Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF MATT JONES

I, Matt Jones, Chair of the Victorian and Tasmanian PHN Alliance and CEO of Murray PHN of 3-5 View Point, Bendigo, Victoria say as follows:

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

2 I am giving evidence to the Royal Commission in my personal capacity and not on behalf of my employers or organisations of which I am a member.

3 In making this statement I wish to acknowledge that I am doing so on Yorta Yorta country and acknowledge the enduring connection and custodianship of First Nations people to this land and waters and pay my respects to their elders past, present and emerging.

Background

4 I am the Chief Executive Officer of Murray Primary Health Network (**Murray PHN**) and the Chair of the Victorian and Tasmanian PHN Alliance.

5 I have a Masters of Public Health from James Cook University. I have extensive experience in rural health management in primary health, acute public health and Aboriginal health settings in Victoria, Queensland, Northern Territory and Western Australia.

6 Prior to my current position, I was:

(a) the Chief Executive Officer of Loddon Mallee Murray Medicare Local between March 2012 and June 2015;

(b) the Chief Executive Officer of the Central Victoria GP Network between January 2011 and March 2012; and

(c) the Chief Executive Officer of the Murray-Plains Division of General Practice between April 2005 and March 2012.

7 Attached to this statement and marked 'MJ-1 is a copy of my curriculum vitae.

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

The role of Primary Health Networks in Victoria's mental health system

8 Primary Health Networks (**PHNs**) are not-for-profit organisations funded predominantly by the Australian Government. PHNs were established in 2015 with the key objectives of increasing the efficiency and effectiveness of physical and mental health services, particularly for those at risk of poor health outcomes, and improving coordination of care to ensure users of services receive the right care in the right place at the right time.

9 There are three tiers of focus for PHNs:

(a) improving the individual practitioner to patient dynamic in terms of improving the quality of care for individuals;

(b) improving service delivery so that parts of the service system are focussing on those areas of particular need, for example, chronic disease, mental health, alcohol and drug and indigenous health; and

(c) at a system level looking at how to enable more alignment, particularly given the fragmented nature of our federated health system and how to enable the alignment of Federal, State, public and private capability at a community and regional level.

10 The concept of the network of PHNs is to enable local decision making to ensure that health care is aligned to the needs of both those who seek and require healthcare and with those individuals and services that deliver health care according to the relevant regional context. The 31 PHNs across Australia are very much geared towards tailoring efforts to the local context and targeting those efforts to address specific needs. This is a really critical part of the PHNs' contribution in terms of strengths, but it can also be seen as a weakness in relation to producing variations verses national approaches.

11 The catchment of Murray PHN spans across Northern Victoria from Mildura, across to Albury-Wodonga, up to Corryong, and down to the outskirts of Melbourne. It covers an area of almost 100,000 square km with a population of more than 644,000 people. As a regional PHN, the context in which Murray PHN is providing services is very much focussed on trying to improve the quality of care, trying to improve access to services and trying to improve equity of service provision. Each of these have some dimension of challenge in the region Murray PHN services.

Mental health services commissioned by Victorian PHNs

12 Within the funding for PHNs, a significant portion is focussed on mental health. Of the $40 to $45 million per annum in funding for Murray PHN approximately $17 to $20 million per annum is specifically allocated to mental health.

13 The programs are consistent across PHNs but as the quantum of funding is determined according to a funding formula, which takes into consideration a range of different factors, such as population, geographic, rurality etc and there is significant variation between the quantum of funding each PHN has for each program.

14 Within that mental health allocation for PHNs there are a number of streams and focusses. At Murray PHN, there are specific interconnected but distinct streams in relation to mental health programs.

Stepped Care

15 A really strong focus for all PHNs is the introduction and delivery of a stepped model of care approach to mental health, which falls into three broad categories of focus:

(a) Psychological therapy services, which supports people with mild to moderate mental illness. It provides cognitive behavioural therapy-based services by qualified clinical staff;

(b) Primary Mental Health Clinical Care Coordination, which are services for people with moderate to complex disorders requiring assertive support within a team approach, delivered by prudential mental health nurses; and

(c) Psychiatric Services provided by acute and specialist tertiary services for people with high intensity mental health needs.

16 This stepped model of care gives people the opportunity to step their care up or down, depending on their health needs. The Murray PHN has $4 million per annum of specific funding for this program.

Psychosocial

17 Psychosocial Recovery Services, which supports people with severe mental illness, comprises Continuity of Supports, Extended Transition Arrangements and the National Psychosocial Support Measure, and is provided by the State.

headspace

18 PHNs have a sizeable footprint in relation to youth mental health services and contract headspace services across Victoria in both metropolitan and regional settings. I discuss the involvement of PHNs with headspace further from paragraph 131 of this statement and the outcomes that headspace is achieving for young peoples' mental health from paragraph 140 of this statement.

Suicide Prevention

19 PHNs also have funding for suicide prevention. In Victoria, the PHNs are part of a joint initiative with the Victorian government and the Victorian Department of Health and Human Services (**DHHS**) in relation to twelve place-based suicide prevention trials. Six of the trials are funded by the State and the other six are each funded by a separate PHN. I discuss the place based suicide prevention trials further in paragraphs 57 - 60 and 119 of this statement.

20 In addition to the place-based suicide prevention trials, PHNs also partner with services such as the beyondblue Way Back service in Mildura to provide non-clinical outreach services and practical support to an individual, following a suicide attempt or suicidal crisis. I discuss outreach programs further in paragraph 114 - 116 of this statement.

Other services

21 There are many other mental health services that are commissioned by PHNs. Some of these other services include:

(a) services as part of specific funding for Aboriginal and Torres Strait Islander mental health;

(b) our general practice investment strategy, which provides funding for secondary consultations for General Practitioners (**GPs**) so that there is more connection to tertiary support psychiatric support; and

(c) psycho-social funding for people with severe mental illness and falling through the gaps in relation to the NDIS funding.

Challenges and successes of PHN's in Victoria's mental health system

22 PHNs undertake needs assessments to identify hot spots in relation to disproportionately high levels of poor health outcomes and also black spots in relation to gaps in service delivery. The combination of looking at hot spots and black spots informs decision making in order to assist in the design of a system that focusses on need and enables delivery from an accessibility, quality and an equity point of view, i.e., where services should be and where as a priority they should be focussed.

23 Broadly the health and service needs within the Murray PHN region have not changed since the initial needs assessment in 2015. There are some slight variations in relation to particular illnesses but largely the hot spot areas of disproportionately high levels of health needs, include chronic disease (including diabetes, cardio vascular disease, chronic obstructive pulmonary disease), cancers and mental health, remain the same.

24 The commissioning of a stepped model of care has been a really substantial and important development for enabling the design of mental health care in a way that focuses

on need as an initial basis and enables services to occur within the context of specific communities and the population.

25 Importantly there was a significant realignment of funding that had been in place for a significant period of time but largely predicated on purchasing services from providers. The historical methodology in terms of what services were being provided was not based on equity or upon a systems approach at a regional level. It was very much a product of focusing upon the provider context. The realignment for a stepped model of care was really important in recognising that there is a significant portion of the community that require access to mild mental health care and that service provision should not be based upon postcodes or the per chance prospect of a local provider being funded to deliver services locally. This similarly applied to the historically commensurate mental health nurse funding through the mental health nurse incentive program, which meant that there were some communities that had access to that program and many others that did not.

26 The stepped model of care now means that there is coverage across the whole Murray PHN region for all providers to enable somebody to have access to care according to their needs, stepped up or stepped down as those needs change. The challenges with this are that it represents a small allocation of funding proportionately to the availability of primary mental health services, so we are trying to introduce a model that is also expected to work in alignment with other parts of the primary mental health system.

27 A further challenge that PHNs experience, is that in some instances we are commissioning organisations that are also receiving funding from the State government. Those organisation are then subject to the State's reporting and deliverable requirements, which differ from our requirements in terms of commissioned care. So in some ways we are pulling providers in two different directions with two different systems servicing the one community as we are asking them to operate in one way for a portion of our funding and in a different way for the State's funding. The hybrid model of purchaser, provider and commissioned activity is incredibly challenging particularly in relation to the navigation of the system and how the system is available.

28 Another further challenge is that PHNs are hampered by the fact that our twelve month funding cycles are quite defined and narrow. Short funding cycles inhibit innovation and do not encourage long term views. Although, we can certainly express that our vision and intention is to continue in a direction beyond a funding contract and into future, organisations often need the guarantee of whether they are going to get the funding next year as well as the current year.

How the role of PHNs could look different in a future Victorian mental health system

29 There are a number of levers to enable more alignment between providers, particularly in the Victorian context. In Victoria there is a devolved governance model of health care where each individual health service operates as a local hospital network and has its own board of management governing its servicing of their respective catchment area. There are approximately 36 local hospital networks in the Murray PHN area and across Victoria about 83 local hospital networks.

30 The starting premise is looking at the population needs, not just at an individual community level but at a regional level. Looking at a model of care that applies to that region. Importantly for us it is the collaboration between providers. So it is around working together in a shared way based upon collaboration and partnership between the providers for the delivery of those elements of that model across that region. It is a very different way for them to be working and thinking.

Covid-19

Emerging changes in mental health service delivery as a consequence of COVID-19

31 COVID-19 has had an impact in primary health care in terms of managing the prospect of infections but significantly it has also influenced change in the way healthcare has been provided and the nature of the demand for healthcare.

32 By way of example, with COVID-19 came the introduction of the COVID-19 Telehealth Medicare Benefits Schedule (**MBS**) items. From a policy and a funding point of view this made telehealth a much more readily available avenue for delivery of care. Around this time last year about 77% of the Murray PHN's funded primary mental health service delivery was conducted face to face, about 17% was by telephone, 5% was by internet and virtually none was conducted by video. By comparison, as of May 2020, approximately 8% of primary mental health service delivery has been conducted face to face, 60% has been by telephone, 12% by internet and 14% have been delivered via video capability. This is a visible demonstration that we actually can use technology better and enable the delivery of care in different ways.

33 In my view, this behoves us to explore how to make sure that delivery of telehealth services is not exclusively determined by provider arrangements and instead also accounts for patient needs. It also behoves us to explore how we can support a transition to delivery of care that is based upon the best and most effective way to provide care and

that is not exclusively dependent upon an individual coming into a practice or a service to see a practitioner face to face.

Changes as a consequence of COVID-19 that may emerge into longer term opportunities for new approaches to service delivery

34 Telehealth is a complementary approach, but it is not necessarily a substitute service. What it can do is certainly strengthen the different modalities of service. We have tended to regard services, particularly mental health services, as a one size fits all approach. In many instances there is a one stop shop approach, where it is considered that you go to a service and the service will provide care, and that if it does not work for you you'll need to go to another one stop shop. COVID-19 has encouraged us to look at the different modalities and enable them to be responsive to care and use the funding and the policies to direct that.

35 COVID-19 has taught us that we can adapt to and accommodate change really quickly. Previously, we had been a bit accustomed to thinking change needed to be incremental and progressive, and that we would slowly but steadily get our way there. I think COVID-19 has shown us that we can be a little bit more forceful in deciding our priorities, how we use our funding and how we use our capabilities to deliver new approaches.

36 We need to understand how much opportunity there is for change based upon what consumers would like and use that to inform how we facilitate the delivery of telehealth and internet and digital health based solutions. Murray PHN predominantly services a regional area, where our relational commissioning approach has been very important. Relational commissioning is about engaging providers as part of the design processes to enable the delivery of care more sustainably and effectively more responsibly according to the needs and the context.

37 PHNs do not want to introduce fragile systems that potentially erode the local capability. This is particularly as we only have twelve month cycles of funding. If we effectively pull funding out from existing providers with experience and capability, and invest that in a different approach that subsequently does not prove to be successful, we have effectively nobbled the local providers and also not delivered alternate service provision. Our approach is to very much engage the existing providers and reorientate them to prioritised need in ways that are predicated on collaboration and partnership. We are not funding individual services into individual communities, rather we are developing regional models. One of the successes is how strongly this has resonated for local providers, in that it has meant that they had a place, they were part of that system change and it was a reorientation for them, but it was not a removal of funding. I think telehealth is a little bit the same in that the focus needs to be on how to strengthen service provision so that it is accessible. That does not just mean that it is only delivered remotely either digitally or

by internet. It is about how to strengthen and build capacity within local providers and then using that capability to strengthen and also align to how consumers would like to access healthcare.

System integration between primary/universal and the specialist mental health system

38 PHNs have specific structural changes that enable system integration between primary health care and specialists. We have different intake models to enable streamlining of how services can be accessed and used. With both structure and funding mechanisms, the PHNs have the capacity to deliver more integration and coordination between the system.

39 One example of a tool delivering system integration is PHNs HealthPathways, which is a web-based portal available for clinicians to access evidence-based, locally accessible patient pathways. It also enables referrals to the appropriate clinicians at the appropriate point of clinical care. Importantly, HealthPathways includes the local service provision arrangements that sometimes are not incorporated because otherwise the local practitioner has to acquire an understanding of who is delivering what services and how, over time.

40 PHNs have hard processes and resources and soft people-based capabilities to deliver integration. In addition to the tools and resources that are available to practitioners through the HealthPathways platform, there is a team of staff that are available to work with providers on how the system is meant to work, what the issues are and how to make it work well. This engagement and support enables that system to work. It acts as almost the lubricant and the realignment in areas where it might have some inability to work as hoped.

41 HealthPathways is not a passive resource. It is very much a two way exchange, where we collect and provide data in terms of service delivery and activity, to assess what is and is not working well, the factors and elements contributing to that, and how we might provide some support or a better understanding of how pathways work. It is there to drive change using data but also with a qualitative experience of what the issues are and how they need to be refined.

42 The data is collected through the engagement of the providers as well as through surveys. As part of a commissioning framework, we have a quadruple aim of population health outcomes, costs per capita, workforce sustainability and strength, and patient experience. Obtaining experiences from patients about the quality of the services and the way services have been provided, feeds into the responses around the modality and opportunity of improving the way services can be provided.

43 Every PHN has a form of clinical advisory council and community advisory council, which are really important mechanisms to help not only the design but understand whether the delivery of the models of care are aligned to clinicians' needs and also consumers' needs.

The defining characteristics of 'good service integration' between service providers

44 Through commissioned models of care, good service integration becomes a focus and an objective rather than a potential by-product of a number of service providers delivering care in close proximity to each other.

Mechanisms and structures to better integrate community based and acute mental health services in order to create pathways for people living with mental illness

45 PHNs have different ways and modalities of delivering and focusing on youth mental health services. The variation that exists is partially reflected by the variation in terms of what services are available locally and how services can best and most effectively be delivered in that area.

46 In regional areas, the focus tends to be on how to stitch together and utilise existing providers and build capacity. In regional areas, like those serviced by Murray PHN, our approach has needed to look at what is available as a starting point and then work out what are the ways in which to deliver those models of care. In metropolitan areas, there tends to be many more providers delivering care to the community. The starting issue is not one of how to increase access as it is in regional areas. It is in actuality more a case of more effective co-ordination between providers.

47 PHNs have a place-based approach to delivery of care only to the portion of the system that we are responsible for. On that basis, it is a combination of different ways and different responsibilities that determine how care is going to be provided. There is no shared and agreed structure on what framework PHNs and other providers are trying to deliver in terms of primary mental health for a community and region. This is a really important issue.

48 Nationally PHNs are delivering a stepped model of care. It would be really good if there was agreement and alignment at a Victorian level as to this being the model of care that we are working to, whether that be through adapting the national model or developing a Victorian model. Not having an agreed framework or a consistent structure of how to deliver services according to the different requirements of our communities is a really major issue in terms of the future of how services are structured and funded.

49 Place-based service is only a portion of the focus. Some population groups have specific needs, for which we need to have much more tailored approaches that incorporate the understanding coming from people with lived experiences and those with specific understandings of populations such as carers, Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse (**CALD**) communities or people with disabilities.

50 In the current context, we are not very good at tailoring care according to the variation that exists within our communities. This is a really critical part of providing service, and it relates specifically to culture within community groups. We are starting to move to a better place based concept, but we need a framework of how to do that consistently and we need a greater recognition that there is actually variation, particularly with mental health, that means that we need to have greater flexibility in the way we design care. Without those elements, it feels like we are just back in a place of incremental and slight change, but what is really needed is substantial and directed change.

Commissioning

The ways in which PHNs and Murray PHN commission mental health services

51 From a commissioning point of view, PHNs regard ourselves as investing in models of care, with the providers of health care as our partners. Working with our partners and providing them with the tools and resources to enable greater integration is very much part of that approach. Relational commissioning is not just around the design of the care, it is also about how to enable it to work. This is particularly true when you are designing in theory and then you are delivering in practice. It requires an identification of what the particular issues are that need some rethought or support to make it work better. It is not just getting a contract, getting a report and saying okay things are working at this level so we will accept that and provide another year of funding, it is about how to maximise that investment to try and strengthen the quality and capacity of the service delivery.

52 Unfortunately, we are unable to fund every application that has merit. The Murray PHN have had experiences with our stepped model of care for mental health as well as chronic disease, where we have had greater subscription of applications for funding than the amount of funding that we have available. Having ranked and assessed each of the applications, it was not the fact that applicants were not able to deliver as described that prevented us providing them with funding, rather it was the limited funding available. It is not possible to break up the funding model and fund for example, 23% of one and 17% of another application, because they need to work in totality. It is more about building and growing the pie rather than moving it around from provider to provider. If we had more funding, we would have more delivery of activity.

53 It is important to understand that there is limited funding available and that there are other providers that could be delivering if the existing activities were not funded or supported. There is an inherent accountability in this, as we have made choices in terms of who we are working with and what is to be delivered, and if it does not deliver that there are other avenues for that to occur. It compels people and services to be focusing on the accountabilities and deliverables of what we are working together to achieve, because there are other choices and alternatives if something is not delivering or working as expected.

54 When commissioning mental health services and engaging providers, PHNs will acknowledge the constraints of short-term commissioning cycles and seek to communicate the vision, direction and performance expectations when working with a provider as an invested partner. In this way, saying that these are the things we are trying to achieve, that we are working with you but that we are also communicating our expectations to our community, provides greater transparency and accountability and avoids surprises in relation to the outcomes that we are seeking to achieve and monitor.

The challenges and opportunities of operating as a regional commissioning organisation, responsible for a geographic population

55 The challenge in regional areas is that our one sized approach to health care in Australia works well in areas of high and large population density. Once we move beyond those settings, small populations stretched over large geographical areas limits access, adds to the cost and inherently is reliant on small scaled and fragile service provision entities. A population approach structured on a regional basis delivering care into individual communities fits well into a commissioning approach based upon provider collaboration and integration.

How PHNs reconcile the long-term nature of supports for people with severe mental illness, with short term commissioning cycles

56 The short term funding cycles stifle investment in innovation and inhibit providers from participation without greater certainty of sustainability. Addressing our mental health needs requires investment in services that reflect the long term and on-going realities of mental health care. Greater recognition of the need to ensure our approaches to delivering health care are not inhibited by short term funding cycles is desperately required.

How Murray PHN and PHNs work with local hospitals in their catchment to deliver on the commitments in the Fifth National Mental Health and Suicide Prevention Plan

57 As previously discussed, PHNs have partnered with the Commonwealth and State Governments to form twelve place-based suicide prevention trial sites. These have been operating for over four years, with another year of activity and a final year of evaluation and transition currently being contracted.

58 The trial site programs have been very successful in the context of their overarching intention. This is not so much around building services and increasing service delivery, it is about connecting with the local systems and working towards greater capacity of the local system to be integrated, coordinated and responsive to the local needs.

59 By way of example, in the Benalla region, which is a current trial site, there were inherent problems in the way the system operated, with a lack of communication between providers. If there was a suicide attempt, it might have been attended to by the health system, whereas if there was a suicide it would be attended by the police. The collation of information and the notification process meant that there was a fragmented picture about what the community was dealing with and not all parts of the system were connected so people were having to tell their story multiple times or in multiple locations. The priority in Benalla became looking at protocols and notification processes so that the system was more connected. A further priority in Benalla was working with the community on a resilience program called the Grit and Resilience Project to build greater capacity within the community to support each other to identify when people needed help and encourage people to access help. Through this, we identified a number of resources that were developed locally within and designed by the community to enable information to be readily available.

60 In the Mildura trial site, as a remote area, there was a close connection of providers with the visibility of the providers meaning that the providers were working closely together. However, there needed to be stronger engagement with the community on the different types of initiatives that would work well. Furthermore, outreach funding has funded a follow up program called Way Back in Mildura in partnership with Beyond Blue, which provides three months of support and assertive outreach for individuals that present to the emergency department with self-harm or suicide issues.

How commissioning arrangements and service provision allow flexibility to respond to local needs while ensuring fidelity to system wide expectations and equity of access between different populations

61 There is a dual combination of needing to have responsiveness at the local level but also not offering a different version of fragmentation that is inherent within the current system. There is an element of needing to work locally so that it resonates and aligns with how services can be delivered within a regional model of care, but there are learnings, evaluation and evidence that has to be incorporated in how to enable that to work well.

62 It should not just be a local experience that determines how to make something work well. Sharing of work using the network of PHNs and the platform of engagement with the State as well as the Commonwealth funded PHN activities means that there are avenues for being able to say *"well this worked in this way, but there are better ways to do what we are trying to achieve"*. So there is an element of transparency and accountability in providing information for people to see what is being done elsewhere.

63 Although the region Murray PHN services is quite varied, there is still an interest and benefit in exploring what is happening in other areas, what has worked well and what could be adapted to the local area. We have not needed to spend a lot of time convincing others of the value of looking to examples and lessons from other locations. It has been recognised that there are some learnings that are available elsewhere that could be applied in the local context. The combination of this means it is inherent and incumbent on PHNs to make sure that the services are evidence based and that we are drawing from other experiences in order to strengthen what we are trying to achieve and not just exclusively looking at the local context and saying if it is not developed here then it will not work.

64 Ideally it is best to have a central intake approach to the delivery of regional models. Where this can be achieved it works well, although that is not to say that if there is not a central intake model it will not work. Within the Murray PHN we have a central intake model for our primary mental health services for the north east and Goulburn Valley region. That is purely based upon the provider environment of being able to do that more effectively in those communities because of the commissioned model of care and how it is being delivered. We do not have a central intake model for the Central Victorian and North West region, as in these regions it is more of a collection of multiple providers, which inhibits the prospect of central intake. However, we work with that to make it work as well as it possibly can, and learn and draw from it in order to then strengthen how to do that in an environment where we need to connect providers and connect people to providers.

65 Across the three metropolitan PHNs there is a shared central intake model for mental health services. It is very much determined by the local context. Ideally though, you are working towards principles and features being included in all contexts. The consistency comes more with the structure and what you are trying to achieve as opposed to something having to be done in a certain way exclusively.

The strengths and weaknesses of consortia as a commissioning approach

66 Fundamentally, consortia as a commissioning approach is an environment that PHNs need to work in regularly because of the relational commissioning context. We do not always have the ability to have one provider delivering across multiple communities, so the concept of consortia coming and working together to deliver a service is very much a feature of how we need to work in regional Victoria. I also think there is value in consortia in building partnerships and collaboration between providers so that there is more alignment in the work that they are doing collectively.

67 Importantly the governance arrangements around consortia need to be understood and supported by all partners. Where consortia approaches fall down is when there are different interpretations or understandings of how the consortia is expected to operate. Whether we call the concept consortia or partnerships, it is about the value proposition that each partner is bringing to the situation; which means they are working in a shared way that delivers individually and collectively the objectives that have brought the partners together. There needs to be structures and communication to enable that to occur well because there will be the hiccups. There may also be changes in theory and practice. But you need the structures to enable that to all work well. As a system, we are getting more experience in the benefits of consortia. Enabling all of those features to work well is critical for commissioners of activity, as they deliver by-products and additional benefits to just having one provider deliver for all instances without exploring opportunities for collaboration.

Examples where commissioning and/or specific funding approaches have worked particularly well in encouraging greater coordination between service providers

68 As part of the Federal and State level required activities, PHNs are currently working through the development of regional mental health plans with local hospital networks. This is important in looking at how we might work together and planning together to service the needs at a regional level. At this stage we are developing foundation plans as to how that will occur within our respective regions. This comes from the experiences of seeing what the system is delivering in relation to what is being provided by the Commonwealth funded activity as well as what is being provided by the State activity to then say, okay, we can see some real value in coming together and having shared planning. In my opinion, it is a really positive and important step towards greater

coordination between service providers. Previously, we have been showing what we are doing and how it can work and I think that has encouraged the desire to then undertake joint planning.

69 One of the key factors for facilitating joint planning is communication. There is a Memorandum of Understanding between the Victorian PHNs and the DHHS specifically in respect to mental health. This has really been important in being able to have a shared platform of communication. There are also other structures, such as bi-lateral agreements and national health reform agreements between the Commonwealth and the State which are really important. Ideally, we would also like tri-lateral arrangements between the Commonwealth, the State and PHNs so that there is agreement and a structure for working together at a regional level, but we have certainly got greater mechanisms now between the Commonwealth and the State as well as arrangements between PHNs and the State.

Governance and accountability

The governance relationship between PHNs and the Commonwealth Government and State Government in the provision of mental health and suicide prevention services

70 The Productivity Commissions' draft report into Mental Health identified the concept of regional commissioning authorities sharing between the Commonwealth and the State.[1] By sharing, I refer to the binary proposal around having either a State run regional commissioning authority (also referred to as the rebuilding option) or by using PHNs (also referred to as the renovating option).

71 There is potentially a third option, which PHNs would regard as a repurposing option, and that is a middle way of having a shared platform of joint planning and commissioning. This would involve co-commissioning and co–planning around the respective responsibilities and capacity at a regional level.

72 The regional mental health plans become important in being able to say, well, in these communities, how might we share or come together with an agreed approach or plan? How would we do that so that there would be complementation between what is able to be provided by the Commonwealth and the State but are being organised at a regional level for delivery according to the particular context in each of those regions. If we have an agreement around a framework in terms of what model what we are trying to achieve, and a platform of planning around how to be able to do that well together, then it would be a good way to move in the direction that is described by the Productivity Commission,

[1] Productivity Commission 2019, *Mental Health*, Draft Report, Canberra.

but not currently offered by the two options that the Productivity Commission has identified.

How PHNs collaborate with each other

73 The way in which PHNs collaborate with each other is a really important growing opportunity. What is probably not well understood is that as new organisations delivering a new role in a quite a different context for commissioning, the ability to do well has been primarily focussed on delivering for our catchments.

74 The opportunity of being able to do well together follows from being assured that you are delivering what you have been funded to deliver and what is expected by our communities and providers. That is going to be a very difficult thing to achieve in the first one to potentially five years of the PHN's existence. However, the further the PHNs collaborate the more that we learn from each other and are able to share about the approaches that work well and the approaches that could be applied consistently within each individual PHN catchment.

75 There is the opportunity of consolidating not only the back end - efficiencies in administrative functions and the support mechanisms in commissioning - but also in the models of commissioning and in the avenues and delivery of services. We are already seeing that in many ways in the central intake model of the Victorian metropolitan PHNs that has come as a by-product of those PHNs offering consistency in commissioning. This could be streamlined and improved for all residents in these collective catchments.

76 There could also be collaboration and consolidation with HealthPathways. Five of the six Victorian PHNs use HealthPathways. We are working through a process of having much greater consolidation to enable that to be a system approach rather than the sum of the total of five PHNs doing it the same way in their respective regions. In my view, each opportunity in terms of commissioning not only strengthens the individual PHN's ability to achieve what is intended, but also opens opportunities to explore how to do that more effectively and consistently together.

Ways accountability mechanisms can be enhanced to better enable performance oversight of PHN commissioned mental health services

77 Whilst still embryonic, and developing, PHN measures of accountability and performance focus upon outcomes and not just outputs. Measures of performance relate to delivery according to contracted activity such as service delivery effectiveness, cost and efficacy, and also include measures for quality, access and equity.

Mechanisms to ensure commissioning of services that are of a high quality and are safe

78 Murray PHN collates and analyses feedback from not only patients in relation to what services have worked well and would could be improved, but also from providers of services. This enables avenues for more informed knowledge, assistance and clinical capability to ensure that delivery of care locally is of high quality and is safe. Furthermore, the flexibility and capacity for PHNs to explore ways to ensure this, brings the system closer together at a local level, which does not always otherwise occur.

Secondary consultation

The role PHNs have in commissioning consultation liaison services for primary care providers in Victoria

79 Commissioning consultation liaison services is an embryonic and growing area for PHNs. There is growing appreciation of the value and importance of that capability. There is currently a national program that is being trialled.

80 Consultation liaison services are about more than case management; they provide system navigation and support, which is also part of the national psycho-social program. Consultation liaison services are important in improving consultations with practitioners so that there is a more informed perspective and support; which is really critical. They are also important in providing the system navigation that is required to enable people, particularly those living with severe mental illness, to receive the care they need.

81 Consultation liaison services are similar to what we have previously had with partners in recovery programs directed to system coordination and system navigation. There is flexibility in how to facilitate that, but structurally consultation liaison services is an area that warrants and needs more investment and focus.

82 The commissioning of consultation liaison services is heading in a direction of being more informed by people with lived experience. This involves peer workforces and people with lived experience as part of a multi-disciplinary team, not only adding to the design, but also enhancing the delivery of care and the consultation and navigation that is required. This is a fundamental area of improvement that is growing in recognition and will be accompanied with an associated focus of funding and policy.

Challenges to commissioning consultation liaison services for mental health or addiction medicine

83 One of the challenges to commissioning consultation liaison services for mental health and or addiction medicine is that there needs to be horizontal integration across multiple sectors. There needs to a focus on treating an individual for their whole needs rather than based solely on a diagnosis of mental health or alcohol and drugs. The system navigation and coordination that is required has to be broader than just looking at mental health; it needs to look at the primary health needs, the physical and emotional needs as well as the support that comes from a variety of sectors and make that part of the approach for the models of care at a regional level. There needs to be integration across the system not only within the system.

Access and navigation

How the Murray PHN and other Victorian PHNs use the HealthPathways portal to develop local 'patient pathways' for people experiencing mental illness or emotional distress

84 The HealthPathways portal is regarded as an important tool to demonstrate the value of PHNs to providers of healthcare; particularly given that it was a significant feature of the PHNs' first years of operation. It also demonstrates at a system level to the DHHS and others about how such an initiative can be used to help connect the system more effectively.

85 HealthPathways improves quality of care in terms of providing clinical information in a way that enables and strengthens the consultation with a patient. It also reduces the variation that exists between practitioners and between practices. Importantly it is not just a tool for a demonstration of how to improve clinical activity or how to understand and to utilise referrals for local service provision. It actually can drive change in terms of how services can be provided and in terms of a more integrated system between the primary care and acute and specialist services. HealthPathways has the ability to provide and prescribe a whole system approach for the practitioner with the patient.

86 Localised mental health pages were published in 2018 in line with the new commissioning arrangements. Central to the establishment of the localised HealthPathways was the development of clinical working groups. The Murray PHN has four clinical working groups that individually inform localised pathways relative to the Mildura, Bendigo, Shepparton and Albury / Wodonga regional areas.

87 The regional variation that led to the introduction of HealthPathways does have the prospect of stifling its use as a system tool if we do not move it to the next stage. That is

to use it to enable the use of the system and in order to address some of the inequities associated with how care is provided differently in different contexts. The inequities in regional variation is one of the things that PHNs are trying to address by having a more streamlined system centred through intakes and connections between specialist services and the primary care system. This is an opportunity to enable improvements in quality, equity and accessibility of care.

88 Initially, the focus was on making sure the system was delivering within your individual PHN catchment region, but ultimately there are opportunities to strengthen not only how we do what we are doing, but what and why we are doing it. Our role as system coordinators means that HealthPathways should not just be compliant to a context of local variation; the elements should, ideally, be consistent across all parts of Victoria. The referral options will change and vary, but HealthPathways should facilitate a system approach by increasing system accessibility and allowing PHNs to pursue opportunities to work together.

89 The individual mental health pages of the Murray PHN HealthPathways are being accessed between 112 to 125 times each month. Not only are the mental health pages frequently used and probably the pages that are most frequently accessed, they are being used to provide practical and locally relevant information to mental health providers. General practitioners are the most frequent users of our mental health pathways with their logins to the platform ranging between 742 and 1015 each month. The HealthPathways pages are geared for the use by health professionals in consultation with the patient. The platform provides clinical information around the assessment, management and treatment of the patient in a sequential stepped approach and it also, where appropriate and available, gives referral options and service arrangements within the local and connected health system.

90 Murray PHN is developing a Community Advisory Group Survey to provide input into the development of HealthPathways; with a focus on consumers identifying service delivery gaps, consumer experiences and the opportunities for service system improvement.

91 In summary, there are several opportunities for improving the HealthPathways tool, which include that:

(a) HealthPathways is presently very regionally focussed, in order to ensure that it is connected to the local service system; however, this may inhibit a state wide approach in terms of streamlining a system approach to enable people to access care.

(b) HealthPathways could be used as a tool to identify inequalities and variations, so that improvements can be made to the way care is provided everywhere.

(c) There are also prospects of introducing information from providers of healthcare to the community (reverse pathways); so that, for example, people in acute need returning to the community after stints in acute settings could then connect to the referral options and the support when discharged, thereby enabling connection to services to be available immediately.

(d) HealthPathways could also be strengthened in terms of a system resource and become a more effective tool in enabling the provision of care whether it is from primary to acute settings; as it is currently structured from an acute setting back into community settings.

How Murray PHN supports and facilitate access and referrals to mental health services for CALD communities, people with an intellectual disability and Aboriginal and Torres Strait Islander people

92 PHNs have specific funding for specific program areas, although there is also an overarching desire to enable more integration and complementation between those silo programs. The funding for the specific programs as well as capacity and flexibility for other cohorts will vary according to the PHN context. There is also some flexibility to prioritise service commissioning and other activities based upon the findings of each PHN's needs assessments which identify groups and populations that require specific attention.

93 Whilst people who identify as Aboriginal or Torres Strait Islander are eligible to access the broad range of mental health services commissioned by Murray PHN, Murray PHN also commissions specialist services for this group, delivered through Aboriginal Community Controlled Health Organisations (**ACCHO**) across the region. These include:

(a) **Specialist Aboriginal or Torres Strait Islander Psychological Therapy Services**: These services are delivered according to a social and emotional well-being framework. Approaches to care seek to build culture into therapy and are informed by an understanding of inter-generational trauma; and

(b) **Dual Diagnosis services (Mental Health and AOD):** Models of care are designed by each ACCHO to provide interventions to support individuals, families and the community experiencing co-occurring substance misuse and mental illness.

In addition to service delivery these services aim to promote local partnerships between Aboriginal and Torres Strait Islander health, primary mental health care, and the broader service system.

94 In terms of specific mental health programs available for people from CALD communities, this is still an area for development for the Murray PHN. It is an important area, having

regard to the rate of newly arrived settlers for humanitarian reasons across the Murray PHN. That rate is higher than the national average. Murray PHN refugee health needs assessment also identified the Murray PHN as having a significant Hazarra (Afghan) CALD community with a history of trauma.

95 PHNs do not currently employ a specialist approach for people with intellectual disabilities, but we recognise the need to do so. We have recently submitted an Expression of Interest to the Australian Government Department of Health to take on a lead PHN site role to focus on the needs of people with co-occurring mental illness and intellectual disability.

96 We need not only place-based approaches, but approaches that are responsive to the different community and cultural contexts; which, in turn, serves to move us away from that one stop shop, one size fits all type of approach. There is a need for tailored approaches to those specific population groups; approaches that are culturally attentive to the way in which information needs to be communicated or programs need to be structured and delivered. These dimensions are presently underdeveloped and not specifically recognised in the way that our funding is provided and structured. The development of those dimensions is important in order to reduce the gaps and instances of people falling through the cracks in our fragmented, federated system.

The use of the Commonwealth's Head to Health platform by PHNs

97 Murray PHN promotes and communicates the value of the Commonwealth's Head to Health platform as a location and resource of information about mental health services. This is as we recognise the importance of digital mental health services and value the platform for making it easier for the community to find a service quickly.

98 Murray PHN has a staff member who has been engaged with Head to Health in a consumer advisory capacity since the development stage of Head to Health. We have since incorporated the use of Head to Health in our commissioning approach with providers; noting that our primary mental health guidelines for commissioned services, which describe the scope of clinical and quality expectations that govern commissioned services, directly references Head to Health. We have also communicated the value of the platform to the community as an avenue for people to get access to information through providing links on webpages and the distribution of promotional material and presentations to consumers, carers and to community and local mental health services.

99 We have received good feedback from consumers about how Head to Health is structured and the breadth of information that is contained on it. The Head to Health platform was a really helpful resource for the bushfire response; as it enabled people to get ready access to information and to help sort through and work out what care they might be requiring. It

was also helpful in providing some immediate avenues for support when people were in distress more recently during the COVID-19 pandemic.

100 Head to Health is one modality that encourages an avenue for breath of information; however we recognise that it is not the sole solution, or a one stop shop for everybody in all instances. One of the challenges, I suspect, is that the wider the Head to Health platform extends, the more that people will have to navigate their way through it in order to find the information that they need. With over 550 difference resources, there is real potential for streamlining and further integration with linking between different areas and enhancing the way the resources are organised.

101 We also see an opportunity for the Head to Health platform to be linked with on the ground services in order to ensure that users who are looking for more intensive support can be directly linked to local services. This could be achieved by a link to the national health service directory of a Department of Health PHN locator website, which would then allow users to find their local PHN.

Intake and assessment

Intake and assessment approaches that Murray PHN and other Victorian PHNs use to manage referrals to the services they commission

102 There are differing arrangements for intake in different PHNs, with some PHNs managing intake centrally, some with a commissioned provider delivering central intake, and some in which each individual provider manages their own intake.

103 As previously discussed, the Murray PHN has formed a distinct central intake approach in approximately half of our catchment region. Specifically, in the Goulburn Valley and the North East we have a central intake model via the provision of primary mental health services supported by the Australian Primary Mental Health Alliance. In the North West and central Victoria portion of the Murray PHN catchment we do not have the same central intake arrangements, which is a direct result of a different system and provider structure. There is some localised intake and it is more organised than it was through the stepped model of care.

104 At a Victorian level, South East, Eastern Melbourne and North West Melbourne have a combined dedicated access and referral service, so they are operating as a collective to enable access and referral. Western Victoria PHN has a central intake model called referral point which assists in managing referrals

105 Murray PHN and North West Melbourne PHN are part of the National Best Practice Project, with the Australian Government Department of Health, to trial national guidance and decision supports in order to increase consistency of PHN intake approaches and to

support clients in accessing the right level of care through stepped care. The trial periods have now concluded and the University of Melbourne is undertaking an evaluation of the project.

The relationship between PHN commissioned services and the triage and intake functions of clinical area mental health services

106 PHNs often use the language "no wrong door". However, the realities are that there is disparity, disconnection and gatekeeping between State and Commonwealth intake systems which often results in the delivery of a fractured service response and poor client journey.

107 The concept of having a central intake and approach that steers and directs people into the provision of care locally - whether it is Commonwealth or State funded - is the ideal, but we do not currently have that capacity. If there was a combining of the capacity organised for the regional level then the incorporation of a centralised intake model could become not just a pipe dream but a reality.

108 The Murray PHN does not currently have a formal relationship with the AMHS for intake processes. If a partnership could be developed, it would enable both providers and patients to be able to access care according to their needs, rather than having to move through parallel systems operating in the same locations. This lack of integration is one of the real inhibitors and problems in the fragmented system that is currently in place.

109 It would similarly be helpful if other parts of the system were integrated so there was a 'whole person's needs' approach to, for example, the consideration of the treatment of chronic disease and for alcohol and other drug use. In regional areas, where there is limited access of services, there could certainly be better integration of the availability of services. This could be done by coming together and planning based upon regional needs and organising how to collectively address that need rather than running two or more versions of the same effort.

Murray PHN's suicide prevention and response efforts

The role of PHNs in suicide prevention and response

110 Approximately 7% of Murray PHN's total mental health funding is spent in relation to suicide prevention and response. The contribution of the Murray PHN in suicide prevention is largely capacity building rather than commissioning service delivery. Our efforts have been targeted towards enabling existing service provision in order to be more readily accessible, more connected and integrated and responsive to the local place based context. In addition, there has been a focus on building capacity within the

community; around resilience and enabling the connection of local services with a focus on pre- and post-vention.

111 These efforts around suicide prevention and response have been a really significant development in the course of the last couple of years. However, as a whole, more is needed in respect to suicide prevention and response, and it is needed not just in specific locations but across all locations.

112 What is really clear is that while the intentions in suicide prevention and response can be consistent, the approaches have to very much be tailored to the specific context, as the needs, capacity and gaps in each community are quite different. In Mildura, there has been an immediate and continuing element of trauma associated with traumas in the community and so making sure the services are being accessed and utilised as early as possible has been important. Whereas in other areas, there has needed to be greater focus around providing access to information so that people know where and how to get support, and in order that they have information available through a range of different resources; such as small pamphlets, wallet based cards and calendars - all developed by the community.

113 As a whole, we have a number of efforts, along similar lines, directed to the fundamental principles of trying to build capacity, enable the connection of local services, focusing on pre- and post-vention and building capacity within the community around resilience. At the same time, those efforts are being geared around a place based context. That has been a really significant development in suicide prevention efforts over the course of the last couple of years. We need more, obviously, and we need for that to be not just in specific locations but across all locations.

Outreach program

114 As previously discussed, there are also some assertive outreach programs - such as the Way Back program in Mildura - where follow up care is provided over a designated period of time to an individual and that individual's family following discharge from acute facilities having endured self-harm or a suicide attempt. The Mildura Way Back program is delivered in partnership with Beyond Blue. The Mildura Base Hospital is the lead agency; having successfully tendered for the service. The program is also informed by a local group of providers who provide advice and input.

115 Although it is still early days, as the Wayback program only launched earlier this year, it has been well received. It is highly regarded by the community as a valuable additional support for a critical issue, particularly within the Mildura community. There are also strong indicators that it is going to be well embraced by service providers.

116 There has been a recognition of the value of these types of outreach programs being expanded to other communities; however, at this stage, this ambition sits in future plans rather than there presently being funding to enable that to occur. It is the intention that the learnings from the existing outreach programs available in a number of different communities - including Mildura - will be transferable to other communities.

Black Dog Institute's Lifespan Framework

117 As part of the PHNs' role in building capacity in suicide prevention and focusing a localised approach, the Murray PHN has also been trialling the Black Dog Institute's lifespan framework. This framework takes a systems approach to suicide prevention in specific locations. It has a post-vention dimension as well as assertive outreach functions. It also incorporates community response planning.

Data around suicide

118 Access to data in respect to suicide is an area that we would like to improve. The PHNs receive data through DHHS in respect to trial site joint projects. The Victorian Tasmanian Primary Health Network Alliance is also currently working to arrange for more real time data in respect to suicide to be shared with services by the Coroner's office. This data would be really helpful as it would be real time data and would relate to all Victorian communities; not just those where there is a trial site joint project with DHHS.

Murray PHNs systems-based approach to suicide prevention and Victoria's place-based suicide prevention trials

119 Murray PHN leads two of the Victorian place-based suicide prevention trials – one funded by the state government in Mildura and other funded by Murray PHN in Benalla.

120 In seeking to strengthen a local system towards prevention of suicide, we see the role of Murray PHN in the trial sites as:

(a) facilitating shared understanding of the nature and operation of a place and its local system;

(b) building opportunity for collaboration and partnership within a place and across its system (better linkage and connection at a local community level);

(c) development of governance mechanisms which are inclusive, representative of place, accountable, transparent, and within which decision-making is based on data, evidence and local voice;

(d) building and focussing upon resilience; and

(e) encouraging people to access support and enabling support that is connected and integrated as early as possible.

121 The place-based approach understands that culture and context are important and that what works in one community might not work in another. However, despite the place-based focus, it is intended and expected that approach to community suicide prevention at the 29 trial sites in Australia will be transferable. The same methodology and evaluation will apply for the trial sites across our region. Murray PHN believe that other PHNs could, for example, learn from how the Mildura and Benalla trial conductors have enacted their work within the communities from the way in which Murray PHN has supported the trial. Furthermore, Murray PHN is currently lifting learnings from the trial sites and looking at how they can be adapted and adopted across the catchments for our suicide prevent strategy over the next few years.

122 The place based system approach to community suicide prevention is considered to be beneficial in that it is more reflective of the nature of suicidalities in communities and that it works towards a more sustainable way of achieving a lasting impact, rather than discrete or solo interventions.

123 Notably, systems change generally takes time and the coordination and management of a place-based system approach requires high level skills and attributes across multiple capabilities. When combined with the difficult nature of the subject nature, this has made trial co-ordinator recruitment and retention difficult in some Victorian trial sites.

Potential reforms recommended to strengthen Victoria's future approach to suicide prevention and response

124 There are a number of key opportunities I see for potential reform in suicide prevention and response. These opportunities include:

(a) more regional planning and a linkage between multiple communities at regional levels in order to enable the availability and provision of mental health support directed to suicide prevention;

(b) greater involvement of people with lived experience, who have been through the issues we are trying to address. This includes enabling lived experience people to have input into the design and planning efforts at a regional and community level;

(c) developing a greater understanding of effective interventions for high risks groups (particularly men); and

(d) further support and roll out of assertive outreach, post-vention and community response planning capabilities in all Victorian local government areas, including 'aftercare' programs such as the Way Back program.

Regional and rural workforce questions

Challenges facing Murray PHN in achieving and sustaining access to a workforce with sufficient mental health capacity and clinical expertise

125 In regional areas there are often issues around recruitment, retention, pay disparity and burn out. Accordingly, in regional areas the starting premise is that there is a real challenge in access to mental health and other primary services because there is less availability of the workforce. This is exemplified by the data associated with the better access MBS items, which shows that there is very small and limited use of private psychology services in regional areas compared to metropolitan areas.

126 Service availability in these areas has historically been very much dependent on and shaped by the availability of the workforce in the community and the ability of PHNs and their predecessors, Medicare Locals, to contract psychologists and mental health nurses to deliver services within the community. Furthermore, the access to state funded primary mental health services and psychiatric services is often very limited in regional areas and this then often determines the type of services that might be available.

127 A stepped model of care changes that significantly by focusing on how to enable access to services addressing mild and moderate mental health needs across a region that are organised and delivered into each community. However, a workforce is still required to enable that to occur. People are looking for working environments where they are part of a team. Working as an isolated practitioner without peer support, mental health support and supervision, as has historically been the case in regional areas, increases the challenges of trying to attract people to regional locations.

128 Solutions to issues around workforce may lie in enabling integrated health networks, partnerships with education providers, greater use of peer work, and student led clinic models or placement opportunities. Accordingly, in regional areas there is a need to build scale and capacity to enable team-based care so as to reflect the type of care that the communities require. This requires partnerships and linkage between communities and providers of healthcare at a community and regional level. If we were to treat workforce as a distinct, isolated issue without also looking at team-based care and partnership, then we become stuck in the perpetual cycle of recruitment and retention in environments that are not considered attractive and are unlikely to be replenished when people leave. The greatest challenge is to assemble integrated teams; which is not just a challenge for regional areas. The right policy and funding is critical.

129 Part of the value of integration and planning between the Commonwealth and State and between public and private is that you are building capacity for more team based care that is responsive to the needs of the patient and the population; not just delivering services dependent upon a part of the workforce.

Approaches, activities or incentives that have been effective in attracting and/or retaining staff in rural and regional settings

130 The area of incentivising health care to reflect the challenges of providing care in rural communities has validity. Such incentives would be welcomed but also need to be evidence based. A number of interesting research papers have explored these issues.

Headspace

131 Murray PHN has around $7 million of funding in relation to headspace. The Murray PHN currently has five existing headspace centres across Mildura, Swan Hill, Wodonga, Bendigo and Shepparton centres. In addition, there is a new satellite centre in Wangaratta and a new centre in Echuca that we expect to be opening this year. This total number of centres would be in the higher range for a PHN, although most PHNs have several headspace centres.

132 Commissioning approaches for headspace centres vary significantly across Victoria and significantly even within the Murray PHN catchment region. Within the Murray PHN, there is a combination of centres with community managed community health services as lead agencies and also centres that have local health services as the lead agency.

133 The PHNs work closely with the headspace centres to increase access and integration, so as to enable local practitioners to be able to refer people with youth mental health needs to specialised youth mental health services.

134 As the headspace model has moved beyond the larger metropolitan and larger regional centres, the breadth of how headspace services are being delivered to offer different modalities and arrangements has increased. Among the Murray PHN headspace centres there is a variety of different approaches. Some of the variation is based on the availability of workforce and some is based upon the local community context. So, whilst there is a headspace brand, model and framework of delivery, it does vary according to various communities and contexts. From a PHN's point of view, the variability and flexibility in how headspace services can be provided is a really important element so that there is responsiveness to local need and context.

135 We have had a strong experience of different modalities of how a headspace service can be provided according to the different contexts. In the small regional areas where outreach models are used to enable services to be available in adjacent communities,

there is a greater focus on having a regional presence as opposed to a community presence. The use of eheadspace services has been a really important dimension in enabling access to services, and in offering choice and different modalities of service provision.

136 For example, the Swan Hill headspace has designated times and capacity where they can take their services beyond Swan Hill and into schools in the southern Mallee and upper Wimmera areas. There are also improvements in transportation arrangements, which they have organised so that there can be access for young people in those communities to come directly into the Swan Hill centre in order to access headspace services. This will be a feature particularly for the new service in Echuca, as its intention is to not just service Echuca/Moama community but also the adjacent southern New South Wales and Campaspe local government based communities.

137 The workforce dimension for headspace is really important, because it has an impact upon meeting demands and reducing the extent of wait lists and waiting times. This is something that the PHNs work with the headspace centres to monitor through data collation. This data is used to help us provide support to improve quality and performance but also work with the services in addressing the local challenges and need. It also aids the support PHNs can offer with funding and flexibility, but also empower efforts of advocacy and encouragement for improvements.

138 The PHNs are then able to work with the Department to increase access to funding in order to enable capital improvements. For instance, we have recently had an increased access to funding to enable capital improvements in Shepparton. This additional funding reflects that the infrastructure requirements for headspace services need to reflect the model guidelines but also keep pace with the growing demand for services.

139 One of the things we have seen is that some of the administration fees associated with previous arrangements were very tight, and that there needed to be a greater reflection of the costs of running the business for the lead agencies delivering the services through the centres. The partnership approach between headspace and PHNs, between PHNs and lead agencies, and between lead agencies and the communities, are all really important in order to enable the responsiveness at the local community level which is focusing on the important area of youth mental health.

The outcomes that headspace is achieving for young peoples' mental health in Victoria

140 As we are commissioning headspace services and they are a partner, we have to work on collectively achieving the desired outcomes. To do this we need to be able access to data relating to headspace services. The provision of data is one area that certainly needs

development. But if the use of data to identify the outcomes that we are collectively trying to achieve could be improved, that would be welcomed.

141 In terms of how we measure and are responsive to the outcomes that we are trying to achieve through the headspace centres, there is a headspace national context and a headspace service delivery context. At both levels, we want to be improving and strengthening our ability to deliver improved outcomes. The experience for the Murray PHN in our regional areas is that by having access and agency of an organisation that has the capability to focus on youth mental health, we really want to utilise it, and we regard it as an asset to work with and invest in, in order to strengthen capacity in this important area.

142 The client experience data that is currently collected is largely positive across our headspace network. The reach of young people is quite impressive, taking into account individual sessions, as well as community and school engagement events which focus on mental health literacy and prevention.

143 Over the last twelve months Murray PHN headspace centres have provided services to 3,767 young people on a total of 16,340 occasions. Of the clients who used the services during the last twelve months:

(a) 61.05% were aged between 12 to 17 years;

(b) 19% identified as LGBTIQ, 9% identified as Aboriginal or Torres Strait Islander and 5% identified as CALD;

(c) 52.8% had an initial Kessler Psychological Distress Scale score in the very high range;

(d) 2% were are homeless or at risk of homelessness;

(e) 44.9% had never seen a mental health professional before;

(f) 54.7% indicated that feeling depressed or anxious was the main reason they attended; and

(g) 84.1% indicated that they did not feel they had to wait too long for their first appointment.

144 Across the five Murray PHN headspace centres, young people who have used the headspace services over the last twelve months reported, on average, on a satisfaction scale of 1 being extremely dissatisfied to 5 being extremely satisfied, that:

(a) they are satisfied with the overall service (4.18 average rating);

(b) they could get help for the things they wanted to get help with (4.10 average rating);

(c) their mental health improved because of their contact with headspace (3.89 average rating);

(d) that the headspace staff listened to them (4.43 average rating); and

(e) that if a friend needed this sort of support, they would suggest headspace (4.47 average rating).

145 Furthermore, the data collected has shown that over the last twelve months on average there has been improvement in the clinical outcome measures (the Kessler Psychological Distress Scale) for the young people using the headspace services.

146 Murray PHN uses this data to help the headspace centres work through the outcomes that we are trying to achieve together. This is an area that needs development and support is needed in order to facilitate it. We need to enable headspace centres to be integrated with the local system. We need for them to be responsive; working with them. As I said, as an asset that is available to focus on youth mental health, when that is an area of under-development and under-capacity in regional Victoria, is really important.

The benefits of CAMHS and community youth mental health services providers funding their own registrars to be located in headspace centres

147 CAMHS and community youth mental health services providers funding their own registrars to be located in headspace centres is certainly welcomed, supported and encouraged by PHNs. The benefits of this include improved pathways for clients to and from the State-based system and stronger clinical governance. Although this practice is a good idea, it tends not to be a widespread practice, and usually only occurs when the lead agency is a local hospital network, for example in Goulburn Valley. The practice is perhaps more localised according to opportunity, rather than being structurally incorporated as an approach.

sign here ►

print name Matt Jones

date 29 July 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT MJ-1

This is the attachment marked 'MJ-1' referred to in the witness statement of Matt Jones dated 29 July 2020.

Matt Jones

Curriculum Vitae

Career Summary

- 15 years CEO experience as leader of health organisations in rural and regional settings.
- 28+ years commitment to the improvement of access, quality and responsiveness of health care to meet the needs of rural and regional communities.
- Extensive experience in partnership building and regional planning.
- Leader of change in complex and evolving environments

Qualifications

- Master of Public Health & Tropical Medicine, James Cook University 1998
- Bachelor of Arts – Ballarat University College (FU), 1992

Work History & Key Achievements

Chief Executive Officer

Murray Primary Health Network (Murray PHN) – $56m annual budget

1 July 2015 - current *(based in Bendigo)*

- Successfully led a multi-disciplinary team in the transition of five Medicare Locals into one Primary Health Network. Included the implementation of a new organisational structure, (100+ staff across five office sites).
- Active leadership role in implementing new governance and strategic initiatives to reposition the PHN contribution in a reformed regional, jurisdictional and national policy environment.
- Established meaningful regional relationships and alliances with General Practice (700+ GPs in 250+ Practices), Pharmacies, Allied Health, Health services (35+ acute health services), Aboriginal Community Controlled Health Organisations (7), Community Health (7) and NGOs.
- Developed Murray PHN commissioning framework using relationship commissioning approach to 1/ reorientate $5.5m funding for general allied health funding for specific chronic disease models of care and; 2/ repurpose $6.5m mental health funding for integrated stepped model of care across catchment region.
- Developed strong working relationships with the relevant 6x federal and state politicians to ensure they are fully briefed with initiatives of the PHN across Murray PHN catchment.
- Developed Murray Exchange as knowledge management and service planning resource (currently being licensed to 4 PHNs)
- Developed a credible voice for health care reform through a visible social media presence and engagement with other media such as open forums, newspapers, radio and television.

Work History & Key Achievements

Chief Executive Officer

Loddon Mallee Murray Medicare Local (LMMML) - $13m annual budget

June 2012 – June 2015 (*based in Bendigo*)

- Established an organisation structure to provide primary health care services and support to the primary care system in order to improve the health outcomes of the 250,000+ residents of central Victoria and southern NSW.
- Oversaw and acquitted an annual funding base of $13m to provide direct allied health and mental health services and support to the primary care system.
- Developed a team of 60+ employees providing clinical services, stakeholder engagement, effective communication mechanisms and processes to progress Medicare Local program development
- Through the application of the organisation's capabilities, provided the localised contribution of the Commonwealth Government National Network of 61 Medicare Locals (17 Victorian Medicare Locals)
- Winner of Bendigo Chamber of Commerce Healthy Workplace Award.
- Upon closure of the Medicare Local Program secured, through competitive tendering process, the contract to establish the Murray PHN organisation as one of 31 Primary Health Networks (PHNs) across Australia (6 Victorian based PHNs)

Chief Executive Officer

Central Vic General Practice Network (CVGPN) - $3m annual budget

January 2011 – June 2012 *(based in Bendigo)*

- Provided management stability and leadership after period of during major management & governance instability.
- Returned organisation to positive and viable financial position after previously been placed "on-watch" with Commonwealth Health Department
- Negotiated implementation of national health reforms locally
- Led a consortia process of 17 local primary health care organisations to successfully secure Loddon Mallee Murray Medicare Local contract (one of only two approved consortia applications to secure a Medicare Local contract among the national 61 Medicare Locals).
- Managed successful transfer of all staff, assets, entitlements and contracts to LMMML

Chief Executive Officer

Murray Plains Division of General Practice (MPDGP) $3m annual budget

April 2005 – June 2012 *(based in Cohuna and Echuca)*

- Grew staff from 7 to 29 and income base from $1.32M to $2.995M
- Instigated and managed organisation relocation from small community to large regional centre.
- Completely reorientated organisational structure
- Introduced Governance Policy and Procedure structure and system
- In 2011 achieved the highest benchmarked category rating of Successful Engagement Culture in the top 5% of rated Divisions of General Practice
- Appointed CEO of adjacent Division of General Practice simultaneously holding both CEO positions (only dual CEO in the 105 Division GP Network)

Matt Jones Curriculum Vitae

Work History & Key Achievements

Quality Manager

Echuca Regional Health (ERH)

May 2001 – April 2005 *(based in Echuca)*

- Implemented and maintained whole of organisation quality program
- Supported organisation to secure 4-year ACHS Accreditation
- Supported organisation to secure 3-year Aged Care Standards Accreditation.

Additional work history

1999-2001 – Senior Policy Officer

Public Health Branch, Department of Health and Human Services, Melbourne

1997-1999 – Director, Non-Communicable Disease Section

Pilbara Public Health Unit, Port Hedland WA

1995-1997 – Director, Medical Department

Townsville Aboriginal and Islander Health Service, Townsville QLD

1994-1995 – Health Manager

Pintubi Homelands Health Service, Walungurru NT

1993-1994 – Sports and Recreation Officer

Urapuntja Aboriginal Corporation, Urapuntja NT

1992-1993 – Council Administration Officer

Kiwirrkurra Aboriginal Council, Kiwirrkurra WA

Professional and Community Membership

Graduate Australian Institute Company Directors (GAICD)
Member Australasian College of Health Services Management (ACHSM)
Member Governing Council, Australian Health & Hospital Association
Member Mental Health Expert Taskforce, Victorian Government appointment
Member Victorian Primary Health Network Alliance (Chair)

Company Director positions

Director, Community Living Respite Services (CLRS) 2010-2015
President 2012-2013
Vice President 2011-2012, 2014-2015
Company Secretary, Regional Employers Alcohol & Drug Initiative (READI) 2018 - current