Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF DR CAROLINE JOHNSON

I, Dr Caroline Johnson, General Practitioner, of 174 Union Road, Surrey Hills, 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.

Please outline your relevant background including qualifications, relevant experience and provide a copy of your current CV.

2 I am a general practitioner at Surrey Hills Medical Centre. I have worked there since 1997, and have worked as a GP since 1993.

3 I am also a Senior Lecturer in the Department of General Practice at the University of Melbourne, and a Medical Educator with EV GP Training.

4 I hold a Bachelor of Medicine, Bachelor of Surgery, Graduate Certificate in University Training and a Doctor of Philosophy from the University of Melbourne. I am a Fellow of the Royal Australian College of General Practitioners (**RACGP**), and a member of the Australasian Association for Academic Primary Care.

5 I regularly act as a RACGP representative on various committees and advisory groups, and for about 13 years I was on RACGP's quality care committee.

6 In the past, I have held various medical educator and academic roles. I have also previously been involved in the development of the RACGP mental health curriculum and continue to be involved in the coordination and delivery of mental health skills training for GP registrars at EV GP Training.

7 In 2015, I completed my PhD in the area of primary mental health care. My topic was the monitoring of people experiencing depression in the general practice setting. As part of this, I explored the views and experiences of GPs, their patients with depression and the patients' nominated carers regarding how depression is monitored in the primary care setting.

Please describe your current role and responsibilities in dealing with patients with mental health issues at the Surrey Hills Medical Centre.

8 I work as a GP at Surrey Hills Medical Centre on average two days a week. I have lived in Surrey Hills for most of my life.

9 I see patients for all types of medical issues, but I have a special interest in mental health. Many of the patients I see have a broad range of psychological problems.

10 I like to treat my patients holistically – I'm not just focussed on diagnosing diseases. I focus on patient-centred care, or relationship-centred care. I take into account the wishes and perspectives of the patient, but also consider things like the health needs of the population. An alternative to this would be care that is health provider-centric. This is sometimes the type of care that a person gets in accessing secondary or tertiary care – the system offers the type of care, and the patient takes it or leaves it.

Please describe your current role and responsibilities in your work in mental health advocacy, including through the Royal Australian College of General Practitioners.

11 Most of my mental health advocacy is largely done through two means: through government committees or advisory groups, and through training of medical students and registrars.

Committees and advisory groups

12 I often sit on committees or advisory groups, often as the RACGP representative, to provide a voice of General Practice when needed. Most of the committees are Commonwealth committees. I've been doing this work for a long time.

13 For example, in 2018, I was an independent GP representative on two of the Medicare Benefits Schedule (**MBS**) taskforce sub-committees, pertaining to MBS mental health item numbers and MBS psychiatry item numbers. In these committees, we provided advice to the taskforce on how the MBS might be restructured to provide better value care for people with mental health conditions.

14 I am currently the RACGP representative on the National Assessment, Triage and Referral project's Expert Advisory Group, which provides guidance to Primary Health Networks about how to determine the right pathways for people accessing mental health care via these networks.

15 I am also the RACGP representative on the Equally Well Implementation Committee, which is a collaborative effort that addresses the significant morbidity and mortality gap experienced by Australians with serious mental illness.

Training

16 I also do quite a bit of training now and as part of that training I advocate in the area of mental health.

17 I work at the University of Melbourne one day a week, which includes teaching medical students. I also work for EV GP Training. EV GP Training offers training for GP registrars which leads to fellowship of either the RACGP or the Australian College of Rural and Remote Medicine (**ACRRM**), which then allows a doctor to become vocationally registered as a GP in Australia. I feel like I've got a good understanding of the journey of becoming a GP, and I'm keen to improve the training of GPs in the area of mental health. I am focussed on ensuring all GPs have the skills to assist patients experiencing mental health issues.

18 My sense is that as soon as doctors come out of the hospital system to undergo placements for their GP training, it hits them pretty quickly that a large part of their work will be in mental health. I think it's well established that it's a big part of a GP's work. My role is to help young doctors to make them feel comfortable with that work.

19 A lot of the work of a GP is about building rapport with and garnering trust with a patient, with the hope that over more time they might feel comfortable enough to reveal their problems so the GP can help them. I often tell the GPs I train that while they may feel that they are opening up a 'can of worms', I tell them 'don't be reluctant to open the can' because it is through that deeper understanding of your patients that you have a better chance of helping them.

Where do GPs fit within the mental health system, and what role do you see the GP playing in the mental health system?

20 Most people will access the mental health system through their GP. I see the GP as the 'gatekeeper' but also the 'steward' of effective use of services that sometimes need to be rationed. The Australian Institute of Health and Welfare's 'Mental health services in Australia' report suggests that GPs will be a person's first port of call for people seeking help with a mental illness.[1]

21 In accordance with the RACGP curriculum, a GP should be able to recognise risk factors for mental health; they should understand potential early intervention for some of the risk factors; and they should diagnose mental illness in the context of what we call multi morbidity. Multi morbidity is a term used to refer to people who have more than one health-related problem, and they're often mental and physical problems combined, and they all impact on each other.

22 I think that GPs have an important role to play in assisting people affected by mental illness – including for people who aren't willing or able to access other services. A GP can be focussed on early intervention, on the relationship with the patient, and

[1] https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/general-practice.

supporting the patient over a long period of time. This is quite different to a hospital scenario, where people go for a specific period of treatment and after a period of time, they are often discharged with a 'you're better' sticker. It's the role of general practice to follow up that person and do what we can to reduce the need for re-admission to hospital.

23 I also think that the GP is in a unique position. We see the impact of community factors more clearly because we often live in the communities we serve. For example, I had a former patient of mine who had very complex mental health concerns and serious physical health issues. I also know there's a bottle shop at the end of her street and I know she can get easy access to cheap alcohol. This helps me treat with community factors in mind. GPs often see much more of these social determinants of health – and we also often have a deeper understanding of the families and communities where our patients come from (particularly if, like me, you get to work in one place for over 20 years).

Who receives treatment for mental health related issues at the Surrey Hills Medical Centre?

24 Everyone – we don't discriminate. I often have people come to see me who do not live in the area because they know I have an interest in mental health.

25 There are often restrictions in terms of availability of appointments, but there are no criteria for people to come and see me.

Do you assist people affected by mental illness with all degrees of severity and complexity? If not, at what point of severity or complexity do patients with mental health issues need to seek help from other providers?

26 Yes I do. I see people with the high prevalence disorders – depression and anxiety – and people experiencing the potentially more serious ones such as bipolar disorder and schizophrenia.

27 There is often a bit of negotiation with the patient about the level of involvement I will have in their care. I prefer a collaborative model – a structured approach to care – but often I accept that some patients just want to see a psychologist and come to me for a mental health plan. I'll do this, but I think limiting my role to simply referring to other providers can be a lost opportunity for me to work with the patient in a collaborative way.

28 In terms of illnesses, there are some mental illnesses that are more complex to diagnose. Some patients have really complex problems, and may have had multiple diagnoses. Sometimes conditions change, and the nature of problems change over

time. The way I diagnose depends on the illness. I rarely give a diagnosis of schizophrenia without getting the patient to also see someone who has the right expertise.

Do you have experience of the "missing middle" – people whose needs are too complex for the primary care system alone but who are not sick enough to obtain access to specialist mental health services? If so, in your experience, how does the mental health system meet or not meet the needs of people who find themselves in that gap?

29 I question the definition of the "missing middle". I do have lots of patients who are managing outside of the mental health system; for example because they say that they've had a really bad experience with the system or because their illness is quite complex or hard to diagnose (for example, it's a mixture of depression, anxiety as well as a learning difficulty or ADHD). I've got patients – who I see as unsung heroes of the community – living with severe symptoms but still holding a job and running a family. Those patients experience quite a high burden of disease and are probably not performing as they should, but can't access certain services.

30 For example, a good psychologist can cost $200 an hour. The primary health network (**PHN**) has set up more affordable pathways to access psychologists, but in my experience these psychologists are not necessarily the best ones to see people with complex problems.

31 Then there are psychiatrists. They are expensive, and only a small number will bulk bill. Sometimes the psychiatrist my patient sees will no longer be available to them – for example, they may have retired – and so sometimes I keep going with the support that was offered to the patient by the psychiatrist, as many of my patients need long term support.

Briefly, how are mental health-related services provided by GPs, funded?

32 Mental health-related services are in part funded by Medicare. It's a fee for service model – GPs get paid when someone comes in for an appointment, and that fee is either bulk billed or paid privately.

What are the challenges from a GP perspective in providing and facilitating care for patients with mental-health related conditions?

33 Sometimes GPs are characterised as part of the problem (that is, one part of dysfunctional system). In my view, they are central to caring for the patient and should be seen as a central part of the solution.

Navigating pathways of care

34 I believe that a GP needs to be trained in navigating and understanding pathways of care. It's not acceptable that someone is just having a stab in the dark because the last thing the patient tried didn't work.

35 Unfortunately, the pathways to better mental health care are overly complex and poorly connected, particularly in the situation where a patient has already accessed some care but has not improved or when there are financial barriers and long waiting times to accessing more expert care. One example of this is that psychologists often move into private practice as they become more experienced, and some people can't afford this type of care. Or sometimes a patient in crisis agrees to get help, but by the time the appointment comes through the crisis has subsided and the patient is no longer willing to follow through with help-seeking (until the next crisis appears and the cycle starts again). Or a service is funded for a while, but then the referral rules or type of service changes just as the service is starting to be known.

36 GPs struggle to keep up with all the different silos of care coming and going around them. In a fee-for-service model that rewards the GP for short consultations and high patient throughput, in my view they will be tempted to choose what is easiest to remember and refer to, rather than struggle and take the time required to find out what new model has popped up since the last time they needed it.

37 At the same time, it is quite hard to refer a patient with a mental health problem to another provider unless there is an existing relationship with that provider. Patients need to know that you are sending them to someone you really trust. While this is possibly true for physical health referrals too, the importance of it is much more obvious in the mental health area, because people often need a lot of encouragement to seek help in the first place.

38 I often find that my patients jump around from one service to another to find out what works. For example, they may be willing to take medication but not ready to engage in a talking therapy, even if that might be better in the long run, or vice versa. Or sometimes a patient may want to see a psychologist, which can be quite expensive, for a problem that might respond to an online therapy, but the patient is not keen on something that is not face-to-face. Or a patient may really need to see a psychiatrist, but we can't find one, so they end up with some other mental health service that is not quite what they need.

39 I think the system could offer better incentives to enable the GP to offer and the patient to choose the intervention best supported by evidence, but ultimately, if the patient is not engaged in the pathway, it is unlikely to be helpful.

40 I think that case conferencing between GPs and other mental health professionals might help. For example, a psychiatrist could provide detailed advice to the GP, preferably with input from a multidisciplinary team, as to what strategies to use with a patient with a complex psychiatric problem. There are item numbers on the MBS to do this, but in my view they are poorly utilised because of the rules and structures around them that make them impractical.

41 A better solution would be to bring the secondary and tertiary mental health experts (psychiatrists, mental health nurses, etc) into the general practice to work with the GPs and their patients, so that care was properly integrated with other parts of primary care and so that patients could get the care they needed in their local community, alongside any physical health care they might need. At the same time, due to mentoring and guidance from the experts, GPs would increase their skills for the benefit of future patients.

Referral options and waiting times

42 I do think services are woefully under-supported, particularly where there is a crisis. I often tell my patients that if they develop thoughts of self-harm or suicide, they can ring the local crisis service, but that they must then honestly tell the person on the phone just how bad they are, and that they must not minimise their symptoms, because the crisis team will often only respond to the most high risk of situations. Imagine how hard it is to tell a stranger that you are thinking of killing yourself? Yet that is what we ask patients every day to do when they ring a crisis service.

43 I also think it's absolutely critical that if people choose to present themselves in a crisis, then we have to provide a good service to them. We've got to provide better services in emergency departments, rather than simply say that presentation is not appropriate. Once someone seeks help, if they don't have a good experience, there is a risk they won't access the system again.

Eligibility criteria for services

44 Many (but not all) mental health services are only available to people if they have a diagnosis of a mental illness. The MBS-item number referred services require the GP to make an ICD-10 diagnosis and obtain patient consent before proceeding. This creates barriers for people who have not yet crossed a categorical diagnostic line but would benefit from some help and support, as well as for patients who do not accept they have a diagnosis but still need help.

45 Hypothetically, if a GP makes a referral for someone who has symptoms of distress but has not yet crossed a clear threshold for formal diagnosis of a mental illness, they may have done a good deed for the patient by way of early intervention, but they may also

have exposed themselves to Medicare fraud and the patient to insurance discrimination down the track, where the patient can't get life insurance, disability insurance or travel insurance, just because they sought early help for psychological symptoms. Nevertheless, in a health care system where funding for mental health services is not matching need, the GP may attempt to ration more expensive services for those with greatest need: even if this contradicts the primary care philosophy of early intervention.

Affordability issues

46 One significant issue is the ability of people to access private psychology and private psychiatry.

47 There was one good initiative, which was the introduction of MBS Item 291. I understand that at the time it was introduced, a lot of psychiatrists were not taking on new patients. Item 291 allows a psychiatrist to attend to a person (more than 45 minutes in duration) and provide an assessment and management plan that would then be undertaken by the GP.

48 This has been very useful to me and where appropriate I refer my patients to get this type of plan done (which theoretically costs around $450 and about $390 is paid back by Medicare, although psychiatrists often charge well above the recommended Medicare fee). But I work in an area that has good access to psychiatrists and I have good professional networks, so I have psychiatrists who will prepare a plan under Item 291 for my patients.

49 In talking with GP registrars, my sense is that most of them know about this item, but they often say their patients can't afford it. Therefore, for some patients in more disadvantaged areas this item may not help them, because being able to pay the fee of a few hundred dollars before receiving the Medicare rebate in return is impossible, as they don't have the financial resources to pay the fee up-front.

Capacity constraints (time pressures, consultation lengths).

50 The 'fee for service' model results in capacity constraints, particularly for patients with complex issues.

51 A big problem with mental health care is that you can invest time in training but as a GP, the more mental health work you do, the less secure your business model is. Most GPs are funded by fee for service. There is an inbuilt disincentive to take longer with a patient because the longer you spend with patients, the less you get paid. That is not to say that GPs don't want to spend time with patients, or that GPs build their practices only around the generation of income, but the disincentive is built into the system.

52 At times, mental health patients may have difficulty meeting appointments. It can be quite disruptive and there's a real tension in terms of financial reward, because if a patient fails to attend an appointment, the GP doesn't get paid. This is particularly problematic if I have allowed for a longer appointment time to accommodate the needs of a more complex patient and then they don't turn up.

53 In essence, I'm paid less to do more complex work. And this disincentive is further exacerbated by the relative inequities in reward for providing mental health care versus chronic disease management for physical health problems. Ultimately, I get paid more to prepare a chronic disease management plan than a mental health treatment plan, but the latter's requirements are much more complex. Similarly, procedural work is significantly more financially rewarding than complex mental health care. For example, lots of GPs will find time to do a skin incision, because there's good financial reward, but that doesn't necessarily apply in the mental health realm.

Training

54 There are also issues around training GPs. In New South Wales, GPs are offered scholarships to do specific training in mental health, which is commendable. But training alone is not enough to get GPs to do the work.

55 Mental health work is challenging, including because of fragmentation between parts of the system. By way of example, I've had Area Mental Health Services contact me in the past asking me to take on a patient, so they can be discharged from the state-funded service. I've said yes. And then I get sent a lot of paper, and nothing else, and then a month later the patient hasn't showed up. While I would like very much to help the patient, in that kind of circumstance it is extremely difficult as a GP, to proactively engage the patient, in part because of there being no financial recompense but also because of taking on an unknown responsibility and therefore an unknown risk. There is little gain or support for GPs to proactively follow up patients.

In your experience, in relation to the needs of people affected by mental illness for clinical treatment:

Is supply keeping up with demand? What gaps have you observed?

56 I think there are big gaps in supply. There are never enough psychiatrists. There don't seem to be enough crisis services, or drug and alcohol services.

57 Private practitioners are good, but if someone has got a limited bucket of money, it's challenging for someone to access it.

58 But then if someone is not getting better when they get those services, what do we do next? I don't think we have addressed the quality gap – and in particular considering the right treatment for the right problem. So, while we have come a long way in convincing people to ask for help, we have much less control in directing people to the service most likely to be of benefit, based on the research evidence. Of course patient preference needs to play a role, but sometimes the incentives are not there to encourage the patient to follow the most beneficial and cost-effective path.

If there is unmet need, what needs are the most critical?

59 In my view, the issue of crisis services, preventing people from self-harm and respite support for carers are all critical. Reducing homelessness and prison time for people with mental illness also should be high priorities.

60 Providing financial support for people who cannot work and appropriate vocational rehabilitation services for people with mental illness who aspire to return to work are extremely hard to access and seem to be poorly resourced, despite the huge productivity gains that could be achieved by helping people with mental illness get into the workforce and lead contributing lives.

What are the key drivers of unmet need?

61 I believe stigma, particularly self-stigma, still plays a big role in people who need help not accessing it. If people finally access the system and have a poor experience, it is hard to get them to have another try. Treatments also take a while to work and people need much more support to stay in care and keep persevering when the going is tough. There are more services available now than at any time in my career, but the specifications of some of these fail to meet the needs of people who have already accessed care and are not recovered. This remains a real challenge.

What kinds of impact does unmet need have on people affected by mental illness?

62 One of the saddest things about unmet need is that it is not limited to the individual who has mental illness: it can lead to generational disadvantage and harm, as that person is unable to lead a fully productive life and thus meet the obligations to their family, children and so on. I am no longer surprised when I get to know patients well, just how common it is to learn that a person with a mental health issue grew up in a family where the previous generations also had mental health issues but they were never acknowledged or spoken about, let alone treated. This has an impact on the whole family over long periods of time.

What are the barriers to people receiving appropriate treatment, from a systems perspective?

63 I think that there can be an issue around the skills of practitioners and clinicians. GPs need to send their patients to the right people to get the right treatment.

64 The introduction of the PHN (primary healthcare network) has been challenging at times. These networks are the 3rd iteration of a Commonwealth funded program of support for primary care, starting in the 1990s with the Divisions of General Practice, followed by Medicare Locals and now PHNs. I see these as networks designed to assist general practice in driving the population health aspects of our work, through additional funding and support for tasks that we know are important but are hard to do in a fee-for-service environment.

65 My sense is that a lot of the funding provided by the PHNs is short-term funding, which is not good when there is a need for continuity of care and strong interprofessional relationships for persons with mental health issues. For example, we may get an email from a PHN about a new drug and alcohol service, and sometime later their phone number may not work anymore. A good idea gets implemented in one funding cycle and by the time General Practice understands it is there and how it works the funding cycle is over and the money is withdrawn because it wasn't fully spent, or the uptake wasn't as good as expected. GPs rely on referral networks of people they know and trust. The turnover of people involved in PHN programs is often too fast for those important relationships to form.

If a person has a chronic mental illness but are not in "crisis" where do they go for immediate support?

66 My experience is that patients go anywhere and everywhere. We at our practice encourage them to come to us.

67 Otherwise, some of our patients go to other providers – such as community mental health services, but I've often heard that there is a high turnover of staff at these services, which is not good for a person who needs continuity of care.

68 As to how often a person with a mental health issue needs to see someone, this is variable. I have one patient with schizophrenia who comes to me once a month. But this is often not enough – I often wish I had access to 'extra vouchers' to get them extra things, such as dental care, but the commonwealth/state funding divide makes it hard to access services that require these two parts of the health care system to work collaboratively together.

How does the complexity of the mental health system (variability between geographic areas, overlaps/duplications between different levels of government, and gaps) impact on people's ability to access services and navigate the system? What tools are in place currently to help people navigate the system? How effective are they?

69 I have found that it is often hard to navigate around the mental health system. For example, there is an Eastern mental health navigation tool that's online – in my view it's hard to find.

70 There is a mental health website which provides people with access to mental health services, but that's only for digital services. Some people may be good at using the internet, but others aren't. And while the internet can be a powerful tool for finding information, I want patients to find reliable information rather than harmful information which can potentially emanate from sites such as chat groups.

71 Aside from the internet and the GP, in my experience people know they can call the local public hospital, but there is always a risk that they may not get help. By way of illustration, I had a colleague who described a case of their patient who was in an acute crisis – she was told she couldn't get help from the hospital because she was on the wrong side of the road and therefore not within the right postcode. I understand that there are pressures on hospitals and they may not want to help people outside a particular local area, but this can cause disruption to the people seeking help.

72 As another example, a patient of mine had established a really good rapport with a team in a community mental health service, but she moved house. She had to transition to another team which was very problematic for her. It would be good to have a bit of flexibility so that didn't happen. Generally, I feel like we have a good public health system, except when a person has mental health issues.

What role does advocacy by mental health practitioners play in focusing governments on the importance of mental health? In your experience, does the mental health practitioner sector need to be strengthened in its capacity to advocate? If so, how?

73 Advocacy is an important part of the role and responsibility of mental health practitioners.

74 My sense is that the ability of the GP sector to speak to government on mental health issues waxes and wanes. The GP colleges tend to focus more on education and standards, and in that respect they do work well in advocacy.

75 Advocacy is challenging when it comes to mental health. In physical health, we talk for example about cancer or Alzheimer's. In that sense, specialisation in advocacy (focus on particular diseases) is accepted. My perception is that on mental health, different

parts of the sector are expected to speak with one voice. However, mental health is complex and includes social as well as medical issues. Different streams in advocacy have to be accommodated. By way of analogy, it would be absurd if advocates for physical disabilities and diseases were expected only to advocate for "physical health" in its totality. That said, increased focus by major health professional bodies and groups on the ways in which they can advocate together, would be a step forward, not limited to medical professionals and including allied health professionals and nursing as well.

What are the barriers to collaboration between mental health service providers?

76 Firstly, it is hard to work together if there are no incentives to do so. Services funded by the state system may not be funded to work with Commonwealth-funded services (like General Practice) and vice versa.

77 Also, General Practice really relies on other health professionals communicating with us in a timely manner and sharing their expertise with us, so we can put together a holistic, whole-person package of care that takes all the competing demands of different needs of the patient into account. Some providers don't appreciate that role or are disinclined to invest time in building those connections with General Practice. This sometimes creates tension for us, when one allied health professional provides a service that the patient values, but this impedes the patient from accessing a different type of service that may be more supported by the evidence or higher value care.

Are there notable examples of the health system facilitating collaboration (features that work particularly well)?

78 Item 291 has helped get psychiatrists to provide more consultation-liaison services with general practice.

79 The Mental Health Nurse in Practice was a good example of the health system facilitating collaboration, but because it was designed to fund a perceived gap in the system (those patients with serious mental illness not accessing state-funded mental health services) it did not realise its full potential as an enabler of better collaboration between state and commonwealth funded services. The Mental Health Professionals Network (MHPN) and the General Practice Mental Health Standards Collaboration (GPMHSC) are both examples of the professions working effectively together when it comes to education and training, but we still need to do more to achieve true clinical collaboration that might directly impact on patient outcomes.

Are there ways in which you think the demand for GPs services for mental-health related issues is changing or will change significantly in the future? If so, what do you think the most significant changes are likely to be?

80 I think that more and more patients are seeking help. The consumer movement has helped a lot with this – by giving people with lived experiences a voice. But there's still a long way to go. I still see a lot of self-stigma, with people telling themselves (and telling me) that they're not worthy, or they've just got to pull their socks up. We could do more work in reducing stigma and normalising help-seeking, but also in focusing more on what social and emotional well-being looks like and calling out practices in the workplace and schools that contribute to poor mental health.

81 A significant challenge facing the system is ensuring that the provision of GP services is financially viable. The Medicare rebate freeze has been a huge threat to the viability of General Practice and to our ability to provide bulk-billed services. We can't improve the quality of GP care (and in particular GP mental health care) if no one wants to work as a GP because they feel that their investment in getting a medical degree will never be realised due to the relatively poor remuneration for GP work compared to other medical specialities. Similarly, we are not realising the potential for nurses (and mental health nurses) in General Practice, because the career paths are not lucrative enough to entice enough nurses away from the hospital sector.

What do you think are the most significant challenges facing the mental health system in meeting the needs of people affected by mental health?

82 One of the challenges is moving from providing care to actually getting good outcomes. There is lots of good activity happening in the mental health system. But if people aren't getting better, we can't just be doing more of the same. There is still more work to be done around best treatments for conditions such as bipolar disorder and treatment resistant depression. Some of this needs to come from better funding of medical research into different treatment options and better pathways of care. We also need to do more to shift the system from accepting 'remission' of symptoms towards achieving 'recovery' and enabling people with mental illness to live contributing lives.

83 We also still have an overly medical model, and we're not looking enough at social factors. I think that a lot can be done in early childhood, as part of early intervention, and with families. There does seem to be a lot of movement in the adolescent space but we also need to do more in supporting families, education and addressing family violence. This is important.

84 I also think that we can learn a lot from different cultural groups and the Aboriginal and Torres Strait Islander communities who may focus on social and emotional well-being

and seeing mental health problems as a community problem and not an individual problem.

What do you think are the critical elements of a well-functioning mental health system?

85 A good touchstone of how well the system is functioning is to ask, if this was a physical problem, what would happen? There's still a lot of stigma; a lot of judgment around mental health. I always wonder: is this person who has a mental health problem getting at least a good deal as a person with a physical health problem? The answer is almost always no.

86 A well-functioning mental health system would also have much better integration between State and Commonwealth funded services. In Victoria in the past, we were able to contact primary mental health teams and they would send out a mental health nurse or social worker to see the patient in our practice. That seems to have faded away.

87 I think there is benefit in having a mental health nurse available in the practice. They could particularly help with people with more complex diagnoses such as schizophrenia. The role of the nurse to act as a kind of 'broker', helping GPs and our patients to navigate the mental health system, would be fabulous. They could be the person to follow up a patient to ensure they were accessing the care as arranged and if not, to ensure that the reasons behind things not going well were explored and addressed. That can't easily happen in a fee-for-service system where the GP only gets paid for when the patient is sitting in the consulting room: more outreach and more integration with the general practice over time would be helpful.

What changes do you think would bring about lasting improvements to help people affected by mental illness, in relation to:

- **access to treatment and services;**
- **navigating the mental health system;**
- **getting help to people when they first need it?**

88 I think the state needs to think more seriously about how it can support better primary health care. The systems need to be more nimble, more affordable, and more focussed on early intervention.

89 I think that there needs to be greater thought given to prevention and education which is a big part of this, and how schools respond to children (and their families) in need.

90 I also consider there to be merit in private psychiatrists working in the public system, as well as in the private system. My impression is that once they are trained, psychiatrists

quickly move away from the state-funded mental health system and into private practice, in part because their work in the public system is so demanding, poorly resourced and stressful. This is unlike many physical health specialists, who hold a public appointment as a measure of their prestige and right of referral in the private practitioner space.

91 I also think there is merit in developing collaborative care models. This has been adopted in several parts of the world to treat depression. It is a structured approach to care which can improve on usual care by about 10%. The concept is simple: ensure that patients are screened in primary care for common mental health conditions, ensure the GPs are trained to assess the patient, use a case manager to ensure the patient once identified stays on treatment and has treatment adjusted (with pro-active support from a visiting psychiatrist) and keep monitoring and supporting the patient until there is clear evidence of improvement.

92 Collaborative care isn't necessarily the total answer, but getting specialists to come into a GP practice to do care and follow-up does have wins – it allows the patient to be supported in their own environment, plus the GPs upskill over time as they see what specialists recommend. In my experience, if you want to work well with psychiatrists, you've got to know them. I've been lucky to establish networks and I've been lucky to have met a lot of psychiatrists in my time. Once I know them, I can ring them and ask for advice.

Drawing on your experience, how do you think the Royal Commission can make more than incremental change?

93 I think that the Royal Commission needs to think about:

(a) early intervention and support for families, and not just youth;

(b) fixing the Commonwealth and state divide in terms of funding and support;

(c) greater integration between nurses and primary health care;

(d) an improvement on crisis services – services need to be responsive, and inclusive, and better linked to general practice;

(e) fixing issues around Centrelink and employment (like ensuring people are working in places they're actually suited to) – this is more subtle but it's important too; and

(f) ensuring that we have enough GPs. Rates are declining for those in GP training.

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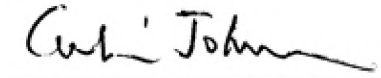

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Victoria's Mental Health System