TRANSCRIPT OF PROCEEDINGS

2015/16 HAZELWOOD MINE FIRE INQUIRY

HEALTH IMPROVEMENT FORUMS

TRARALGON

MONDAY, 28 SEPTEMBER 2015

THE HONOURABLE BERNARD TEAGUE AO - Chairman

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CHRONIC DISEASE MANAGEMENT

MR ROZEN: Good afternoon, everyone. My name is Peter Rozen. I was the resource person/facilitator for one of the groups that met this morning which was dealing with chronic disease management. We actually met as a group of six, but one of our members, Dr Stephen Ah-Kion from the Latrobe Regional Hospital, had to leave. He had a very good excuse, which was that he had to go and treat someone with a chronic disease, so that seemed entirely appropriate. He was on call, so he has excused himself.

I thought we might start with very brief introductions. Perhaps we can start with you, Professor Campbell, just name and organisation, and we will go down the line, please.

PROFESSOR CAMPBELL: Don Campbell, I'm a general physician at Monash Health.

MS BOGART: Marg Bogart from Gippsland Primary Health Network.

MS BOVERY-SPENCER: Petra Bovery-Spencer from the Latrobe Community Health Service.

ASSOCIATE PROFESSOR RASA: John Rasa from Networking Health Victoria.

MS BARRY: Sylvia Barry from the Department of Health and Human Services.

MR ROZEN: Thank you. Perhaps, Don, if you wouldn't mind kicking us off with a bit of an overview of the topics that were discussed by the group this morning.

PROFESSOR CAMPBELL: Thanks, Peter. First up we were fined $5 each for not actually acknowledging the consumer as being at the centre of our efforts. So the message we got was "nothing about us without us" and that we were going to need to make sure that the customer or the patient or the

person living in the community was at the centre of the design efforts.

As far as chronic disease management was concerned, we looked at segmenting the population group based on how they were travelling in terms of their ability to self-manage, whether they needed a collaborative management style, a supported self-management style or they fell into a super user group.

We had a bit of a discussion about what this super user group might be. It is basically the 2 per cent of people who are responsible for 25 per cent of the direct health care costs, and that seems to be a pretty consistent finding across a range of health services. We had a bit of a discussion about how we would find out (a) who they were, (b) what was their pattern of service usage and what might constitute an improved service model.

Then the next group sitting below them was the emerging group where a broader based set of strategies might be beneficial. We felt that it was likely that, as far as illnesses were concerned, that the two per cent would have chronic diseases including diabetes, heart failure, chronic airways disease, with a reasonable chance there would be a mental health problem that goes with them and potentially frailty in the older age group, and that there would need to be an integrated service model. We thought it might be important for the services to have a conversation space within which they could talk to each other, build trust and establish commitments to action, but only after consulting with the users.

Aside from that, we felt that there would need to

be a focus on short, medium and long-term outcomes and that there would be a need for the services to hold themselves accountable for what they were delivering in that space as a means of collaboration, coordination and cooperation because we recognised that each individual service on its own wasn't going to be able to do all of it on their own. We felt there was a huge value in focusing facing towards general practice, supporting general practice and we recognised the role of the community nurses and we felt that the hospitals and the specialist physicians had a role to play and we didn't get much into that role. I think that's an overview.

MR ROZEN: Thank you very much. That's great. One of the issues, and I think you have already mentioned this, that was discussed by the group at some length was co-morbidity and the particular challenges that are thrown up for the health services by a patient having more than one chronic disease which I think the suggestion was that's something that's becoming more common.

Perhaps, John, that was something you made some references to. What are the particular challenges of such patients for the health service?

ASSOCIATE PROFESSOR RASA: I think the literature sort of points to the fact that by the time people hit 80 they have usually got seven co-morbidities, and I think that puts a different challenge, I think, for a structure that we currently have at the moment where perhaps the broader assessment may be done by general practitioner, but we have a fairly siloed system when it comes to specialist support, and there's referral after referral to the different specialists for care.

How do you bring that together? Who is responsible for coordinating care when it comes to the fact that people may have three or four conditions that they are trying to live with, when in fact the service structure is not set up for that? And also we identified even if we try and improve the scope of practice in general practice itself, that there's challenges in the way that the funding model currently works in terms of what GPs can do because there are many aspects of chronic disease which can be tackled quite effectively within the context of general practice or referred to community health services, but there are some challenges around how the current structure works.

So we talked a lot about how can specialists better support general practice in trying to deliver a more integrated care model, but we also identified that GPs were an important part of that early assessment of the whole person and then look at the way that the management of various diseases, whether it's heart disease, whether it is COPD, diabetes, et cetera, is then managed and coordinated between the different specialties.

But definitely that there needed to be good support coming out of the system which at the moment is acute care focused to be able to provide a different model which can be more community focused. Certainly having the complexity of diseases that may be out there due to lifestyle as well as due to other impacts is something that's quite complex, but the current system is not well set up for that.

MR ROZEN: Petra, if I can just ask you, you made reference to there being within the community health service four

levels, a hierarchy, essentially, of care. Could you perhaps inform the board about that?

MS BOVERY-SPENCER: So when we have been working in our early intervention in chronic disease service we have identified four categories, if you like, of clients: Self-managers, so they are your independent self-managers who will access specific services when and where they are needed and are fairly health literate.

Then your collaborative self-managers who need a little bit of help navigating the health service, but once they have established themselves and established a routine, understanding their disease process, understanding who is who within the health services, they are able to work towards self-management.

Then there's the supported self-managers who often will have co-morbidities who will also often have fairly complex social situations who are unable to effectively manage their chronic condition due to some of those other extenuating circumstances, but when linked within a service can gradually over time work towards self-managing some aspects and hopefully all aspects of their chronic disease, but need a lot of sorting out of things.

Then we had a fourth category that Don referred to as the super users who come in with a chronic disease and need a specific service, but really can't engage in the service, really can't engage in anything because there is so much going on in their life, their personal and social situation, their financial situations. We are talking about significant mental health issues, family and domestic violence, carer issues, but those issues that are

so significant that it impacts on their ability to even engage with any self-management strategies.

So, what we have looked at is looking at the first three categories and then obviously the ideal situation is that many people are good self-managers; the literature certainly points towards us helping people to self-manage their chronic conditions. But, if we start off with somebody who is in the supported self-management category, if you like, there's a lot of work that needs to be done to enable that self-management on an ongoing basis, and for it to be sustainable and for them to be resilient enough to overcome any obstacles and continue their self-management of their chronic condition. So they are our four.

MR ROZEN: You mentioned in relation to the fourth category the particular challenge thrown up by people who are suffering on the one hand from a chronic disease or perhaps more than one and in addition mental illness. Could you perhaps just expand on what are the particular challenges? It may be obvious, but what are the particular challenges thrown up by that scenario, and if anyone else wants to add anything, then please feel free.

MS BOVERY-SPENCER: I guess as a chronic disease service we are certainly not - we are actually not working with those people. We are referring those people to appropriate agencies and services to assist with their mental health issues because if somebody has so many things going on in their life we can't actually apply any of the strategies or the evidence around things like the stand for self-management strategies. We can't apply any of that because they are not in a position to self-manage their

diabetes, for example, because they are too focused on everything else that's going on or they are unable to care for themselves at the very basic level, let alone administer any medication or follow any medication regime in relation to their diabetes. That's probably my comment on that.

MR ROZEN: Does anyone else want to add anything to that particular issue; that is, the implications of mental illness on top of chronic diseases?

PROFESSOR CAMPBELL: Just to say that we know from some Scottish work that people with three or more co-morbidities have a 60 per cent chance of having an extra mental health co-morbidity, be it anxiety, depression or other, by virtue of having multiple co-morbidities, that the age of onset of multiple co-morbidity is lower in persons from a lower socioeconomic background and lower again for Indigenous people.

So, having an age cut-off for whatever eligibility criteria for a chronic disease management service isn't going to necessarily work and just the features of that chronic disease management model, the Stanford model, is that it focuses on diet, exercise and medication management, peer support and coaching, and coaching might be coaching for the patient and their family and also coaching of the health service delivery team so that they do a better job. So, coaching is a very broad concept and one that I think is an emerging one.

PROFESSOR CATFORD: I wonder if I could just jump in here. I'm quite interested in this notion of a coach or a case manager. Did you consider that and do you think there's

any prospects for any innovations?

PROFESSOR CAMPBELL: I think we did. We had quite a lot of discussion about who saw themselves as the care coordinator. GPs would put up their hands and I think say that they were the care coordinator, but there is also a formal role for a care coordinator.

As far as coaching is concerned, I really think that is a promising area for innovation. We know that some teams are better at looking after patients in chronic disease management models. We know that some patients are better at it. Peer support is a means by which you can transfer the learning, and coaching might be a very valuable way of bringing some groups of health care practitioners up to a better standard.

MS BOGART: I think we have to define what does care coordination really mean, although the GP will probably put his hand up and say he's the care coordinator around medical services and then referring on to specialists and allied health services. But care coordination can also mean someone who actually helps a person navigate the system without actually providing any clinical advice or care in that process.

MS BARRY: Just on this point, John. We have done some work around service coordination in the state funded sector and in that work we have embodied the construct of a key worker who takes that leadership role and usually we would say that it should be the person who has the most trust with the particular client that they are looking after. I think GPs and GP practices potentially are prepared to do that work, but I think we need to do a little bit of work with the Commonwealth around the MBS and how that

actually recognises the cost of intervention that is beyond just the face-to-face consultation, if you like. So, hopefully the medicare review might give us an opportunity to do some of that.

ASSOCIATE PROFESSOR RASA: If I could just add to that too. The recent work done by McKinseys in relation to diabetes management and the use of care coordination did demonstrate that better health outcomes were achieved where clients were being coordinated in their care. But that was a fairly simplistic one because it was only focusing on one disease category and that was diabetes, where in fact I think it is even more essential when it starts to get into multiple conditions, particularly when it comes to issues around polypharmacy and the likelihood of having multiple medications means higher risk for individuals and so care coordination supported by a good team approach, I think, particularly pharmacists, can lead to better health outcomes in that situation.

PROFESSOR CATFORD: I'm conscious that the primary health network is just forming and it is still early days. Is there an opportunity for the key agencies to work through this, the question of how do you take forward care coordination in a new, bright, dynamic way, because I think people do talk about this problem, but is there a next step where the principal players who are on the platform now can actually work together to try to nail this one?

ASSOCIATE PROFESSOR RASA: I think there's a key opportunity with the primary health networks to see how their role, which they have a role from the Commonwealth around practice engagement, how they might be able to perform an

effective role in looking at scope of practice for not only GPs, but practice nurses as well, because I think they can play a key role in that coordination process.

I think the way that the PHNs might interact with community health services and also the acute sector is important in terms of looking at coordination of providers and the roles respective providers might play, because sometimes it's appropriate that the hospital is engaged in a planned and structured way, and other times it may be appropriate to refer to community health for the particular specialist clinics.

I think there is a general move now to try to see can we move more care out of the hospital into a community setting and what would that look like, but certainly workforce issues come up there, skilling issues, all those things need to be looked at. But I think PHNs are in a good position to look at that, along with looking at population health planning and what needs to occur in the community which may be at risk that needs a broader perspective applied in terms of what could be possibly done by different providers, and particularly how the consumer is involved in that service design process.

MS BARRY: With our work around service coordination we have developed, in concert with the sector, a set of standards around service coordination and how best practice service co and referral actually should look, and certainly the work has largely been focused in the state funded sector and we are very keen to work with PHNs to actually extend that work now more broadly into general practice and including private allied health and maybe even specialists into the future, so that would be something that we see

would be a natural complement to some of the work that we have already been doing.

MS BOGART: And I think it should be noted that even though the primary health network commenced its business on 1 July, it is built on a foundation of other networks that significantly supported primary health and in Gippsland we have a reputation of working with a broad range of stakeholders right across Gippsland to achieve some great outcomes based on data, health planning, based on how we commission services and how we can best integrate between primary health, community health, acute sectors and private specialist services.

MR ROZEN: Thank you. Sylvia, one of the points that you made I think on more than one occasion during the discussion this morning was the importance of building on existing work so that it shouldn't - I think the expression you used was we shouldn't assume it is a greenfield site in the Latrobe Valley and these sort of concepts we are talking about. Could you expand on that in general terms and maybe give us an example of an initiative that can be, in your view, built upon?

MS BARRY: Sure. The first thing to say is that obviously there are a lot of services already coming into Gippsland and many people with chronic and complex conditions would be accessing them. In addition to those programs there are a number of actually tailored and targeted chronic disease type programs. As well as service delivery, we have certainly been pursuing quite an agenda around system integration now for some time. We obviously established our primary care partnerships back in 2000, so they are now obviously quite mature partnerships and while they

progress their work variably across the state they have had a very strong remit around building service coordination and integration and as a result of their efforts we have got, for instance, a set of statewide standards and an accompanying quality improvement framework that sits alongside that.

Their approach has not just been in health. A lot of their partnership partners involve health and broader human services, so they have had a remit around vulnerable communities as well and I think it would be true to say that they have developed great cohesion in the system. But it's been very much anchored, I guess, in the state funded sector because essentially that's potentially where our leaders have been.

Apart from the work around PCPs we have obviously seen the work around HARP, the consolidation of HARP now with the health independence programs. We have seen the work around the integrated cancer services, the clinical networks. There has been a body of work associated with building capacity around integration and working collectively together.

I think, having said that, we can always do better and I certainly think there's areas that we can enhance. There's a number of - to this point, actually, we have just initiated or the government has initiated a reform discussion in Victoria with their Health 2040 document that they released just - I think it was last week and certainly they are keen to review some of the underpinnings of our service system to see how it can be improved. So some of the areas that we have talked about are around patient centred care, around more integrated

health and social care, and we heard a good example of that in our session today around the pathways to good health for out-of-home children.

Also needing to progress e-health is another important component where we have done some work and there has been some very good work happening in that space in Gippsland, actually, but we certainly do need to take that forward and we are just about to embark on a project with the National e-Health Transition Authority to in fact do that and make the transfer of information more seamless into client management systems, so that will be a major enabler for integrated care.

The other thing we have been doing as part of our PCP strategy and also a part of our early intervention in community health, which you heard Petra talk about in part earlier, was around introducing the Wagner chronic care model as an underpinning of how best practice chronic and complex care needs to look, and I guess one important point that that provokes me to mention, and we heard in our session this morning and even in a number of the reform documents that we have seen from the Commonwealth, we have seen elements of what a best practice response might look like and whether that's care planning or pathways or care coordination or self-management. These are all elements that we would acknowledge as part of a best practice response, but I think what is sometimes lost that is really important is it is really the interplay of those elements that actually will deliver the best outcomes.

So, yes, care coordination is important. Yes, self management is, care planning, et cetera. But at the

end of the day it's how those things interplay with one another in a consolidated integrated model that the evidence suggests is going to give you the best outcome.

So, I guess that's just a small flavour of some of the work we have been taking forward. Of course I should have mentioned work like Carepoint and Healthlinks which is to come, which looks again at more innovative models around how we might look after the super users that we potentially talked in our group about earlier today.

MR ROZEN: Thank you. Petra, one of the examples that we heard about in our group of an initiative that was specifically related to diabetes care was the high risk foot clinic that you made reference to and that you yourself have been involved in. Can you perhaps tell us a little bit about the background to that and probably also talk about how you think the lessons from that might inform future potential developments in the valley?

MS BOVERY-SPENCER: Yes. So we talked about what would be an example in terms of a particular pathway. I talked about an initiative in my area that is a podiatry-led high risk foot clinic. So, that came about from a number of clients being documented as being linked into the Dandenong-Monash Health high risk foot clinic who would be supposedly travelling up and down to Dandenong.

Now, we know from our analysis or audits of our files and follow-up with the clients, we had a little mini-focus group with clients who would have been in that high risk category, that sometimes they didn't go up to Dandenong because they couldn't afford the transport up. Sometimes if they also had caring responsibilities they

had to focus on that. Sometimes they didn't really understand what the difference was between going up to the high risk foot clinic at Dandenong and going to their local service. We know that many of them were poorly engaged with other services such as specialists and GPs and other services that are relevant to the management of their health.

So, we had this on the drawing board for quite some time, but then we took an opportunity through an advanced practice model submission through the Department of Health and Human Services for allied health and developed the model in conjunction with Monash Health, the Dandenong high risk foot clinic, who were very supportive of what we were doing. The MOU is still not quite signed because at the moment of signing there was a bit of a change in process, but an MOU is under way with Monash.

We also have developed a pathway for tele-health support. In the six months that that's been going we have one advanced practice clinician operating that two days a week, one at Morwell, one at Moe, and it's a multi-disciplinary clinic so it involves three tiers: The primary health care team which is your diabetes nurse educator, your podiatrist, dieticians and a care coordinator in chronic disease; your secondary team which includes the GP, the Gippsland wound nursing service and your endocrinologist and other specialists; and then your tertiary or virtual team which is the Monash Health high risk foot team.

So we have just developed our data framework, but essentially we will be measuring whether or not the person engaged in the service, how many hospitalisations occur.

We understand we can't actually measure that in conjunction with how many did or didn't occur previously, but we have already had some significant clinical outcomes, which of course I didn't bring with me, but clinical outcomes in relation to wound healing and function and the ability of people to function.

The interesting thing with that is that although it came under the umbrella of a podiatry-led high risk foot clinic, one of the biggest wins we have had is the involvement of a dietician, which is often overlooked. If a person gets a referral to a podiatrist for looking at their wound, their lower limb wound, the podiatrist will do what they need to do or the wound nurse will do what they need to do, but that ability to increase the rate of wound healing with appropriate nutrition is very important. So, looking at the broader team, and certainly that's supported by the literature.

What was the second part of the question?

MR ROZEN: It was really drawing on that, how can we draw on that - - -

MS BOVERY-SPENCER: So, we talked in our group about looking at extended or advanced roles or upskilling our staff instead of looking for new options all the time, and we talked about the extension of care coordination, for example, which I already have care coordinators in my team specifically for chronic disease. They don't do clinical interventions; that's all they do.

But we looked at where could that also sit and we talked about whether that sits with the practice nurses, with the GPs and really looking at champions and supporting those people and improving their scope to

enable them to do some of the care coordination, because we know health literacy is an extremely challenging area and I think we are all signed up to try to improve our understanding of it and what we do around that, but I think navigating the health system is still something that will always be a challenge for the consumers.

That's just some of the ideas we came up with in our group today.

MR ROZEN: Does that program have implications for an ability to attract and retain staff as well?

MS BOVERY-SPENCER: I did mention to the group that I did have an ulterior motive for this. It was about trying to keep my allied health clinicians, which is why I went for the submission in the first place, so that was actually the motive for upskilling the allied health clinicians. But I think we are going to get some really good outcomes out of this.

I did forget to mention that we have had nobody who needed to go up to Dandenong. We have had a couple of phone calls to Dandenong, but we haven't even needed to switch the monitor on because things are going quite well. It just goes down to the fact that sometimes we don't need super-duper specialists - sorry to the specialists in the room - but sometimes it's just actually we need people to engage in the actual service in the first place. So we don't assume that their wound is not healing because they haven't seen all the right people; it may be they really haven't had the time.

It does take time. We are not churning them through. We see four in an afternoon compared to our normal output in an afternoon would be 12, but they do do

health coaching, they do see the other clinicians in there. It's a much more integrated approach than just going to see one clinician for one part of your body.

MR ROZEN: Perhaps I can ask you, Don, are there implications for the work of the board in terms of making recommendations about improving the management of chronic diseases from this example?

PROFESSOR CAMPBELL: Yes, I think there are, Peter. Part of it is really having a focus, saying that we are going to focus on the needs of particular groups of clients; we use a term that's at least not too value-ladened, if you like. We want to know what exactly are the needs of the super users by actually going to the data. It's not easy to find that at the present. We think we know what that group of people look like, but in order to arrive at their needs we will actually need to basically identify them, look at the patterns of service use and their particular diseases and look at the other factors that contribute to why they are service users and then design the services around meeting their needs.

For instance, if we say we have two per cent of customers who are using 25 per cent of our direct health care costs, we already know the budget that is allocated to their care. The question is could we allocate that budget in a more sensible way that gave them better satisfaction as patients, customers, clients? Could we perhaps get a return on our investment that could be better invested in more front-line services to meet people's needs? So really thinking about what does chronic disease management look like for people with multiple co-morbidities as opposed to people who happen to

have this disease that's managed according to that plan, this disease that's managed against this plan and that disease over here.

We know that for this group of people a lot of their health care costs are indirect costs related to transport, merely going backwards and forwards, and that that's really not to anyone's advantage. There's a bit about that in there, I think, that needs to be considered.

I think we also talked about the fact that arguably this is a group of people whose care needs can't be met by one agency on their own and therefore the agencies need to talk with each other. There's a need for conversation spaces to enable the agencies to trust each other and off the back of trust to develop commitments to do things differently.

We ask the question what would that look like? For instance, would it be a contracting model? They have to collaborate, coordinate, cooperate, potentially based on contracting, because at the moment there aren't financial incentives to drive their behaviours. But if there were financial incentives that involved potentially saying, "Well, here is the money that's being spent, what is your affordable loss? Can we do this differently and potentially reinvest savings in a better service model?" So that's a challenge. Thank you.

MR ROZEN: Thank you. You mentioned in our discussions earlier the example I think was from New Zealand of pooled money and how that might achieve greater cooperation and coordination.

PROFESSOR CAMPBELL: We talked about a model that the New Zealanders have used between the District Health Board and

the primary health care organisation where they have an alliance contracting scheme for specific targeted activities, not all up, but for specific areas. They identify the budget that each agency is going to put in, on the basis that they have borrowed this from the building industry for a big building contract, all the contractors put money into a central pool and no one gets paid until the project is delivered, on the basis that if one individual agency fails, the whole project fails and therefore they are all committed to each other and helping each other out to make sure it can't fail and that this could be applied to the organisation and delivery of health care, this so-called alliance contracting.

So, for specific project areas like chronic disease management, the money goes into the pot, the service is paid for out of the pot and no one gets paid until it actually delivers. So it's quite a challenging concept.

ASSOCIATE PROFESSOR RASA: With the establishment of the PHNs, the Commonwealth's desire for them to move from purchasing to commissioning could fit in quite well with that model, because the idea is based on population planning that they do where they identify where there are service gaps and what needs to happen is that they are supposed to then take up a commissioning role in actually procuring the services to be able to meet the needs of that community. So that is a sort of plan which is supposed to come into play next year with the PHNs.

The other thing that is being looked at at the Commonwealth level is blended payment systems. The minister is currently examining the possibility of looking

at more capitation payments for people with chronic disease, so that then it won't be getting rid of the current MBS items, but basically looking at whether in fact it can be reformed so that people with chronic disease can be paid differently so it encourages better outcomes, which is what you really want to see happen, rather than the current fee for service type arrangements which are in general practice at the moment.

So they are things to consider in terms of moving forward in terms of the way that the service system is being restructured and refinanced.

MS BARRY: Just on the super users, I would also urge - obviously HARP should provide quite a lot of information about the needs of this group. Obviously they have been working with this group for some time.

The other project that the board may be interested in looking at, which is specifically about enhancing navigation and coordination for this group, is the Carepoint trial. The Carepoint trial is one that we are doing. It's part of a national set of arrangements. We are working with Medibank Health Solutions. The cohort includes a group of both privately insured but uninsured patients and we are looking at building in some navigation assistance, recognising GPs as central to their care, but certainly there should be some good findings out of that exercise in terms of how navigation can assist with achieving better outcomes.

The other piece of work that I alluded to briefly earlier was the Healthlinks work and that is still under development, but it is essentially informed, I think, by the accountable care evidence coming out of the US where

Healthlinks will essentially be about encouraging hospitals to look at and be able to use existing funding in more flexible and innovative ways to actually get better outcomes again for this super user group, with an intent to reduce the risk of readmission. So I think that would also be useful for the board to consider.

MR ROZEN: Thank you. Margaret, can I ask you, please, to share with the board the example you gave us of the Gippsland dementia project and particularly what the implications might be for that type of coordination model for the management of chronic diseases.

MS BOGART: I think this came out of our round table discussion when we were talking about trust and whether or not we have the partnerships within Latrobe Valley particularly with significant stakeholders about can we achieve short term, medium term, long term strategies to address some of the chronic diseases particularly in Latrobe Valley.

Just sitting on the table with Petra, we all know that we have worked on a number of projects that have influenced care coordination or pathways or referral pathways, but one that did come to mind was a project that the Primary Health Network or the Medicare Local, even the division the general practice, was invited to be involved in many years ago through the regional Department of Health, and that was working together with numerous stakeholders to ensure that people within Gippsland who are diagnosed with dementia and their carers and their care coordinators, whether their care coordinators be the general practitioner, the allied health provider or a specialist, had one place to go to navigate the system in Gippsland.

You just have the website up on the screen and you just need to look at it. It is a one-stop shop for people in Gippsland to go to. Our role was around the general practitioner pathway, so we worked with local general practitioners and specialist services to enable that we had a diagnostic and a referral pathway that the GPs can go to and be able to navigate a sort of complex system for that type of people.

So, this is just one of many examples of our ability as stakeholders to get together, not only at a strategic level but also at an operational level, to effect change within the community around health and health outcomes.

MR ROZEN: As I understand it, what it's trying to do is bring together in one place, one virtual place, the services that are already out there being provided in the Gippsland area in relation to the treatment of dementia, education about dementia and so on.

MS BOGART: Yes, exactly. So whilst we have a website and everyone can go to the website, it was also about the formative planning, how do we develop the systems and processes to support everyone in the community, but also informing our clinicians and our general practitioners about the support they can have, but it also combined a very extensive education program for a number of clinicians across all disciplines, not only general practitioners, practice nurses, allied health providers, community health, and it was a holistic approach to get one diagnosis into a central suppository of how we can work together.

MR ROZEN: And it's been up and running for about four years,

I think you told us?

MS BOGART: Yes. The initiative is out of the regional Department of Health. It's probably four years old. It is ongoing. We still meet. We are talking about evaluation now and we are talking about ensuring that the information out there is updated. Probably the central focus of the whole project was having a consumer engagement. A consumer is on our meetings at all times and is a very strong voice to ensure that the pathway is patient-centric and we have the right information out there for consumers who are not familiar with our health system broadly, but have difficulty in navigating our health system even in Gippsland.

MR ROZEN: Perhaps you can take that the next step, if you can, or maybe others would like to have some input, but is that something which you think could be adapted for the type 2 diabetes, the other chronic diseases that we looked at, heart disease and so on, because one of the themes seemed to be that it was hard to navigate your way around the system to know where to go for particular sorts of care. So is there a lesson to be learned in this experience for the work the board is doing in relation to chronic diseases?

MS BOGART: Absolutely. Like I said, dementia is just one diagnosis among thousands that we can focus on. Our group are talking about diabetes. A lot of work already has been done in terms of navigating the referral and diagnostic pathways for diabetes in Gippsland. We can apply the principles to heart failure, respiratory diseases. It is just getting the stakeholders together, identifying the strategy and implementing an operational

system that will work.

All I can say is that, having worked within this environment for quite a long time with numerous stakeholders across Gippsland, we are all passionate and committed to actually making a difference regardless of what disease we pick. It's just choosing it, getting the experts together and then implementing it. It can be done. This is just one project that is a good demonstration of what we do in Gippsland and what we can do in the future.

MS BARRY: We did identify in the group essentially that it was about trust and relationships at the end, and we know that can take time to develop. So, one of the suggestions was that we actually should build on where those trustful relationships already exist.

PROFESSOR CAMPBELL: I think in closing we talked a bit about some short term and more medium term objectives and in the short term we felt it was important to go to the data to identify the two per cent, what they look like, what their health care needs look like, and potentially to focus on some specific project within there. The diabetic foot care one looked to be an opportunity area because it was an opportunity to extend scope of practice. We were looking for community based models, but which would have an impact, and to then look to how in the medium term we could look back and demonstrate that there was a process put in place based on data and which would have some demonstration of progress towards measurable outcomes and structures that were resilient, I think. Is that a fair summary? Thanks.

PROFESSOR CATFORD: I wonder if I could just pick up on a

couple of comments. I'm sort of prompted by the internet presentation there. The question is about technology and how technology could assist. Sylvia mentioned the initiatives in e-health. I'm also conscious from the other consultations that a lot of patients, clients, are travelling to see specialists, not here locally but often in Melbourne, and it begs the question about do they really need to move and could the technology actually help greater access through tele-medicine, tele-health.

Then there's the question about whether in fact some of the tests could be actually done where people are in their own home. I'm conscious of some of the advances going on with home monitoring, remote sensing and so on. I just wondered if you touched on that or whether you have any views about the use of technology in terms of chronic disease management.

PROFESSOR CAMPBELL: The starting point for our discussion about the diabetic foot care was really started as a tele-medicine discussion, but actually quickly transferred to the fact that it was more about relationships because, when people got to the bottom of the issue, it wasn't about distance and travel, it was about enabling and capitalising on the skills of people locally. So, there is a bit of a curious contrast here, that if we empowered the local practitioner who happened be the podiatrist, there wasn't the need to go to the Dandenong diabetic foot clinic and tele-medicine was used to support the local practitioner. I think, John, you had some thoughts about this area.

ASSOCIATE PROFESSOR RASA: Yes. The system is probably broader than Gippsland because we had that escalation based on the

level of severity that we are looking at, in particular chronic disease, so there clearly has been links built up with Monash over the years. So, if you can avoid people, particularly when they are unwell, having to travel, then you should try to set up a system to be able to do that.

Clearly there are areas out of the research that's been done around tele-medicine where it has been proven that it can provide, particularly for wound management and skin care and also for cancer, particularly with improved imaging that's occurring, as long as you can set up the scheduling systems that are needed, you can avoid travel. Particularly if they are linked in with their GP at the local level and the specialist at the other end, you can avoid that time that's spent on the road.

So that's improving, I think, and certainly I think the challenge we talked about was payment for that. From the specialists' end that can be problematic, but certainly the tele-medicine trials, and we have been involved in Melbourne with a number of the hospitals, including the Children's Hospital and Monash and others, that there's greater acceptance growing amongst the specialists in the use of tele-medicine. It's just a question of how do you structure it.

I think the review of MBS is a good opportunity to be looking at not only how is chronic disease paid for in the context of the MBS, but also how is tele-medicine used to be able to reimburse the providers so that they are not out of pocket as a result of using tele-medicine. But certainly for regional centres I think it's a great boon and also in paediatrics and also in mental health.

So, there's a number of areas where I think tele-medicine can be more cost-effective and also deliver a better outcome for the patient as well.

PROFESSOR CATFORD: Can I just ask: are there actually any regional trials going on at the moment and could Latrobe Valley be a future trial pilot area?

ASSOCIATE PROFESSOR RASA: There have been a number of trials going on. I think the issue is that they are really being stymied by the current funding models and that's where it's produced a bit of a barrier that needs to be overcome. That's why I'm suggesting further discussions with the Commonwealth, particularly for regional centres, that could be enhancing service structures and new models of practice by using tele-medicine would be useful.

MS BARRY: As well as using tele-health for specialist consultation, it would be nice if the Commonwealth also considered that modality for general practice consultation with their clients, at least in targeted rural communities where isolation is much more significant, and again it's not just about the technology, as John says, it's also about the price and how you incentivise the use of that, which hasn't been ideal even in terms of secondary consultations.

PROFESSOR CATFORD: It is a moot point, but of course the price is being borne by the client or the patient if they are having to hike in and give up a day's work or the cost of actually travelling for a 10-minute consultation or something when it could have been done actually more effectively through a tele-link.

MS BARRY: Yes.

MR ROZEN: Thank you. I'm very conscious of the time. I know

we have two other sessions to get through, so now might be an appropriate time if any members or all members of the group want to make any fairly brief closing observations about this morning's discussions. Don't feel compelled, but if you do have anything. John?

ASSOCIATE PROFESSOR RASA: There is one area that we didn't quite touch on. I think the importance of having a patient/GP relationship, the literature does show that you get better health outcomes. So if that sort of relationship can also influence behaviour change, because I'm mindful that in many cases it does require some lifestyle changes to occur and so the literature does show that the GPs and other health professionals are in a fairly influential position, including nurses, in being able to drive that change. So I think that's an important thing to consider.

Then it also begs the question do you have enrolled populations where in fact there is some accountability on the GP to ensure the good outcomes are being achieved for people with chronic and complex conditions. So that's another thing to consider, but you would need to have the patient identify with that particular general practice, not necessarily a general practitioner, but a general practice so that their records are held there, et cetera.

The other thing we talked about is how do you know what care is being delivered? If in fact someone has got multiple conditions, then we need to look at things like the Myhealth record which the Commonwealth is rolling out and I think they are being a bit more vigorous in rolling that out now, of how to actually capture

information summaries about what's being delivered to a particular client and whether in fact all the services that were ordered were actually delivered. So I think that's another important component of actually being able to monitor what's happening in a person's life in terms of engagement with the system.

MR ROZEN: Thanks, John.

PROFESSOR CAMPBELL: We talked a little bit about the importance of sort of multiple layers of the service provider group. There was the community nursing service that, as an outsider looking in, I think the community nursing model you have here is a particular strength, and the ability to build on existing capabilities, the importance of the electronic record, and the new service model that you develop in this space should be targeted and focused and it's a combination of a service with an IT platform, but the IT is an enabler and you don't wait for that to arrive because we've spent the last 25 years waiting for the promise that an e-health record might deliver, so I don't think we would want to hold our breath waiting for that. It's an enabler only.

I think it's focus, focus, focus, because if you're focused you can answer a question and if you're not focused you will never be quite sure what you did. It's focusing on initially the super users and arguably the next group, the emerging group, who have multiple co-morbidities and who are at risk. We are not focusing on the objective of reducing their hospital use; we are focusing on improving their health. If we get that right, they won't use as much acute hospital time. Thanks.

MS BARRY: Just a couple of comments from me. A lot of the

conversation has been on the super users. I would urge people not to forget about prevention and early intervention and I know other groups will touch on that, but particularly I have a bias to early intervention, so I will declare my hand.

I think it's also a really exciting time at the moment that we have reform processes happening at both the Victorian level and the national level. Just an ad on the Victorian process. The Health 2040 document is on the web, submissions are open until 7 October, so I think it's a really important opportunity for people to feed into that process, and then of course that there are a number of processes happening at the Commonwealth level. Given that they are such a major funder and player in this space, I would also urge inputting into that process as well.

MS BOGART: I would just like to add that one of the things that we did talk about is that we work on a 9 to 5 model of providing health care and if we are talking about prevention and early intervention, particularly for people of 40 years and over who are going to be at risk of having chronic disease and complex issues, that there has to be a model that supports services to be able to open after hours to provide some prevention care. At the moment the MBS model probably doesn't support general practices to do that, given that it will only support a GP to be present in the practice after hours, not any supporting staff like a receptionist or practice nurse to undertake some of that care.

MS BOVERY-SPENCER: My last word is about consideration of using terms such as "episodes of care" when looking at

funding models as opposed to "occasions of service". I think that will strengthen our multi-disciplinary approach to the care of people with chronic diseases.

MR ROZEN: I will just check if any of the members of the board have any further questions for the panel. No. It just remains for me to thank you all very much for your time today. It's been a very beneficial exercise, very helpful for the board, so thank you. We will do a quick costume change and then move into our next session which will be health behaviours.

(Short adjournment.)

HEALTH BEHAVIOURS

MS SHANN: This is the fabulous health behaviours forum with the fabulous participants. Just to introduce it quickly, before I think it is going to essentially run in a pretty self-sufficient manner, but I might jump up and down if need be. We have some slides to put up which I think will come up soon. So, what we have is anything that comes up bold is a suggested short term improvement, underlined will be medium term and italic will be long term. But, as people go through, they will refer to those as they do.

Kellie is going to chair the feedback session and just throw to different participants as we hit different types of improvements that people had some real ownership of in the group. Perhaps firstly before I just hand over to Kellie, if people could just identify their name and the organisation that they are from and then I'm sure there will be a bit more expansion on that as we deal with some particular improvements suggested.

DR BOLAM: I'm Bruce Bolam. I'm a member of the executive team of VicHealth, the Victorian Health Promotion Foundation

established as a statutory agency here in Victoria in 1987.

MS SKELDON: I'm Alison Skeldon. I'm the Executive Director of community support and connection at Latrobe Community Health Service and we're a partner in Healthy Together Latrobe.

MR ATKIN: My name is Luke Atkin. I'm from QUIT Victoria which sits as a part of the Cancer Council Victoria.

MS MARTIN: I'm Jane Martin. I'm representing the Obesity Policy Coalition, but I also manage alcohol and obesity policy at the Cancer Council Victoria.

MR SWITZER: I'm Barry Switzer, the Executive Officer of Gippsport, which is Gippsland's regional sports assembly.

MS PIONTEK-WALKER: I'm Holly Piontek-Walker from the Department of Health and Human Services and I'm from the population health and prevention strategy branch of the department.

MS RHODES-WARD: I'm Sara Rhodes-Ward, the General Manager of community liveability from Latrobe City Council.

MS JOLLY: I am Kellie-Ann Jolly. I manage the health programs at the Heart Foundation which is a non-government organisation.

MS SHANN: I will hand over to you, Kellie. My last word is forget about me and eye contact with me. I have had the pleasure of your company all morning. These are the three people to be directing your suggestions and recommendations to, so really focus on these three and I will sit down and disappear into the background.

MS JOLLY: Thanks, Ruth. This is definitely going to be a collaborative effort in the spirit of a lot of the discussion that happened this morning, really about

collaboration. So I will, as Ruth said, be throwing to various people to perhaps expand on some of the points that are coming up on the slide.

But first of all we did start with some, I suppose, overarching principles or just some notes to consider before we went into looking at some of the priorities. I'm sorry it's very wordy, but we didn't have a chance to wordsmith, so hopefully we will expand it a bit more to make it a little bit more meaningful for you.

But I think one of the things that we really felt was the need to really - we have to look at sustainability, and we know that this is a word that we hear all the time, but if we are really going to make a difference we need to look at things that are sustained and over time to really get to achieve any form of change, particularly in this area of healthy behaviours, and to really invest.

What kept coming through this morning was really the importance in investing in community and how we engage the community in this process, rather than us coming up with a whole lot of priorities that we think we should do to people with people. It's very much around engaging the community, and to resource that kind of action is something that we felt really strongly about, that this really needs to be resourced; rather than keep adding in a whole lot of additional activities and interventions, how we can actually build on where the community is at now and how we can listen to them and take our lead, I guess, from them.

Another key, as you see the dot point there, the second dot point, is really looking again on building on

the good work that's already happening down here at the valley and taking a much more positive strength approach rather than always talking about the deficits or even the negative statistics or the poor statistics that we tend to hear. So, how we can really build on that positive work that's already been done and the strengths that we have, and to really start to take a more coordinated - again kind of a jargonistic term - but that notion of a systems approach rather than just always looking at the individual, and again really building on the work that's already been happening down here through the Healthy Together Latrobe.

So this really does set a foundation for any actions that go forward and that was a lot of our conversation, particularly around looking at some of the shorter term things that we can start to think about, were really about building on the good work that's already happening.

So, again picking up on that it's about behaviours, and I know that this group was about behaviours, but really that sits within a broader system and environmental change. Yes, people can change their behaviour, but if we are not supporting that behaviour by the environments and the systems around them, that's not going to be helpful.

One of the comments that was made, and we thought this was quite nice, that we want to nudge rather than shove people into going in a certain direction, so it's really about how we bring people with us. As we have said, there are good examples of initiatives, innovation already working in Latrobe and we need to continue to

build and extend on these. So, these are the kind of broad discussion points that we started with.

It's not just about delivering services. Again, it's about enabling communities to take action for themselves and that's the only way we feel that we are going to get that sustainable action as we go forward.

The other thing is to really use, I suppose, staff in agencies such as the council. We were very fortunate to have someone from the council, Sara, and Alison from community health on our group to really be the voice, I suppose - we called it the amplified voices of the community - so to really help by advocating and championing for their voice will be the most effective way.

I might just flick to Sara here because I think it's important to hear a little bit about the work that's currently going on that's really about engaging community that's starting to get some traction. So I might pass over to you, Sara.

MS RHODES-WARD: We were fortunate enough to be able to speak about some of the work that we have been doing in the recovery space to date. We have mobilised a trial approach, engaging the community in a trial neighbourhood of Morwell, actually the community closest to the mine wall, and have moved door-to-door through a designated area speaking to residents about opportunities that they may feel present themselves to enhance their overall health and wellbeing.

We are particularly interested in the key areas that sit within our municipal public health and wellbeing plan, so being active, eating well, staying safe, feeling

connected, and asked a range of questions prompting them into a more sort of positive future orientated space as opposed to a reflective deficit based space, seeking to really unearth what's working well as a position of strength and how that might be an opportunity for moving forward or to leverage into further action with that particular community.

So, we spoke to roughly an area of about 230 households, roughly. We spoke to just over 70 individuals in that space and we had about 35 of them come together in a community workshop. I guess the conversation I was having with the group is that obviously within council we work with the community on a regular basis and there are lots of very engaged, very active community members, and we often hear from those same engaged and active community members on a range of subjects.

Certainly when I attended the first workshop for this neighbourhood it was just absolutely delightful that there were 35 people who I had never met, who council hadn't engaged with before and who were quite honest about saying that they would never have come to a council thing if we hadn't actually gone to their house and asked them first. So we worked with the community and we asked them the questions and then we reflected the results of the survey back to them.

I was sharing with my colleagues that my favourite statistic was one largely around social cohesion and the question we asked is "Are you comfortable asking your neighbours for help?" And 93 per cent of respondents said "yes". So we were instantly present to the fact that this is a community that already feels connected and how

do we then leverage that as a position of strength for ongoing health and wellbeing work.

So we are now moving through a process with that particular community. They are creating their own plan. It's not council's plan. It is their plan and the initiatives they think they can use to enhance their health and wellbeing.

During one of the meetings, two gentlemen started to have a conversation together talking about old walking tracks that were around the neighbourhood that they lived in and "wouldn't it be great if we could discover those again" and within moments they had organised a time to meet with their secateurs because they were going to reclaim those tracks for their group that they now felt very committed to and for the broader community. The last time I met with them, they had indeed been rambling in the wild finding these hidden tracks.

So, as an opportunity to work with the community and to support them in that space it's been an absolute privilege to be supporting them in coming forward with those ideas. So walking tracks was one thing. We actually this week will be launching a new walking group for them connected to the rose garden in Morwell. That launch will be occurring in the coming days, and there's a number of other things that they have asked council to investigate that either council can support and facilitate or we can leverage services or investment and interest from a range of other allied services.

So, their report will then go back to council as information, but it will and always will remain their report, their document on how they would like to support

an increase in their health and wellbeing. It was a pleasure to be able to share that with my colleagues today.

MS JOLLY: Thanks, Sara. I will go into that in a little bit more detail because we are actually looking at that as one of our options. The other thing that we identified, too, is that it is quite timely of how this process can fit into some of the bigger contextual work that's going on at state level. There is the State Public Health and Wellbeing plan that Holly had held up that has just been released which has a broad framework for the state, and then of course every council then is mandated or has a mandate to develop a local public health and wellbeing plan which happens to be coming up next year in 2016. So there's a potential opportunity to look at how we can link this work together.

Also we talked a bit about the importance of looking at some of the broader state programs and systems that are around that we can actually tap into, such as two that came up were the Achievement Program that's currently around and Live Lighter that needs to be utilised or sustained. So they are some of those overarching issues that we discussed in talking about our options.

As Ruth said, they are a little bit all over the place but we have tried to code these around the bold. So some of the options that we came up with and picking up on what Sara talked about was really recognising that if we are really wanting to engage the community in a way that is meaningful and does empower them and if we are going to look at building on the example that Sara spoke about, it does need support and quite considerable resource - we are

talking people power - to be able to do that.

I think Sara was mentioning that there were about 16 neighbourhoods just in that kind of Morwell area, so if we were to expand that kind of methodology of trying to engage, it would require some more resources. But we felt that by investing in that process that's going to have a greater benefit down the track. So, again we have been thinking about how we sustain this activity and this investment in healthy behaviours.

So, one of the key options was to support and resource the development and implementation of looking at neighbourhood local plans as opposed to just looking at a broader council public health and wellbeing plan, just to get it down into a more neighbourhood setting, I guess.

The second one was looking at - and this was probably more from some of the statewide programs, and there were a number of us there: QUIT was there, us as the Heart Foundation, Jane from the Obesity Policy Coalition and others, and VicHealth, which were really looking at how we can more proactively work with Latrobe Valley communities to tailor activity according to needs, so that opportunity to really link a little bit more, so the statewide work really starting to tailor a bit more with the local community, which perhaps hasn't been done as much as it could and we recognise that's something that we can do in a relatively short period of time.

MS SHANN: Can I just stop you there. Could you or maybe one of the other panel members just expand on that one a little bit and explain what some of those ideas were about how you could link state and local levels.

MS JOLLY: I might pass to Jane or even Luke, because you were

specifically talking about some examples.

MS MARTIN: I will just briefly talk about Live Lighter. Live Lighter last week released a whole lot of mailings that went out to GPs. Live Lighter is a campaign, a statewide social marketing campaign, but it also provides other supports. It is around the next campaign which will be on television which is focused on sugary drinks, to try to reduce sugary drink consumption, but the materials that go out to GPs are to empower them to have the conversation, to support and encourage their patients to be more physically active and to have that discussion around diet as well.

So, that's just one example of how these bigger campaigns can provide some hooks for local communities and resources for local communities to engage around risk factors.

MR ATKIN: I will talk a little bit more about tobacco in a few minutes, but one of the things that we thought about here is there is some really good evidence that proactive offers of support around quitting work really well, so engaging with people who aren't coming to us, so cold calling people, bringing them in, to offers of Quitline support, so telephone based counselling support, as well as them being able to refer people back into local community health centres that have been really empowered to provide a co-managed model of care, so being provided with support around tobacco smoking and quitting behaviours within their local community health centre as well as receiving telephone based support, so kind of linking the two together.

DR BOLAM: I will be very practical about it and attempt to be

brief. From a Vic health perspective, already the inquiry has been really useful in that it has prompted us as an organisation, we are VicHealth, Victoria, but very much in the terms of the inquiry it is a long way from Carlton to here where we are today. It's two hours on the train. Therefore, what the inquiry has actually prompted us to do is look at the work we are actually doing in a concrete sense, funding work in the area, in Latrobe, and then kind of we are thinking about how do we coordinate that, how do we share that information, not just internally at our organisation, but how do we go out and engage more right the way across Victoria.

That's a piece we are already thinking about internally organising. Our organisation works very closely with QUIT, with Jane, with Barry from Gippsport and so forth, so it is quite easy for us organisationally to think about, okay, there is just purely a piece of coordination that we can do more effectively and that has already been prompted by the inquiry, so it is something we will hopefully be following through on.

MS JOLLY: Something that came up, actually I think in the other group, which was picking up on the third dot point here, which is the notion of looking at the issue of touchpoints and how we can capitalise on when people are talking to others, that there's an upskilling of some of the messaging and the information. So starting a conversation; for instance, you might go to someone in the community health service that might be their physio and how that might prompt a discussion around smoking or physical activity or diet. So it's not that everything is siloed. I think this was the idea. I think we came up

with this. So this notion of upskilling others to get this sort of constant reinforcement of the messaging and raising it with people, so whether it's your GP, someone in your community health service, you go to your community sporting facility and someone is talking about smoking, so there is this constant engagement and reinforcement of messaging. So it's not just coming from your GP, but it's a range of different community agencies and individuals. I think that's what we were - - -

MS MARTIN: It was about the consistency with all those touchpoints throughout the community, that they are giving a single consistent message so it's all mutually reinforcing.

MS JOLLY: And capitalising on that opportunity when you have someone there and, as Sara said, some people are not always engaging across the board. So, if you have a person or a family coming to you, you are capitalising on that opportunity to speak around a range of things, so at least have a conversation. But that would require some level of upskilling with various providers.

The other thing that we talked about was extending the Health Champions program and looking at how we can embed this and build and expand on this within the local neighbourhoods, and that we thought would link to the notion of the health advocate that was coming through. I might quickly pass to Alison, for those who aren't aware what the Health Champions model is.

MS SKELDON: Sure. Thanks. The Health Champions are community members, like anybody else in this room, who have an interest really in healthy behaviours and healthy eating. They have actually enrolled with us as Health Champions.

So we currently have 236 people within the community who receive our messaging through the Health Champions networking that we do and 156 of those are actually registered Health Champions who come along to our events, attend our training and really become ambassadors or champions out in their everyday working and community life as, I guess, ambassadors for health messages and they want to do that work and they are engaged.

We understand from looking at other examples of where health championing works that that number of people engaged is a real achievement for this area and I guess it just builds on what Sara was saying about the fact that people do generally have an interest in doing these things in their own community, but it would be really good to be able to capitalise on that engagement and involvement.

MS JOLLY: While you have the floor, Alison, you might want to pick up on extending it, because another value add or something that we can leverage some good work is the Food Sense program. So I might get you to keep going.

MS SKELDON: Sure. So, the Food Sense program is a three-step program which is about encouraging people to learn more about buying food and cooking food, and buying and cooking healthy food. So there are three sessions and the team have delivered this session to parents through primary schools at this stage, but they are very keen to extend it to other outlets or avenues, for instance neighbourhood house groups.

So, there's three sessions. People come along and learn about budgeting and what it's like to budget to purchase shopping for cooking. They do a supermarket visit where they look at labelling and look at the way

things are priced and shopping lists. Then they actually have a cooking session as well. So it is an evidence based program and the research has shown that there is a definite increase in the amount of fruit and vegetables consumed by the families that have been through the program and they definitely feel more confident about undertaking that.

It does require resourcing because it assumes a level of numeracy and literacy in the groups. The groups that it's being worked through with currently, though, have all been engaged through primary schools and parents of any age pretty much have managed it really well. So that would be another area. That links once again back to the opportunity to link it with other activities or other campaigns that might be happening at any one time.

MS JOLLY: Another area that we felt we could look at is the area of considering publicly funded services and looking in Latrobe Valley to model procurement like healthy food procurement and to actually establish some level of - whether it's catering, active living or healthy food in predominantly public funded services in Latrobe Valley.

That was something that we are not mandating it, but looking at ways in which we can bring people along with us and again there are some good examples of this sort of work happening already down here, I think particularly with the community health service and I think even through the council and through others where it's modelling, it's good modelling around ensuring that healthy eating, physical activity, smoke free, all those things are being modelled and built into the services that are being provided, as well as trying to look at that in

the community. Does anyone want to add to that?

DR BOLAM: VicHealth is working on a program called Leading Thinkers Initiative at the moment and we are working with Dr David Halpin and the behavioural insight team, a UK based team. They have a really useful and interesting framework for thinking through health behaviours. It's called the east framework and it focuses on four things: For behaviour to change it has to be easy, it has to be attractive, it has to be social and it has to be timely. When we think about the environment in which behaviour occurs, we realise that we are getting little nudges in one direction or another all the time or it could even be a shove.

What I find interesting, and we discussed this pretty extensively at our meeting, is that I was sitting out here in the crowd before and it was really interesting. The challenge here is this is actually a workplace, but we are all sitting down and the research tells us that we shouldn't be sitting down all day long, we should be getting up every 30 minutes or so, and in our working group we had the opportunity to get up and do that.

But it's a really interesting example of how the simple act of just standing up actually needs to be authorised and that's one of the major opportunities of the inquiry and of the reason why we should be focusing in the first easy wins on publicly funded services, because if we can't do it, if we can't collectively do it, if VicHealth, Gippsport, if we can't collectively make that happen, what hope do we have of influencing the communities who actually are our staff, the local public

services, our major employers within the Latrobe area. If we can do more to energise that change within public services, we can go a long, long way in terms of showing the commitment to a healthy, to a thriving Latrobe that we are here to do.

We were just thinking, in terms of particularly in the short-term, it actually sounds very, very simple. It is extraordinarily difficult and anybody who has tried changing a food vending system or going into a local leisure centre, take away hot chips, will find out quite how on the wish list of health behaviours we talk about health behaviours as "They're really, really nice, as long as I don't actually have to change anything."

PROFESSOR CATFORD: All right. I think we can stand up now.

MS SHANN: Can I just ask a question about that. How do you change? What are the ideas that the group came up with for how the board might recommend changes in that space?

MS MARTIN: I will just give one example that's happened in the health care setting. The Alfred Hospital in Melbourne wanted to reduce the consumption of sugary drinks but they didn't want to remove sugary drinks altogether. So, in their vending machines they changed the position and the amount of sugary drinks in the vending machines and at the canteen they put the sugary drinks out of sight so you couldn't see them.

What happened was the amber drinks, which are the not healthy but better for you than the sugary ones, and the waters, they sold more of those, the sales of sugary drinks went down, the concession didn't lose any money, but it changed the behaviour and it was also important modelling.

So, there are examples like that which can show proof of concept which are nudges. It's slowly changing things. They also changed the portion sizes in the canteen as well and got rid of the larger portion sizes and put the healthy food close to the checkout and changed the pricing. But there are a lot of ways you can intervene. There is quite a lot of success now with the Healthy Together Victoria. We have quite a lot of really good examples that have been evaluated of success, which I think is fantastic.

MS RHODES-WARD: Certainly within the council setting we have created a catering framework that actually requires individuals who are sourcing catering for council functions and events, they are required to actually have a larger proportion of healthy choices available to people attending, be they staff or be they members of the public. Certainly if I think about five, six years ago at council, if I even think of council meetings and council meals, there was a councillor that we loved dearly but his dinner order was always six dim sims, six fried dim sims. He can't have six fried dim sims any more, he now has to have a salad or a risotto. He still wants six dim sims, but he can't have them because the catering framework doesn't allow those meals to be ordered any more.

So it's a stronger push in terms of supporting behaviour change, but certainly in terms of an organisation we have a range of levers that we can pull and we really did feel that we could be quite comfortable enabling that one.

We also operate a large number of children's services in the municipality, 24 to be precise, and

likewise we have ensured that the same food guidelines are present in our children's services and then we extend those activities out beyond that, with children doing gardening in their playgrounds. Every time I go to a child-care centre or visit a daycare or a preschool, the first thing the children want to do is show you their vegetables. They are enormously proud of their vegetables. They know what they are, which is fantastic, and they always seem to think you don't know what broccoli is and they have discovered the source of life for the universe. But they will show you their carrots and their broccoli and they will talk about how the teachers cut them up and they all have them for their lunch.

So at a local government space there are a range of levers that we can pull and a range of avenues into the community, certainly in some of the places where we have used that approach.

MS PIONTEK-WALKER: At a statewide level we have the Healthy Choices guidelines for hospitals and health services, and likewise of course the school canteens guidelines. So there is I guess statewide support, so we have the Healthy Eating advisory service that provides advice then to those settings, but I think what the Latrobe area has done really well is actually work with the settings, so rather than just relying on the statewide service, there has been an incredible amount of leadership at the local level to work with. For example, the Latrobe Regional Hospital has been working with the local staff, but also the statewide service, to revamp their cafe and vending machine choices and all of that.

MS SKELDON: Certainly as part of the workplace settings

there's been work around helping organisations and workplaces to embed healthy catering policies into their policies and procedures. So we have certainly done that at Latrobe Community Health Service. We have also trialled a couple versions now of Think on your Feet, which is exactly about what Bruce was talking about, which is about making sure that we reduce sedentary behaviour and creating the opportunity to do that by putting sit/stand meeting spaces in at work. So there are people who have access to a bookable sit/stand desk and also meeting rooms that have a sit/stand table in there as well. We have built that into our policy and procedure now for future development work that we might do that will ensure we have those available at every new development that we do; so by modelling that but also giving ideas about how we can practically build that into the achievement program and then helping other agencies to do that.

MS JOLLY: Thank you. I think that was again another opportunity to look at how we can get that consistency and reinforcement across various settings rather than just focusing on one.

I think the last one there was really a ramping up on the Health Champions, which is really more a mid-option, which is really to expand the Health Champion model but then to strengthen that by looking at how we could develop more peer support components of that. So that will just be part of that mid perhaps a little bit later down the track.

In terms of tobacco, we did talk a little bit about tobacco. I might just pass to Luke to kind of pick

up on this particular one that we felt would be able to be achieved within the first one to two years.

MR ATKIN: I guess we do kind of see that tobacco or the example of tobacco has some translation into all the other areas we have talked about, but it is really around looking at how we can better empower and enable people living in the Latrobe Valley to be able to quit. The evidence is really strong that most people want to quit; it's just around being able to enable and empower and support them to be able to do that.

I guess the way we talked about it was that it's really again leveraging off the really good local base of services that we have here. So again picking up on the model of local champions, looking at how we can continue to build those local champions to be advocates for quitting, advocates for smoke-free living, looking at how we can provide complementary messaging. So we do lots of statewide social marketing around trying to push people into quitting and triggering quit attempts, how we can use perhaps some local messaging to do that as well.

We know again from a lot of research, particularly within Aboriginal communities but more broadly, that seeing a local face around providing some of these messages is a really good way of engaging people and emboldening them to make a quit attempt.

There's a lot of opportunities to be able to use the local service providers that are already here, so the really good health services. Latrobe Regional Hospital is one of the first health services in Victoria that went smoke-free many, many years ago before I started working in this area. But there's good links into community

health centres, there are other health providers in the community, and I guess looking at how we can empower them and authorise them to be able to talk to people around smoking, kind of looking at how we can collect more information about who smokers are but then authorising these health providers to be able to provide support as well as push them into the statewide supports that we provide like Quitline and providing that co-managed model of care.

We really wanted again to talk about those various touch points across the community so that you are getting consistent messaging at wherever you are intersecting particularly across the health and community health settings, and that things like screening become normalised behaviour. So if you are a consumer of health services in Latrobe Valley, you kind of have the expectation that it happens every time you intersect with the health service that someone talks to you about your smoking, they ask how it is going, they ask if you want some support about it or if you would like a referral.

Then we talked about, and this kind of feeds into the next thing a little bit which Barry will pick up on, looking at how we can further activate the healthy environments, so further reinforcing or denormalising smoking behaviour, reinforcing smoke-free environments, looking at how we can do that in partnership with the sporting clubs, looking at how we can do that in partnership with any of the other activities that are going on around urban planning or urban renewal in the area and looking at creating more and more smoke-free environments that denormalise smoking behaviour; and then

going on to the stuff that I touched on earlier, what are the ways we can innovate to go out and find people and provide quitting support. Is it by cold calling people on the phone, through the phone directory? Is it around going into local shopping centres and providing brief interventions in local shopping centres to push people into quitting support? We know that the more support people are provided with, better access to things like nicotine replacement therapy, the more likely people are to have a success around quitting smoking.

MS JOLLY: Sport, as Luke said, we recognise as a really strong setting where the environment - I suppose sport has two roles. One is to increase participation in physical activity to get people more engaged. It helps with a sense of connection and engagement. It's also an environment where you can actually promote healthier messaging. So it has a really strong role to play. So we recognise that.

Luke mentioned the notion of trying to look at the environment, particularly around, say, smoke free, and Barry did talk a lot about or enlightened us about the exciting and important work that Gippsport does down here, and I know you have a fantastic record down here, Barry, of the work you are doing around canteen and trying to engage particularly those who are less likely to participate.

One of the key challenges that we identified was that people are really shifting and changing what they are looking for in sport, and that we need to adapt to the community need, particularly around providing informal sport options. People aren't necessarily willing to

commit to the old training and playing and everything else. They still want the competitive aspect but not necessarily the commitment of signing up and being a member of a local sports club.

Barry, rather than speak on behalf of you, I will pass to you and you might want to pick up on this issue. One of the priorities or recommendations was to look at how we can better equip clubs to support these informal sport options.

MR SWITZER: Thanks, Kellie. Clearly the research that the Australian Sports Commission has carried out recently around market segmentation supports what Kellie has said with regard to the segments of the sporting community, and the evidence certainly indicates that there are many more people now not wanting to actually be engaged in formal sport. We still have a number of people who do and participate very actively and very happily.

So I guess a couple of things that we have been addressing in terms of challenging the sports and the sporting clubs was to actually have a look at their product, what they are actually offering and looking at ways in which they might be able to offer some modified forms of sport or not formal sport. We are finding that a bit of a challenge in a sense because a lot of our sporting clubs gauge their success, as you know, on what happened at Traralgon on Saturday when Traralgon won the premiership. Obviously that's a mark of success.

We take the position that that's not the only mark of success for a sporting club, and we really strongly encourage clubs to take a position that they are providing an opportunity for people to engage in physical

activity but also an opportunity for people to be socially connected as well as the opportunity to, if you like, engage with other people and to encourage a healthy lifestyle.

Within that context we are doing a lot more work with sporting clubs around things like social inclusion, hoping that our sporting clubs are welcoming and they are inclusive. Certainly the healthy canteen space is a space that we are very interested in. Quit, obviously it would be remiss of us not to be working with Quit because we are very, very, very strong about trying to provide smoke-free environments in that situation as well.

Prevention of men's violence against women is a space we have been doing some work in. Also the illicit drug space, supporting clubs in policy development and implementation there; and also of course alcohol management policies with the Australian Drug Foundation Good Sports program; and in particular a partnership that we have with VicHealth, who have been a fantastic partner of Gippsport for a number of years, I might say. We have just embarked on a new program called the VicHealth regional sport program which is based around engaging inactive and somewhat inactive people in sport. So I guess we are not targeting those people who are currently involved in sport; we are targeting those who we hope will become involved.

Within that context we have a lot of work to do to engage with our community, and Latrobe City is included in this of course. We want to have conversations with various segments of our community in an effort to find out what they would like to do rather than us telling them

what we think they should be doing.

In conjunction with our state sporting associations and our sporting clubs we are going to be doing quite a bit of work in that space over the next three years. Our goal will be to increase the number of inactive and somewhat inactive people and having them involved in community sport in an ongoing way rather than the six-week "come and try" sort of thing. That's a little bit of work that we are involved with at the moment.

I guess from our point of view the work that we do with community sporting clubs is really important. I guess there may be some people out there who are members of committees of sporting clubs and would understand that sporting clubs are now being asked to be involved in a whole raft of things, and unfortunately they are in a situation where they are in a declining volunteerism situation, and that's another part of the market segmentation that indicates that there are a lot more people now who are quite happy to participate in sport but don't particularly want to volunteer their time to add value to the club in terms of coaching or whatever the case may be. So we are looking forward to the next three years in increasing participation in community sport and in particular in Latrobe City.

MS JOLLY: Thanks, Barry. The other thing we had quite a significant discussion around was the one that, John, you mentioned which was about the free fruit for kids and felt that, if this is something that we would consider, it needs to be done within a broader context rather than seen as a discrete program or project that's being run in a

school.

For instance, we discussed ways in which that could potentially link in to other work that's being done, whether it's how can you engage the local fruit producers, for instance, and how can they be part of this program; is there some way that fruit can be grown at the school so it's part of that learning process rather than just seen as a handout; is there some way that we can link this program into the food sense work that we were talking about before. So I don't think the group were overly keen to be recommending this as a standalone initiative, but could see that there might be potential for that to be looked at within the bigger context of other things that are going on. So again it's another reinforcement.

It did get raised that perhaps if we are providing fruit that could potentially be that there's a sense that because it's being provided at school it may not need to be provided in any other time. I think we discussed that it could be something in the mix but it needs to be seen within a bigger context. Does anyone want to add anything more to that?

DR BOLAM: I think everybody recognised the importance of the message that something like that sends; a really clear message to community about what we stand for. Something that was implicit within all of our discussion around health behaviours was that it's a balance of, on the one hand, changing the environment so that the healthy choice is the easy choice but also sending a very clear message. This is where concepts like healthy cities previously worked. For example, there was one campaign around Glasgow's Miles Better, which at the time was rather

oxymoronic. Glasgow is famous for having the worst - the sick man of Europe in the true sense of not just the worst health in the UK but in large swathes of northern Europe as well, incredibly poor health and wellbeing outcomes there. Yet the campaign itself served a really powerful platform for a whole suite of activity through government into health services, into general community, a kind of coordinating voice in a way, a rallying point around which community could activate.

Those kinds of things like free fruit at school as a symbolic exercise can be incredibly powerful if linked through to wider kind of system change which obviously is a bit more off stage, a bit more behind scenes, but ultimately can potentially lead to those significant changes on an individual behaviour level.

PROFESSOR CATFORD: I wonder if I could just jump in there. Some of the commentary has been about trying to take statewide programs, customise it, localise it for Latrobe Valley. But in some ways we have lots of vertical programs running. Did you talk about actually could you just bundle all this together and have something which was uniquely Latrobe?

MS JOLLY: As things were coming up we recognised there was a whole lot of initiatives and we were only just touching the sides, really, in the time that we had and felt that there was an opportunity to pull all that together - we talked about it from a menu perspective, but recognised also that we needed to value what the community wanted as well. There is this challenge between evidence base and the community has to own and be empowered with this. So we can bunch everything up and say, "Here you go." But it

was almost this notion of if we did this community engagement work at the neighbourhood level to determine what it is that is coming through that the community felt that they needed and wanted, then there could be a whole range of things to help support them. We called it a menu, I think, like a menu of things and options that could potentially support the community to engage in those things. Is that a fair assessment?

MS RHODES-WARD: Yes, and I think to some extent the strength of an approach would be its capacity to change and alter depending on the community that it's working with and that the community's priorities and the community's views around what would support their health and wellbeing, that the system is adaptive and flexible enough in that it can then go into that space with that particular community and meet those needs.

I think it is about being comfortable to some extent with the fact that it probably will be widely variable. The community closest to the mine wall, it's a community that's been there for a long time. They are very proud and they love living and working in that area; whereas some of our other communities we know that residents in that area change over quite regularly. So they are likely to be there for one or two years. So the issues that they raise around impediments to their health and wellbeing are likely to be very different from the community we have just finished working with. Any approach will need to be flexible and adaptive enough that it can actually cater to that.

DR BOLAM: One of the things that we were really very clear on as a group collectively was the importance of making sure

that the legacy of Healthy Together Victoria, particularly Healthy Together Latrobe, is really captured in this. Obviously one of the main things we were thinking about was the reality is that program and its associated funding, as I understand it, is going to conclude at June 2016 next year and obviously that's post the recommendations of the inquiry. But thinking about in a concrete sense that's actually a fantastic piece of architecture for Latrobe that has been put in place that does have that potential. That's something for, I guess, the inquiry to consider.

MS SHANN: We are getting very close to the time. I know there's another slide perhaps to touch on briefly, and maybe to have an opportunity for any panellist who wants to just highlight one thing that they would like the board to be considering as a recommendation. You don't have to take up that opportunity, but if there was something in particular that you just wanted to emphasise that might be a nice way to conclude. Kellie, do you want to just touch on that last slide first?

MS JOLLY: Yes. This was trying to get into the longer term, and we probably didn't spend as much time on this as we could have; but really looking at the whole issue of really wanting to make some changes around people being active in getting out; we need to look at some of the changes to infrastructure potentially, whether that's particularly around how we are planning our spaces, our public spaces, whether that's through hard infrastructure, whether it's the way we are planning and designing new areas or retrofitting existing ones, or how we are creating green spaces and places for people to recreate,

and recognise there is already work going on in that area but that's going to take some time. We might get something happening in the shorter period, but usually that's more of a longer term.

Then thinking about social determinants we talked a little bit about the issue of sport and that one of the issues is the cost of being a member of a community sports club and looking at what we could do and is there potential opportunities for further investigation.

Although I think Barry said that's definitely going to be a long-term affair, just to give an example, it could be cricket, we weren't picking any particular sport, but we talked about is there potential to develop a cooperative of local clubs where, yes, they are competitors when they are actually playing a game but how can they be collaborators when it comes to helping to support each other with things such as equipment, uniforms, things like that that could be an impediment for people actually participating in community sport; is there a potential for some form of collaborative where they could actually come together on those sorts of things, or whether it is transport, rather than the actual recognising they are competitors in other areas but perhaps they can work together a bit more in that.

Then another idea was to even look at how local clubs could be developed - I think we called it social enterprises or something, Luke, I think you mentioned - looking at again that cross-fertilisation of messaging and what we are trying to do here. So you might be going to play sport at a local community club, but is there potential for that area to engage in a community garden,

for instance; so does it have to be just about providing sport. So there's opportunity for further investigation on that. I think they are the key things.

MS SHANN: Does anyone want to take up the invitation I without warning have just thrown out there in very brief terms, because we are at the end of the time? But is there a top recommendation that is close to your heart from perhaps the particular backgrounds you are coming from?

MS RHODES-WARD: I'm going to take that opportunity, thanks, and again reinforce that I think an approach that empowers communities and supports communities to create a healthy and positive future for themselves is one that probably has the greatest sense of being sustainable beyond finite funding periods.

I'm certainly not leveraging the self-interest. Whilst council is currently undertaking a piece of work, the methodology could be well handed on to the advocate or somebody in that space to continue that piece of work. It doesn't necessarily need to be council. But it certainly is an opportunity to take that piece of work forward if we were looking for something that could create localised plans and then build up into an overarching document which then sets a framework for the development and implementation of a range of initiatives.

MS SKELDON: The work of Healthy Together so far has really started a lot of that work and a lot of those conversations. So really the idea around engaging with the community and increasing capacity within the community, Health Champions, those kinds of things are those things that will transcend the life of a government and potentially also connect with the life of a health

conversation zone or health advocate as well. So I just wanted to reiterate that, and that there are lots of really good initiatives happening and the opportunity is there to actually join those dots and then build capacity with what's already happening on the ground.

MS SHANN: Thanks, Alison. Anyone else?

MS PIONTEK-WALKER: Just to state, because I think most people are aware, that Healthy Together was largely funded by the Commonwealth through the national partnership agreement on preventative health. So that national agreement was withdrawn from the Commonwealth in 2014. So that's left the state in a difficult situation.

But, just to reiterate what we all spoke about, there is not going to be one single program or one single thing that's going to fix things. Health behaviours are driven by complex environmental factors and social factors. So it's really all the multiple reinforcing activities that involve community and are community driven that will make a difference.

MS SHANN: Thanks, Holly. Anyone else, or do we feel like it's been covered?

DR BOLAM: There is such a thing as an unsafe food stuff but there is no such think as an unhealthy food stuff because if you are starving to death at the top of a mountain a Mars Bar is very healthy. But, within that context, sugar-sweetened beverages specifically are pointing in the right direction. The public is aware these products - they are on the wane. There are a lot of campaigns and focus in this area: VicHealth's H20 campaign, Live Lighter, the Rethink Sugary Drinks. There is a lot of opportunity in the short to medium term to focus on that

as a particular area.

In the long term unfortunately for many of us in here, while we are all capable of behaviour change, often we don't do it. The reasons why are because behaviour is deeply embedded, and it is deeply embedded from childhood. So for that longer term change it's all about getting in with families, particularly getting into kids and getting into school based settings that leads to long-term generational changes and expectation.

It is worth reflecting on that in light of most of our success in smoking cessation has actually been more driven by reductions in people taking up smoking than it has been through quitting. That isn't to say quitting isn't important. Quitting is incredibly important, but it is phenomenally hard to do. What has really brought around the change over the last 20 years has been we used to have one in four young people smoking; I think it is down to one in eight or one in 10, somewhere around that, in a 25-year period. That's a huge change and it is the kind of scope that obviously is the ambition of health improvement here in Latrobe.

MS MARTIN: I would like to say one thing, and that is really the community setting its own priorities, but really having that ability to leverage from statewide campaigns as well. I think that's really important. You don't need to re-invent the wheel. It is more creating those relationships and partnerships to support communities where their priorities lie.

MR ATKIN: What I was going to say just complements that. Using tobacco as an example because it is the one that I know, but you have the systems here already. So you

have the systems. You can leverage the statewide stuff off that really easily to provide even more support for people around changing behaviours like having access to more support around quitting smoking or changing behaviours around sugary drinks and diet and things like that by having that complementary reinforcing message pushed up by your local systems into the statewide services and programs.

MR SWITZER: I think it's fantastic that community sport is being recognised in the sense of what it can actually bring to the table in terms of people's health and wellbeing. We connect really closely to many of the things that we have been talking about here in a community sporting environment.

MS JOLLY: I agree with pretty much what each individual just said. I think that kind of sums up where I'm at. Coming from an organisation that is predominantly state based but we do like to tailor and target to particular communities, I pick up what Luke and Jane were saying. If there is any way that we can help with our state based work and tailor that and make it much more specific and targeted and meaningful for the people in the valley, I think that would be ideal.

MS SHANN: Anything from the board just to close things off? All right. I would like to thank the fabulous health behaviours panel. Lovely, informative, fabulous. So thanks. We will just change over now to mental health.

(Short adjournment.)

MENTAL HEALTH

MS STANSEN: We might get started on our last topic for this afternoon. My name is Justine Stansen. I'm one of the

lawyers supporting the board today. I'm just taking a quasi-barristerial role this afternoon, so that's a bit of fun. We had the session of mental health and I will firstly throw over to the panellists to introduce themselves and their organisation and then we will get started.

MS HUMPHRIES: Robyn Humphries, Assistant Director, system transformation in the mental health and drugs branch, Department of Health and Human Services.

DR HOPPNER: Cayte Hoppner. I'm the Director of Mental Health at Latrobe Regional Hospital.

PROFESSOR CLARKE: Dave Clarke. I'm a psychiatrist at Monash Health and Monash University.

MS VERINS: Irene Verins. I'm manager of mental wellbeing at VicHealth.

MR TONG: Steve Tong, manager of community development at Latrobe City Council.

MS HUGGINS: Jo Huggins, centre manager, Relationships Australia, Victoria, Gippsland.

MS SCANLON: Kerry Scanlon, manager of AOD and counselling services at Latrobe Community Health.

MS STANSEN: We might just ask Cayte to give us a short background about the mental health issues that are here in the Latrobe Valley just to set the scene.

DR HOPPNER: Thank you. We had a lot of interesting discussions this morning around the status of mental health in the valley. We know in this region that we have more registered contacts with mental health services than the rest of Victoria. We know that we have higher rates of suicide in this region than other areas in Victoria. We know that there are barriers to accessing mental health

care, we know there are areas of social disadvantage and there are impacts on economic participation, social connectedness and a range of other issues around family violence, child protection issues, alcohol and drug issues.

We know that there's no health without mental health and we know that good mental health is associated with better physical health, better education attainment, increased economic participation, social participation, social relationships and connectedness, so we need to ensure that we reduce stigma and reduce discrimination and increase social inclusion in the community.

In terms of what we talked about today, which you can see on the Powerpoint there and each of us will talk about the components that we were leading the discussion in, and really what we focused on was looking at how do we transform and lead community action around improving mental health. We know that mental health has been talked about in the other presentations and we know that it cuts across all of the work that we do within our community and within the sector and within the health services.

So we know that we want to look at having a transformational community action plan that looks at network mapping, community engagement and consultation, really developing up some community leadership across Latrobe Valley, improving health literacy, self-management and recovery and we want that to be underpinned by a message of hope and positivity and not focusing on disadvantage. We also know that we need to acknowledge the trauma that's occurred in this community, but also to how we value and acknowledge that and look forward to the

future.

We also had some discussion around modelling a whole of community approach and how we may completely re-design the health and community service system to meet the needs of the community and we also had some discussions around the social determinants of mental health and what actions we can build within that.

In terms of looking at the network mapping, I will hand over to Jo and Kerry.

MS HUGGINS: Thank you, Cayte. It became apparent in our discussions that there is an incredible lot of good work being done across different sectors and there's a lot of individual programs, a lot of initiatives that are being currently run and very successfully, and also acknowledging that service mapping has been done in the past but probably not in a cross-sector way. So we talked about the possibility of doing some service mapping, looking at all the different funding streams and then identifying the networks which exist, which are a number of networks, and somehow trying to get leadership roles or people, whether it is chairs or a representative from each of those networks, to come together to talk about the mental health needs across this area.

We also wanted to include community leaders and spiritual leaders as well in that process so you have a broad cross-section, with a view of looking at early intervention and also looking at giving clear consistent messaging across organisations around mental health.

MS SCANLON: Yes, just to sort of reiterate what Jo is saying, there has been a lot of service mapping done in the past and I guess a lot of people sitting in this room would

say, "Oh, service mapping again." But I guess when you think of the context of some of that service mapping in the past it's been under particular reforms, so it might have been service mapping in regards to mental health or AOD, but what we are talking about is a different kind of service mapping and that's including, as Jo said, across the sector.

There's a lot of great things being done, but how do we pool those resources, how do we share and how do we synergise all that we are doing and make those linkages together, and just having the strategies and messages about supporting one another in a consistent way. It's a big project, I guess, and we talked about some of the advantages and the barriers and I guess we would probably need to have a person, like a project worker or something like that; to be able to pull that together is quite a big task.

MS HUGGINS: And it's around pooling those resources. A concrete example would be there's a family violence prevention committee which Gippsport sit on and part of that program is that there is family violence prevention programs being run in local sporting clubs. It would be relatively easy to include some messaging around mental health. So, it's around building on the resources that we have and working even more collaboratively together.

DR HOPPNER: Back to me. We had a discussion around not just building health literacy, but increasing mental health literacy. We know there are some gaps in terms of the health literacy of our community and in particular we see some gaps around mental health literacy. So one of the short, medium and long term goals we talked about was

actually building that capacity, capability and mental health knowledge and literacy amongst the community and not just the general community, but industry, schools, health services, community organisations, spiritual services, the broad range of community members.

In relation to building that capacity and capability, it was around looking at building resilience and focusing on people's strengths, building supports, ensuring that we can build self-management skills within the community and also change people's health seeking behaviours so that they do seek access to services early, improving access to care and ensuring that people know when to seek help and really focusing on promotion and prevention and early intervention and doing that in partnership with the community members.

There is a range of evidence based programs that are already being run that focus on really targeted approaches to building mental health literacy and they range from youth mental health first-aid, to mental health first-aid, teen mental health first-aid and applied suicide intervention skills training. There's a whole range in the education system of kids matters, safe talk, and these things actually build people's knowledge and capacity to access help in a way that's around early intervention and early screening.

One of the key things that we have implemented at Latrobe Regional Hospital is called the optimal health program and that is a consumer-led, person-centred, recovery-focused self-management program and it has actually come from the work in chronic decease self-management and we have been implementing that over

the last couple of years in the mental health system, in the tertiary system. It has also been implemented in a number of the non-government mental health service systems, in local community health services. So we already have built quite, I guess, a capability in that program and using that as a self-management and recovery tool.

That program really focuses on a whole range of factors looking at health and wellbeing, looking at goal setting, developing partnerships and connectedness, good health promotion, managing stress, managing medication, looking at recovery and strategies to assist people to improve their health and lead their own health and take some ownership and being empowered around accessing the health care system, and the aim of that program is then to reduce the number of health crises, reduce acute hospitalisation, reduce ED presentations and improve long-term wellbeing.

So we thought that that is something that is actually already implemented in the community and we have some capacity to then build on that and improve the community capacity to manage their recovery and to move forward with improving health in partnership with health service providers and community providers.

The next topic we had was around community engagement and I will hand over to Steven for that one.

MR TONG: Thanks, Cayte. There is obviously a plethora of programs available to support people who are dealing with mental health issues in the Latrobe Valley. A couple of things that we discussed, and one is that community engagement in terms of design of the programs is probably

one of the fundamental things. When you hear of all the different programs through all the different sessions that are currently happening, gee whizz, there's a lot going on, but has anyone checked in with the community to see whether that's actually what they want? It's one thing making them aware of the opportunities, but is that the community's priority?

So, I suppose we have begun a process more recently that Sara Rhodes-Ward alluded to around community engagement and doing some localised neighbourhood level work which is revealing some interesting things and we look forward to continuing that work to inform the work of others and I suppose to advocate on behalf of the community for those types of outcomes.

There's some things in terms of mental health and community engagement that are concerning to me, and one is that normally after an event there would be some acknowledgment that this community had been through a very difficult and stressful, traumatic time and that people rather than responding through support programs, a simple apology or acknowledgment of what the community have gone through can be quite healing and powerful within itself.

We have seen a range of programs come through the Latrobe Valley, including programs like the ministerial taskforce and all other iterations that have tried to make improvements to the community that make this a more liveable place and therefore will make contributions towards people's mental health. But they have come and gone and it feels a bit like the circus is coming through town and at the moment we have Barnum & Bailey, so we are hoping to get some good things out of that. But at the

end of the day these things need to be sustainable and produce real outcomes for this community and it includes a legacy of the built capacity and higher levels of liveability is really what we are trying to achieve as local government.

The tertiary services that are provided are excellent. There is no doubt with that. But the pathways to them are a little bit confusing and hazy and for people that have suffered or who are subject to high levels of disadvantage, it's just the access because the knowledge and understanding isn't there.

Engagement needs a conversation with people, not about designing things elsewhere and sort of making it fit and land here beautifully and we all celebrate how that looks, but people actually need them, want to be involved with them and want to engage with the programs first and foremost.

One type of opportunity that I showed, we have a couple of programs within the community development department. One is our youth leadership program. Traditionally it was run like a Williamson type project and it was all nice and we took young people all over the place and taught them how to be leaders and it was fantastic and produced some great results.

More recently we have decided perhaps we will go and reach the people we don't normally reach, so we chose young people at skate parks and engaged with them about their sport, in their sport, as a way of developing leadership skills. The first program commenced last year and they are a one-year program and that's been a very successful program and young people who have traditionally

never been involved in any form of leadership designed and developed their own skate competition and we will be doing it again this year because it was so successful and so nice to talk to people that we don't even get to talk to.

But I think it was mentioned before: don't do it to me, do it with me. It's a principle that any of the work that we do really must have high levels of community engagement to produce the ownership where people take responsibility for themselves and are ably supported by a professional sector as opposed to a system that is imposed upon people. I think that's something that's quite generic across the board and local government are certainly well positioned to look after the wellbeing and wellness of people, and people who look after people who are chronically ill need to also be well positioned to do that as well.

MS STANSEN: Before you leave that topic, Steve, one of the discussions we had this morning was about having a series of events to start that healing process. I'm not sure whether you wanted to speak about that or maybe Irene.

MR TONG: I'm happy to talk about it. Being formerly the recovery manager for Latrobe City, one of the standard approaches and a very worthwhile approach is to have events that do recognise the trauma that people have been through as part of the beginning of a healing process, the recognition or symbolic part of it, but also how you engage those people in the journey and give them some responsibility. So they may come to grieve or hear apologies or whatever, but they end up going away with a bit of a task list and being actively involved and remain actively involved in civic participation for the duration

here.

So, the events need to target a range of people, a range of demographics, with the young, old, indigenous people, multi-cultural CALD backgrounds. People love a good activity, a good event to get together and celebrate. There has been some good efforts at that, but again it's almost it was too close to the event and the timeliness was always going to be a challenge, the right time for some, but not for all. Communities coming together to celebrate is always a grand thing and should happen more often.

MS VERINS: Just to add to that, it is not to be underestimated that there is an opportunity here, as a result of a terrible thing occurring, for a transformational action plan to be developed, staged and co-designed with the local community. So obviously the timing of what occurred for people and the support that was there or wasn't there for various groups in the community needs to be revisited as part of this development of a new transformational action plan. Our group discussed what's positive about actually taking a step forward into the future and saying, "All right, the next bit is a very important bit" about, as you said, grief acknowledgment, acknowledgment of pain, management of trauma, articulation of that trauma for people and for the various groups who were traumatised and the various experiences that occurred. That may have happened to some degree already, but obviously it hasn't happened enough.

I think in stepping forward there is the precursor activity that needs to be taken which is exactly that, acknowledgment, and through that some of the

pointers that are available for communities to then begin to be able to move forward and look forward towards whatever the sort of aspiration might be in terms of the next bit of planning.

MS STANSEN: Irene, did you want to go on and talk about some of the initiatives to the social determinants of mental health?

MS VERINS: Okay. Some of the things that we have talked about, and we know and it's in the evidence and it is certainly in the background papers, is that mental wellbeing is caused by and contributed to by a range of external factors outside of the health sector and setting. Broadly those contributing factors include things like engagement and involvement in work, being employed, being employed gainfully, being involved and connected to school, having various strong and close attachment to family, peer-to-peer relationships, all of those factor are incredibly important.

What we at VicHealth have been looking at, and we haven't released it yet, it's to be launched in November, but we have been developing a new mental wellbeing strategy which actually looks at resilience building for both individuals and at a community and organisational level. I would just like to bring that forward and say that we are very happy to share some of the information around what we have found.

We have undertaken four evidence reviews around definitions and concepts of resilience, evidence reviews around interventions that work at an individual and community level and those that need more research. But one of the things that we did find - and I would now like

to acknowledge Marianne from the Voices group, Voices of the Valley Group - is that resilience isn't necessarily just about, "Get up and get over it." It's much more complex than that in the way that we would like to engage with it. It is actually very much about saying at an individual level what it looks at developing for individuals is self-regulation, self-esteem, self-confidence, a level of perseverance and ability to sort of move, adapt to change absolutely.

But that adaptation and sort of adaptive skills are actually exactly what we are seeing now that is needed in a lot of the foresight reports. So as part of the development of our mental wellbeing plan for VicHealth we have actually looked at - and this is particularly for young people because that's what we have focused on, but I think it is relevant to communities at large - what are the skills and resources required for young people in particular and the community in 10 to 20 years time.

What we know with regard to resilience is that those skills around being able to be adaptive, being able to have skills which allow you to move in those areas of work that are available because we know lots of young people currently are being trained in skills for jobs that will not exist in the next 10 years, those types of adaptive skills are really important. The impact of what that means for organisations such as schools, workplaces, employment policies more generally is something that we really need to look at.

This is more of an issue for Wednesday in terms of employment, but certainly with regard to mental wellbeing and what's possible in this region now and in

relation to social determinants we actually need to look at what are the opportunities right now. From a policy point of view we know that Minister Robin Scott, Minister for Employment, has said that he is prioritising young people; they are a priority for work.

How can we leverage that policy ether and that policy opportunity for this particular region and this particular area? What do we do in looking at future economy and future planning for the economy? We know that there are a lot of unemployed people here now. But again what are the opportunities for us to look at what work really means for people? There are a lot of grandparents who are retiring or are out of work who are providing an incredibly important function in terms of child-care for young people here so that the parents can go back to work. Those kind of issues all impact mental wellbeing in a major way. They are the make it or break it sort of contributing factors that I think are really important to consider in a mental wellbeing plan for the area.

MS STANSEN: David, we will move on to you. This is in answer to question 3, which was what more do we need to do to understand how we can implement some of these initiatives or ideas going forward.

PROFESSOR CLARKE: We would like to suggest to the board they might consider recommending fully integrating community mental health services with community health services. The argument for that is that the current system of keeping them separate does not work; that a significant proportion of people with chronic mental illness suffer physical diseases and die early and, vice versa, 30 per cent of people with chronic physical illness have

significant mental illness.

How would that look? A community nurse might be doing a physical check-up for a diabetic patient. They might ask, "How are you going" or do a screening for depression. A community nurse might be visiting a mental health patient delivering medication and they might do an annual HbA1c or check about smoking. It is very hard for a person with chronic heart disease or diabetes to be compliant with medication, to follow regimes about exercise and diet if they are depressed, feeling hopeless and have no energy. Patients with chronic mental illness find it hard to get organised to go to medical appointments and so forth. The complexity of those two things means that it is almost imperative, a very strong argument, to combine at the community level mental health and physical health.

You might think that that's not a good fit. You would be wrong. In both physical health and mental health, well, mental health emphasises what's called recovery now; physical health emphasises the importance of chronic disease management. They are both about patient activation in decision making, in understanding their illness, in understanding the symptoms of their illness, in recognising relapse of illness and knowing how to negotiate the health system. Chronic disease management and recovery principles are almost identical. So combined community health would work well.

We put it in category 3 because it was suggested, "But how do we do this?" We will leave that for you. There has been a lot of research about those co-morbidities. Obviously the services are distinct.

I would think it's an issue for government and about the commissioning of services how that would happen. I would think myself it's very feasible. Thanks.

MS STANSEN: Our group didn't rank ours in any particular order. We thought they were all pretty much things that could be implemented now and then progressed throughout the years. So I just wanted to throw it open to you all to provide any further points that you wanted to discuss today that we haven't. One of the things that I noted in my notes is that we did discuss the media and other discussions around the Latrobe Valley and making it a more positive framed voice. I wonder whether anyone wanted to pick up on that point.

DR HOPPNER: Yes. That was something that I had raised, and we do have an opportunity in terms of transforming and progressing this work to engage our media partners in collaboration and sell a positive story and market a positive message around where we live and the potential and the strengths of this community and how we can move forward and actively engaging the media in supporting that strategy through print and television and social media and using that to our advantage to promote the work that's happening, and focus less on the negative and the disadvantages.

MS STANSEN: Thank you. Did anyone else have any particular comments they wanted to make before we wrap up or I open it up to the board? I'm thinking not. The board?

PROFESSOR CATFORD: Thank you very much indeed. Could you just talk a little bit more about mental health literacy and what are the opportunities to improve knowledge, awareness, education in this space? Did you look at that?

DR HOPPNER: Yes, that was one of our key areas of discussion. From the perspective of the specialist mental health service we have done a lot of consultation with consumers and carers across Gippsland around what they want from the service, but what are the things that they need and often it comes up that people don't understand mental health issues, they don't know how to access services, they don't know where to go.

LRH has done a lot of work with a whole range of football clubs, netball clubs, CWA, Rotary and a whole range of other community groups, and the one question we get asked most is, "We don't know about mental health and we need to know what to do if someone says, 'I'm feeling suicidal' or 'I have a mental health issue' and people don't know how to respond." We know that the community want to have those skills and we also know that we already have capacity in the region that we can build on where we are delivering those evidence based interventions such as mental health first aid, youth mental health first aid, suicide intervention, and they give people in the community those general skills and more confidence to actually identify that someone is at risk or needs help and that they can then refer them to the appropriate service, and that means people get help early and that's around early intervention rather than waiting until someone is so unwell, and that's a poor outcome for that person and their family.

PROFESSOR CLARKE: The other important point I suppose about health literacy is you don't learn things unless you need to. So giving it at the opportune time, either when you are ill or a family member is ill, is important; so maybe

changing the clinical encounters so that clinicians learn to give more information to patients and families.

MS VERINS: From an educational point of view I just wanted to draw the attention of the board to the fact that resilience is now squarely mandated as a curriculum topic by the Department of Education, who launched their resilience and wellbeing framework not so long ago. Within that framework is teachers being required to learn themselves about what is their own resilience about and being able to build it before they can begin to teach it in classrooms, which I think is a very healthy action to be taken.

Within that resilience framework there is also Respectful Relationships curriculum that will be developed and that will be mandated to be put through all state schools, which is a fantastic achievement again in terms of looking at strengthening some of those building blocks at that sort of policy level. That resilience and wellbeing framework is available and open for everyone to go on-line and look at, download and use. It's not a closed system. It's actually something that's available for all schools.

As a sort of important component of community infrastructure, schools are a great place to start in terms of building both that sense of acknowledgment of what has happened. Obviously it's been talked about. Obviously there was quite a lot of work done early on. But, just to take your point again, there needs to be stepping forward a new acknowledgment and recognition of the pain, the trauma that was caused, the fear that still exists.

As far as building sort of a broader community resilience there needs to be a bit of work done around what is the next step, what are the aspirations that this community has or the five or six different communities within the region, what are those aspirations. Those facilitated conversations that will draw out those positive messages and reignite that sense of pride and ability to look to the future are the kinds of things that are actually very helpful in terms of rebalancing where this community may be, may have been for some time. That's not to say that the economics in the area does not need to be regarded as well. They both need to be well balanced and hand in hand.

But in terms of literacy around resilience building both for individuals and communities there are opportunities that exist that have been created both at a state government level and elsewhere that enable that to occur and they should be picked up and maybe promoted more by us.

PROFESSOR CLARKE: Could I raise one other thing about literacy, about the language we use. It seems to us sometimes that everything seems to get reduced to being a mental illness. If things are going badly you feel depressed. To sum up the life of a woman who is the subject of violence who feels like killing herself and saying she is depressed is hardly capturing the essence of the situation. The same with people who have fears associated with fires and so forth.

So that harks back to the issue of social determinants and all the problems. It sometimes helps to give a diagnosis of depression if it leads to some

treatment, but if it disguises what the real core problem is that is not a helpful thing.

PROFESSOR CATFORD: Were you able to discuss the issue of service coordination and particularly whether or not there are any unmet service needs, for instance, in terms of family violence or drug and alcohol and what's happening with young people and ice, for example, et cetera? Were you able to touch base on those areas or do you have a view at all?

MS HUGGINS: We did have a very brief conversation and mentioned family violence. We felt that there is a separate process going on in regards to the resources needed in this area around family violence. There is no doubt the services are at capacity. So we did talk about service coordination and the importance of that. We also acknowledged that there is a lot of wonderful work being done. I suppose it's around demand as well. There is incredibly high demand for services, but we didn't go into great detail.

MS VERINS: The only thing we did touch on, it was another one of our ideas around needing to be aspirational, but I think it's looking at budget siloing and if there was an opportunity to provide modelling, to do a bit of action research into the economic modelling - a trial or a pilot, if you like - because it came from the discussion that budget siloing often is very restrictive and derails potentially successful outcomes because it's sort of limiting, that if it were possible to develop and look at something perhaps like the mental health services integration in a more effective way, the budgeting processes that restrict open conversations about better

integration might be worth looking at. We don't know what that looks like. It was more about a research proposal.

MS STANSEN: I think some of that is going to be picked up in the mapping as well, to work out what exists, who is doing it, where the duplication is, where the gaps are. So it is part of that process to really understand what's going on.

DR HOPPNER: There has been quite a lot of work on service coordination and care coordination in this region, but I think ultimately there are still service gaps and that is because of the way we are funded and how we work. We still work in quite disparate ways, I think, and there's lots of potential to then actually look at a new way of re-designing how we deliver that care.

MS SCANLON: I guess the service mapping project feeds into that as well.

PROFESSOR CATFORD: Justine, are you going to ask for their last one proposal?

MS STANSEN: One last proposal if you have one, or not?

DR HOPPNER: I would just like to say I think they are all important and I think this is a really good opportunity for us to work in a collaborative way and really take advantage of what we can achieve and some transformation for this community around mental health. I also think that it was a shame we didn't have some mental health consumers on our panel today and I would have liked to have had that direct input. There's quite a number of peer workers within the region and I think there is an opportunity to actually have some further engagement with the mental health consumer/peer workforce across this region around how they may also drive the action plan and

tell us what they want rather than us telling them.

PROFESSOR CLARKE: Obviously this region has to design and discover its own solutions, but the structural problems in health are really, it seems to me, the same everywhere. But there is an opportunity here, the opportunity of this - I don't know if I can call it a crisis, but whatever "this" is - and with the possibility of a health conservation zone et cetera means that it is possible to make some structural changes in the way health is delivered. That would be fantastic for this region and would be a showcase for Australia and the world.

MS VERINS: I would just like to finish by, in addition to what David was saying, mentioning that there is an initiative that VicHealth isn't leading but we are involved in it called 101 Resilient Cities. It is actually an international initiative. It might be worth making contact with them, and I'm happy to provide the contact details, in that it might provide some interesting examples internationally on what may be of relevance to this area.

MS STANSEN: Nothing further? So thank you very much for your participation today. It's been extremely interesting and very, very valuable. Thank you again.

CHAIRMAN: Can I ask you to say there because I'm now going to bring an end to the day's proceedings. It has brought home to me the complicated nature of the health issues that have been addressed today, and we have another two more days exploring separate areas. I might say that it's a tribute to John, as I mentioned earlier. He mentioned his plan for these forums and it really seemed that it was just too ambitious in the time that was available.

But I think there's the immense value that we will have of having recorded all that you have said that we can look at to look at what our conclusions and recommendations will be, but there's also been those other benefits of bringing together people who are able to understand what others in the areas are able to contribute, and there's also the benefit to the locals who have come here and understand that so many people are interested in their future. So I thank all those who have been here, but I thank in particular those who have given up their day so that they can have the opportunity of being involved in those discussions.

Can I indicate to you that we are going to return for those next couple of days and a couple in a future time, and you can be assured that the benefit of these sessions will be recorded ultimately in the report that we hand down. So thank you all very much once again.

FORUMS ADJOURNED