EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO THE ROLE OF DIET IN TYPE 2 DIABETES PREVENTION AND MANAGEMENT

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 21 November 2018

SESSION ONE

Members

Ms J.M. Freeman (Chair)
Mr W.R. Marmion (Deputy Chair)
Ms J. Farrer
Mr R.S. Love
Ms S.E. Winton

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Hearing commenced at 10.21 am

Ms CAROL ROLSTON
Clinical Psychologist, Western Surgical Health, Advance Surgical, examined:

The CHAIR: On behalf of the committee, I would like to thank you for agreeing to appear today to provide evidence in relation to the committee's inquiry into the role of diet in type 2 diabetes prevention and management. As I said, I am Janine Freeman; I am the Chair of the Education and Health Standing Committee. On my right is Bill Marmion, the Deputy Chair; Josie Farrer; Shane Love in the corner; and Sabine Winton. These are our research officers, Sarah and Jovita—you may have spoken to them before; and Hansard. It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. It is not so contentious in this particular area, but your evidence is protected by parliamentary privilege. However, this privilege does not apply to anything that you might say outside of today's proceedings, so, if you go outside and give media on this.

Before we begin today, do you have any questions about your attendance here?

Ms Rolston: No.

The CHAIR: Did you want to make a brief opening statement or shall we just go straight into questions?

Ms Rolston: I guess I should give a brief opening statement. My role is essentially one as a clinician. Whilst I was quite heavily involved in research about 10 years ago, and I think this is particularly where my involvement with Diabetes WA came in and my knowledge around that, I have moved away from research in the last few years. My role now is pretty much as a clinician, particularly focusing on people who are pursuing bariatric surgery—I work for several surgeons involved in the delivery of the surgery—because overall as a treatment, it is very effective. That is where again diabetes fits into it, because we know that bariatric surgery provides pretty dramatic, immediate results in terms of resolution or improvement in diabetes.

The CHAIR: When you say you are involved in preparing them for the bariatric surgery, do you also work with them post the surgery as well?

Ms Rolston: I do, Janine, yes; that is right.

The CHAIR: In preparing them for the bariatric surgery, do you have any role in saying to the clinician, "No, this person is not suitable for bariatric surgery"?

Ms Rolston: Definitely.

The CHAIR: What would make a person not suitable for bariatric surgery?

Ms Rolston: In terms of the surgery population, one thing to point out at the start is about 50 per cent of the people that we see will have a lifetime history of what we would call an Axis I disorder—depression, anxiety, the range of psychiatric illnesses. Up to 50 per cent of the people that we would see would have that history, and at any time 25 per cent of the people that I see in the pre-op period would be on some form of medication for their mental health issues. To answer your question, the type of things I would be looking at would be if their mental health condition is not adequately managed, whether it is a medication issue or regarding the support that is in place in terms of a psychiatrist, psychologist, that sort of thing. That would be one. Things like active substance abuse; if it is a substance abuse problem that is —

The CHAIR: So alcohol, cigarettes?

Ms Rolston: Alcohol or other substances. Cigarettes, not so much in terms of substance abuse, but certainly if someone is a smoker, it does impact quite dramatically on their wound healing and all that sort of stuff. Pretty much every surgeon would say, "If you are a smoker, I am not going to do surgery on you." That would be a given. It is less seen as a substance abuse problem and probably more as a threat to their recovery post-op. Substance abuse, active psychosis—again that comes back to the mental health issues. If someone experiences psychotic episodes, if there perhaps had been some suicide attempt in the previous 12 months, or a psychiatric hospitalisation would be another reason why we would want to—what we are really looking for is stability in people's functioning as well as the fact that they have really good support in place, whether that is from mental health professionals or, more broadly, people who have really good social support tend to do best with something like that. That also goes for diet and the use of more conservative means of reducing weight.

The CHAIR: Studies such as the MILES–Australia survey, which I understand is Management and Impact for Long-term Empowerment and Success studies, show that people with type 2 diabetes who are insulin dependent fare worst in terms of psychological and emotional wellbeing. Has that been your experience? Do you want to talk about that experience and the difference between insulin-dependent and non–insulin-dependent type 2 diabetics in terms of the psychosocial aspects of their disease?

Ms Rolston: I could not really comment specifically on the type 2 diabetes because, with the work that I do, diabetes is very much part of the mix for a lot of patients. Sorry; can you just go back and repeat that? I got lost in the fact that I do not have that specific —

The CHAIR: Yes. Studies such as MILES–Australia show that people with type 2 diabetes who are insulin dependent fare the worst in terms of psychological and emotional wellbeing. Has that been your experience? If yes, why do you think there is a difference between insulin-dependent and non–insulin-dependent type 2 diabetics in terms of their emotional and psychological wellbeing?

Ms Rolston: I could not give a definitive answer on why without looking at the literature around that, but I would suggest that perhaps with insulin dependency, in terms of having injections and all that stuff, the sense of empowerment or sense of control and management is really important in terms of self-esteem and that sort of thing. Often for the obese population, particularly the people that I see prior to surgery, see surgery as the end point. They see it as the ultimate failure. They have often come with a long history of being stigmatised and there are often issues of depression and anxiety mixed up with that. It may well relate to the fact that to be insulin dependent, that is kind of an end point and it may well be that, "I've failed every other means of managing my diabetes and I'm now at this point." It may well be that that is part of it, but again that is probably just an educated guess rather than based on the literature.

[10.30 am]

The CHAIR: Yes, but that is a really interesting point, is it not? What you are saying is when people come to have the surgery, they often see it as being as a failure and not as a new opportunity?

Ms Rolston: Absolutely.

The CHAIR: How do you change that way of someone thinking about it?

Ms Rolston: Okay. One of the realities that we face now is that surgery works; it is the best option we have for sustainable weight loss. That is part of it. It is about recognising the person's, I suppose, strength or knowledge to come forward and say, "You know what? I've tried everything else; I've tried diets and exercise and all of those things. Nothing's worked for me. I am now at a point

where"—for most people it is driven by health and they do not have any options left. Part of it is about saying to them, "Look, this is a solution that we offer that does work; however, it only works when you are able to make all the other changes to support a good treatment outcome." So it is an active —

The CHAIR: Yes, they still have to do all of those other things that have not worked.

Ms Rolston: Absolutely, absolutely right.

The CHAIR: So, to say to someone, "Surgery works", it assists you to be able to succeed in all those other things you have tried, really. That is a different thing, is it not?

Ms Rolston: That is it, yes. It is the best option that we have in terms of resolving a lot of those health issues. We know that it works, but to a point. Even with surgery there will be sort of 20 per cent of people who will not succeed with it, but it is that sense of empowerment.

The CHAIR: How do they not succeed? They just go back to eating habits and stretch their stomach?

Ms Rolston: Probably less stretching the stomach—that is maybe about a 10 per cent thing. It is about, yes, eating the wrong foods.

The CHAIR: Consuming high-energy foods, yes.

Ms Rolston: Unfortunately, with having surgery, things that are energy dense—such as the chocolates, the chips, high fat, low nutrient–value foods—are actually really easy to consume. Whereas a big part of that lead-in, the work that I do with people, and postoperatively as well, is about making time to eat, making good food choices, sitting down eating mindfully, not eating as a result of emotion, or whether there are any eating disorders sort of pathology there as well.

The CHAIR: How do you change all of that?

Ms Rolston: It is, and that is exactly right.

The CHAIR: I mean, all of us eat on the run or eat because it is comfort food.

Ms Rolston: Yes, exactly right. That is part of that pre-op assessment. As part of some of the stuff I brought today, which I thought I could perhaps leave with you, there is one which is a PowerPoint presentation that I do for surgeons as well. It is about the identification of all of those things, right from the start of a family history of obesity, because we know that certain things are environmental, that certain things are genetic, and it is teasing apart those things that a person can do to help with weight managements but there are other things that they cannot. So, we go back and work through all these sorts of factors, but identifying importantly all those things we can change, whether that is through psychoeducation or things that I will get them to practice prior to —

The CHAIR: Do you do CBT or ACT?

Ms Rolston: Yes, all of that. Predominantly CBT because that really still is the gold standard treatment. About 10 years ago—and I brought this to leave with you as well—I was involved in a research project with Diabetes WA and I worked with Sophie McGough and we presented a weight management program which is a group program delivered over 12 weeks, predominantly looking at making those behavioural changes but also with a CBT side of things too.

The CHAIR: The CBT that you teach, has that got a mindfulness and meditation aspect to it?

Ms Rolston: That aspect to it as well, yes, absolutely.

The CHAIR: Yes. So you actively teach people to —

Mr W.R. MARMION: What is CBT?

The CHAIR: Cognitive based therapy, sorry.

Ms Rolston: Yes.

Mr W.R. MARMION: CBT.

The CHAIR: It is Jon Kabat-Zinn, yes, the one that you teach?

Ms Rolston: That is mindfulness, yes. He is the guru I suppose.

The CHAIR: Yes, but the cognitive based therapy that you teach people—you were talking about mindful eating.

Ms Rolston: Yes.

The CHAIR: Does that set them a regular meditation practice?

Ms Rolston: Yes, that is the ideal scenario. What we are looking at there is those people for whom stress, emotional eating, all of that sort of stuff, is part of the mix. Part of that is treated in terms of the CBT stuff, but the mindfulness stuff can help them to tap into what the experience is that they are having. Whether it is emotional, whether it is stress, whatever that is, and learn to ride it through by anchoring themselves in the present moment knowing that whatever it is they are experiencing is actually going to pass. So it is really upskilling people. I guess, getting back to that original point about in terms of the pre-op and the stuff that I do with people, it is really that element of empowerment. You know, talking about being injected, having the insulin injections, with people it is like, "I have to do this, this is all I've got, this is what keeps me able to function every day" as opposed to a more active approach, which is really what the CBT/mindfulness is. It is about upskilling and that sense of people having a feeling of empowerment and being master of their own destiny to an extent.

The CHAIR: Being able to make choices.

Ms Rolston: Yes, absolutely, but with those choices —

The CHAIR: Knowing that they are choices.

Ms Rolston: — knowing what those are. So that is where the behavioural part of the CBT comes in. That might be about slowing down the speed of eating. How do you do that? Whether it is with a gadget or whether it is counting the number of chews you do, putting down your knife and fork between mouthfuls, making sure that you are in that calm state prior to eating that you are not distracted by the TV or mobile phones and all of that. There is a behavioural element to it, and obviously exercise and all that fits into that too. Then there is the cognitive stuff, and that is where we would also start to perhaps get people to do things like keep thought diaries where we are looking then at them identifying those vulnerabilities. So we actually get them over a period—constantly actually, over the group therapy program—to jot down when they are eating, where they were when they ate, what was going on, you know.

The CHAIR: Is that about establishing what habits they have?

Ms Rolston: Yes, yes. And so the difference between a normal food diary and the psychologist's diary, if you like, is identifying what is going on for the person. A picture starts to emerge which is unique to that individual. From that pattern we can then more accurately address what it is that this person actually needs and involve them in that process of identifying those vulnerable times. If you know, for instance, that, "I get" —

The CHAIR: How do they counter food marketing then? Because that is the thing that —

Ms Rolston: It is incredibly difficult.

The CHAIR: Especially food marketing that tells them that they will be happy if they eat this.

Ms Rolston: Yes, exactly, absolutely. I guess this is where it comes back to readiness to change. One of the first things we do as part of the weight management program is to look at, "Am I in that stage of change where I really want to make changes?" This is where, in terms of the diabetes stuff, the pros and cons of making those changes, knowing that, "These foods are not helpful for me, they might be sometimes foods, but again they might be foods that I only eat when I'm with somebody else" because that significantly reduces the risk of bingeing and stuff, which we know predominantly happens when people are on their own. It is identifying all those high risk situations, sitting down watching TV at night and between 6 and 9 you have got all those food ads and all that sort of stuff. It might be that, you know, if that is when a particular show is on, "I might watch it on iView instead" or, "I've had my dinner first, cleaned my teeth, then I sit down and watch my show". Those sorts of things can actually help.

[10.40 am]

The CHAIR: So they are changing behaviours in terms of habits and stuff like that?

Ms Rolston: Yes.

The CHAIR: In your experience, have you worked with people who have come in to do bariatric surgery and the psychological assistance you have done through cognitive based therapy has assisted them enough to think that they can control what they—you know, "I've tried everything, I can't do it, I've tried everything". When they say that, have they tried cognitive based therapy?

Ms Rolston: Yes.

The CHAIR: Have they tried that previously?

Ms Rolston: That is something that I do go into for a couple of reasons. We want people to be able to demonstrate their inability to lose weight by other means because surgery carries risks with it and it is expensive and all of that sort of stuff. If someone goes, "Oh, I've got 20 kilos to lose. I'm not going to bother with diet. I'll just go and have surgery", then that is not how it works. We actually want people to be able to demonstrate not just that they have been on diets, but how long they have been on that diet for, what the outcome was and what was the reason it did not succeed for them so that we can actually start to identify some of those factors. Again, it is about then tailoring the treatment for the individual and what they need, because even with surgery, as I said, 20 per cent of people are not successful with it, and particularly with the first six months. We call that the honeymoon phase in surgery because things are new: "I'm losing weight. I'm feeling great about myself"—and all of that stuff—"People are telling me I look great. I'm motivated." Then after that time it is kind of like: "This is the new normal." Life then gets in the way: "My job is stressful"—and this and that. That is where unless we have provided or identified early on what those deficiencies are in their skills, people will revert back to using those coping strategies that they previously used. For a lot of people, that is where food comes into it. Again, the high fat, high sugar foods give us that dopamine hit and we can revert back to food serving that function for the individual.

The CHAIR: In terms of preventing people becoming diabetic or pre-diabetic, would they be given psychiatric or psychological assistance through the public health system so that they—do you know if that occurs currently?

Ms Rolston: This study that we were doing about 10 years ago with Diabetes WA was really about trialling that. Unfortunately, my colleague had never actually written it up as a publication—it is going back quite a few years ago. But I ran a couple of groups over six months and it was great. The background to it was actually an individual therapy that was developed by Chris Fairburn who is a professor at Oxford Uni. He was using it for the treatment of eating disorders. From that, Sue Byrne

from UWA—she actually did her second PhD with Chris—came back and said, "Look, I'm going to modify this as a group program." So we were then running it as part of a research project at UWA and then, through that, at Diabetes WA. Anyway, I ran a couple of the groups there but unfortunately I have not got a publication to show you and Emma Dove, who I was involved with, was going to try and get me the analysis as a result. But certainly I can tell you that to do a group with a psychologist and a dietitian, in this case it was Sophie McGough, worked really, really well. It is exactly the sort of gold-standard weight management program and it was great because it is also about that group dynamic. It is not just presenting the information and all the things associated with getting people's weight down, but it is that group dynamic and normalising things as well. Each week we would go around and review the week that has been for people and —

The CHAIR: Is that why Weight Watchers is so successful?

Ms Rolston: It is, but imagine Weight Watchers with the element of all the psychological stuff as well. It is all the things like how to manage emotional and stress eating and addressing issues like body image, because if someone has a poor body image it is really difficult to keep them motivated. How do we get them to engage in exercise? How do we get them to monitor what it is that they are eating, to identifying things and to get them to weigh once a week? Again, people are often what we call avoiders or checkers. They are either constantly on the scales, maybe multiple times a day, or they avoid it all together. What we get people to do is we get them to weigh themselves once a week and then not just get the number but actually review the week that has been. This would be where they have a look at their monitoring records and think, "Oh, actually I did three extra walks that week." If they have gained weight they might say, "Oh, I ate out a couple of times. I had alcohol a couple of times." A pattern emerges that is unique to the individual and then the psychologist helps them put the pieces of the puzzle together. Ultimately, they get this idea of what are the things that impact on their weight. I should say that with this program too it is not just about weight loss. It is a discreet nine weeks of weight loss and then we get people to stop losing weight: "No more. We don't want you to lose any more weight." We lock in the weight that they have achieved and then we get them over the next two weeks to maintain their weight within a kilo and a half of that point. Again, they are starting to add in, it might be a little bit more food, it might be whatever it is, and for the next three months, we basically get them to maintain their weight within that kilo and a half either side. We do that successfully and then we can then launch into another period of weight loss.

The CHAIR: And that is the one that you do currently or that is the one you did with Diabetes WA?

Ms Rolston: That is the one I did with Diabetes WA.

The CHAIR: And currently now with bariatric surgery you just go from getting people prepared for the surgery and saying if they are not capable, and then surgery and then working with them when they go through the massive weight loss. Do you do the same thing: get them to plateau and normalise their weight and then go again?

Ms Rolston: No, that is quite different. As I said, this was kind of going back a decade or so now, but still a lot of the stuff that we do with weight management is actually part of the same sort of CBT because that is actually the gold standard. A lot of those elements form part of—

The CHAIR: Do you know if that psychological aspect of looking at diabetes is used in a broader sense in the public health system?

Ms Rolston: I am not aware because in terms of my exposure to diabetes now, it is really just for those patients that I see. But certainly from doing the groups with Diabetes WA, we noticed that, because they were monitoring their blood sugars and stuff as they went through, even with a

three per cent weight loss—that is not a lot. For a 100-kilo person you think that three kilos does not sound like much at all, but it is actually quite significant in terms of the impact on their blood glucose levels. We are not talking major stuff here. The goal with this particular program in that 12-week period is that people would lose somewhere between five and 10 per cent. Certainly, something like this, the weight management groups that I have been involved with, would be —

The CHAIR: Do you know of any other research around it? I would have thought that given mindfulness is the groovy thing that everyone is doing at the moment—you cannot turn around without someone not talking about mindfulness—there must have been some research in other countries around cognitive based therapy and mindfulness training and diabetes. Do you know of any other —

Ms Rolston: I do not Janine. Certainly, I could do some stuff for you and put something together.

[10.50 am]

The CHAIR: If you would that would be fantastic. That would be good because, obviously, that is the technique that is being used and it has been around for 20-odd years, cognitive based therapy.

Ms Rolston: Yes, absolutely, even longer. We are talking going back to, really, the 70s when it really started, and then mindfulness is what we call the third wave. CBT with the addition of mindfulness is pretty much where things are at now and both of those elements form what these weight management programs are based around.

Ms S.E. WINTON: I noticed talking earlier about how patients have a variety of issues or things that you consider, and you talked about substance abuse. That led me to my favourite topic of addiction again. Is there a link with addictive kind of behaviours or the kinds of people you are seeing with obesity?

Ms Rolston: Yes. Often, Sabine, it can be found in terms of eating disorders as well. It is where we see those personalities or characteristics, if you like, with things like binge eating disorders, for instance. With bulimia there definitely is that overlap there. There are definitely those sorts of personality factors in the mix. Again, this is kind of getting at what is the function that food is serving for the person in the same way as what is the role of that substance that they are using. For instance, when people are binge eating they are typically alone and they will eat really quickly. The type of foods that they eat are high in fat and high in sugar, which again creates that kind of neurochemical buzz, if you like, in a similar way. In fact, Roger Paterson at Hollywood, likes to see binge eating and kind of frames—as a psychiatrist he sort of sees that close link between addiction and—well not so much. He actually looks at binge eating disorder within that sort of frame of addiction. We do not and the literature does not support it but that is what Roger does.

The CHAIR: But the literature does not support it as being an addiction but there would be some debate, especially for binge eaters or people with eating disorders, be they not eating or eating too much, as a psychiatric issue, yes?

Ms Rolston: Yes. Binge eating disorder is actually classified as a psychiatric illness along with bulimia and anorexia nervosa. That is in that mix.

The CHAIR: So it is less to do with that idea of it being addictive like with alcohol, other substances or cigarettes, and more to do with a psychological dependence on being able to control something or getting out of control with something.

Ms Rolston: Yes, it is more seeing it as a way of coping whether it is in response to a level of distress or emotion such as the inability to regulate emotion effectively or, “I’ve just had a crappy day. I’m going to go home and I’m going to—

The CHAIR: Eat comfort food.

Ms Rolston: Yes. People actually plan binges and plan for that because they are feeling a level of distress and that, for a short period of time, is almost like going into a trance-like state. There is definitely those personality links. If you wanted to do it really well, there is evidence from a fairly extensive personality inventory and we can actually pick up on those sorts of things. If you wanted to have a sense of who is going to struggle, we have measures that we can use to say, "Look, this person is going to find things a bit more difficult than this person." There is definitely that overlap.

Ms S.E. WINTON: That is what put them in that position in the first place.

Ms Rolston: Yes, exactly right. As a psychologist, my thing would be about, again, that sense of upskilling people so that their coping mechanisms, if you like, and their repertoire of skills that they can call on is the first step that they would take rather than eating, or for somebody using alcohol or other drugs as a way of coping with whatever is going on.

The CHAIR: How do you counter the food industry and the marketing of food that tells us that if we eat this ice cream then life is going to be much more pleasant for us, or if we snack on these chips and a beer, then we will be able to relax and stuff like that. How do you deal with that in your therapy sessions in terms of that aspect of things?

Ms Rolston: That would probably be more around when I talk about that monitoring-in-diary stuff. The vast majority of people would feel worse after a binge. It is building up that evidence base for the person: "I had that really stressful day at work and then I went and pigged out on some chocolates and chips and got my UberEATS and all the rest of it and then I actually felt so sick, I wanted to puke." That sort of thing. It is helping the person to say, "You know what? That actually didn't make me feel better about things. It didn't make all of that stuff go away." It is helping the person build up their own evidence base: "That's not going to work. I get that this is how these things are marketed to me but that doesn't solve my problems." That would probably be the approach that I would take.

Mr R.S. LOVE: You talked about the types of personality where someone may plan to go and eat or order some sort of food. That does not sound like that is being triggered by an advertisement in a newspaper or on the television for a particular ice cream or a hamburger or whatever. That is something completely different. I am sort of struggling to see how you can attribute advertising to those types of behavioural activities. They might go home and eat white bread—I do not know. But it seems to me to conflate advertising with a bit of planning behaviour like that. It does not make any sense.

Ms Rolston: Yes, I agree. It is more about talking about the vulnerabilities if someone is vulnerable to—with advertising generally, they are sort of separate issues, if you like. With the marketing side of things and if somebody is particularly vulnerable to those sorts of binges or eating those sorts of foods, obviously—"I know that if I have had a bad day, if I sit down in front of the tele and see all that food advertising, that's going to make me vulnerable to wanting to get on the phone and order some food." In that sense, I suppose the advertising started in individuals, but again, the binge eating side of things is really quite a separate thing. The person is going to binge eat regardless of what ads are on the tele, pretty much. Those ads on tele would be a trigger for eating.

Mr W.R. MARMION: I have a system question. Say that I am the client. I am overweight. I might have been sexually abused as a kid or something like that. Whatever has gone on, I am fat. How does the system work? There is a clinical psychologist and there are all sorts of other psychologists. There are other types of—what are they called? The other ones that do not get funded by Medicare, and then you have Roger Paterson who charges like a wounded bull. What do I do? How do I find

my way through the system? How does it work? Who is going to look after me and tell me what I need to do and guide me through the system? Then I end up having bariatric surgery. I am absolutely lost even if I have someone who knows the system.

[11.00 am]

Ms Rolston: Yes. For instance, somebody might go to the GP and they get a referral to a clinical psych who works within this area. That would be a good start. It might be that the doctor has identified the fact that the person's depression is a big part of why they are struggling to manage their weight. The referral to a psych under the Better Access initiative would be a good step, I guess. That is how that would work. Reflecting on doing this program years ago and the benefit of group therapy with something like Diabetes WA, I see real strength in that. That is where, again, there can be cover under the Better Access initiative for group therapy, making it more affordable to do something where it is actually really focused around the specific needs of individuals who have type 2 diabetes or are in that pre-diabetic stage, I suppose. GPs are really the gatekeepers and unless your GP has good knowledge of the clinical psychs out there that are doing this sort of work, they sometimes manage it themselves but —

Mr W.R. MARMION: The follow-on question is the cost. Who is paying for all the different things? If the GP is switched on and Diabetes WA has coached them or whatever and they know a bit of an idea of where to head to and send you to the right people, who pays for all that and are there limits on what you get?

Ms Rolston: Yes. I will put my work to the side for a moment because the way that I work is that I will see people postoperatively to provide that support under a mental health care plan but I bulk-bill because, for me, it is about providing the support to people.

The CHAIR: There are six postoperative sessions you can do under a mental health plan?

Ms Rolston: Yes, that is right.

The CHAIR: And they can get that extended to another six within the same 12 months?

Ms Rolston: Another four.

The CHAIR: You can get 10 in a year, can you not?

Ms Rolston: Yes, that is right. Yes, that would be a good thing. For my patients that is what I would do, but again, like you said, Bill, you front up at the GP, "I need help, my diabetes management" — whatever. It would then be the GP would say, "Look, I'll check it out, I've got half a dozen psychologists that I can refer you to, I'll write up a plan", so of course they need that longer appointment. I think GPs charge about $180 for that longer session to outline what the goals of the therapy are. They send that off, the person sees the clin psych and they go through a treatment. Yes, so that is pretty much it. Then that will just be ongoing.

The CHAIR: Can I just ask you: one of the pieces of evidence that we have been given previously is that people who have been sexually abused can often have weight issues in terms of that.

Ms Rolston: Yes.

The CHAIR: In your experience, is bariatric surgery a good option for them in terms of that, or you have to deal with other stuff first?

Ms Rolston: Yes, I think that is where the role of the psychologist really comes to the forefront, because I would estimate that around 25 per cent of people that I would see have been sexually abused. Sometimes there is other abuse going on with that as well, but 25 per cent are sexually abused. On top of that you have got—whether it is being exposed to domestic violence and all other

sorts of trauma and stuff as well. So this is where, again, food is serving some sort of function for you. Say, for instance, in terms of those significant relationships that you did not have, whether the people closest to you, your mother or father or whatever, you were not getting from them what you needed, or it was a betrayal of trust or whatever. Food is that comfort; food is comforting for people. It is not just those neurochemical changes, it is also the action of just chewing actually reduces anxiety. So food becomes very much a part of how you cope, how you zone out from those painful feelings and all of that sort of stuff. That is an area where you really need to develop those coping strategies. That is where, in terms of the pre-op assessment, checking in on whether there has been sexual, physical, verbal, emotional abuse is really important, because we know that that is an issue.

The CHAIR: Thank you for that. Thank you so much. That was really great.

Ms J. FARRER: Yes, thank you.

Ms Rolston: My pleasure.

The CHAIR: It was very interesting to see how you have to develop your clinical expertise in this area and we appreciated it.

Ms Rolston: Sure.

The CHAIR: You have got some information to give us?

Ms Rolston: I have, yes.

The CHAIR: We are really appreciative of information. The slides that you give will be handy. You haven't got a slide there of the operation? One of the previous witnesses gave us a slide of the whole bariatric surgery.

Ms Rolston: Was that Jeff Hamdorf?

The CHAIR: Yes.

Ms Rolston: Yes. Well, again, this is a PowerPoint as slides, but it really does I think encapsulate what it is that we do. This has actually got a lot of my scribbly notes in it, but that is actually the group program that I did for type 2 diabetes. This is just a little sheet that I use to guide the interview that I do with patients as well.

The CHAIR: Thank you very much.

Hearing concluded at 11.07 am

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