



Formal submission cover sheet

Central Victorian Primary Care Partnership submission

Primary Care Partnerships (PCPs) is a placed-based Victorian Government funded program to support health services, social services and local government to work together on identified common priorities. There are currently 28 PCPs across the state of Victoria, two thirds in rural & regional Victoria and one third in metropolitan Melbourne, connecting over 850 organisations across many different sectors. The combination of their broad membership, cross-sector partnerships, engagement across the continuum of care, and operation at local, regional and state levels make PCPs a unique feature of the Victorian health and human services landscape.

[Central Victorian Primary Care Partnership](#) catchment includes Central Goldfields, Mount Alexander and Macedon Ranges. The partner organisations represented on the CVPCP Board are:

- Asteria (Disability Service)
- Castlemaine Health
- Castlemaine District Community Health
- Central Goldfields Council
- Centre for Non Violence (Family Violence service)
- Cobaw Community Health
- Kyneton District Health
- Macedon Ranges Shire Council
- Macedon Ranges Health
- MIND (Community Mental Health)
- Mount Alexander Shire Council
- Women's Health Loddon Mallee

A small team is employed to support the collaborative work of the partners. The common priorities identified in the CVPCP strategic plan are mental health and wellbeing and social inclusion.

This submission is on behalf of these partners.

Your contribution

Should you wish to make a formal submission, please consider the questions below, noting that you do not have to respond to all of the questions, instead you may choose to respond to only some of them.

1. What are your suggestions to improve the Victorian community's understanding of mental illness and **reduce stigma** and discrimination?

There is considerable amount of work happening in Central Victoria to improve our communities understanding of mental illness and reduce stigma but more support for this local work is needed. The research consistently shows that innovative and targeted outreach models are needed to support our harder to reach cohorts, especially for mental health where there is still stigma attached. This is particularly seen in farmers that are struggling with the impacts of climate change.

There are a number of examples where mental health supports are reaching out into the community:

- **local community networks** are doing a lot of the heavy lifting when it comes to engaging the community in awareness raising activities and encouraging people to talk and respond to suicide ideation. They do much of this work in their own time and rely on resourcing from small grants and fund-raising activities. In Central Victoria these local networks includes Macedon Ranges Suicide Prevention Action Group ([MRSPAG](#)) and in Mount Alexander, Every Life Matters ([ELM](#)).
- The Youth Affairs Council Victoria (YACVic) led the [When Life Sucks consultation](#) (across 6 LGAs), to ensure the expenditure of funding of the **Youth Our Critical Asset** (now known as KIT – Keep In Touch) is coming from a foundation of youth voice. The result of these consultations is an outreach model that includes a bus that will travel to events and provides connections to local services and activities. It is anticipated that this project will also include support for sexual health as this seems to be strongly linked to mental wellbeing in young people.
- Macedon Ranges is exploring a **community support model** to support people with mental illness or suicide ideation. When people in our community have a physical illness they are often inundated with cooked meals and offers of help. This is not the case with mental illness due to the stigma. A community support model would involve volunteers rallying around a person in need to provide practical help such as shopping, gardening and taking them to appointments. To get this implemented requires expertise and resources to design a model that will work and be sustainable in the local context.
- There are a number of training options available to **build the capacity of our community** to identify and respond when some-one needs mental health support and suicide prevention. Mental health 1st Aid and Applied Suicide Intervention Skills training are all delivered locally and local networks are delivering SafeTALK. However, we are constantly looking for funding to subsidise places for people that cannot afford the participation fees.
- [Live4life](#) is a program in the Macedon Ranges schools that aims to reduce youth suicide in rural communities by decreasing stigma and building help seeking behaviours. This program has been predominantly supported by Macedon Ranges Shire Council but now is

being implemented and evaluated in Glenelg Shire and Benalla, we are seeking the state government to make a commitment to fund this existing initiative.

- Castlemaine District Community Health - Children's Counsellor & Community Health Nurse have developed a program for primary schools ("Making Friends with Worry") which aims to enhance emotional intelligence & resilience in children. Due to the funding limitations of the organisation it is necessary to charge a fee for the program which limits its reach in the community.
- In Mount Alexander, a youth network of service providers are working with a local secondary college to **build leadership and resilience** alongside building the capacity of teachers, parents and students to identify and respond to young people with mental health concerns.
- **HALT** ([Hope Assistance Local Tradies](#)) is a successful ground up organisation, based in Mount Alexander, that supports Tradies to seek help and prevent suicide.

Local Government plays a pivotal role in the prevention space. They have:

- responsibility for developing the municipal health and wellbeing plan
- broad and deep reach across our communities (from delivering services to supporting clubs and engaging volunteers)
- a wide range of public spaces for community to gather and socialise (from libraries and community halls to swimming pools and kindergartens)
- a library of reports from consultations with the community on the key issues impacting them
- demonstrated expertise in advocating for local solutions for local issues.

2. What is already working well and what can be done better to prevent mental illness and to support people to get **early treatment and support**?

Accessible and early treatment and support is essential to prevent mental illness.

- GPs in schools are predominantly seeing young people with mental health concerns. Schools in our area highly value the **Doctors in Secondary Schools program** and we would like to see this rolled out further to include Castlemaine Secondary College and Gisborne Secondary College where there is identified high need.
- We need to promote and support **help seeking behaviour** at a young age. The Live4life program includes the encouragement of help seeking and promotion of local services.
- Community health services are funded to provide 4 sessions p.w. children's counselling. Castlemaine District Community Health currently have a waiting time of 3-4 months for a child's counselling service; Child and Adolescents Mental Health Service has a similar waiting time. There is a need for increased funding (e.g. 8 sessions p.w.) which would ensure a more timely/ early intervention for children in the community.
- Victorians currently see their GPs more than any other health professional, with more than 87.8% of the population seeing a GP at least once each year. To ensure best therapeutic mental health practice there may need to be **incentives for GPs** to build their capacity and skill to identify and manage mental illness and suicide ideation.
- There is a reoccurring theme at community forums; a lack of awareness of local services. The local Primary Care Partnership has tried to support the use of a **single service directory**, the National Health Service Directory. However, the support from Health Direct

Australia was so poor that it was not feasible to promote this directory. Ideally, a single service directory would mean that services only have one site to keep their information up-to-date rather than multiple directories. It is a directory that both service providers and community members could use to find services at a time of need.

- Central Victoria has two **Community Health universal services** that provide a wide range of services across both health and community service platforms. Both services have limited counselling positions and could readily support the community with additional psychologists, social workers and community engagement / development roles.
- **Multiple services/fragmentation:** It is well recognised locally that young people are falling through the gaps, are being left highly vulnerable and without the supports required to address the challenges they face. This is despite the best efforts of the current youth support system. Currently the youth service system in rural areas is fragmented. Many services only work within the shire a few days a week, and precious service contact time is taken with travel from regional offices. This prevents a co-ordinated team-based approach, and without local management there is no opportunity for local voices to influence service delivery. The young people who are accessing the existing service system have extremely complex needs. In Central Goldfields Shire, the most prevalent presenting conditions are mental health (68%), family issues (55%), alcohol and other drug issues (42%) and disengagement from school (45%). The issues these young people faces are so complex that 45% of those who access services present with 4 or more conditions.
- **Specialist youth mental health services** eg Headspace do not provide out reach services. Teachers have reported that they are taking time out of school to take Castlemaine students to appointments at Headspace in Bendigo. It is unfair that only young people living in regional or metro areas have easier access to government funded specialist youth services.
- With stigma still attached to mental illness, people in rural areas often feel that there is a lack of anonymity in small towns. Embedding mental health services within our **universal organisations** (eg community health and rural hospitals) protects people's privacy and makes these services more accessible.
- Specialised services are required to focus on **high risk cohorts**. In Macedon Ranges we have a very successful program [supported by DHHS] to support young LGBTIQ+ people in our community. The [Wayout program](#) (Cobaw Community Health) has operated since 2002 and focuses on:
 - Support and referral
 - Information and education for professionals
 - Facilitating a youth group
 - Organising and delivering celebratory community events
- In Mount Alexander, has a higher proportion of the population who identify as LGBTIQ+ compared to the national average. There is evidence of increased risk of mental health issues amongst this population. Anecdotally local counsellors report an increase in the number of children identifying as transgender over the past 1-2 years. Parents are seeking support to assist their child/young person. There are no specific LGBTIQ+ support services in the shire & many families are not able to travel to Bendigo or Macedon Ranges.

- With the introduction of **NDIS**, we have concerns that the funding model does not allow community mental health services to provide outreach to people living outside of large towns. Anecdotally we hear that some NDIS clients are not receiving their services and do not know how to follow up with the service.
 - We cannot access information to identify if there is market failure from DHHS or NDIS. However, the marketisation and individualised funding for aged care and the NDIS no longer gives community sector organisations the flexibility in working with communities and bringing people together in groups collaborating through a similar interest or passion.
- As rural communities change, we hear about instances of **social isolation and loneliness** across the age cohorts that mean we may need to think differently about how governments deliver on responsibility for the wellbeing of citizens.
- Mental health (and AOD) services need to be more pro-active in identifying and responding to at risk or **vulnerable children** of their clients. A family safety plan needs to be developed with the parents, that includes the care of children if parent become clinically unwell and require hospitalisation or rehabilitation.

3. What is already working well and what can be done better to prevent **suicide**?

Mount Alexander and Macedon Ranges have high rates of suicide according to the National Coronial Information System. Both shires have a focus on suicide prevention and are building an impressive body of work. These include:

- Active **local community suicide prevention networks** that are essential for sustainable place-based outcomes.
 - [Macedon Ranges Suicide Action Group \(MRSPAG\)](#) members are a combination of people with lived experience and service providers. Their action plan includes raising awareness of suicide, building the capacity of community members to identify some-one who may have thoughts of suicide and where they can get help, and support people bereaved by suicide. The formation and development of MRSPAG is strongly supported by Macedon Ranges Shire Council and committed individuals that have been long term members.
 - [Every Life Matters \(ELM\)](#) is a Mount Alexander community suicide prevention network. Their aim is to increase understanding and awareness of suicide and suicide prevention, increase the capacity of the community to look after themselves and each other and support people bereaved by suicide. The formation of ELM was supported by Castlemaine District Community Health and the local Primary Care Partnership but is now self sustaining.
 - It is increasingly difficult for service providers to participate in local networks as current funding models do not make provision for **collaborative work or professional development**.
- **Place-based approach** is a person-centred, location centric way of working that prioritises the unique needs of people in a given location. By working collaboratively with the people who live and work locally, it aims to build a picture of the system from a

local perspective. Ideally, a place-based approach is led and owned by local people and generates and sustains positive outcomes by building on local strengths (such as existing community activity and networks) and fostering peer supports, social capital, community resilience and social cohesion. A critical element is the government support for delivering on enabling structures to ensure vibrant local communities scaled to population, to address the rural health inequities that are well documented.

- Central Victorian Primary Care Partnership (CVPCP) received funding from Murray Primary Health Network to implement and integrate suicide prevention activities in Mount Alexander. Local service providers and the local community network, ELM had equal decision making power on determining the outputs and outcomes of the [Mount Alexander Suicide Prevention project](#). As a result of a place-based approach there is community investment in the outcomes and this work continues after the funded project is finished.
- Macedon Ranges is a suicide prevention pilot site and the funding sits with the North West Primary Health Network (NWMPHN). NWMPHN covers a wide geographical area of 3,212 km² from Lancefield to Northcote and beyond Werribee. As a Melbourne based organisation, their local knowledge and established relationships within Macedon Ranges was understandably limited. Eighteen months into the pilot there was strong advocacy from the local suicide prevention group (MRSPAG) and the Macedon Ranges Shire Council to implement a *local* governance structure so establish transparency and trust in the process. Macedon Ranges Shire Council in partnership with local services have worked hard to support the NWMPHN to turn this around.
- **Peer support** for people bereaved by suicide is currently being delivered by volunteers without any financial support. The community groups, ELM and MRSPAG rely on donations to keep this service operating eg venue, promotion, catering. Although it is recognised that there is demand for peer support for people with suicide ideation, people with lived experience would need more support than can be provided by volunteers. This would require auspicing and support through a service local provider to ensure local accountability.
- Professional **crisis support** for people bereaved by suicide is an essential service as we know that these people are also at greater risk of suicide. Currently our catchment is serviced by Support after Suicide: Standby and Jesuits Social Services. However, there have been some issues in that referrals from Vic Police go directly to the Jesuits Social Services and there have been delays in the referral reaching Standby who service different geographical locations. Standby and the Jesuits have had discussions to resolve this issue but have not been able to agree on formalising the arrangement with an MOU. A statewide system with an assured local interface will help resolve some difficulties.
- **Reliable and timely data** is essential to improve systems or processes. Data not only enables us to accurately identify problems, it also assists to prioritise improvement initiatives and enables objective assessment of whether change and improvement have indeed occurred.
 - Through MRSPAG, suicide data was obtained from the National Coronial Information System. This data has identified suicide prevention is a priority for Macedon Ranges and Mount Alexander Shires.

- The attempted suicide data from the hospitals is less reliable with the coding of 'self harm' not always captured along with the physical presentation and does not distinguish from 'self harm e.g. cutting' to an actual suicide attempt. This data capture needs to be clearer and more accurate if it is to inform our work.

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

- It is challenging for services to **understand people's experience** of the service system at a local level. Co-design is a buzz word that is commonly used but poorly understood and under resourced. To do this well and deliver on the best local outcomes and improvements requires dedicated appropriate personnel to walk in the shoes of their clients and undertake deep research to understand their values and motivations ([TACSI](#)). Until quality improvement is better resourced the service system will remain orientated to the needs of service providers rather than the clients. Resourcing of quality improvements needs to move from a compliance driven model to one defined by the human experience and connections.
- The literature continually reinforces that an **out-reach services** are the most effective for reaching young people. A new program *Enrich* (Cobaw Community Health) works with young people who are experiencing (or at risk) mental health issues. This program offers:
 - home-based [or other settings] appointments to help with initial engagement and assessment, especially for those experiencing difficulties in connecting with clinical based therapies.
 - Capacity building for young people who deliver services to young people and education providers
 - Collaborative consultation within the support systems for and around young person and their family to improve outcomes.
 - Linking young people into appropriate long term mental health and psychosocial supports.

Early evidence suggests that this model is making a significant difference in the way that it works with young people and their families.

- The Enrich program is an example where the **funding model is not working**. There are parts of the shire that are unable to access this service due to the funding organisation (North West Melbourne PHN) boundaries, that cuts across the shire and the organisations service boundaries. As is often the case, we have a program that is really needed in our community and only funded for 12 months. Twelve-month funding models effects continuity of care for the clients, work-force stability and adds to the intensity of organisational resourcing that then requires applications for more funding to continue the service. This is not feasible or fair for our vulnerable community members.
- The people most in need are often the **harder to reach**. This maybe the person living in a shack on an isolated property with no utilities and very little contact with the community or service providers. These people require an outreach approach with consideration of occupational and health safety standards for the clinicians and support services – again requiring more resourcing.

- We can also attest that systems designed to support access to services like **My Aged Care and NDIS** are negatively impacting on the mental health of people. Intake and referral systems are increasingly centralised to telephone or the internet, which is challenging for people at vulnerable times of their lives. The waitlists for services are also a negative impact. The local service options need to grow, so people can connect more readily.
- There is a lack of awareness of mental health services, which instigates the development of local service directories that are not accessed, not maintained and are quickly out of date. As GPs are often the point of assessment and referral – it makes sense that the system supports **GPs to identify local services and social supports** that are needed. The PHNs have developed Health Pathways to support clinicians to access evidence based, locally accessible patient pathways. However, the success of this initiative depends on the up-take of this product. Some local services attempt to address such gaps with GP specific newsletters to maintain currency of information.
- We need to do more to **integrate and support universal services** as so often mental health is not isolated, people may present with trauma impacts that has meant AOD or homelessness or family breakdown, so we need less siloed funding models.
- **Local government** has many staff across a diversity of roles who work face to face with residents, often at their home. This includes animal control officers, local laws officers, customer service officers, parks and gardens staff, maternal and child health nurses, emergency recovery staff, and community support workers. While these staff are generally skilled and capable in their roles, residents experiencing poor mental health can generate complex situations for staff to manage including hoarding, homelessness, animal collecting, anti-social behaviour, dementia, self-harm, and suicide or suicidal thoughts.

Council's ability to manage and resolve issues where mental illness is a factor is hampered by the lack of connection and support to the mental health system. Council staff usually have little knowledge of where and how to access mental health expertise, or what support might be available and the referral pathway required to secure help for these residents. For example, Council has received limited support to assist us to manage instances of hoarding where we are usually directed to fact sheets and studies on hoarding, or to local funded agencies who can only help with peripheral issues such petrol or food vouchers, or housing support.

- Rural areas need better **after hours mental health services**. The only 24hr services are rural hospitals and they do not employ mental health practitioners. Upskilling staff to manage clients with low-moderate mental illness requires resourcing, especially in the smaller health services where there is low coverage of shifts and back-filling is required.
 - Due to the lack of after hours local mental health services the ambulance is often called, and the patient is transported to the regional hospital (Bendigo Health). This means that the ambulance is out of our area for any hours. Often the patient is not admitted so may find themselves without a way home (up to 90km) in the middle of the night with no public transport available. There have been occasions where patients are left to arrange their own transport home after an emergency unit visit or hospital admission. This causes significant stress and may deter people from seeking initial assistance.
 - The regional health service (Bendigo Health) provides mental health triage by phone but the response has been inconsistent across Central Victoria.

- Although video conference facilities for assessment has been provided by Loddon Mallee Rural Health Alliance several years ago it is still not functioning for mental health triage assessment.
- People with mental illness/suicidal ideation and their families experience **poor follow-up** after a hospital discharge. Clinical mental health services will refer to a community mental health service and possibly to a GP- if a GP is nominated. Families/carers are often not part of the discharge plan and social services are not often considered in the discharge planning.
- Police have said that if a person knows that they are going to be **transported to Bendigo** for a mental health assessment they will often abscond, especially at night as they are concerned about how they will home. Bendigo Health used to provide taxi vouchers when there is no public transport available but this practice has stopped/reduced as they felt clients were abusing the system.

5. What are the needs of **family members and carers** and what can be done better to support them?

Carers of people with mental illness constitute a significant 'hidden' health workforce. The total annual replacement cost of these carers in 2015 would be \$13.2 billion (University of Queensland, 2016). One in eight Victorians is an unpaid family or friend carer. Yet support for carers is poor and there is a lack of recognition of the role of carers in the NDIS model.

- **Ps My Family Matters** provides practical and Peer Support to families in the Macedon Ranges living with Mental Illness. They have found that many carers come to us and are in distress as they do not know where to go to get help for their loved one and are often suffering depression and anxiety as a result. Having an organisation to support the family in navigating a complicated Mental Health System, advocating for the family and giving the carers is integral in the ongoing support required of the person they are caring for. Carers are often fatigued and becoming unwell trying to cope with the in some cases 24 hour care and suicide watch for their loved ones.

Providing simple things like cleaning, gardening and meals to these families relieves some of the pressure and shows that people care, but evidence suggests that access to such supports are reducing over time. Being able to talk to some-one who has had similar experiences and truly understands the challenges is vital in the family being supported. Families knowing that they can come in and out of our program and that they will be provided with respect, skills for coping and friendships with other carers provides resilience and stronger carers to cope with the day to day and equips them for a crisis situation. PS My Family Matters is a voluntary organisation that relies on donations and small grants. We would like to continue this program but it requires financial resources to cover practical supports, insurances, admin costs, wages for 1EFT and respite services for up to 20 families.

- **Carers** have higher rates of mental illness compared to the general population. A majority of carers (56%) are estimated to experience at least moderate depression and one fifth severe depression, as well as experiencing high levels of anxiety, psychological distress and lower perceptions of self-efficacy and personal well-being.

- A family centred approach to service delivery should include a conversation about the needs of a carer. This may lead to the carer accessing mental health support as an individual.
- With the introduction of **NDIS** there appears less support for carers within the NDIS planning and funding model. There is also concern with the reduced Commonwealth funding allocated to Integrated Carer Support programs. Anecdotally, we hear that carers value the carer support service delivered by Bendigo Health but there has been uncertainty of the sustainability of this service over the last 2 years, again as the funding model changes and adapts it creates uncertainty.
- We support Victorian Carer Strategy 2018-2022 priority areas:
 - Carers have better health and welling.
 - Carers are supported in school, study and work environments.
 - Carers can access support and services that meet their needs.
 - Carers have less financial stress.
 - Carers are recognised, acknowledged and respected.
- **Hospital discharge planning** needs to include family/carers, who will be providing the ongoing care and support.

6. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

- Workforce incentives to attract the best and brightest to psychology, social work, AOD specialist work are significant gaps in the rural workforce.
- Fund workforce initiatives that we know work eg incentives for training, supported places
- Fund Leadership courses to ensure that leaders in the community service sectors understand the complexity and drive real changes in supports of communities
- There is lots of evidence around the value of peer support but these models need real investment in training and capacity building.

7. What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

8. Thinking about what Victoria's mental health system should **ideally look like**, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

Response

The concept of a regional 'Hub' appears to be a popular solution to health and social reforms. However, a hub may work in the metropolitan areas and regional cities, but it does not address access and coordination of services in rural areas. Mental health reform may not be about creating a completely new system but rather improving the mental health system using current infrastructure.

This may include:

- In rural areas the only 24hr service is the **hospitals** that do not provide mental health services
 - The Loddon Mallee Rural Health Alliance invested in video conferencing (CISCO) for health services. This enables health services better capacity to communicate over long distances. This should mean that local rural hospitals can now video-conference with the mental health triage team located in the regional hospital, to better assess if the client needs to be transferred. Yet this is still not happening. It is important to have this function as:
 - this means that clients maybe accessed as safe to be discharged home with a follow-up appointment with community mental health or require overnight observation in local hospital with follow-up with mental health services the next day or requires transfer to regional hospital to be admitted to a specialist mental health ward

- this may reduce transfers that will result in ambulance being out of the area for 2-6hrs and clients having to find their way home (80 kms) in the middle of the night when there is no public transport available
- **Community health services** are well placed to provide mental health outreach programs into their local communities. However, they need long term secure resourcing to ensure continuity of care as recommended by the Victorian Auditor General's report in June 2018.
- **GPs** need more support to connect their clients with local social and community services. Co-locating a local community health worker within a general practice may provide that place-based approach to care coordination. This would need require a funding model that works for general practice (MBS) and community health. Mental health plans only meet the needs of a small number of people and places limitations on options for people.

There may also be recognition of GPs that specialise in mental health/suicide ideation (specialised training/accreditation) to provide a referral point for local services and increase the client's confidence in the service.

- All service providers need resources and capacity to apply a **quality improvement approach** on how they actively engage and involve their clients in reviewing health services and practice. Given the diversity of funding and services some organisations may need to be compliant with 7-10 different accreditation systems. Simplification of a compliance system for community services would reduce a compliance driven approach and focus on truly what matters and that is a quality service.
- Mental health practitioners need more support given the dysfunction, vicarious trauma and complexity that they deal with on a day-to-day basis. **Debriefing, supervision and reflective practice** is important when supporting families through difficult times and trauma. Traditionally supervision is poorly done in hospitals and there needs to be training and time capacity for managers to properly support their frontline workers
- There needs to be **clear pathways** to professional mental health care that are intuitive to find, easy to access and navigate for families and carers.

Applying a place-based approach means that one size does not fit all. What may or may not work in metropolitan areas may or may not work in rural areas.

Prevention

For at least 20 years evidence is clear that the return on investment in prevention is irrefutable. But we need courageous decisions about shifting the funding over time to prevention.

Prevention needs to start with the young people in our community. Across Australia in 2016, nearly one in four 15-19 year old had a probable serious mental health illness (Mission Australia, 2016). We also know that about 75% of mental illness commence before 25 years of age and investing in the early years establishes good health and resilience that will have benefits throughout life.

- There are a number of successful initiatives that promote help seeking behaviours (e.g. Live4Life) and improve access to health professionals (e.g. GP in Schools) but these are not in every school.

Local community and service providers networks need more support to raise awareness of mental illness and suicide, to deliver and coordinate training and provide peer support where appropriate. The

Primary Care Partnerships (Victorian funded initiative) play an important role in supporting local networks but need more capacity.

- Communities need support and training to identify and assist some-one who may be experiencing mental illness or suicide ideation. This training needs to be geographically and financially accessible to all community members.
- Often the lack of meaningful work or under employment can be a reason that contributes to poor mental health – is there need for a conversation that shifts this connection.
- Perhaps we need a national/statewide campaign – a little like seatbelts around shifting the stigma of mental health?
- Deliver a COAG agreement around a national strategy around mental health.

9. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

10. Is there anything else you would like to share with the Royal Commission?

Privacy
acknowledgement

I understand that the Royal Commission works with the assistance of its advisers and service providers. I agree that personal information about me and provided by me will be handled as described on the Privacy Page.

Yes No