don't you book him in to see myself or my colleague?"

37 It is really important to employ people from diverse backgrounds in order to address stigma about mental health. I myself grew up in communities "of diversity". My mum is Sri Lankan; my dad's Afghani. I have seen different perspectives of people from diverse communities so I can engage with people in a different way. It helps me to engage with patients, because I can share small insights of my own when appropriate. I understand something about their life journey—I know people like them. But mostly, I think I understand that within "diversity", there is diversity. That being brown or Asian or gay or young or old doesn't give you a particular set of values. There are no assumptions to be made. If you're a Muslim woman, you are more often than not happy to see a male GP. If you're "young", you might like to be seen on your own without your parents present—perhaps you are the breadwinner of the family. If you're a refugee on benefits, you almost never fit the trope of the lazy immigrant. Assumptions really hurt people's health. Health workers asking questions sensitively and respectfully is lifesaving. It can be really important to have that sort of cultural competence in workplaces.

38 We can also use targeted public health communication campaigns, and educate community leaders and religious leaders about mental health. People are often more

receptive than we think, and those sorts of leaders can have huge impacts on their communities. Attitudes can change fairly rapidly.

39 Another way to address stigma would be to integrate brief mental health checks into all healthcare interactions, although that would take time. For example, we can integrate mental health checks into GP check-ups: when someone comes in for their blood pressure check and prescriptions, we could do a quick mental health check and ask some brief screening questions. At maternal child heath checks we're already doing that: when someone comes in for their baby's vaccination we check on maternal wellbeing. When we're doing care-of-the-aged reviews, we could be checking in on memory and mental state. That's the beauty of general practice done well.

The value of culturally-specific health services

40 I worked with VAHS, and although it wasn't perfect, it was really excellent in many ways because of the approach to care across the life course, from birth to old age. VAHS functions with lots of services under one roof, but those services also communicated with each other regularly, because it had a strength-focused, resilience-focused kind of care. There was a lot of cultural pride that was evident.

41 VAHS did some of the things that I mentioned before to make their service more accessible.[1] VAHS had provisions to see both booked appointments and walk-ins. It had general practitioners who had lots of different interests, working under the same roof and sharing resources, and it also had other health workers. It didn't push a model of seeing people quickly: the standard appointment was half an hour. There are very few general practices that are providing half-an-hour appointments to patients (even though I think a lot of patients would really likely benefit from them).

The need for mainstream health services to support culturally and linguistically diverse communities

42 There is a role for culturally specific organisations, but all organisations need to be culturally competent. For example, I think VAHS is pretty unique in providing a safe clinical space for Aboriginal people, but we do need to recognise that not all Aboriginal people want to go to a culturally specific health service. All organisations have to be culturally competent, regardless of whether they are targeting a particular cultural population.

43 It is also important to educate young immigrants and invite them into healthcare provider roles, as well as facilitate the transition of immigrant healthcare workers into mainstream

[1] See above at paragraphs 26 and 27.

Australian healthcare roles. That representation can be as powerful for communities as designated culturally-specific specialist organisations.

44 The health needs of immigrants are very dynamic and heterogeneous. There are so many other factors at play: gender, socio-economic status, education and English literacy level, and the circumstances of immigration. Things change quickly over time: these needs are dynamic. Language limitations for immigrants change within a generation or often less. So that can be where an advocacy organisation, or a resource-linking organisation, can be really useful to support the wider a range of community services.

45 The mainstream mental health system can do more to support communities with diverse needs to access community mental health services.

46 The public mental health system is so over-stretched that many vulnerable patients fall through the cracks. Those vulnerable patients can be suffering immensely, but unless they are a risk to themselves or others, or unless they can afford expensive private care, they remain out of the mental health system. For the lucky ones, GPs sometimes pick up the slack.

47 We need to make it clearer to patients from non-English speaking backgrounds and at-risk backgrounds how they can access services using an interpreter or a support worker. It would be really useful to have a centralised resource for GPs to refer to psychologists who can communicate in a patient's first language when a patient has limited communication abilities in English. I think there needs to be extra funding for psychologists who undertake that work.

48 I referred above to the need for services to be flexible with appointments and to relax their referral requirements. Those changes would also help mainstream mental health services support vulnerable communities. For example, last year I had a patient who kept getting rejected by the mental health team I had referred her to. I just kept referring her back, because I really needed help and she was really struggling. But every time they called her, she would hang up, because she didn't understand English. They then thought she was rejecting their care, but actually she was desperate for care. They thought she was rejecting care, but it was a mixture of her mental state, her isolation and her paucity of English language. Whenever she would see me she would ask, "When is the psychiatrist going to contact me? When is the mental health team going to contact me?" It was hard because I would have to re-refer every time that they had closed the case.

49 Community health centres in general need more funding. We don't have any extra funding really for general practice in community health compared with the private system. I think this is a huge gap, and I'd like to see it changed. We need to be able to recruit and retain excellent GPs to service particular areas of need.

50 The paperwork that GPs are given takes too much time, especially within the current system. I think that a detailed referral letter with the mental state exam and a risk assessment should be sufficient for a referral to a psychologist and a psychiatrist to access mental healthcare funds. If you filled out all the paperwork properly for a mental health care plan, it would take hours to do. I don't have that sort of time, although I do often wish for longer consultations, to better understand my patients, and funded administrative time to serve them.

Trauma

The ways in which refugees and asylum seeker communities seek information and advice about mental health

51 We see a lot of chronic and physical ailments in the refugee and asylum seeker communities, which speaks to an underlying, unresolved, psychological malaise. It is also worth noting that there is stigma in both being labelled someone with mental health issues and being labelled an asylum seeker or a refugee.

52 Many of these people were really healthy high achievers in their own communities, because of the "healthy immigrant effect" that we see. (The healthy immigrant effect is a public health phenomenon where we see that the healthiest, most motivated and mobile people are the ones who are able to immigrate to new places.)

53 Then the trauma of violence and war and persecution sets in, and that trauma is multiplicatively augmented by detention and uncertainty about visas.

54 I find that these patients can present at later stages of mental illness. For example, an older patient with depression and dementia who doesn't speak English might fly under the radar for a longer period of time. I suspect that's related to many factors, like:

(a) cultural awareness of mental health;

(b) difficulties accessing the healthcare system;

(c) difficulties advocating for themselves;

(d) difficulties with trust building and engagement;

(e) lack of appropriate services; and

(f) all of a person's energies being focused on other matters of survival.

55 I also note that sometimes refugees and asylum seekers, in particular asylum seekers, seem to get stuck in the 'sick role,' because they've been dehumanised by the removal of things like their right to study, work and volunteer. So the medical practice can become a place of community and support. That can be good, but it can also be bad. Sometimes

we over-medicalise their distress, and push them into the sick role. Sometimes it's been their main form of psychological support. That can be a barrier to recovery-focused care. It's important for clinicians to remember that most health maintenance happens outside of a clinical setting: people need healthy environments to thrive.

Barriers encountered by people from refugee backgrounds who have experienced torture or other traumatic events

56 People from refugee backgrounds who have experienced torture or other traumatic events may encounter barriers to seeking help or support for their mental health. I want to talk about six issues that this community experiences in seeking help for their mental health: (1) lack of trust; (2) cost; (3) visa concerns; (4) loss of agency; (5) lack of trauma-informed care; and (6) lack of support for healthcare workers.

Lack of trust

57 There is a lack of trust and clarity around separation of the Department of Home Affairs or the migrant service from the health and support workers. That can be quite confusing for people from refugee backgrounds, not knowing who's in a punitive role, or what each person's role is. That confusion can impair trust. In general I find that most refugees and asylum seekers are unbelievably trusting, but the grief, loss and uncertainty can be really hard for them to express.

Cost

58 Cost is a huge issue for people who are asylum seekers particularly, and for refugees as well. Transport is another issue for these communities. That's the same for CALD community members who are really financially struggling.

Visa concerns

59 Asylum seekers and refugees can also experience concerns around asking for help, in case it affects their visa. Sometimes I see people worried about that.

Loss of agency

60 I also see that there are sometimes issues around agency. After being in prolonged detention, people sometimes become very passive recipients of care, for various reasons. We really need to focus on empowerment and getting people back into productive, healthy and joyful roles in society.

Lack of trauma-informed care

61 There's a lack of trauma-informed psychological support services in the mainstream system. There is also the segmentation of trauma services away from other mental health services. There are some really specialised services, but we do need that understanding of trauma in the broader mental health system.

Lack of support for healthcare workers

62 GPs and other health workers struggle to engage because of the feeling that it's too hard, so we really do need the support to be able to do it. Support comes in various forms. Clinicians doing this work probably do suffer from vicarious trauma: hearing these stories can be quite traumatic. So there's a need for de-briefing and supportive supervision, formally and informally. I have found this to be lacking. And, as I mentioned earlier, this work needs to be better funded. This work is time-consuming and not very well remunerated under our MBS. We need high-functioning, supportive and proactive clinical teams to do this work well.

Responding to the needs of people from refugee backgrounds who have experienced torture or other traumatic events

63 In responding to the needs of refugees who have experienced torture or other traumatic events, we should not throw out the community health centre model. I think we need to strengthen the model by building good multi-disciplinary teams, and rewarding quality of care and positive health service cultures. Community health centres bring multiple disciplines under the one roof, and when they're done well, they facilitate communication between those disciplines. I would really encourage policy makers to think about how we can support community health services that aim to provide responsive care to vulnerable populations, because we act as a safety net for a lot of people.

64 It does seem that there have been efforts to corporatise and streamline some of these services. Some of these efforts I think will backfire, only because those models serve more well-off populations better and depend on a Medicare model for GPs that focuses more on quantity of care, and less on quality.

65 I think it's important to remember that GPs are the first point of contact for many mentally unwell people, and this is the way it should be: now we need to look at how we can make GP clinics, and especially community health centres, especially welcoming and responsive services. Doing this will enable us to meet people's mental health support needs earlier in their struggles.

66 I would also look to the Victorian Refugee Health Services as an example of how we can respond better to our patients' needs. I'm sure there are lessons there about how to engage with patients, both clinically and administratively.

Improving the capacity of health providers serving diverse communities

Understanding diversity at individual, family and community levels

67 To be responsive to diversity at different levels, services need to know how patients identify, and how it affects their wellbeing.

68 I think that most people we see have multiple forms of diversity. You might be from a linguistically diverse background and young, or you might be older. It is important that GPs acknowledge that people seem to have multiple facets to their identity, and it is about the ability to engage with that person and understand their journey every single time we meet someone. That's hard work, but it's rewarding.

69 Questions about identity need to be asked in a non-judgmental, sensitive and respectful way. We need to understand the patient's level of literacy and language. We also need to understand the patient's communication style, their social supports and their health journey. There are supports and setbacks every patient has faced. Those are all really complex stories, and often in this cohort there are hidden traumas—and triumphs. GPs need to tease that out over time, and it takes trust.

70 My one message, or my undercutting message, is that the current system doesn't facilitate that at the moment. It is possible to do but it's less well funded, and it's hard to do in a poorer population in particular. GPs who do this work in a community health setting are paid inferior salaries to their colleagues, or are dependent on an underfunded MBS. Most of my patients would struggle to pay for private consultation.

Features of effective community partnerships

71 There are a lot of support services out there, like domestic violence support, addiction support, aged care and mental health, social support and group programs. But these support services need to be accessible to be able to refer to them. Patients need to be able to refer themselves to them if they're given the resources, and the services need to be accessible for people with low literacy. For example, lots of programs expect you to be able to do things like type in answers on a website, or listen to an English voice phone menu. We need to be conscious that those services are often not particularly culturally competent or accessible to patients who have diverse needs.

72 Effective partnerships that I've seen between doctors, patients and other workers are often co-located, so that patients, caseworkers and doctors are able to easily meet and speak about their priorities and plans. We need more multidisciplinary meetings—these

happen a lot in hospitals, but much less frequently in general practice settings. I worked as a Registrar for the VAHS a few years ago, and I felt like that was done pretty well, or much better than I had seen anywhere else. Within that building there was that easy communication between workers.

73 I also think the national translating and interpreting service, including the phone interpreting service, should be listed as a national treasure; it's an excellent resource.

Making specialist mental health expertise available to other service providers

74 There are a number of ways in which we could make existing mental health expertise available to services working with diverse communities.

75 First, some Primary Health Networks (**PHNs**) (which are local support services for vulnerable patients and primary care providers), provide a telephone psychiatric advisory and support service for GPs, although my local PHN does not provide this. It would be really useful to be able to speak directly with a colleague in psychiatry about our more complex or difficult to engage patients. This could be a useful tool. Our PHN does provide an excellent centralised intake to support particularly vulnerable patients. They fund a number of providers to patients who need extra mental health clinician support because they are at risk.

76 The mental health triage line is a useful service, but as a GP it can be really frustrating because it takes so much time to get through. You can be waiting for a really long time. It might not seem like it, but for a GP to wait on hold for 45 minutes is really unsustainable, particularly if they're doing that a couple of times a day. It's hard. You can ask for a call back, but then you have to get the patient to wait. An agitated patient is often unlikely to wait.

77 Second, I also think that we could make better use of expert GPs. There are a lot of mental health trained GPs, and mental health is the single most common reason that patients now see their GP.

78 Third, mental health needs to be considered an essential part of the generalist's toolbox. We need more mental health education in medical school and in pre-vocational and GP training across the board, and we should be upskilling GPs to be experts in mental health. There are already GP mental health specialists, and they could be working with psychiatrists to provide some extra capacity. Given that the majority of our patients at DPV Health can't afford to see a private psychiatrist because of the gap, perhaps that could fill some of the gap.

79 GPs can use MBS item 291 to refer patients to a psychiatrist for a one-off "opinion and report", which will then help the GP to provide on-going care. MBS item 291 is a great

initiative. I see a lot of patients who are unhappy with the single-point assessments that are made by psychiatrists, because they don't feel like they were really able to express themselves within that 45-minute interview.

80 Finally, we also need stronger linkages in general between GPs and mental health services. I would love it if we had an in-house psychiatrist at our community health service. I think there would be plenty of work. I would also love it if we had a psychologist as part of team (we already have a mental health nurse).

Facilitating access to services beyond community-based mental health services

81 Consumers sometimes require other services, such as employment and education supports, instead of or in addition to community-based mental health services. I think it's important to acknowledge that the bulk of looking after people's wellbeing occurs outside of the healthcare system. It's vital that we facilitate meaningful engagement (and sometimes withdrawal of engagement) with employment and education.

82 Doctors can be powerful advocates for our patients, and, strangely enough, our patients often listen to our opinions. There are two aspects of facilitating consumers' access to other services, and they are relevant both for GP and for other specialist mental health services.

83 First, we have a responsibility to advocate for vulnerable patients who are struggling to get appropriate care from community services. They can often feel dismissed or misunderstood as lazy or ignorant by service providers in other sectors, while GPs and mental health workers are privileged with the knowledge (and understanding) of their mental health status.

84 Second, we also have an opportunity to support our patients to engage meaningfully and to understand how this engagement can aid with recovery.

The role of telephone helplines in the mental health system

85 Telephone helplines aim to offer assistance to people in need of immediate assistance for mental health concerns. There are limitations to the current helpline services, but I think they're valuable services. I can't be there for my patients 24 hours of the day, so having things like Lifeline and eHeadspace where patients can contact someone who has mental health training, even just to help get them through a mini situational crisis, for them to cope overnight and see their GP in the morning or in the next few days. That can be valuable, and I appreciate those services. I think they have saved lives. However, I think some patients do get frustrated that there's not a higher level of service, and I'm not sure what's available for my non-English speaking patients.

Workforce considerations

The attributes, skills and capabilities needed in a workforce to respond to diversity

86 There are two really important things that a workforce needs, for a service to be responsive to diversity. These are communication skills and an understanding of the social determinants of health. That understanding needs formal and informal education. The education needs to start with prevocational training and then continue. There needs to be space for mentorship and continuing professional development, and that needs to be for both clinical and non-clinical workers.

87 The lack of linguistically diverse services is a real challenge. We need to include people from diverse backgrounds across each of the different services that are available, and not just in community health services. For example, at the moment I am struggling to find for one of my patients an affordable Arabic-speaking psychologist in the local area.

Practical ways to develop the competencies needed to respond to diversity

88 Everyone who provides treatment, care and support has to be able to develop the competencies needed to respond to diversity. I have already mentioned one practical way of helping the workforce to develop these competencies, which is the provision of formal and informal training, mentoring and prevocational training.[2]

89 In addition to this, workers also need supportive supervision to be able to provide care that is responsive to diversity. For example, I'm employed as a contractor. I'm not on a salary, and I don't have any funding to do that sort of educational work, to improve my own competencies. I think our current model doesn't support that ongoing education or supportive supervision particularly well. It's all expected to be individually organised, outside of working hours. The RACGP and other organisations (such as the refugee health networks) do provide some Continuing Professional Development in these areas, but these are all optional opportunities. The GP training providers are also aware of and do reasonably well in this area of education, but there really needs to be lifelong learning here.

Priorities relating to the skills, training and development of healthcare professionals

90 Training in mental health, and gaining the skills to really stop and listen to a patient's narrative—the verbal hints and nuances and non-verbal cues that we are constantly receiving—should be a core part of our training. I think we're only really starting to understand what this could look like. I teach medical students in a subject called Professional Practice at the University of Melbourne. The Department of Medicine recognised that alongside biomedical and traditional clinical skills training, medical

[2] See above at paragraph 86.

professionals need training in communication, close listening, reflective practice and teamwork—from the earliest stages of their medical career and continuing into their professional lives. The course encourages creative thinking and engagement with the medical humanities. I've been really impressed by how receptive the students are to these concepts, when they are taught well, inclusively and with real-life application. It's a new course, developed in response to feedback from students, educators and clinicians over many years, and I really look forward to seeing how it impacts on healthcare practice in our local communities over the coming years.

91 These skills are core to working as a GP. Patients want to be seen and heard, and we need to work collaboratively with them and our colleagues to ensure this. Training needs to start in early university, but it also needs continuous, responsive development throughout pre-vocational and vocational education.

92 We received some mental health training during GP training, but I think many of us felt that there could be more mental health skills training, because what we had was so valuable.

93 I did a couple of inpatient psychiatry terms as a resident medical officer and registrar, which were incredibly useful. Though in retrospect, it would have been really useful to have more exposure to mental health care and psychological strategies for outpatients.

94 I don't think any of my fellow graduates realised just how much mental health work we would be doing as general practitioners. I certainly feel that my colleagues who fellowed at the same time as I did all had a very similar experience of being shocked by the burden of mental health that we were seeing.

The importance of bi-cultural workers

95 The main advantage of having bi-cultural workers is that they're able to explain context and culture in a way that language interpreters can't. Bi-cultural workers see themselves as patient advocates as much as they are interpreters. This means that they can deal with relationships and community, and I think they often save lives because of this.

96 For example, I called an Aboriginal support worker from an Aboriginal housing organisation about a patient who needed to go to hospital and who had significant mental health issues. He was going to lose his leg imminently because of his physical health issues, but for weeks he had been highly resistant to the idea of going to hospital. The Aboriginal worker saved his leg—and possibly his life, because she organised for someone to take care of his dog, and she organised that he would be reunited with his family. She organised all these extra social components that I didn't have the capacity to understand or to engage with him about. She could do this because she understood his context. She and I together were able to convince him to go to hospital. As a result, his

leg was re-vascularised and he didn't need an amputation. I couldn't have done that alone; it was possible because I could connect with a community health worker who was able to support that.

97 The other thing that I think is worth saying is that all roles could benefit from representation from different cultures. From administration to logistical staff to GPs and allied health clinicians—we all benefit when there is representation from diverse backgrounds. Multicultural workplaces can provide real welcome, warmth and sharing of cultural knowledge.

Untapped diversity capability in the broader workforce

98 We should aim to develop cultural competency across our entire workforce. Perhaps it's worth asking all of our staff about what strengths and understanding they have. I think the point has previously been made that our health workforce does not look like *All Saints* or any of those TV programs where people are generally white, tall, handsome and male, with a few token female love interests thrown in. But if you walk into any healthcare setting, you'll see a really diverse group of workers. The majority of healthcare workers around the world are now women. All of us have diversity capability, and by sharing our own experiences, we can really enrich the care we provide.

99 I also think that stories are powerful. I'm currently studying narrative medicine, because I really see that there is opportunity for exploring untold stories. These less-heard narratives can really unlock some of the secrets to why patients appear to be "treatment-resistant" or disengaged. Focussing on narratives can revolutionise the way we understand people's health and wellbeing. They allow us to empathise and care in a way that the standard efficient history-taking and examination skills we learned in medical school do not. I'd love to teach these skills of close listening and engagement to the next generation of health workers.

100 I think those stories are within all of us. It's really important to get stories out there from our patients, from our health workers and colleagues. That's just as important as the kind of quantitative evidence base that a lot of doctors are clued into.

101 The healthcare service that I work at is full of diversity: both our staff (GPs and other clinicians, administration, program workers) and our patients. It's absolutely fantastic. It is an absolute goldmine of rich conversation, education and emerging leaders.

Enablers and barriers to diverse, responsive workforces

102 The barriers to diverse, responsive workforces include:

(a) the lack of multi-disciplinary communication, and therefore lack of awareness of siloed services;

(b) (for GPs specifically) the lack of funding for non-clinical duties, or duties that are not face-to-face clinical contact with patients;

(c) over-stretched community health services, that are catering to the needs of dynamic, complex communities;

(d) high turnover of clinical and leadership staff; and

(e) the systemic biases that we all hold towards people of colour, which prevents us from listening to their experiences and wisdom.

103 The enablers to encouraging diverse, responsive workforces include:

(a) working actively to create inclusive spaces for health workers as well as patients (across cultural or economic background, disability, age or gender identity and personality types);

(b) pouring energy and funds into attracting and retaining high-calibre health workers, and encouraging their growth as workers (this leads to institutional memory and the ability to share journeys); and

(c) making inclusivity a priority across:

(1) recruitment of staff;

(2) supportive supervision;

(3) relationship building within teams;

(4) support for career growth; and

(5) team-building opportunities.

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print name Mariam Tokhi

date 12/05/2020

Dr Mariam Tokhi MBBS (Hons), MPH, DRANZCOG, FRACGP

Education

Fellow of the Royal Australian College of General Practitioners (FRACGP) **Fellowed June 2016**

Completed training in General Practice through the Royal Australian College of General Practice in Melbourne, Australia.

Certification of Professional Achievement in Narrative Medicine **Feb 2020- ongoing**

Online Certificate, Columbia University, New York, USA
Narrative medicine is an interdisciplinary field that brings powerful narrative skills of radical listening and creativity from the humanities and the arts to address the needs of all who seek and deliver healthcare. Narrative medicine enables patients and caregivers to voice their experience, to be heard, to be recognized, and to be valued, improving the delivery of healthcare.

Masters of Public Health **Graduated May 2013**

Johns Hopkins Bloomberg School of Public Health, Baltimore, USA

Graduate studies in Public Health. Concentration in Women's Health.

Completed American Public Health Association Certification in Public Health (CPH)

Diploma of the Royal Australian College of Obstetricians and Gynaecologists **Graduated 2011**

Practical and Theoretical Obstetrics & Gynaecology experience undertaken at Monash Health, Melbourne; written and oral examinations conducted by the Royal Australian New Zealand College of Obstetricians and Gynaecologists

Advanced Life Support Training (ALS) **July 2011, refreshed 2015**

'In-Time' Obstetric Emergency Training **June 2012**

Bachelor of Medicine/ Bachelor of Surgery (Honours) **Graduated 2008**

Monash University, Melbourne, Australia
Awarded The John Desmond Prize (2006)

Undergraduate clinical training undertaken across a variety of health care settings, including metropolitan Melbourne, rural and remote Australia, as well as overseas electives (Sri Lanka; Malaysia)

Victorian Certificate of Education **Graduated 2003**

Professional Experience

University of Melbourne (February 2020- ongoing)

Teaching medical students Professional Practice.

DPV Health Hume (February 2019- ongoing)

General Practitioner at Broadmeadows community health service addressing the needs of an underserviced population, in the heart of a public housing commission area. Working with women, men, children, young people and seniors, Aboriginal and Torres Strait Islander people, and the LGBTIQ community. Providing mental health services, travel medicine, chronic disease care plans, complex needs and disability services.

Pascoe Vale Health (February 2016- September 2019)
General Practitioner at an metropolitan general practice in Pascoe Vale, Victoria. Diverse suburban population.

Gap Rd Medical Centre (September 2017- January 2018)
Fellowed General Practitioner at an outer metropolitan general practice in Sunbury, Victoria. Gap Rd Medical Centre provides much needed services to a rapidly growing population Melbourne's North West.

University of Melbourne/ World Health Organization (June 2018- January 2018)
Research fellow working on WHO (EMRO) commissioned guideline for Child and Adolescent Health in Humanitarian Settings. Researched, wrote and collaborated on humanitarian health guideline for use by clinical and non-clinical health personnel (for government and non-governmental organisations) throughout the Eastern Mediterranean Region.

Pascoe Vale Health (Feb 2016- October 2016)
General Practice Registrar (GPT4) at an inner metropolitan general practice in Pascoe Vale, Victoria. Fellowship of the Royal Australian College of General Practice obtained during this period.

Victorian Aboriginal Health Service (Feb 2015- Jan 2016)
General Practice Registrar (GPT3) Fitzroy. The service addresses the specific healthcare needs of Victorian Indigenous communities.

- Provision of general medical care to Aboriginal patients from diverse backgrounds, including catering to the needs of people facing significant social disadvantage
- Engaged patients with complex medical and psychosocial needs
- Learnt invaluable cross-cultural skills
- Managed complex, acutely unwell medical patients through 'Treatment Room'

Gap Rd Medical Centre (Feb 2015- Jan 2016)
General Practice Registrar (GPT2) at an outer metropolitan general practice in Sunbury, Victoria. Gap Rd Medical Centre provides much needed services to a rapidly growing population Melbourne's North West.

- Worked with a population facing numerous barriers to specialist health services
- Cemented understanding of Medicare services and logistics
- Excellent general practice procedural skills training

Burnet Institute (Feb 2014-Jan 2015)
Women's & Children's Health Officer (0.5 EFT) at the Centre for International Health, conducting research in Women's and Newborn Health to strengthen the knowledge base and program practice about Male Involvement in Maternal and Neonatal Health, Healthy Ageing, Menstrual Hygiene Management amongst adolescents in low resource settings. Duties included research, development and teaching for Masters of Public Health Students.

Summit Medical Group (Feb 2014- Jan 2015)
General Practice Registrar (GPT1) at busy urban general practice in Melbourne, Victoria. The clinic prides itself on high quality healthcare provision across the life course.

- Worked with a diverse urban population across a range of medical conditions
- Developed excellent GP organizational skills for follow-up and continuity of care
- Developed a solid base of psychological strategies in General Practice

Medical Registrar **July 2013- Feb 2014**
The Alfred Hospital

Alfred Health is the main provider of health services to people living in the inner southeast suburbs of Melbourne and a major provider of specialist statewide services. These services are provided across the continuum of care from ambulatory, to inpatient and home and community based services.

- Provision of psychiatry and general medical inpatients services as a registrar, with a team of medical and allied health staff – Psychiatry and General Medical rotations

Developed excellent acute mental health clinical assessment and management skills

Managed complex, acutely unwell medical patients requiring hospitalisation

Undertook a leadership role: supervising junior doctors and medical students

Public Health Communications Intern **2012-2013**
Jhpiego

Jhpiego is an international, non-profit health organization affiliated with Johns Hopkins University. For more than 35 years and in over 150 countries, Jhpiego has worked to prevent the needless deaths of women and their families. Jhpiego works with health experts, governments and community leaders to provide high-quality health care for their people.

Infographic Communications Project - collaborating with experts, graphic design and social media representatives, researching and designing health communications to translate Jhpiego's research for lay people.

Global Health Gateway www.globalhealthgateway.org.au **2009-2014**

Jobs and Volunteer Coordinator
Founding member

The Global Health Gateway is an online network connecting interested Australian/NZ health professionals with global-health related ideas, events, work, study and volunteer opportunities. As well as delivering Global Health resources and information, it also fosters a community between individuals and organizations who are interested in Global Health.

Designed and helped build online portal for global health workers (launched at AMREP World Health Day Conference 2010)

Co-ordination of content (involving editing and some original writing, and coordination of writing team): Global Health blog, interviews, reviews and original articles

Facilitated links between the Global Health Gateway and its major partners and global health institutions (Burnet Institute, Nossal Institute, Australian Youth Ambassadors for Development, AUSAID, Australian Volunteers International, Monash University)

Recruitment, coordination and mentoring of new volunteers

Obstetric Registrar (Maternal Health) **2012**
Alice Springs Hospital/ Northern Territory Department of Health & Families

Alice Springs Hospital provides clinical and public health services to the largest catchment area in Australia spanning >1,000,000 sq. kilometers. Clinicians are required to have broad clinical skills, excellent communication skills, a working knowledge of the prevalent public health issues, as well as Indigenous cultural awareness.

Provision of clinical obstetric healthcare (antenatal, birth, and post-natal) care to a predominantly Indigenous Australian population.

Participation in research and clinical auditing of maternal healthcare provision and outcomes in Central Australia

Developed working understanding of public health issues relating to provision of maternal/child healthcare provision in remote areas (presentations and

Undertook teaching of post-graduate Flinders University medical students

Developed operative obstetric management skills (Caesarean-sections, instrumental delivery) - ongoing

Internal Medicine Registrar (Adult Medicine) **2011**
Alice Springs Hospital/ Northern Territory Department of Health & Families

Provision of inpatient and outpatient care to Central Australia particular emphasis on Remote and Indigenous health

Experience in management of high acuity adult medicine, with particular region-specific morbidity (rheumatic fever, cardiomyopathy, end-stage renal failure on haemodialysis, severe bronchiectasis, chronic liver disease)

Experience in management of acute resuscitation and arrest calls. Attained certificate in Advanced Life Support

Teaching and supervision of Interns, Resident Medical Officers, as well as Flinders University post-graduate medical students

Participated in research and clinical auditing relating internal medicine.

Residency & Internship **2009-10**
Southern Health, Melbourne, Victoria

Southern Health is Victoria's largest public health service, undertaking care across the lifespan from pre-birth to the aged. Southern Health serves a remarkably diverse community, with a large refugee and immigrant population. The network is comprised of 7 teaching hospitals, affiliated with Monash University, and has a strong research and academic focus.

Clinical work across a number of medical specialties:
Paediatrics, Adult Medicine, Geriatrics, Adult Psychiatry, Obstetrics & Gynaecology (including completion of DRANZCOG), Emergency Medicine, General Surgery

Work in rural and metropolitan clinical settings- rotations to rural Victoria

Research and medical audits

Teaching of junior medical students through the Monash Rural Clinical School and the Southern Clinical School

Creative Nonfiction & Essays - Health

- *Female GPs now outnumber male GPs — but barriers remain in mentorship and support,* ABC Online, 2020
- *My patients don't separate their physical mental health. Medicare must stop asking us to,* The Guardian, 2020
- *On Heatwaves and Unlikely Friendships,* Life in the Fast Lane Literary Medicine, 2019
- *Slow Medicine and Listening to the Patient Saves Lives,* Sydney Morning Herald, 2019
- *I have grappled with belonging in white Australia- naively I didn't think my kids would too,* The Guardian, 2019
- Remembering fallen war heroes is insincere if it excludes those suffering today, The Guardian, 2017
- *A tax on disease will hit us all,* The Conversation, 2014

Research Publications

- Tokhi M., Graham H., (2018), *Child and Adolescent Health in Humanitarian Settings: a field guide, for WHO EMRO Press*
- Tokhi M, Comrie-Thomson L, Davis J, Portela A, Chersich M, Luchters S (2018) *Involving men to improve maternal and newborn health: A systematic review of the effectiveness of interventions.* PLoS ONE 13(1): e0191620. https://doi.org/10.1371/journal.pone.0191620
- Tokhi M., Graham.H et al., (2014*) Clinical Guidelines: Perception and Use in Afghan Paediatric and Obstetric Hospitals.* WHO Eastern Mediterannean Health Journal, Cairo, Egypt.
- Tokhi, Mariam et al. "Challenging gender inequity through male involvement in maternal and newborn health: critical assessment of an emerging evidence base." Culture, health & sexuality vol. 17 Suppl 2,sup2 (2015): S177-89. doi:10.1080/13691058.2015.1053412
- Wilson, A., Tokhi, M, et al. (2018), Big Formula follows Big Tobacco playbook, MJA Insight Plus, Issue 28, 23

- July 2018Tokhi M., Graham.H et al., (2013*) Clinical Guidelines: Perception and Use in Afghan Paediatric and Obstetric Hospitals,* Abstract accepted for Presentation at The International Society for Quality in Health Care, Edinburgh
- Tokhi M., Theilhaber M., Wilson G, Cheng W., (2011) *Case Report: Haemolytic Uraemic Syndrome in Child with Empyema,* Monash Childrens. Abstract presented at Southern Health Research Week., Melbourne Australia
- New. G., Tokhi. M. et al., (2008) *Safety and Efficacy of Elective and Emergent Percutaneous Intervention With Off-Site Surgical Services,* Melbourne, Australia
- New. G., Tokhi M. et al., Melbourne Intervention Group, (2008) *Clinical Outcomes Of In-house and Transferred Patients After Primary PCI At A Tertiary Centre With Off-Site Surgical Back-up.*, Melbourne, Australia. Presented at Cardiac Society of Australia and New Zealand annual scientific meeting in August 2008 in Adelaide.
- Tokhi, M., Marovic, P., (2007) *A Health Needs Analysis of People Experiencing Homelessness: Clients of Wesley Eastern Homeless Crisis Service (WEHCS).* Published by Wesley Mission Victoria.