



**Knox**Community

**Health** Service

*Working together -  
a healthy partnership*

**Organisational  
Integrated  
Health Promotion Plan  
2006 – 2009**

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## Vision Setting

### 1. What is your organisation's vision for Health Promotion and in which organisational documents is it stated?

Knox Community Health Service has a strong commitment to health promotion. This commitment underpins the organisations Mission, Vision and Values statements, and has informed the 2006 - 2009 Strategic Plan: Rising to the Challenge. In addition to the organisation's Strategic Plan, the principles of health promotion are fundamental to the range of KCHS operational documents, including our Operational Plans, Policy and Procedures Manual, Quality Improvement Plan, the organisation's Position Descriptions and health information and education material. While these documents clearly reflect a commitment to health promotion and integrated health promotion practice, the Strategic Plan in conjunction with the development of this current Health Promotion Plan, sets a clear plan for the further direction and ambition of KCHS in health promotion.

The 2006 - 2009 Strategic Plan: Rising to the Challenge documents our vision "for a future in which the communities we serve will [be] greatly strengthened by our overarching health promotion focus, by our approach to health service delivery and by our contribution to the broader service sector". The Strategic Plan sets out three key Strategic Directions, each with a focus on, and reflecting the guiding principles of integrated health promotion. In summary these are as follows.

#### Strategic Direction 1 - Strengthening communities' health & wellbeing.

Strategic Objective 1.3 Targeted and effective health promotion delivered.

Our health promotion plan and its execution will be integral to our overall planning and operational processes. Our approach will be evidence based, targeting areas of greatest need in ways that use our resources as effectively as possible. Also, we will ensure that our health promotion plans are adequately linked to other agencies plans and that our delivery efforts are integrated with those of others.

#### Strategic Direction 2 - Expanded Community based health care in Knox.

Strategic Objective 2.6 Maximised health outcomes through integrated services and health promotion programs.

We will identify and act on ways to achieve better health outcomes for our communities. We will do this through out leadership and a coordinated and integrated approach to health service delivery and a whole-of-population approach to health promotion. We will further develop our service model to ensure we have a holistic approach to address the needs of our community.

#### Strategic Direction 3 - Leadership in Community health.

Strategic Objective 3.4 Recognised for integrated health promotion.

We aim to build on our existing health promotion strategy and initiatives by integrating health promotion into all aspects of our operations. Thus, whatever their presenting needs, consumers will experience a holistic approach to their health and wellbeing. We aspire to do this so effectively that others will follow our lead within the community health sector and beyond, thus enabling us to broaden our sphere of influence to engender a more proactive approach to community health and wellbeing. Our ambition is for our influence to be felt in a broad context including policy and infrastructure development.

In addition to these specific references to health promotion in the Strategic Plan, KCHS is also committed to aligning our Strategic and Health Promotion Plans with other local planning documents, and ensuring complementarity. These external key documents include the Knox City Council Municipal Health Plan, and its sub-plans such as the Early Years Plan, the Knox

Youth Plan and the Alcohol and Drug Action Plan, and the Primary Care Partnership Health Promotion Plan. KCHS has a clear relationship strategy which fully describes the various kinds of partnership arrangements and seeks to ensure cooperation and collaboration in all its health service delivery, but particularly in integrated health promotion.

KCHS's organisational structure and recruitment policies reflect the organisation's drive to embed health promotion across the variety of service delivery streams. Health promotion leaders have been identified from within existing staff and targets and role functions have been adapted to ensure these staff have the capacity to take on specific health promotion activities. Staff with health promotion responsibilities are drawn from all levels of the organisational structure.

## **2. What health promotion policies and procedures do you have in place and which important health promotion concepts and strategies do they incorporate?**

KCHS is currently undergoing a major review of its organisational Policy and Procedures. The current KCHS Health Promotion Policy will be reviewed during this process and up-dated to ensure that it is current and contextual. Once the review process is completed, the KCHS HP Policy will be reviewed annually as part of the KCHS annual planning cycle.

The current policy refers to both the Ottawa Charter (1986) and the Djakarta Declaration (1997) and provides a definition for all staff on health promotion

There are a number of health promotion frameworks used to support organisational processes in health promotion planning.

The Integrated Health Promotion Resource Kit guides planning for our DHS IHP planning processes. The VicHealth Mental Promotion Framework 2005-2007 has been used extensively for planning and implementation in our Mental Wellbeing and Social Connectedness priority over the last year and in planning for the next 3 years.

## **3. What capacity building strategies will the organisation undertake this year?**

The opportunity to reflect and develop new priority areas and a community development approach to projects for 2006- 2009 in health promotion brings with it the need to resource and skill up staff to meet the challenges involved.

A number of capacity building strategies have been identified as being critical to our success over the next three years.

These strategies are listed under categories below which come from the document "A Framework for Building Capacity to improve Health" by NSW Health.

### **Workforce development**

- All new staff will attend the Community Health Special Interest Group (CHHPSIG) Introduction to Health Promotion 4 hour course.
- Full-time and appropriate part-time staff will attend the 5 day Short Course in Health Promotion when made available by DHS.
- Health Promotion Skills audit conducted annually to identify staff skills and needs and an action plan developed.
- Annual Health Promotion internal forums (to disseminate information and outcomes from all priority areas to all staff (including co-located services) and

to provide opportunity for identification and discussion of emerging health promotion issues.

- Other relevant training to our priority areas (see individual priority areas). In particular, staff involved with Physical Activity and Mental Wellbeing and Social Connectedness priorities will undertake in-services around Participatory Action research methodologies.
- Continued partnerships/opportunities for students in Health Promotion

### **Organisational development**

- Team co-ordinator position has been created in health promotion (Health Promotion, Community development and youth). The position will lead a small team of health promotion workers and will be responsible for overseeing health promotion planning and implementation of activities within the service. The Co-ordinator has a key role in representing KCHS in PCP planning and activities.
- The 2006-2009 Strategic Plan explicitly includes health promotion across the three key strategic directions as identified above. The Business Plan operationalises this and provides for appropriate Health Promotion resources to meet the objectives of the new HP plan including recruitment of staff with more specialist HP and community development skills to support the action research and community consultation components of the first two years of operational plans.
- Continued refining of health promotion policies as described above.
- Development of a new internal structure to support health promotion planning and implementation for 2006-2009. This will be based on work begun in 2006 and includes a series of functional learning circles and working groups to support both priority areas and functions required at the time. Title of the group is chosen by the group and reflects the key features and to an extent the stage of development of each group, ie learning circles are those where there is a focus on developing a common understanding of the health promotion topic under consideration whilst working groups are at the stage of being more task focussed. This is a voluntary process with staff electing to be involved in the group on the basis of skills and interest.

#### Current Learning Circles and Working groups include:

- Sexual Health and Young People Learning Circle (Planned HP)
- Elderly Chinese Social Connections Learning Circle (Flexible/emerging issue).
- Smoking Cessation (Internal working group to complement Planned HP).
- Participatory Action Research (PAR) working group (Supporting research function of Physical Activity and Social Connectedness Planned HP).  
Active Community Engagement (ACE) working group (Supporting development of the model and strategies to engage hard to reach community members targeted in Physical Activity and Social Connectedness Planned HP).

The latter two groups combine on a quarterly basis as the MOTHERS (Mentoring Others To Health, Exercise, Relationships, Social Connectedness) group. This group's focus is the co-ordination of phase 1 of the Physical Activity and Social Connectedness operational plans  
This structure also has connections to partnership groups (please see Attachment 1).

The Health Promotion Committee which traditionally has had representation from all working groups, managers, the Health Promotion Officer and the

CEO is currently being reviewed in light of the new working group structure. It is expected that it may change form but there will still be a senior group with management responsibilities for health promotion planning across the organisation.

### **Leadership**

- Continued development of the Convenor role for Health Promotion working groups as key advocates and champions for change in the organisation around Health Promotion. Some health promotion resources are used to support this group with regular meetings, opportunities for professional development and research support for their project areas.
- The development of the new Team Co-ordinator position in Health Promotion will be a designated leadership role in the organisation.

### **Partnership**

- Much work has occurred in 2005-06 in developing and consolidating partnerships with local and regional stakeholders to further health promotion aims. As a result there are Memorandums of Understanding or partnership agreements now being developed with a range of agencies including Knox City Council (various sections), Women's Health East, Department of Education, Ranges Community Health Service, Eastern Access Community Health, Anglicare, Care Connect, and local Neighbourhood Houses. As part of the partnering process a need has been identified by some partners for introductory health promotion training to ensure there is a common understanding for project development. As a result it is planned to hold a brief Introduction to Health Promotion workshop (3-4 hours) for staff from any of our partner agencies currently working on our shared health promotion projects who would find this useful early in 2007. It is intended to have this co-facilitated by another service that has completed the Introduction to Health Promotion Certificate IV training.
- Other partnership capacity building strategies include continued participation in the Community Health Promotion Special Interest Group (CHHPSIG) and the Outer East Health Promotion Workshop.
- Participation in Outer East Primary Care Partnership activities will continue including the Planning and Partnership group and working groups to implement the health promotion plan within the OEPCP Community Health Plan.
- As part of the partnering approach within the OEPCP it is planned to develop a strategy or mechanism for sharing learning's from current KCHS activities with engaging vulnerable communities and gaining input from member agencies.

## Identifying Issues - Needs

### 1. What does the local population health data indicate are the important health issues in your community (Commonly referred to as Normative Need)?

#### General demographic profile of the Knox Local Government Area (LGA)

As at 2003 the population of Knox was 150,157 (49.1% male, 50.9% female). The 60-69 and 70-79 age groups are projected to almost double by 2015. The ageing of the population will put increased demand on aged and disability focussed community support and health services. The area of Knox also has a greater average of children under 18 than the Melbourne Standard Data Percentage.

24% of the Knox population were born overseas, with 16% of Knox residents born in non-English speaking countries. In 2001, the predominant CALD (Culturally and Linguistically Diverse) populations in the Knox area were from Malaysia, Sri Lanka, Germany, India and Italy. Wantirna South and Rowville in particular have a larger proportion of people from other countries than other areas in the Knox catchment (ABS 2001). Main languages spoken at home include Chinese languages, Italian, Greek and German.

80% of residents in Knox either own their own homes fully or are currently paying off their own home. A further 14% rent either privately or publicly. The average income for Knox residents is \$36,579 (compared to \$39,418 Victoria wide). Average income for residents in the Rowville area average almost \$40,000 annual income, while Bayswater residents average under \$34,000 per annum. The disparity between suburbs within the Knox area is evident (ATO 2004, cited Knox City Council 2006). 2001 data shows that approximately 54% of Knox residents have no professional qualifications for employment. In comparison with average Victorian rates, Knox residents have a higher rate of vocational qualifications in trades. Unemployment rates in comparison to the overall Melbourne average are lower at 4% in 2001 (improved from 5.7% in 1996). This must be placed in context of the increase in part time employment becoming available over full time options.

(Sources - ABS Data 2001; Knox City Council 2006)

#### Burden of Disease data for the Knox LGA

The top diseases or conditions causing the greatest Burden of Disease in the City of Knox (as measured by the DALY - or Disability Adjusted Life Years (combines loss of years of life due to premature death and the loss of healthy years of life due to disease or injury) are as follows:

Both Males and Females

1. Cancer
2. Cardiovascular Disease CVD
3. Mental Disorders (depression, psychiatric disabilities, alcohol and drug dependence)
4. Neurological and sense disorders
5. Chronic Respiratory diseases.

This is the same order of diseases/conditions as for the EMR Burden of Disease data for 2001. Knox is ranked 14th in health status amongst State LGAs for both males and females which is above average and reflects the fact that the EMR has the best comparative health status. Having said that Males in Knox were ranked lower than the state average in DALYs for mental conditions indicating a poorer health status (55th/78 rankings) and were also ranked lower in terms of diabetes (38th/78) i.e lower

than the state average.

Risk factors associated with the Burden of disease data have been identified at region level (EMR) and are not LGA specific. For the EMR the following applies in order of importance:

Males- tobacco use, high blood pressure, obesity, high cholesterol, low fruit and vegetable intake, alcohol harm, physical inactivity, illicit drugs

Women - obesity, high blood pressure, tobacco use, high cholesterol, physical inactivity, intimate partner violence, low fruit and vegetable intake, alcohol harm, illicit drugs.

The EMR figures do not vary a great deal to those for state, nor does the order.

### Health Demographic Profile for Knox LGA

A comprehensive demographic health profile has been developed for the Knox LGA as part of the planning process in health promotion. The data has come from a number of primary and secondary sources (national, state, regional and local government) and a more detailed exploration of some of the risk factors and social determinants that contribute to the health issues described above are considered here:

#### *1. Mental Wellbeing and Social Connectedness*

Family Violence- Knox has the highest number and rate per 1000 population (910) of reported family violence incidents in the outer east in 04-05. This number was also above the state average. The majority of reports were from women aged 25 -44 years. Knox also has the second highest child abuse notifications in the EMR (2002-03). Most notifications related to children under 3 and babies. Parental domestic violence was the most common problem associated with child abuse. Almost half of substantiated child abuse cases involved sole parent (mother) families.

Suicide and deliberate self harm- Whilst admissions to EDs as a result of self harm was identical to the state average, Knox had a much higher average number of admissions (20%) by people in the age group 30-39 than for the rest of the state (13%) and this was despite a smaller than average proportion of the population in this age group compared to the state. Women presented more frequently than males (59% female)

Community Strength Indicators - There are interesting findings in relation to indicators of community strength, which is a relevant measure in terms of its relationship to social connectedness and social capital. For example, fears around safety continue to increase as demonstrated by the KCC annual survey, rising from 22% in 2001 feeling less safe to 36% in 2004. Yet crime rates are the lowest in a decade. Volunteer rates are similar to the state average but fewer parents in Knox are involved with their children's schools (\*50% compared to 65% for the state average). Similar results were found in the Improving Lives of Young Victorians report (Bond et al., 2000) which found that connection with parents and school was lower in Knox. School retention and articulation to tertiary education is much lower in Knox than across the state despite the relevant affluence of the community. Again despite this affluence 37% of people said they could not raise \$2000 in an emergency which may suggest financial over commitment or lower levels of social capital in the catchment area. Finally Knox was also noted for its lower levels on indicators such as feeling valued by society and feeling there is a real opportunity to have a say on important community issues (69% and 50% respectively compared to state averages of 74% and 60%). (All data from Swinburne University and Dept for Victorian Communities 2006)

## 2. Physical Activity

The Victorian Population survey for 2003 revealed that close to 40% of people were not exercising at the level to gain health benefits (32%) or were sedentary (6.4)% in the Eastern Metropolitan region. More recent Knox specific data suggests that Knox residents were more likely to be sedentary than other LGAs and that people aged 35-54 years most likely to be sedentary. In the 35-44 age group 33% did no activity compared with 18% of the Melbourne metropolitan sample and in the 45-54 age groups the figures were 30% sedentary in Knox compared to 13% of the Melbourne wide sample. In addition cycling was less frequent than in LGAs and this was noted as significant. This is despite a large network of bike paths that have been built and maintained by council. (All data from the Victorian Local and Neighbourhood Environments - VicLANES study by the Melbourne University, 2006)

## 3. Food and Nutrition and Healthy Weight

In the VicLANES study Knox LGA was not found to be significantly different around food purchasing or knowledge of food. Data on obesity and overweight from the Victorian Population Health Survey suggests that the EMR is not different to the state in these rates either. Data from VicLANES on weight is not available however the general results from the survey suggest that when controlling for all factors place is significant in determining likelihood of overweight and that women in particular in lower socio-economic suburbs are on average 3 kilos heavier. This may be more of an issue in the less affluent suburbs in the Knox catchment

## 4. Tobacco, Alcohol and Other Drug issues

In terms of lives lost through avoidable causes, the Tobacco Tragedy report 1999-2002 indicates the following-

<u>Deaths in Knox LGA</u>	=772
Caused by Smoking	= 91
Caused by Alcohol	= 19
Caused by Other Drugs	= 5

Tobacco was by far the biggest cause of avoidable deaths both within Knox (11.82%) and across the state- (12.15%). The Improving the Lives of Young Victorians study (2001) found that Knox had the second highest number of young people taking up smoking and that this was significantly higher than other LGA's across the state.

According to a Knox City Council summary document (draft) for the Drugs Issues Profile "Knox had high levels of alcohol consumption - the highest per capita consumption in the eastern region, higher than the state average and higher than at least half of all Victorian municipalities (mid-1990s data). Above (regional) average rates of alcohol-related deaths, years of life lost and hospital admissions are a predictable consequence. Despite this, Knox's standardised alcohol-related mortality and morbidity rates are still below the Victorian average. All measures, however, have trended upward between the middle of last decade and earlier this decade, such that Knox's rate of alcohol-related deaths and hospital admissions have moved from being (statistically) significantly lower than the Victorian average, to rates that are no longer considered to be a major (statistical) variation."

## 5. Sexual Health

The Victorian DHS Perinatal Data Collection Unit (2005) indicates that Knox has the second highest number of pregnancies under 20 years in the eastern region, and the numbers of pregnancies for under 20 year olds increased between 2003 to 2004 by around 30%; where only one other LGA in the eastern region had an increase. Additionally the Angliss Hospital Maternity Specialised Support Service has indicated

that around 40% of young women accessing their program between 2005 and 2006 have been from Knox, and the numbers of young women accessing their program is currently increasing annually.

Notification for family violence and sexual abuse have been reported by DHS (Bond, Thomas, Toumbourou, Patton & Catalano 2000) as second highest in Knox for young people across the state. This study as also shown young people in Knox are the second most sexually active young people in the state. Additionally a national study (Secondary Students and Sexual Health 2002) has indicated an increase in levels of sexual activity amongst secondary students, combined with inconsistent condom use and inconsistent use of contraception. Young men in Year 10 were shown to be of particular concern with poor knowledge about STIs, high rates of partner change and high rates of sex with someone they have met for the first time. The study also reported high rates of binge drinking amongst young people and that they were more likely to be drunk or high at their last sexual encounter.

## **2. What does the community consultation that the organisation has undertaken, suggest are the major health challenges for the organisations service population (commonly referred to as Felt Need)?**

A variety of consultations have been held with the community that provide relevant information in consideration of the health issues in Knox.

Consultation with mothers by KCHS during the previous health promotion plan provided important data on felt need. In the first stage, telephone interviews with a small sample of mothers of children 0-6yrs (living in Ferntree Gully) raised issues of: social isolation, tiredness/exhaustion, demands of children (especially regarding illness, disability and time management) and emotional difficulties (depression, anxiety, feeling out of control). The main perceived strengths (and potential protective factors) were strong family unit, good communication and spending recreation time together outdoors. On the community level respondents suggested the physical environment and friendly community were important strengths while public transport, demand for parent support services and the built environment were identified as issues.

Focus group consultations with larger samples (over 100 women from 15 play groups across Ferntree Gully) supported previous consultation in identifying the main issues as social isolation (from other adults), tiredness, infant demands, time issues and feeling out of control. Mothers noted that their own health needs were overtaken by infant needs and reported further the issue of lack of time spent on physical exercise. Critical external supports (for mental wellbeing) in this early period were: the maternal child health nurses for support/information and connection to other mums (ie. new mothers groups), the Angliss hospital and (later) playgroups. To improve community support for new mothers they suggested pram strolling groups and flexible settings for increase opportunities for mothers to meet (eg. coffee mornings). Third stage data (project journals) from consultation during implementation of interventions (coffee morning, pram stroll and consultation with the two Maternal Child Health Nurse Clusters covering all of Knox) raised further points: The extra challenges and isolation for new mums moving to the area, women of CALD background, with mental health issues (or other added challenges) who often don't join local playgroups and new mother networks, difficulties during the transition of children starting primary school, and those living in certain localities in Knox region(eg. in new housing estates).

Community Felt Need regarding families also emerges from consultation by other organisations. The family issues identified in the Knox Community Council Early years plan: "Off to a Flying Start" consultations include isolation of new mums, young mums, limited parenting support for families with a wide variety of organisations in the development of the new plan. Consultations with CALD Communities (Muslim families in Rowville/Lysterfield) raised specific difficulties for CALD communities: added difficulties for women to access physical activities, cultural appropriateness of childcare and community services.

Recent consultation with young people in secondary schools (as part of the launch of the Knox Smoke Free school education campaign and as part of the Safe Party school education days attended by KCHS staff) confirmed that young people were concerned about the rates of smoking by their peers and also by their parents and grandparents. In one small group consultation every parent, step parent or carer of the young people in the group smoked and many of the young people's friends did as well. Smoking was seen as attractive and socially enhancing and whilst young people saw it as an issue for others they often did not identify it as being a problem or addictive for themselves, even if they did smoke. As part of the evaluation, young people suggested that they needed more timely and realistic information on the likely health problems and the addiction that resulted.

In addition, information has been gathered from a wide variety of youth service providers at the local, regional and state level in the development of the new plan. This large consultation process has identified a number of issues for young people in terms of their sexual health needs. Themes that emerged from these consultations included: a) a range of issues for young people including teenage pregnancies, unwanted sex, sexually transmitted infections, sexual risk taking and sexuality discrimination; and b) gaps in terms of timely and appropriate access to services and the provision of preventative and educative programs.

A range of information was gathered from a number of professionals working within school settings in particular, including the Department of Education's Secondary School Nurse Program, the Knox Student Well-Being Coordinator Network and the EMR Department of Education Student Wellbeing and Drug Education Officer, which all highlighted sexual health issues as a large area of concern for young people in schools. Particular areas of concern were increasing numbers of teenage pregnancy, with young women wanting to continue their education, but with limited resources within schools to support this effectively; a lack of safe, inclusive sexual health services to refer young people to; a lack of confidence and skills amongst school staff along with competing curricular pressures to effectively deliver sexual health information; and increasing numbers of young people participating in unsafe sexual risk taking practices, including drug and alcohol misuse.

Consultation with professionals from the Eastern Centre Against Sexual Assault (ECASA) has indicated that very few of their Knox referrals come from General Practitioners (GP). It was suggested that young people generally do not feel safe talking about sexual health/sexual assault issues with their GP, with confidentiality and shame issues being significant barriers. It was also highlighted that young people often need longer sessions with doctors to discuss their issues and do not feel confident asking for this. ECASA workers suggested that GPs in Knox need resourcing and support to work more effectively with young people and youth service providers.

Consultation with young people as part of the Safe Parties program also suggests that alcohol related and induced sexual conduct is problematic amongst young

people at parties. Informal consultation with young people in the outer east region currently being conducted and considered by services in the Yarra Ranges catchment including Yarra Valley and Ranges CHS suggest recent issues with reported (and unreported) sexual assault, drink spiking and young women swapping sexual favours for transport and alcohol. Whilst the level of this activity is unknown in Knox at present it is likely that similar practices are occurring in schools in this catchment.

### **3. What does the data that the organisation collects, indicate about the needs of the community (commonly referred to as Expressed Need)?**

KCHS has recently begun analysing service usage data by suburb and other demographic categories such as country of birth and age. As the mechanisms are still being developed and the categories defined not all data is currently available. However the basic demographic data suggests:

- 8.5% of clients are 17 or under
- 45% of clients are between 18 and 64
- 39% are 65 and over
- 7.5% are over 85

In terms of income:

- 70% of clients are on a pension such as aged, carers, sole parent, disability, child disability or other government pension
- 16% are employed but low income earners
- 12% did not state
- 2% are on unemployment benefits.

The highest service usage is (in order) by people living in Ferntree Gully, Boronia, Wantirna (including Upper Ferntree Gully, Mountain Gate, Lysterfield) , Rowville, Bayswater.

Information provided by the KCHS Intake service suggests that there are a number of issues raised by callers to the service for which KCHS does not currently provide services. These include:

- Material aid requests
- Financial counselling requests
- Asthma education and support
- Low cost Counselling for those in the medium income bracket
- Counselling for children aged 5-12 (gap)

In terms of demand for current services those with the longest waitlist over the last two years have been:

- Paediatric Occupational Therapy (around 8 months)
- Paediatric Speech Pathology

In recognition of the high demand for children's early intervention services KCHS has recently formed a partnership with Eastern Health to deliver increased Paediatric Speech pathology, early child psychology service and is currently investigating the need for a children's dietetics service.

**4. How does this region compare to other similar regions/communities (commonly referred to as Comparative Need)?**

Knox has been recognised as having gaps in support services for people parenting in difficult circumstances. One of the largest gaps has been the lack of specialist domestic violence services, when compared to bordering and comparable LGAs, yet as the demographic data above demonstrates this is a high need in Knox. The Knox Family Care Network, a network of local agencies including Knox City Council, Knox Community Health Service and Anglicare Victoria, developed the KFCN Action Plan for 2006-2009 which identifies service gaps in the area of affordable and suitable housing, child psychology and counselling services, counselling services for people on low incomes, provision of family violence programs, social connectedness projects and programs for families in isolation and supports for parent-child relationships in vulnerable families.

Gaps in terms of a service response to deal effectively with the sexual health needs of young people in Knox have been identified across the outer eastern sub region. Both the Shire of Yarra Ranges and the City of Maroondah each have a youth health clinic that services young people in their area. Whilst the clinic in Maroondah (Eastern Access Community Health Youth Health Clinic) provides a service for homeless young people from all three outer eastern LGAs, including Knox, consultation with youth service providers has identified that this service is inaccessible to young people in terms of transport and its limited hours of opening.

As demonstrated above, smoking is a major risk factor in Knox and the Knox Smoke Free committee has identified a lack of programs to respond to smoking cessation. With the recent training of a staff member as a QUIT facilitator Knox CHS has been able to offer the QUIT Short course twice to the general public and has promoted this via the QUIT website. They were the only two courses available in the east listed on the website demonstrating a general lack of service response in this area.

**5. Create a list of the health issues that were identified in the previous questions, in the table below and select the type(s) of need which suggests that these are issues:**

Selected Health Issues	Summary of Need
Physical Activity	<p>Normative: Inactivity linked to obesity (number one risk factor for women), high rate inactivity in State, (in Knox): women 35-55 have significantly lower activity rates. Links between local physical environment and physical activity (Viclanes). Women with children more likely to use the car for short trips. areas of higher socio-economic disadvantage have lower physical activity levels.</p> <p>Comparative need: Knox has lower walking/biking rates by women, despite good bike paths network.</p> <p>Felt need: Women see children as barrier to activity.</p>
Tobacco, Alcohol and Other	<p>Smoking Normative Need- Smoking is the largest cause of avoidable death in Knox and the state.</p>

Drug issues	<p>Felt need- Young people in the pilot of the smoking prevention program in 2005-06 identified information about the pros and cons of smoking delivered by credible authorities- in this case a GP and health workers- was useful and more likely to be accepted.</p> <p>Expressed needs - responses from a range of people both in and outside of the Knox Catchment for KCHS QUIT courses suggest there is interest in this form of smoking cessation program. Making it timely (i.e frequent enough) to be effective is the challenge for a single service.</p> <p>Comparative need - smoking appears to be as problematic in Knox as it is in other areas, but smoking uptake by young people appears to be happening at a greater rate.</p>
Mental Wellbeing and Social Connectedness	<p>Normative need: Mental disorder is no.3 on the Burden of Disease. Social isolation is a major risk for Mental health issues. Knox has high family violence/ reported child abuse compared other EMR areas, low social capital on some indicators relating to families with children.</p> <p>Felt Need: Social isolation identified as an issue in all consultations with mothers/families. Further difficulties: single, sole, CALD parents especially mothers and parents facing other issues eg. mental health.</p> <p>Comparative need: A high demand for children's services including counselling, gaps of social connectedness/wellbeing programs for low income, vulnerable families.</p>
Sexual health	<p>Normative need: Chlamydia in young people considered most pressing sexual health issue in Victoria.</p> <p>Felt need: Many workers identified teenage pregnancy, sexual assault and sexual risk taking as pressing. Shared concern that school staff not equipped to deliver sexual health education. Same sex attracted young people continue to experience discrimination leading to depression, early school leaving and suicide.</p> <p>Comparative need: Knox has second highest number of teenage pregnancies in EMR and a higher number of family violence and sexual abuse incidents than the average for Victoria.</p>

## Identifying Issues - Determinants

**6. Summarise the key contributing factors that are impacting on the occurrence of each of the health issues below. Consider the wider social, environmental and policy context fully when completing this section.**

### PHYSICAL ACTIVITY

In May 2006 KCHS formed a Knox Women and Physical Activity Working group with representation from various departments of Knox City Council, Care Connect (disability support), Women's Health East and Neighbourhood Houses. Consideration was given to identifying the key contributing factors to mother's inactivity (an issue identified in the VicLANES data). This was achieved through an exploration of the literature, review of programs from other catchments and consultation with the above organisations that represent a variety of mothers in the Knox region. The following factors were identified:

- Environmental issues- Barriers such as quality and connectedness of footpaths and walking tracks that allow access between mother's key activity centres. Geographical barriers such as hills, cul de sacs etc. Mother's knowledge of local pathway/cycle path network. Lack of pause points, way-finding signs and information on length of tracks and ability of children to complete. Research shows a very strong link between physical environment and walking (VicHealth 2003; Butterworth 2000; VicLanes 2006) and confirms the importance of environmental factors in encouraging people (including mothers) to walk. Conclusions from this research are that suburbs need to be designed to encourage people to walk. Main environmental barriers and enablers include: destinations (schools, shops, public transport etc.) being more than 400m (5 minutes) from a large percentage of homes (at which point people are more likely to drive rather than walk); street environments: position of main roads and pedestrian crossings, accessible Public Transport; the presence, width, level of maintenance and attractiveness of bike and walking paths and street scapes including lighting and after hours access. Welcoming spaces for particular groups including youth, women and children.
- Safety - A recent paper at the Walktober 21 conference confirms that Australian mothers are significantly more likely (than in other researched countries) to raise perceptions of the dangers of walking as a barrier to walking with their children. Perceptions of safety are affected by environmental elements eg. mixed land use, large numbers and mix of people on the street vs. isolated spaces or unwelcoming space, degree of lighting, levels of surveillance from shops houses etc. and inability to walk after dark (Butterworth 2000). It can also be affected by cultural perceptions about crime and about safety for children while walking or cycling. Perceptions of safety can also be affected by the level of people who participate in decisions about the environment, either adding to their sense of connection and community (and therefore the level of usage) or excluding them and undermining their tendency to use local space either recreationally or in active transport.
- Social/Cultural – There are considerable issues around body image, weight, role of mother and lack of time for self and exercise, lack of awareness of non threatening/low cost options for physical activity and availability of supportive partner or extended family. These issues will particularly impact women with fewer resources and those in low socio-economic areas. Research again shows strong interconnections between culture and walking/cycling levels (Butterworth 2000;

Viclanes). Sense of community is a factor within communities which can contribute to greater local use of facilities and therefore physical activity. A key contributing factor is communities where diverse groups/ages/abilities/cultures etc. are involved and empowered. This may include their involvement in improving the physical and cultural environment: eg. Art works and community development projects.

- Other- Cost of formal physical activity options is a deterrent for many. Other factors include loss of neighbourhood and community connections (decreased social capital) and isolation due to language barriers, disability or mental health issues. There are career issues for some resulting in disconnection from local communities and the impact of the encroachment of technology.

**Organisation has a role? Yes**

## **MENTAL WELLBEING AND SOCIAL CONNECTEDNESS**

Research on social exclusion (summarised in the Evidence Based Mental Health Promotion Resource) outlines 4 dimensions of social exclusion. These will be used here to outline key contributing factors for social exclusion for women (and more specifically mothers and mothers parenting under difficult circumstances). Many of these issues have been raised via previous research in Knox conducted as part of previous health promotion work and have also been identified by both internal and external working groups in the planning process for the three year health promotion plan.

### 1. Impoverishment or exclusion from adequate income or resources.

General social/economic/political factors contributing to poverty also contribute to women's and particularly mothers poverty. These include:

- reduced social security for jobless and policy not fully taking account of costs of disability, children, cost of moving from poverty & long-term unemployment
- Low minimum wage/ decreasing power for those on low wages to secure and protect basic work conditions (without fear of dismissal).
- Cost and lack of equitable access to basic living needs (housing, food, transport, health, education, child care, disability services, respite care) (ACOSS 2005).

In addition women have further factors contributing to impoverishment:

- Women's experience structural inequity in that policies have historically been developed without their involvement nor without taking account of their experience
- Women are more likely to work part time and predominantly carers of children.
- Traditional women's jobs are more likely to be lower waged
- Being single parent, indigenous, jobless and renting add to women's risks of impoverishment.

### 2. Labour market exclusion

Limited employment opportunities also contribute to social exclusion and women as a group are more likely to experience this (Evidence based mental health promotion resource). Factors contributing to this include:

- Mothers are predominantly responsible/carers for children;
- There is a lack of fully paid maternity leave of sufficient length;
- Workforce inflexibility to allow balance of childcare and work
- Lack of universally subsidised/accessible childcare;

- For mothers from racial & ethnic minority groups and refugees there are further factors of racist attitudes among employers, lack of recognition of their qualifications, language barriers, and some refugee visas not allowing to work;
- For mothers living with disabilities, chronic illness (including mental illness) limiting factors include the lack of accommodating workplaces and social policy not taking account of their diverse needs.

### 3. Service Exclusion

Factors affecting ability to access services include:

- Limited access due to cost of or not wanting to use external childcare when services do not allow or accommodate children;
- Mother-specific services eg. Play groups, new mothers groups, not always accommodating of diverse mothers eg. mothers with disabilities, mothers from indigenous or CALD backgrounds or those experiencing other forms of marginalisation;
- Access to mother-specific services which are often set up for new mothers can infringe on access for all mothers eg. those with older or subsequent children, who have moved to the area, or adopted older children.

### 4. Exclusion from Social Relations

Environmental factors

Built environments that promote social interaction and participation also lead to development of social networks, social ties, social support, sense of community, community cohesion and a sense of place. All these are important determinants of mental wellbeing (Butterworth 2000). Some of the factors of the built environment that contribute to isolation include:

- Paths (quality and connectivity) and public transport options are not always accessible for mothers with prams thus restricting opportunities for social contact;
- Housing built around privacy rather than connection or shared activities eg high fences, individual backyards;
- Roads built for cars and not pedestrians: increasing fear for safety and reducing walking, biking in local areas. This limits neighbourhood/ economic environmental and social benefits of local walking& biking including connectedness.

Cultural factors

- Lower perceived safety in terms of crime, cars etc, leading to less walking, less people in local spaces and therefore even lower perceived safety which also leads to less neighbourhood connectedness.
- Expectation that “Mothers should know and cope” leads to less chance they connect with others, join networks or ask for help from friends, family or services.
- Restrictive cultural perceptions for example, what mothers should do (in services and in the community) leading some mothers who feel they don't fit these expectation (eg. CALD mothers) to not link to family, friends, other mothers' services.
- The reduction of family to nuclear components in Anglo-Australian culture reduces possible connections for mothers with women of different generations and different parts of the family.
- Women having less access to a car (again more likely for those of low income, CALD backgrounds, unemployed).

#### Individual factors

- The multiple tasks done by mothers leading to lack of time and increased stress.
- The natural stresses and chaos of motherhood are further compounded for those living in poverty, in unstable employment and /or housing, with disability, violence and other difficult circumstances and result in difficulties in meeting service expectation regarding appointment times and frequency.
- Young mothers have the added factor of being young eg. Stigma of using services, lower confidence and knowledge, lack of youth friendliness of services.

**Organisation has a role? Yes**

### **TOBACCO**

Tobacco use is of particular concern in Knox due to the impact it has on the burden of disease. Consumption of alcohol and illicit drugs whilst causing harm to health are not at the problematic levels of smoking in Knox. However, this is not to say that alcohol consumption, especially binge drinking, by young people and the ensuing problems with emotional and physical health, relationships and sexual crimes is not of concern (Centre for Adolescent Health 2000, Knox City Council).

The numerous legislative and policy imperatives that restrict and limit the scope and of smoking in public has successfully impacted on smoking rates in Australia and other industrialised countries. The exception to the decline in smoking is the continued uptake of smoking by young people (Tyas & Pederson 1998). What is known about adolescent uptake of smoking is that: it is more likely when parents smoke and this is more likely when they have blue collar occupations; that it significantly increases the likelihood of smoking as an adult (Tyas et.al); that there are perceived social benefits by adolescents to smoking and that information on health risks alone does not change this (Rugkasa, Stewart-Knox, Sittlington, Abaunza & Treacy 2003).

It is therefore recognised that prevention of smoking in young people requires a multi- faceted approach working with young people, schools, parents and work places (Rugkasa et.al). The individual, social, biological, physiological, environmental and political aspects of smoking and its appeal can not be underestimated. (Tyas etal, 1998)

**Organisation has a role? Yes**

### **SEXUAL HEALTH**

Initial local consultations have occurred with local youth service providers and organisations working with young people to determine key contributing factors to young people's sexual health. Timely provision of information and services to young people who may have limited knowledge and understanding of issues that affect their sexuality and sexual health is a key factor in determining overall health. These consultations indicated that whilst a number of sexual health services exist for young

people including clinical services, generic youth and family services and educational and prevention programs, the service system has a number of significant gaps in terms of responding effectively to the sexual health needs of young people. A lack of coordination has been identified as contributing to these service gaps, making clear pathways for referrals to services difficult.

The KCHS internal Sexual Health Learning Circle researched and considered these issues further. Key factors identified included access for young people to services that deal with their sexual health needs is limited due to a range of barriers that include limited transport options, a lack of provision of confidential and inclusive sexual health services that are youth friendly, including limited hours of opening, cost of services (lack of bulk billing), lack of knowledge about available sexual health services, and young people lacking confidence in accessing services. Other contributing factors identified include poor access to sexual health education in schools and a lack of confidence in young people dealing with their own sexual health issues.

In 2005 Knox City Council Youth Services developed a Knox Youth Plan for 2005-2009. In developing this plan extensive consultations occurred with Youth Service Providers across Knox, which highlighted a range of issues and gaps in the youth health service system, and in particular in the sexual health service system for young people. Barriers in young people accessing services, a lack of referral pathways for young people and a lack of coordination in response to sexual health issues for young people were identified. A number of key recommendations highlight the need to create better access for young people to health services. These recommendations included advocating to local health and youth service networks the need to develop a strategy regarding distribution of information about health and support services in Knox for young people, facilitating and supporting with Knox Community Health Service stronger relations between local health practitioners and young people, and in particular, recommending the undertaking of a feasibility study of establishing an outreach sexual health clinic in Knox.

Other relevant national and state policies and initiatives which prioritise young people in relation to their sexual health needs include:

- 1) The National Sexually Transmissible Infections Strategy 2005-2008, which has identified young people as a priority group,
- 2) The Gay & Lesbian Health Action Plan 2005
- 2) The Victorian Womens Health and Wellbeing Strategy 2002-2006
- 3) Future Directions: An Action Agenda for Young Victorians 2006, which involves the implementation of a Whole School Sexuality Education Project
- 4) The Sexual and Reproductive Health of Young Victorians, FPV, CAH, WHV, 2006

<b>Organisation has a role? Yes</b>
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## Identifying Issues - Gaps

**7. Are there any gaps in knowledge about any of the health issues that have been identified at this stage and what further research is necessary? Who could assist with or fully undertake the gathering of that information?**

### **Physical Activity**

There is a lack of detailed, specific information regarding barriers and enablers for diverse groups of mothers to low cost, physical activity options such as cycling and walking in Knox. While the Viclanes research has established that the SES of an area affects health (eg. BMI of women) substantially, we are not clear about how exactly health, area, behaviour, culture, perceptions etc. interact to create this effect. Also given that the mothers most affected are those in low socio-economic areas how are mother's exercise patterns further affected when they are significantly disadvantaged by other factors that create isolation and a potential lack of support structures? Detailed qualitative explorations are needed of the way these factors interconnect for individual mothers especially those facing difficult parenting circumstances: from low socio-economic areas with disabilities and mental health issues or as carers of others with disabilities, sole and young mothers, newly arrived migrant and refugee mums, and mums who are socially isolated as a result of other circumstances- see below under Mental Wellbeing and Social Connectedness).

Research required has been discussed by the Women and Physical Activity (WAPA) Working group and as a result of a submission for funding to the Department of Infrastructure for a Travel Smart grant has been submitted. If this submission is successful (for 2007/8) it will allow for a much expanded research phase and extra support for implementation of the recommended interventions. If not the WAPA agencies led by KCHS are still committed to undertaking this research in Bayswater in partnership with local mothers utilising a peer research model (utilising tools from the Narrative Evaluation Action Research - NEAR - evaluation method).

### **Mental Wellbeing and Social Connectedness**

Previous research by KCHS around the needs of mothers has verified the importance of the experience of social support especially in the early years of parenting. The data gathered also raised further questions about the experience of mothers who have less social support, particularly mothers parenting in difficult circumstances such as:

- women with children with disabilities or with disabilities themselves;
- women as sole parents (particularly in financially challenging situations);
- mothers from CALD backgrounds (especially those who may be newly arrived or refugee) and;
- Isolated mothers struggling with financial, social or family problems.

Bayswater has been identified as a particularly disadvantaged area and has been the recent focus of a joint council submission by Knox and Maroondah City Council's for needs identification and community building activities to increase social cohesiveness. As such it has been chosen as the site for health promotion intervention for both Physical activity and Mental Wellbeing & Social Connectedness priorities for the term of this plan.

The planning processes to date have utilised best practice principles from evidence of projects of this type. It is anticipated that as an area based approach it will add to

the knowledge and research in the field. The Evidence-Based Mental Health Promotion Resource (Keleher and Armstrong 2005) in its review of evidence regarding area based community building projects suggests the conjunction of area based and people based interventions are a new yet fruitful area for mental health promotion, where there is much to learn. Particular gaps in knowledge include how process elements and types of partnership influence effectiveness of programs and effectiveness of neighbourhood programs for improving social exclusion. Also the resource suggests that while there is knowledge about developing community, gaps occur in knowledge about creating networks across and between communities or across differences in ways that benefit vulnerable people. The Bayswater project, while taking a whole of community approach aims to specifically identify the gaps in social connectedness for vulnerable groups ie. mothers parenting in difficult circumstances as outlined above.

In particular in developing best practice processes it has become apparent that more information is needed regarding the processes used in area based research, consultation and engagement from those involved including workers, agency staff, partners, community members and mothers. As a result the data collection will occur within a participatory action research framework with significant opportunities for periodic reflection. The method chosen to ensure these multiple perspectives on process is the story dialogue method (Labonte 1997). A further gap identified is the lack of detailed local knowledge about the experience of social connectedness from diverse groups of mothers in Bayswater area. Again the action research method proposed will address this question and add to the understanding of social needs in Bayswater.

### **Sexual Health**

Through extensive consultation processes with youth service providers in Knox KCHS have identified a number of gaps in knowledge in terms of addressing the sexual health needs of young people. Particular gaps exist in terms of information from local young people about their sexual health needs and how these can most effectively be addressed. There is a lack of information from marginalised groups of young people, including same sex attracted young people, young people from CALD backgrounds, refugee and newly arrived young people, young people with alcohol and other drug issues, young people with mental health issues and disabilities and indigenous young people.

Gaps in knowledge from service providers have been identified particularly in relation to young people's sexual health needs and issues and potential strategies for developing a more coordinated and effective response, as well as information about what already exists in the community to respond to young people's sexual health needs. As a result a partnership group (KCHS, Women's Health East, Dept Education and Training and Knox City Council) has been formed to address some of the gaps in the knowledge in Knox.

## Identifying Issues - Stakeholders

### 8. Who are the key stakeholders? Are there resources that can be provided by these stakeholders?

Stakeholders	Potential or Current Stakeholder Contribution
<b>Physical Activity &amp; Mental Wellbeing and Social Connectedness</b>	
<ol style="list-style-type: none"> <li>1. Knox Community Health Service (PARTNER)</li> <li>2. Knox City Council- (PARTNER) specifically representatives from Maternal Child Health; Walking School Bus, Playgroup co-ordinator, social planning, transport and engineers</li> <li>3. Glen Park Community (PARTNER)</li> <li>4. Care Connect (PARTNER)</li> <li>5. Women's Health East (PARTNER)</li> <li>6. Local women, especially those from identified target group</li> <li>7. Maternal Child health nurses(local)</li> <li>8. Anglicare</li> <li>9 Knox Family Care Network</li> <li>10. Local activity centres- such as preschools, libraries, local businesses, playgroups</li> </ol>	<ol style="list-style-type: none"> <li>1. Staffing, research support &amp; project development</li> <li>2. Staffing, research support &amp; project development</li> <li>3. Action Research support and project development</li> <li>4. Action Research support and project development</li> <li>5. Action Research support and project development</li> <li>6. Action Research support and project development</li> <li>7. Action Research support and project development</li> <li>8. Networking</li> <li>9. Networking</li> <li>10. Networking, assistance with interventions</li> </ol>
<b>Tobacco, Alcohol and Other Drug issues</b>	
<ol style="list-style-type: none"> <li>1. Knox Division Of General Practice</li> <li>2. Knox Community Health Service</li> <li>3. Angliss Hospital - Health Promotion</li> <li>4. DHS secondary school nurses</li> <li>5. Secondary schools</li> <li>6. Knox City Council- Social Planning</li> <li>7. Knox City Council- Youth services</li> <li>8. Knox City Council - School Focussed Youth Service</li> <li>9. Private QUIT providers</li> </ol>	<ol style="list-style-type: none"> <li>1. Partner &amp; Facilitator / Knox Smoke Free committee</li> <li>2. Participant in Smoke Free Knox Committee and partner for delivery of interventions</li> <li>3. Participants- Knox Smoke Free committee</li> <li>4. Partners for delivery of intervention</li> <li>5. Partners for interventions</li> <li>6. Participants- Knox Smoke Free committee</li> <li>7. Participants- Knox Smoke Free committee</li> <li>8. Participants- Knox Smoke Free committee</li> <li>Participants- Knox Smoke Free committee</li> </ol>

**Sexual health**

GROUP A - The Core partnership group has been established & will be responsible for managing & driving the project, & contributing resources.

1. Knox Community Health Service
2. Knox City Council Youth Services
3. EMR Dept Education & Training Student Wellbeing/Drug Ed
4. Knox School Focussed Youth Service
5. Women's Health East

GROUP B includes organisations & networks that are key stakeholders in terms of contributing knowledge & expertise regarding merging issues, but also may be involved in project development.

1. Knox Division of General Practice,
2. DHS Secondary School Nurse Program, Knox Student Welfare Coordinator Network,
3. Knox Youth Service Provider Network

GROUP C includes organisations that will provide expertise & knowledge regarding emerging issues.

1. SEA (Same Sex Attracted Eastern Action Group)
2. Family Planning Victoria
3. Centre for Adolescent Health
4. Starting Out
5. Angliss Hospital Maternity Support Service (Teenage Birthing Program)
6. Eastern Access Community Health
7. Eastern Centre Against Sexual Assault Migrant Information Resource Centre

1. Staffing, action research support and project development
2. Staffing, action research support & project development
3. Action research support & project development
4. Action research support & project development
5. Staffing, action research support & program development

GROUP B will provide expertise & knowledge, program development

GROUP C will provide expertise & knowledge

## Identifying Issues - Prioritising

### 9. Based on the above information, what will be the agency's Priority Health Issues for the next 12-24 months?

Priority Health Issues	Rationale for Assigning Priority
Physical Activity	<p>Rationale:</p> <p>Prevalence- Across Australia 57% of the population does not exercise at the level to achieve a health benefit. Almost 15% are completely sedentary. As previously stated physical inactivity is experienced at higher than expected levels in the Knox catchment.</p> <p>Severity - Physical Inactivity is a major risk factor for the top 3 disease/conditions in the Knox Catchment. It is a larger risk factor for women. The Planning for Healthy Communities framework states that physical inactivity costs the health system around \$400 million per year in Australia. It is second to tobacco as a key contributor to preventable deaths.</p> <p>Selectivity - Research conducted as part of the Planning for Healthy Communities Framework, suggests that women are the most physically inactive. Within this group, women who are married, women with two or more school aged children and women aged 30 or over are particularly inactive. VicLanes gives local support to this data finding that 1 in 5 women in Knox stated that their children were a barrier to physical activity and 2 in 5 stated they were a barrier to walking.</p> <p>Amenability to HP intervention- It is acknowledged that comprehensive multi-strategy Health Promotion projects can have an impact on the uptake of physical activity by those most at risk (Planning for Healthy Communities - Chapter 7). Best practice elements of effective community wide physical activity interventions that have succeeded and that are incorporated into this project are-</p> <ul style="list-style-type: none"> <li>- intersectorial partnership including local government with commitment of resourcing and incorporation into municipal and organisational processes, structures.</li> <li>- an action research response that identifies barriers (community audit) through inclusion of local mothers as peer researchers and builds community strength</li> <li>- a focus on community ownership from the earliest stage utilising the peer research model to generate and implement community action solutions.</li> </ul> <p>Relation to the work of other agencies- The Knox Women And Physical Activity (WAPA) group has formed a partnership with the agencies described elsewhere to consider the issues raised by the VicLANES data. (This group has now expanded its focus to consider social connectedness and community building aspects) All member organisations have identified women's lack of physical activity and the barriers for them, specifically mothers with disadvantage, as an important priority in their internal planning. It has been a PCP priority for the previous three years. As a result of the commitment of agencies to work together, a funding opportunity was sought and submitted for on the basis of a three year project. A decision was made to narrow the geographical target area to ensure the project was</p>

	<p>manageable, aimed at the most disadvantaged population (as specified above) and was amenable to a concentrated whole of community approach. As a result Bayswater was selected on the basis of its high number of single parents, people on low incomes, low cost rental and public housing.</p> <p>This project complements the direction of key partners such as Knox City council who have identified Bayswater as an area for infrastructure and community development (Knox CC Community Health and Wellbeing Strategy and the Knox Structure Plan). It complements the work of KCHS as Bayswater has been identified as the location for health promotion interventions around social connectedness.</p>
<p>Tobacco, Alcohol and Other Drug issues</p>	<p>Rationale for Continuation of Smoking prevention component of the previous IHP 2005-06</p> <p>Prevalence- Smoking is the highest primary preventable cause of death in Knox. Approximately 20% of adults in the EMR currently smoke and this figure is over 28% for young people aged 18-24 years. (Victorian Population Health Survey 2003).</p> <p>Severity- Smoking is a major cause and risk factor for the burden of disease in Knox. Smoking uptake is slowing in all groups except young people and this is confirmed for Knox. The prevention aspect of our previous HP plan is therefore acknowledged to be of prime importance.</p> <p>Selectivity- Smoking is more likely to be taken up by people in blue collar occupations which is a major characteristic of the working population of Knox. It is also more likely where parents smoke which is also problematic in some of the suburbs of Knox.</p> <p>Amenability to HP intervention As stated in previous sections, smoking is a multi faceted issue best tackled with the variety of responses and tool available within a health promoting framework.</p> <p>Relationship to the work of other agencies The work currently being undertaken in Knox is a joint initiative of the Smoke Free Knox committee where various health, education, welfare and youth agencies have joined together to make smoking prevention and cessation a priority in their work.</p>
<p>Mental Wellbeing and Social Connectedness</p>	<p>Rationale</p> <p>Prevalence- Burden of Disease data suggests that mental disorders are widespread in the community, particularly substance misuse and depression and anxiety. Depression is increasing globally as a primary factor in the burden of disease. By 2020 it is predicted that unipolar major depression will be the second highest burden of disease (Murray and Lopez 1997). As one of the determinants for good mental health, social inclusion and connectedness is vital. The mental health of mothers is impacted by the level of connection to others and the community. The demographic data provided for Knox demonstrates that there are significant issues for women in terms of risk of social exclusion, particularly in areas that are economically disadvantaged such as Bayswater.</p>

	<p>Severity – Burden of Disease data shows mental disorders (depression, psychiatric disabilities, and alcohol and drug dependence) to be third highest both in the State and in Knox. The impacts from this are felt in the workforce, community and family and are intergenerational with a higher risk for further isolation and exclusion for children. This creates a destructive cycle with exclusion and poverty in turn being major determinants for further mental illness. Social inclusion/connectedness are protective factors for improving and maintaining mental health and as such points for intervention and community building interventions.</p> <p>Selectivity- Mental health problems particularly depression and anxiety are more likely to impact women, especially those who are: impoverished, facing barriers to work opportunities and those excluded from services and from social relations. (Healey, 2003; CDHAC, 2000). Mothers are more likely to be disadvantaged economically and with regard to social connections because of lower opportunities for participation in employment, their role as child carers and other factors outlined in key contributing factors section. Women parenting in difficult circumstances are at particular risk of marginalisation. This includes mothers who have fewer financial resources, those from CALD backgrounds, those with disabilities or children with disabilities, sole parents and other with limited financial and social connections.</p> <p>Amenability to intervention: There is a great deal of evidence that increasing walking and walkability in local communities has strong social capital, a neighbourhood strengthening impact as well as a direct impact on mothers (in terms of mental health) from increased physical activity. Mothers are also more likely to be affected by local area, and can be a driving choice in change in communities. Mothers as primary carers for children also have the potential to increase social connections and support for their entire family, especially their children.</p> <p>Best practice elements for creating social connectedness (from the Evidence Based Mental Health Promotion resource) and increasing the likelihood of change include: Community building/community wide focus (with multi-agency partnership local government, skill enhancement and sustainability); structured opportunities for participation (particularly by mothers parenting in difficult circumstances); volunteering, physical activity and exercise.</p> <p>Relation to the work of other agencies- Enhancing the mental wellbeing and social connectedness of vulnerable populations is the current PCP priority for the next three years. As such KCHS will participate fully in all catchment wide interventions aimed at building capacity to learn from and work with this population group. In terms of the Knox area KCHS has formed a partnership group whose focus has expanded to consider both physical activity and social connectedness issues in Bayswater (as described above under Physical Activity) and this group has strong internal support. Its planning processes are being informed from the activities undertaken in the previous health promotion plan around social connectedness and mothers.</p>
Sexual health	<p>Rationale: Prevalence- There are a range of indicators regarding the state of sexual health of young people in Knox. Knox has the second highest number of</p>

pregnancies under 20 years in the EMR, with anecdotal evidence that numbers are increasing in local schools. A national study of secondary students highlighted high rates of unwanted sex, particularly in relation to alcohol use. National research shows a decline in the levels of knowledge amongst students about HIV and poor levels of knowledge of Sexually Transmitted Infections (STIs), especially Chlamydia. Chlamydia in young people is considered the most pressing sexual health issue in Victoria. There is a growing body of national evidence showing around 10% of young people experience same sex attraction. Knox has the second highest number of family violence and sexual abuse for young people in Victoria (DHS, 2000).

**Severity-** It is difficult for young women to continue their education while pregnant and after having their baby due to a lack of resources and support in local schools, reducing their opportunities for financial independence and support. Young mums are more likely to experience disadvantage, mental health issues, domestic violence and sexual abuse, and engage in substance abuse (FPV, 2006). The development of STIs in young people can have important effects on their future sexual and reproductive health, including cervical cancer, infertility and recurrent pain. The anxiety and fear of rejection by potential partners or of not being able to conceive can lead to depression, isolation and relationship breakdown. Early sexual activity is often associated with risk taking behaviour which can lead to teenage pregnancy and STIs. Young people with mental health problems and drug use have also been reported as having a higher incidence of sexual risk-taking behaviour putting them at greater risk of further mental health issues. Unwanted sex can have wide ranging and persistent effects on young people's physical and mental health, including unwanted pregnancy and STIs.

**Selectivity-** Marginalised groups of young people including same sex attracted, Indigenous, young people with disabilities and from CALD backgrounds and young people with substance abuse and mental health issues experience the poorest sexual health outcomes. A national study of same sex attracted young people [SSAY] (Writing themselves in again, 2005) revealed 38% had experienced discrimination. Additionally, suicide rates are higher among SSAY than for other young people.

**Amenability to HP intervention-**

This planned activities will use a range of health promotion interventions encompassing a balance of both individual and population wide interventions, including 1) health education and skill development, 2) community action and 3) settings and supportive environments. All partner organisations are committed to ensuring that policies, service directions and practices integrate health promotion principles, and will aim to create supportive environments for integrated health promotion activities within their own schools and local organisations. Community action interventions will include using young people as researchers, which will provide opportunities for young people to take control of their own needs and issues. CHAD (Community Health and Drama) is a collaborative project with schools using drama and role play to educate health professionals of young peoples health issues and needs, and skilling them up as coaches and experts to deliver this material to health professionals. This project will therefore provide opportunities for young people to have a voice, and to facilitate activities where they are considered the expert.

	<p>Research supports the rationale that comprehensive approaches to sexuality education such as those described above can delay the onset of sexual activity and promote safer sexual activity, including the prevention of unplanned pregnancy, and rising rates of STIs in young people.</p> <p>Relation to the work of other agencies-</p> <p>A partnership has been established with key organisations across Knox, including Women's Health East, Knox City Council Youth Services, Knox School Focussed Youth Service and the Victorian Department of Education and Training to develop an evidence base that will inform processes, partnerships, programs and systems required for a young peoples sexual health strategy. Each of these organisations has identified a gap in terms of service response to meet the sexual health needs of young people. This project compliments strategic directions for each of these partners, in particular Women's Health East who have also prioritised Sexual Health and young people within their Health Promotion Plan.</p>
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## Organisational Goals – 2006-2009

As a result of the needs identification and prioritisation processes outlined above the following 4 priority areas and program goals have been selected. However as the work that has been occurring on the Tobacco, Alcohol and other Drug Issues priority is due to conclude in the next twelve months it is anticipated that this will leave the organisational plan before 2009. When this occurs more resources will be dedicated to one of the other priority areas as they move beyond community engagement, consultation and research phases into action plan implementation.

### PHYSICAL ACTIVITY

<b>Program Goal</b>	To increase active transport (walking and cycling) by mothers and their children in Bayswater.
<b>Population Target Group(s)</b>	1. Women with children 2. Families

### MENTAL WELLBEING AND SOCIAL CONNECTEDNESS

<b>Program Goal</b>	To enhance the mental wellbeing and social connectedness of mothers parenting in difficult circumstances living in Bayswater.
<b>Population Target Group(s)</b>	1. Women with children

### TOBACCO, ALCOHOL AND OTHER DRUG ISSUES

<b>Program Goal</b>	To reduce the uptake of smoking amongst young people in the City of Knox.
<b>Population Target Group(s)</b>	1. Young people

### SEXUAL HEALTH

<b>Program Goal</b>	To enhance sexual health outcomes for young people in the city of Knox.
<b>Population Target Group(s)</b>	1. Young people

## **Reflections on the Planning Process**

The planning process for the 2006-2009 organisational plan began formally in late 2005. From the beginning it involved representatives of the existing working groups (Physical Activity, Social Connectedness, Nutrition and Smoking) in gathering information regarding local needs and target groups. The whole of staff group was surveyed to ascertain their thoughts on priority issues in the catchment which provided the Health Promotion committee with information to guide the process. The Health Promotion committee considered information being gathered in the Service's Health demographic profile (which formed the basis of the needs assessment outlined in this plan). A set of criteria was developed and utilised to judge the relevant merit of possible health promotion priorities. This was completed for each Health Promotion Committee meeting which consisted of senior management and representatives from each working group and across teams in the organisation. The criteria appear in the Rationale for assigning priorities in this plan. The planning coincided with planning processes for the KCHS Strategic Plan which was most beneficial and allowed considerations around appropriate and strategic resourcing for health promotion to be raised and highlighted.

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