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EASTERN MELBOURNE

An Australian Government Initiative

# Eastern Melbourne PHN

## Needs Assessment Report

November 2017

We would like to acknowledge the contribution of our stakeholders who provided valuable insights and data regarding the needs of their communities.

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# List Of Abbreviations

**ABS** – Australian Bureau of Statistics
**ACSC** – Ambulatory Care Sensitive Condition
**ACP** – Advance Care Planning
**ADIS** – Alcohol and Drug Information Service
**AIHW** – Australian Institute of Health and Welfare
**AIR** – Australian Immunisation Register
**ALMS** – Australian Locum Medical Service
**AMES** – Adult Migrant Education Service
**AOD** – Alcohol and Other Drugs
**APSU** – Association of Participating Service Users
**ASGS** – Australian Statistical Geography Standard
**ASR/100** – Age-Standardised Rate per 100 population
**ATAPS** – Access to Allied Psychological Services
**ATS** – Australian Triage Scale
**BHNEM** – Better Health North East Melbourne
**CALD** – Culturally and Linguistically Diverse
**CH** – Community Health
**CHS** – Community Health Service
**CIV** – Community Indicators Victoria
**CMHN** – Community Mental Health Nurse
**CNA** – Comprehensive Needs Assessment
**CRM** – Customer Relationship Management System
**CSA** – Crime Statistics Agency (Victoria)
**DoH** – Department of Health (Commonwealth)
**DHHS** – Department of Health and Human Services (Victoria)
**Dept. Imm. & BC** – Department of Immigration and Border Control
**EACH** – Eastern Access Community Health
**ED** – Emergency Department
**EMPHCC** – Eastern Melbourne Primary Health Care Collaborative
**EMML** – Eastern Melbourne Medicare Local
**EMPHN** – Eastern Melbourne PHN
**EMR** – Eastern Metropolitan Region
**ERAHMS** – Eastern Ranges After Hours Medical Service
**HARP** – Hospital Admission Risk Program
**HCFMD** – Family Household Composition (Dwelling)
**HRVic** – Harm Reduction Victoria
**IEMML** – Inner East Melbourne Medicare Local
**ISRAD** – Index of Relative Socio-economic Advantage and Disadvantage
**LGA** – Local Government Area
**LGBTIQ** – Lesbian, Gay, Bisexual, Transgender, Intersex and Queer
**LHN** – Local Hospital Network
**MBS** – Medicare Benefits Schedule
**MDS** – Medical Deputising Service
**MHCSS** – Mental Health Community Support Services
**MHWP** – Municipal Health and Wellbeing Plan
**ML** – Medicare Local
**MRC** – Migrant Resource Centre
**NGO** – Non-Government Organisation
**NHDS** – National Home Doctor Service
**NHPA** – National Health Performance Authority
**NHSD** – National Health Service Directory
**NMML** – Northern Melbourne Medicare Local
**PACER** – Police and Clinician Emergency Response
**PCP** – Primary Care Partnership
**PHIDU** – Public Health Information Development Unit
**PPH** – Potentially Preventable Hospitalisation
**PTSD** – Post-Traumatic Stress Disorder
**RACF** – Residential Aged Care Facility
**RDNS** – Royal District Nursing Service
**SA2** – Statistical Area Level 2
**SA3** – Statistical Area Level 3
**SEIFA** – Socio-Economic Indexes for Areas
**STI** – Sexually Transmissible Infection
**SVN** – Shared Vision for the North
**VAADA** – Victorian Alcohol and Drug Association
**VAED** – Victorian Admitted Episode Dataset
**VCGLR** – Victorian Commission for Gambling and Liquor Regulation
**VEMD** – Victorian Emergency Minimum Dataset

# Section 1: Narrative

Eastern Melbourne PHN (EMPHN) was formed on 1 July 2015, incorporating the catchments and drawing on the resources and experience of three former Medicare Locals (ML); Eastern Melbourne ML, Inner East Melbourne ML, and part of Northern Melbourne ML.

## About The Catchment

The EMPHN catchment (Figure 1) comprises 12 Local Government Areas (LGAs) – nine fully and three partially covered.

LGAs entirely within the EMPHN border include:

- Banyule;
- Boroondara;
- Knox;
- Manningham;
- Maroondah;
- Monash;
- Nillumbik;
- Whitehorse; and
- Whittlesea.

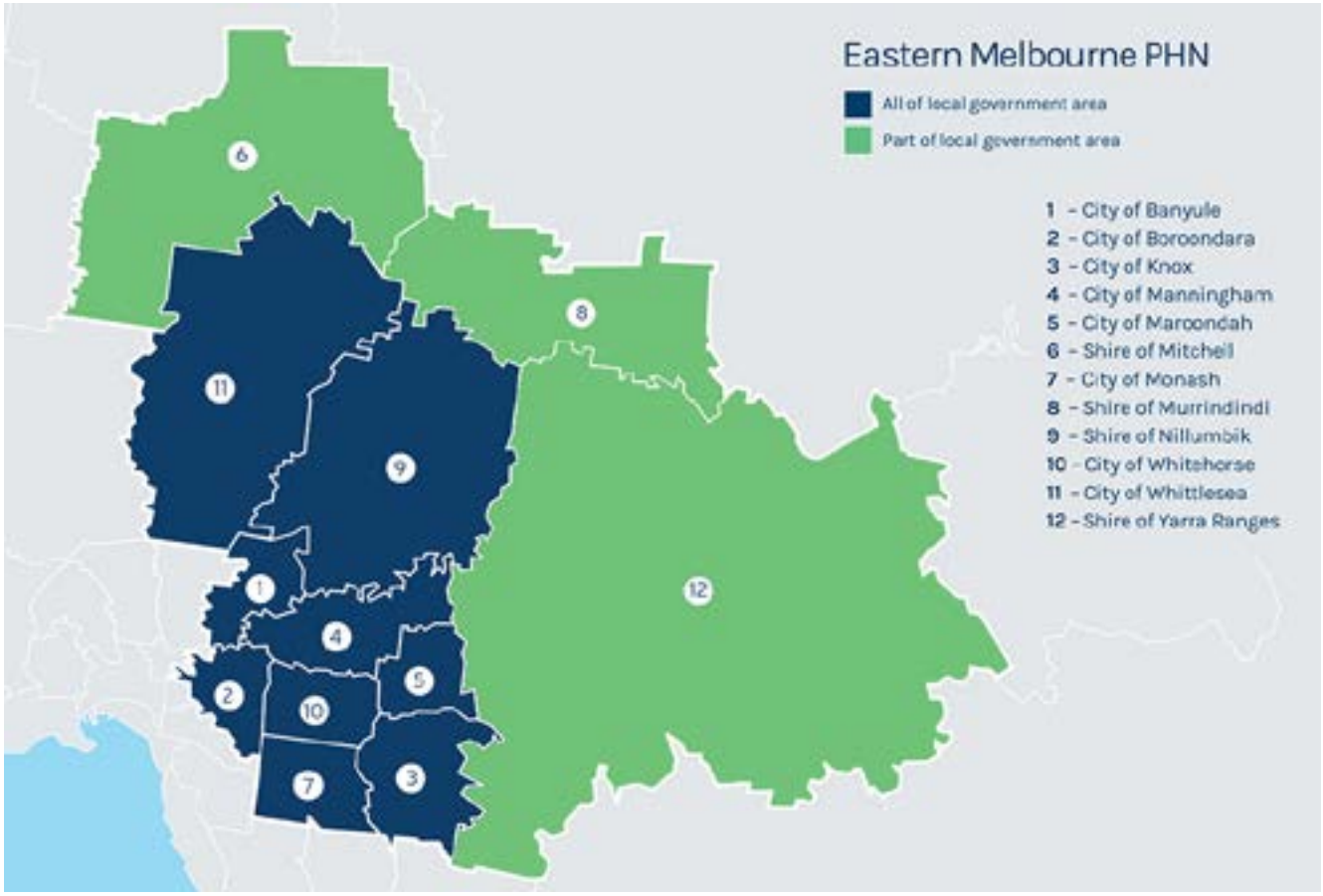


Figure 1: EMPHN Catchment Boundary

The catchment also covers part of Mitchell and Murrindindi, amounting to 35% and 27% of their respective populations. Additionally, the catchment includes part of Yarra Ranges, although it should be noted that the portion which falls outside the EMPHN catchment is largely uninhabited national park.

## Demographics

The total population of the EMPHN catchment was estimated at over 1.43 million people in 2016, up from 1.32 million people in 2011. This represents 24% of the Victorian population. Figure 2. shows the population distribution across the catchment, as well as the projected population increases, by SA3.

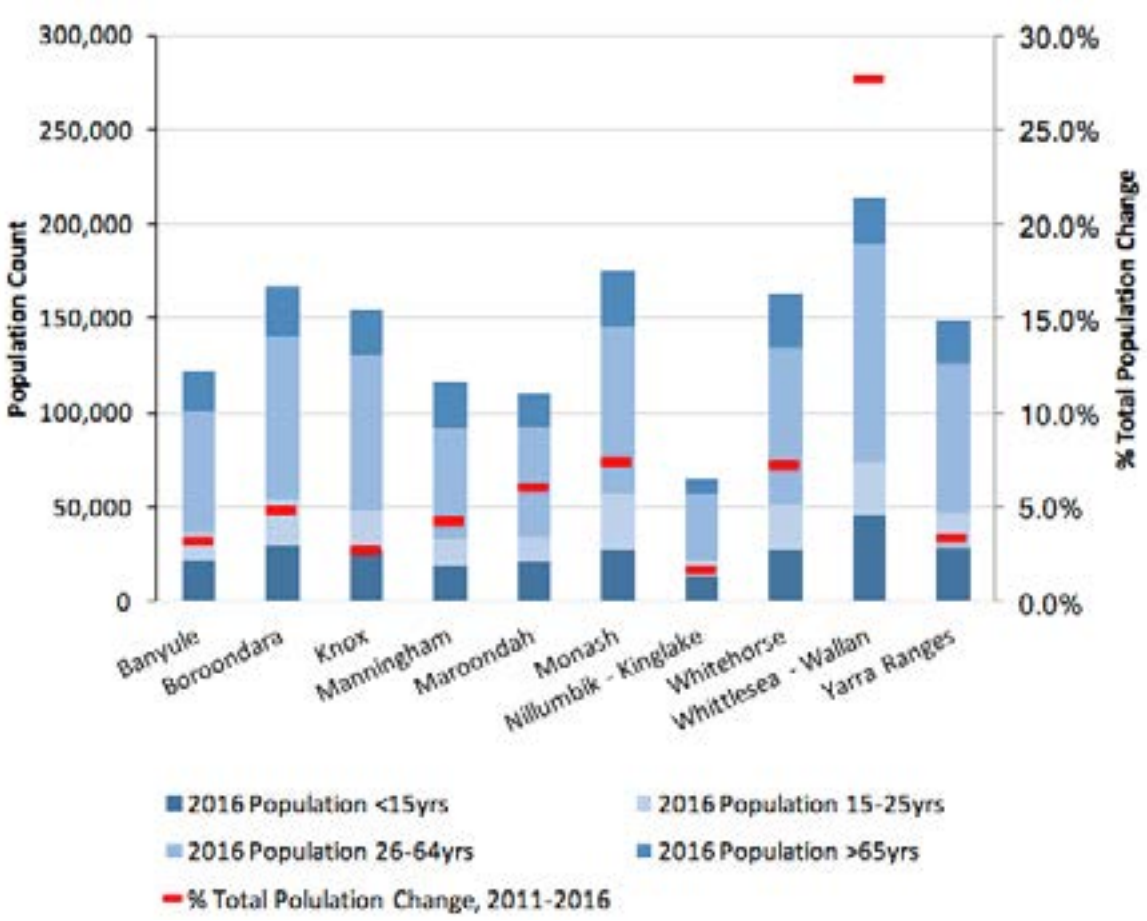


Figure 2: EMPHN Catchment Population

Some key features of the Eastern Melbourne PHN population include:

- Over 6,800 Aboriginal and/or Torres Strait Islander people live in the catchment, particularly in Knox (754), Banyule (706), Whittlesea-Wallan (1,885), and Yarra Ranges (1,357);
- A higher than average number of people born in countries where English is not the first language live in Monash (China 12.7%, Indian sub-continent 8.9%), Whitehorse (China and Hong Kong 12.9%), and Manningham (China and Hong Kong 11.9%). Whilst Whittlesea had the most diversity in terms of countries of origin, Monash had a higher concentration of CALD populations, with 8.2% of the Monash population non-English speaking, almost twice the Victorian average (4.5%) (although with a lower mix of nationalities);
- The majority of immigrant arrivals has largely settled in Monash (1,599), Whitehorse (1,335) and Whittlesea (1,294) and the majority of the humanitarian arrivals has settled in Whittlesea (320) and Maroondah (191);
- Whittlesea has both a high growth rate and a relatively young population. The population in Yarra Ranges is also relatively young.

## Socioeconomic Disadvantage

Figure 3: Depicts the areas of disadvantage/advantage (IRSAD) as they exist in the catchment.

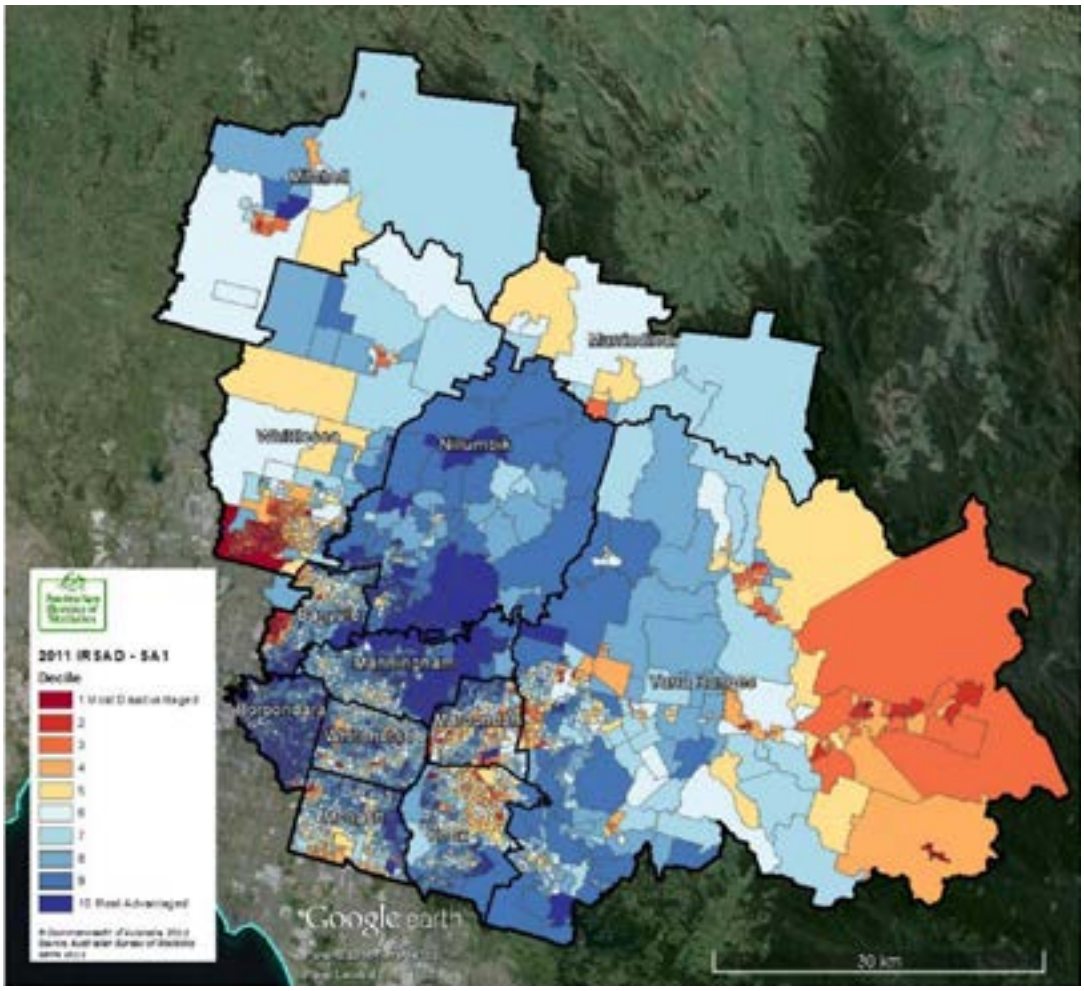


Figure 3: IRSAD Profile By SA2

Areas with higher proportions of low socioeconomic status (SES) are identified by the spectrum of red to orange (red being most disadvantaged) and those of higher SES by the light to dark blue (dark blue being most advantaged). A band of advantaged areas spans from Boroondara up through Manningham, Banyule and Nillumbik, whilst LGAs of lower SES remain unchanged, specifically:

- Knox;
- Maroondah;
- Monash;
- Whittlesea; and
- Yarra Ranges.

Socioeconomic disadvantage is generally associated with lower levels of health literacy and poorer health outcomes, impacting both morbidity and mortality. Whilst more details are provided in the attached Indicators Spreadsheet, a data review for our PHN region noted the following key highlights:

- Life expectancy at birth in Victoria is 79.0 years for males and 84.3 years for females -both slightly below the national average.
- Within the EMPHN catchment there are areas of relatively low socioeconomic advantage located adjacent to areas of relative high socioeconomic advantage. For example, Heidelberg West has one of the lowest SEIFA IRSAD scores in urban Melbourne and Heidelberg one of the highest. Looking at a map, they are separated by a road, obviously there is a degree of advantage/disadvantage boundary blurring that occurs between regions on a fluctuating and permanent basis (i.e. gentrification.
- Life expectancy in years at birth was lowest in Knox for both males (79.7) and females (83.0), and highest for males in Boroondara (82.2) and Nillumbik (82.3), and for females in Boroondara (85.8) and Monash (85.8).
- The avoidable mortality rate from all causes of death was well above state average for 0-74 year-olds in Whittlesea for both males (275.9/10,000) and females (180.7/10,000) (highest for our region). EMPHN catchment averages are 229.6/10,000 for males and 152.04/10,000 for females. The lowest rates

are found in the more affluent suburbs: Boroondara (males: 184.6/10,000) and Manningham (females: 114.7/10,000).
- Chronic disease prevalence across the catchment exhibits the common trend of being overrepresented in areas with a relatively low SES. For example, diabetes, COPD and heart disease are all higher in the areas that have a SEIFA IRSAD score below 1000. In fast developing areas such as Whittlesea the effect can be obscured by migration into the area of young middle class families and the pre-existing disadvantage of previously rural town.
- Rural areas tend to have the highest rates of disease and reduced life expectancy when compared to urban regions. Again, this is a national trend that deserves attention. For example, the rural areas of Mitchell, Murrindindi, Whittlesea and the Yarra Ranges all have higher rates of chronic disease, alcohol related violence and injury, smoking and obesity. As a PHN, these areas make up roughly a third of our catchment in landmass.
- The prevalence of anxiety and affective disorders was highest in Whitehorse (12.8, ASR/100) and lowest in Nillumbik-Kinglake (11.1, ASR/100), close to and lower than the state average of (12.7, ASR/100) respectively.
- Above state average prevalence (11.4, ASR/100) of high psychological distress in adults was found in Whittlesea-Wallan (12.1, ASR/100) and when available data was disaggregated by gender, it shows women as having disproportionately higher levels of anxiety and affective disorders (14.1, ASR/100) compared with men (8.5, ASR/100).

# Needs Assessment Process And Issues

## Purpose Of This Report

The mapping and assessment process aims to scope and detail the catchment's current and future health care needs and service delivery gaps. An initial assessment of some of these needs and services was documented in a report submitted to the Australian Government Department of Health in March 2016.

A reassessment of the data and further consultations were submitted in a subsequent report in November 2016. Available primary and secondary data were accessed from ABS, AIHW, Victorian Department of Health and Human Services, and local general practice data via the MBS.

This report entails a further update, and incorporates new findings from the 2016 Australian Census of Population and additional consultation data from various stakeholders, particularly those garnered through the Strategic Annual Planning session with stakeholders. As a 'refresh' of the previous report, changes and additions have been made using the 'tracked changes' feature.

## Process

### Framework

The conceptual framework used by the Australian Institute of Health and Welfare (AIHW) was adopted. This approach employs the precept that a person's health and wellbeing, "result[s] from complex interplays among biological, lifestyle, socioeconomic, societal and environmental factors, many of which can be modified to some extent by health care and other interventions" . A social gradient lens was used to identify levels of disadvantage, income and financial stress, education/literacy, employment, early childhood, family violence, gender equity, cultural and ethnic diversity, disability, and social inclusion/exclusion.

### Data Review

The November 2017 Needs Assessment relies on the consultations and quantitative findings of the previous assessments (March 2016, November 2016), expanded and amended where additional and/or updated data were available. In November 2016 the additions looked to address deficits in qualitative and quantitative data by broadening the Mental Health and Alcohol and Other Drug needs assessments, undertaking further provider consultation within the catchment to further test or validate quantitative findings and incorporating further community consultation.

In this iteration of the needs assessment, data has been updated where possible and a desktop analysis of further quantitative and qualitative findings has been included. In line with EMPHN's new Annual Planning Cycle process, a workshop was conducted with members of the Board, Clinical Council, Community Advisory Committee, representatives from agencies on Collaboratives and other key organisations. Participants were asked to reflect on a summarised version of the needs assessment across the seven priority areas of:

[1] Australian Institute of Health and Welfare. Canberra: AIHW; 2014. Australia's Health 2014. Australia's health series. Number 14. Catalogue number AUS 178. Available: http://www.aihw.gov.au/australias-health/2014/

- Mental Health
- Reducing hard from alcohol and other drugs
- Chronic Disease
- Systems Integration
- After Hours
- Aboriginal Health
- Immunisation

These were reflective of both the key areas of funding by PHN and captured the key needs emerging from the needs assessment. During the session, qualitative feedback was provided on what stakeholders would like to see more of, see change in, and the key factors to consider in planning. This information has been reflected in Sections Two and Three. The session guided participants through to prioritising potential opportunities for 2018-19 which have been grouped or refined, prioritised by ease of implementation and potential for impact, and included in Section Four.

Data sources are listed in the Descriptions of Evidence in Sections Two and Three. In addition to statistical sources, existing documents from the region were sourced for the original needs assessment and a comprehensive desktop review was undertaken for this needs assessment to provide further rich qualitative data regarding local consultation, strategic directions and priorities.

The review of Municipal Health and Wellbeing Plans revealed the following themes, largely common across LGAs: health and wellbeing, mental health, safety, culture and diversity, social inclusion/ exclusion, healthy eating and physical activity, alcohol and other drugs, infrastructure, environment and socio-economic issues. Local government are in the midst of developing their next plans however these will not be available for desktop review at the time of this iteration of the needs assessment.

EMPHN has been undertaking an ongoing rollout of a data extraction and GP clinical auditing tool. Localised GP data of GP service users and for chronic diseases (including mental health) have now been included in this iteration of the needs assessment. In addition, MBS item use, particularly for mental health and chronic disease management, were reviewed and incorporated into Section Two and Three findings, where relevant.

We used geospatial mapping to identify areas lacking services and to compare service levels with SEIFA information.

### Provider And Stakeholder Consultation

Extensive qualitative information had been obtained previously from face-to-face interview consultations with stakeholders (providers and relevant local government representatives) from across the catchment.

Findings were drawn from:

- Consultation with a wider range of primary care providers: eight councils, eleven community health services, five primary care partnerships, two women's health organisations and refugee settlement services.
- Mapping of refugee health service referral pathways undertaken on behalf of the Outer North Refugee Health and Wellbeing Network.
- Information from the AOD stakeholder consultation conducted in March 2016 and coordinated by the Victorian PHN Alliance. Organisations consulted at that time were DHHS, Association of Participating Service Users (APSU), Harm Reduction Victoria (HRVic), and the Victorian Alcohol and Drug Association (VAADA).
- Mental Health forums conducted during 2017 in preparation for the Stepped Care Mode.
- Immunisation forum conducted with councils
- Working with DHHS to undertake the Outer North Service Plan
- Working with Banyule CHS to understand the requirements for after-hours services
- Engaged consultancy to prepare a report on Eastern Health referral pathways
- Palliative Care Forum
- Collaboratives
- EMPHN Annual Planning session on 22nd September 2017 seeking feedback on key areas for change across priority areas.

EMPHN has continued to consult with LHNs, State Government, community health, PCPs and general practice through its collaborative structures, which align with the large public health services in the catchment. These Collaborative structures have sought to create a common platform for systems change work, sharing information, identifying common priorities and developing cross-sector systems change projects. This platform has allowed for the ongoing sharing of data and consultation of key services.

### Survey

In October 2016, a 30-question general practice-focused survey was mailed to 394 general practices and links to an electronic form extensively advertised via newsletter and on our website. A similar survey of allied health providers, directed at pharmacists, community nurses and other community-based clinicians was also emailed and survey links advertised.

We received 124 responses to the general practice and 106 responses to the allied health surveys. The return rate for general practice surveys was 14% of all practices in the region and for allied health was indeterminate.

### Community And Consumer Consultation

Consultations have added local knowledge and understanding about underlying contributory factors, specific geographic locales and pockets of need, and how these are being addressed.

We have also incorporated:

- findings from councils' consultations with communities as they develop their strategies and Municipal Public Health and Wellbeing Plans;
- findings from the National Health Priority Areas (NHPA) Initiative; and
- information from existing consultations, particularly those undertaken within the Aboriginal community through the Koolin Balit Strategy.

It was decided that further consultation with the community would be most constructive if it were based on the priorities identified from existing data. Therefore, we have continued to explore opportunities for community consultation through the Collaborative structures.

### Mental Health And AOD Needs Assessment

A single provider, in partnership with other Mental Health Community Support Services (MHCSS) providers and stakeholders, is undertaking the catchment-based planning function of the MHCSS. The updated mental health and AOD needs assessments draw on an expanded range of indicators and the most recent catchment-based plans undertaken in the region by EACH and cohealth. We have established links with mental health and AOD Catchment Planners, but no further consultation data are yet available.

Much of the AOD-related data were drawn from the Turning Point AOD statistics obtained from the Victorian data maps (StatPlanet) which largely reflect 2012–13 and 2013–14 data by LGA. Data for Murrindindi and Mitchell Shires were generally excluded from comparative discussion with other LGAs, as the rate-based data for their relatively small populations were potentially misleading. In addition, State funded community AOD service data were made available via POLAR Population Health and findings were included within the Needs Assessment.

## Additional Data Needs And Gaps

There continue to be issues limiting access to the necessary data:

- Data about the health of Aboriginal and/or Torres Strait Islander people are not published, particularly where populations are small and can reach identifiable thresholds We are therefore unable to provide detail on the experience of health for this population group at the localised level other than through qualitative and limited quantitative information.
- There are inconsistencies in the level of aggregation of data from different sources. PHN boundaries were derived from the Australian Statistical Geography Standard (ASGS), where there is an exact match between the SA3 level and the PHN boundary. The corresponding LGA areas do not align with the EMPHN boundaries, particularly in the outer regions, such as the Yarra Ranges, Murrindindi and Mitchell. The names 'Nillumbik-Kinglake' and 'Whittlesea-Wallan' used in this report are those given by the ABS to these regions and are recognised as the standard SA3 nomenclature.
- Where possible, we have used SA2- and SA3-level population data. The NHPA had begun to offer SA3 as the standard geographical unit for new reports, however LGA-level data are difficult to disaggregate to ASGS.
- AIHW data are available primarily at national and state level, with little accessible at the SA3/SA2 level.
- Qualitative data are considered to be supportive, not representative of the full experience of any sector.

# Section 2 – Outcomes Of The Health Needs Analysis

# Section Two – Outcomes of the Health Needs Analysis

## Outcomes of the Health Needs Analysis – General

***Please note that rates for Mitchell and Murrindindi should be treated with caution due to low crude numbers and a relatively smaller population, of which the EMPHN catchment includes just 34.7% and 27.4% respectively.***

| Outcomes of the Health Needs Analysis – General | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Potentially preventable hospitalisations (PPH) – General | **Hospital**<br>In the 2015-16 financial year, the top five ACSCs were:<br>• Diabetes complications (18,013 presentations – down 277 separations from 2014-15; 123,261 bed days – up 604 bed days from 2014-15);<br>• Pyelonephritis (8,068 – up 140 separations; 84,587 bed days – up 3,288 bed days);<br>• Dehydration and gastroenteritis (6,382 – up 32 separations; 48,817 – up 2,362 bed days);<br>• Congestive heart failure (5,643 – down 202 separations; 61,354 – up 411 bed days); and<br>• Chronic obstructive pulmonary disease (5,268 separations; 39,592 bed days).<br><br>This is a change from the top five conditions in 2014-15:<br>• Diabetes complications (1st for both years);<br>• Hypertension (2nd, now 7th) (4,320 separations – down 8,792; 47,485 – down 62,033 bed days from 2014-15) – *this may be attributed to a change in coding*;<br>• Pyelonephritis (3rd, now 2nd);<br>• Dehydration and gastroenteritis (4th, now 3rd); | VAED (2015-16 with comparisons from 2014-15).<br><br>Catchment wide, all LGAs.<br>Time series analysis for the period 2012/13 – 2015/16 for all ACSC including gender disaggregation can be found in the Addendum 1 - ACSC Analysis.<br>The colour coding indicates a value below the Victorian state average (green), up to 25% above (yellow), between 25% and 50% above (orange) and over 50% above the state average (red).<br><br>Consultation: |

| Outcomes of the Health Needs Analysis – General | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Potentially preventable hospitalisations (PPH) – General | • Congestive heart failure (5th, now 4th); and<br>• Chronic obstructive pulmonary disease (6th, now 5th).<br><br>When viewing the ACSC data in a time series format, it can be seen that rural areas and areas with a large rural component (Mitchell, Murrindindi and Whittlesea) have rates that are consistently 25% or more greater than the Victorian average across a range of conditions. ACSCs which are 50% or more than the Victorian average over the four-year period 2012/13 – 2015/16 are:<br><br>• COPD (Mitchell, Murrindindi)<br>• Congestive heart failure (Murrindindi, Whittlesea)<br>• Diabetes Complications (Murrindindi, Whittlesea)<br>• Iron deficiency anaemia (Murrindindi, Whittlesea)<br><br>When comparing for the overall change between 2012/13 and 2015/16, the ACSC with the most noticeable percentage change is for *Other Vaccine* preventable conditions. Although the total numbers are small in comparison to other ACSCs, the rate of change is considerable, the smallest being a threefold increase (Manningham, Monash, Murrindindi, Whittlesea) and the greatest being a 20-fold increase (Nillumbik).<br><br>*Please refer to Addendum 1 for more analysis.*<br><br>*Please note that different coding is utilised for AIHW potentially preventable hospitalisations which results in dental conditions, iron deficiency/anaemia and heart failure being the top 3* | • EMPHN General Practice Survey (October 2016). |

| Outcomes of the Health Needs Analysis – General | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| | *potentially preventable hospitalisations for 2015-16.*[2] *For the sake of consistency, the POLAR data above, as per previous years, will be the key source of data for potentially preventable hospitalisations.*<br><br>**General practice**<br>The most commonly presenting infections to general practice were:<br>• Kidney and urinary tract infections (66% of respondents);<br>• Gastroenteritis/dehydration (47%);<br>• Cellulitis (42%); and<br>• Ear, nose and throat infections (77%) (indicated as one of the most common presenting infections/infectious conditions in the preceding month [September]). | |
| Potentially preventable hospitalisations (PPH) – Respiratory | Suboptimal management of asthma and COPD among RACF residents was reported in Yarra Ranges. | EMML (2015), *Supporting GPs and RACFs to reduce ED admissions amongst RACF residents with asthma and/or COPD* project.<br><br>Consultation:<br>• EMPHN RACF interviews. |
| Potentially preventable hospitalisations | There was a higher proportion of age standardised admissions for heart failure among RACF residents in Whittlesea-Wallan. | Australian Commission on Safety and Quality In Healthcare (2015), |

[2] Australian Institute of Health and Welfare analysis of the National Hospital Morbidity Database 2015–16 and Australian Bureau of Statistics, Estimated Resident Population 30 June 2015. http://www.myhealthycommunities.gov.au/interactive/potentially-preventable-hospitalisations

| Outcomes of the Health Needs Analysis – General | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| (PPH) – Cardiovascular | | *Australian Atlas of Healthcare Variation.* |
| Potentially preventable ED presentations (Category 4 and 5) – General | **Hospital**<br>In the 2015-16 financial year, the top five category 4 and 5 diagnoses were:<br>• Abdominal / Flank pain /cramps / Intestinal colic (6,296 presentations; 426 per 100,000);<br>• Fracture of wrist / Fracture of hand (includes finger) (4,393 presentations; 297 per 100,000);<br>• Viral infection (4,099 presentations; 277 per 100,000);<br>• Open wound of wrist and hand (includes finger) / Bite (non-venomous) of wrist and hand (3,755 presentations; 254 per 100,000); and<br>• Sprain/strain of ankle (2,798 presentations; 189 per 100,000).<br><br>The most common diagnosis given at time of presentation was *No Diagnosis given* with 11,529 cases (780 per 100,000) and *No disease found/Illness NOS/Other symptoms/generally unwell* with 2,824 cases (191 per 100,000).<br><br>In 2015-16, there were a total of 349,023 ED presentations / 23,623 presentations per 100,000 population in the EMPHN catchment. 170,394 (47%) of those presentations were category 4 and 5. Primary care type presentations were highest in the after-hours period (8,949 or 57% of all category 4 and 5 presentations).<br><br>Fracture clinics receive referrals from emergency departments for non-displaced fractures that could be seen in primary care. Fractures of the wrist are the second most common Category 4 & 5 primary care type cause for ED presentation. Almost 30% of fractures | Consultation:<br>• EMPHN General Practice Survey (October 2016).<br><br>EMPHN (2017), *Fracture management project overview*; VEMD (2015-16). |

| Outcomes of the Health Needs Analysis – General | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Potentially preventable ED presentations (Category 4 and 5) – General | managed and treated in fracture clinics are non-displaced and could be managed in primary care.<br><br>**General practice**<br>The following conditions were common in general practice and would also be expected to present to the ED:<br>• Acute asthma and exacerbations of COPD<br>• Vaccine-preventable influenza and vaccine-preventable pneumonia (the predominant respiratory conditions seen in general practice in the preceding month [September]).<br>• Upper respiratory tract infection (URTI). | |
| Potentially preventable ED presentations (Category 4 and 5) – Hotspot analysis | A comprehensive analysis of all category 4 and 5 (primary care type ED attendances) for three financial years (2012-13, 2013-14, and 2014-15) has been undertaken to identify those conditions that are above the Victorian state average. This is detailed in Addendum Attachment 2. | VEMD (2014-15).<br>Catchment wide, all LGAs.<br>Time series analysis for the top 20 Category 4 and 5 presentations can be found in Addendum 2 - Emergency Department Category 4 and 5 Analysis.<br>The colour coding indicates a value below the Victorian state average (green), up to 25% above (yellow), between 25% and 50% above (orange) and over 50% above the state average (red). |

| Outcomes of the Health Needs Analysis – General | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Childhood immunisation rates – Coverage | The national target for immunisation coverage, aimed at achieving herd immunity, is 95.0%. As at 30 June 2017, half the LGAs were not meeting the target in the key five-year (60-<63 months) age group (Murrindindi* [89.7%], Manningham [91.0%], Monash [93.1%], Nillumbik [93.2%], Maroondah [93.4%] and Boroondara [93.9%]).<br><br>Examination of Murrindindi at the SA2 level (for postcodes within the catchment) suggests similar rates (93.6%), whereas the lower rate for the entire LGA (89.7%) (includes areas outside the EMPHN catchment) would indicate a more critical shortfall. Crude numbers, however, are relatively low—providing potential opportunity to effectively prioritise Murrindindi in pilot catch-up activities.<br><br>It is important to note that there is marginal fluctuation between quarterly immunisation coverage reports. This may be due to variable use of the immunisation register and/or shifting of children into older age cohorts. For example, Maroondah met the 95.0% target for children fully immunised at five years at 31 March 2017 (95.7%) but was below target at 30 June 2017 (93.4%). In the same three-month period, Knox was below target at 31 March 2017 (92.1%) but above target at 30 June 2017 (95.5%). The fluctuations suggest that interpretation of these figures should be made with caution. | AIR (2017 [June]), *Coverage report*; AIR (2017 [March]), *Coverage report*. |
| Childhood immunisation rates – Vaccine refusal | Local analysis and anecdotal reports from local government suggest that childhood vaccination refusal is higher in specific regions; pockets of vaccine refusers were reported in Nillumbik and Yarra Ranges. However, overall coverage rates for children at age five (at 93.2% and 95.7% respectively) may be relatively resistant to the effects of refusal in these LGAs. This does not negate the issue of below-threshold-herd immunity in particular pockets that put the local community in these areas at greater risk. | AIR (2017 [June]), *Coverage report*.<br><br>Consultation:<br>• Council – Yarra Ranges Shire Council; and<br>• CHS – healthAbility. |

| Outcomes of the Health Needs Analysis – General | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Childhood immunisation rates – Survey response | Over three-quarters of survey respondents (to this item) from general practice indicated community education as their preferred means of increasing childhood immunisation rates. Other favoured strategies included client reminder/recall systems, vaccination programs in schools and immunisation programs for women, infants and children in non-medical settings. | Consultation:<br>• EMPHN General Practice Survey (October 2016). |
| Childhood immunisation rates – Aboriginal and/or Torres Strait Islander community members | Age five immunisation coverage for Aboriginal and/or Torres Strait Islander children in the catchment (92.8%) was below the national figure (94.6%).<br><br>Aboriginal and/or Torres Strait Islander people consulted in both the Inner and Outer Koolin Balit reports stated that there was a lack of immunisation awareness amongst mothers, especially first time mothers. It was also noted that there was little knowledge of the types of support available (e.g. maternal and child health services) and how to access them. | Inner East: Department of Health EMR Koolin Balit and Aboriginal Health Community Consultation Workshop (September 2013); MyHealthyCommunities (2015-16);<br>Outer East: Department of Health EMR Koolin Balit and Aboriginal Health Community Consultation Workshop (September 2013). |
| All of population influenza immunisation | This influenza season, local emergency departments contacted EMPHN regarding the high number of influenza presentations to ED. Influenza vaccination remains a priority for each season. | Consultation:<br>Local Hospital Networks. |
| Cancer screening rates | Survey respondents from the allied health sector highlighted that the following population groups either avoid, or have particular difficulty in accessing or understanding the reason for cancer screening:<br>• Aboriginal and/or Torres Strait Islander peoples;<br>• Culturally and linguistically diverse people, refugees and asylum seekers;<br>• The aged, especially those who are homebound or have dementia;<br>• Low socioeconomic groups due to cost and transport barriers; | Consultation:<br>• EMPHN Allied Health Survey (October 2016). |

| Outcomes of the Health Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| | • People residing in areas with lack of transport and/or poor access to health services;<br>• Women who have experienced sexual abuse; and<br>• Men (attitudes towards help seeking). | |
| Bowel cancer screening rates | Whittlesea-Wallan (35.7%) and Knox (39.8%) had below state average proportions (39.9%) of bowel cancer screening rates.<br><br>Over two-thirds of survey respondents (to this item) from general practice believed that the main contributing factor to low bowel cancer screening rates in the catchment was poor understanding on the part of consumers of the value/benefit of screening. Other commonly reported issues were people feeling embarrassed and not understanding the value/benefit in doing the test. | AIHW (2016).<br><br>Consultation:<br>• EMPHN General Practice Survey (October 2016). |
| Cervical cancer screening rates | One-quarter of SA3s had above state average proportions (59.2%) of cervical cancer screening participation (Whittlesea-Wallan [54.0%], Monash [55.4%] and Whitehorse [58.2%]).<br><br>Lower rates of cervical cancer screening were reported among refugee women, particularly in Whittlesea.<br><br>More than three-quarters of survey respondents (to this item) from general practice believed embarrassment was the main contributing factor to low cervical screening in the catchment. Other commonly reported barriers included fear of pain, cultural concerns in accessing screening and the value/benefit of screening being poorly understood. | AIHW (2016).<br><br>Consultation:<br>• CHS – AMES Australia;<br>• PCP – North East PCP;<br>• NGO – Whittlesea Community Connections; and<br>• EMPHN General Practice Survey (October 2016). |
| Breast cancer screening rates | Whittlesea-Wallan (50.9%) and Monash (51.8%) had below state average proportions (52.6%) of breast cancer screening participation. | AIHW (2016).<br><br>Consultation: |

| Outcomes of the Health Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| | Lower breast cancer screening rates were reported among Aboriginal and/or Torres Strait Islander and refugee women, particularly in Whittlesea.<br><br>Approximately half the survey respondents (to this item) from general practice believed that the main contributing factors to low breast cancer screening rates in the catchment were people not understanding the value/benefit of screening and/or fear of pain. Other commonly reported issues included people's cultural concerns in accessing screening, embarrassment and lack of familiarity with the medical/health care system and what is available. | • CHS – AMES Australia;<br>• PCP – North East PCP;<br>• NGO – Whittlesea Community Connections; and<br>• EMPHN General Practice Survey (October 2016). |
| Health status – Food insecurity | Half the LGAs had above state average proportions (4.6%) of people who experienced food insecurity (Murrindindi* [14.0%], Yarra Ranges [8.7%], Maroondah [6.5%], Knox and Whittlesea [both 6.3%] and Mitchell* [5.0%]). In Knox and Maroondah, food insecurity was reportedly of greater concern among Aboriginal and/or Torres Strait Islander peoples. Food affordability was also reported as an issue in Boroondara and other inner east areas, particularly for tertiary students. | Vic. DHHS (2015), LGA Profiles.<br><br>Consultation:<br>• Council – City of Boroondara; City of Whittlesea; Yarra Ranges Shire Council;<br>• CHS – Mullum Mullum Indigenous Gathering Place; and<br>• PCP – Inner East PCP. |
| Health status – Pre-obese persons | More than half the LGAs had above state average proportions (31.2%) of people reporting being pre-obese (Murrindindi* [37.7%], Knox [36.0%], Nillumbik [35.6%], Yarra Ranges [33.1%], and Maroondah, Monash and Whittlesea [all 31.6%]). | Vic. DHHS (2015), LGA Profiles. |

| Outcomes of the Health Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| | Split by gender, almost 60% of LGAs had above state average proportions (38.4%) of males who reported being pre-obese (Murrindindi* [45.4%], Maroondah [44.9%], Nillumbik [44.1%], Knox [43.9%], Monash [43.5%], Manningham [39.5%] and Yarra Ranges [38.9%]).<br><br>Over half the LGAs had above state average proportions (24.3%) of females reporting being pre-obese (Mitchell* [32.1%], Whittlesea [31.3%], Nillumbik [30.7%], Murrindindi* [30.5%], Knox [28.4%], Yarra Ranges [27.2%] and Banyule [24.6%]). | |
| Health status – Obese persons | One-third of the catchment's LGAs had above state average proportions (18.8%) of people reporting being obese (Mitchell* [28.8%], Whittlesea [24.1%], Murrindindi* [22.0%] and Banyule [19.8%]).<br><br>One-third of LGAs had above state average proportions (20.4%) of males who reported being obese (Mitchell* [34.2%], Whittlesea [29.3%], Murrindindi* [26.9%] and Banyule [21.6%]).<br><br>One-quarter of LGAs had above state average proportions (17.2%) of females reporting being obese (Mitchell* [21.6%], Whittlesea [18.9%] and Banyule [18.0%]). | Vic. DHHS (2015), LGA Profiles. |
| Health related behaviour – Physical activity | Two-thirds of LGAs had above state average proportions (54.0%) of people who do not meet the physical activity guidelines (Whittlesea [61.7%], Mitchell* [57.9%], Banyule and Maroondah [both 56.7%], Manningham [55.6%], Yarra Ranges [55.5%], Whitehorse [55.3%] and Monash [55.1%]).<br><br>Half the LGAs had above state average proportions (52.0%) of males who do not meet the physical activity guidelines (Banyule [62.3%], Maroondah [61.3%], Yarra Ranges [57.9%], Whitehorse [57.7%], Whittlesea [57.1%] and Knox [53.3%]). | Vic. DHHS (2015), LGA Profiles. |

| Outcomes of the Health Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| | Over 40% of LGAs had above state-average proportions (56.1%) of females who do not meet the physical activity guidelines (Whittlesea [67.0%], Mitchell* [64.9%], Murrindindi* [64.8%], Manningham [63.7%] and [Monash 59.4%]). | |
| Health related behaviour – Healthy food and drink intake<br><br>Health related behaviour – Healthy food and drink intake | Almost 60% of LGAs had above state average proportions (48.6%) of people who do not meet the dietary guidelines for either fruit or vegetable consumption (Murrindindi* [55.8%], Boroondara [53.5%], Yarra Ranges [50.9%], Maroondah [50.6%], Banyule [49.5%], Whittlesea [49.1%] and Knox [48.8%]).<br><br>Two-thirds of LGAs had above state average proportions (54.0%) of males who do not meet the dietary guidelines for either fruit or vegetable consumption (Murrindindi* [72.2%], Whitehorse [58.7%], Boroondara [58.4%], Yarra Ranges [58.2%], Knox [57.6%], Banyule [57.0%], Whittlesea [55.5%] and Monash [54.4%]).<br><br>Over 40% of LGAs had above state average proportions (43.4%) of females who do not meet the dietary guidelines for either fruit or vegetable consumption (Boroondara [48.8%], Maroondah [48.5%], Manningham [46.2%], Mitchell* [44.5%] and Monash [44.0%]).<br><br>Over 40% of LGAs had above state average proportions (11.2%) of people who consume sweetened soft drink every day (Maroondah [21.4%], Murrindindi* [21.1%], Mitchell* [16.8%], Whittlesea [14.0%] and Banyule [11.9%]).<br><br>There was reportedly poor access to healthy food options in Nillumbik. | Vic. DHHS (2015), LGA Profiles.<br><br>Consultation:<br>• Council – Nillumbik Shire Council; and<br>• PCP – Lower Hume PCP. |

| Outcomes of the Health Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| Health related behaviour – Smoking | One-third of LGAs had above state average proportions (13.1%) of people aged 18 years and over who are current smokers (Murrindindi* [24.4%], Whittlesea [15.1%], Maroondah [13.4%] and Knox [13.3%]). | Vic. DHHS (2015), LGA Profiles. |
| Presence of ill health or disease – General | Survey respondents from general practice indicated that chronic disease management and/or chronic mental illness take up the majority of their time.<br><br>Allied health survey respondents reported a range of barriers that people with a chronic disease experience in accessing a regular GP:<br>• Lengthy waiting times to see a regular GP;<br>• Consultation time constraints favour symptomatic treatment (problem redress) over more holistic approaches and detailed education on self-management—impacting client care.<br>• Inadequate client knowledge of their condition and poor understanding of the need for ongoing chronic disease management;<br>• If the client has complex and/or multiple needs, chronic disease management may not be a personal priority;<br>• The client may be homebound or have difficulty accessing transport.<br><br>Survey respondents from the allied health sector also highlighted the risk of chronic diseases such as type 2 diabetes, stroke and heart disease among middle aged people as a key existing or emerging issue in the community. A major challenge, particularly for the eastern region, will be the increasing incidence of chronic conditions as the population ages.<br><br>Iron deficiency anaemia was noted as a common chronic issue presentation by 38% of general practice respondents across the catchment. | Eastern Health (2013), *Strategic clinical service plan;* Inner East: Department of Health EMR Koolin Balit and Aboriginal Health Community Consultation Workshop (September 2013).<br><br>Consultation:<br>• Council – Nillumbik Shire Council;<br>• CHS – Inspiro CHS;<br>• PCP – Lower Hume PCP; Outer East PCP;<br>• EMPHN General Practice Survey (October 2016); and<br>• EMPHN Allied Health Survey (October 2016). |

<table>
<tr><th colspan="3">Outcomes of the Health Needs Analysis – General</th></tr>
<tr><th>Identified Need</th><th>Key Issue</th><th>Description of Evidence</th></tr>
<tr><td>Presence of ill health or disease – General</td><td>There was a reported increase in incidence of respiratory diseases and cancers following the bushfires in Nillumbik.<br><br>Higher rates of long-term health conditions were reported among Aboriginal and/or Torres Strait Islander people in the outer east and Lower Hume.<br><br>Aboriginal and/or Torres Strait Islander people consulted in the Inner East Koolin Balit report stated reasons for the ‘very high’ presentation for end-stage renal disease included:<ul><li>More Aboriginal and/or Torres Strait Islander people accessing diabetes services; and</li><li>Aboriginal and/or Torres Strait Islander people becoming more aware of diabetes services and programs through health promotion programs delivered in the region over the last six years.</li></ul></td><td></td></tr>
<tr><td>Presence of ill health or disease – Comorbid conditions</td><td>In the 2016-17 financial year, approximately 40% of GP clinic patients across the EMPHN catchment had one and 17% had two to three chronic diseases. Only a small population had more than three chronic conditions.<table><tr><th>No. of comorbid conditions</th><th>Outer north</th><th>North east</th><th>Inner east</th><th>Outer east</th><th>EMPHN</th></tr><tr><td>1</td><td>34.1%</td><td>42.1%</td><td>39.1%</td><td>41.2%</td><td>39.7%</td></tr><tr><td>2 to 3</td><td>17.5%</td><td>20.0%</td><td>15.5%</td><td>15.8%</td><td>16.8%</td></tr><tr><td>4 to 5</td><td>4.7%</td><td>4.3%</td><td>2.5%</td><td>2.4%</td><td>3.1%</td></tr><tr><td>6 +</td><td>2.8%</td><td>2.1%</td><td>1.1%</td><td>0.9%</td><td>1.5%</td></tr></table></td><td>POLAR GP (2016-17).</td></tr>
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| Outcomes of the Health Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| | Total 59.1% 68.5% 58.3% 60.4% 61.0%<br>*Proportion of people who presented to a local GP clinic with at least one chronic disease in the 2016/2017 financial year* | |
| Chronic Disease Management- MBS Items claimed | *GP Management plans (GPMP)*- Whittlesea has the highest number of GPs claims for item 721 for their chronic disease patients (25,364) and Whitehorse the second highest (20,387).<br><br>*Team Care Arrangements (TCA)*- Whittlesea also has the highest number of TCAs (723) claimed. Across the catchment the ratio of GPMP and TCA is consistent at 0.9. What this means is that GPMPs outnumber TCAs when, ideally, they should be the equal.<br><br>*Chronic Disease Reviews (GPMP-R*)- The GPs in Whitehorse (30,017) and Whittlesea (29,098) the second highest have claimed the most number of review items (732). The ratio of GPMP and reviews is highest in Whitehorse at 1.5. This is important as their should ideally be at least 2 reviews per GPMP. | DoH, (2017) |
| Presence of ill health or disease – Diabetes | Whittlesea-Wallan (7.4, ASR/100) and Monash (4.7, ASR/100) were on par with or above the state average Age Standardised Rate (ASR) (4.7, ASR/100) of type 2 diabetes. Diabetes reportedly accounted for a significant proportion of hospitalisations in Whittlesea. An increase in diabetes prevalence was reported in Yarra Ranges. A higher prevalence of diabetes was also reported among the Asian population in Whitehorse.<br><br>Type 2 diabetes was identified by 82% of general practice survey respondents across the catchment as one of the top five presenting chronic conditions. | PHIDU (2011-13); VAED (2014-15).<br><br>Consultation:<br>• Council – Yarra Ranges Shire Council;<br>• CHS – Carrington Health;<br>• PCP – Hume Whittlesea PCP;<br>• EMPHN General Practice Survey (October 2016); and<br>• EMPHN Allied Health Survey (October 2016). |

| Outcomes of the Health Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| Presence of ill health or disease – Cardiovascular disease | Mitchell* (17.4, ASR/100) and Murrindindi* (17.1, ASR/100) had above state average ASRs of cardiovascular disease (17.0, ASR/100).<br><br>Catchment-wide, cardiovascular issues contributed substantially to general practice attendances. Survey respondents identified the following as most common amongst chronic disease presentations over the preceding month: angina (20% of respondents), congestive heart failure (36%) and hypertension (86%). | PHIDU (2011-13).<br><br>Consultation:<br>• EMPHN General Practice Survey (October 2016). |
| Presence of ill health or disease – Asthma | Half the LGAs had a higher than state average ASRs (10.9, ASR/100) of asthma (Mitchell* [13.0, ASR/100], Murrindindi* [12.5, ASR/100], Nillumbik and Yarra Ranges [both 11.8, ASR/100], Maroondah [11.5, ASR/100] and Banyule [11.4, ASR/100]). | PHIDU (2011-13). |
| Presence of ill health or disease – Chronic obstructive pulmonary disease | One-third of LGAs were on par with or above the state average ASR (1.9, ASR/100) of chronic obstructive pulmonary disease (Mitchell* and Murrindindi* [both 2.0, ASR/100], and Banyule and Yarra Ranges [both 1.9, ASR/100]). | PHIDU (2011-13). |
| Presence of ill health or disease – Musculoskeletal conditions | One-third of LGAs had had above the state average ASRs (26.6, ASR/100) of total musculoskeletal conditions (osteoporosis, osteoarthritis and rheumatoid arthritis) (Mitchell* and Murrindindi* [both 27.7, ASR/100], Yarra Ranges [27.3, ASR/100] and Whittlesea [27.0, ASR/100]). | PHIDU (2011-13). |
| Presence of ill health or disease – Hepatitis B | Half the LGAs had above state average rates (32.2 per 100,000) of hepatitis B (Whitehorse [57.7 per 100,000], Monash [56.8 per 100,000], Manningham [51.3 per 100,000], Whittlesea [43.6 per 100,000], Boroondara [34.2 per 100,000] and Maroondah [32.7 per 100,000]).<br><br>A higher prevalence of hepatitis B was reported among Chinese, Indian and Nepalese populations in the inner east region. | Vic. DHHS (2016).<br><br>Consultation:<br>• CHS – Access Health and Community; Carrington Health; Link Health and Community; and |

| Outcomes of the Health Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| | | • NGO – Women's Health In the North. |
| Presence of ill health or disease – Cancer | Cancer incidence was on par with or above state average (5.2 per 1,000) in more than 80% of LGAs (Murrindindi* [7.1 per 1,000], Manningham [6.1 per 1,000], Banyule and Mitchell* [both 5.7 per 1,000], Knox [5.6 per 1,000], Whitehorse [5.5 per 1,000], Maroondah [5.4 per 1,000], Monash [5.3 per 1,000], and Nillumbik and Yarra Ranges [both 5.2 per 1,000]).<br><br>Two-thirds of LGAs had above state average (5.6 per 1,000) cancer incidence among males (Murrindindi* [7.8 per 1,000], Manningham [6.3 per 1,000], Knox [6.2 per 1,000], Whitehorse [6.1 per 1,000], Mitchell* and Yarra Ranges [both 5.9 per 1,000], Banyule [5.7 per 1,000], and Maroondah and Monash [both 5.6 per 1,000]).<br><br>Nearly 80% of LGAs had above state average (4.8 per 1,000) cancer incidence among females (Murrindindi* [6.5 per 1,000], Manningham [5.9 per 1,000], Banyule [5.7 per 1,000], Mitchell* [5.5 per 1,000], Maroondah and Monash [both 5.1 per 1,000], Knox [5.0 per 1,000], Whitehorse [4.9 per 1,000] and Nillumbik [4.8 per 1,000]). | Vic. DHHS (2015), LGA Profiles. |
| Presence of ill health or disease – Sexually transmissible infections | Mitchell* (468.0 per 100,000) had the highest rate of sexually transmissible infections in young people. This figure was well above the Victorian average (406.4 per 100,000).<br><br>The prevalence of newly acquired HIV was below state average (1.8%) in all LGAs, with Nillumbik the closest (1.6%). Nillumbik also had the highest overall prevalence (3.2%), which was equal to the state prevalence.<br><br>The highest prevalence of gonococcal infection occurred in Boroondara (45.0 per 100,000). This figure was below the Victorian average (47.3 per 100,000). | Gafforini, S.A. (2016), *Outer Northern Prevention Taskforce: Sexual and reproductive health prevention action plan report*, Hume Whittlesea Primary Care Partnership.<br>Victorian Child and Adolescent Monitoring System [VCAMS] (2012); Vic. DHHS (2017), Communicable |

| Outcomes of the Health Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| Presence of ill health or disease – Sexually transmissible infections | All LGAs had below state average syphilis prevalence (17.1%), with Mitchell and Boroondara the closest (14.2% and 13.8% respectively).<br><br>Survey respondents from the allied health sector identified sexual health among young people as a key existing or emerging issue in the community.<br><br>Sexual and reproductive ill health is known to disproportionately affect the following groups:<br>• Adolescents and young people<br>• Aboriginal and/or Torres Strait Islander people<br>• People with disabilities<br>• People living in rural and remote areas<br>• People from CALD backgrounds, including refugees<br>• Gay, lesbian, bisexual, transgender, intersex and queer people<br>• Sex workers<br>• People in prison<br>• Homeless people | Disease Epidemiology and Surveillance.<br><br>Consultation:<br>• NGO – Women's Health East; Women's Health In the North; and<br>• EMPHN Allied Health Survey (October 2016). |
| Social determinants of health – Social isolation | Social isolation was reported among the elderly in Whitehorse and other inner east areas, refugees in Whittlesea, Aboriginal and/or Torres Strait Islander youths in the outer east, and residents of Manningham and Nillumbik. | ABS (2011), HCFMD; CIV (2011).<br><br>Consultation:<br>• Council – City of Whittlesea; Manningham City Council; Nillumbik Shire Council; |

| Outcomes of the Health Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| | | • CHS – Carrington Health; Mullum Mullum Indigenous Gathering Place;<br>• PCP – Inner East PCP; and<br>• NGO – Whittlesea Community Connections. |
| Social determinants of health – Health literacy and understanding of the health system | Poor health literacy and understanding of the health system was reported, particularly within refugee and CALD communities in Whittlesea-Wallan and Monash.<br><br>Variation in understanding of information given by health providers was reported. Goals are often clinician-directed and consumers are not active participants in their care, particularly in the hospital context (defining treatment goals, choice of referral options). | ABS (2006), Health Literacy, Australia; ABS (2011) Proficiency in Spoken English (ENGP).<br><br>Consultation:<br>• CHS – AMES Australia; Link Health and Community; Nexus Primary Health;<br>• PCP – Hume Whittlesea PCP;<br>• NGO – Whittlesea Community Connections; and<br>• LHN – Eastern Health.<br><br>Refugee health service referral pathways mapping consultation:<br>• CHS – cohealth; and<br>• LHN – Northern Health. |

| Outcomes of the Health Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| Social determinants of health – Family violence | Mitchell* (2,275) had the highest number of reported family violence incidents in 2016-17.<br><br>Family violence was also reported as an issue in Manningham, Maroondah, Nillumbik, Whitehorse, Whittlesea and Yarra Ranges. Higher rates were reported among women with disabilities (Manningham), and refugees, asylum seekers and people on Partner (Provisional) visas (Whittlesea).<br><br>Violence in same-sex relationships was reported in the eastern metropolitan region.<br><br>Mitchell* had the highest rate of total definite alcohol-related family violence in 2014-15 (23.6/10,000), followed by Murrindindi* (17.7/10,000).<br><br>In addition to alcohol, family violence was generally associated with disaster (i.e. bushfires in Murrindindi and Nillumbik) and gambling.<br><br>Survey respondents from the allied health sector noted gender inequity and family violence as key existing or emerging issues in the community. | AOD stats by Turning Point (2014-15); CSA (2016-17); Vic. DHHS (2013); Whittlesea Community Futures and Whittlesea Community Connections (2012), *Whittlesea CALD Communities Family Violence Project Scoping Exercise Report.*<br><br>Consultation:<br>• Council – City of Whittlesea; Manningham City Council; Maroondah City Council; Nillumbik Shire Council; Yarra Ranges Shire Council;<br>• CHS – AMES Australia; Banyule CHS; Carrington Health; EACH; healthAbility; Nexus Primary Health;<br>• NGO – Whittlesea Community Connections; Women's Health East; Women's Health In the North; and<br>• EMPHN Allied Health Survey (October 2016). |

| Outcomes of the Health Needs Analysis – Mental Health | | |
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| Identified Need | Key Issue | Description of Evidence |
| Presence of ill health or disease – Anxiety and depression: Burden | Most of the surveyed GPs indicated that anxiety and depression were the most common mental health conditions they treat. Chronic, non-specific, mental health issues were listed as a common presentation to general practice by 14 surveyed GPs.<br>Of all the conditions GPs are presented with, those surveyed reported that treatment of psychological disorders takes up the majority of their time, and felt they needed the most support with.<br>Surveyed allied health practitioners noted that mental health issues are common, and that effective management is complex and exacerbated by larger social and environmental influences. They also noted that the stigma of mental illness and difficulties with access to care (particularly to a regular/preferred GP) were major concerns for people with enduring mental health conditions. Particular mention was made of young people (<18yrs), the elderly, males of all ages, women aged between 18 and 45, people with a history of substance abuse, CALD people, Aboriginal and/or Torres Strait Islander people, non-English speaking people and others from disadvantaged backgrounds. | Consultation:<br>• EMPHN General Practice Survey (October 2016); and<br>• EMPHN Allied Health Survey (October 2016). |
| Presence of ill health or disease – Anxiety and depression: Prevalence | Whitehorse had the highest ASR of people experiencing affective and anxiety issues (12.8, ASR/100). The ASR of affective and anxiety issues amongst males was also highest in Whitehorse (12.2, ASR/100) and amongst females in Whittlesea-Wallan (14.1, ASR/100). Whittlesea-Wallan (12.1, ASR/100) also had the highest ASR of high or very high psychological distress among people aged 18 years and over.<br><br>Depression and anxiety were also reported in Boroondara, Manningham, Maroondah, and Nillumbik. | PHIDU (2011).<br><br>Consultation:<br>• Council – City of Boroondara; City of Whittlesea; Manningham City Council; Maroondah City Council; Nillumbik Shire Council; and<br>• CHS – Carrington Health; healthAbility; Nexus Primary Health. |

| Outcomes of the Health Needs Analysis – Mental Health | | |
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| Identified Need | Key Issue | Description of Evidence |
| Presence of ill health or disease – Anxiety and depression: Aboriginal and/or Torres Strait Islander people | Aboriginal and/or Torres Strait Islander people tend to experience poorer social and emotional wellbeing outcomes, including significantly higher levels of psychological distress.<br><br>According to national data, rates of admission among Aboriginal and/or Torres Strait Islanders were higher at all ages, with the exception of women aged over 75 years. Major causes of admission for mental disorders for Aboriginal and/or Torres Strait Islander people were schizophrenia, mood disorders, AOD and neurotic disorders. Apart from mood disorders, rates of admission for Aboriginal and/or Torres Strait Islanders were more than twice those for non-Indigenous Australians. | AIHW (2015), *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples.* |
| Presence of ill health or disease – Anxiety and depression: Social effects | Mental health issues and self-harm were reported among youths in Boroondara, Manningham, Maroondah, Monash, Nillumbik and Whittlesea. High prevalence conditions and the associated psycho-social impacts were highlighted, including school absenteeism and social isolation. Monash had the highest proportion of adolescents who reported being bullied (over 50%).<br><br>Mental health issues were also reported among men in Nillumbik, particularly following the bushfires. Increased suicide rates were reported among 50-55 year olds.<br><br>Elder abuse (neglect and financial) was reported in Knox, Lower Hume, Manningham and other inner east areas. Isolation and mental health issues were reported among the aged in Whitehorse and other inner east areas.<br><br>A high prevalence of mental illness was reported among refugees, particularly in Whittlesea. Precipitants included torture and trauma. Concerns were raised about the physical, sexual, and mental health and wellbeing of females from communities where female genital cutting is traditionally practiced. | Consultation:<br>• Council – City of Boroondara; City of Whittlesea; Knox City Council; Manningham City Council; Maroondah City Council; Nillumbik Shire Council;<br>• CHS – AMES Australia; Banyule CHS; Carrington Health; healthAbility; Link Health and Community; Mullum Mullum Indigenous Gathering Place; Nexus Primary Health; and<br>• NGO – Whittlesea Community Connections; Women's Health East; Women's Health In the North. |

| Outcomes of the Health Needs Analysis – Mental Health | | |
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| Identified Need | Key Issue | Description of Evidence |
| Presence of ill health or disease – Anxiety and depression: Social effects | Whittlesea's socio-cultural profile reportedly was not conducive to LGBTIQ safety.<br><br>Psychological trauma was reported among the transgender community in Nillumbik and Lower Hume. | Refugee health service referral pathways mapping consultation:<br>• Council – City of Whittlesea;<br>• NGO – Spectrum MRC;<br>• LHN – Austin Health; Northern Health; and<br>• Nursing – RDNS. |
| Mental Health Management-MBS Items claimed | Treatment of mental health conditions within general practice accounts for a significant amount time and input from general practitioners. The MBS schedule for mental health items is divided into care plans, care plan reviews and consultations.<br>• For the EMPHN catchment the SA3 with the greatest rate of **mental health care plans** claimed in 2015-16 was Nillumbik-Kinglake with 805/10k ppl. The SA3 with the highest number of patients was Whittlesea-Wallan with 11,915.<br>• The SA3 with the greatest rate of **mental health review** items completed in 2015-16 is Nillumbik-Kinglake with 377/10k ppl. The SA3 with the highest number of patients who were reviewed was Whittlesea-Wallan with 3,836. Ideally the ration between care plans and reviews should 1:1, however this is rarely, if ever, seen. The SA3 where this ratio is highest is Banyule with 58% (1:0.58) of mental health patients with a care plan being reviewed.<br>• The SA3 where GPs provide the greatest rate of **mental health consultations** in 2015-16 is the Yarra Ranges with 1,216/10k ppl. The SA3 with the greatest number of patients being consulted is Whittlesea-Wallan with 11,548. | Commonwealth Department of Health, Medical Benefits Schedule (MBS), (2017) |
| Presence of ill health or disease – Suicide | Comparing the EMPHN catchment to the Victorian state average:<br>• Nine LGAs out of 12 (75%) had suicide counts higher than the state average (23.4).<br>• Three LGAs out of 12 (25%) had suicide rates higher than the state average (11.8/10,000), and an additional three LGAs had rates less than 2.0 below the state | VEMD (2014-15); Vic. DHHS (2014). |

<table>
<tr><th colspan="3">Outcomes of the Health Needs Analysis – Mental Health</th></tr>
<tr><th>Identified Need</th><th>Key Issue</th><th>Description of Evidence</th></tr>
<tr><td>Presence of ill health or disease – Suicide</td><td>average.<br><br>In 2015-16, emergency department presentations for suicide attempts and ideation (>50) were in the following statistical local areas (SLAs):
<table>
<tr><th>SLA Desc.</th><th>Pres. Count</th></tr>
<tr><td>Knox (C) - North-East</td><td>163</td></tr>
<tr><td>Yarra Ranges (S) - Lilydale</td><td>137</td></tr>
<tr><td>Maroondah (C) - Croydon</td><td>99</td></tr>
<tr><td>Whittlesea (C) - North</td><td>94</td></tr>
<tr><td>Whitehorse (C) - Box Hill</td><td>92</td></tr>
<tr><td>Whittlesea (C) - South-West</td><td>85</td></tr>
<tr><td>Banyule (C) - Heidelberg</td><td>76</td></tr>
<tr><td>Monash (C) - Waverley West</td><td>73</td></tr>
<tr><td>Whittlesea (C) - South-East</td><td>71</td></tr>
<tr><td>Manningham (C) - West</td><td>71</td></tr>
<tr><td>Maroondah (C) - Ringwood</td><td>67</td></tr>
<tr><td>Whitehorse (C) - Nunawading W.</td><td>59</td></tr>
<tr><td>Whitehorse (C) - Nunawading E.</td><td>54</td></tr>
</table>
<br>In 2015-16, emergency department presentations for suicide attempts and suicidal ideation were:
<table>
<tr><th>ED Campus</th><th>Presentation Count</th><th>Ave. LOS (mins)</th><th>Ave. Time to Treat. (mins)</th></tr>
<tr><td>Maroondah Hospital</td><td>489</td><td>386.7</td><td>39.2</td></tr>
<tr><td>Box Hill Hospital</td><td>376</td><td>323.9</td><td>46.0</td></tr>
<tr><td>The Northern Hospital</td><td>253</td><td>440.0</td><td>40.6</td></tr>
</table></td><td></td></tr>
</table>

| Outcomes of the Health Needs Analysis – Mental Health | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| | Austin Hospital 232 284.0 24.1<br>Angliss Hospital 143 478.9 11.2 | |
| Estimated treated population with mental illness | The National Mental Health Service Planning Framework Tool (a population-based planning model) became available in September 2017 to assist with mental health planning, service delivery, and development of the Stepped Care Model.<br><br>The estimated treated population with mental illness for EMPHN catchment is as follows:<br>Mild 67,521 people<br>Moderate 54,823 people<br>Severe 46,385 people<br>(Using this tool, approximately two-thirds of the treated population fall into the 18-64 year age group). | The University of Queensland (2016), *The National Mental Health Service Planning Framework – Commissioned by the Australian Government Department of Health*. Version AUS V2.1. The University of Queensland, Brisbane. |

## Outcomes of the Health Needs Analysis – Alcohol and Other Drugs

| Outcomes of the Health Needs Analysis – Alcohol and Other Drugs | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Presence of ill health or disease – Alcohol use: Burden | More than one-third of surveyed GPs indicated that substance abuse issues were more common amongst their patients than what might be expected. The most common drug of choice was alcohol, followed by tobacco and pharmaceutical drugs. It was reported that prescription drug and alcohol misuse were comorbid in many instances.<br><br>A number of allied health practitioners noted alcohol abuse amongst their clients. Several reported that alcohol abuse is often undiagnosed and resultant of underlying personal and social issues. Many respondents expressed the time pressures already experienced by GPs impact early diagnosis/ detection.<br><br>Other issues raised include:<br>• childhood education on the negative effects of alcohol;<br>• creating a cultural shift around attitudes to alcohol consumption, i.e. same category and social stigma as drug use, especially dangerous doses;<br>• increased alcohol abuse among the older population; and<br>• stay-at-home mothers with a loss of social life and sense of self. | Consultation:<br>• EMPHN General Practice Survey (October 2016); and<br>• EMPHN Allied Health Survey (October 2016). |
| Health-related behaviour – Alcohol use: Social influences | Alcohol was linked to stress/mental health, social isolation, family violence, gambling and public violence. Whittlesea (51.8%), Yarra Ranges (30.6%), Maroondah (29.9%) and Knox (21.8%) had the highest proportion of people living in areas with a SEIFA IRSAD score <1000, that is, were the areas where the most people aged 18 and over experience disadvantage. Whittlesea had relatively high rates of housing stress — it had the highest proportion of households with a mortgage costing 30% or more of gross income and was on par with Yarra Ranges for the proportion of households with rent costing 30% or more of gross income. | ABS (2015, 2017); AODstats by Turning Point (2014-15); CIV (2017); Vic. DHHS (2012-13), LGA Profiles (2015); VCGLR (2017).<br><br>Consultation:<br>• Council –Knox City Council; Yarra Ranges Shire Council;<br>• CHS – Banyule CHS; |

| Outcomes of the Health Needs Analysis – Alcohol and Other Drugs | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Health-related behaviour – Alcohol use: Social influences | Whittlesea also had the highest electronic gaming machine expenditure per adult aged 18 years and over ($775, compared to the catchment average of $516 per person) and a relatively high rate of definite alcohol-related family violence (6.2 per 10,000). However, the highest rates of alcohol related family violence were in the rural shires of Mitchell* (23.6 per 10,000) and Murrindindi* (17.7 per 10,000). Other notably high rates were in Yarra Ranges (9.5 per 10,000) and Maroondah (9.4 per 10,000).<br><br>The the highest rates of alcohol-related violence against women were in Mitchell* (31.9 per 10,000), Murrindindi* (22.6 per 10,000), Yarra Ranges (14.5 per 10,000), Maroondah (13.2 per 10,000) and Banyule (10.0 per 10,000).<br><br>Murrindindi* had more than three times the number of licenced liquor venues and twice the number of licenced packaged liquor outlets per head of population as the catchment average. Of the comparable LGAs, Yarra Ranges had the highest proportion of packaged liquor licensed outlets and licensed liquor venues. | • PCP – North East PCP; Outer East PCP;<br>• NGO – Whittlesea Community Connections; Women's Health East; Women's Health In the North; and<br>• Peak body – Victorian Alcohol and Drug Association (VAADA). |
| Health-related behaviour – Alcohol use: Incidence | Mitchell* and Murrindindi* (both 3.3, ASR/100) and Yarra Ranges (3.0, ASR/100) had the highest ASR of adults aged 18 years and over who consumed alcohol in amounts considered high risk to health. Healesville was reported as an area of high problem drinking.<br><br>Nillumbik (14.9%), Murrindindi* (13.9%), Knox (13.4%) and Yarra Ranges (12.8%) also had above state average proportions (9.1%) of adults at risk of long term harm from alcohol consumption.<br><br>Harmful alcohol use was also reported in Banyule and Boroondara. | AIHW (2015), *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*; AODstats by Turning Point (2012-13); Vic. DHHS (2012-13), LGA Profiles.<br><br>Consultation:<br>• Council – City of Boroondara; Knox City Council; Yarra Ranges Shire Council; |

| Outcomes of the Health Needs Analysis – Alcohol and Other Drugs | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Health-related behaviour – Alcohol use: Incidence | Consultations suggested a high prevalence of health and social problems resulting from alcohol use among Aboriginal and/or Torres Strait Islander people. | • CHS – Banyule CHS; Mullum Mullum Indigenous Gathering Place;<br>• PCP – Lower Hume PCP; North East PCP; Outer East PCP;<br>• NGO – Whittlesea Community Connections; and<br>• Peak body – Victorian Alcohol and Drug Association (VAADA). |
| Health-related behaviour – Alcohol use: Ambulance attendances | Maroondah (41.1/10,000) had an above state average rate of total alcohol ambulance attendances (37.0/10,000). | AODstats by Turning Point (2014-15). |
| Health-related behaviour – Alcohol use: ED presentations | Total ED presentations for alcohol use were highest, and well above the catchment average of 10.1/10,000, in Whitehorse (15.0/10,000) and Maroondah (14.3/10,000). Coincidently, both of these LGAs have a public hospital ED with ICU beds to which ambulances might be most likely to present. Whitehorse had the highest alcohol-related ED presentation rate among males (19.4/10,000), and Whitehorse and Maroondah had the highest rates among females ([11.0/10,000] and [10.7/10,000] respectively). | AODstats by Turning Point (2012-13). |
| Health-related behaviour – Alcohol use: Hospitalisations | Knox (73.5/10,000), Boroondara (71.7/10,000), Whitehorse (60.7/10,000), Maroondah (58.6/10,000) and Yarra Ranges (55.8/10,000) had above state average total alcohol hospitalisation rates (55.0/10,000). Across the catchment, rates were higher among males than females. Boroondara (89.5/10,000) and Whitehorse (75.7/10,000) had above state average alcohol hospitalisation rates among males (67.8/10,000). Knox (85.2/10,000), Yarra | AODstats by Turning Point (2014-15). |

| Outcomes of the Health Needs Analysis – Alcohol and Other Drugs | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| | Ranges (57.6/10,000), Boroondara (55.0/10,000), Maroondah (52.8/10,000) and Whitehorse (46.7/10,000) had above state average rates among females (42.5/10,000). | |
| Health-related behaviour – Alcohol use: ADIS episodes | Yarra Ranges (43.3/10,000), Knox (38.8/10,000) and Maroondah (34.5/10,000) had above state average rates of total ADIS episodes of care (28.8/10,000). As with hospitalisations, ADIS episodes of care rates were higher among males than females. These LGAs had above state average rates among both males (Knox [50.8/10,000]; Yarra Ranges [48.3/10,000]; Maroondah [43.3/10,000]; Victoria [37.9/10,000]) and females (Yarra Ranges [38.4/10,000]; Knox [27.0/10,000]; Maroondah [26.1/10,000]; Victoria [19.9/10,000]). | AODstats by Turning Point (2014-15). |
| Health-related behaviour – Illicit drug use | Surveyed GPs indicated that many people with illicit drug addiction cannot access the support services required. Both GPs and allied health practitioners noted that addiction to illicit substances should be treated as a medical condition rather than criminal activity.<br><br>The most salient suggestions put forward were:<br>• better referral pathways into counselling and addiction medicine treatment services;<br>• more GPs providing pharmacotherapy services;<br>• closely monitored safe injecting rooms; and<br>• drug/pill testing to prevent overdoses and avoidable deaths.<br><br>Cannabis use was reported in Boroondara, Whittlesea and Nillumbik. | Consultation:<br>• Council – City of Boroondara; City of Whittlesea; Nillumbik Shire Council;<br>• EMPHN General Practice Survey (October 2016); and<br>• EMPHN Allied Health Survey (October 2016). |
| Health-related behaviour – Illicit drug use: Ambulance attendances | All LGAs had below state average rates of total illicit drug ambulance attendances (15.5/10,000), with Maroondah (12.9/10,000), Knox (12.6/10,000) and Mitchell* (12.2/10,000) the closest. | AODstats by Turning Point (2014-15). |

| Outcomes of the Health Needs Analysis – Alcohol and Other Drugs | | |
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| Identified Need | Key Issue | Description of Evidence |
| Health-related behaviour – Illicit drug use: ED presentations<br><br>Health-related behaviour – Illicit drug use: ED presentations | Across the catchment, total illicit drug ED presentation rates were very close. Maroondah (2.9/10,000), and Nillumbik and Whittlesea (both 2.4/10,000) were slightly higher than the other LGAs. Presentations were higher among males compared to females. Gender differences were most notable in Yarra Ranges, Whittlesea and Whitehorse, where ED presentation rates per 10,000 head of population for males were over 50% higher than for females (59.3%, 54.8% and 50.0% difference respectively).<br><br>Maroondah (3.4/10,000) and Whittlesea (3.1/10,000) had slightly higher illicit drug presentation rates among males than the other LGAs, and Maroondah (2.4/10,000) and Knox (2.2/10,000) had marginally higher rates among females. | AODstats by Turning Point (2012-13). |
| Health-related behaviour – Illicit drug use: Hospitalisations | Yarra Ranges (34.5/10,000) and Manningham (28.1/10,000) had above state average total illicit drug hospitalisation rates (25.3/10,000). Across the catchment, hospitalisation rates were generally higher among males than females, with the exception of Maroondah. Manningham (45.4/10,000) and Yarra Ranges (35.7/10,000) had above state average illicit drug hospitalisation rates among males (30.8/10,000). Yarra Ranges (33.3/10,000), Maroondah (25.4/10,000), Banyule (21.5/10,000) and Knox (20.8/10,000) had above state average presentation rates among females (19.9/10,000). | AODstats by Turning Point (2014-15). |
| Health-related behaviour – Illicit drug use: ADIS episodes | Knox (49.3/10,000) and Maroondah (46.2/10,000) had above state average rates of total ADIS episodes of care (38.9/10,000). As with ED presentations and hospitalisations, ADIS episodes of care rates were higher among males than females. These LGAs had above state average rates of ADIS episodes of care among both males (Knox [68.0/10,000]; Maroondah [54.9/10,000]; Victoria [51.3/10,000]) and females (Maroondah [38.0/10,000]; Knox [31.1/10,000]; Victoria [26.7/10,000]). | AODstats by Turning Point (2014-15). |

| Outcomes of the Health Needs Analysis – Alcohol and Other Drugs | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Health related behaviour – Amphetamine use: ADIS episodes | Knox (21.4/10,000), Maroondah (18.9/10,000) and Yarra Ranges (16.8/10,000) had above state average rates of total amphetamine ADIS episodes of care (15.1/10,000). Across the catchment, rates were higher among males than females. These LGAs had above state average rates of ADIS episodes of care among males (Knox [31.2/10,000]; Maroondah [21.9/10,000]; Yarra Ranges [21.7/10,000]; Victoria [19.5/10,000]). Maroondah (16.0/10,000), Yarra Ranges (11.9/10,000), Knox (11.8/10,000) and Mitchell* (10.9/10,000) had above state average rates among females (10.8/10,000). | AODstats by Turning Point (2014-15). |
| Health related behaviour – Crystal methamphetamine (ice) use: Directline rates and reported use | The state average total crystal methamphetamine (ice) Directline rate was 9.2 per 10,000 population. The rate among females (10.8/10,000) was higher than males (7.6/10,000).<br><br>Ice use was reported in Manningham and Whitehorse, and amongst young males in Whittlesea who have weekend binges.<br><br>Increased ice use was noted among Aboriginal and/or Torres Strait Islander people in the outer east region. There was a reported association between ice and elder abuse in the context of kin care in Whittlesea. | AODstats by Turning Point (2015).<br><br>Consultation:<br>• Council – Manningham City Council; Yarra Ranges Shire Council;<br>• CHS – Carrington Health;<br>• PCP – Hume Whittlesea PCP; Outer East PCP; and<br>• NGO – Whittlesea Community Connections. |
| Health related behaviour – Pharmaceutical drug use | Deaths from pharmaceutical opioid medications are surpassing those of illicit drugs like heroin, with death statistics now rivalling the road toll. Prescription medications contributed to 82.5% of Victoria's fatal drug overdoses in 2012, with opioid analgesics and benzodiazepines the top contributors, and general practitioners being front-line prescribers. Oxycodone is the fourth leading medication prescribed in general practice. General practice is the primary target in prescription drug diversion activities. Commonly diverted drugs are opioids, benzodiazepines, stimulants, antipsychotics, and anaesthetics. | Coroners Court of Victoria (2016); EMPHN (2015), *Literature review – Prescription drug misuse harms: a project to support a proactive response from general practice*.<br><br>Consultation: |

| Outcomes of the Health Needs Analysis – Alcohol and Other Drugs | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| | Surveyed GPs indicated that pharmaceutical drug misuse is an ongoing issue. The main concerns included doctor shopping, patients misunderstanding the risk of dependency and pressures to prescribe. Prescription medications are commonly taken with alcohol, increasing the risk of overdose and hospital admission.<br><br>Pharmaceutical drug use was reported in Boroondara and Nillumbik. | • Council – City of Boroondara; Nillumbik Shire Council;<br>• CHS – Access Health and Community;<br>• NGO – Whittlesea Community Connections;<br>• Peer-based organisation – Harm Reduction Victoria;<br>• EMPHN General Practice Survey (October 2016); and<br>• EMPHN Allied Health Survey (October 2016). |
| Health related behaviour – Pharmaceutical drug use: Ambulance attendances | Mitchell* (22.3/10,000), Maroondah (20.0/10,000) and Yarra Ranges (19.5/10,000) had above state average total pharmaceutical ambulance attendance rates (17.0/10,000). | AODstats by Turning Point (2014-15). |
| Health related behaviour – Pharmaceutical drug use: ED presentations | The highest ED presentation rates for pharmaceutical drugs were in Maroondah (11.3/10,000), Whittlesea (10.9/10,000) and Monash (10.4/10,000). Presentation rates were higher among females compared to males. Whittlesea (8.2/10,000), Maroondah (8.0/10,000) and Banyule (7.6/10,000) had the highest pharmaceutical drug presentation rates. Nillumbik (14.6/10,000), Maroondah and Mitchell* (both 14.5/10,000) and Monash | AODstats by Turning Point (2012-13). |

| Outcomes of the Health Needs Analysis – Alcohol and Other Drugs | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Pharmaceutical drug use: Hospitalisations | generally higher among females compared to males. Boroondara (14.7/10,000), Banyule (14.2/10,000), Murrindindi* (12.9/10,000) and Maroondah (12.3/10,000) were on par with or above the state average rate of hospitalisations among males (12.3/10,000). Females from all LGAs were below the state average rate (19.8/10,000), with Yarra Ranges the closest (19.7/10,000). | |
| Health related behaviour – Pharmaceutical drug use: ADIS episodes | Maroondah (3.9/10,000) and Knox (3.6,000) had above state average rates of total pharmaceutical drug ADIS episodes of care (3.5/10,000). Across the catchment, there were limited rates available by gender. Maroondah (3.9/10,000) had an above state average rate of pharmaceutical drug ADIS episodes of care among males (3.4/10,000). Maroondah (5.0/10,000) and Knox (4.0/10,000) had above state average rates among females (3.6/10,000). | AODstats by Turning Point (2014-15). |

## Outcomes of the Health Needs Analysis – After-Hours

<table>
<tr><th colspan="3">Outcomes of the Health Needs Analysis – After-Hours</th></tr>
<tr><th>Identified Need</th><th>Key Issue</th><th>Description of Evidence</th></tr>
<tr>
<td>Service accessibility – GPs and other primary health care services in the after-hours period</td>
<td>In the 2015-16 financial year, almost half (~49%) of the after-hours ED presentations in the EMPHN catchment were category 4 and 5 (semi urgent and non-urgent). In the same financial year, the majority of primary care type hospital presentations occurred on weekdays between 18:00–22:59. The highest number of category 4 and 5 ED presentations in the EMPHN catchment were for children aged 0–4 years. Presentations peaked again among people aged 20–29 years.
<table>
<tr><th></th><th>Outer North</th><th>North East</th><th>Inner East</th><th>Outer East</th><th>EMPHN</th></tr>
<tr><td>ED presentations 2015/16</td><td>62,157</td><td>47,468</td><td>117,058</td><td>114,065</td><td>340,748</td></tr>
<tr><td>ED presentation 2015/16 per 10,000</td><td>3,147</td><td>6,347</td><td>7,545</td><td>8,256</td><td>25,295</td></tr>
<tr><td>No. of GP type pres. (Cat 4 & 5)</td><td>27,972</td><td>23,297</td><td>57,195</td><td>58,736</td><td>167,200</td></tr>
<tr><td>No. of ED pres. in business hours</td><td>27,116</td><td>20,915</td><td>49,247</td><td>50,338</td><td>147,616</td></tr>
<tr><td>No. of GP type pres. in business hours (Cat 4 & 5)</td><td>13,164</td><td>10,989</td><td>25,173</td><td>27,134</td><td>76,460</td></tr>
<tr><td>No. of ED pres. in after-hours</td><td>35,041</td><td>26,553</td><td>67,811</td><td>63,727</td><td>193,132</td></tr>
<tr><td>No. of GP type pres. in after-hours (Cat 4 & 5)</td><td>14,808</td><td>12,308</td><td>32,022</td><td>31,602</td><td>90,740</td></tr>
<tr><td>% of total ED pres. in business hours</td><td>44%</td><td>44%</td><td>42%</td><td>44%</td><td>44%</td></tr>
<tr><td>% of total ED pres. in after-hours</td><td>56%</td><td>56%</td><td>58%</td><td>56%</td><td>56%</td></tr>
<tr><td>% of Cat 4 & 5 pres. in business hours (all pres.)</td><td>21%</td><td>22%</td><td>22%</td><td>24%</td><td>22%</td></tr>
<tr><td>% of Cat 4 & 5 pres. in after-hours (all pres.)</td><td>24%</td><td>24%</td><td>27%</td><td>28%</td><td>26%</td></tr>
<tr><td>% of Cat 4 & 5 pres. (all pres.)</td><td>45%</td><td>46%</td><td>49%</td><td>51%</td><td>48%</td></tr>
</table>
</td>
<td>Australian Commission on Safety and Quality In Healthcare (2015), Australian Atlas of Healthcare Variation; EMML, IEMML and NMML (2012-13), Comprehensive Needs Assessments; EMPHN After Hours Survey (September – October 2015); EMPHN research on MDS coverage in the catchment; Jaffe Consulting Pty Ltd for EMPHN (2017), After hours primary health care diagnostics and prioritisation project - final report; Larter Consulting (2015), ACP Consortium Needs Analysis; VEMD (2014-15), VEMD (2015-16).<br><br>Consultation:<br>• CHS – EACH; Plenty Valley CH;<br>• Ambulance service – Ambulance Victoria;<br>• GP clinic – After Hours GP Clinic Box Hill; Clayton Road Doctors Medical Centre; ERAHMS clinics;</td>
</tr>
</table>

| Outcomes of the Health Needs Analysis – After-Hours | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Service accessibility – GPs and other primary health care services in the after-hours period | *Emergency department presentations for time and triage category (VEMD, 2016) by patient residence*<br><br>In 2013–14, more than 70,000 MDS services were provided after-hours in the EMPHN catchment, with almost 40% delivered to RACF residents.<br><br>There is minimal access to MDSs in the outer metropolitan areas. It was noted that there is also limited access to primary health care services, including GP clinics, pharmacy, radiology and pathology in the after-hours period, particularly in the outer metropolitan areas. Issues were experienced in accessing timely and appropriate after-hours care and it was reported that the quality of after-hours care varies between facilities.<br><br>Discussion was made of high demand and waiting lists for services such as mobile X-rays, pathology, pharmacy, palliative care, Advance Care Planning (ACP) and geriatrics.<br><br>Reduced access to respiratory, chronic disease, cancer care resources after-hours was noted.<br><br>Some RACF staff were seen to lack knowledge of after-hours primary health care services.<br><br>Poor access to services was reported for families of children with developmental disorders or intellectual disabilities.<br><br>Significant levels of aggression in residents with dementia were noted. The issue appeared to be exacerbated after hours by the lack of staffing and resources to manage residents. | Nexus GP SuperClinic Wallan; Warburton Medical Clinic;<br>• MDS – ALMS; My Home GP; NHDS;<br>• LHN – Austin Health; Eastern Health; Northern Health; Southern Health Dandenong; St. Vincent's Hospital; and<br>• EMPHN RACF interviews (September 2015 – February 2016). |

| Outcomes of the Health Needs Analysis – After-Hours | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Service accessibility – After-hours primary health care services | Some RACF staff and GP locums were considered to be unfamiliar with local after-hours services availability and how to support residents with after-hours clinical needs.<br><br>Information in the NHSD was suggested as being often inaccurate or not up-to-date, as some services were unfamiliar with the information updating process.<br><br>There was comment that limited opportunities existed for GP services and pharmacies to expand their opening hours unless additional funding were made available. After-hours services were often viewed as functional aspects of general practice rather than part of planned care. | EMML, IEMML and NMML (2012-13), Comprehensive Needs Assessments; Larter Consulting (2015), *ACP Consortium Needs Analysis*.<br><br>Consultation:<br>• GP clinic – Clayton Road Doctors Medical Centre; ERAHMS clinics; Nexus GP SuperClinic Wallan; Warburton Medical Clinic;<br>• MDS – ALMS; My Home GP; NHDS; and<br>• EMPHN RACF interviews (September 2015 – February 2016). |
| Health related behaviour – After-hours service access<br>Health related behaviour – After-hours service access | Inappropriate after-hours service usage (ambulance and ED) was proposed, partly due to inadequate community knowledge of available and appropriate after-hours services, including MDS and after-hours clinics and pharmacies.<br><br>It was suggested that there was a community perception that EDs offer best clinical care, are cost free and are a one-stop-shop for care. It was also believed that people would be prepared to wait long periods if there were no fee for treatment.<br><br>There were perceptions of significant numbers of inappropriate calls to 000 for an ambulance due to misconceptions about the role of the service. | EMML, IEMML and NMML (2012-13), Comprehensive Needs Assessments.<br><br>Consultation:<br>• CHS – EACH<br>• NGO – Migrant Information Centre; and<br>• Ambulance service – Ambulance Victoria. |

| Outcomes of the Health Needs Analysis – After-Hours | | |
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| Identified Need | Key Issue | Description of Evidence |
| | It was thought that there was a lack of consistent, multilingual information about after hours care options. | |
| Service accessibility – Culturally safe and accessible primary health care services | A limited number of practices had undergone cultural awareness training.<br><br>The low self-identification rates among people from Aboriginal and/or Torres Strait Islander backgrounds were thought to decrease the likelihood of their accessing culturally safe health care.<br><br>Some residents experienced poor transport access to after-hours services. | EMML (2014), *Aboriginal Health Priorities Framework*; IEMML (2014), *Reconciliation Action Plan*. |
| Service accessibility – CALD appropriate primary health care services | There is currently a lack of available multilingual GPs.<br><br>There was reportedly inadequate knowledge of available after-hours services for marginalised groups, including CALD and refugee people. | Consultation:<br>• CHS – AMES Australia; EACH; and<br>• NGO – Spectrum MRC; Migrant Information Centre. |
| Service accessibility – Mental health services in the after-hours period | Attendance for mental health issues was one of the top two after hours call-outs reported by Ambulance Victoria.<br><br>There were limited community-based services for people with mental health needs after hours, resulting in a lack of capacity to provide onsite psychological support as a second response to mental health crisis situations.<br><br>A 'Police, Ambulance and Clinical Early Response' (PACER) program exists in a limited capacity in the inner north, but does not cover the outer north. It was suggested that | NMML (2012), *Comprehensive Needs Assessment*.<br><br>Consultation:<br>• CHS – Banyule CHS; EACH Ringwood and Maroondah; Inspiro CHS;<br>• LHN – Austin Health; and<br>• Ambulance service – Ambulance Victoria. |

| Outcomes of the Health Needs Analysis – After-Hours | | |
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| Identified Need | Key Issue | Description of Evidence |
| | expanding the PACER program would enable Crisis and Assessment teams to increase operating times. | |

# Section 3 – Outcomes Of The Service Needs Analysis

## Outcomes of The Service Needs Analysis – General

| Outcomes of The Service Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| Potentially preventable emergency department presentations and admissions | There was a high utilisation of emergency departments (ED) for primary care-type presentations during business hours, particularly in the 25-35-year-old age group.<br><br>Users of ED services highlighted factors in choice of ED over primary care as including:<br>• cost benefit;<br>• perception of timeliness and convenience of having multiple diagnostic services in one place;<br>• home location relative to service location; and<br>• perceptions of greater expertise in tertiary facilities by parents and many GPs (including higher rates of GP referral rate for children into the ED).<br><br>A higher tendency to present to the ED was noted among first-time parents and parents of infants and children aged 0-4 years (generally over-represented in Australian EDs), and by parents of low income status and/or of lower education level.<br>Despite use of ED services for primary care-type paediatric presentations, most survey respondents from general practice rated their expertise in paediatric care as either somewhat proficient, very proficient or highly proficient, with almost half, most of whom were either practice nurses or general practitioners, self-rating as very or highly proficient. | AIHW (2015), Workforce Data; University of Melbourne Department of General Practice November (2015), *Prevention of low and non-urgent presentations of children to emergency departments* (draft report); VEMD (2015-16).<br><br>Consultation:<br>• LHN – Eastern Health;<br>• EMPHN Provider Survey (February 2016);<br>• EMPHN General Practice Survey (October 2016); and<br>• EMPHN Allied Health Survey (October 2016). |

| Outcomes of The Service Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| Potentially preventable emergency department presentations and admissions | General practice survey respondents nominated several drivers perceived to cause consumers (especially parents of 0-4 year olds and people aged 20-35 years) to access an ED rather than a GP for non-urgent care. The most frequently nominated reason was the cost differential (cost-free care from the ED) and about half of respondents indicated one or more of the following:<br>• not having a regular GP;<br>• inability to access a GP in their desired timeframe; and<br>• the attraction of the 'one-stop-shop' ED for medical consultation, and additional diagnostic services (X-ray, pathology test/s and medication/s).<br><br>Some references were also made by survey respondents to:<br>• consumer desire for after-hours access;<br>• lack of consumer health literacy/knowledge and/or understanding of the health system and the purpose of ED; and<br>• lack of faith in GP skills.<br><br>Allied health survey respondents added the following as further barriers to using GPs instead of EDs: cultural issues, usual pattern of accessing health services and the perception of attentiveness from a multi-specialist service such as a hospital compared to a shorter interaction with a GP.<br><br>Suboptimal specific-GP same day appointment availability (bulk-billed) was reported for the northern growth corridor. This was likely created by lower GP concentrations in the outer suburbs of the northern growth corridor. | |

| Outcomes of The Service Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| | In addition to addressing access issues, cohort over-representation in the ED suggests opportunity for targeted health literacy initiatives aimed at improving understanding of both the wellness-illness spectrum relevant to key groups, and of their system literacy. | |
| Potentially preventable hospital admissions – Specialist aged care services: Unnecessary transfers | Inadequate GP locum knowledge in palliative care has contributed to unnecessary hospital transfers at end-of-life in the Eastern Health and Northern Health catchments.<br>Systems were lacking that would enable discharged palliative care patients to access medicines in a timely manner from community pharmacy. | Consultation:<br>• EMPHN RACF interviews (September 2015 – February 2016);<br>• GP working extensively in RACF in the EMPHN catchment; and<br>• LHN – Eastern Health. |
| Potentially preventable emergency department presentations and admissions – Complex needs | Current HARP and Hospital-in-the-Home arrangements are often engaged when the client/patient has more acute/complex needs. There is a gap between general practice-based care and when hospital services are required, which presents a targeting opportunity.<br><br>The increasing rate of obesity is reducing mobility of more patients within the community – home-based outreach models that support general practice to maintain care in the community require further investigation.<br><br>Chronic disease management and psychological conditions impact most heavily on general practice time, suggesting these services are resource intensive whether provided by general practice or the public hospital system. | AIHW (2015-16), *Potentially preventable hospitalisations interactive data table*; EMPHN (2017), *New collaborative program to improve medication safety in Melbourne's east*; Health Workforce Australia (2012), *Health workforce 2025,* March 2012, vol. 1-3.<br><br>Consultation:<br>• LHN – Eastern Health; and<br>• EMPHN General Practice Survey (October 2016). |

| Outcomes of The Service Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| | General practice survey responses suggested that chronic disease management and/or chronic mental illness take up the majority of general practice time: 74% of respondents nominated chronic conditions and/or psychological conditions (69% of respondents) as those conditions taking up the most time. Infections/infectious conditions and respiratory conditions also factored heavily—over one-third of respondents nominated one or both as predominating in terms of practice time. One respondent pointed out the added complexity of multiple conditions, particularly where chronic physical and mental health issues coincide.<br><br>For the EMPHN region, 1,090 of the 2,304 (47%) potentially preventable hospitalisations in 2015-16 were for chronic conditions. The projected health workforce shortage lends further urgency to the need for change to the current system.<br><br>Medication errors occur in up to 40 percent of older home nursing clients. Approximately 13 percent of this cohort experience an adverse medication event requiring hospitalisation or medical consultation. Older people are at risk of experiencing medication errors and adverse medication events due to having multiple conditions, multiple prescribers, and multiple medications, and the risk is higher in older people with complex health issues requiring home nursing services. | |
| System design – Integrated services | Attention was drawn to suboptimal interconnectivity between services:<br>• coordination difficulties across primary, secondary and tertiary services;<br>• disconnected tertiary-CHS care;<br>• between-sector refugee services (such as education/employment) in the priority refugee resettlement area of Whittlesea and the northern growth corridor;<br>• one allied health survey respondent highlighted the need for improved coordination between the acute sector and community health; | Austin Health (2016), *Consumer expectations and experience project*; Austin Health (2017), *Project charter – changing healthcare for the better: the complex patient*; Diabetes Australia (2017), *Fixing Australia's disconnected care systems*; Eastern |

| Outcomes of The Service Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| System design – Integrated services | • another respondent conveyed the need for an increase in My Health Record sign up;<br>• another respondent identified the need for better integration with case workers in supporting the vulnerable with complex issues or experiencing trauma to access routine health care and cancer screening; and<br>• two allied health survey respondents reported that pharmacy staff are not always familiar with cancer screening programs.<br><br>There was ineffective/suboptimal integration of primary care services into the client journey, characterised by:<br>• client knowledge of services poorer amongst disadvantaged people;<br>• bypassing of community health services by referrers<br>  ○ stigma of CHS use<br>  ○ easy/easier to refer into tertiary services, and<br>• acute practitioners unaware of services/failing to refer.<br><br>Suboptimal continuity of care and subsequent disengagement of clients was noted in the outer east:<br>• poor retention of locum GPs, outreach care workers due to travel requirements; and reduced faith in services by locals, especially in Yarra Ranges.<br><br>Traditional service delivery is driven by clinicians, directed by referrals and reflection of best practice guidelines. With increased emphasis on patient-centred care models and self-management, active participation of consumers is encouraged. According to Professor Greg Johnson, CEO of Diabetes Australia and member of the Consumers Health Forum, *"people* | Melbourne Primary Health Care Collaborative (2017), *Primary health strategic plan*; Larter Consulting (2017), Progress report for Greensborough area integrated care clinic; Shared Vision for the North (2016), *Chronic disease forum notes*; University of Melbourne Department of General Practice November (2015), *Prevention of low and non-urgent presentations of children to emergency departments* (draft report); Swerissen, H., & Duckett, S. ( (2016), *Chronic Failure in Primary Care* – Grattan Institute Report.<br><br>Consultation:<br>• Council – Maroondah City Council; Yarra Ranges Shire Council;<br>• CHS – healthAbility; Link Health and Community;<br>• PCP – Hume Whittlesea PCP;<br>• EMPHN Provider Survey (February 2016) response with |

| Outcomes of The Service Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| | *with chronic conditions like diabetes are often very confused by our fragmented health system. We have world class primary care health professionals, specialists and hospitals, but they are too often disconnected and consumers feel the health system lacks coordination, communication and integration…The solution is to be better linked up and for consumers to be the focus of how health services are planned, organised and delivered."* Commissioned services must therefore provide the framework and means in which to engage patients in their care. This may be through the technology used to record and communicate the treatment plan as a living document or through the methods in which self-management is monitored by patient and clinician.<br><br>Austin Health also noted that clients do not have easy access to a seamless model of care between and within services, contributing to the following issues:<br>• Lack of care in a timely manner.<br>• Patients are siloed.<br>• Quality of care is variable.<br>• Inefficiency in processes – patients have to answer the same questions.<br>• Inconsistency in information and advice provided.<br>• Confusion for patient.<br>• Lack of forward planning.<br>• Poor satisfaction and experience for the client and their carers.<br><br>The interface between services is not robust enough to prevent repetitious assessment and history taking by different providers. The reliance is on the patient to navigate the system. The Grattan Institute report, *Chronic Failure in Primary Care*, recognises some additional issues with the current system:<br>• Duplication of services. | CHS respondent (Carrington Health); and<br>• EMPHN Allied Health Survey (October 2016). |

| Outcomes of The Service Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| | • Poor care sequencing.<br><br>There are barriers that must be considered in the development of integrated primary care services. The overall message from GPs consulted about the proposed integrated primary care centre in Greensborough for example, was that they felt it would be a threat to their business (they would lose patients) and that if they referred patients there, it would undermine their own expertise. Therefore, it is necessary to capitalise on and reconfigure services and pathways for the existing workforce in looking at integration of services.<br><br>Developing service and workforce models for people with multiple or complex chronic conditions has been identified as a strategic priority in the Austin Health Clinical Service Plan 2025. Austin Health, together with EMPHN and others through the Better Health North East Melbourne Collaborative will help drive this work as one of four priority projects identified for action.<br><br>The Shared Vision for the North collaborative also includes chronic disease as a priority, focusing on integration across the spectrum of prevention to treatment and rehabilitation.<br><br>Similarly, the Eastern Melbourne Primary Health Care Collaborative priorities look at an integrated regional chronic disease system via the following elements – end of life care, HealthLinks: Chronic Care, rising risk and Integrated Diabetes Education and Assessment Service (IDEAS) (diabetes expansion). | |
| System design – Integrated services: Diabetes | One allied health survey respondent noted lower than expected rates of referral of newly diagnosed patients with diabetes from general practice to community health service diabetes educators in Whitehorse. Potential under-referral was seen to impact on prevention of long-term diabetes complications. | Consultation:<br>• EMPHN Provider Survey (February 2016). |

| Outcomes of The Service Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| System design – Integrated services: Aboriginal and/or Torres Strait Islanders | Experience of cultural insensitivity from hospital staff to Aboriginal and/or Torres Strait Islander people who presented or were admitted, resulting in:<br>• clients experiencing discomfort in having to volunteer their indigenous status;<br>• clients feeling physically unsafe about waiting in an ED;<br>• clients discharging themselves without treatment due to long waiting times, especially if children involved; and<br>• confusion regarding the exact role of the Aboriginal Health Liaison Officer. | Inner East: Department of Health EMR Koolin Balit and Aboriginal Health Community Consultation Workshop (September 2013); Outer east: Department of Health EMR Koolin Balit and Aboriginal Health Community Consultation Workshop (September 2013). |
| System design – Communication between health services and other service providers<br>System design – Communication between health services and other service providers | Improved ease and timeliness of communication are needed between providers, between providers and services, and between clients/patients and providers/services using secure e-technologies that integrate with practice software.<br><br>There was support, or suggestions made, for the following:<br>• electronic patient portal;<br>• application-based means of communication;<br>• electronic case conferencing (telehealth); and<br>• secure email capability.<br><br>Security, privacy and appropriate funding for non face-to-face communications were cited as issues by GP survey respondents.<br><br>eHealth support to Practices to ensure eligibility for the eHealth Practice Incentive Payment (ePIP), uptake of the My Health Record and eReferral projects has resulted in, as of June 2017, over 40% of practices in the region registered for the ePIP and 38% engaged in eReferral projects. This uptake has then resulted in over 32,000 shared health summaries | Consultation:<br>• EMPHN General Practice Survey (October 2016); and<br>• EMPHN Allied Health Survey (October 2016). |

| Outcomes of The Service Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| | and over 12,000 discharge summaries uploaded to the My Health Record. Increased participation in eHealth reform provides greater opportunity for better integrated care, reduced duplication in assessment and treatment and supported continuity of care from the patient's provider team. | |
| System design – Communication between services | Claims were made of inadequate discharge communication from LHNs (Northern Health was cited as just one example) and consultation with the RACFs and private hospitals in the inner and outer east catchment. There is a resultant major risk of preventable hospital readmissions.<br><br>Key themes include:<br>• timeliness of discharge;<br>• communicating adequately so that RACFs can assess if they are resourced to manage the resident's condition;<br>• the value of being able to speak to someone who can provide relevant information;<br>• discharge summaries issues; and<br>• medicines reconciliation. | Consultation:<br>EMPHN RACF interviews (September 2015 – February 2016). |
| System design – Alternative models for infrastructure development | 'Green wedge' embargo on infrastructure development in Nillumbik requires co-design service planning around co-location and alternative delivery models. | Consultation:<br>• Council – Nillumbik Shire Council. |
| System design- Anti-microbial stewardship | Australia is amongst the highest users of antibiotics amongst OECD countries, with 75% of antibiotic prescribing coming from general practitioners. Antimicrobial resistance results in treatment failure, hospital admission for treatment with highly monitored and more toxic antibiotics, and threatens successful prophylactic therapy necessary for modern day routine | EMPHN 2016 -Antimicrobial stewardship – briefing paper: QUM program supporting a proactive |

| Outcomes of The Service Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| | practices. Up to 50% of patients who had a cold or upper respiratory tract infection had an antibiotic prescribed when it was not actually required.<br><br>Effective AMS programs in Australian hospitals have decreased antibiotic use by between 22% and 36%, improved patient care, improved appropriateness of antimicrobial use and reduced hospital resistance rates, as well as reduced morbidity and mortality. There is an opportunity to better utilise pharmacy in antimicrobial stewardship. | general practice response to antimicrobial resistance |
| Service accessibility – Primary health care | The use of outreach services presents an opportunity for the services in EMPHN to build the case for more innovative models of service delivery, such as increasing access through telehealth consultations. A preference for increased co-location services with shared administrative costs was expressed in community consultations, particularly in the outer areas. Future commissioning of services must consider such solutions to overcome the geographical barriers to access for consumers, and the financial disincentive for services. Survey respondents from the allied health sector highlighted a number of barriers for people with a chronic condition in accessing a regular GP, including corporate drop-in style practice models not supporting access to a regular GP and general practice availability: e.g. waiting lists and/or practice is closed after hours.<br><br>Allied health survey respondents reported the need for increased access to community-based specialist services for people experiencing disadvantage.<br><br>Availability, location and accessibility of primary and adjunct health care services:<br>• general lack of GP, specialist and support services (in context of greater demand) in Yarra Ranges and semirural/rural Kinglake; and<br>• no respite, rehabilitation services in Nillumbik, Kinglake. | ABS (2011), Census of Population; AIHW (2015), Workforce Data; CIV (2011, 2012), Transport proximity data; EMPHN CRM (2016); HICSA (2017), *Community engagement report*; VEMD (2014-15); University of Melbourne Department of General Practice November (2015), *Prevention of low and non-urgent presentations of children to emergency departments* (draft report).<br><br>Consultation:<br>• Council – City of Whittlesea; Manningham City Council; Maroondah City Council; |

| Outcomes of The Service Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| Service accessibility – Primary health care | Service locations in the east are mostly aligned with population. However, the north is home to a rapid growth corridor where the availability of service sites is not increasing in line with the growing population, causing greater travel distances for people seeking access to services. On the other hand, in Manningham, services are clustered in one area that is poorly serviced by public transport. Poor public transport options create a problem in the northern and outer areas.<br><br>There is a lack of services (in general) in the northern growth corridor (areas of recent [and anticipated to be ongoing] population growth): Nillumbik, Wallan, Whittlesea (and notably mental health services in Whittlesea).<br><br>Healthcare 'islands' were described in Whittlesea – namely northern Lalor, Thomastown, Mill Park and outer Epping.<br><br>Service accessibility in the outer north and Yarra Ranges areas is problematic due to distribution of services towards the more population-dense inner areas of those regions.<br><br>It was noted that Aboriginal and/or Torres Strait Islander people have difficulty accessing services in the outer east, with many having to travel long distances for dental procedures, eye and ear specialists, special testing etc.<br>Travelling to services is difficult for people who face issues leaving their homes due to physical and/or mental health or substance abuse issues. | Nillumbik Shire Council; Yarra Ranges Shire Council;<br>• CHS – Access Health and Community; Nexus Primary Health; and<br>• PCP – Hume Whittlesea PCP; North East PCP. |

| Outcomes of The Service Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| | It was also noted that, in situations where primary care givers are unavailable to provide care, Aboriginal and/or Torres Strait Islander clients are less likely to engage services and/or adequately monitor their health. | |
| Service accessibility – Specialty service needs | There are insufficient care facilities specific for:<br>• younger people who are currently housed in aged care facilities, e.g. acquired brain injury, younger onset dementia; and<br>• ageing people with a disability (functional and mental health). | Consultation:<br>• PCP – North East PCP; and<br>• EMPHN RACF interviews (September 2015 – February 2016). |
| Service accessibility – Specialist clinics | According to health.vic, in the first three quarters of the 2016-17 financial year, there were more than two million new specialist clinic appointments at Victorian local hospital networks. This is estimated to reach around 2.7 million for the entire 2016-17 financial year. Demand for specialist clinic services is increasing, "driven by an ageing population, the increasing burden of chronic disease and rising community expectations."<br><br>Patients attend specialist clinics for various reasons including:<br>• Initial referral to get specialist opinion and diagnosis;<br>• Pre-admission assessment;<br>• Treatment (may be a series of treatments); and<br>• Review and follow up to check outcomes and/or continuing symptoms.<br><br>Of the total number of specialist clinic appointments in Victoria, nearly 1.6 million, or 79%, are review appointments.<br><br>Austin Health noted the following issues with the current state:<br>• Default to "continued management" review letters, influenced by registrar and intern lack of confidence to discharge. | Commonwealth Department of Health (2013), *Specialist clinics in Victorian public hospitals: Access Policy*; EMPHN and Austin Health (2017), Managing specialist clinic review appointments at Austin Health through the development of secondary care pathways linking to primary care; Victorian Health Services Performance website, *Specialist Clinics activity data*, accessed 10/7/2017. |

| Outcomes of The Service Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| | • "Specialist Culture," in which specialists, GPs and patients see specialist clinics as the only option for care thereby bolstering referrals.Medical workforce model where clinic workforce is visiting or at a low EFT.<br>• Unit and individual clinician variation and discharge ratios.<br>• Consumer preference, as Public Health appointments (including specialist appointments) incur no direct consumer cost.<br>• Medico-legal considerations and management of discharge risk.No established secondary care/primary health partnerships, leading to lack of confidence in clinical handover. | |
| Service accessibility – end of life care | In the development of the EMPHN End of Life Care Improvement model and literature review, it was noted that Australia's rate of dying at home is comparatively lower than other similar OECD countries. According to the Grattan Institute report, Dying Well (Sept. 2014) 54% of patients die in hospital, 32% die in residential care and 14% die at home, despite surveys consistently showing more than 60% of Australians would prefer to die at home. Whilst there are many reasons for a patient to be admitted into hospital at end of life, many services report that there are cases where patients could have died at home, with appropriate support.<br><br>The Grattan Institute report, Dying Well (Swerrissen and Duckett, 2014) states "in the next 25 years the number of Australians who die each year will double. People want to die comfortably at home, supported by family and friends and effective services." Whilst acknowledging that people want to be able to die in their place of choice, there are numerous factors that preclude this from happening for many people.<br><br>Survey data from local end of life care providers identified the following barriers to patients dying in their desired location: | EMPHN (2017), *End of life care - improvement model*; Swerissen, H and Duckett, S. (2014), *Dying Well. Grattan Institute*. |

| Outcomes of The Service Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| | • Priority 4. Individualised holistic care – including isolated/difficult to reach people/cultural and ethical issues/disabilities.<br>• Priority 5. Availability of resources to support people to die in their place of choice – physical and financial.<br>• Priority 6. Staff and/or family unwillingness/ability to follow EOLC plans – resources, practicality, knowledge, capability, comfortable with choices.<br>• Priority 7. Addressing variation in understanding of patient centred care.<br>• Priority 8. Staffing skill mix to provide EOLC in Residential Aged Care Facilities.<br>• Priority 9. Staff recognising end of life and then being comfortable with having appropriate discussions with families – identification of dying, the timing of the conversations and all options being discussed, cultural differences around language.<br>• Priority 10. Advanced Care Plans – ensuring the 'where' is part of the planning – not just 'how'. | |
| Service accessibility – Primary health care: Transport | Inconveniently distributed or orphaned services and location at sites poorly served by public transport create access barriers:<br>• scattered service locations in Maroondah;<br>• services at distance from coordinated public transport networks in: Manningham (of note: Warrandyte), Whittlesea (of note: Mernda), in servicing Maroondah Hospital, Boroondara (Balwyn North) and in outer east and isolated areas off highway (Yarra Valley-Warburton); and<br>• Manningham has poor transport access and experienced recent bus route cuts. Although it is within the catchment of some services, many choose not to locate a branch within the region, increasing travelling distance for clients. | ABS (2011), Census of Population; AIHW (2015), Workforce Data; CIV (2011, 2012), Transport proximity data; EMPHN CRM (2016); HICSA (2017), *Community engagement report*; University of Melbourne Department of General Practice November (2015), *Prevention of low and non-urgent presentations of children to emergency departments* (draft report); VEMD (2014-15). |

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| Identified Need | Key Issue | Description of Evidence |
| | Travel is often too costly and lack of adequate public transport makes it difficult for many Aboriginal and/or Torres Strait Islander people to access services. | Consultation:<br>• Council – City of Whittlesea; Manningham City Council; Maroondah City Council; Nillumbik Shire Council; Yarra Ranges Shire Council;<br>• CHS – Access Health and Community; Nexus Primary Health;<br>• PCP – Hume Whittlesea PCP; North East PCP; and<br>• NGO – Whittlesea Community Connections; Women's Health East. |
| Service accessibility – Affordability | Affordability of care is challenging in areas of greatest social disadvantage, for those experiencing unemployment and for CALD communities:<br>• general disadvantage in areas of Knox, Mooroolbark, West Heidelberg, Watsonia, Whittlesea, Yarra Valley;<br>• masked disadvantaged in generally more affluent areas: St Andrews, pockets of asset-rich/cash poor elderly in Boroondara, pockets of general disadvantage in Boroondara, Manningham and Nillumbik; and<br>• above-average rate of delayed presentation for care and deferral of prescribed medication purchases in Banyule, Maroondah, Knox, Whittlesea-Wallan and Yarra | ABS (2011).<br><br>Consultation:<br>• Council – Banyule City Council; City of Boroondara; Manningham City Council; Nillumbik Shire Council; Yarra Ranges Shire Council; and<br>• CHS – Link Health and Community. |

| Outcomes of The Service Needs Analysis – General | | |
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| Identified Need | Key Issue | Description of Evidence |
| | Ranges, with uninsured patients in Nillumbik-Kinglake, Ashwood, Mulgrave, Oakleigh, Clayton. | |
| Service accessibility – Culturally safe primary health care: Identification of Aboriginal and/or Torres Strait Islander people | Under-identification of Aboriginal and/or Torres Strait Islander clients:<br>• Many clients do not identify until trust has been established (requires continuity of care) due to fear of experiencing discrimination, stigma and racism.<br>• Aboriginal and/or Torres Strait Islander people consulted in the Koolin Balit workshop stated that staff usually did not ask if they identify.<br><br>Access to suitable services for Aboriginal and/or Torres Strait Islander clients:<br>• Centralisation of Aboriginal health services creates access difficulties and disincentive for the greater numbers of clients in catchment's outer areas needing culturally appropriate care:<br>○ no local, culturally appropriate specialty services provision; and<br>○ affordability is an issue, compounded by limited bulk-billing.<br>• Many mainstream services do not demonstrate an appropriate understanding of transgenerational trauma associated with Indigenous-colonial relations and its impacts on Aboriginal and/or Torres Strait Islander peoples' mental health, AOD use, suicide rates, children in out-of-home care and overall health and wellbeing:<br>○ a significant issue for community members is that many mainstream services are not culturally appropriate;<br>○ it was noted that if staff were not providing culturally appropriate care, clients wanted to leave the service as soon as possible, even against medical advice and/or would neglect to attend multiple appointments; and | ABS (2011), Census of Population; HICSA (2017), *Community engagement report*, Inner East: Department of Health EMR Koolin Balit and Aboriginal Health Community Consultation Workshop (September 2013).<br><br>Consultation:<br>• Council – Yarra Ranges Shire Council;<br>• CHS – healthAbility; Mullum Mullum Indigenous Gathering Place;<br>• LHN – Eastern Health;<br>• EMPHN General Practice Survey (October 2016); and<br>• EMPHN Allied Health Survey (October 2016). |

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| Identified Need | Key Issue | Description of Evidence |
| | ○ community members want staff on hand who they know and trust. Many have felt let down by mainstream services and are becoming more reluctant to engage those services again.<br>• Service providers often assume that Aboriginal and/or Torres Strait Islander community members can access their service, have a means of contacting them, and are aware of the services they offer and what financial support is available:<br>○ community members have difficulty arranging appointments when they do not have phone or internet access. Many people seek assistance from Aboriginal services with scheduling appointments and for information about available services; and<br>○ a perceived lack of financial support prevents some community members from accessing services.<br>• Some service providers can come across as insensitive, rude, uncaring, and seen by the community as just 'ticking a box.'<br><br>Around three-quarters of general practice survey respondents (to this item) from general practice indicated that Aboriginal and/or Torres Strait Islander clients, and in particular children and youth under 18 years, did not tend to present (or were not being identified as attending) their practice. This was confirmed by the majority of allied health survey respondents. | |
| Service accessibility – Culturally safe primary health care: Access for | Prolonged waiting periods for refugee mental health services were described:<br>• gap-fill services needed to counter long wait times and red tape processes; and<br>• lack of services supporting mental health and wellbeing noted for refugee youth in Nillumbik, Afghan community in south east. | Consultation:<br>• CHS – AMES Australia; healthAbility; Link Health and Community; |

| Outcomes of The Service Needs Analysis – General | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| refugee/asylum seeker/CALD populations | There are insufficient early years and childcare support services (health and/or education).<br><br>Service barriers exist for asylum seekers due to fee-for-service (versus no out-of-pocket for refugee clients) in respect of infectious diseases treatment (Hepatitis B, Tuberculosis).<br><br>More than half of general practice survey respondents from general practice indicated that people from culturally and linguistically diverse communities, refugee and asylum seeker clients, and in particular children and young people under 18 years, did not present to their practice. This was confirmed by survey respondents from the allied health sector.<br><br>Workforce:<br>• more refugee health nurses are required; and<br>• more interpreters (qualified, rarer languages) are required. | • NGO – Women's Health in the North;<br>• EMPHN General Practice Survey (October 2016); and<br>• EMPHN Allied Health Survey (October 2016).<br><br>Refugee health service referral pathways mapping consultation:<br>• CHS – AMES Australia; headspace; Plenty Valley CH. |
| Service accessibility – Culturally safe primary health care: Responsiveness to risk | Lack of refugee and emerging CALD groups-oriented infectious diseases planning response noted in the north. | Consultation:<br>• CHS – Nexus Primary Health. |
| Service accessibility – Culturally appropriate sexual and | There is increasing refugee/asylum seeker/CALD settlement with unique and culturally sensitive health considerations, including:<br>• a tradition of female genital cutting; and<br>• poor/absent history of cancer screening | Consultation:<br>• NGO – Women's Health East; Women's Health In the North. |

| Outcomes of The Service Needs Analysis – General | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| reproductive health services | Community understanding and awareness of regular screening opportunities is low.<br><br>There is momentum within the region for addressing local sexual and reproductive health needs and access issues to services with the following leading regional initiatives with a variety of health agency partners, including the PHN:<br>• Shared Vision for the North<br>• Women's Health East<br>• Women's Health in the North<br><br>Actions look at increased primary care workforce capacity to address consumer need for long acting contraception, medical termination of pregnancy, sexual and reproductive health literacy, health screening and HPV vaccination, local advocacy and service access improvement.<br>The regional Sexual and Reproductive Health needs assessments undertaken by these initiatives have identified sexual and reproductive health service gaps to include:<br>• service coordination through shared health summaries– eHealth;<br>• coordinated care – catchment based planning;<br>• there is no specialist, comprehensive sexual and reproductive health service based in Hume or Whittlesea;<br>• sexual education is often not comprehensive enough and is inconsistent across Hume and Whittlesea;<br>• there is limited access to free condoms, these are most commonly available through needle exchange services;<br>• there are limited providers of long acting reversible contraception (LARC) and prescribers are often not publicised; | Target groups: African origin, Sri Lankan and Arabic/ Persian-speaking CALD immigrants, noted as settling in outer areas, during consultation with:<br>• Council – City of Whittlesea; Nillumbik Shire Council;<br>• CHS – AMES Australia; and<br>• PCP – North East PCP; Outer East PCP.<br>Regional Strategies – Going South in the North (WHIN), SRH Action Plan (WHE), Shared Vision for the North Sexual & Reproductive Health Strategy, Eastern Melbourne Primary Health Care Collaborative<br><br>Women's Health In the North 2016, Sexual and reproductive health of young women - evidence brief and issue analysis.<br>Women's Health in the East 2015, Sexual & Reproductive Health Needs Assessment<br>Gafforini, S.A. 2016. Outer Northern Prevention Taskforce: Sexual and |

| Outcomes of The Service Needs Analysis – General | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| | • GPs do not always provide the sexual and reproductive health services women seek and care depends on practitioner youth friendliness; and<br>• emergency contraception is often not understood and is too expensive for young people to purchase.<br>• Medical Termination of Pregnancy availability in the East is limited and hindered by provider perceptions that current practices and systems do not mitigate the associated clinical risks. Recent diagnostics noted that there is a need for an integrated approach with hospitals for surgical intervention in the case of retained products following a medical termination (utilising medication as opposed to surgical means for termination) or unintended reactions to medication. Radiology for ultrasound and secondary consultation support is needed in order to increase availability in the region.<br>• Advocacy is required for more comprehensive Medicare-funded STI screening programs in order to increase screening rates of youth. | Reproductive Health Prevention Action Plan Report, Hume Whittlesea Primary Care Partnership. |
| Service accessibility – RACF access to after-hours primary medical care | Lack of access after-hours to a practitioner willing to prescribe medicines for end-of-life management has led to unnecessary hospital transfers. | Consultation:<br>• GP working extensively in RACF in the EMPHN catchment. |
| Presence of ill health or disease – Specialist aged care services | Survey respondents from the allied health sector indicated the increasing ageing population and the health issues of ageing, such as senile dementia, as key existing or emerging issues in the community. | Australian Commission on Safety and Quality In Healthcare (2015), *Australian Atlas of Healthcare Variation.* |

| Outcomes of The Service Needs Analysis – General | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| | Inadequate resources to manage aggression in RACF residents with dementia in Boroondara have purportedly resulted in high (second percentile) antipsychotic use. | Consultation:<br>• EMPHN RACF interviews (September 2015 – February 2016); and<br>• EMPHN Allied Health Survey (October 2016). |
| Service needs – Childhood immunisation | Anecdotal reports from general practice indicate suspicion that low catch-up rates of vaccination, particularly in Monash, accounts for a proportion of suboptimal immunisation rates. Therefore, whilst community awareness and education is an important tenet of increasing immunisation coverage, support to proactively engage and support those in catch up programs will also be key to improving immunisation rates, underlining the key role of general practice in immunisation coverage.<br><br>Key themes emerging from the EMPHN immunisation forum for providers include:<br>• Each local government area is very different.<br>• Coverage rates tell just part of the story.<br>• Hesitant parents account for a small proportion of the non-immunised population.<br>• Understanding the community is important to increasing immunisation rates.<br>• There have been significant improvements in immunisation rates for Indigenous children. The learnings from this can help inform ongoing improvements.<br>• Targeting can be effective.<br>• There are issues with consent card return and GP reporting.<br>• There are issues with data, e.g. families moving out of an area and not changing their address, etc. | Juliet Frizzell Consulting (2017), *Report on the EMPHN childhood immunisation forum: Who isn't immunised and why?* |

| Outcomes of The Service Needs Analysis – General | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| | The main barriers are:<br>• Resources<br>• Time<br>• Where immunisation sits within organisational structures (in health or family services)<br>• Need for catch-up immunisations | |
| General practice identified learning and development gaps | Eastern Melbourne PHN has collected and collated event feedback on education needs since August 2015. The main areas identified by providers for further education include:<br>• Paediatrics<br>• Asthma and COPD<br>• Mental health<br>• Pregnancy<br>• Emergencies<br>• Palliative care<br>• Diabetes<br>• Chronic disease management<br>• Dermatology<br>• Fractures<br>• Oncology | EMPHN (2017), E*astern Melbourne GP education alliance presentation 31 July 2017*. |

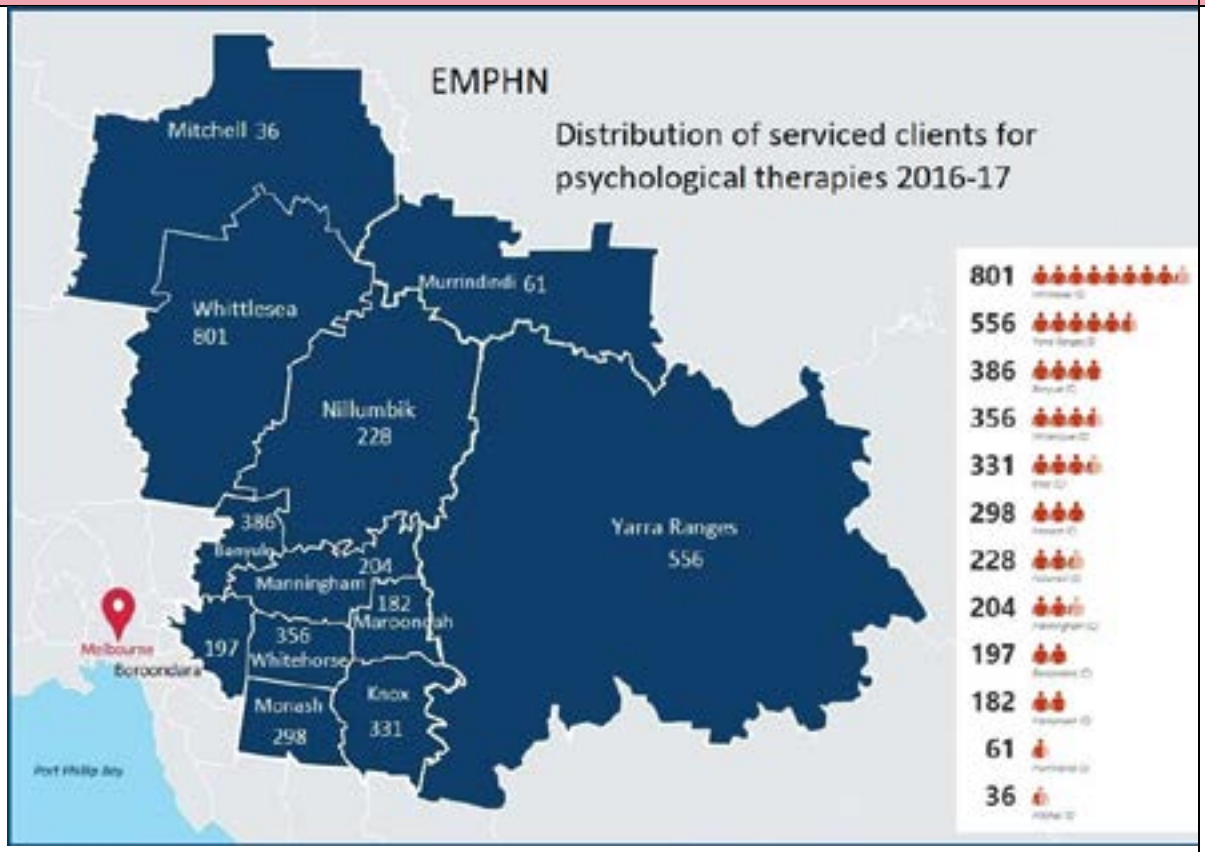
## Outcomes of the Service Needs Analysis – Mental Health

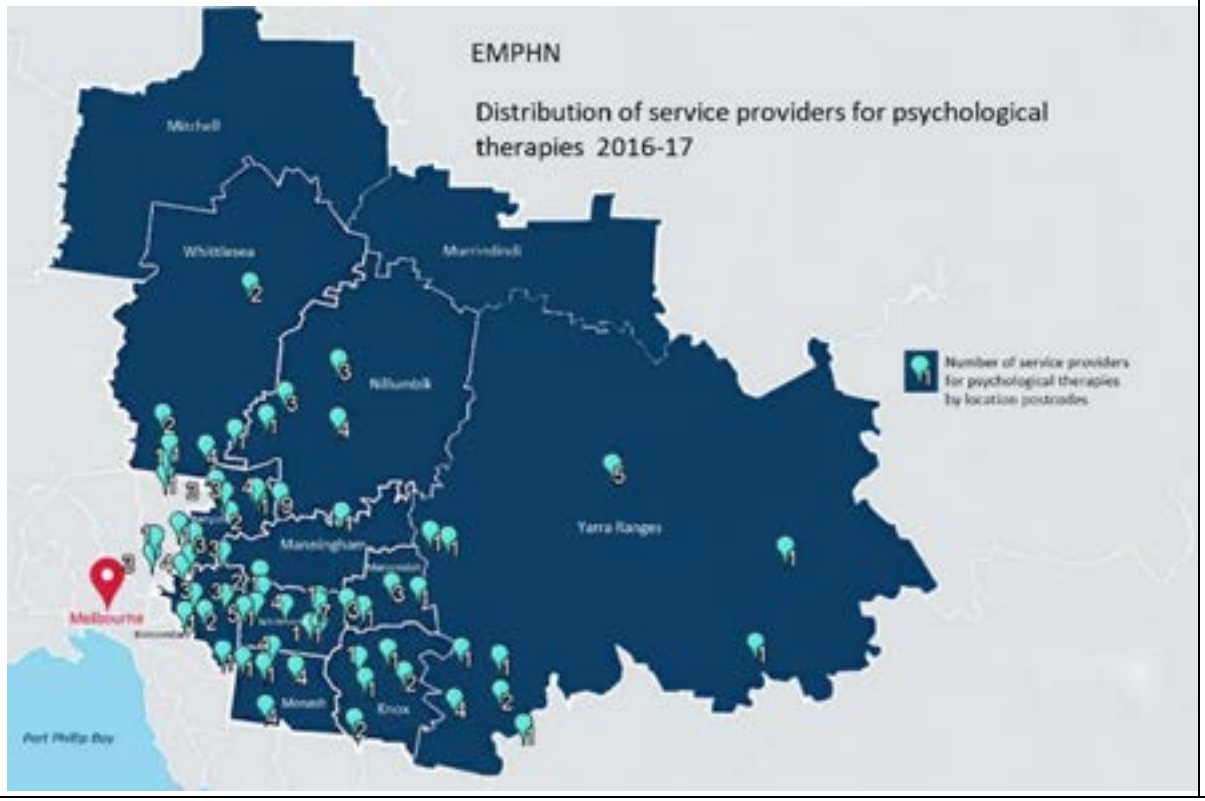
| Outcomes of the Service Needs Analysis – Mental Health | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Service accessibility – Mental health services for diverse communities | Diverse communities face the following mental health challenges:<br>• apparent under-representation of CALD populations, relative to their numbers in the community, accessing community-based mental health and AOD services in the Eastern Metropolitan region;<br>• paucity of mental health services catering to refugees, CALD community members and people from non-English speaking backgrounds;<br>• ageing CALD groups in Manningham (Bulleen); and<br>• large CALD population with mental health needs and coincident levels of social disadvantage in Banyule and Monash.<br><br>Extensive consultative work has been done towards identifying the 'hard to reach' populations with mental health care needs. All these identified groups experience barriers to accessing health services, both mental health and other health services, for a number of reasons. Consultation shows that these community members are perceived as at significant risk of experiencing poor health outcomes across the lifespan.<br><br>These groups include those who:<br>a. do not have consistent /readily available access to mental health services<br>b. experience one or more barriers to accessing mental health and other health services<br>c. are likely to have low service uptake with respect to mental health and other health services<br>d. are underserviced through existing psychological therapy services due to workforce limitations, and/or unsuitability of available services | EACH (2015), *Eastern Metropolitan Region Integrated Mental Health and Alcohol and Other Drugs Catchment Plan 2016-18*;EMPHN (August 2017), *Hard to reach target groups community collaboration identification project*, version 1 Report; Commonwealth Department of Health (2016), The PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Psychological Therapies Provided by Mental Health Professionals to Underserviced Groups; Plenty Valley Community Health (2016), *Evidence brief and issue analysis – Promoting mental health among refugee and asylum seeker children and families.* Report; Commonwealth Department of Health (2016), The PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: |

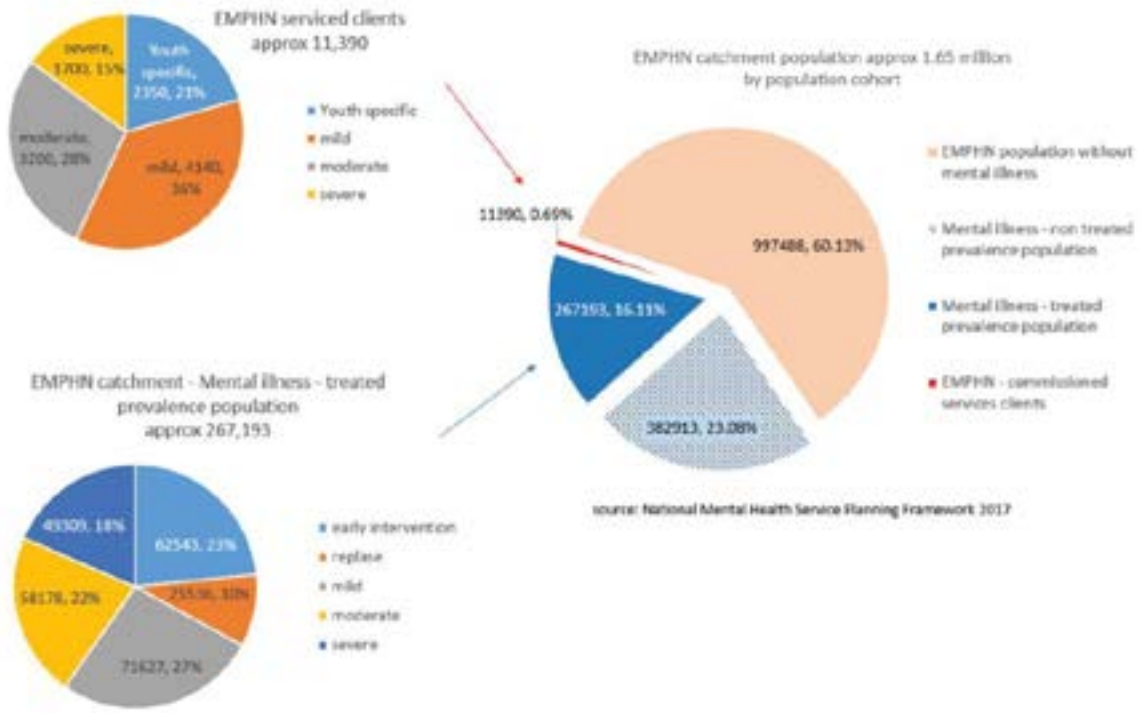
| Outcomes of the Service Needs Analysis – Mental Health | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| | e. are likely to experience poor health outcomes because of a) – d) and likely to have negative experiences of a number of biological, psychological and social health determinants.<br>EMPHN is home to a considerable number of cohorts meeting these criteria, and the list extends beyond that outlined in the Operational Guidelines for Access to Allied Psychological Services (ATAPS) and PHN guidance documentation on underserviced groups. Consideration of local needs assessments is therefore extremely important. With the addition of key groups identified at consultation the list then includes:<br>• People living in rural and remote communities/geographic isolation<br>• Children under the age of 12 years<br>• People experiencing, or at risk of, homelessness<br>• Women experiencing perinatal depression<br>• Single parents/women with young children (without support)<br>• Males/fathers<br>• Adolescents, early school leavers and youth<br>• People in the LGBTIQ community<br>• Older people<br>• People with intellectual disability<br>• People from culturally and linguistically diverse (CALD) backgrounds<br>• Humanitarian entrants<br>• Population groups that are the subject of separate guidance material (Aboriginal and Torres Strait Islander people, people at risk of suicide and young people)<br>• Carers, including child carers, and carers with MH issues<br>• People who have difficulty identifying MH symptoms | Psychological Therapies Provided by Mental Health Professionals to Underserviced Groups; State Government of Victoria-Department of Health and Human Services (August, 2016), *Refugee and asylum seeker health settlement in Victoria*. Fact sheet, available from https://www2.health.vic.gov.au/about/populations/refugee-asylum-seeker-health#lp-h-7<br><br>Consultation:<br>• Council – Manningham City Council; Maroondah City Council; Nillumbik Shire Council;<br>• CHS – Access Health and Community; AMES Australia; Banyule CHS; Link Health and Community;<br>• NGO – Whittlesea Community Connections;<br>• EMPHN General Practice Survey (October 2016); and |

| Outcomes of the Service Needs Analysis – Mental Health | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| | • People affected by PTSD (includes natural disasters such as storm and bushfire)<br>• People resistant to receiving MH services<br>• People at risk of MH issues or undiagnosed<br>• People with a dual diagnosis (i.e. MH and co-morbid AOD issues)<br>• People experiencing family breakdown and/or family violence.<br><br>Plenty Valley Community Health's own evidence brief and issues analysis (focused on refugee and asylum seeker mental health) highlights issues that should be noted in consideration of mental health service planning in the catchment:<br>• Children of refugees and asylum seekers are as vulnerable as adults and, with vulnerable women and young people, are considered a priority;<br>• Victoria has the largest intake of humanitarian arrivals in Australia, settling around 4000 refugees each year, while another 11,000 asylum seekers live in the Victorian community on bridging visas awaiting the determination of their refugee status (38% of national total);<br>• Some asylum seekers are Medicare ineligible which can negatively impact service access. (NB. Medicare status is usually linked to visa status and so may change during the refugee determination process.)<br>• Linkages with housing/resettlement assistance need to be considered. | • EMPHN Allied Health Survey (October 2016). |
| Service accessibility – Mental health services general | Suboptimal alignment of location with areas of greatest need — paucity of services in new growth areas and in outlying areas of disadvantage:<br>• Whittlesea – poor transport links;<br>• Yarra Ranges – poor transport services and few service hubs; | cohealth (2015), North Western Region Catchment Based Mental Health Community Support Strategic Plan 2015-18; EACH (2015), Eastern |

| Outcomes of the Service Needs Analysis – Mental Health | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Service accessibility – Mental health services: General | • Manningham – drift in distribution of services in established area. Services covering Manningham catchment have moved out of the municipality in recent years, creating accessibility issues. No rail network and poor bus services, particularly in Warrandyte.<br>• Whittlesea has just two ATAPS providers in outer areas and is in the bottom 10 (state-wide) of numbered services per 1000 head of population.<br>• In 2016-17, at least one-third of clients residing in the suburb of Whittlesea had to travel a considerable distance to receive mental health services and transport access difficulties may well be a contributing factor in the relatively higher percentage in outer areas of non-attendance for psychological services. For example, clients residing in the suburb of Whittlesea, 74% travelled an average distance of 25 km to receive psychology therapies from the cluster of service providers in the southern part of this region, or from the neighbouring North East region that includes Banyule and the Nillumbik-Kinglake area.<br>• In 2016-17, a significant amount of resources for psychological therapy had been shifted to service clients in areas identified with higher needs. For example, in comparison with 2015-16, there was a 39% increase in the number of sessions delivered for Whittlesea, 26% increase for Yarra Ranges, 32% increase for Maroondah and 58% increase for Banyule. The map below demonstrates the distribution of serviced clients for psychological therapies | Metropolitan Region Integrated Mental Health and Alcohol and Other Drugs Catchment Plan 2016-18; EMPHN (2017), *Navigating the transition of PIR to NDIS. Report*; Fixus database (2016-17), *EMPHN providers and service location data;* PHIDU (2011-13); VEMD (2014-15).<br><br>Consultation:<br>• Council – Manningham City Council;<br>• CHS – Access Health and Community;<br>• PCP – Hume Whittlesea PCP;<br>• EMPHN Provider Survey (February 2016);<br>• EMPHN General Practice Survey (October 2016); and<br>• EMPHN Allied Health Survey (October 2016).<br>• ConNectica Consulting. Mental Health Stepped Care Model – |

| Outcomes of the Service Needs Analysis – Mental Health | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Service accessibility – Mental health services: General |  <br>Whilst the following map demonstrates that the current service providers for those psychological therapies are in line with the population spread, the areas of higher use overall have less service locations and thus longer distances to travel to access services. Hence why | EMPHN Stakeholder Forum Notes. (September 2017).<br>• EMPHN funded program use statistics 2017 |

| Outcomes of the Service Needs Analysis – Mental Health | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| | better use of online options is indicated to potentially supplement the face to face access of services to ensure consumers remain supported an engaged.   | |

| Outcomes of the Service Needs Analysis – Mental Health | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| |  <br>The figure above details the estimated prevalence of mental illness versus use of EMPHN funded services. This does not account for General Practice, Acute or other funded services. This shows whilst only a small percentage of the population is currently reached through EMPHN funded services, service use is predominantly for mild-moderate mental health needs. Prevalence data of mental illness severity suggests that moderate and severe are predominant needs and presents a challenge with the transition of services to NDIS for severe mental illness that a potential gap may be seen in this reform approach. | |

| Outcomes of the Service Needs Analysis – Mental Health | | |
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| Identified Need | Key Issue | Description of Evidence |
| | Suggestion of suboptimal service access exacerbated by policy.<br>• Existing referral pathway guidelines bind community mental health nurses to registration with a single general practice. (Practitioner recommendation to open up referral pathways to Community Mental Health Nurses [CMHN] in northern area to more than a single practice).<br>• One allied health survey respondent also noted access to psychological support for people who are ineligible for the NDIS as a key existing or emerging issue in the community.<br><br>Partners in Recovery consumers will be gradually transitioned from the PIR program to the NDIS as the reforms roll out throughout our region. The NDIS became available in the north-eastern Melbourne area from 1 Jul, 2016, and the outer eastern area from 1 Nov, 2016. Continuity of care for the severe and persistent mentally ill is a potential challenge under the new scheme. A smooth transition and continuity of care is needed for those who are not eligible for, or choose not to take up the NDIS, and for those who are under NDIS who may still need clinical mental health services. Support for the phased transition by geographic region is underway and required services are included in the Stepped Care model.<br><br>Consumers group-interviewed by ConNetica Consulting on the transition to Stepped Care raised the following perceived priorities within an urgency framework. Based on a 'Now', 'Soon' and 'Later' scheduling, these priorities were:<br><br>**Now**<br>• Better diagrams to explain clinical staging and stepped care to consumers; | |

| Outcomes of the Service Needs Analysis – Mental Health | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| | • Collaborative Care – Ensuring social services, housing, stakeholders, all involved are engaged and take ownership over this new model of care;<br>• Ensuring the consumer is cared for during transition between services and between the old and new model;<br>• Facilitation of building networks and relationships between services before roll out of model.<br>**Soon**<br>• Education so everyone understands what is happening;<br>• Articulating the logistical changes required when moving through the stepped care model;<br>• Increasing technological literacy in hard to reach, vulnerable and ESL populations;<br>• Reinforcing better communication and cohesion between services.<br>**Later**<br>• Service delivery that is holistic in nature– including multidisciplinary teams that focus on both mental and physical health;<br>• Place emphasis on individualised care packaging and improving links to partnered services;<br>• Having ability to step back into stepped care model at any stage without having to retell consumer story repeatedly;<br>Simplification of eligibility criteria, funding models, certainty around service delivery and reduction of being turned away from services due to complex criteria. | |

<table>
<tr><th colspan="3">Outcomes of the Service Needs Analysis – Mental Health</th></tr>
<tr><th>Identified Need</th><th>Key Issue</th><th>Description of Evidence</th></tr>
<tr><td></td><td>Survey of EMPHN catchment general practices indicated the need for greater support structures for general practice-coordinated management of patients with psychological conditions.<ul><li>Over half of general practice survey respondents nominated patients with psychological conditions as amongst those whom they felt least supported to manage;</li><li>Approximately one-quarter of general practice survey respondents asked to nominate required or deficient services or service pathways indicated a mental health care service issue or need. A common theme was the need for public mental health care: bulk-billing psychiatrists or other mental health services.</li></ul>Carer issues of stress/depression/anxiety/post-traumatic stress disorder (PTSD)/fatigue/inability to address their own health issues were described, along with a lack of low-cost or no-cost counselling/support/monitoring for high prevalence mental health issues, that is, anxiety, depression.</td><td></td></tr>
<tr><td>Service Access – Mental Health, Acute</td><td>Use of ED services by region for the key disorder groups demonstrates that overall Anxiety followed by Depression constitute the higher percentage of ED visits across all triage codes<br>Table 1 ED presentations for the financial year 2015/16, all triage codes
<table>
<tr><th></th><th>North</th><th>North East</th><th>Inner East</th><th>Outer East</th></tr>
<tr><td>Anxiety</td><td>404</td><td>285</td><td>673</td><td>670</td></tr>
<tr><td>%</td><td>38.3%</td><td>42.9%</td><td>33.5%</td><td>32.2%</td></tr>
<tr><td>Bipolar affective disorder</td><td>30</td><td>15</td><td>68</td><td>56</td></tr>
<tr><td>%</td><td>2.8%</td><td>2.3%</td><td>3.4%</td><td>2.7%</td></tr>
<tr><td>Depression</td><td>273</td><td>172</td><td>575</td><td>740</td></tr>
<tr><td>%</td><td>25.9%</td><td>25.9%</td><td>28.7%</td><td>35.6%</td></tr>
</table></td><td>VEMD (2016-17)</td></tr>
</table>

| Outcomes of the Service Needs Analysis – Mental Health | | | | | | |
|---|---|---|---|---|---|---|
| Identified Need | Key Issue | | | | | Description of Evidence |
| | Schizophrenia | 93 | 45 | 262 | 200 | 600 |
| | % | 8.8% | 6.8% | 13.1% | 9.6% | 10.3% |
| | Mental disorder due substance abuse | 151 | 108 | 331 | 330 | 920 |
| | % | 14.3% | 16.2% | 16.5% | 15.9% | 15.9% |

Whilst for semi-urgent and non-urgent (Category 4 & 5) the overall numbers are reasonably low, there is a markedly higher percentage of presentations for anxiety related issues compared to other disorder groupings. This may be related to panic attack symptoms and the somatic experience mimicking that of serious physical health events such as heart attack, indicating management by self or community provider of anxiety symptoms may have the potential to reduce Category 4 & 5 ED presentations and thus acute negative experiences for consumers.

*Table 2 ED presentations for the financial year 2015/16, triage codes 4 & 5*

| | North | North East | Inner East | Outer East |
|---|---|---|---|---|
| Anxiety | 157 | 134 | 360 | 320 |
| % | 57.3% | 57.8% | 46.4% | 40.1% |
| Bipolar affective disorder | 5 | 3 | 21 | 24 |
| % | 1.8% | 1.3% | 2.7% | 3.0% |
| Depression | 59 | 52 | 214 | 290 |
| % | 21.5% | 22.4% | 27.6% | 36.3% |
| Schizophrenia | 11 | 10 | 67 | 60 |
| % | 4.0% | 4.3% | 8.6% | 7.5% |
| Mental disorder due substance abuse | 26 | 31 | 77 | 85 |

| Outcomes of the Service Needs Analysis – Mental Health | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| | % 9.5% 13.4% 9.9% 10.6% | 10.5% |
| Service accessibility – Children and youth services | A lack of services specifically catering to the needs of children and young people was described. Hotspots were created by:<br>• service gaps in Manningham resulting from movement of services out of the municipality; and<br>• Nillumbik having a large youth population and high problematic use of alcohol and other drugs.<br><br>There is identified service gap between the primary Mental Health care support provided by headspace and that of the Tertiary Early Psychosis services. EMPHN has recently directed $2.5 million to programs for young people with severe psychological distress. | cohealth (2015), *North Western Region Catchment Based Mental Health Community Support Strategic Plan 2015-18*; EACH (2015), *Eastern Metropolitan Region Integrated Mental Health and Alcohol and Other Drugs Catchment Plan 2016-18*; EMPHN (2017, July 13), *$2.5M to help young people with severe psychological distress* – media release.<br><br>Consultation:<br>• Council – Manningham City Council; and<br>• CHS – healthAbility. |
| System design – Integrated services | Allied health survey respondents reported the need for improved service coordination between mental health and AOD services.<br><br>Very few services cover the client from illness recognition right through to crisis, save for telephone advice, help and referral lines. There is a gap where consumers will need to exit one service and enter another, creating a risk for continuity of care. | EACH (2015), *Eastern Metropolitan Region Integrated Mental Health and Alcohol and Other Drugs Catchment Plan 2016-18*; EMPHN (2017), *Mental Health Stepped Care Model Discussion Paper.*<br><br>Consultation: |

| Outcomes of the Service Needs Analysis – Mental Health | | |
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| Identified Need | Key Issue | Description of Evidence |
| | EMPHN has initiated the phased implementation of a Stepped Model of Care to be introduced in Jan 2018 for the outer north and north east region (Whittlesea, Nillumbik, Banyule, parts of Mitchell and Murrindindi). The Stepped Model of Care seeks to reddress service gaps for hard to reach groups and address continuity of care for existing clients, byaccommodating variation in client acuity and facilitating their access to the right care, at the right time and place. | • EMPHN Allied Health Survey (October 2016). |

## Outcomes of the Service Needs Analysis – Alcohol and Other Drugs

| Outcomes Of The Service Needs Analysis – Alcohol And Other Drugs | | |
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| Identified Need | Key Issue | Description of Evidence |
| Service accessibility – Access to services: General | Several survey respondents from the allied health sector expressed a need for better access to addiction specialists and credentialed mental health nurses with capability/interest in AOD.<br><br>Services for carers of people with substances abuse issues were reported as wanting. Carers, too, often experience a range of negative health outcomes such as stress, depression, anxiety, PTSD, fatigue and an inability to address their own health issues.<br><br>**Access to Treatment Services**<br>A review by AIHW of alcohol and other drug treatment services (publicly funded AOD treatment service agencies only) in Australia showed that 1 in 160 people in Victoria received treatment. Counselling, withdrawal management, and assessment only were overall the most common types of treatment, with counselling the most common principal treatment type provided for clients (37% of episodes).<br><br>Principal drugs of concern for this treatment have remained alcohol, cannabis, amphetamines, and heroin since 2006–07, however treatment episodes for amphetamines rose by 175% over 5 years, indicating a key focus for service delivery.<br><br>For clients aged 30 and over, alcohol was the most common principal drug of concern, whilst cannabis was the most common for those aged 10-29 years.<br><br>Figures 3-6 below provide a geographic representation of the rates of treatment episodes in relation to the population for different substance abuse types; alcohol, amphetamines, cannabis and heroin respectively. | Consultation:<br>• EMPHN Allied Health Survey (October 2016).<br>• AIHW 2017. Alcohol and other drug treatment services in Australia 2015–16. Drug treatment series no. 29. Cat. no. HSE 187. Canberra: AIHW |

| Outcomes Of The Service Needs Analysis – Alcohol And Other Drugs | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| |  <br>Figure 3 Rates of treatment episodes for Alcohol abuse 2014-15<br><br>Numbers of consumers accessing treatment services for alcohol abuse were noticeably higher within the Outer East region compared to other sub-regions. Of all substances, treatment rates for alcohol were the highest and almost double that where amphetamine was the principal substance of misuse. | |

| Outcomes Of The Service Needs Analysis – Alcohol And Other Drugs | | |
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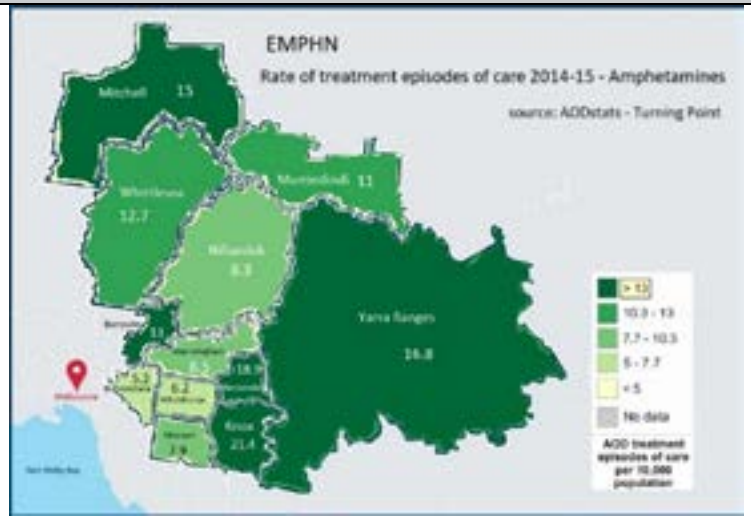
| Identified Need | Key Issue | Description of Evidence |
| |  <br>Figure 4 Rates of treatment episodes for Amphetamine abuse 2014-15<br><br>Amphetamine treatment was largely spread across the catchment, however the areas of highest treatment rates per 10,000 of the population again were in the Outer East. | |

| Outcomes Of The Service Needs Analysis – Alcohol And Other Drugs | | |
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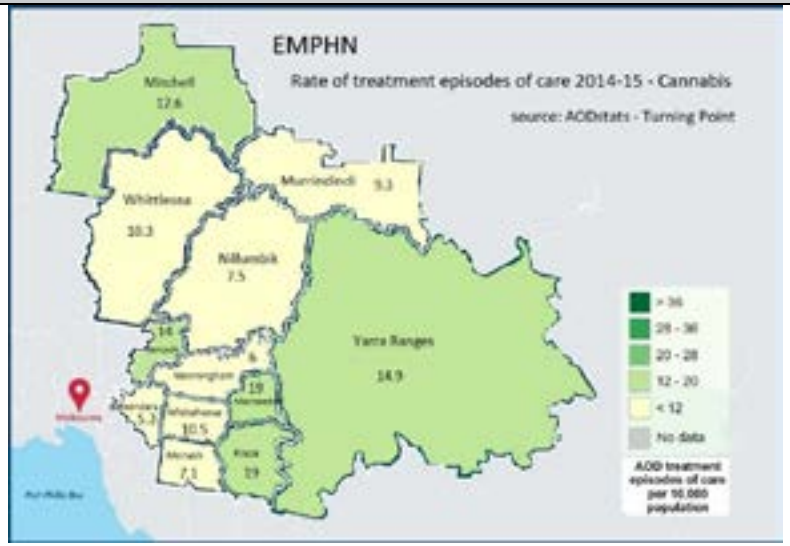
| Identified Need | Key Issue | Description of Evidence |
| |  <br>Figure 5 Rates of treatment episodes for cannabis abuse 2014-15<br><br>Cannabis use treatment rates were lower than treatment episodes for amphetamine use. Again, Outer East local government areas featured in the higher rates with the Northern areas (particularly Banyule and Mitchell) closely behind. It is not clear, however, whether higher rates of substance use or higher occurrences of help-seeking behaviour are driving the higher treatment episode rates in these areas. | |

| Outcomes Of The Service Needs Analysis – Alcohol And Other Drugs | | |
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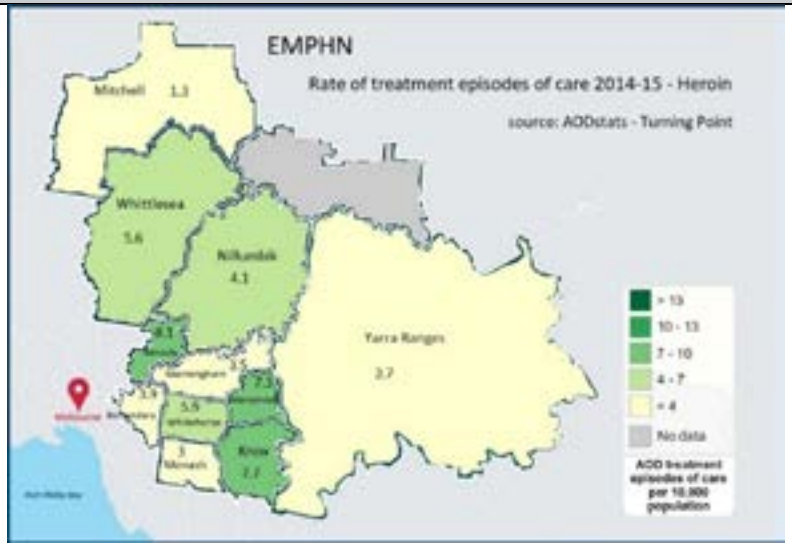
| Identified Need | Key Issue | Description of Evidence |
| |  <br>Figure 6 Rates of treatment episodes for heroin abuse 2014-15<br><br>Areas of higher heroin treatment episode rates were spread across the catchment; North East – Banyule (8.1), Outer East – Knox (7.7) and Maroondah (7.3), Inner East – Whitehorse (5.9) and Outer East - Whittlesea (5.6). Treatment where heroin was the principal substance abuse issue was the least frequently accessed of the treatment types. | |
| Service accessibility – Aboriginal and/or Torres Strait Islander people | A dedicated Aboriginal and/or Torres Strait Islander harm reduction workforce is needed to support AOD strategies in line with the National Drug Strategy.<br><br>The mental health model and service access models for AOD are different – need to separate. | ABS (2012-13), *Australian Aboriginal and Torres Strait Islander Health Survey: First Results*. AIHW (2014); HICSA (2017), *Alcohol and other drugs engagement report*; Inner East: Department of Health |

| Outcomes Of The Service Needs Analysis – Alcohol And Other Drugs | | |
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| Identified Need | Key Issue | Description of Evidence |
| Service accessibility – Aboriginal and/or Torres Strait Islander people | AOD issues in teenagers are more likely to be unrelated to mental health.<br><br>Up to one-quarter of Aboriginal and/or Torres Strait Islander adults (males>females) are exceeding single occasion and lifetime risk levels for harm from alcohol.<br><br>Access to AOD services for Aboriginal and/or Torres Strait Islander peoples may be impacted by geography, e.g. physical distance to health service and transport, the cultural competency of services, affordability and availability of services:<br>• Aboriginal health services are centrally located (transport issues), and there are insufficient local services perceived as culturally safe/appropriate to Aboriginal and/or Torres Strait Islander people.<br><br>It was reported that clients are asking for out-reach and that a non-judgemental conversation is not a normative experience. The majority of clients experiencing clinical care have found that there has been little support post-discharge, and they end up falling back through the cracks.<br><br>One challenge with AOD engagement is when clients do not show for appointments or are not home/do not answer the door for out-reach. This was said to change after a rapport has been built with the client.<br><br>Another challenge is the state of housing the community and its impacts on clients' self-worth and overall health, particularly if they are known in the community as someone with AOD issues. | EMR Koolin Balit and Aboriginal Health Community Consultation Workshop (September 2013).<br><br>Consultation:<br>• CHS – Inspiro; Mullum Mullum Indigenous Gathering Place;<br>• PCP – Outer East PCP;<br>• Consumer Representative Body – Association of Participating Service Users (APSU);<br>• Peer-based organisation – Harm Reduction Victoria; and<br>• Peak Body – VAADA. |

| Outcomes Of The Service Needs Analysis – Alcohol And Other Drugs | | |
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| Identified Need | Key Issue | Description of Evidence |
| | There is a lack of funded structures, such as Moreland Hill, that work with Aboriginal and/or Torres Strait Islander men through men's groups and other programs.<br><br>There is also a lack of education services and programs for parents about the consequences of heavy drug use.<br><br>Additional barriers to finding support include cultural beliefs and attitudes concerning AOD use, such as shame associated with seeking treatment, concern about getting into trouble with the law and fear of losing children to the Welfare System.<br><br>In terms of resources (staff time and organisational) the key social and emotional wellbeing issues reported were: depression, hopelessness, family relationship issues and grief and loss issues.<br><br>In 2016-17, Aboriginal and Torres Strait Islander-specific services were implemented at HICSA (Yarra Ranges) and Bubup Wilam (Aboriginal Family Centre, Thomastown [Whittlesea LGA]). | |
| System design – Service integration | Survey respondents from the allied health sector reported the need for improved service coordination between AOD and mental health services. They also highlighted the need for integration of AOD services and chronic pain clinics.<br><br>Funding for reducing harm from Alcohol and Other Drugs began in 2016-17. Activities include: after hours AOD clinicians in Emergency Departments, increasing access and treatment for young people, funding of Aboriginal and Torres Strait Islander AOD support | Consultation:<br>• EMPHN Allied Health Survey (October 2016). |

| Outcomes Of The Service Needs Analysis – Alcohol And Other Drugs | | |
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| Identified Need | Key Issue | Description of Evidence |
| | facilitators within Aboriginal Community Controlled Organisations, increasing after hours staffing at AOD access points and workforce development.<br><br>Other AOD strategies implemented in 2016-17 include: AOD@theGP in Whittlesea, Medication Support and Recovery Service for pharmaceuticals misuse, on-line counselling and support program for problematic alcohol use, and youth-focused AOD program (Supporting Health, Education, Recreation and Personal Autonomy (SHERPA). | |
| Health-related behaviour – Use of alcohol and other drugs<br><br>Health-related behaviour – Use of alcohol and other drugs | Regions or pockets of problematic alcohol use among young people were particularly apparent in the outer east and north:<br>• Whittlesea-Wallan had the highest percentage in catchment (69.8%) of underage people having consumed alcohol in the last 30 days; and<br>• Knox, Maroondah and Yarra Ranges had the highest rates in the catchment of ADIS episodes of care.<br><br>Areas of problematic alcohol consumption in people over 18 years were also apparent in the outer east (Knox, Maroondah and Yarra Ranges, and in the outer north (Mitchell* and Murrindindi*, which between them had the highest rates in the catchment of risky drinking) and the north (Banyule, Nillumbik-Kinglake).<br><br>Ice, 'chroming' and large scale selling of prescription drugs were noted as major issues in Healesville.<br><br>Problematic alcohol use in select refugee/asylum seeker communities, in the presence of acculturated reluctance to engage in help-seeking behaviours, was seen especially in the Chin (Burmese) community in Knox and Maroondah. | AODstats by Turning Point (2013-14); cohealth (2015), *North Western Region Catchment Based Mental Health Community Support Strategic Plan 2015-18*; DH (2012).<br><br>PHIDU (2011-13, accessed 2016).<br>Consultation:<br>• Peer-based organisation – Harm Reduction Victoria;<br>• EMPHN General Practice Survey (October 2016); and<br>• EMPHN Allied Health Survey (October 2016). |

| Outcomes Of The Service Needs Analysis – Alcohol And Other Drugs | | |
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| Identified Need | Key Issue | Description of Evidence |
| | Most general practice survey respondents indicated that they saw opportunities for addressing problematic alcohol use by improving awareness of available services, improving access to available services, supporting more services (particularly counselling), or accessing existing specialised drug and alcohol services.Illicit drug use was perceived as requiring similar approaches, with three respondents emphasising a need for more publicly funded services.<br><br>One allied health survey respondent recommended additional funding into borderline personality disorder and trauma, citing the high risk for AOD misuse. | |
| Health-related behaviour – Use of alcohol and other drugs: Aboriginal and/or Torres Strait Islander people<br><br>Health-related behaviour – Use of alcohol and other drugs: Aboriginal and/or | Problem use of alcohol and other drugs in Aboriginal and/or Torres Strait Islander people is characterised by:<br>• Lower alcohol usage rates than in the community overall, but higher individual problem usage.<br>• (Anecdotally) potentially higher ice use among Aboriginal and/or Torres Strait Islander people (numerical data not available).<br>• An under-resourced AOD sector – perceived workforce and organisational capacity constraints.<br>• Lack of rehabilitation and detoxification services that are accessible and culturally appropriate for Aboriginal and/or Torres Strait Islander people experiencing issues with ice and poly drug use.<br>• A perceived disconnect between AOD service providers and Aboriginal and/or Torres Strait Islander people—attributed to lack of specialist provider knowledge on culturally safe service provision and policy. | AIHW (2011), Substance use among Aboriginal and Torres Strait Islander people (report); Outer East: Department of Health EMR Koolin Balit and Aboriginal Health Community Consultation Workshop (September 2013).<br><br>Consultation:<br>• Council – Yarra Ranges Shire Council;<br>• CHS – AMES; Mullum Mullum Indigenous Gathering Place<br>• PCP – Outer East PCP; and<br>• State Government – Vic. DHHS. |

| Outcomes Of The Service Needs Analysis – Alcohol And Other Drugs | | |
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| Identified Need | Key Issue | Description of Evidence |
| Torres Strait Islander people | • A perception that mainstream psychiatric services lack the capacity to respond to drug-related mental health problems in Aboriginal and/or Torres Strait Islander people.<br>• A perception of lack of systematic, schools-based AOD awareness education. | |
| Potentially preventable hospital presentations – Use of alcohol and other drugs | Research in NSW has suggested that substance use contributes to 30 per cent of presentations to the emergency department. In a baseline patient survey, approximately 12 percent were multiple (two or more) substance users. The impact on the ED is both substantial and preventable: presentations to the ED are in the main not from people receiving care elsewhere as the majority (75%) of those identified in the survey as having drug and alcohol issues had never accessed specialist substance-use treatment services.<br><br>Reducing avoidable hospital presentations requires additional preventative (public health) and case-managed AOD intervention.<br><br>A review by AIHW of alcohol and other drug treatment services (publicly funded AOD treatment service agencies only) in Australia showed that 1 in 160 people in Victoria received treatment. Currently approximately 40,000 people are accessing treatment services each year, although the number who experience issues relating to alcohol use is not easily determined, challenging attempts to target services.<br>Anecdotally, however, there are above average drug overdose risks in Yarra Ranges and Maroondah. | Butler K, Reeve R, Viney R, Burns L. Estimating prevalence of drug and alcohol presentations to hospital emergency departments in NSW, Australia: impact of hospital consultation liaison services. Public Health Research & Practice. 2016;Vol. 26(4):e2641642.<br>AIHW 2017. Alcohol and other drug treatment services in Australia 2015–16. Drug treatment series no. 29. Cat. no. HSE 187. Canberra: AIHW<br><br>State Government of Victoria-Department of Health and Human Services. Alcohol and other drug treatment services. Available from https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services<br>AODstats by Turning Point (2014-15); cohealth (2015), *North Western Region* |

| Outcomes Of The Service Needs Analysis – Alcohol And Other Drugs | | |
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| Identified Need | Key Issue | Description of Evidence |
| | Since 2006-7, the principal drugs of concern for treatment services have been alcohol, cannabis, amphetamines, and heroin, however treatment episodes for amphetamines rose by 175% over 5 years, indicating a key focus for service delivery.<br><br>Amphetamine treatment episodes of care were largely spread across the catchment, however the areas of highest treatment rates per 10,000 of the population were in the outer east.<br><br>Areas of higher heroin treatment episode rates were also spread across the catchment; north east – Banyule (8.1/10,000), outer east – Knox (7.7/10,000) and Maroondah (7.3/10,000), inner east – Whitehorse (5.9,10,000) and outer east – Whittlesea (5.6/10,000). Treatment where heroin was the principal substance abuse issue was the least frequently accessed of the treatment types.<br><br>At consultation, problem-drinking hotspots included:<br>• inner and outer north (Banyule and Nillumbik-Kinglake) and east/outer east (Knox, Maroondah and Yarra Ranges); and<br>• Boroondara – with a sub-group of (often) relatively affluent divorced women living alone.<br><br>Data from AODstats by Turning Point showed that the numbers of consumers accessing treatment services for alcohol abuse were noticeably higher within the outer east region compared to other sub-regions. Of all substances, treatment rates for alcohol were the highest and almost double that where amphetamine was the principal substance of misuse. | *Catchment Based Mental Health Community Support Strategic Plan 2015-18*; EACH (2015), *Eastern Metropolitan Region Integrated Mental Health and Alcohol and Other Drugs Catchment Plan 2016-18*; Vic. DHHS (2012).<br>Consultation:<br>• Council – City of Boroondara;<br>• Consumer Representative Body – Association of Participating Service Users (APSU); and<br>• Peak Body – VAADA (Case managed intervention). |

| Outcomes Of The Service Needs Analysis – Alcohol And Other Drugs | | |
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| Identified Need | Key Issue | Description of Evidence |
| | Numbers of consumers accessing treatment services for alcohol abuse were also noticeably higher within the outer east region compared to other sub-regions. Of all substances, treatment rates for alcohol were the highest and almost double that where amphetamine was the principal substance of misuse.<br><br>The AIHW review found that counselling, withdrawal management, and assessment only were overall the most common types of treatment services provided, with counselling the most common principal treatment type provided for clients (37% of episodes).<br><br>Considerations suggested by surveyed allied health personnel in planning local responses included:<br>• childhood education on the negative effects of alcohol;<br>• creating a cultural shift around attitudes to alcohol consumption, risky drinking being in the same category of potential harm and social stigma as drug use, especially dangerous doses. | |
| Presence of illness and disease – Use of alcohol and other drugs | Two survey respondents from the allied health sector expressed the need for patients discharged from hospital with multiple medications to receive a supported referral from the hospital and GP to their pharmacy for medication packaging. | Consultation:<br>• EMPHN Allied Health Survey (October 2016). |
| Health related behaviour – Pharmaceutical drug misuse | At the level of PHN the prescription drug classes with the highest rates of treatment episodes are Sedatives and Hypnotics, followed by Analgesics. In exploration by SA3, the outer east again features, with Knox accounting for the highest number of treatment episodes followed (interchangeably) by Banyule and Maroondah. | POLAR (2017).<br>Consultation:<br>• EMPHN General Practice Survey (October 2016). |

| Outcomes Of The Service Needs Analysis – Alcohol And Other Drugs | | |
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| Identified Need | Key Issue | Description of Evidence |
| | Of the multiple suggestions made by GP survey respondents for addressing 'doctor shopping' for duplicate prescriptions, most centred on improved communication between pharmacies and general practice and the need for a real-time e-solution that encompassed e-prescribing and/or prescription monitoring and/or incorporating a flagging system at prescription point. | |

## Outcomes of the Service Needs Analysis – After-Hours

| Outcomes of the Service Needs Analysis – After-Hours | | |
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| Identified Need | Key Issue | Description of Evidence |
| Service accessibility – After-hours primary health care services | After-hours access to GPs, MDSs, pharmacies and other healthcare services varies across the EMPHN catchment, with some geographic areas (mostly outer suburbs) lacking after-hours services altogether. General practices have limited opening hours in the after-hours periods, particularly after 8 PM on all days of the week, and there is a shortage of GPs that are prepared to work in after-hours clinics. The increased costs of running an after-hours GP clinic make after-hours services less viable.<br><br>Additionally, there is limited availability of other health care services such as pharmacy, radiology and pathology in after-hours periods, particularly in outer metropolitan areas.<br><br>Access to travel options is also an issue, especially for those residing in the outer regions.<br><br>Some general practice survey respondents indicated a belief that there were consumers accessing the ED for non-urgent care because they preferred and were unable to otherwise obtain after-hours access. | EMML, IEMML and NMML (2012-13), Comprehensive Needs Assessments; EMPHN After Hours Survey (2015); EMPHN research on MDS coverage in the catchment; Jaffe Consulting Pty Ltd for EMPHN (2017), *After-hours primary health care diagnostics and prioritisation project – final report*; VEMD (2014-15).<br><br>Consultation:<br>• CHS – EACH; Plenty Valley CH;<br>• Ambulance service – Ambulance Victoria;<br>• GP clinic – After Hours GP Clinic Box Hill; Clayton Road Doctors Medical Centre; ERAHMS clinics; Nexus GP SuperClinic Wallan; Warburton Medical Clinic;<br>• MDS – ALMS; My Home GP; NHDS; and<br>• EMPHN General Practice Survey (October 2016). |

| Outcomes of the Service Needs Analysis – After-Hours | | |
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| Identified Need | Key Issue | Description of Evidence |
| Service accessibility RACFs – Access to GPs and other primary health care services in the after-hours period | Research on RACFs indicates that:<br>• Some RACF staff are not appropriately trained to make confident decisions about residents' after-hours healthcare interventions.<br>• Cost issues can impact the employment of RACF staff with adequate skills for addressing after-hours healthcare needs.<br>• Advanced Care Plans are either not used at all, not used consistently, or not used appropriately to make decisions with residents and their families about after-hours healthcare requirements.<br>• A RACF's policies and procedures may prevent consideration of a range of after-hours healthcare responses, e.g. policies that emphasise calling an ambulanceas a first response.<br>• Relationships between RACFs and GPs are generally based on a reactive regime rather than one that is proactive, e.g. it is not commonplace to have a medication management agreement between the RACF, GPs and pharmacists that would reduce long waits for prescriptions for medications after-hours and encourage in-hours prescribing.<br><br>A poor after-hours system response for residents in some RACFs and variable quality of locum care were reported, contributing to:<br>• insufficient residential in-reach services; and<br>• inappropriate referral to emergency departments for some conditions.<br><br>It was also noted that:<br>• Inadequate back-fill for residential in-reach programs impacts service delivery. | Australian Commission on Safety and Quality In Healthcare (2015), *Australian Atlas of Healthcare Variation*; Jaffe Consulting Pty Ltd for EMPHN (2017), *After hours primary health care diagnostics and prioritisation project - final report.*<br><br>Consultation:<br>• LHN – Austin Health; Eastern Health; Northern Health; Southern Health Dandenong; St. Vincent's Hospital; and<br>• EMPHN RACF interviews (September 2015 – February 2016). |

| Outcomes of the Service Needs Analysis – After-Hours | | |
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| Identified Need | Key Issue | Description of Evidence |
| | • Some RACF staff lack knowledge of after-hours primary healthcare services.<br>• There is a critical workforce shortage of nurses and personal care attendants.<br>• Procedures and processes for admitting and discharging of patients are confusing, arduous and can lead to medication mismanagement and patient deterioration.<br>• Poor access to radiology, palliative care and pathology in the after-hours periods, particularly in outer metropolitan areas, and the lack of pharmacy access both in and out of hours can result in avoidable hospitalisations.<br>• Lack of access to after-hours locum care might contribute to unnecessary transfers to hospital.<br>• High (second percentile) antipsychotic use in Boroondara may have been associated with the reported inadequate resources to manage acute aggression in residents with dementia. | |
| System design – After-hours primary health care services | Research, literature and the findings of the Jaffe Consulting Report suggest that after-hours healthcare services may be less effective because:<br>• They do not respond directly to some peoples' presenting needs e.g. people with mental health or AOD issues, who have a disability, who are homeless, from CALD backgrounds etc.<br>• They might not be well integrated and there is not a continuum of care between services provided during business hours and those after-hours.<br>• There is not adequate cross-sectoral collaboration e.g. GPs collaborating with RACFs, mental health professionals, disability workers, CALD workers etc.<br><br>There is often poor communication between service providers (e.g. inadequate reporting provided by MDSs back to local GPs). | EMML, IEMML and NMML (2012-13), Comprehensive Needs Assessments; Jaffe Consulting Pty Ltd for EMPHN (2017), *After-hours primary health care diagnostics and prioritisation project - final report*; Larter Consulting (2015), *ACP Consortium Needs Analysis*.<br><br>Consultation:<br>• GP clinic – Clayton Road Doctors Medical Centre; ERAHMS clinics; |

| Outcomes of the Service Needs Analysis – After-Hours | | |
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| Identified Need | Key Issue | Description of Evidence |
| System design – After-hours primary health care services | Some MDS GPs lack expertise in elements of specialised after-hours care, including palliative and end-of-life care.<br><br>There is apparent underuse of telephone interpreter services.<br><br>The information provided in the National Health Services Directory (NHSD) can be inaccurate or outdated.<br><br>It was proposed that there were limited opportunities for GP services and pharmacies to expand their opening hours unless additional funding were made available. After-hours services are often viewed as functional aspects of general practice rather than part of planned care.<br><br>Data and research suggests that systemic consolidated approaches are required to address the identified after-hours healthcare issues across the EMPHN catchment. Consultations highlight that the integration of EMPHN after-hours programs within in-hours programs could produce more seamless approaches for addressing after-hours healthcare issue, and generate new opportunities, e.g. the mental health program including after-hours healthcare, the GP Engagement team working with after-hours GPs, etc. | Nexus GP SuperClinic Wallan; Warburton Medical Clinic;<br>• MDS – ALMS; My Home GP; NHDS; and<br>• EMPHN RACF interviews (September 2015 – February 2016). |
| Health-related behaviour – After-hours service access | Community knowledge of after-hours services, including MDS and after-hours clinics, pharmacies and other primary health care services is limited. Previous EMPHN work, research by other organisations and the findings of the Jaffe Consulting Report highlight that many people in the community: | EMML, IEMML and NMML (2012-13), Comprehensive Needs Assessments; Jaffe Consulting Pty Ltd for EMPHN (2017), *After-hours primary health care* |

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