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EASTERN MELBOURNE

An Australian Government Initiative

EMPHN Needs Assessment Report

November 2018

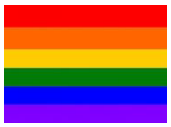
ACKNOWLEDGEMENTS

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

Australian Government

We acknowledge funding from the Commonwealth Government as the principal funding body for PHNs.

We acknowledge and pay our respects to the traditional owners of the country where we work, the Wurundjeri People of the Kulin Nation. We pay our respects to their Elders, emerging leaders and community members, past and present.



We acknowledge and celebrate diversity in all its forms and recognise the contribution people from diverse backgrounds and life experiences make to a strong, healthy and resilient community. We welcome everyone in the community as part of our organisation.

Notes

- In this document, the terms 'EMPHN', 'catchment'. and 'community' are used interchangeably. All refer to the geographic area and people of the Eastern Melbourne Primary Health Network.
- The term 'primary care' refers to the broad range of community-based services that are a point of first contact for people with health problems. 'General practice' is one of a range of primary care service providers.
- Definitions of acronyms, initialisms and abbreviations can be found in the Table of Abbreviations at the front of the document.
- Detailed data for population measures of health are available for local government and statistical areas from EMPHN upon request.

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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 Primary Health Network
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

EXECUTIVE SUMMARY

The purpose of this needs assessment is to identify key primary health care issues and priorities in our region.

All Primary Health Networks (PHNs) are required to perform an evidence-based needs assessment of their region to identify their unique regional and local priorities. These are in addition to the priorities set down by the Australian Government when it established the PHNs in 2015.

Eastern Melbourne Primary Health Network (EMPHN) is one of 31 PHNs nationally. Our organisation's vision is to achieve better health outcomes for the community we serve, a better health care experience for all and a more integrated healthcare system.

Our needs assessment identifies our organisation's priorities to achieve this vision. This needs assessment is informed by robust stakeholder consultation (described in the Appendix) and supported by data and evidence. This approach ensures that the services we fund meet the clearly identified health and healthcare needs for our communities.

EMPHN's Board has set six transformative strategies to help focus the organisation's resources over the next three years on successfully addressing the priorities identified in this needs assessment.

Our community

EMPHN is home to about 1.45 million people, representing about a quarter of Victoria's entire population. The catchment comprises all or part of 12 local government areas and is characterised by broad cultural and socio-economic diversity and range of health care needs.

The major challenge our community face is meeting the primary health needs of a population that is both expanding and ageing, and is affected by mental health problems and a growing burden of chronic disease.

Much of this disease burden is currently not being adequately addressed in a coordinated way by health services, leading to avoidable deaths, hospitalisations and emergency department presentations.

Our older people are living longer, usually with chronic conditions and some degree of disability. Simultaneously, mental health problems are increasing and most people with mental health needs have comorbid chronic conditions, contributing further to an upward spiral in chronic care demands. People with severe mental health problems experience a disproportionately large chronic disease burden and premature death. Our Indigenous community also experiences a disproportionate degree of chronic disease, leading to lower life expectancy and increased disability.

This situation will likely become substantially worse without decisive, evidence-based action by the organisations, such as ours, that can influence it.

Managing chronic conditions needs proactive care by health professionals who work as a team with the patient and focus on outcomes. We must have a clear plan to influence change in how we manage the health of our community.

EMPHN has a vital role in transforming the management of chronic conditions in our community, from a reactive model of primary care to care that is planned and comprehensive.

General health

Australians' health needs are changing as more people experience chronic disease.

At least three quarters of people over the age of 65 years have at least one chronic health condition that puts them at risk of serious complications and premature death.[1] And the chronic disease burden in our community is growing. Most people with mental health problems also have chronic diseases.

This increasing prevalence of chronic conditions, combined with a rapidly ageing populating and a growing number of people with mental health problems, means that the EMPHN must have a clear plan to influence change in how we manage the health of our community.

Managing chronic conditions in primary care needs proactive care by health professionals who work as a team with the patient and focus on outcomes. Many chronic diseases can be self-managed with limited health care support, especially during their early stages. As they become more serious and disabling, more intensive team care may be required, and hospital care may be needed for acute episodes.

Our priority is to transform the management of chronic conditions in our community, from a reactive model of primary care to care that is planned and comprehensive and our key priorities reflect this approach to transformation.

Indigenous health

The EMPHN community is home to more than 6,800 Aboriginal and Torres Strait Islander people, mainly in Whittlesea-Wallan, Yarra Ranges, Knox and Banyule. Aboriginal people living in Victoria make up 0.9% of our population, the lowest proportion of any state or territory.

Aboriginal and Torres Strait Islander people experience significant health inequities compared to the rest of the EMPHN population. They have a greater burden of chronic diseases like heart disease, diabetes, respiratory diseases and kidney disease and die approximately 10 years earlier than non-Aboriginal people in our state. Aboriginal people also experience higher rates of psychological distress and substance use problems.

Mainstream health services are not always capable of providing culturally-appropriate care and many Indigenous people experience cultural insensitivity when attempting to access the care they need.

Meeting the health needs of our Aboriginal and Torres Strait Islander community is therefore a priority for EMPHN. Through *Koolin Balit – Victorian Government strategic directions for Aboriginal Health 2012–2022* and through consultation, the Indigenous community in our catchment has identified the following priorities, which we have adopted:

1. A healthy start to life
2. A healthy childhood
3. A healthy transition to adulthood
4. Caring for older people
5. Addressing risk factors
6. Managing illness better with effective health services.

Mental health

Mental health problems and mental illness are the third leading cause of disability burden in our community.

Mental and behavioural disorders, such as depression, anxiety and substance use disorders, are all major contributors to the burden of disease in the EMPHN catchment. One in five people in our community will have a mental health problem every year. Mental health problems cause of disability, reduced quality of life, shorter life expectancy and impaired productivity in our community.

Most people with mental health problems also have chronic diseases

People who have mental health problems often experience poorer general health, have higher rates of chronic diseases and have higher rates of death, including by suicide.

Rates of suicide are high in older people – men over the age of 85 years have the highest suicide rates of all age group. Yet people over the age of 65 years have poor access to mental health services.

People with severe and enduring mental disorders die 15 to 20 years earlier than the general population.

Mental health problems also contribute to disability and psychosocial support needs. At present, the psychosocial support needs of people with psychotic illnesses are not being adequately met.

We as a community need to make major efforts to improve the physical health of clients who receive mental health treatment. We need to support the systems that support people to work, socialise and be an active part of our community.

Our priorities are to:

- Implement our mental health stepped care model. Our model:
  - integrates with general practice;
  - targets mental health needs of people across different age groups, including older people;
  - addresses the physical health needs of people with mental health problems; and
  - provides psychosocial support for people with complex and enduring mental health problems.
- Support community-based suicide prevention initiatives across the age continuum
- Develop an integrated regional mental health, alcohol and other drug and suicide prevention plan
- Address the priorities in the fifth national mental health and suicide prevention plan.

Alcohol and other drugs treatment

Alcohol is the main cause of substance-related harm in our community

Health problems caused by alcohol and other drug use affect the EMPHN community as a whole. Misuse of alcohol and other drugs has a substantial impact on the health and wellbeing of people in our community, contributing to deaths from overdose each year.

Our community experiences around 7 deaths per 10,000 population each year from overdose in the EMPHN catchment, which is similar to Victoria and Australia as a whole.

Misuse of drugs other than alcohol causes death and disability and is a risk factor for many diseases. It is also closely associated with risks to users' families and friends and to the community.

Most adults in our community consume alcohol, and many consume alcohol responsibly. However a substantial proportion of people drink alcohol in quantities that exceed the recommended level, which increases their risk of alcohol-related harm.

The majority of alcohol-related treatments can be delivered in the community by our primary care workforce.

Whilst we do have a highly developed alcohol and drug services network, we can strengthen our community-based systems further in order to:

- reduce avoidable emergency department presentations, hospital admissions and deaths caused by alcohol and other drugs
- reduce the impact of alcohol and other drugs on our communities including our Aboriginal community
- reduce harm associated with ice.

Our priorities are to:

- build the capacity of the primary care workforce to respond to alcohol and other drug issues; and
- facilitate better integration of specialist alcohol and other drug and primary care services.

Older people

The EMPHN region is experiencing an unprecedented rise in the median age of our population. In just 13 years, we will have nearly double the number of people aged 65 and over.

The combined effect of our ageing and growing population means that the number of people aged over 65 will increase from around 203,000 now to 370,000 by 2031.

Our older people are living longer and often with some degree of disability in their later years. Over three quarters of people over the age of 65 years have at least one chronic health condition that puts them at risk of serious complications and premature death.[1]

Older people in our community are at risk of becoming socially isolated—81% of our older people don't have daily contact with people outside their home.

The key factors in enhancing and maintaining older people's mental health and wellbeing are healthy lifestyles, social connection, mental wellbeing and a sense of purpose.

Older people in our community experience a substantial mental illness burden. This disproportionately affects older people in residential aged care – an estimated 50% of people in residential aged have mental health problems.

Our priority is to improve mental health care for older people. Our most urgent need is for improved access to mental health care for people residing in residential aged care.

EMPHN STRATEGIC PLAN

The EMPHN Strategic Plan describes transformative strategies our organisation has adopted to address health care issues and priorities in our community.

EMPHN's Strategic Plan for 2017-2022 outlines the organisation's vision to achieve:

- Better health outcomes for the community we serve;
- Better health care experiences for all; and
- A more integrated health care system.

Our strategic priorities to achieve this vision are:

- Addressing health gaps and inequalities;
- Enhancing primary care;
- Leveraging digital health, data and technology;
- Working in partnerships to enable an integrated service system; and
- A high performing organisation.

EMPHN's Board has set six transformative strategies to help focus the organisation's resources over the next three years.

Addressing Health gaps and inequalities

1. Implement stepped care approaches that are responsive to consumer needs

Enhancing primary care

2. Support and encourage primary care to adopt team-based care that is person centred
3. Build on practice-based evidence and practice-based innovation

Leveraging digital health, data and technology

4. Enable health information continuity between providers

Working in partnerships to enable an integrated service system

5. Develop commissioning and system change strategies that encourage integration across the boundaries of primary, community and acute services

A high performing organisation

6. Build a positive culture of high performance

These transformative strategies describe our overarching approach to addressing the health care priorities outlined in this needs assessment.

EMPHN Transformative Strategies

Our Mission

With our partners, we facilitate health system improvement for people in eastern and north eastern Melbourne.

Our Values

Leadership
Understanding
Outcomes
Collaboration

TRANSFORMATIVE STRATEGY

- implement stepped care approaches that are responsive to consumer needs

OUTCOMES

- improved access to the right care, in the right place, at the right time, particularly for at risk and vulnerable groups
- more effective care for people with chronic complex diseases and those at risk of poor health outcomes

TRANSFORMATIVE STRATEGY

- build a positive culture of high performance

OUTCOMES

- EMPHN is recognised and highly valued by funders, partners and our community
- a healthy, highly skilled and sustainable organisation
- accountable governance and effective stewardship of commissioned funds and contracts
- our business systems, processes and infrastructure enable highly effective ways of working together

TRANSFORMATIVE STRATEGIES

- support and encourage primary care to adopt team-based care that is person-centred
- build on practice-based evidence and practice-based innovation

OUTCOMES

- primary care providers deliver person-centred integrated services
- primary care providers deliver timely, high quality and safe health care

TRANSFORMATIVE STRATEGY

- develop commissioning and system change strategies that encourage integration across the boundaries of primary, community and acute services

OUTCOMES

- joint planning and co-ordinated investment results in better integrated, person-centred, service delivery
- service system improvement occurs through co-design processes that are person-centred, clinician-led and provider informed
- strategic commissioning delivers better outcomes for people and an improved service system

TRANSFORMATIVE STRATEGY

- enable health information continuity between providers

OUTCOMES

- health data, economic analysis, planning and evaluation drives impactful service and system development
- improved use of data and technology to support providers in delivering high quality co-ordinated care, and people in managing their own health

1 | EMPHN Strategic Plan 2017–2022

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SECTION 1:
OUR COMMUNITY

About our community

The Eastern Melbourne Primary Health Network (EMPHN) is home to about 1.45 million people, which is 24 % of the Victoria's total population. Our catchment comprises 12 Local Government Areas—the entire areas of nine and partial areas of an additional three.

Geography

The EMPHN catchment (Figure 1) comprises 12 Local Government Areas. The Local Government Areas entirely within our border include:

- City of Banyule
- City of Knox
- City of Maroondah
- Shire of Nillumbik
- Shire of Whittlesea
- City of Boroondara
- City of Manningham
- City of Monash
- City of Whitehorse

Our catchment also covers part of the following LGAs:

- Shires of Mitchell (35% of population
- Shire of Murrindindi (27% of population)
- Shire of Yarra Ranges (portion which falls outside the EMPHN catchment is largely uninhabited national park)

Figure 1. EMPHN catchment boundary

We have 1.45 million people living in our community.[2] This is 24% of the Victorian population. **Error! Reference source not found.** shows the population distribution across our community areas.

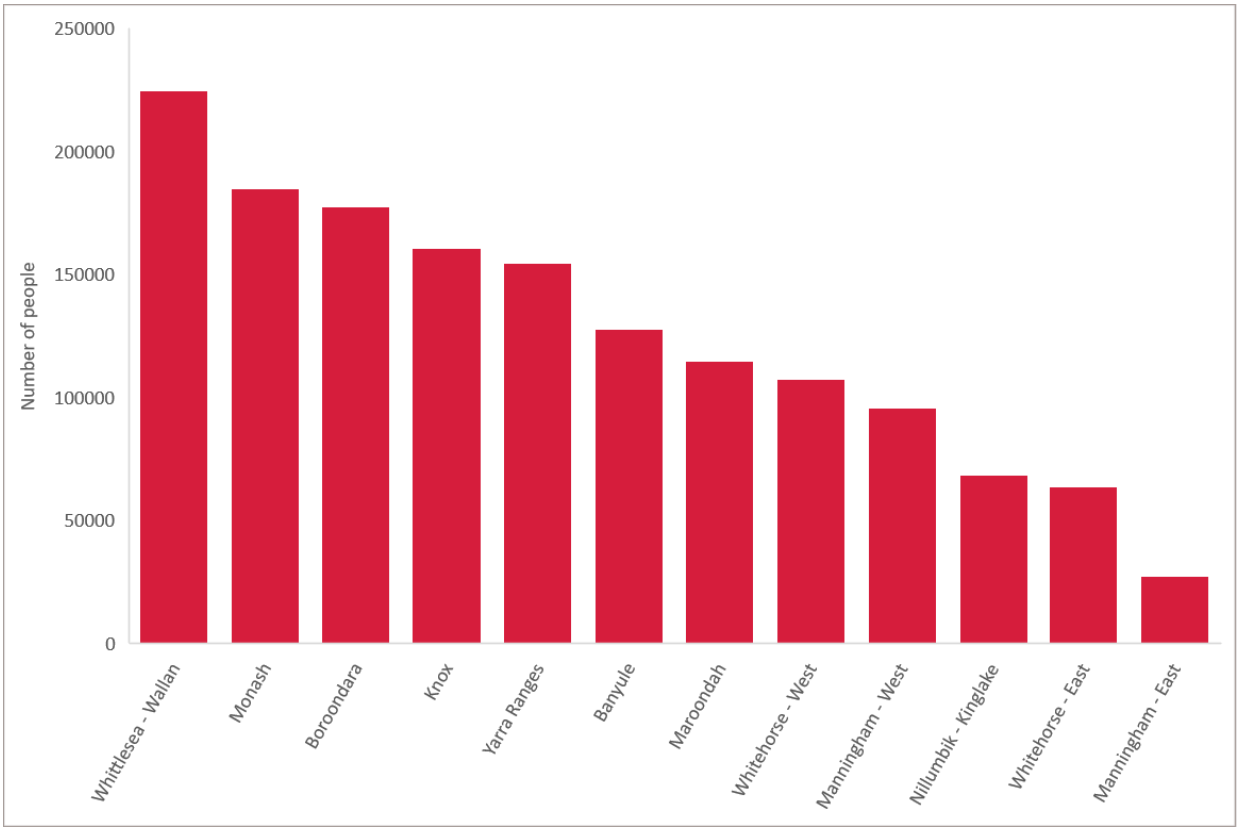


Figure 2. EMPHN catchment population | 2016

Our age distribution

Figure 4 illustrates our population pyramid—the distribution of age groups by sex in our community and the change between 2011 and 2016.[3]

The population pyramid demonstrates a 'working-age bulge', where people aged 25—59 years are more strongly represented than younger age cohorts in our population. There is also a large percentage of people in the 5- to 14-year-old age group. This reflects the demographic impacts of young families moving into more affordable areas of housing, such as Whittlesea.

When the population of working age people entering into older age is larger than the younger population entering the workforce, workforce challenges to care for people with chronic disease and disability can result.[4]

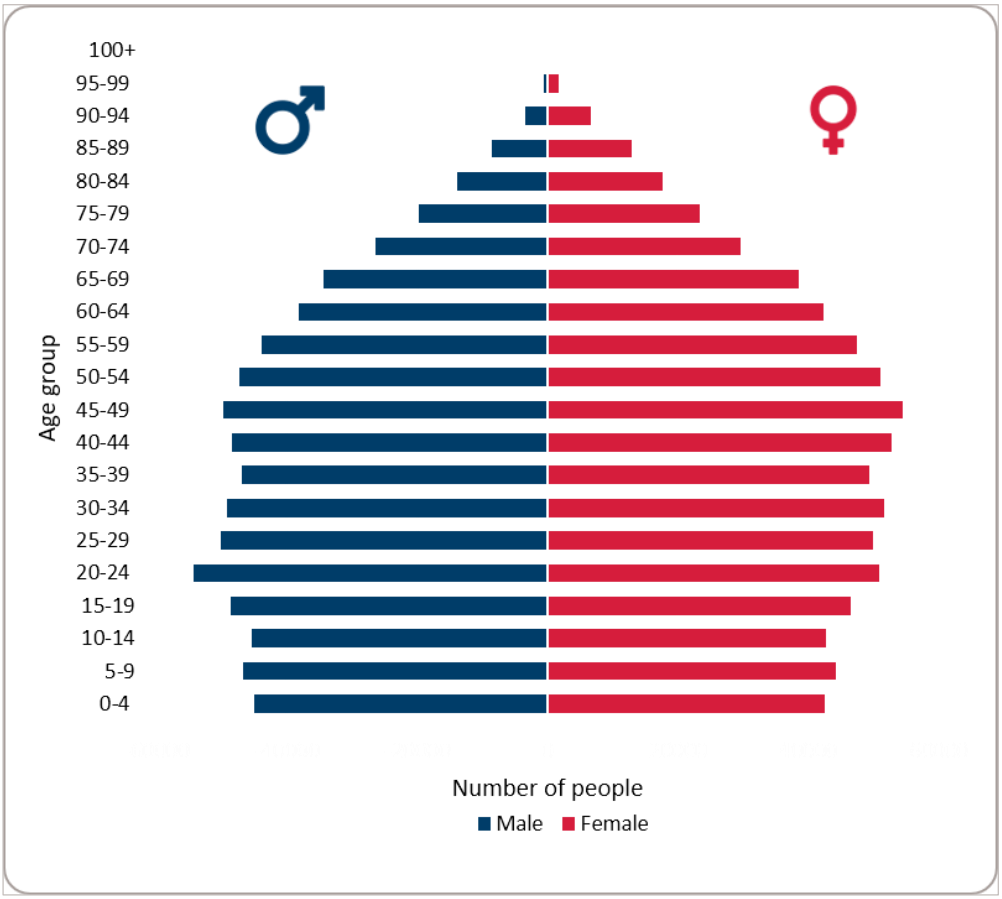


Figure 3. Change in age and sex distribution, EMPHN population | 2011-2016

Our community is culturally diverse

The EMPHN catchment is a region of high cultural and linguistic diversity. According to the 2016 Census, there were 454,000 people residing in our community who were born overseas in one of 200 countries. This represents 32% of our local community. The largest number (80,236 people) were born in China (Figure 5).

Over 6,800 Aboriginal and Torres Strait Islander people live in our community, mainly in Whittlesea-Wallan (1,885 people), Yarra Ranges (1,357 people), Knox (754 people) and Banyule (706 people).

English language proficiency helps people to navigate the health system. According to the 2016 Census over 73,100 people in the EMPHN catchment speak very little or no English. The main languages spoken other than English include Mandarin, Hindi, Cantonese and Italian.

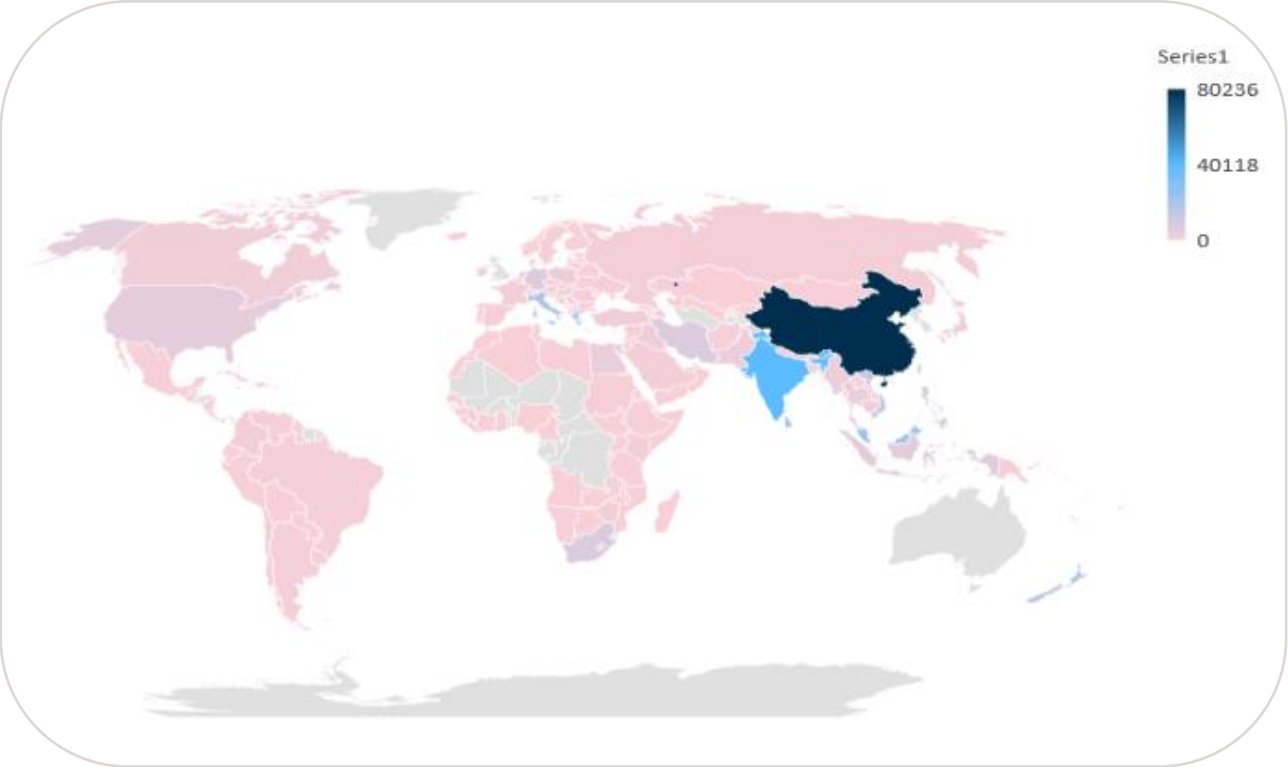


Figure 4. Country of birth, EMPHN residents | 2016

Figure 6 shows the largest percentage of people with poor English language proficiency reside in the Manningham-West, Whitehorse-West and Monash areas.

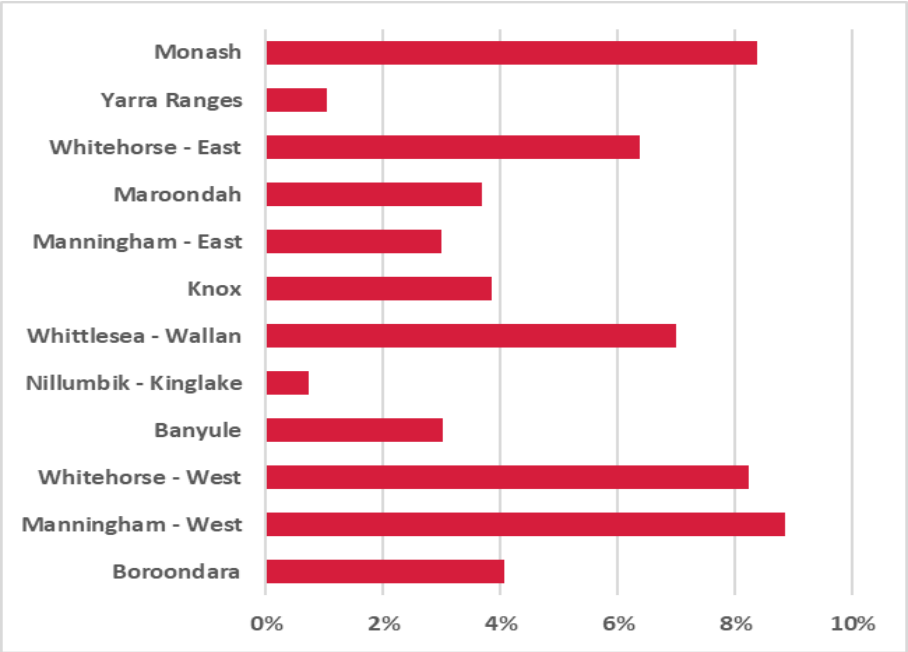


Figure 5. Percentage of population with little or no English language proficiency, EMPHN catchment | 2016

Our community is socio-economically diverse

Our socio-economic status is influenced by our income, education, occupation and ability to participate in our community. Socio-economic disadvantage is strongly associated with poorer health outcomes. Figure 7 depicts the areas of socio-economic disadvantage (coloured red and orange) within our community.

Areas with the most socio-economic disadvantaged people include Knox, Maroondah, Monash, Whittlesea and Yarra Ranges.[5] Areas with the most socio-economic disadvantage are located beside areas that are relatively advantaged. For example, Heidelberg West is one of the most socio-economically disadvantaged areas in urban Melbourne and located beside Heidelberg, which is one of the least disadvantaged.

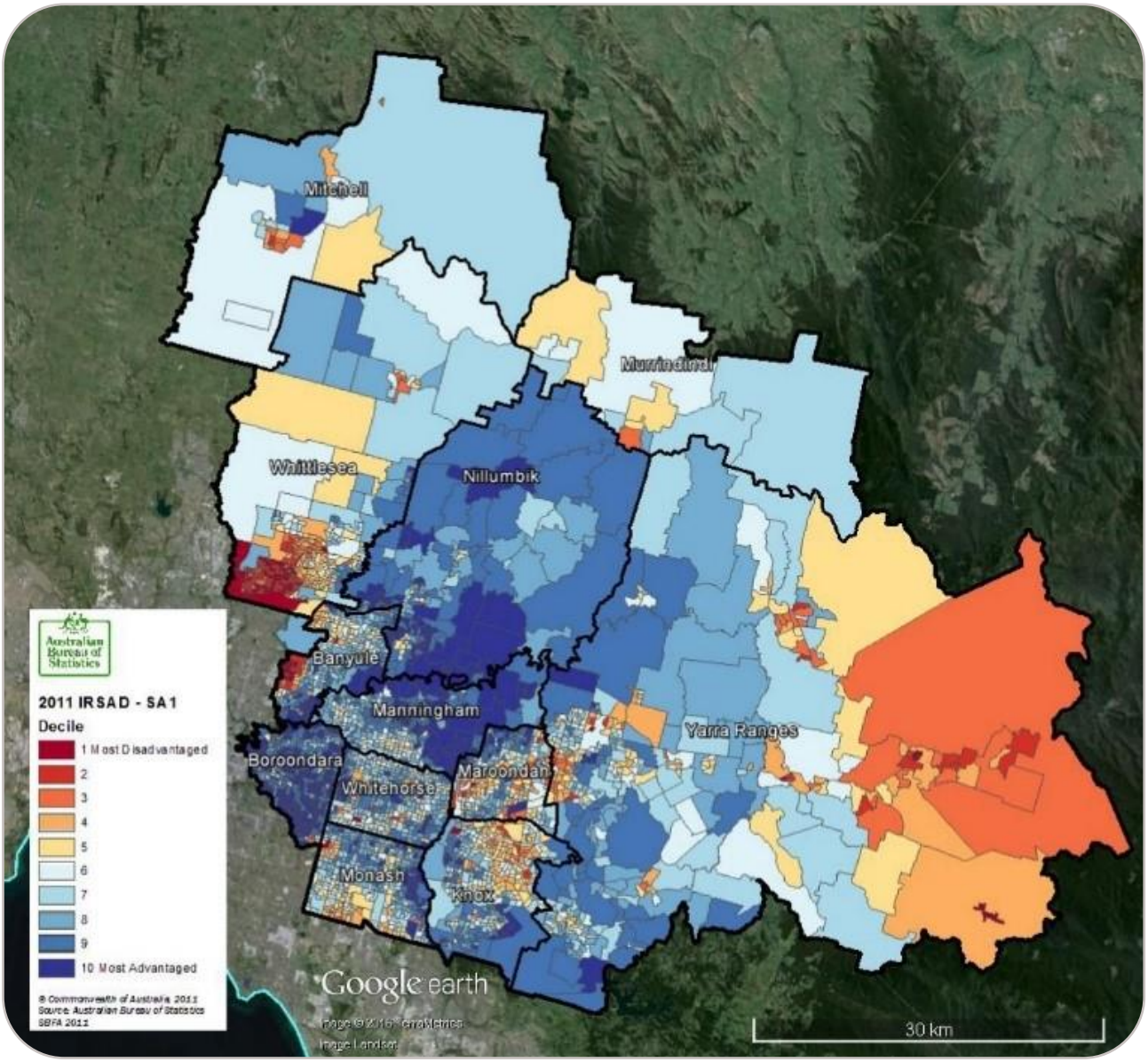


Figure 6. Socio-economic disadvantage in the EMPHN catchment | 2011

Our population is growing

Services will be needed to deliver care to a growing number of people over the next 10 to 15 years

The EMPHN catchment includes areas of rapid urban expansion. The largest increases in population will be in Whittlesea (Figure 8).

By 2021, there will be more than 1.6 million people living in our catchment.

By 2031 this will increase to 1.85 million people.

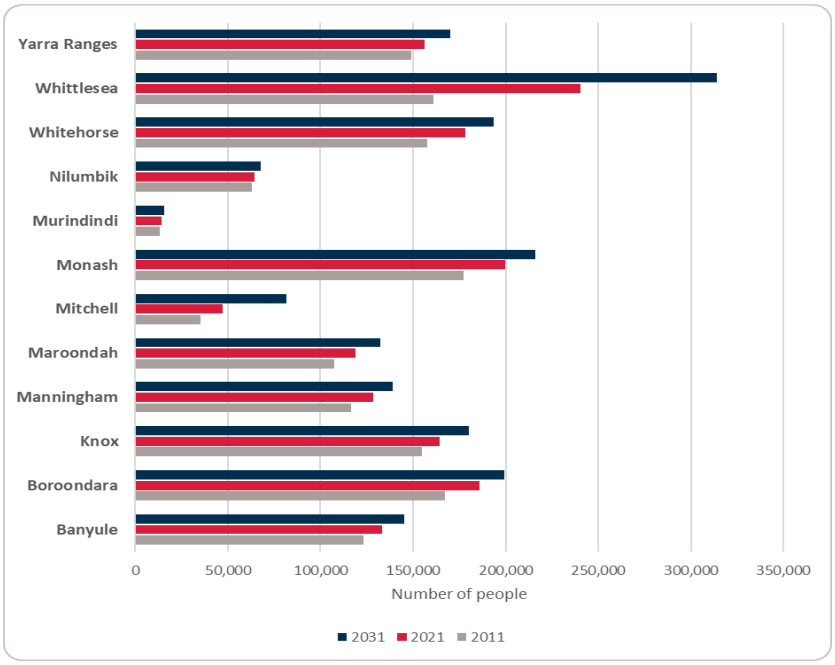
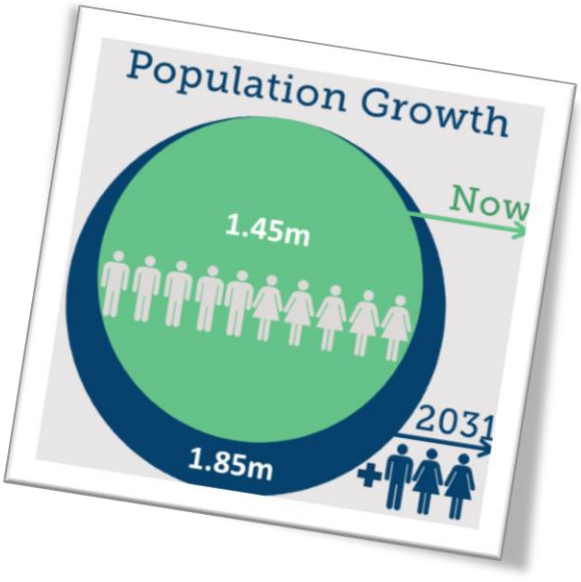


Figure 7. Predicted increases in EMPHN catchment population | 2021–2031



Our population is ageing

Older Australians are accounting for an increasing share of the population. Most Australians consider themselves to be in good health and manage to live independently through to old age. However, many health conditions and associated disability become more common with age, and older people are higher users of health services.

In the EMPHN catchment, 14% of our population is currently aged 65 years and older. This is expected to increase to 20% by the year 2031. The increase is predicted in all local areas, with the largest increases expected in Whittlesea (Figure 9).

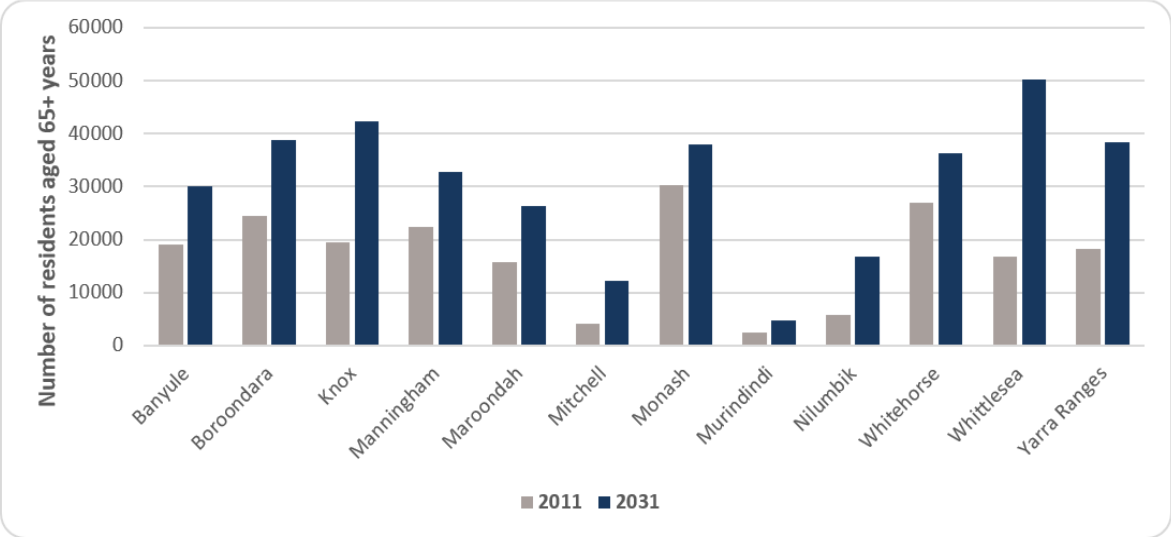
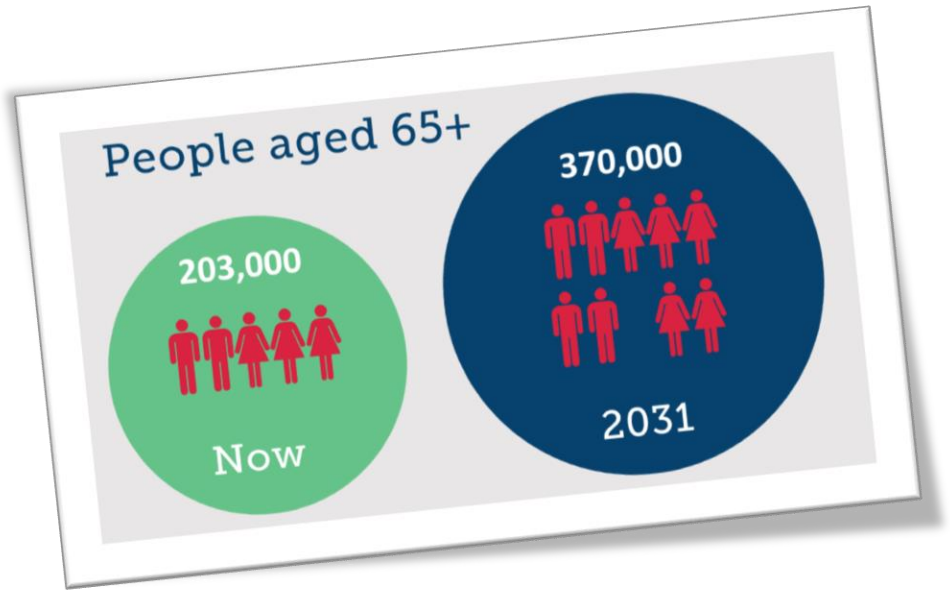


Figure 8. Increases in number of residents aged 65+ years | 2011–2031



Many people in our community experience disability

Over 68,000 people in the EMPHN catchment need assistance on a daily basis due to disability.

Many people receive their assistance from unpaid carers or loved ones. 5% of people in the EMPHM catchment need daily assistance due to a disability. In the 2016 Census 10% of people in our community reported that they provide unpaid assistance to people with a disability.

Rates of disability increase with increasing age. Increases in the number of residents aged 65 years and over in the EMPHN are likely to be associated with more people with disability requiring assistance, and with more people providing unpaid assistance to people with a disability (Figure 10).[6]

Profound disability:	A person always needs help or supervision always help to perform activities that most people undertake at least daily.*
Severe disability	A person sometimes needs help to perform activities that most people undertake at least daily.

**The core activities of self-care, mobility and/or communication.*

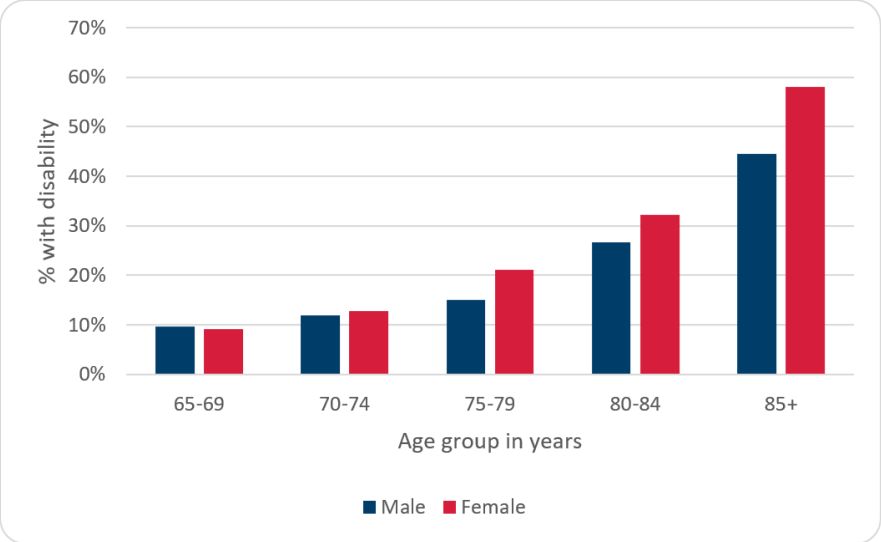


Figure 9. Percentage of people in EMPHN catchment with severe or profound core activity limitation, by age group | 2016

SECTION 2:
GENERAL HEALTH

INTRODUCTION

Australians' health needs are changing as more people experience chronic disease

The chronic disease burden in our community is growing.

Over three-quarters of adults have at least one chronic health condition that puts them at risk of serious complications and premature death and 44% of adults have three or more chronic conditions.

An increasing prevalence of chronic conditions, combined with a rapidly ageing populating and a growing number of people with mental health problems, means that EMPHN must have a clear plan to influence change in how we manage the health of our community. This is outlined in our Strategic Plan and the six transformative strategies set out by our Board.

Managing chronic conditions in primary care needs proactive healthcare by professionals who work as a team with the patient and focus on outcomes. Many chronic diseases can be self-managed with limited health care support, especially during their early stages. As they become more serious and disabling, more intensive team care may be required, and hospital care may be needed for acute episodes.

EMPHN has an important role to play in transforming the management of chronic conditions in our community, from a reactive model of primary care to care that is planned and comprehensive. Our transformative strategies in the EMPHN Strategic Plan reflect this role.

Our approach is to match services to need and measure outcomes that are meaningful to people.

Our health status

To determine our health needs we must first understand our health status. This is assessed using a wide range of indicators—qualities or features of our population that we can measure to describe our health.

Indicators are important when monitoring overall improvements in health or comparing improvements across regions, jurisdictions or with Australia as a whole.

The following indicators were included in assessing our health status:

A. Self-assessed health
B. Life expectancy
C. Infant mortality
D. Causes of death
E. Chronic health conditions
F. Cancer rates

A. SELF-ASSESSED HEALTH

People who live in the EMPHN catchment report high levels of self-assessed health

Self-assessed health status is among the most frequently-measured indicators of population wellbeing.

Self-assessed health is believed to mainly reflect physical health problems and, to a lesser extent, health behaviours and mental health problems.

Overall, 87% of adults in our community report excellent, very good or good health, compared with 85% of Australians overall.[7]

B. LIFE EXPECTANCY

Life expectancy at birth refers to the average number of years a newborn baby could be expected to live if the current mortality rates remain the same.

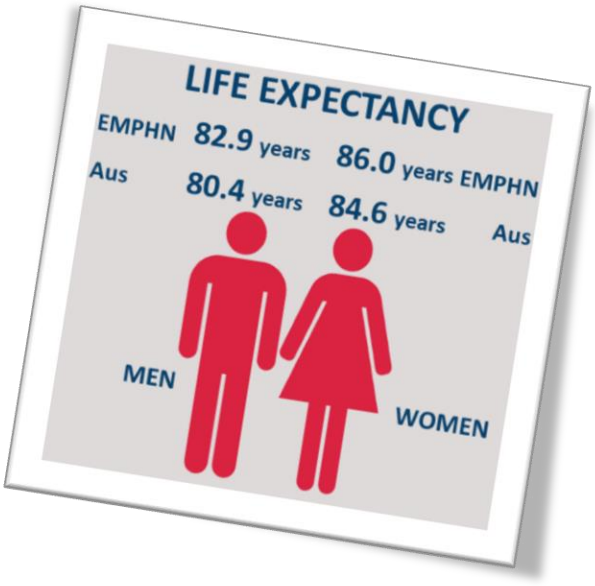
Life expectancy has increased significantly over the past century, reflecting the considerable decline in mortality rates— initially from infectious diseases and, in later years, from cardiovascular disease.

Reductions in deaths from cardiovascular disease have been linked to medical advances, improvements in diet, and less smoking.

People who live in the EMPHN catchment have a higher life expectancy than Australians overall

Males born today can expect to live to 82.9 years (compared with 80.4 years for Australian males) and females born today can expect to live to 86 years (compared with 84.6 years for Australian females).[8]

Aboriginal people in our community have a lower life expectancy than the non-Indigenous population.



C. INFANT MORTALITY

The EMPHN catchment's infant mortality rates are lower than the Australian average

Infant and young child mortality (i.e. deaths under five years of age) is an important indicator of the general health and wellbeing of a population and has a large influence on life expectancy at birth.

There are 3 deaths per 1,000 live births in the EMPHN. This is lower than the Australian average of 4.1 deaths per 1,000 live births.[9]

D. CAUSES OF DEATH

The most common causes of death in our community are related to chronic diseases.

Table 1 illustrates the EMPHH's top causes of death.

These data are consistent with the most recent mortality data for Victoria as a whole

Top causes of death are:

- cancer—mainly of the lung, bowel, breast, prostate and lymphoid systems
- diseases of the circulatory system—mainly coronary heart disease, stroke and heart failure
- dementia
- respiratory diseases—mainly chronic obstructive pulmonary disease.[10]

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Table 1. Top causes of death, EMPHN | 2012–2016

Cause of death	No. of deaths	% of all causes
Cancer	7,453	16.9
Coronary heart disease	5,371	12.1
Dementia and Alzheimer disease	4,200	9.5
Cerebrovascular disease	3,213	7.3
COPD	1,688	3.8
Heart failure and complications, and ill-defined heart disease	1,203	2.7
Influenza and pneumonia	1,137	2.6
Diabetes	1,130	2.6
Accidental falls	1,020	2.3
Kidney failure	819	1.9

Some premature deaths can be avoided

The leading causes of death in people under 75 years of age are cancer and cardiovascular disease.[11]

Potentially avoidable deaths refer to deaths in people below the age of 75 years where death may have been be avoided through effective interventions against specific diseases in a population.

Potentially avoidable deaths include *potentially preventable deaths* and *deaths from potentially treatable conditions*.

- *Potentially preventable deaths* are those where screening and primary prevention, such as immunisation or tobacco control measures, may have reduced the chances of premature death.
- *Deaths from potentially treatable conditions* are those where access to safe, high-quality clinical care may have reduced the chances of premature death.

The EMPHN catchment has a low rate of potentially avoidable deaths (78 deaths per 100,000 people) compared with the Australian average (106 deaths per 100,000 people).

E. CHRONIC HEALTH CONDITIONS

Chronic conditions are common in the EMPHN catchment

Chronic health conditions refer to long-term conditions (lasting more than six months) that can have a significant impact on a person's life.

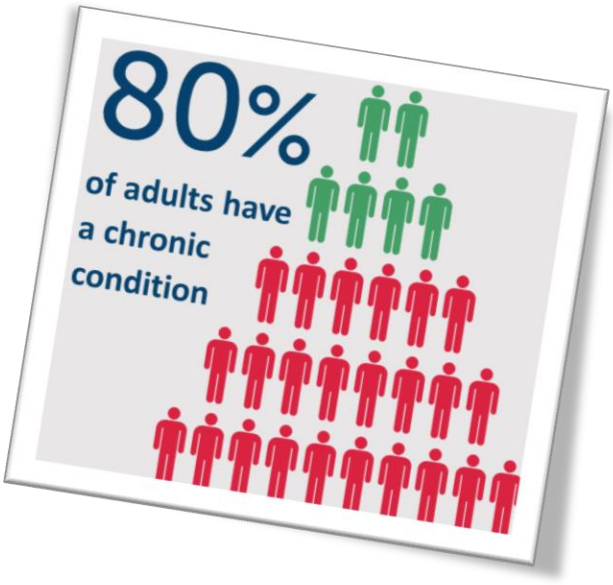
Approximately 80% of adults in our catchment have at least one chronic condition and 44% of adults have three or more long-term health conditions (an increase from 40% of adults since 2001).[12]

The major chronic conditions experienced by adults are musculoskeletal conditions, mental health problems and cardiovascular diseases (Table 2).

As people grow older, their likelihood of having chronic conditions increases.

Table 2. Adults with chronic conditions, Victoria | 2014–15

	Persons (%)
Total musculoskeletal/ connective tissue diseases	31.0
Cardiovascular diseases	16.8
Asthma	11.9
Mental and behavioural problems	17.5
Diabetes mellitus	5.2
Dementia	<1.0



F. CANCER RATES

Cancer affects a significant proportion of our population

Between 2009 and 2013 there were 36,434 new cases of cancer diagnosed in the EMPHN catchment. This is a rate of 463 new cancers diagnosed per 100,000 people (age standardised), which is lower than the Australian rate of 497 per 100,000 people.[13]

Rates of different types of cancers vary. The most common cancer diagnoses in our community between 2009 and 2013 are shown at Figure 11. These include:

- prostate cancer (6,537 new cases)
- breast cancer (4,894 new cases)
- bowel cancer (4,479 new cases)
- melanoma (2,828 new cases)
- lung cancer (2,787 new cases)

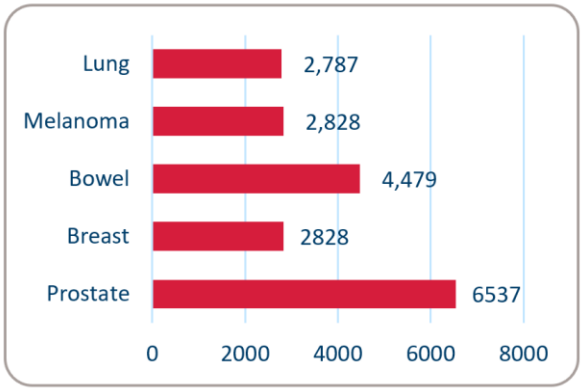


Figure 10. New cancer diagnoses, EMPHN | 2009–2013

Rates of cervical cancer have been decreasing over time. Between 2009 and 2013 there were 182 new cases of cervical cancer in the EMPHN catchment.

Cancer screening participation can be improved

Cancer screening programs aim to reduce illness and death resulting from cancer by using an organised approach to early cancer detection. In Australia, we can screen for cancers of the breast, cervix and bowel as part of national population-based screening programs. Screen-detected cancers of the breast, cervix and bowel are less likely to cause death than those diagnosed in never-screened participants.

BreastScreen Australia was established in 1991. It provides free, two-yearly screening mammograms to women aged 40 and over, and actively targets women aged 50–74.

In the EMPHN catchment.54.9% of women aged 50–74 years participated in *BreastScreen Australia* in 2015–2016. **This means almost half of eligible women do not participate in the program**

The *National Cervical Screening Program*, established in 1991, targets women aged 20–69 for a two-yearly Papanicolau smear, or 'Pap test'.

In the EMPHN catchment, 58.6% of women aged 20–69 years participated in the *National Cervical Screening Program* in 2015–16. **This means over 40% of eligible women do not participate in the program.**

In December 2017, the Cervical Screening Test replaced the Pap test in Australia. The Cervical Screening Test is more effective than the Pap test at preventing cervical cancers, because it detects the human papillomavirus—a common infection that can cause cervical cell changes that may lead to cervical cancer. The Cervical Screening Test is performed every five years in women aged 25–74 years. Data are not yet available for participation in the new program.

The *National Bowel Cancer Screening Program*, established in 2006, currently targets men and women turning 50, 54, 55, 58, 60, 64, 68, 70, 72 and 74, inviting them to screen for bowel cancer using a free faecal occult blood test. Once fully implemented in 2020, the program will offer free two-yearly screening for all Australians aged 50–74.

In the EMPHN catchment, 43.2% of eligible people participated in the National Bowel Cancer Screening Program in 2015–16. **This means over half of all eligible people do not participate in the program.**

Survey respondents from the allied health sector report that the following population groups either avoid, or have particular difficulty in accessing or understanding cancer screening:

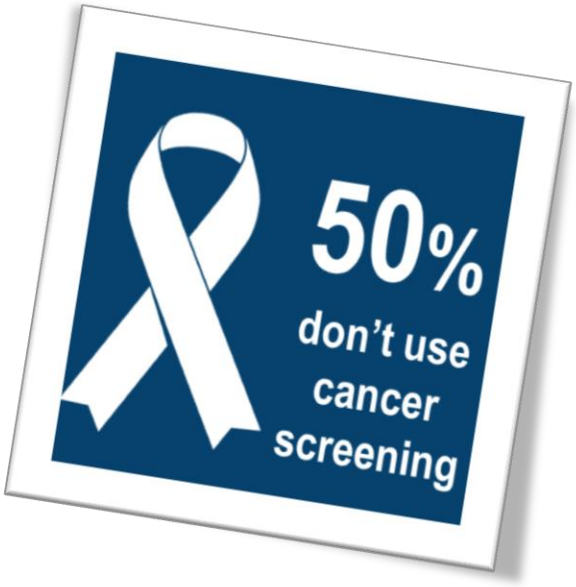
- Aboriginal and/or Torres Strait Islander peoples
- Culturally and linguistically diverse people, refugees and asylum seekers
- The aged, especially those who are homebound or have dementia
- Low socio-economic groups due to cost and transport barriers
- People residing in areas with lack of transport and/or poor access to health services
- Women who have experienced sexual abuse
- Men.

Table 3. EMPHN participation rates of people eligible to participate in cancer screening programs | 2015–16

Program	Participation rate
BreastScreen Australia	54.9%
National Cervical Screening Program,	58.6%
National Bowel Cancer Screening Program	42.3%

Reliable data showing participation of Aboriginal and Torres Strait Islander people in the national screening programs are only available for Victoria not specifically the EMPHN catchment.

- Participation of Indigenous women in *BreastScreen Australia* in 2013–14 was 34% compared with 54% in non-Indigenous women.
- Only 24% of Indigenous males and 9% of Indigenous females reported participating in bowel cancer screening tests in 2012–13.
- However, in 2012–13 in Victoria 76% of Indigenous women reported they had regular pap tests.



Our health risk factors contribute to chronic disease

Our health risk factors increase our risk of chronic disease

Health risk factors are characteristics associated with an increased risk of developing an illness or health condition.

The major preventable behavioural risk factors for disease are:

A. Tobacco-smoking
B. Excess alcohol consumption
C. Physical inactivity
D. Poor diet and nutrition
E. Overweight and obesity

Other biomedical risk factors for disease include hypertension and high blood lipids.

A. TOBACCO-SMOKING

Our smoking rates are high compared with the rest of Australia

Tobacco-smoking is a leading cause of preventable disease and death in Australia. Lung cancer, chronic obstructive pulmonary disease and ischaemic heart disease account for more than three-quarters of this disease burden.

Many other diseases are also associated with smoking, including: other cancers, a wide range of respiratory and cardiovascular diseases, pregnancy complications, hip fractures and low bone density, peptic ulcers, and dental problems.

In our catchment, 18% of adults smoke, compared with 14.7% nationally.[14] Smoking rates are very high in Knox (27% of adults) and Whittlesea-Wallan (23% of adults).

Aboriginal and Torres Strait Islander people in our community have very high rates of smoking (31%).[15]

B. EXCESS ALCOHOL CONSUMPTION

Drinking too much alcohol is associated with a variety of short-term health consequences, including road injuries, suicide and violence, as well as long-term consequences, such as liver cirrhosis, mental health problems, pancreatitis, foetal growth retardation and several types of cancer.

In the EMPHN catchment, 15% of adults exceed lifetime alcohol risk guidelines and drink more than two standard drinks per day on average, compared with 17% nationally.[16]

C. PHYSICAL INACTIVITY

Physical inactivity is increasingly recognised as detrimental to health, as it can contribute to cardiovascular disease, mental health problems, type 2 diabetes and some cancers.

In our catchment, 52% of adults are physically inactive, compared with 56% nationally.[17,18]

D. POOR DIET AND NUTRITION

Poor diet, such as low consumption of fruit and vegetables and high intake of salt, saturated fats and sugar is linked to poor health and disease.

In particular, cardiovascular disease, some cancers, type 2 diabetes, overweight and obesity, osteoporosis, dental problems, gall bladder disease and diverticular disease.

In our catchment, 46% of adults do not consume the recommended intake of fruit and vegetables.[19]

E. OVERWEIGHT AND OBESITY

Obesity and overweight increase our risk of a wide range of health problems, including cardiovascular disease, type 2 diabetes, some cancers, degenerative joint disease, obstructive sleep apnoea and mental health problems.

Table 4 illustrates prevalence of obesity in 2014–15 in the EMPHN. Almost two-thirds of adults in the catchment were overweight or obese—higher than the Australian average.[20]

Table 4. Adults with overweight and obesity | 2014–15

	EMPHN	Australia
Overweight	40.6%	35.4%
Obese	24.7%	27.5%
Overweight or obese	64.7%	62.8%

Our immunisation coverage rates are high

Immunisation coverage rates are high in our catchment compared to the rest of Australia

National immunisation targets require 95% of children to be fully immunised by five years of age. Table 5 shows the percentages of children in the EMPHN catchment in 2016–17 who were fully immunised at one, two and five years of age.

Our percentages were higher than for Australia as a whole, but less than the national target.

Aboriginal and Torres Strait Islander children living in our community have lower immunisation rates at one year of age, but rates are above the 95% target by five years of age.[21]

In 2015–16, 82% of girls and 77% of boys were fully immunised against human papillomavirus in the Eastern Melbourne PHN catchment compared with 80% of girls and 74% of boys nationally.[22]

Table 5. Childhood immunisation coverage, EMPHN | 2016–17

AGE	Percent of children fully immunised				Number of children not fully immunised	
	Eastern Melbourne PHN		Australia		Eastern Melbourne PHN	
	All	ATSI	All	ATSI	All	ATSI
1 year	94.3%	91.3%	93.8%	92.2%	991	18
2 years	91.2%	94.0%	90.9%	88.6%	1,572	10
5 years	93.9%	96.4%	93.5%	95.7%	1,118	–*

(– cell suppressed as small numbers)*

Our palliative care needs will increase

Our palliative care needs

Palliative care is an approach that improves the quality of life of people and their families facing the problems associated with life-threatening illness.

This is done through the prevention and relief of suffering by early identification, assessment and treatment of pain and other physical, psychosocial and spiritual problems.[23]

In the next 25 years the number of Australians who die each year will double.[24] More than 60% would prefer to die at home.[25]

Australia's rate of dying at home is comparatively lower than other similar OECD countries. According to the Grattan Institute report, *Dying Well*, 54% of people die in hospital, 32% die in residential care and 14% 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 people could have died at home, with appropriate support.

Stakeholder perspectives on palliative care services

Stakeholders identify after-hours access to palliative care as a service issue in the EMPHN catchment.[26]

According to stakeholders, 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.

Further, systems are lacking that would enable discharged palliative care patients to access medicines in a timely manner from community pharmacy.

Survey data from local end-of-life care providers identified the following barriers to people dying in their desired location:

- Inability for providers to allocate palliative clients a high priority for home care package in a timely manner.
- Family/carer stress.
- Uncontrolled symptoms.
- Resources or support not available in the place of choice of the person's death.
- Client living alone.
- Complexity of care needs.
- Syringe driver unavailability with RACFs.

Our work to improve palliative care service availability in the EMPHN catchment

Eastern Melbourne Primary Health Care Collaborative (EMPHCC) partners have committed to a joint priority project on end-of-life care, across the following priority areas:

- Priority 1. Training and education. All staff community and acute care and families, across all phases of end-of-life care; death literacy in the community, community awareness to make informed choices, carer capability to deliver person's choice.
- Priority 2. Service gaps. Inter-agency coordination and communication channels at transition of care; after-hours access to services.
- Priority 3. Services for carers throughout whole process by all service providers. Bereavement support.
- Priority 4. Individualised holistic care, including isolated/difficult to reach people/cultural and ethical issues/disabilities.
- Priority 5. Availability of resources to support people to die in their place of choice – physical and financial.
- Priority 6. Staff and/or family unwillingness/ability to follow end-of-life care plans – resources, practicality, knowledge, capability, comfortable with choices.
- Priority 7. Addressing variation in understanding of patient-centred care.
- Priority 8. Staffing skill mix to provide end-of-life care in residential aged care facilities.
- 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.
- Priority 10. Advanced Care Plans. Ensuring the 'where' is part of the planning – not just 'how'.

In addition, the Australian Government has commissioned a project exploring barriers to palliative care for nine population groups that are under-served or have complex needs.

These groups include:

- people who are lesbian, gay, bisexual, transgender or intersex (LGBTI)
- people from culturally and linguistically diverse (CALD) backgrounds
- Aboriginal and Torres Strait Islander people
- people with a disability
- people experiencing homelessness
- veterans
- refugees
- prisoners
- care leavers (which includes Forgotten Australians, Former Child Migrants and Stolen Generations) and people affected by forced adoption or removal.

SERVICE NEEDS ANALYSIS

To determine how we use our available health services and how well they meet our general health needs, we looked at:

- Our health service use
- Stakeholder perspectives on how well they thought available services meet our needs.

Health service use is increasing

Primary care is the main pathway into the health system for most people with chronic disease. It is their first point of contact and often their main form of care.

Primary care services include medical, nursing, pharmaceutical, diagnostic, allied health, mental health and dental, and for many, home and community support services.[27]

General practice services are accessed by the majority of people

Approximately 82% of adults living in the EMPHN catchment see a GP at least once every 12 months. On average, people attend their GP six times a year.[28]

Some people require more visits to their general practice to manage their health care needs. In the EMPHN catchment, 10% of adults visit the GP 12 or more times a year. People who lives in a residential aged care facility see a GP an average of 19 times a year.[29]

Most of the chronic disease burden in our community is managed in general practice[30,31]

We have 388 general practices in the EMPHN catchment. Of these, 57% are small in size—76 (20%) are solo practices (one general practitioner) and 142 (37%) have between 2 and 4 general practitioners; 93% have at least one practice nurse working in the general practice.

POLAR GP

POLAR GP stands for Population Level Analysis & Reporting for general practice. It is proprietary software that uses health analytics to inform quality improvement in general practice through analysis of their own identified patient data.

Not all practices have allied health providers co-located with the general practice. One in four practices provide GP services without co-located allied health providers, 14% have one allied health provider co-located in the practice and 61% have multiple allied health providers delivering services within the practice.

EMPHN analysed general practice data from 127 general practices across the EMPHN catchment, providing non-identifiable information on 518,200 active patients through a system called POLAR GP.

These data suggest that general practice manages significant proportions of people with respiratory diseases, cardiovascular diseases and musculoskeletal diseases. Rates of treatment of musculoskeletal diseases are lower than expected. This may be because general practices are not coding all people with musculoskeletal conditions in their data systems. Alternatively, people with musculoskeletal conditions may not be seeking treatment for these through general practice.

Table 6. Frequency of managing chronic conditions in general practice compared with self-reported prevalence of chronic conditions | 2018

Category	EMPHN rate of treatment in general practice	Victorian disease prevalence
Cardiovascular	20.5%	18.4%
Respiratory	33.3%	31.8%
Mental health	14.8%	17.5%
Musculoskeletal	20.2%	29.4%
Cancer	1.2%	1.4%
Diabetes	6.7%	5.1%

The management of chronic conditions requires a team of health professionals to be involved in care

In 2016–17, 17% of adults saw three or more health professionals for the same health condition.[32]

People attend a GP after-hours much less frequently than in regular hours

On average, 10% of people see a GP after-hours each year.

Rates of after-hours access for Indigenous people are the same as for non-Indigenous people.[33]

There are 0.6 after-hours GP attendances per person in the EMPHN catchment. This is higher than the national average of 0.5 after-hours GP attendances.

People may need to see a GP but do not

In 2016–17, 14% of adults in the EMPHN catchment needed to see a GP but did not.

The reasons people do not see the GP vary, and include being unable to get a timely appointment, unable to afford an appointment, not having time to see their GP and/or not prioritising their own health needs.[34]

Access barriers appear to be the main barrier. In the EMPHN catchment, 20% of adults report they feel they wait longer than acceptable to get an appointment with a GP and 29% of adults report they cannot access their preferred GP when they want to.

In comparison, only 4% of adults report they did not see or delayed seeing a GP due to cost and 6% of adults delay or avoid filling a prescription due to cost.[35]

Health conditions may require treatment from a medical specialist

In 2016–17, 36% of adults in the EMPHN catchment saw a medical specialist. On average, there was one specialist attendance per person.[36]

Hospital use is increasing

Hospitals provide emergency department, outpatient, day hospital and overnight care to people with a broad range of health conditions.

ED use is lower than the Australian average

Only a small number of people in our community use hospital emergency departments.

Hospital emergency departments are visited by a minority of people in the EMPHN catchment. An estimated 11.5% of our population visit an emergency department in any 12-month period, lower than the Australian average of 13.8%.[37]

Roughly equal numbers of people use emergency departments within regular hours as out of hours. In 2015–16 there were 66 emergency department attendance per 1,000 people in regular hours and 71 attendances per 1,000 people after-hours.[38]

Most of us have health insurance

Approximately 63% of people in our community have private health insurance, compared with 57% nationally.[39] Both public and private hospitals deliver care to people in the EMPHN catchment.

Hospitalisation rates are increasing

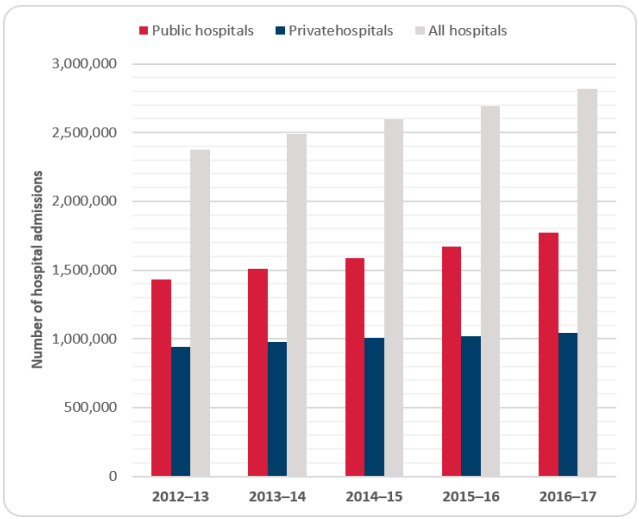


Figure 11. Admissions to Victorian public and private hospitals | 2012–13 to 2016–17

Hospitalisations refer to hospital 'separations' or episodes of care in a hospital. Rates of hospitalisation are increasing over time.

Figure 12 shows the rate of hospitalisations, which has increased by 4% per year in Victoria between 2012–13 and 2016–17.[40,41] Most of this increase was to public hospitals.

In our catchment, hospital admissions are also increasing over time. Further increases are predicted over the next 10 years, as illustrated in Figure 13.[42] This is largely due to our ageing population and predicted increases in chronic disease burden.

The number of admissions to public and private hospitals are relatively equal in our community, with the exception of Whittlesea-Wallan where most patients are admitted to public hospitals, and Boroondara where most patients are admitted to private hospitals[43] (Figure 14).

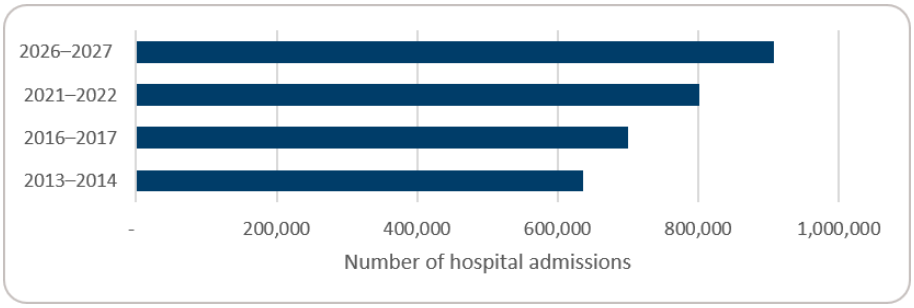


Figure 12. Current and predicted hospital admissions to public and private hospitals, EMPHN catchment | 2013–14 to 2026–27

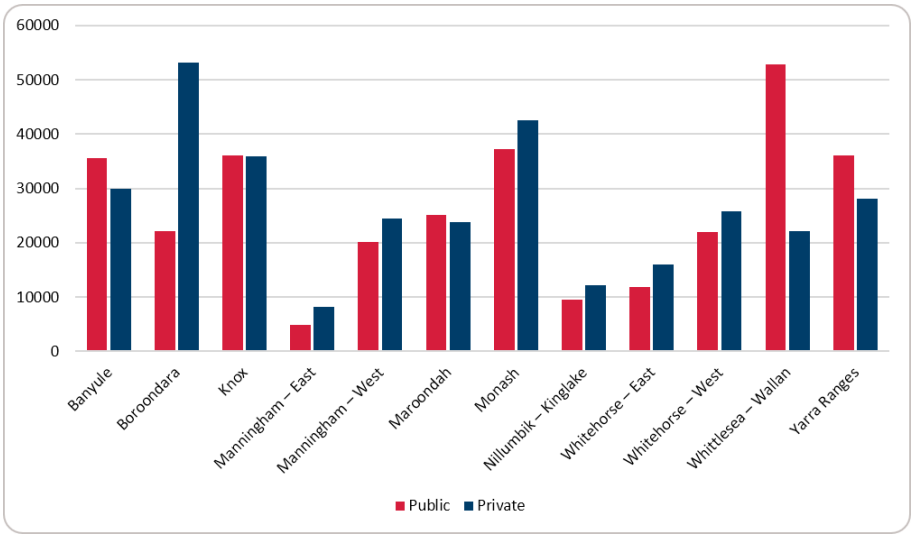


Figure 13. Admissions to public and private hospitals, Eastern Melbourne PHN catchment | 2016–17

The main reasons people were admitted overnight to a public or private hospital in Victoria in 2016–17 were injury and poisoning conditions, pregnancy and childbirth and diseases of the digestive, respiratory and cardiovascular systems[44] (Table 7).

Most hospital admissions for "injury, poisoning and certain other consequences of external causes" were falls (38%) followed by complications of medical and surgical care and exposure to mechanical forces (15% respectively).[45]

Table 7. Overnight admissions to Victorian public and private hospitals | 2016–17

	No. of overnight hospital admissions	Percentage of all admissions
Injury, poisoning and certain other consequences of external causes	81,173	12%
Pregnancy, childbirth and the puerperium	70,061	11%
Diseases of the digestive system	67,413	10%
Diseases of the respiratory system	65,696	10%
Diseases of the circulatory system	64,347	10%

Table 8 shows the main reasons for hospital admissions—public and private combined—in the EMPHN catchment in 2016–17. These were dialysis, chemotherapy and endoscopies.[46]

Table 8. Admissions to EMPHN public and private hospitals | 2016–17

EMPHN hospital admissions 2016–17	
Reason	**Number**
Renal dialysis	95,435
Chemotherapy	43,188
Colonoscopy	25,477
Complex gastroscopy	16,800
Other gastroscopy	15,989
Follow-up after completed endoscopy	15,907
Non-acute rehabilitation	15,899
Lens procedures	15,732
Vaginal delivery	10,367

Admissions for cancer are predicted to rise

Figure 15 illustrates that substantial increases in admissions are predicted in the future in our catchment for haematological / oncological conditions (cancers), compared with other clinical conditions.[47]

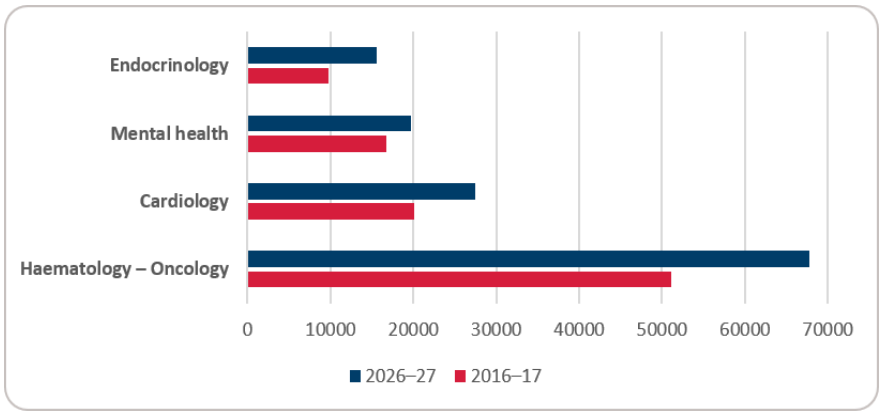


Figure 14. Admissions for major chronic conditions, Eastern Melbourne PHN catchment | actual 2016–17, predicted 2026–27

Preventable hospitalisations

Potentially preventable hospitalisations (PPHs) are defined as a group of medical conditions where hospitalisation is believed to be avoidable if timely and adequate non-hospital (primary) care had been provided.

Separation rates for PPHs are used as indicators for monitoring the quality or effectiveness of non-hospital (primary) care in the community.

PPHs are grouped into three broad categories:

- vaccine-preventable
- acute conditions
- chronic conditions.

In the EMPHN catchment approximately 37,000 hospital admissions per year are preventable.[48]

Chronic conditions account for 50% of our PPHs, followed by 43% for acute conditions and 7% for vaccine-preventable conditions.

Congestive heart failure, chronic obstructive pulmonary disease and diabetes complications account for the largest chronic disease PPH burden (in terms of total bed days in hospital and cost) in our community.

Kidney and urinary infections, cellulitis and gangrene account for the largest acute disease PPH burden[49] (Table 9).

Table 9: Potentially preventable hospitalisations, EMPHN | 2015–16

	Separations	Bed days	Cost ($M)
		CHRONIC	
Congestive heart failure	3,858	29,139	37.8
COPD	2,841	17,997	23.4
Diabetes complications	2,677	15,933	20.7
Iron deficiency anaemia	4,681	6,705	8.7
		ACUTE	
Kidney/urinary infection	3,658	15,900	20.6
Cellulitis	3,023	13,450	17.5
Gangrene	862	12,676	16.5
Convulsions and epilepsy	1,898	5,766	7.5

STAKEHOLDER PERSPECTIVES

The health system faces many pressures. There is growing demand for services, contributed to by an ageing population with increasing chronic disease burden. Avoidable hospital admissions remain a growing concern and presentations to EDs for complaints that could be managed in general practice remain high.[50]

Health services are fragmented

Issues repeatedly identified by stakeholders included:[51,52,53]

- poor coordination of care across primary, secondary and tertiary services
- poor communication and information sharing between services
- a lack of accountability of providers to support their patient's care needs when the patient changes care setting; e.g. hospital providers supporting hospitalised patients once back in the community.

Providers and consumers lack knowledge of available services

This results in narrow referral patterns—providers are referring to a few services that are well known to them rather than to the broad range of services that are available.

Improved ease and timeliness of communication are needed between providers

Communication and information-sharing by private hospitals with the rest of the service system are a particular issue in the EMPHN catchment.[54] RACFs often do not receive sufficient information from providers to facilitate ongoing care of their residents.

Digital health, data and technology are under-utilised

Digital health, data and technologies can enable health information continuity between providers. These technologies must meet security and privacy requirements of providers and consumers if they are to be adopted. Further, providers need to be appropriately funded and technologies need to integrate with practice software if providers are to adopt them. Technologies may include:[55]

- electronic patient portal
- application-based means of communication
- telehealth
- secure email capability.

People want access to services in the community and as close to home as possible.[56] There are a range of barriers that people with a chronic disease may experience in accessing a regular GP.[57]

- Sometimes lengthy waiting times to see a regular GP.
- Consultation time constraints favour symptomatic treatment (problem redress) over more holistic approaches and detailed education on self-management, impacting client care.
- Inadequate client knowledge of their condition and poor understanding of the need for ongoing chronic disease management.
- If the client has complex and/or multiple needs, chronic disease management may not be a personal priority.
- The client may have difficulty accessing transport.

People use hospital Emergency Departments inappropriately

People choose to present to an ED rather than a primary health service for many reasons, including:

- cost (no cost to attend ED)
- perception of timeliness and convenience of having multiple diagnostic services in one place
- close proximity to an ED
- greater expertise in tertiary facilities
- not having a regular GP
- inability to access a GP in their desired timeframe
- lack of consumer health literacy/knowledge and/or understanding of the health system and the purpose of ED
- lack of faith in GP skills. [58,59]

To divert patients from EDs to other care settings, we need to address factors at the level of patient, provider and system. This could include:

Patient	• Improved access to specific-GP same day appointments in the northern growth corridor. • Where possible, services should be located within the public transport network.[60] • Innovative telehealth models can be grown to overcome geographical barriers to access to services for consumers and overcome some transport issues.
Provider	• Mechanisms that support payment of providers for delivery of services through telehealth will enable innovation in telehealth service delivery.[61]
System	• Improved affordability of care is needed for people experiencing social and economic disadvantage.[62]

EMPHN can support general practice providers to identify people at 'rising risk' of hospital service use and enable intervention before these people become frequent presenters to hospital.[63] We are working with practices using POLAR predictive analytics to achieve this.

POLAR GP

POLAR GP stands for Population Level Analysis & Reporting for general practice. It is proprietary software that uses health analytics to inform quality improvement in general practice through analysis of their own identified patient data.

Identified service gaps

The following specific service gaps in the EMPHM catchment were identified by stakeholders:

Sexual and reproductive health services need to cater to a culturally and socioeconomically diverse population	Increased primary care workforce capacity is needed to address consumer need for long-acting contraception, emergency contraception, medical termination of pregnancy, improved sexual and reproductive health literacy, sexual health screening and HPV vaccination.[64]
End-of-life care can be improved	Approximately half of the population die in a hospital. Over 60% of people would prefer to die at home. Issues to address to enable people to die in their desired location include:[65] • Delivering individualised holistic care, including to isolated/difficult to reach people/different cultural groups and people with disabilities. • Making resources available–physical and financial–to support people to die in their place of choice. • Improving staff and/or family willingness/ability to follow end-of-life care plans. • Addressing variation in understanding of patient-centred care. • Improve the staffing skills mix in RACFs to provide end-of-life care. • Staff skills development to recognise end of life and to be comfortable with having appropriate discussions with the person and their families and carers. • Improve Advanced Care Plans – ensuring the 'where', not just the 'how', is part of the planning. • Provide better support for carers to respect patient wishes to die at home.
Immunisation coverage can be further improved	Community awareness and education is an important component of increasing immunisation coverage. Actions to proactively engage and support those in catch-up programs is also required to improve immunisation rates, underlining the key role of general practice in improving immunisation coverage. Rates of immunisation in children of parents that conscientiously object to immunisation are stable.[66]
General practice should be meaningfully engaged	General practice engagement with EMPHN is high for educational events. Engagement is variable in other EMPHN work areas.[67] The current model for general practice engagement is not effective or sustainable as there is one FTE of PHN staff liaison per 90 practices.[68] A more strategic engagement model is favoured by stakeholders, where EMPHN resources and tools are directed towards practices on the basis of their readiness to engage. Central to the success of this model is identifying and supporting the development of GP clinical leaders that can champion innovation in general practice.[69]

PRIORITIES

Our needs assessment shows that in the EMPHN catchment—and as per the World Health Organization (WHO)— the main chronic diseases contributing to our disease burden are cardiovascular diseases (like heart attacks and stroke), cancer, chronic respiratory diseases (such as chronic obstructive pulmonary disease and asthma), diabetes and mental health problems.[70]

Stronger primary care systems result in better health outcomes for people with chronic conditions. Systems are stronger if they are more comprehensive, coordinated, community-focused, universal, affordable and family-oriented. Available data shows that the chronic disease outcomes achieved by our primary care system need to be improved.[71]

Strengthening the primary care system to better manage chronic disease, including identifying people with rising risk, is one of the most important challenges for the EMPHN catchment. EMPHN's Strategic Plan articulates the transformative strategies we are adopting to facilitate health system improvement for people living with chronic conditions.

Stepped care for chronic conditions

EMPHN's priority is to implement stepped care approaches to chronic conditions management that are responsive to consumer needs.

The impacts of chronic illness fluctuate over time. Finding the right level of care depends on monitoring the person's chronic diseases over time and understanding their goals and wishes for care.

A stepped care approach to chronic conditions management provides proactive, planned care for people with chronic illnesses.

Care is based on guidelines for evidence-based management of chronic conditions. Simpler, less restrictive, less intensive options are tried initially. Care is guided by the patient's response to treatment and by regular review of the patient by the care team.

When care needs increase, a person in a stepped care model is supported to move from lower to higher levels of care.

The end result is people receive more effective, efficient, person-centred care.

EMPHN has supported the implementation of health pathways within general practice in our catchment through our *HealthPathways* program. These pathways enable providers to deliver evidence-based care appropriate to the patient's care needs. They also support providers to escalate people to higher levels of care as the need arises.

EMPHN is working with general practices to identify, through POLAR, people at increased risk of hospitalisation. Practices can identify people whose care needs are escalating and implement more intensive community-based care to keep people out of hospital.

Team-based, person-centred care

EMPHN's priority is to support and encourage primary care to adopt team-based care that is person centred.

In contrast to traditional models of managing chronic conditions, new models of chronic disease management require a team-based approach to care where people take a more active role in the day-to-day decisions about the management of their illness.

Partnership between the patient and health professionals is essential for effective chronic conditions management. This is because it offers the opportunity to empower people to become more active in managing their health. When people are more informed, involved, and empowered, they interact more effectively with healthcare providers and strive to take actions that will promote healthier outcomes.

When providers deliver chronic conditions management that is experienced positively by people, they are more engaged in their own care.

EMPHN integrates a team-based approach to delivery of care through all of its commissioning activities. In addition, through its Integrated Team Care work, is improving health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions. The Integrated Team Care program provides better access to coordinated and multidisciplinary care that is patient-centred.

Evidence-based care

EMPHN's priority is to build on practice-based evidence.

In order to be effective, care for chronic conditions should be based on evidence and coordinated primarily within general practice. General practice brings:[72]

- strengthened knowledge of the needs of individuals and local communities
- better leadership of change
- a focus on improving the quality of primary medical care as a key part of a clinically-led practice-based innovation.

A range of practice supports facilitate evidence-based decision making by general practice team members. Clinical pathways are one important tool to enable evidence-based decisions to be made by health care professionals within the consultation.

EMPHN will continue to work with primary care providers to implement *HealthPathways.* Through this work, providers are supported to deliver evidence-based care.

HealthPathways Melbourne Progress Report 2017–18 reported the following statistics:

- 95 new pathways
- 536 localised pathways
- 727 online requests
- 734 users per month
- 280,286 page views

136 GP clinics, community health centres and hospitals have automatic access.

EMPHN will continue to provide general practice with access to timely practice reports. Our practice reports deliver participating general practitioners with advice regarding their performance against evidence-based standards of care.

Innovation in care

EMPHN's priority is to build on practice-based innovation.

Transforming chronic conditions management will require innovative approaches to how we deliver primary care.

Practices may adopt a range of approaches to improve chronic conditions management, including:[73]

- voluntary patient enrolment with a practice or clinician who will coordinate and manage their care
- people, families and their carers are 'partners in care' and self-manage with the support of a health care team
- people have enhanced access to care; for example, videoconferencing and email support
- people nominate a preferred clinician who is responsible for coordinating their care
- service delivery is flexible.
- providers work at top of scope to better manage rising acuity in a community setting

Practice-based innovation requires general practice leadership as leadership is a key determinant for teams to deliver care. Leaders also create a practice-wide vision with concrete goals and objectives and are fully engaged in the process of change.[74]

EMPHN's *Practice 2030* program is developing the leadership and management capability of general practice within our catchment.

Health information continuity

EMPHN's priority is to enable health information continuity between providers.

EMPHN is advancing the use of technology and data to enable delivery of better care.

The growing number of administrative tasks imposed on clinicians, their practices and their patients divert time and focus from the more clinically important activities of clinicians and their staff.[75]

Using technology, particularly electronic communication and information-sharing, will reduce this administrative burden on clinicians and increase the availability of information for clinical decision support, hence improving the patient experience of care.

Information and data continuity between providers is essential for the delivery of coordinated care for chronic conditions.

Our 2016 survey of GPs and allied health providers demonstrated the following:

- 99% of general practices and 55% of allied health practices record patient notes electronically
- 65% of general practices are viewing and uploading to My Health Records. This is significantly higher than the national PHN benchmark of 47%.
- 42% of general practices and 15% of allied health practices are using secure messaging to send patient information to other providers securely.

EMPHN will continue to work with providers to increase eReferral and shared electronic health record adoption to enable delivery of better care for chronic conditions.

Robust data is used to inform and measure health outcomes.[76] EMPHN supports practices to use computer-based technology to track clinical, operational and patient experience metrics to monitor progress towards our goals and objectives.

Some people are at higher risk of frequent hospital service use. Through POLAR, EMPHN has developed a system for the early identification of people at increased risk of hospitalisation.

We assist providers to identify high-risk population groups using risk stratification techniques followed by implementation of targeted interventions.

Using POLAR, we also develop meaningful and robust data reporting for general practice that support quality improvement.

Integration of care

EMPHN's priority is to develop commissioning and system change strategies that encourage integration across the boundaries of primary, community and acute services.

Care that is team-based, person-centred and facilitated using health information technologies supports better integration of care across primary care and other health services.

Reduced fragmentation of services between primary care and other services to ensure the delivery of "the right service, at the right time, in the right place by the right team".

EMPHN supports a range of activities to improve health system redesign, with the aim of better service integration. Through the Eastern Melbourne Primary Healthcare Collaborative (EMPHCC), EMPHN is working with community health services, the Department of Health and Human Services, EACH, Eastern Health and general practice to support the management of chronic disease and complex conditions for people at risk of poor health outcomes across the catchment. A key focus is improving alignment of primary and secondary services providers in the shared objective of slowing the progression of chronic and complex disease, and preventing deterioration in the patient's clinical conditions.

SECTION 3:
MENTAL HEALTH

INTRODUCTION

Mental health problems and mental illness are one of the greatest causes of disability, reduced quality of life, and impaired productivity in our community.

A mental health problem is a clinically-diagnosable disorder that significantly interferes with a person's cognitive, emotional or social abilities.

The Diagnostic and Statistical Manual of Mental Disorders defines and classifies mental disorders into many types, including psychotic disorders, personality disorders, mood disorders and substance use problems.[77]

People affected by mental health problems often experience poorer general health, have higher rates of disease and are represented in higher rates of death, including by suicide.

Mental and behavioural disorders, such as depression, anxiety and substance use disorders, are major contributors to disability and morbidity.

Mental health problems and mental illness are the third leading cause of disability burden in our community.

Mental and behavioural disorders, such as depression, anxiety and substance use disorders are all major contributors to the burden of disease in the EMPHN catchment. Although classified as mental health disorders, substance use disorders are described in a separate chapter in this needs assessment.

One in five people in our community will have a mental health problem every year. Mental health problems cause disability, reduced quality of life, shorter life expectancy and impaired productivity in our community.

Most people with mental health problems also have chronic diseases. People with severe and enduring mental disorders die 15 to 20 years earlier than the general population.[78]

Mental health problems also contribute to disability and psychosocial support needs. At present, the psychosocial support needs of people with psychotic illnesses are not being adequately met.

We as a community need to make a major effort to improve the physical health of clients who receive mental health treatment. We need to support the systems that support people to work, socialise and be an active part of our community.

EMPHN has the following mental health priorities:

- Implement our mental health stepped care model. Our model:
  - integrates with general practice;
  - targets mental health needs of people across different age groups, including older people;
  - addresses the physical health needs of people with mental health problems; and
  - provides psychosocial support for people with complex and enduring mental health problems.
- Support community-based suicide prevention initiatives across the age continuum
- Develop an integrated regional mental health, alcohol and other drug and suicide prevention plan
- Address the priorities in the fifth national mental health and suicide prevention plan

Figure 15. Snapshot of mental health problems in Victoria | 2018

Mental health problems are a major part of our burden of disease

Mental and behavioural disorders are responsible for about 12% of the total burden of disease in our community. This ranks as our third broad disease group after cancer (18%) and cardiovascular diseases (15%).[79]

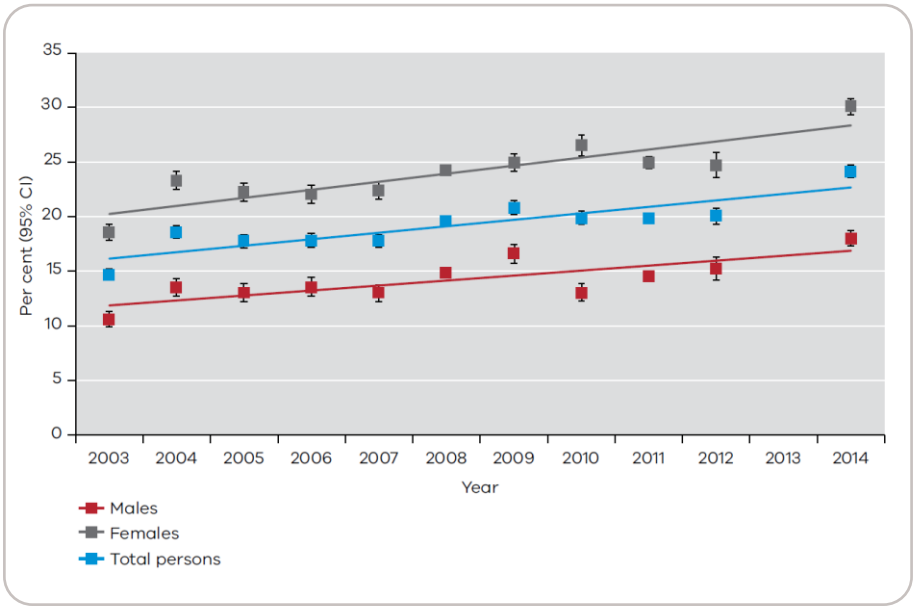
Mental health problems are common in our community

Around 45% of people aged 16–85 years will experience a common mental health-related condition such as depression, anxiety or a substance use disorder in their lifetime.[80]

The most common mental illnesses are anxiety and depressive disorders.

- Anxiety disorders are the most common with 14% of the Australian adult population experiencing an anxiety disorder in the past 12 months. This is followed by affective disorders such as depression (6%) and substance use disorders (5%).[81]
- An estimated 10% of adults in the EMPHN catchment report high or very high levels of psychological distress, lower than the Victorian rate of 12.5%.[82,83]
- Psychological distress is more common in disadvantaged socio-economic groups. Rates of high or very high psychological distress are highest in Whittlesea-Wallan (12%).[84,85]
- Women experience higher levels of high or very high psychological distress than men (14% compared with 8.5%).[86]
- Aboriginal Victorians are nearly twice as likely non-Aboriginals to report high distress.[87]
- 1 in 6 adolescents reports high or very high psychological stress.[88]

Severe mental illness affects 2–3% of our population



It's estimated that 2–3% of our population have a severe mental disorder.[89] This is not just people with psychotic disorders—it includes people with severe and disabling forms of other mental health problems.

Mental disorders can vary in severity and be episodic or persistent in nature. Severe mental illness includes conditions with low prevalence and severe consequences. This includes psychotic illnesses and severe personality disorders.

Figure 16. Prevalence of depression and anxiety, Victoria | 2003–2014

Psychotic illnesses are characterised by fundamental distortions of thinking, perception and emotional response.

The 2010 National Survey of People Living with Psychotic Illness report estimates that 0.5% of people in our community have a psychotic illness and are in contact with public specialised mental health services each year.

The most frequently recorded psychotic illness is schizophrenia which accounts for almost half of all diagnoses (47%).[90]

Young people experience a significant mental illness burden

- **Young people aged 18–24 years have the highest prevalence of mental illness of any other age group.**
- **Mental health disorders that emerge during childhood can have a lasting impact on the health and wellbeing of the person and on the lives of those around them.**
- **The onset of mental illness is typically around mid-to-late adolescence.**

Almost 1 in 7 (14%) of children and adolescents aged 4–17 years report having had a mental health problem in the previous 12 months.[91] Attention Deficit Hyperactivity Disorder (ADHD) is the most common mental disorder (7.4% of all children and adolescents), followed by anxiety disorders (7%), major depressive disorder (3%) and conduct disorder (2%).

Young people are at increased risk of experiencing multiple mental health problems simultaneously. Almost one-third (4% of all 4- to 17-year-olds) with a mental health problem have two or more mental disorders at the same time.[92]

There is a relationship between suicide and self-harm behaviours, with around half of all young people who die by suicide having previously engaged in self-harm behaviours.[93]

Approximately 11% of young people aged 12–17 years have ever self-harmed. Females are three times more likely to self-harm than males of the same age.[94]

Suicide is still a problem in our community

In 2016, 624 Victorians lost their lives to suicide.[95] For every suicide there are many more people—family, friends, carers, colleagues and communities — who are deeply affected.

Whilst this is a reduction on 2015 where 654 died by suicide, it demonstrates that more work needs to be done to help vulnerable Victorians who are at risk of suicide.

The most affected regions in our catchment are Maroondah and Whittlesea. Older people are increasingly represented in these statistics. Men over the age of 85 years have the highest suicide rate of any age group.

In 2015-16 there were 1,280 hospital admissions of people in the EMPHN catchment for intentional self-harm, including attempted suicide.[96]

One-third (4% of all 4- to 17-year-olds) of young people with a mental health problem have two or more mental disorders at the same time.

People with mental health needs often have additional physical health issues

Physical health conditions are prevalent in people with mental health problems. Almost 60% of people with a mental health problem report they have a physical health condition as well.[97]

COMORBID CONDITIONS **are health problems that are additional to the person's primary health issue**

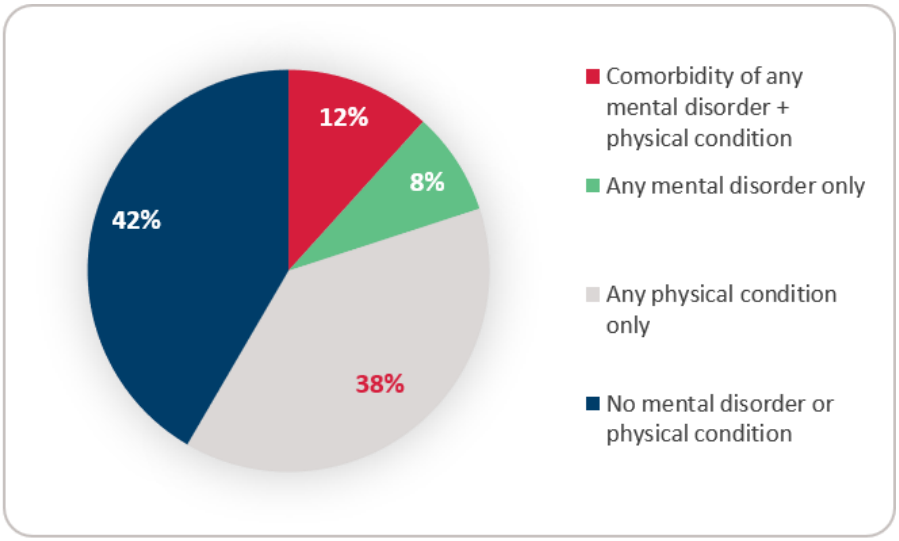


Figure 17. Prevalence of mental and physical comorbidity, ABS | 2012

Common comorbid conditions

- **People with severe mental health problems have poorer physical health, shorter life expectancy and die younger than the general population.[98]**
- **People with severe mental health problems are the most affected by comorbid conditions.**

Most people with mental health problems have chronic diseases. The most common additional health conditions that people living with mental illness experience are:[99]

- Heart and circulatory conditions
- Diabetes
- Epilepsy
- Severe headaches & migraine

People with severe and enduring mental disorders die 15 to 20 years earlier than the general population.[100]

Many chronic diseases are more prevalent in people with severe mental health problems[101] (Table 10).

Table 10. Prevalence of chronic disease in people with severe mental disorders, Australia | 2012

Chronic disease	Prevalence – general population	Prevalence – people with severe mental disorders
Heart / circulatory conditions	16%	27%
Severe headache / migraine	9%	25%
Diabetes	6%	21%
Epilepsy	0.8%	7%

Over one-quarter (27%) have heart or circulatory conditions and over one-fifth (21%) have diabetes (compared with 16% and 6% respectively in the general population).

Other comorbidities included epilepsy—7% compared with 0.8% in the general population, and severe headaches/migraines—25% compared with 9% in the general population.[102]

People with mental health problems also have higher rates of tobacco-smoking than the general population.

In 2015-16, 33% of registered clients of Victorian public mental health services who were hospitalised were smokers.[103] Unlike the general population, there has been little change in rates of tobacco-smoking over time in people with mental health problems.

Because chronic diseases and related risk factors are common in people using Victoria's mental health services, efforts are required across the health system— including public mental health services— to improve the physical health of clients receiving mental health treatment.

Many chronic diseases are made worse by mental health problems

Table 11 illustrates how many chronic diseases are made worse by the presence of a mental health problem.[104]

Table 11. Impact of chronic disease on mental health problems

Disease	Impacts
Diabetes	Depression increases risk of poor glycaemic control and microvascular complications
CVD	Mood disorders double the risk of poor outcome after cardiac event
Chronic lung disease	• People with COPD 2.5 times more likely to be depressed and depression in COPD increases exacerbations • 58% of people with exacerbations of COPD experience an anxiety disorder
Cancer	25% of people with cancer have anxiety or depression but only 20% of these are diagnosed and treated

Good mental health is central to the wellbeing of people, families, and communities. Maintaining good mental health in our population is a priority.

Mental health problems contribute to disability and psychosocial support needs

People with psychosocial support needs report a range of functional limitations, including problems with learning and applying knowledge, social and community activities, interpersonal relationships and working and employment. The majority of people have problems with more than one of these functional areas.[105]

People who need psychosocial support care have a range of mental health diagnoses, most commonly including mood disorders, anxiety disorders and psychotic delusional disorders. The data suggests that demand for psychosocial support is increasing over time.[106]

The psychosocial support needs of people with psychotic illnesses are substantial and largely unmet107

- Nearly one quarter of people with psychotic illness report feeling socially isolated and lonely.
- Two-thirds say their illness makes it difficult to maintain close relationships.
- Almost one-third live alone, however, 40.6% of reported they would prefer to be living with someone else.
- The majority of people had at least one friend (86.5%), however, 13.3% had no friends at all, 14.1% had no one they could rely on and 15.4% had never had a confiding relationship.
- Two-thirds (68.6%) had not attended any social programs and a similar proportion (69.4%) had not attended any recreational activities.
- Just over half (56.4%) of people with psychotic illness reported receiving no or minimal support from any source.

SERVICE NEEDS ANALYSIS

This section describes statistics and related information on the use of mental health services in the EMPHN catchment, with a focus on the primary mental care service system where data are available.

A broad range of health services deliver mental health care

Mental health care is delivered in a number of settings. Most mental health care is delivered by general health services rather than specialised psychiatry services. The most common service providers are:

1. **General practice**
2. **Hospital**
3. **Community based services**
4. **Disability and psychosocial support.**

1. General practice

General practitioners provide most of care for people in our community who have mental health problems.

According to the BEACH (Bettering the Evaluation and Care of Health) data, just under 18 million estimated GP visits were mental health-related in 2015–16, representing about 12% of all GP encounters.[108]

There has been an annual average increase of 4.7% in the number of estimated GP encounters that were mental health-related since 2011–12.

- Depression was the most commonly managed problem during a mental health-related estimated GP encounter—about one-third, or 32.1%, of encounters.
- The most common management of mental health-related problems was for the GP to prescribe, supply or recommend medication (61.6 per 100 mental health-related problems managed).
- People aged 65+ had the highest rate of encounters of all the age groups at 1,198.2 per 1,000 population, compared to a national rate of 749.9 per 1,000.

General practice is a key service for mental health.

Mental health problems are managed **in general practice**

As at 21 October 2018 there were 127 practices in the EMPHN catchment that provide non-identifiable data on 518,200 active patients to EMPHN through POLAR.

There are 77,974 patients in POLAR that have an active mental health diagnosis. Of these, most are experiencing mood disorders.

An additional 361 patients are being managed within general practice for problems associated with suicide or self-harm.

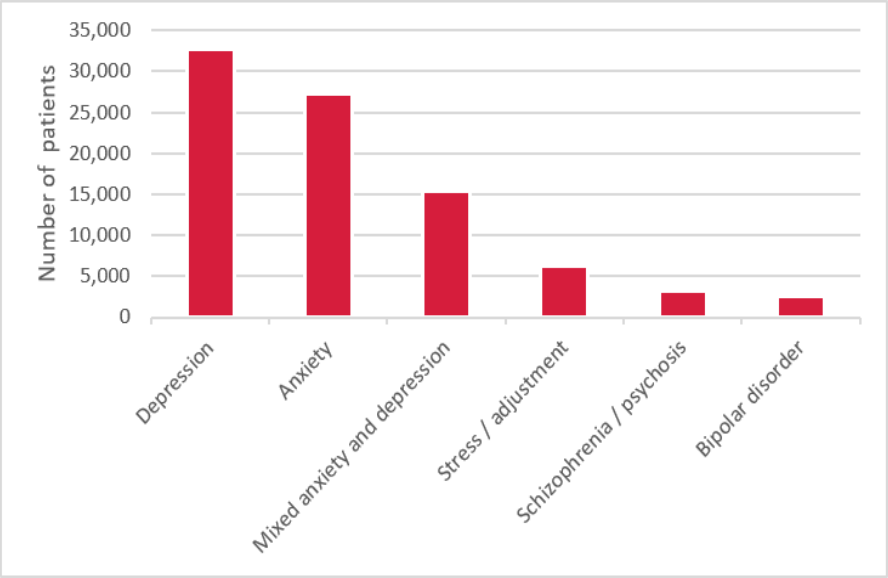


Figure 17. Mental health problems managed in general practice | 2018

POLAR GP

POLAR GP stands for Population Level Analysis & Reporting for general practice. It is proprietary software that uses health analytics to inform quality improvement in general practice through analysis of their own identified patient data.

2. Hospital services

Hospital mental health services are under increasing pressure

Hospitalisations of adults for mental illness are increasing, many services have very high occupancy levels, and people are being discharged after a relatively short time.[109] Hospital mental health services, particularly inpatient services for adults, are under increasing pressure to meet demand.

Almost 4% of all presentations to Australian emergency departments are mental health-related. Of these, 79% are triaged as semi-urgent (patient should be seen within 60 minutes) or urgent (seen within 30 minutes).

More than half (53.5%) of mental health-related emergency department presentations have a principal diagnosis of either neurotic, stress-related and somatoform disorders or mental and behavioural disorders due to psychoactive substance use.[110]

Highest inpatient demand is adults aged 26-44 living with schizophrenia

Inpatient public mental health services are accessed by 1.1% of the population.[111] Adults aged between 26 and 44 years comprise the largest group admitted to public hospitals for mental health problems. The most common diagnosis is schizophrenia.

Mental health hospitalisation rate in our catchment is lower than national rate

Rates of overnight hospitalisation for mental health problems are lower in the EMPHN catchment (84 per 10,000 people) than Australia as a whole (102 per 10,000 people).[112] Relative use of hospitals for mental health conditions by people who live in the EMPHN catchment is higher for private hospitals than public hospitals.[113]

When adults are admitted to a public hospital for a mental health problem in Victoria, they have an average length of stay of 9.5 days.[114] 57% of these admissions are compulsory. Upon discharge, 79% are followed up with a community mental health service within seven days.

Most adults are referred to public mental health services by hospitals (43%), followed by GPs (12%) or their families (8%).[115]

Children and young people usually receive their mental health treatment in the community

When hospitalisation is required, the length of stay is 6.9 days on average. Only 17% of these admissions are compulsory.[116]

3. Community-based services

Limited data is available

Data describing the use of community-based services by people with mental health problems are limited. There is no overarching data collection for community mental health services due to the diversity of community-based services available.

People access these services through a number of pathways, such as through hospital and community-based services, and through consultations with GPs, allied health professionals or medical specialists.

Mental health patients need accessible community-based services

Available data for people with severe mental health problems show these people have a high need for community-based services; three in ten people with psychotic illness receive mental health services through community-based non-government organisations.[117]

More than two-thirds (69.2%) of people with psychotic illness have a case manager; of these, 62% are provided by public services and 20% through community-based non-government organisations.[118]

School and health services are vital for young people

Young people commonly access community mental health services. Health and school services are the most common services used by 4- to 17-year-olds. *Headspace* is an early intervention service model aimed at providing mental health services to 12- to 25-year-olds. Over 7% of young people who participated in the Young Minds Matter Survey reported they had accessed *Headspace* services.[119]

4. Disability and psychosocial support services

Disability services and psychosocial support services deliver care to people with severe mental health problems

One in 250 people in our community use disability support services for mental health problems in any year.[120]

Psychiatric disability is the most frequently reported primary disability for people receiving non-residential disability support services. It is the second most frequently reported disability for residential disability support services.[121]

Employment services are the most frequently provided service for people with a psychiatric disability who don't use residential services.

Group homes are the most frequently used service for people with a psychiatric disability who also received residential services in 2015–16.[122]

Compared with non-Indigenous Australians, twice as many Indigenous Australians with a psychiatric disability use both residential and non-residential disability support services.

When accessing disability support services, people with psychiatric disability may receive residential support services, non-residential services, or both, depending on availability and their individual needs.

Non-residential support services include accommodation support, community support, community access, respite services, employment services, advocacy, information and alternative forms of communication and other support.[123,124]

Psychosocial support services aim to increase recovery opportunities for people whose lives are severely affected by their experience of mental illness. These services take a strengths-based recovery approach to helping participants better manage their daily activities and reconnect with their community.[125]

These services provide holistic support including providing links with other services such as:

- housing support
- employment and education
- drug and alcohol rehabilitation
- independent living skills courses
- clinical services
- other mental health and allied health services.

The psychosocial support services ensure services accessed by participants are coordinated, integrated and complementary to other services in the community. There is thus crossover between psychosocial support and disability support services for people with mental health problems.[126]

Psychosocial support services take a strengths-based recovery approach to helping people better manage their daily activities and reconnect with their community.

STAKEHOLDER PERSPECTIVES

Extensive consultation has been undertaken to identify the 'hard-to-reach' populations with mental health care needs.

Hard-to-reach populations are at significant risk of experiencing poor health outcomes across their lifespan and often do not have consistent or readily available access to mental health and other health care services.[127]

EMPHN commissions mental health services across the following operational priority areas where stakeholders provided feedback:

1. **Low intensity**
2. **Severe and complex**
3. **Comorbid conditions**
4. **Youth mental health**

1. Low intensity

People living with chronic, non-specific, mental health issues are a common presentation to general practice.[128]

Mental health issues are commonly encountered problems in allied health practice in the EMPHN catchment. Management is complicated by social and environmental factors for many patients.

2. Severe and complex

Some consumers with complex and severe mental health problems will be gradually transitioned to the National Disability Insurance Scheme (NDIS) for their care and support needs. Continuity of care for people with severe and persistent mental health problems who are not eligible for the NDIS is a priority. 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.[129]

Primary care providers need more support for general practice-coordinated management of people with psychological conditions. GPs feel that their patients with psychological conditions are among those they feel least supported to manage.[130]

According to allied health providers, 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.[131]

Priority needs of people living with severe and enduring mental illness include symptom control, social support (financial, housing, employment), addressing physical health needs, supporting access to mental health services and supporting families and carers.[132]

Effective supports for people with psychosocial support needs include supported employment and education, family psycho-education, social skills training, cognitive remediation and CBT.

Integrated drug and alcohol treatment is a priority and substance use disorders are a common comorbidity for people with severe and complex mental health needs. Intensive case management and supported housing are required supports for some people.

3. Comorbid conditions	Coordination of services between mental health and AoD, and services for assessment and management of people with dual mental health and AoD diagnoses are needed.[133] Addressing the physical care needs of people with mental health problems is a priority. We need to: • Build successful models of comprehensive care that integrate services to address mental and physical health needs • Develop clinical leadership in these models • Work with consumers to identify opportunities to improve the delivery of integrated service models • Use existing services and infrastructure wherever possible.
4. Youth mental health	There is a gap between the primary mental health care provided by *Headspace* and tertiary mental health services. Youth with severe mental health problems are under-served.[134] According to allied health providers, the stigma of mental illness and difficulties with access to care (particularly to a regular/preferred GP) were major concerns for young people with mental health problems.[135]

PRIORITIES

Our needs assessment demonstrates mental health problems affect a large proportion of our community and adversely affect the wellbeing of many people in our community. Responding to the large and growing mental health illness burden in our community is an important priority for EMPHN.

EMPHN recognises the importance of preventing mental health problems from developing. Participation in evidence-based mental health prevention initiatives is important for our community as a whole.

We commission mental health services across a continuum of illness severity, from prevention and early intervention, to care and support for people with severe and complex mental health problems.

This includes supporting delivery of:

- low-intensity, short-term, adult complex and severe, and psychosocial support services
- youth prevention and early intervention and youth severe mental health services
- services to respond to the mental health care needs of Aboriginal people and people receiving aged care services in our community.

Our priorities

EMPHN's Strategic Plan articulates the transformative strategies we adopt to facilitate health system improvement for people living with mental health conditions.

Through our commissioning activities and our partnerships with stakeholders, EMPHN is working towards a more integrated health service system that reduces mental health, alcohol and other drug and physical health silos of care. Our approach is characterised by:

- Multi-disciplinary approaches to the delivery of mental health care, providing care through mental health nurses, psychologists, other allied health providers, peer workers and general practice providers who work together and to their maximum scope of practice;
- Building the capacity of primary care to respond to the needs of people with mental health problems;
- Comprehensive assessment and clinical staging of people with mental health problems;
- Collaborative approaches to care planning for people' mental health needs; and
- Clear pathways between levels of mental health care as people's needs for care change, including streamlined pathways for re-entry to mental health services if required.

Our organisational priorities include to:

- Implement our mental health stepped care model. Our model:
  - integrates with general practice;
  - targets mental health needs of people across different age groups, including older people;
  - addresses the physical health needs of people with mental health problems; and
  - provides psychosocial support for people with complex and enduring mental health problems.
- Support community-based suicide prevention initiatives across the age continuum.
- Develop an integrated regional mental health, alcohol and other drug and suicide prevention plan.
- Address the priorities in the fifth national mental health and suicide prevention plan.

These are described next.

Implementing our mental health stepped care model

EMPHN's priority is to implement stepped care approaches in mental health that are responsive to consumer needs.

EMPHN has developed a mental health stepped care model that underpins how mental services will be commissioned by our organisation across our community.

Implementing a mental health stepped care model is a priority for EMPHN to ensure people with mental health problems receive care tailored to their needs that is timely and coordinated across different services.

Mental health stepped care is an evidence-based, staged system of care that includes a range of mental health interventions, from the least to most intensive. The level of intensity of care is matched to the complexity of the person's mental health need.

The model emphasises collaborative care, working with the patient, their general practitioner, care team and specialist mental health service providers when appropriate. The model addresses care needs holistically, and includes the person's mental and physical health, education and employment, alcohol and other drug, family and social functioning, and suicide and self-harm care and support needs.

The provision of psychological therapies for under-services and hard-to-reach groups in our community, and the delivery of mental health services for people with severe and complex mental illness are incorporated into our stepped care model.

Within the EMPHN catchment, a phased transition to our mental health stepped care model is progressing well. The Phase 1 transition commenced in January 2018 across the local government areas of Whittlesea, Nillumbik, Banyule and parts of the shires of Mitchell and Murrindindi. Phase 2 commenced in July 2018 across the outer east local government areas of Knox, Maroondah and Yarra Ranges. Phase 3 will commence in January 2019 across the local government areas of Manningham, Boroondara, Whitehorse and Monash.

Electronic communication and information-sharing facilitates better triage and integration of services.

EMPHN will continue to work with commissioned providers who care for people with mental health problems to increase the uptake of shared electronic health record adoption and eReferral. These are important tools to improve communication and information-sharing between mental health providers and the rest of the service system.

Supporting community-based suicide prevention initiatives

EMPHN's priority is to build on practice-based evidence and practice-based innovation in suicide prevention.

EMPHN will continue to work towards a systems-based regional approach to suicide prevention. Our mental health stepped care model that is inclusive of assessment and management of people with or at risk of suicide.

Our community-based suicide prevention activities include liaising, training and capacity-building activities with local health networks and other providers. We will help ensure appropriate follow-up and support arrangements are in place at a regional level for individuals after a suicide attempt and for other people at high risk of suicide (including Aboriginal and Torres Strait Islander people).

EMPHN, together with other Victorian PHNs, has partnered with the Victorian Government to support local communities to develop and implement place-based approaches to suicide prevention. The purpose is to take a systematic, coordinated approach to suicide prevention, with each site supported to implement proven suicide prevention initiatives. This approach brings together different parts of the community including those with who have been affected by suicide. It also includes schools, businesses, local councils, transport, police, health services, ambulance services, community agencies and the Aboriginal community-controlled sector.

Together, stakeholders will identify what is needed to prevent suicide and what types of initiatives will best support people in their local communities. We recognise suicide in older men is a particular issue in our community.

We have two suicide prevention project trial sites: Maroondah and Whittlesea.

EMPHN is also supporting the *Hospital Outreach Post-Suicidal Engagement (HOPE)* initiative, which provides assertive outreach support for people leaving hospital following a suicide attempt or intentional self-harm. The program is underway in six sites including Maroondah Hospital.

Developing our regional Integrated Mental Health, Alcohol and Other Drug and Suicide Prevention Plan

EMPHN's priority is to develop system change strategies that encourage integration in mental health, alcohol and other drugs and suicide prevention across the boundaries of primary, community and acute services.

Primary Health Networks have been tasked with the development of a Regional Integrated Mental Health, AOD and Suicide Prevention Plan. Developed in partnership with Local Hospital Networks (LHNs) and other key stakeholders in the region, the Regional Plan aims to support more integrated service delivery pathways that are targeted to consumers' needs across mental health, AOD and suicide prevention.

EMPHN commenced consultation on the development of the Regional Plan in late July 2018.

Addressing the priorities in the Fifth National Mental Health and Suicide Prevention Plan

In 2017 the Fifth National Mental Health and Suicide Prevention Plan was approved by the Council of Australian Governments. The Fifth Plan describes eight priority areas to improve mental health outcomes for Australians.

Table 12 shows where EMPHN will embed the priorities in the Fifth Plan across our mental health commissioning activities.

Table 12. Intersection of EMPHN commissioning areas with the priorities of 5th National Mental Health Plan | 2017

	Fifth National Mental Health Plan							
EMPHN areas	**Achieving integrated regional planning and service delivery**	**Suicide prevention**	**Coordinating treatment and supports for people with severe and complex mental illness**	**Improving ATSI mental health and suicide prevention**	**Improving the physical health of people living with mental illness and reducing early mortality**	**Reducing stigma and discrimination**	**Making safety and quality central to mental health service delivery**	**Ensuring the enablers of effective system performance and system improvement are in place**
Low intensity				✓		✓	✓	
Child and youth mental health services				✓		✓	✓	
Community based suicide prevention		✓						
ATSI mental health services		✓	✓	✓	✓	✓	✓	
Stepped care approach	✓	✓	✓	✓	✓	✓	✓	✓
Regional mental health and suicide prevention plan	✓	✓	✓	✓	✓	✓	✓	✓

SECTION 4:
INDIGENOUS PEOPLE

INTRODUCTION

The EMPHN community is home to more than 6,800 Aboriginal and Torres Strait Islander people, living mainly in Whittlesea-Wallan, Yarra Ranges, Knox and Banyule.[136]

Aboriginal and Torres Strait Islander people experience significant health inequities compared to the rest of the EMPHN population. They have a greater burden of chronic diseases like heart disease, diabetes, respiratory diseases and kidney disease and die approximately 10 years earlier than non-Aboriginal people in our state. Aboriginal people also experience higher rates of psychological distress and substance use problems.

Mainstream health services are not always capable of providing culturally-appropriate care and many Indigenous people experience cultural insensitivity when attempting to access the care they need.

Meeting the health needs of our Aboriginal and Torres Strait Islander community is a priority for EMPHN.

Through *Koolin Balit – Victorian Government strategic directions for Aboriginal Health 2012–2022* and through consultation, the Indigenous community in our catchment has identified the following priorities, which we have adopted:

1. A healthy start to life
2. A healthy childhood
3. A healthy transition to adulthood
4. Caring for older people
5. Addressing risk factors
6. Managing illness better with effective health services.

This section provides an overview of key Aboriginal health data. This evidence informs our priorities to support Aboriginal people to improve their health and wellbeing.

A limitation in our available data is that not everyone who is of Aboriginal and/or Torres Strait Islander background in our community is identified as such. Caution is therefore advised in interpreting some of these data.

Further, statistical data collected in smaller populations are less reliable than those from larger populations. Therefore, some data reported here are for the Aboriginal population of Victoria as a whole, rather than just our catchment.

Our Aboriginal population

Aboriginal people living in Victoria make up 0.9% of our population (Figure 19), the lowest proportion of any state or territory. The Northern Territory has the largest proportion at 30%.[137]

Our Aboriginal population is younger than the population as a whole

The Victorian Aboriginal population has a younger age structure than the non-Aboriginal population. We have larger proportions of young people and smaller proportions of older people. This is due to higher birth rates and reduced life expectancy compared to the non-Aboriginal population.

The median age of non-Aboriginal Victorians in 2011 was 37.3 years and in Aboriginal Victorians it was 21.7 years. More than one in three (35.2%) Aboriginal Victorians were under 15 years of age and just 4.3% were aged 65 or older.

Our Aboriginal population has a lower life expectancy

Aboriginal Victorians have, on average, a life expectancy approximately 10 years less than that of the non-Aboriginal Victorian population.[138]

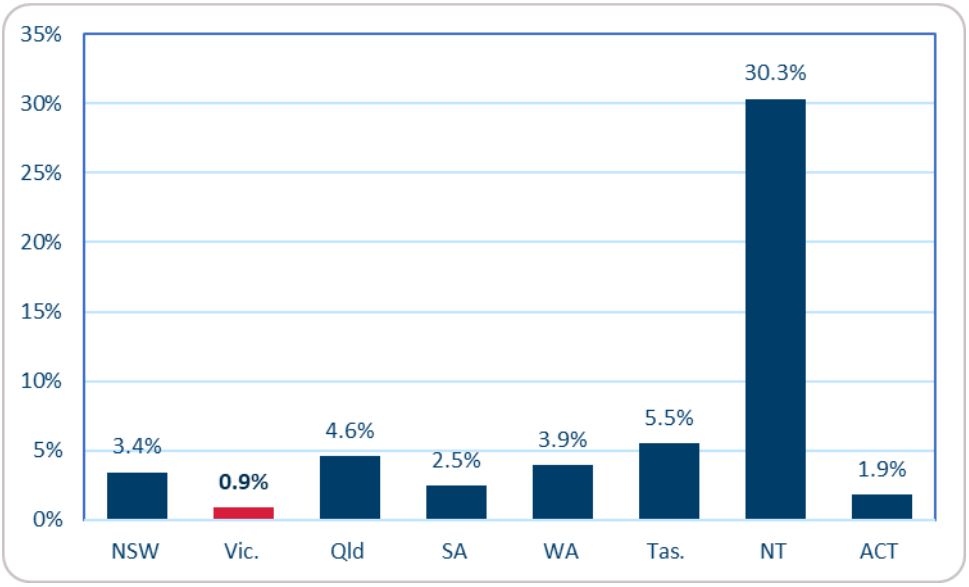


Figure 18. Percentage of Indigenous people by state/territory

Our Aboriginal population experiences more chronic disease

Aboriginal people experience disproportionately high rates of chronic diseases and health risk factors, despite being younger overall than the non-Aboriginal population. In the Aboriginal population within the EMPHN catchment:

- 76% report having a long-term health condition, with 60% having two or more chronic conditions.[139] This is higher than the Australian Aboriginal and Torres Strait Islander population as a whole, where 67% report having a long-term health condition and 46% have two or more chronic conditions.
- People report poorer self-assessed health (33.5% have fair or poor self-assessed health) than the non-Indigenous population (13% of non-indigenous people have fair or poor self-assessed health).[140]
- People experience high rates of overweight and obesity (62% of people aged over 2 years) and high rates of tobacco-smoking (33% of people aged 15 years or over).[141]
- Pregnant Aboriginal women also have high rates of smoking (31%).[142]

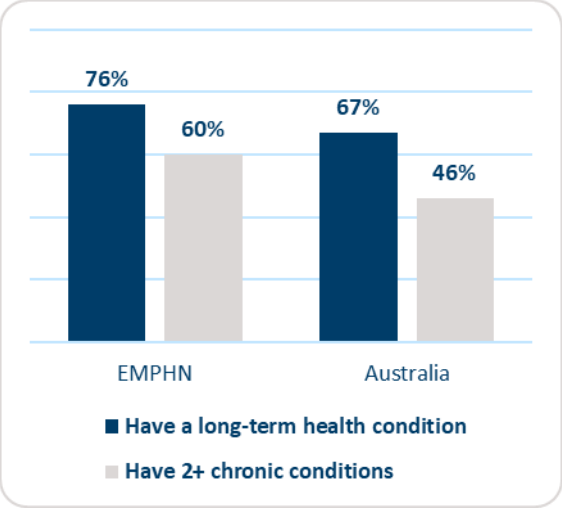


Figure 19: Chronic disease rates in Aboriginal people | 2012–13

Our Aboriginal population has a poorer health status

The following factors can indicate the health status and outcomes of a population:

- Low birthweight
- Disability
- Mortality
- Cancer
- Cardiovascular disease
- Respiratory disease
- Diabetes
- Chronic kidney disease

These indicators demonstrate areas where health status has improved for Aboriginal people in our community, but also where there are opportunities for further improvement.

Low birthweight

Low birthweight is more than twice as common among babies born to Indigenous mothers compared with those born to non-Indigenous mothers in Victoria (13.2% compared with 6.4%).[143]

Low birthweight refers to babies who weigh less than 2,500 grams at birth. Low birthweight usually means the baby has been born early or is small for their gestational age, which indicates that there may have been a restriction of their growth within the uterus.

Low birthweight infants are at a greater risk of dying during their first year of life. They are prone to ill-health in childhood and to developing chronic diseases as adults, including cardiovascular disease, high blood pressure, kidney disease and type 2 diabetes.

Disability

In Victoria in the 2014–15 year, 49% of Indigenous Australians aged 15 and over reported having a disability or a restrictive long-term health condition.[144] This compares with 31% for non-Indigenous people.

Almost 7% of Indigenous people in Victoria report they need assistance with core activities. For Indigenous people in Victoria under the age of 65 years, 50 per 1,000 had used disability support services, 2.9 times the rate of non-Indigenous people.[145]

High mortality rate

The death rate of a population provides a summary measure of the overall health status of that population. The all-cause mortality rate for Indigenous Australians is 1.7 times that for non-Indigenous Australians. Figure 21 illustrates the age-standardised avoidable death rate for Indigenous Australians, which is 3.3 times the rate for non-Indigenous Australians.[146]

Unfortunately, there is no Indigenous mortality data for the state of Victoria because there is not enough Indigenous identification in this data.

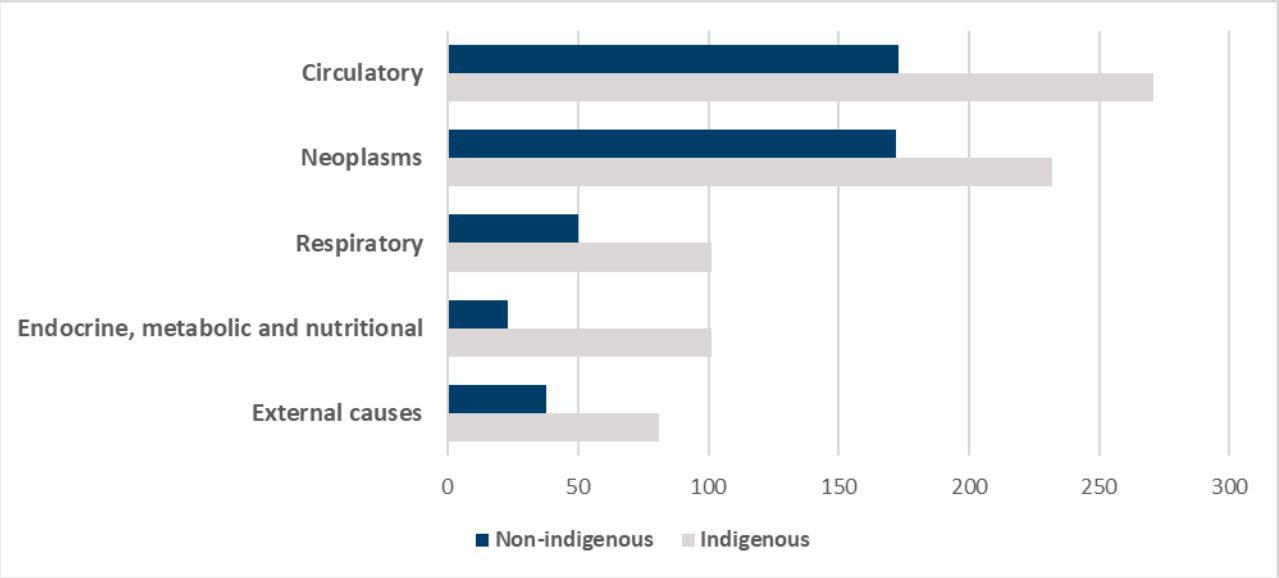


Figure 20. Age-standardised mortality rates for most common causes of death

Potentially avoidable deaths

Potentially avoidable deaths in Indigenous Australians refers to deaths in the 0–74 age range, from conditions that are considered avoidable. This means that the death could have been avoided if timely and effective health care had been accessed. This includes disease prevention and population health initiative).

Cancer

Indigenous Australians have higher rates of death due to cancer, and higher incidence of some screen-detectable and many preventable cancers.[147] They are also diagnosed at more advanced stages, and often with more complex comorbidities. In 2008–2012 in Victoria, the age-standardised incidence rate of cancer was higher for Indigenous people (504 per 100,000) than for non-Indigenous people (405 per 100,000). Incidences of bowel, digestive system, lung, and cervical cancers were higher for Indigenous than for non-Indigenous people.[148]

Cardiovascular diseases

In Victoria, 10% of Indigenous Australians have a heart/circulatory condition.[149]

Between July 2013 and June 2015 the age-standardised rate for hospitalisation for circulatory diseases was 1.3 times the rate for non-Indigenous people in Victoria.[150]

There has been a 79% increase in hospitalisation between 20014–15 and 2014–15 for circulatory diseases. For non-Indigenous people there was a 19% decline.[151]

Circulatory diseases are a major cause of morbidity and mortality for Indigenous Australians. They are more common among Indigenous than non-Indigenous Australians and tend to occur at younger ages.

Deaths from most conditions are influenced by a range of factors in addition to health system performance, including the underlying prevalence of conditions in the community, environmental and social factors and health behaviours.

Respiratory disease

In 2012–13, 38% of Indigenous people in Victoria reported having a respiratory disease that had lasted or was likely to last for six months or more.[152] This was 1.4 times the rate that non-Indigenous people in Victoria reported having respiratory diseases.

The age-standardised hospitalisation rate for Indigenous people in Victoria for respiratory diseases is 1.6 times the rate for non-Indigenous people. This rate increased by 68% from 2004–05 to 2014–15. In comparison, the rate for non-Indigenous people remained relatively stable.[153]

Aboriginal and Torres Strait Islander peoples experience higher mortality and morbidity from respiratory diseases than other Australians. Diseases include asthma, chronic obstructive pulmonary disease (COPD—which includes bronchitis and emphysema), pneumonia and invasive pneumococcal disease.

Diabetes

Type 2 diabetes is a significant contributor to morbidity and mortality for Indigenous Australians. Nationally, the age-standardised rate for Indigenous Australians aged over 18 with diabetes was 18%. This was 3.5 times the proportion for non-Indigenous Australians (5%).[154]

Hospitalisation rates for diabetes for Indigenous people were three times the rate for non-Indigenous people in Victoria for the 2013–14 and 2014–2015 years.[155]

Victorian prevalence data for Indigenous people are not available from national surveys.

Chronic kidney disease

Indigenous Australians experience twice the rate of kidney disease compared with non-Indigenous Australians.[156]

Nationally in 2011–13, based on biomedical results, the age-standardised rate of Indigenous Australians aged 18 and over with chronic kidney disease was 22%. This was twice the proportion for non-Indigenous Australians (10%).[157]

In Victoria, for the 2013–14 and 2014–2015 years, hospitalisation rates for kidney disease for Indigenous people were 40% higher than the rate for non-Indigenous people.[158] This does not include people who attended for dialysis.

Kidney disease can be a disease in its own right or can be caused by the kidneys being permanently damaged by various acute illnesses or by progressive damage from other chronic conditions.

Data on kidney diseases are not available from national surveys for Victoria.

Social and emotional wellbeing is important for better health outcomes

For Indigenous Australians, health is not just the physical wellbeing of the individual but the social, emotional and cultural wellbeing of the whole community. Our available data show more needs to be done to support Aboriginal people in Victoria to achieve higher levels of social and emotional wellbeing.[159]

Psychological distress

In 2012–13 in Victoria, the age-standardised rate for Indigenous Australians aged 18 and over who reported high or very high levels of psychological distress was 32%, compared with 11% for non-Indigenous Australians.[160]

Mental health

From July 2013 to June 2015, the age-standardised hospitalisation rate for Indigenous Australians in Victoria for mental health-related conditions was 23 per 1,000, compared with 15 per 1,000 for non-Indigenous Australians.[161] The highest hospitalisation rate for Indigenous Australians was in the 35–44 age group.

Self-harm

Death data for intentional self-harm for Indigenous Australians in Victoria are not available. Nationally between 2011 and 2015 the age-standardised death rate for Indigenous Australians for intentional self-harm was 2.1 times the rate for non-Indigenous Australians.[162]

In 2014–15 in Victoria, community mental health services were accessed by Indigenous people at 3.1 times the rate for non-Indigenous people.[163]

The age-standardised hospitalisation rate for mental health-related conditions for Indigenous Australians in Victoria increased by 22% between 2004–05 and 2014–15 whereas the rate for non-Indigenous Australians decreased by 24%.[164]

Substance use

40% of Indigenous people in Victoria report using substances in the last 12 months. Primary health care services deliver care to people with substance use disorders. Between June 2014 and May 2015 in Victoria, 57% of Indigenous primary care organisations provided alcohol use treatment and prevention services compared with 40% of services nationally.[165]

Community functioning improves social and emotional wellbeing

Community functioning has a direct impact on the health and wellbeing of Aboriginal people.[166] Community functioning is the ability and freedom of community members and communities to determine the context of their lives and translate capability into action.

Connectedness to Country, land and history; culture and identity

In 2014–15 in Victoria, 69% of Indigenous Australians aged 15 and over reported that they recognised their homelands, 57% identified with a clan or language group, and 52% had attended an Indigenous cultural event in the last 12 months.[167]

Indigenous people show resilience

In 2014–15 in Victoria, 88% of Indigenous Australians aged 15 and over reported that they did not avoid situations due to past discrimination, 85% agreed that their doctor could be trusted and 67% agreed that the local school could be trusted. 96% had participated in sport, social or community activities in the last 12 months, and 33% of employed people said work allowed them to fulfil cultural responsibilities.[168]

Role, structure and routine

In 2014–15 in Victoria, only 33% of Indigenous Australians 15 and over reported that they had lived in one dwelling in the last 12 months.[169]

Some of our Aboriginal community do not feel safe

In 2014–15 in Victoria, 79% of Indigenous Australians aged 15 and over reported that they had not experienced physical or threatened violence in the last 12 months, 86% felt safe at home alone after dark, and 63% felt safe walking alone in the local area after dark.[170]

SERVICE NEEDS ANALYSIS

This section describes available information about our current use of health services and feedback from our stakeholders about services to meet our Indigenous health service needs.

Hospitalisations for Aboriginal people

The age-standardised hospitalisation rate (excluding dialysis) for Indigenous Australians in Victoria from July 2013 – June 2015 was 359 per 1,000. This was the same as the rate for non-Indigenous Australians.[171]

The age-standardised rate for care involving dialysis was the leading reason for hospitalisation for Indigenous Australians in Victoria (252 per 1,000). The next most common reasons were pregnancy and childbirth (51 per 1,000) and diseases of the digestive system (38 per 1,000).[172]

Rates of care involving dialysis are much higher for Indigenous people than non-Indigenous people. In Victoria, the age-standardised hospitalisation rate (excluding dialysis) increased at a faster rate between 2004–05 and 2014–15 for Indigenous Australians than for non-Indigenous Australians: an increase of 92% (from 191 to 371 per 1,000) compared with 4% (from 332 to 351 per 1,000).[173]

Hospitalisation rates are highest for people aged 65 years and over, the same as the general population.

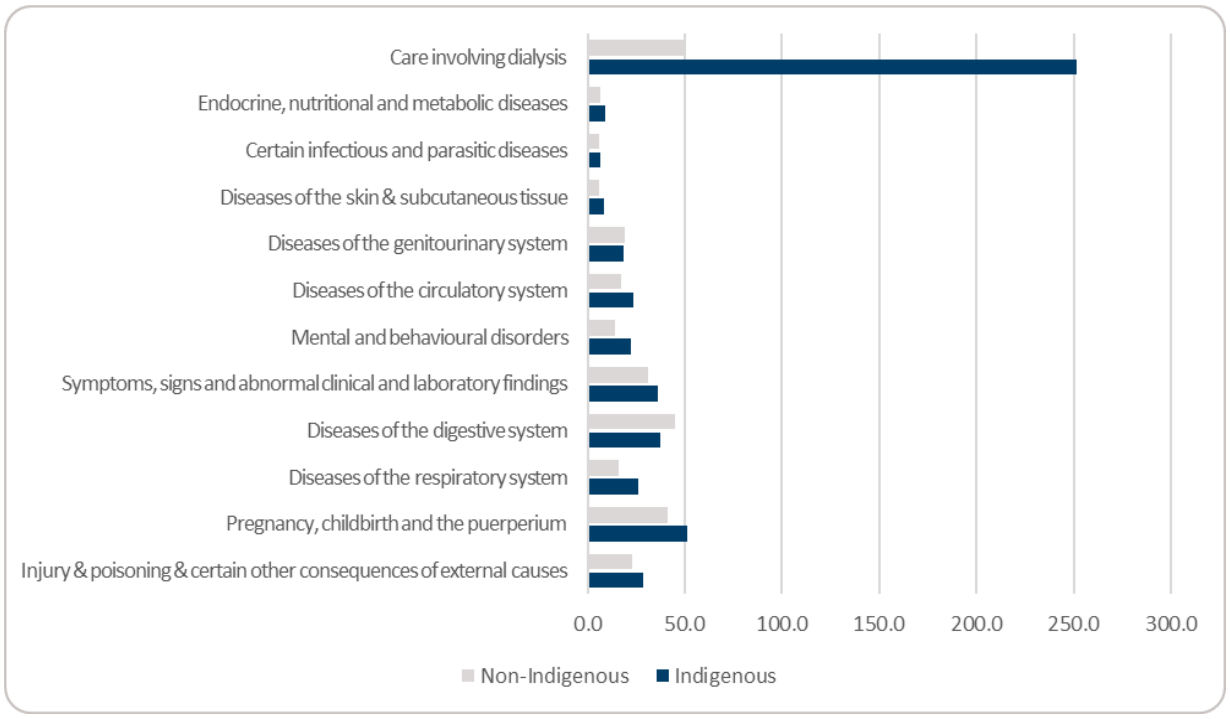


Figure 21. Age-standardised hospitalisation rate per 1,000 population, by principal diagnosis and Indigenous status, Victoria, July 2013– June 2015

Primary care services used by Aboriginal people

Primary care services deliver the majority of health care. Avoiding or delaying seeking care can lead to worsening of people's health status and increased need for hospital services. In 2012–13 in Victoria, 37% of Indigenous people aged two and over were reported to have not seen a health provider when it was necessary.[174]

The dentist was the most common service not accessed when needed (23%), with cost the most common reason (38%). For Indigenous Australians of all ages in Victoria, other services that were not accessed when needed included doctors (20%), other health professionals (14%) and hospitals (8%). For those aged 18 and over, 15% didn't access counsellors.[175]

Improving the cultural competency of health care services can increase Indigenous Australians' access to health care, increase the effectiveness of care that is received, and improve the disparities in health outcomes.

In 2012–13, 43% of Indigenous Australians didn't access a health service for reasons relating to the cultural appropriateness of the service (discrimination or language problems, dislike of the service or professional; was embarrassed or afraid, felt the service would be inadequate or didn't trust the service).[176]

Indigenous-specific primary care data are available for diabetes management in Victoria.[177] In 2012–13 in Victoria of all Indigenous Australians with current and long-term diabetes or high sugar levels:

- 72% reported having undergone HbA1C testing in the last 12 months, compared with 58% for non-Indigenous Australians
- blood glucose levels were checked for 98% of Indigenous Australians, compared with 94% for non-Indigenous Australians
- feet were checked for 65% of Indigenous Australians compared with 72% for non-Indigenous Australians.

For Victoria and Tasmania combined, the proportion of Indigenous clients of Indigenous Specific Primary Health Services (ISPHS) with type 2 diabetes who had a GP management plan (GPMP) in the past 2 years increased from 37% in 2012 to 40% in 2015.[178] A similar pattern was seen for ISPHS clients with a team care arrangement (TCA): the proportion increased from 35% in 2012 to 37% in 2015.

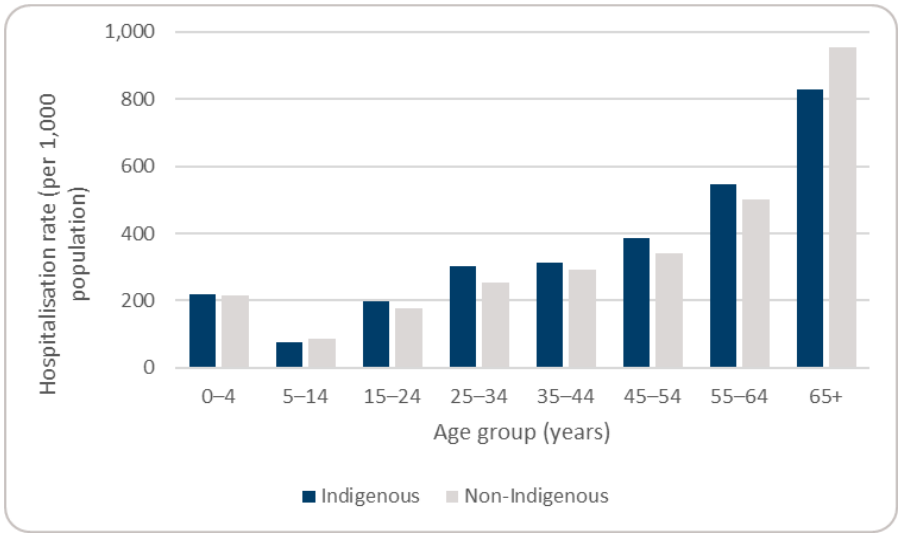


Figure 22. Age-specific hospitalisation rate (excluding dialysis), by Indigenous status, Victoria | July 2013–June 2015

The importance of the Aboriginal community-controlled sector

Aboriginal Community Controlled Health Organisations (ACCHOs) are the preferred provider of services to Aboriginal people wherever possible. An ACCHO is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected board of management.

Leadership in ACCHOs involves both ACCHO management and the community. Local communities determine their health and social care priorities.

The place-based approach needs to be supported to encompass a community development approach, fostering local partnerships.

The models of comprehensive primary health care developed with government and research partners that are used in ACCHOs is team-based and well described in the literature.

Clinical services, health promotion, cultural safety and community engagement are the essential components in these models. In addition, particularly for maternal and child health, models of family-centred primary health care extend comprehensive team-based care of individuals to members of families or households, often with outreach services.

These models complement the resources, time and evidence base needed to manage more problems of greater complexity at each consultation than are usually seen in mainstream general practices.

Aboriginal Community Controlled Organisations within our community are:

- Mullum Mullum Indigenous Gathering Place
- Healesville Indigenous Community Services Association
- Boorndawan Willam
- Bubup Wilam for Early Learning.

The Victorian Aboriginal Health Service provides services in the EMPHN catchment.

The role of mainstream health services

Not all services can be provided by ACCHOs. Therefore, high-quality, culturally safe mainstream services are also required to be accessed by Aboriginal people.

Historically, not all clinical services have provided culturally sensitive and appropriate services. This can range from providers displaying bias or discrimination to simply failing to identify their Aboriginal and Torres Strait Islander people, resulting in that person not having access to relevant care and support.

Contributing to this situation is the fact that for many health services, Aboriginal and Torres Strait Islander people are a small proportion of their patient population. This has made it challenging for such practices to develop the necessary competence in Aboriginal and Torres Strait Islander health.

Effectively responding to the prevalence of chronic disease in the Aboriginal and Torres Strait Islander population relies on meeting these challenges.

STAKEHOLDER PERSPECTIVES

Two community consultation workshops were undertaken in September 2013. They were the Department of Health EMR *Koolin Balit* and Aboriginal Health Community Consultation Workshops for the inner east and outer east regions.

In addition, we have drawn feedback from the Healesville Indigenous Community Services Association *Community Engagement Report,* to better understand the specific needs of our Indigenous peoples.

Cultural insensitivity is experienced frequently

There are significant reported experiences of cultural insensitivity by hospital staff to Indigenous people who presented at or were admitted to hospital, resulting in:[179]

- people experiencing discomfort in having to volunteer their Indigenous status
- people feeling physically unsafe about waiting in an emergency department
- people discharging themselves without treatment due to long waiting times, especially if children were involved
- confusion about the exact role of the Aboriginal Health Liaison Officer.

Aboriginal people experience difficulty accessing services

Aboriginal and Torres Strait Islander clients often have difficulty accessing suitable services.

Centralisation of Aboriginal health services creates access difficulties and disincentive, especially for the greater numbers of clients who are in catchment's outer areas.

These clients need culturally appropriate care and often there are no local, culturally appropriate specialty services. Affordability is an additional issue which is compounded by limited bulk-billing services.

Mainstream health services can be culturally inappropriate

A significant issue for community members is that many mainstream services are not culturally appropriate. 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.

Many mainstream services don't have an appropriate understanding of the transgenerational trauma associated with Indigenous-colonial relations and its impact.

The consequences of these relations have had a major negative impact on Aboriginal peoples' mental health, use of alcohol and other drugs, suicide rates, children in out-of-home care and overall health and wellbeing.

If staff were not providing culturally appropriate care, clients wanted to leave the service as soon as possible, even against medical advice, or would neglect to attend multiple appointments.

Aboriginal people experience difficulty arranging appointments

Service providers often assume that Aboriginal and/or Torres Strait Islander community members are able access their service, have a means of contacting them, and are aware of the services they offer and what financial support is available.

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. A perceived lack of financial support prevents some community members from accessing services.

Around three-quarters of general practice survey respondents and the majority of allied health survey respondents indicated that Aboriginal and/or Torres Strait Islander clients, and in particular children and youth under 18 years, tended not to attend, or were not identified as attending, their practice.

PRIORITIES

EMPHN works with Aboriginal people to progress *Koolin Balit – Victorian Government strategic directions for Aboriginal Health 2012–2022*.

The key priorities our Aboriginal stakeholders have shared with us through our consultations and *Koolin Balit* are:

Koolin balit means 'healthy people' in the Boonwurrung language

1. A healthy start to life
2. A healthy childhood
3. A healthy transition to adulthood
4. Caring for older people
5. Addressing risk factors
6. Managing illness better with effective health services.

EMPHN initiatives to support key priorities

EMPHN is committed to support the achievement of these key priorities. We will achieve this through improving data and evidence, supporting strong Aboriginal organisations and improving cultural responsiveness. We continue to support cultural safety training for practice staff.

EMPHN is developing a Reconciliation Action Plan to improve cultural understanding.

We are developing a Reconciliation Action Plan in consultation with Aboriginal communities across our region. The Reconciliation Action Plan will help refine and consolidate the way we engage and work with Aboriginal Communities. It will continue to drive the organisation toward better understanding of the best ways of supporting our Aboriginal communities.

The Reconciliation Action Plan will help guide how we integrate community knowledge, the best evidence and our own learnings, with the planning, development and implementation of future commissioning policies and practices.

Supporting good mental health

Aboriginal Victorians experience higher rates of psychological distress than non-Indigenous Victorians, and more Aboriginal children have emotional and behavioural problems when they start school.[180]

The Victorian 10–year mental health plan (2015) aims to reduce the gap in mental health and wellbeing for Aboriginal Victorians. A framework has been developed under the plan:

Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework

The Framework aims to improve the social and emotional wellbeing and mental health outcomes for Aboriginal communities. The framework focuses on Aboriginal healing, trauma-informed practice and recovery and, most importantly, self-determination.

The Framework commits to action to deliver locally-designed community responses and to build a more culturally responsive service system with an expanded skilled Aboriginal workforce.

Statewide initiatives supporting the strategic priorities in *Balit Murrup* include:

- new service models for Aboriginal Victorians with moderate to severe mental illness, trauma and other complex social support needs
- expanding the Aboriginal mental health and drug and alcohol workforce.

SECTION 5:
ALCOHOL + OTHER DRUGS TREATMENT

INTRODUCTION

Alcohol is the main cause of substance-related harm in our community.

Health problems caused by alcohol and other drug use affect the EMPHN community as a whole.

Most adults in our community consume alcohol, and many consume alcohol responsibly, however a substantial proportion of people drink alcohol in quantities that exceed the recommended level, which increases their risk of alcohol-related harm.

The majority of alcohol-related treatments can be delivered in the community by our primary care workforce.

Misuse of other drugs besides alcohol causes death and disability and is a risk factor for many diseases. It is also closely associated with risks to users' family and friends and to the community.

Whilst we do have a highly-developed alcohol and drug services network, we can strengthen our community-based systems further in order to:

- reduce avoidable emergency department presentations, hospital admissions and deaths caused by alcohol and other drugs
- reduce the impact of alcohol and other drugs on our communities including our Aboriginal community
- reduce harm associated with methamphetamines ('ice').

EMPHN's alcohol and other drugs treatment priority is to adopt the transformative strategies outlined in the EMPHN Strategic Plan in order to:

- build the capacity of the primary care workforce to respond to alcohol and other drug issues; and
- facilitate better integration of specialist alcohol and other drug and primary care services.

Misuse of alcohol and other drugs has a substantial impact on the health and wellbeing of people in our community. Alcohol and other drugs contribute to deaths from overdose each year. There are approximately 7 deaths per 10,000 population each year from overdose in the EMPHN catchment,[181] which is similar to Victoria and Australia as a whole.

Alcohol-related harm is significant in our community

Risks from consuming alcohol in excess can be considered in two categories:

- Single-occasion risks: drinking more than four standard drinks on any one occasion
- Lifetime risks: not drinking more than two standard drinks a day on average.[182]

Single-occasion risks include injury, road accidents, trauma, self-harm and suicide.

Lifetime risks include cancers of the liver, throat and breast, chronic liver disease, brain damage and dementia, and heart disease and stroke.[183]

For children and young people under 18 years, and for women who are pregnant, planning to become pregnant or breast-feeding, not drinking is the safest option.

One in seven people in the EMPHN catchment drink to levels that increase lifetime risk of alcohol-related harm. One in three people exceed the single occasion risk guidelines.[184]

Young people (42%) and people with mental health problems (19%) are more likely to exceed the lifetime risk guidelines than the population as a whole.[185]

In Victoria there has been a decline in the proportion of people that exceed the guidelines for lifetime risk. Risk has dropped from 18.8% in 2010 to 15.3% in 2016.[186]

Up to one-quarter of Aboriginal and/or Torres Strait Islander adults (males>females) exceed single-occasion and lifetime risk levels for harm from alcohol.

Drug misuse causes harm in our community

Misuse of other drugs besides alcohol causes death and disability and is a risk factor for many diseases. Misuse of other drugs is also associated with risks to users' family and friends and to the community.

Illicit drugs

Illicit use of drugs includes use of illegal drugs, misuse or non-medical use of pharmaceutical drugs, or inappropriate use of other substances such as inhalants.

In 2016 in the EMPHN catchment 13.7% of people aged 14 years or older had recently used an illicit drug. This is on par with the Victorian average of 15%.[187]

In 2016 in Victoria, lifetime use of any illicit drug was 41% of the population.[188] The illicit drugs most likely to be have been used in the previous 12 months were cannabis (9.9% of adults), Ecstasy (2.4%), cocaine (2.5%) and meth/amphetamines (1.5%).

Illicit drug use is associated with increased risk of criminal conviction and imprisonment.

Figure 24 illustrates the rate of recorded drug offences per 100,00 population within the EMPHN catchment. This is generally below the Victorian average.

The highest rates of offences are for possession, followed by trafficking and use.

Knox and Mitchell are above the Victorian average offence rates for both drug trafficking and possession. Whittlesea is above the Victorian average offence rate for drug trafficking.[189]

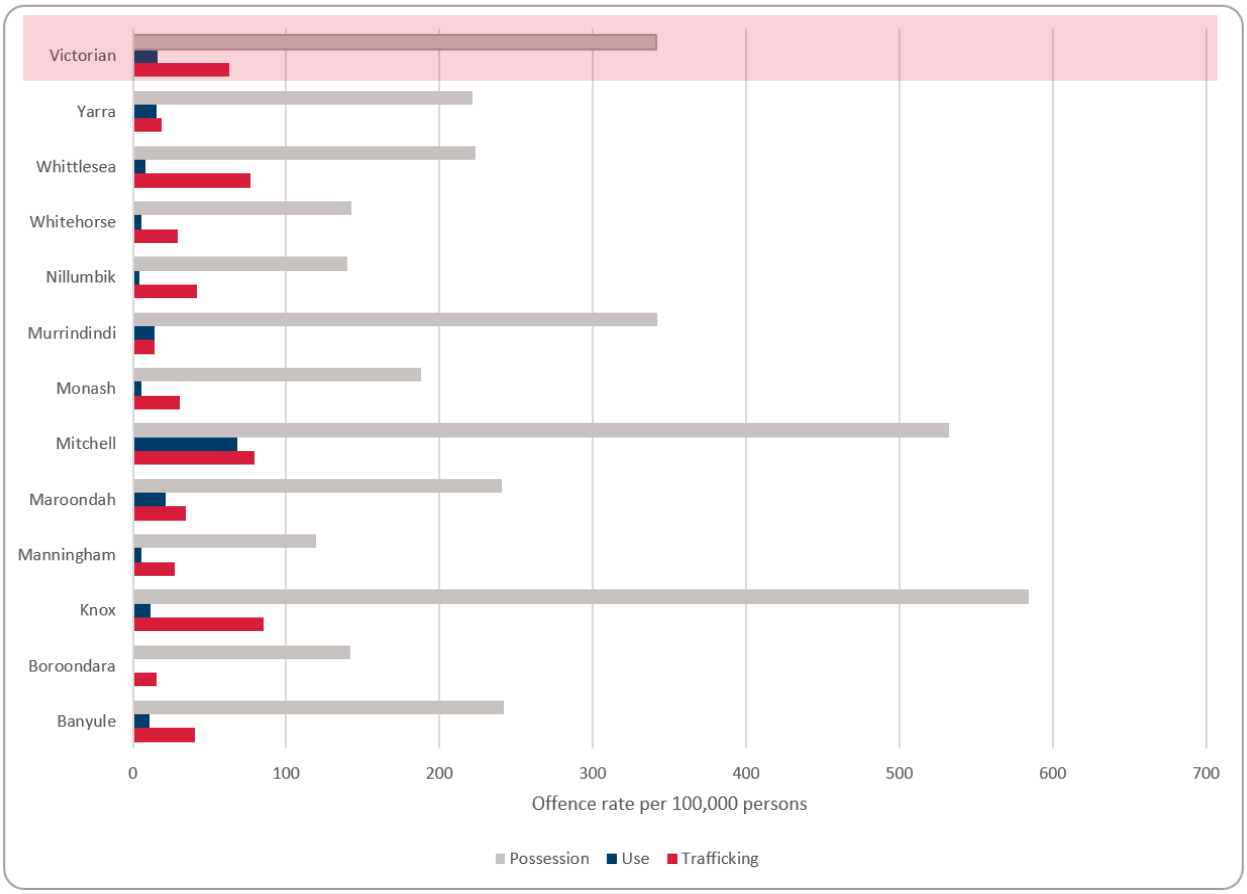


Figure 23. Rates of drug trafficking, use and possession, EMPHN | 2017–18

Pharmaceutical drugs

The misuse of pharmaceuticals refers to the consumption of a prescription or over-the-counter drug for non-therapeutic purposes.

There is a growing problem of prescription drug misuse and prescription drug-related misuse deaths in our community and nationally.

People may misuse pharmaceutical drugs for a range of reasons including to induce euphoria, to enhance the effects of alcohol and other drugs, to self-medicate illness or injury, to mitigate the symptoms of withdrawal from alcohol and other drugs, or to improve performance.

Drugs with high potential for misuse and significant volumes of prescribing include opioid analgesics and benzodiazepines.[190]

In Victoria, an estimated 1 in 20 people aged 14 years or older misuse pharmaceuticals in any 12-month period.[191]

Oxycodone (including oxycodone/naloxone) continues to be the highest misused prescribed opioid in Victoria. The most commonly misused prescribed benzodiazepine is diazepam.[192]

Diversion of these prescription medications to other people who, they were not prescribed for is a known problem.[193]

Benzodiazepines

Benzodiazepines are commonly prescribed in Australia. Approximately seven million benzodiazepine prescriptions are recorded each year.[194] According to evidence-based guidelines there are a broad range of clinical indications where benzodiazepines may be prescribed, including insomnia, anxiety disorders, alcohol withdrawal, seizure disorders, palliative care and musculoskeletal disorders. However, in general dose reduction and cessation should be discussed with the patient on first prescription and long-term prescribing is seldom indicated.[195]

Caution in prescribing is advised as benzodiazepines have the potential for misuse. Deliberate misuse of benzodiazepines for non-medical purposes occurs for a variety of reasons. People use benzodiazepines to:[196]

- enjoy the effects (especially taking large intermittent doses in a binge pattern)
- enhance an opiate effect
- help come down from stimulants
- combat opiate withdrawal symptoms
- substitute for their drug of choice.

Problematic use has been identified in men and women of all ages. According to the *National Drug Strategy Household Survey,* benzodiazepines were used for non-medical purposes by 1.6% of Australians in the 12 months before the survey.[197]

Medical practitioners are the main source for benzodiazepine misuse. Individuals obtain prescriptions from doctors through a variety of means, including multiple doctors, drug theft, forgery of prescriptions, procuring medicines from family, friends or acquaintances and the internet.[198]

When misused, benzodiazepines are often used in combination with other drugs, including alcohol. This dramatically increases the risk of harm and death. In Victoria there are an estimated 165 deaths per year where benzodiazepines are a factor associated with the death.[199]

Opioids

Opioids are commonly prescribed in Australia. Approximately three million prescriptions are written each year. However, 5% of people prescribed opioids account for 61% of the prescriptions, indicating there is a smaller group of people with large opioid use.[200]

Available alcohol and other drug treatment services

We have a highly developed alcohol and drug services network

Table 13 describes services available within the EMPHN catchment. The majority of alcohol and other drugs treatment episodes in the EMPHM catchment occur within the community.

Table 13. Alcohol and other drugs treatment services in EMPHN, September 2018

Type of service	Number
GP clinics	391
Specialist prescribers of pharmacotherapies for AOD treatment	103
Needle and syringe program providers	16
Outpatient counselling services ▸ EACH ▸ Anglicare Victoria ▸ Inner East and Eastern Alcohol and Drug Services (ECADS) ▸ UnitingCare ReGen (including Odyssey House) ▸ Caraniche ▸ Primary Care Connect ▸ Goulburn Valley Alcohol and Drug Service	7
Care and recovery and non-residential withdrawal service providers ▸ EACH ▸ Anglicare Victoria ▸ Turning Point ▸ UnitingCare ReGen (including Odyssey House) ▸ Primary Care Connect ▸ Goulburn Valley Alcohol and Drug Service	6
Intake and assessment services ▸ EACH ▸ Anglicare Victoria ▸ Turning Point Eastern Health ▸ Access Health and Community ▸ Link Health and community ▸ Inspiro Community Health ▸ SalvoCare Eastern ▸ SHARC ▸ UnitingCare ReGen (including Odyssey House)	9
Residential withdrawal services ▸ Uniting Care ReGen (x 2 services) ▸ Eastern Health Wellington House ▸ Residential rehabilitation services are provided across the community, including specialist Aboriginal and Torres Strait Islander residential rehabilitation services	3

Peer support programs are offered by EACH, Access Health and Community and Banyule Community Health. Ngwala Willumbong Coop run outreach services for Aboriginal and Torres Strait Islander people and Healesville Community Services Association delivers case management services. For youth, Youth Drugs Alcohol and Advice provide information services and Youth Support and Advocacy Services provide outreach. Each, Access Health and Community and Link Health and Community also provide youth outreach services in the catchment.

Our use of hospital, emergency department and ambulance resources

In spite of the number of community treatment services available in our catchment, alcohol and other drugs use still contribute to a substantial use of hospital-related resources.

Hospitalisations

- There are 8 overnight hospitalisations per 10,000 people each year for drug and alcohol disorders in the EMPHN catchment. This is lower than the national rate of 20 per 10,000 people.[201]
- In the 2015–16 financial year we had 1,530 overnight hospital separations. The majority of these are alcohol-related.[202]

Ambulance use

Ambulance services provide urgent care for people for alcohol and other drugs problems. Each year in the EMPHN catchment we have:

- 300 ambulance attendances per 100,000 population for alcohol
- 180 ambulance attendances per 10,000 population for illicit drugs.[203].

Emergency Department presentations

Each year in the EMPHN catchment there are:[204]

- 10 emergency department attendances per 10,000 population where alcohol is the principal reason for attendance
- 2 ED attendances per 10,000 population where illicit drugs are the principal reason.

Table 14. EMPHN annual service use per 100,000 population related to alcohol and other drug treatment | 2016–17

	Alcohol	Drugs
Ambulance	300	180
Emergency Department	10	2
Overnight Hospitalisations, AOD combined	8	

Treating alcohol and drug misuse

In Victoria, alcohol is a drug of concern (principal or additional) in 46% of all specialist community treatment episodes. It is the most common principal drug of concern in 32% of specialist community treatment episodes. This is according to the AIHW's Alcohol and Other Drug Treatment Services National Minimum Dataset (AODTS NMDS).

The most common type of treatment is counselling (43% of patients) followed by withdrawal management (18% of patients).

In Victoria there are 39 episodes of Victorian government-funded drug treatment services per 10,000 population for illicit drugs.[205] The highest treatment rates per 10,000 population are in Maroondah, followed by Yarra Ranges and Knox.

Alcohol and other drug treatment in Victoria

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 receive treatment for alcohol and other drugs issues.[206]

- 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).
- 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 five years, indicating a key focus for service delivery.
- For clients aged 30 and over, alcohol was the most common principal drug of concern.
- Numbers of consumers accessing treatment services for alcohol abuse are almost double that where amphetamine was the principal substance of misuse.

Our stakeholders provided feedback on treatment services for alcohol and other drug use.

Primary care stakeholder groups (including general practice and community allied health) report that the most common substance use disorders they are faced with managing relate to alcohol use.

According to stakeholders, alcohol-related problems and the misuse of prescription medications are the most significant substance use problems they manage in the EMPHN catchment.

Alcohol abuse is often undiagnosed

Providers report that alcohol abuse is often undiagnosed and is a result of underlying personal and social issues.

Although a broad range of specialised services are available to manage alcohol-related problems, access to these is often not timely. As a result, the burden of management of alcohol-related problems often falls upon general practice.[207]

Prescription medication misuse is common in our catchment

Prescription medication misuse is a problem encountered by primary care providers in the EMPHN catchment. Opioids, benzodiazepines, stimulants and antipsychotics prescribed in primary care have the potential for misuse. GPs report that pressure to prescribe drugs of misuse is a commonly encountered problem in general practice.[208,209]

While some providers support people who use illicit drugs (including methamphetamine use disorders), primary care providers reported that these people' substance use disorder is more commonly managed by specialised alcohol and other drug services and is less of a priority in primary care.[210]

We need to improve service coordination

Referral pathways into counselling and addiction medicine treatment services are important to facilitate management of these patient groups.[211]

There is a need for improved service coordination between mental health and alcohol and drug services.[212]

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])

A dedicated Aboriginal and/or Torres Strait Islander harm reduction workforce is needed to support AOD strategies in line with the National Drug Strategy.[213]

- 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:
- 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.
- Clients are asking for out-reach and a non-judgemental conversation is not a normative experience.
- There is a lack of services that work with Aboriginal and/or Torres Strait Islander men.
- There is also a lack of education services and programs for parents about the consequences of heavy drug use.
- 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.

Service gaps

A recent AOD-specific analysis commissioned by EMPHN identified the following additional needs in alcohol and other drug services:[214]

- Better access to addiction specialists and credentialed mental health nurses with capability/interest in AoD.
- Services for carers of people with substances abuse issues.

PRIORITIES

Health problems caused by alcohol and other drug use affect the EMPHN community as a whole. Alcohol misuse cases the greatest disease burden and impact on wellbeing.

Through strengthening community-based systems of care for people with alcohol and other drugs problems, we can:

- reduce avoidable emergency department presentations and hospital admissions due to alcohol and other drugs
- reduce the impact of alcohol and other drugs on our communities including our Aboriginal community.

EMPHN's alcohol and other drugs treatment priority is to adopt the transformative strategies outlined in the EMPHN Strategic Plan in order to:

- build the capacity of the primary care workforce to respond to alcohol and other drug issues; and
- facilitate better integration of specialist alcohol and other drug and primary care services.

Selected achievements in adopting these transformative strategies are highlighted below.

Service integration

EMPHN's priority is to develop commissioning and system change strategies that encourage integration across the boundaries of primary, community and acute services.

The majority of alcohol-related treatments can be delivered in the community by our primary care workforce.

EMPHN is working to align state-funded Departmental alcohol and other drug treatment services with other funded services.

Through the Area Four Pharmacotherapy Network, EMPHN has partnered with stakeholders to improve access to pharmacotherapy services in our catchment.

Through our commissioning activities, EMPHN increasing available treatment for the community, as well as improve service integration, consistency and quality. This will provide a basis for a more sustainable drug and alcohol treatment sector in the future.

Comorbidity of mental health problems and substance use disorders is a significant challenge facing service providers in the EMPHN catchment. Despite a great deal of work in this area over the past decade, single disorder treatment models remain dominant.

Through EMPHN's stepped care approach to mental health care we can improve access to the right care in the right place at the right time for people with mental health and alcohol and other drug comorbidities.

Practice-based evidence and data

EMPHN's priority is to build on practice-based evidence.

General practice has an essential role in identifying and managing people with alcohol and other drugs issues, particularly for people with alcohol or prescription medication misuse.

Through our work with POLAR, EMPHN is supporting general practice to identify people with alcohol issues and prescription medication misuse so that they can receive comprehensive, team-based care within the community.

Digital health

EMPHN's priority is to enable health information continuity between providers.

Electronic communication and information-sharing facilitates better triage and integration of services.

EMPHN will continue to work with commissioned providers who care for people with alcohol and other drug treatment needs to increase the uptake of shared electronic health record adoption and eReferral. These are important tools to improve communication and information-sharing between alcohol and other drug treatment providers and the rest of the service system.

SECTION 6:
OLDER PEOPLE

INTRODUCTION

The EMPHN region is experiencing an unprecedented rise in the median age of our population. We will have nearly double the number of people aged 65 and over in just 13 years.

The combined effect of ageing population, and a general population increase, means that the number of people aged over 65 will increase from around 203,000 now to 370,000 by 2031.

The key factors in enhancing and maintaining older people's mental health and wellbeing are healthy lifestyles, social connection, mental wellbeing and a sense of purpose. At present, 81% of our older people don't have daily contact with people outside their home.

We are responsible for maintaining the wellbeing of the older people in our community. We must take a proactive approach to ensure we have the capability to provide quality services for our older people.

Our community values the wealth of support older people provide to others in our community, whether as employees, employers, volunteers, carers, grandparents or in a multitude of other roles. We experience many advantages from our ageing population.

We must configure our health services to address our current needs and also to plan for the potential additional needs our ageing population will have for health services.

While our community experiences many advantages from our ageing population, this also means that more people will be living longer but also with some degree of disability in their later years.

We are taking a proactive approach to maintaining the wellbeing of older people in our community, whilst also planning for the potential additional demand our ageing population will place on health services.

People in our community generally manage to live independently well into old age. However, many people aged over 65 will live with some degree of disability.[215]

At age 65 men can expect to live on average for another 19 years and women for another 22 years. Over half of these years are lived with some degree of disability (Figure 23).

Older people who are frail or vulnerable may not perceive themselves as such. This places a responsibility on primary care providers to identify and support older people to receive the care they need to maximise their health and wellbeing.

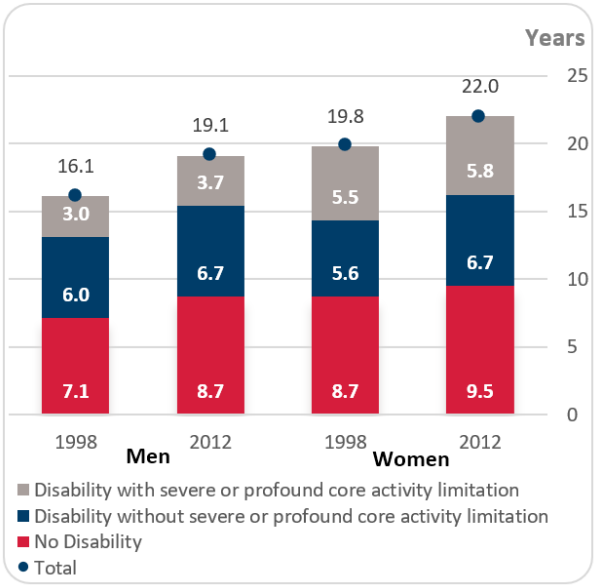


Figure 24. Number of years that older people are living with disability.

Our population is ageing

Over the 15 years from 2016–2031 the overall size of our population will increase, from 1.45 million people currently to 1.85 million, and the percentage of people aged over 65 years in our catchment will increase from 14% to 20%.

Whittlesea will have the highest proportion of older people by 2031.[216]

Chronic conditions are more common with age

Many long-term chronic health conditions become more common with age and therefore require greater use of health services.

Chronic disease prevalence across the catchment exhibits the common trend of being over-represented in areas with a relatively low SES.[217]

Over the next 10 to 15 years an *additional* 100,000 people a year aged 65 years and over in our EMPHN catchment will require treatment for chronic conditions.

Population ageing will contribute to an in the number of people living in the EMPHN catchment with selected chronic conditions. In particular, the number of people aged 65 years or over living with musculoskeletal conditions and/or cardiovascular diseases will increase substantially (Figure 26).[218,219]

These include musculoskeletal and connective tissue diseases (including lower back pain and osteoarthritis) and cardiovascular diseases (including hypertension, ischaemic heart disease, stroke and heart failure) (Figure 27).

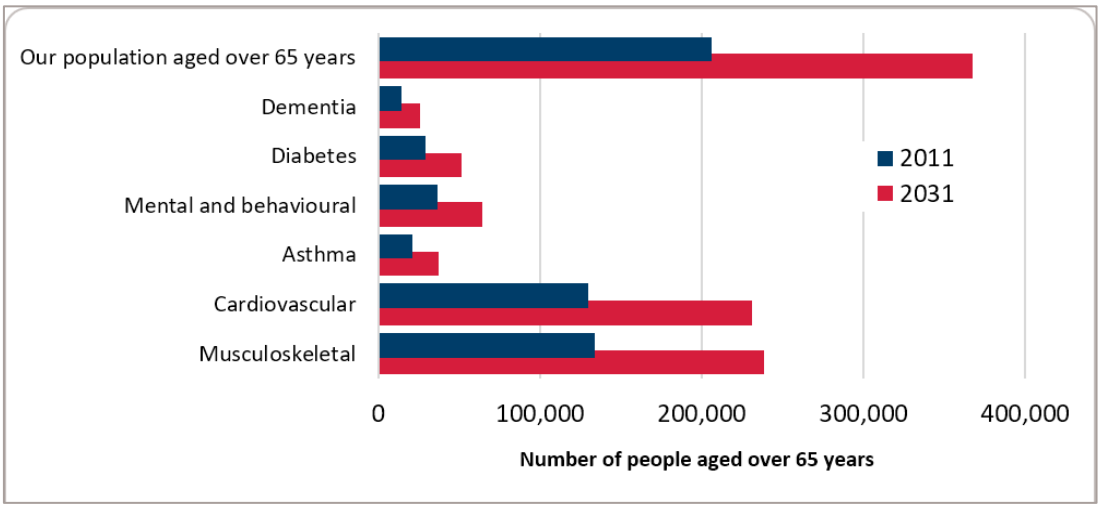


Figure 25. Predicted number of EMPHN residents aged over 65 years with selected chronic conditions | 2011–31

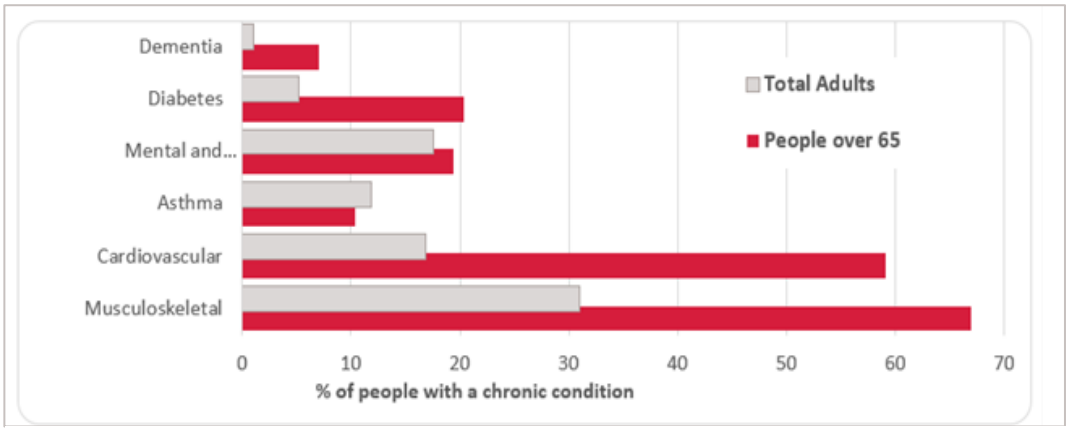


Figure 26. Rates of chronic conditions, total adults versus adults aged 65+ years, Victoria | 2014–15

More people in our community will be living with dementia

Dementia is classified as a mental health condition. However, it is not a single specific disease. It describes a syndrome linked with over 100 different diseases that impair brain function.

Figure 28 depicts the most common types of dementia, which are:[220]

- Alzheimer's disease (up to 50–75% of cases)
- vascular dementia (20–30% of cases), with frontotemporal dementia
- dementia with Lewy bodies accounting for around 5% of cases.

Dementia is usually of gradual onset, progressive and irreversible. 93% of people with dementia are aged 65 years or over. The type and severity of dementia varies considerably.

The number of people with dementia in our community is predicted to more than double by the year 2046.[221]

Dementia is a leading cause of death and burden of disease. The demand that dementia places on health and aged care services is therefore expected to increase considerably.[222]

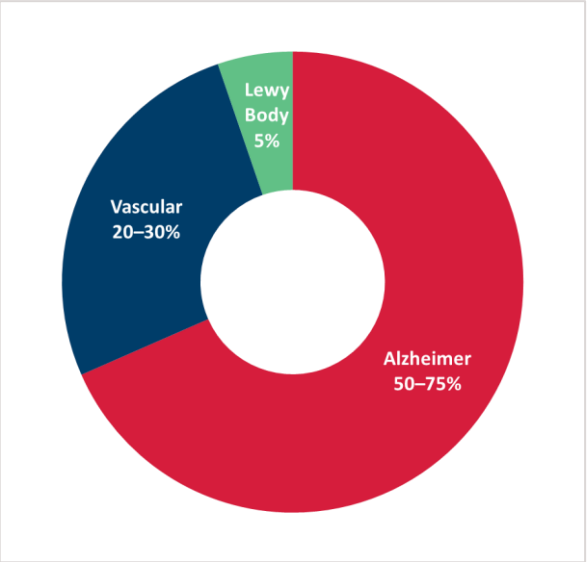


Figure 27. Percentage of types of dementia in Australia | 2012

SERVICE NEEDS ANALYSIS

Healthy ageing involves more than just promoting good physical health. Social and mental wellbeing are important determinants for a high-quality life into older age.

Mental and social wellbeing in older people needs more attention

Older people typically have lower levels of psychological distress than the adult population as a whole, according to the National Health Survey.

However, they are less likely to seek treatment for mental health problems. When older people seek treatment, they are less likely to actually receive mental health treatment (Figure 29).

Further, untreated depression or anxiety may impact quality of life and contribute to increased suicide rates. Women aged 65 and over account for 14% of all female suicides in Australia and men aged 85 and older are the most likely of any age group to take their own lives. [223]

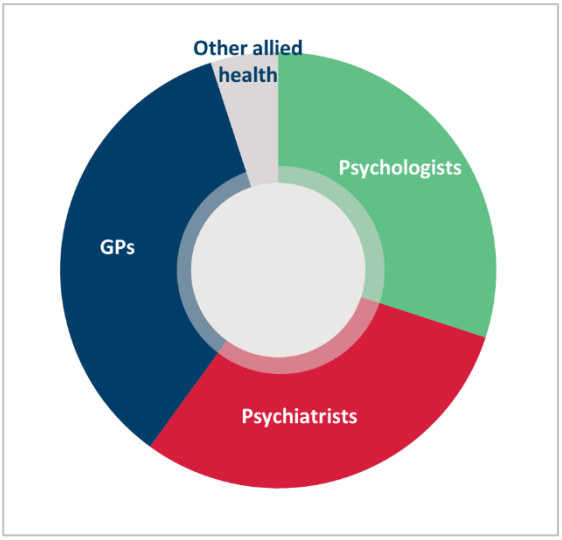


Figure 28. Medicare-subsidised services for mental health for people aged 65+, by provider type | 2013–14 ('Other allied health' includes mental health workers, occupational therapists and social workers)

Mental health problems and older people

EMPHN analyses non-identified patient data from 129 general practices across our catchment using POLAR.[224] There are 109,156 patients in POLAR aged 65 years or above. Of these, 24,946 patients aged 65 years or above are recorded as having active mental health problems.

According to these data, most older patients with active mental health problems in the EMPHN catchment have mood disorders.

Table 15. Number of patients aged 65+ years with mental health problems, by age category, POLAR analysis, EMPHN

Age group (years)	Total number of patients in age group in POLAR	Number with mental health diagnosis
65–69	28,721	5,919
70–74	26,040	5,461
75–79	19,961	4,281
80–84	15,483	3,679
85+	18,919	5,606

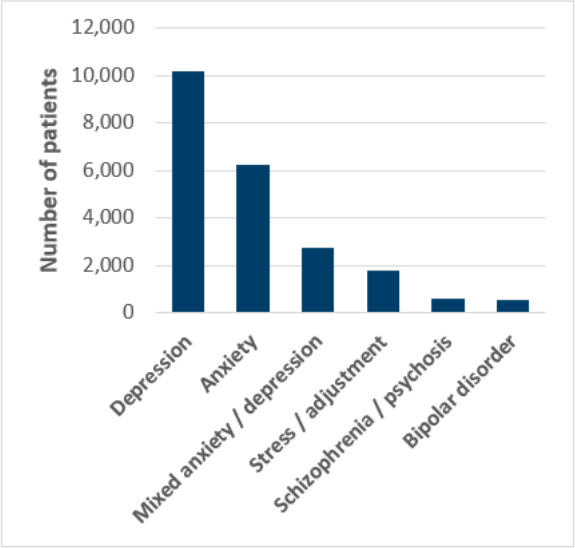


Figure 29. Number of patients aged 65+ years with selected mental health problems, POLAR analysis, EMPHN

Chronic disease and medications in general practice

Almost 95% of patients aged 65 years or over in the EMPHN catchment have three or more chronic conditions according to data captured by POLAR. The most common chronic conditions are hypertension and osteoarthritis.

Table 16. Number of patients aged 65 years or over with selected chronic conditions, POLAR analysis, EMPHN

Diagnosis	Number of patients
Hypertensive disorder	48,556
Osteoarthritis	20,529
Hypercholesterolaemia	18,525
Gastroesophageal reflux disease	16,038
Osteoporosis	11,546
Hyperlipidaemia	11,489
Diabetes mellitus type 2	10,552
Asthma	9,872
Vitamin D deficiency	9,729
Depression	8,552

Patients with chronic diseases often require multiple medications to manage their chronic conditions. Most patients in POLAR in this age group take three or more medications concurrently.

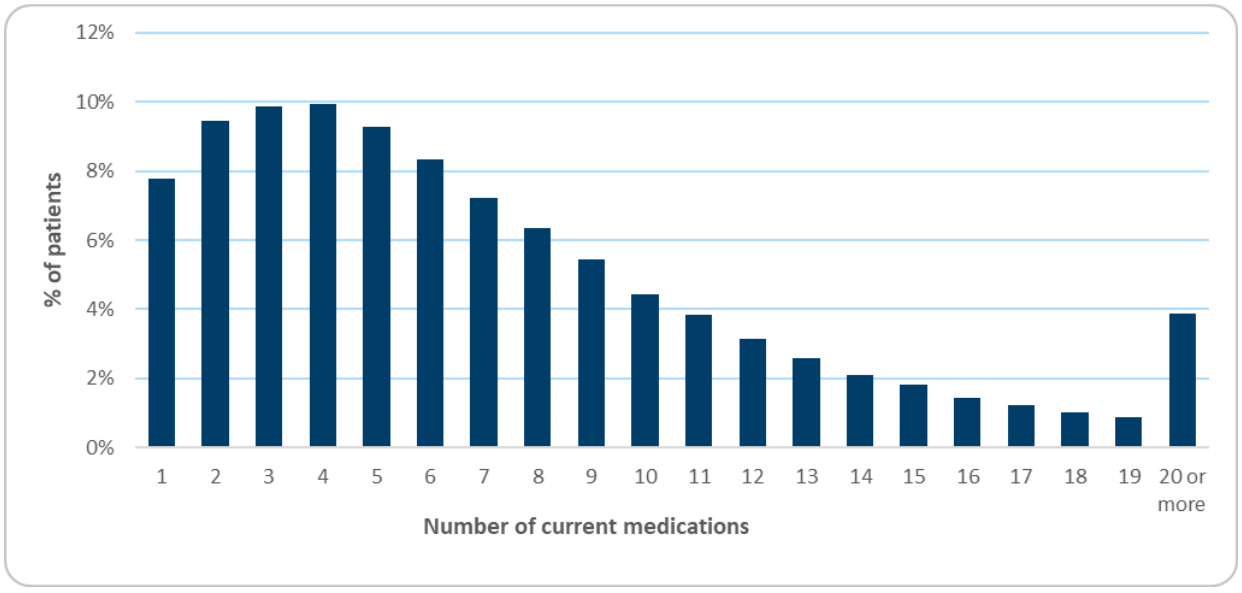


Figure 30. Percentage of patients by number of medications prescribed to them, POLAR Analysis, EMPHN

Different classes of medications are used to treat different chronic conditions. Medication groups that are most commonly prescribed for chronic diseases in people aged 65 years and over in POLAR include cardiovascular, nervous system and digestive system medications.

Table 17. Medication group prescribed to patients aged 65 years or over, POLAR analysis, EMPHN

Medication group	Percentage of patients prescribed medication
Cardiovascular	78%
Nervous system	58%
Digestive system	61%
Musculoskeletal system	34%
Respiratory system	31%

Across these five clinical conditions, the medication types most commonly prescribed are anti-inflammatory and antirheumatic products and drugs for peptic ulcer and gastro-oesophageal diseases.

Table 18. Medication type prescribed to patients aged 65 years or over, POLAR analysis, EMPHN

Medication Type	Patient %
Lipid modifying agents	43%
Drugs for peptic ulcer disease	41%
Opioids	21%
Non-steroidal anti-inflammatory agents	20%
Angiotensin II antagonists	20%
Antidepressants	19%
Beta blocking agents	19%

Some medications increase risk of adverse events, including syncope and falls in older people. Opioid medications, antidepressants, benzodiazepines and antipsychotic drugs can increase risk of these adverse events.[225] In patients aged 75 years and above, opioids were the most frequently prescribed of these medication categories, followed by antidepressants.

Table 19. Medication type prescribed to patients 75 years and over, POLAR analysis, EMPHN

Medication type	Patient %	Most commonly prescribed medications
Opioids	23%	Codeine, oxycodone
Antidepressants	20%	Mirtazapine
Benzodiazepines	11%	Diazepam, oxazepam
Antipsychotics	3%	Quetiapine, risperidone

Social connection is key to wellness for older people

Social connectedness and engagement are important to maintaining the mental and physical wellbeing of older people.

81% of people aged 65 and over do not have daily contact with people outside their household; 37% do not have weekly contact.

People with strong social relationships have a 50% increased likelihood of survival compared with those with weaker social relationships. [226]

Social engagement through community groups, sports, societies and volunteering helps to improve health outcomes.

The influence of a lack of social relationships on mortality is comparable with well-established risk factors, such as smoking and excessive alcohol consumption.

When looking for support, 92% of people aged 65 and over believe they have someone outside the household in whom they can confide. [227]

STAKEHOLDER PERSPECTIVES

Our stakeholders tell us that the risk factors for poor mental health in older people have a significant impact in our community.

These risk factors are:[228]

- Disability
- Chronic disease
- Prior depression
- Bereavement
- Social isolation
- Unhealthy lifestyle.

Services received by older people represented 8% of the total 9 million mental health-related services subsidised by Medicare.

There were 708,000 Medicare-subsidised services related to mental health received by people aged 65 and over in 2013–14. GPs, psychologists and psychiatrists provided services for a similar proportion of all mental health related services for people aged 65 and over. [229]

According to stakeholders, our older EMPHN community members are a diverse group, with different ages, socioeconomic backgrounds, life experiences and lifestyles. Individuals have different abilities and resources, and their experience of ageing will be influenced by these differences.

While there is a large and growing group of older people who are generally well, others require financial support, are unable to care for themselves at home, or require support services to do so.

Older people who experience disadvantage are affected both mentally and physically. Their opportunities for social and economic engagement within their communities are also limited. Our stakeholders and the literature report these include people: [230]

- from Aboriginal and Torres Strait Islander communities
- from culturally and linguistically diverse backgrounds.
- who are veterans of the Australian Defence Force or an allied defence force (or the spouse, widow or widower of a veteran)
- who are homeless or at risk of becoming homeless
- who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI).

PRIORITIES

Our EMPHN population is ageing, which will potentially result in increased care needs within our community. Older people with mental and social health risk factors are at particular risk of poor health outcomes in the EMPHN community.

We need to maximise the social and emotional wellbeing of older people, particularly for older people with mental health problems or poor social relationships.

EMPHN considers supporting older people to remain at home and independent a priority for our community.

General practice plays an important role in the identification and management of mental health problems and poor social relationships among older people. Build the capacity of general practice for social prescribing, older people's mental health literacy and the delivery of care that promotes healthy ageing will maximise the social and emotional wellbeing of older people.

Improving chronic conditions management

In the General Health section of this needs assessment, our priorities and transformative strategies for improving the management of chronic conditions have been described. As older people experience a disproportionately large burden of chronic disease, our actions to transform chronic conditions management will have a direct impact on older people.

Supporting RACFs to identify and respond to the mental health care needs of their clients

EMPHN's priorities are to:

- **Implement stepped care approaches to mental health in older people that are responsive to consumer needs;**
- **Support and encourage primary care to adopt team-based mental health care for older people in RACFs that is person centred;**
- **Build on practice-based evidence and practice-based innovation in the delivery of mental health care within RACFs; and**
- **Develop commissioning and system change strategies that encourage mental health service integration across the boundaries of primary, community and acute health services for older people with mental health problems.**

Older Australians in residential aged care facilities are five times more likely to experience mental health issues than those living independently. Whilst available data suggests that about 10% of older Australians have depression or anxiety, more than 50% of those living in aged care facilities have either or both disorders, and just under 50% enter residential with a pre-existing depressive condition.[231,232]

EMPHN is supporting the delivery of comprehensive mental health care within residential aged care. This entails increasing access to multidisciplinary care across a range of therapies and building the skills of the general workforce in identifying mental health problems among residents.

General practitioners provide the majority of medical care in residential aged care. GPs have an important role in assessing, screening, managing and referring those who have mental health issues.[233]

When residents are recognised to have a mental health problem, they are often only prescribed medications. Medications are effective but are often associated with side effects, and for older adults may not be recommended alongside some other medications and conditions[234].

Multidisciplinary mental health care can deliver a range of different therapies. Psychological interventions are at least equally effective as medications.[235]

Other interventions such as exercise, music and singing, animals and pet therapy, reminiscence-based activities (such as reviewing one's life, talking with others about the past). Behavioural activation (such as doing pleasant activities) can also be effective.[236,237]

APPENDIX

ASSESSMENT METHODOLOGY

This needs assessment scopes and details the catchment's current and future health care needs and service delivery gaps.

Conceptual 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".[238]

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 companion document to this needs assessment is the EMPHN Health Intelligence Report, which provides an update of the EMPHN November 2017 Needs Assessment, expanded and amended where additional and/or updated data were available.

Data sources are listed in the *Descriptions of Evidence* in Sections Two and Three of the EMPHN 2017 Needs Assessment. This document is available upon request from EMPHN.

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
- 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, was 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 wide 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 Model
- 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.

This needs assessment is informed by EMPHN's Annual Planning Cycle process

in September 2018 a workshop was conducted with members of the Board, Clinical Council, Community Advisory Committee, representatives from agencies on collaboratives and other key organisations. The feedback from that workshop has been incorporated into this needs assessment.

EMPHN has in place collaborative structures which align with the large public health services in the catchment.

Through these collaboratives, EMPHN continues to consult with LHNs, State Government, community health, PCPs and general practice.

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.

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
- 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, alcohol and other drug 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. In addition, a robust service mapping exercise is being undertaken by EMPHN to build a mental health atlas for the region which is anticipated to be prepared early December 2018.

The updated mental health and AOD needs assessments continue to 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, and the findings of further consultations undertaken through forums and projects are included in this iteration.

Much of the AOD-related data were drawn from AOD statistics by Turning Point (2014–15 data by LGA). In addition, state-funded community AOD service data were made available via POLAR GP. 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.

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