

SOUTH EAST PRIMARY CARE PARTNERSHIP

**COMMUNITY HEALTH PLAN
2003 – 2004**



June 2003



**SOUTH EAST PRIMARY CARE PARTNERSHIP
COMMUNITY HEALTH PLAN 2003-2004**

CONTENTS

Introduction

SEPCP Overview

1. Achievements

2. Operational Plan

2.1 Service Coordination

2.2 Health Promotion

Appendix 1. Service Coordination Status Report

Appendix 2. Health Promotion Grid



Introduction

The SEPCP Community Health Plan 2003-04 builds on the work contained in previous plans. The 2001-04 plan was an extensive document covering a three-year implementation period. As such the 2003-04 document will utilise much of that information rather than duplicating it here.

The format utilised for the 2003-04 Community Health Plan is based on the template recommended by the Department of Human Services. It should be noted that another document will be developed in July 2003 which will be in a different format and directed at key SEPCP stakeholders other than DHS. As such it will not be structured around specific key population groups, as seen in Part 2 of this document, but will continue to follow the format commenced last year and utilised in Part 1 of this plan.

It should be noted that the PCP Strategy is a long-term one with many of the outcomes dependent on significant change processes both at the organisational and structural levels within the primary health care sector. Considerable time and resource commitments are required from key stakeholders to achieve the expected PCP outcomes. A strong sense of partnership has been integral to the current successes of SEPCP and an acknowledgment of the resources required to sustain productive partnerships is required.



SEPCP - OVERVIEW

The South East PCP Area

The SEPCP comprises the three Local Government Areas of the Cities of Greater Dandenong, City of Casey, and the Shire of Cardinia. The South East sub region is an extremely diverse socio-demographic area.

The City of Greater Dandenong includes the culturally and linguistically diverse suburban and industrial centres of Springvale and Dandenong, with an increasing ageing population and age related illness and conditions. The City of Greater Dandenong has significant social and economic disadvantage as reflected in the Social Health Research Report.

The City of Casey has experienced rapid growth in recent years, resulting in the establishment of new housing estates and increased numbers of young families. This rapid and high level of growth is projected to continue until at least mid century. Several communities within the City of Casey have limited health and welfare services, shops, schools and recreational facilities. Geographic and social isolation are also priority issues within the City of Casey with the lack of transport links, economic disadvantage and isolated pockets of culturally and linguistically diverse groups.

The Shire of Cardinia is geographically a comparatively a large rural area that includes a number of small townships and a relatively small but increasing population. This is particularly the case around Pakenham and Beaconsfield where there is rapid and increasing housing development. One of the key issues in the Shire of Cardinia is the lack of emergency services and the lowest ratio of GPs per population in Victoria. Geographic and social isolation is also a priority issue and is associated with large distances between outlying communities, lack of transport links, economic disadvantage and lack of infrastructure to support community participation and recreation.

Strategic Objectives

The South East Primary Care Partnership (SEPCP) has been established as a voluntary alliance of agencies providing primary care services in the South East sub-region of Melbourne, comprising the municipalities of Cardinia, Casey and Greater Dandenong.

The Partnership members are committed to incrementally develop and implement a new working arrangement within the South East area to achieve a more strategic and systematic approach to population health improvement and the integrated provision of Primary Care services. This new working relationship builds on the strengths of the current South East primary care service system(s) and fosters a collaborative approach.

The Memorandum of Understanding signed by each partner establishes an agreement between local government and primary health and community support providers to develop and improve both the service system and the health and well being of people living within the South East area.

SEPCP Vision and Objectives

In 2000 SEPCP decided to adopt as its vision to achieve Primary Care service delivery and planning which is:

- Client Focussed
- Accessible
- Simplified
- Flexible
- Integrated
- Empowering for consumers / clients

In support of this vision SEPCP member agencies have agreed for the three year period 2001-2004 to work towards the development of a strong integrated primary health and community support system that



has, as its primary focus, the improvement of the health status and quality of life of the population through reducing burden of disease, ill health, disability and dependence.

This will be achieved through a primary health and community support system that:

- Is client focussed;
- Is accessible and responsive to the needs of individual consumers;
- Maximises consumer independence;
- Undertakes comprehensive and systematic health care planning;
- Recognises that priority setting and purchasing should be based on comprehensive planning, best available evidence and on criteria that are open to public scrutiny and debate;
- Maximises the use of resources through targeting and reducing duplication;
- Is flexible in delivery to accommodate the range and extent of consumer service requirements;
- Recognises itself as a part of a broader service system that requires effective interface arrangements, and is linked through effective processes to that broader service system; encourages and facilitates collaboration between and contribution by providers, clients, carers and the community at all levels to facilitate continuity of care;
- Recognises the importance and increases the utilisation of population health interventions; strengthens infrastructure and capacity;
- Incorporates evaluation and continuous improvement as an integral feature; and
- Identifies research, teaching and training as an integral activity.

Community Health Plan Development

Each Primary Care Partnership (PCP), of which there are 32 across Victoria, is charged with working with the community and the Department of Human Services to develop and implement Community Health Plans. The first of these plans was developed and submitted in June 2001. The extensive work that led to the production of these documents covers a three year period with specific emphasis on the strategies and expected outcomes for the first year (2001-2002). The Plans identify the priority health and well being needs of their communities and describe how the providers in the Partnership are working together and with other key stakeholders to respond to these needs, using a social model of health. Putting these plans into effect will:

- Contribute to the health and well-being of all Victorians and help alleviate the burden of disease.
- Improve people's experience of primary care services.
- Strengthen health promotion and community building.
- Reduce preventable hospital admissions by responding to the early signs of disease and/or people's need for support.
- Develop a primary care service *system* that helps people to get the services they need when they need them.

Community Health Plans will become a key tool for negotiating and implementing change in the primary care sector. The Plans will not only document and guide the actions of PCPs - but importantly - inspire further collaboration and improvements to the health and well-being of Victorians.

It should be noted that this document is still linked to the broader discussions outlined in the three year plan submitted in 2001.



Part 1: ACHIEVEMENTS

The first section of this document deals with achievements made by the SEPCP in the year ending 30 June 2003. They are listed in accordance with the key result areas identified in previous SEPCP Community Health Plans.

Partnerships

Committee of Management

The Committee of Management continues to move forward under the leadership of Peter Waters (ERMHA) as Chairman, and Larry Osborne (DDDGP) as Deputy Chair. Consistent membership and representation has been maintained with a high level of commitment by agencies and their representatives. Unfortunately, however, greater engagement of small agencies continues to be difficult. The Committee continues to reconfigure its meeting structure in an effort to ensure a greater focus on strategic issues. This has become more of a focus due to the discussions around the future of primary care reform at many levels.

Community Engagement

SEPCP's Community Reference Group continues to meet monthly with a consistent attendance from committed community representatives from across the three municipalities. This core group has enhanced its understanding of the issues and concepts involved in primary care partnerships over the past twelve months and is now able to discuss topics in greater detail and provide greater input into SEPCP activities. Representatives of the Community Reference Group continue to attend each Committee of Management meeting.

SEPCP has held discussions with the three other PCPs in the Southern Metropolitan Region regarding sharing resources and offering workshops on consumer participation at a regional level. Mark Smith, Executive Officer, has also participated on the reference group for a statewide project entitled Enhancing Consumer, Carer and Community participation in PCPs which completed June 2003. It is hoped to utilise the findings from this project to further develop regional activities in the coming year. It is also intended to arrange a community awareness program regarding consumer rights and responsibilities in late 2003.

GP Participation

SEPCP has maintained a very strong and productive relationship with the Dandenong District Division of General Practice (DDDGP), most directly through the Integrated Disease Management (IDM) Project. SEPCP staff working on this very successful initiative are located within the division's office and are integrated into the division's culture. This has proven to be a very successful strategy.

GPs participating in the IDM project have utilised the Service Coordination Tools developed by DHS in order to access the services provided and this has resulted in over 123 GPs participating. In addition to this, GPs participating in a project entitled 'Access to Allied Health Services' funded through the Commonwealth's *Better Outcomes in Mental Health Care* initiative also involves utilisation of the tools. These two projects have shown that GPs will become involved in multidisciplinary integrated projects where a clear immediate benefit for their patients can be identified.

To follow on from the success of this GP engagement, DDDGP has been funded by DHS to undertake a small project of 'Training for GPs and Practice Staff in using electronic service coordination proforma' during the last half of 2003.

Service Coordination

This is an area of activity where there has been a great deal of commitment from many players which has resulted in a project involving 27 agencies at present. Indeed the project continues to grow as further agencies express interest in joining the integration.

HDG Consulting has provided support to agencies as they have worked together to develop shared Practices, Processes and Protocols for the sharing of client information. The outcome of this was creation of a protocol manual owned by all agencies. The Service Coordination Tool Templates developed by DHS have been utilised in this and have been an integral part of the process. Other tools



such as feedback sheets have been designed by the project team to assist with the development of protocols.

The Service Coordination Work Group continued to direct the development of the Protocol Manual across the PCP whilst workshops were held in each agency to acquaint service delivery staff with all elements of the model and project. Many agencies subsequently formed in-house task groups to assist with development and execution of an implementation plan. To add further support HDG have facilitated a Practitioner Support Group for staff directly involved in the implementation of the model. This group has met four times thus far and aims to ensure consistency in interpreting and executing the model across agencies and also facilitating joint problem solving of practical issues that arise during implementation. Representation of agencies at this group changes as different agencies undertake implementation, thereby reflecting the various stages of the agencies involved.

In the initial stages agencies funded from the following program areas were targeted:

- Community Health
- Home and Community Care
- Aged Care Assessment Service
- Drug and Alcohol
- Mental Health
- GP Services.

Important inroads have since been made into the post acute and sub-acute services through inclusion of Post Acute Care, Hospital in the Home, Outpatients, and some of Southern Health's HARP (Hospital Admission Risk Program) projects.

SEPCP has initiated discussions with the three other Southern Metropolitan Region PCPs regarding further development of the PCP models to work toward a region-wide model. There is commitment from all to this aim and dialogue will continue through the remainder of 2003. In the interim the four PCPs will establish a region-wide evaluation framework, however this will be hampered somewhat by DHS evaluation of the tool templates not due to occur until after July 2004.

Service Directory

Last year a service directory was developed in partnership with Infoxchange and its Service Seeker. This service continues to be available to all agencies via SEPCP's website together with the statewide directory developed by DHS. A recent mini audit showed that many agencies continue to rely on existing referral patterns and service provider knowledge rather than accessing the directory. It was agreed that this could be addressed through another series of education and awareness sessions across the sub-region, however as a new version of the statewide directory is expected by late 2003 it has been agreed to postpone any more sessions until the new directory and its different elements can be included. In the interim several agencies which use the directory regularly, such as Discharge Support Services at Southern Health, have volunteered to act as resource to other agencies experiencing difficulties.

ICT (Information Communication Technology Infrastructure) Funding

All PCPs submitted reports in late 2002 however announcements on funding are still pending. It is expected that an announcement on allocation of funds will occur soon and further work with Southern Health will occur to ensure a 'whole-of-health' approach.

Health Promotion

SEPCP has drawn upon the expertise of Casey Community Health Service's Health Promotion team and contracted three of their staff, under the leadership of their Team Leader Jan Mattrow, to further develop the three elements of SEPCP's Community Health Plan: Older People, Mental Health and Capacity Building. In undertaking this work the team has been keen to incorporate existing networks and meetings rather than setting up more, this has been augmented by telephone and email contact. At this early stage it appears that this strategy is proving effective and practitioners are grateful for the avoidance of more meetings.



Older People

Social connectedness is seen as a key issue for older people, particularly the frail and those from CALD backgrounds. One emerging issue is the increasing role grandparents or older people are taking as carers of children. In partnership with other agencies SEPCP is exploring a health promotion initiative that aims to increase the social connectedness and well being of older CALD grandparents caring for young children.

Mental Health

Mental Health activities will be linked in with the social connectedness activities being undertaken with Older People, however SEPCP will also endeavour to provide a framework for the coordinated development and implementation of programs and initiatives to develop, encourage and support mental wellbeing. Some of this is already evident in the establishment of self-help groups that SEPCP has supported financially throughout the year.

Capacity Building

SEPCP is currently linking into existing networks and alliances to offer workforce development opportunities around Integrated Health Promotion and the Social Model of Health. This has grown out of a desire by service providers to focus on enhancing the capacity of agencies to undertake integrated health promotion and that opportunities for shared learning and collaboration be fostered.. Stakeholders feel it necessary that agencies become more familiar with the Social Model of Health.

Integrated Disease Management Project

Several Health promotion initiatives have been established through the IDM project and these are targeted at those newly diagnosed or those 'at risk'. It is planned that these will be launched during Diabetes Week in July 2003.

The physical activity component of the IDM model has been a significant and successful outcome. This program, based on International Diabetes Institute's 'Lift for Life' program has been implemented in the Greater Dandenong Community Health Service in Dandenong and Casey Community Health Service in Doveton. After a comprehensive program by physiotherapists at these centres participants are able to 'graduate' to specially run maintenance sessions at Oasis Recreation Centre.

Integrated Disease Management (Diabetes) Project

The IDM project has been a major success in the past twelve months. Under the guidance of Project Manager, Christine Crosbie, the project has exceeded all of the targets set in the amended plan last year and has been recognised through presentation at many conferences in the past six months.

A self-management model has been developed and has been introduced at two sites: Casey Community Health Service (the existing Diabetes service at Doveton), and introduction of a new service at Greater Dandenong Community Health Service (Dandenong) under a joint agreement between SEPCP and Southern Health.

To ensure service coordination a Diabetes Coordination and Assessment Service (DCAS) has been established at Dandenong District Division of General Practice to provide intake, support and triage of people in the catchment area who are newly diagnosed with Type 2 Diabetes. Referral into the program is usually by GP and executed using the Service Coordination Tool Templates developed by DHS. A clinical pathway has also been established with Dandenong Hospital.

Action groups continue to meet for the three main components of the project: Service Redesign, Health Promotion, and Physical Activity. These action groups are multidisciplinary with GP and consumer representatives, and a Consumer Reference Group with a specific Diabetes focus has also been established (ie distinct from the SEPCP Community Reference Group). The GP is the key point of referral into the SEPCP IDM Model with a total of over 260 participants referred by 123 GPs.

Evaluation of the project is currently underway with the current project due to finish at the end of December 2003. Initial findings are very positive and all key stakeholders are currently working to ensure continuation of the program. Different funding sources are being explored.



Reduction in Avoidable Hospital Admissions

Progress has been made in many areas toward this objective, although it is acknowledged that many of the initiatives underway can only be expected to have significant impact on hospital demand in the longer term. For example, the IDM project targets people newly diagnosed with Type 2 Diabetes, thereby enhancing their ability to self-manage their condition. Improved self-management is known to reduce the risk of serious complications later in life. The project has already demonstrated a significant reduction in the waiting times for access to Diabetes education in the sub-region.

SEPCP continues to have representation on Southern Health's Primary Care & Population Health Advisory Committee and this committee has now taken on the role of over-seeing Southern Health's HARP projects. In the recent lead-up to this year's HARP funding round several representatives from SEPCP participated on the various working groups that developed Southern Health's submissions.

Significant progress has also been made through the Service Coordination model encompassing sub-acute and post-acute Southern Health agencies, with the Service coordination model also being incorporated into the HARP Care in Context project, with plans to also incorporate it into some of this year's projects if successful in selection.

Health Planning

SEPCP has endeavoured to continue advocating for and working with the priority issues previously identified in its Community Health Plans:

- Isolation – Social and Geographic
- Emerging Populations (Special Needs Groups)
- Service Appropriateness, Efficacy and Targeting
- Underlying Socio-Demographic Influences on Health

The Executive Officer worked closely as a member of City of Greater Dandenong's Municipal Public Health Plan reference group and the reference group ensured that these priorities were incorporated into the new plan. SEPCP will continue to work with other key agencies to work toward greater consistency and sharing of information when compiling plans.

An important element of all planning is the underpinning of the Social Model of Health and further awareness/education sessions are planned for health practitioners in 2003 as part of the Capacity Building element of health promotion activities.



Part 2: OPERATIONAL PLAN

This section of the Community Health Plan is presented as per the format outlined by DHS in the Template for 2002-03. It should be noted that this format focuses on key population groups, health and wellbeing issues, and current government initiatives. Many of the major projects underway at SEPCP are not targeted at particular groups and therefore do not necessarily fit well into such a format. Both Service Coordination projects, for example, will be a major focus of activity in 2002-03 but will involve all of the groups included in this operational plan. GP and Consumer engagement and participation will also be key elements across the spectrum.

The IDM Project continues to be a key activity for SEPCP and although mentioned frequently in this plan it is acknowledged that there are separate reporting mechanisms for that project.

2.1 SERVICE COORDINATION

Service Coordination activity for SEPCP will continue to build on the strong foundation already developed through the implementation of SEPCP's Service Coordination Model within the following 24 agencies:

Casey City Council
Mecwa Cardinia Care
City of Greater Dandenong/ Silver Circle
Kooweerup Regional Health Service
Wresacare
Scott St Day Centre
South Eastern Region Migrant Resource Centre
Dandenong CRC/PAG/Aged & Disability Service
Bunurong Community Care
Dandenong ACAS
RDNS Cranbourne & Springvale
Dandenong Aboriginal Cooperative
Greater Dandenong Community Health Service
Casey Community Health Service
Cardinia Community Health Service
Southern Health Community Dental Services
MECAS
Vision Australia
Do Care
Dandenong District Division of General Practice
South East Alcohol and Drug Service
ERMHA
Care In Context project
Post Acute Care
Hospital in the Home
Southern Continence Services

A report on the current stage of implementation for each agency appears at Appendix 1.

HDG Consulting has been contracted until end of December 2003 to continue providing support for all the above agencies as they all move toward full implementation of the model. Currently agencies are at various stages of implementation for a variety of reasons including changes in key staff and delays awaiting computer software upgrades.

In addition HDG will introduce other agencies into the model as they express interest in being involved. This is already starting to happen.

SEPCP will also continue discussions with the other Southern Metropolitan Region PCPs regarding the move toward a regional model encompassing all four PCP areas. This is seen as a major benefit for



many agencies whose catchment areas cross PCP boundaries. It is hoped that all four PCPs will be ready for such a progression by early 2004. In the meantime all four PCPs have agreed to commence work on a common region-wide evaluation framework.

It is also planned to continue to benefit from the involvement of GPs in SEPCP projects and the utilisation of the service coordination tools through the six-month project being undertaken by Dandenong District Division of General Practice and other opportunities such as the IDM project which may arise. It should be noted that some GPs have already started to utilise the tools for referrals other than for those services involved in SEPCP projects. As more GPs become familiar with the tools being available electronically on packages such as Medical Director it is expected that this will increase.

SEPCP plans to continue to increase awareness and utilisation of the service directory however it has been agreed that no further formal promotion will occur until the new version of the directory is developed by DHS later in the year.

It is hoped that SEPCP will be successful in receiving assistance through the ICT (Information Communication Technology infrastructure) Funding. Discussion has been held with Southern Health regarding this but more formal dialogue will occur with the Chief Information Officer if notification of funding is received. From this SEPCP will work in partnership to achieve a 'whole of health' approach. It should be noted that it is anticipated that some agencies committed to SEPCP's Service Coordination model will not see any benefit from a successful submission at this stage as the funding is targeted at connectivity and will only be of true value at this stage if agencies are at a stage of preparedness where they can benefit from improved connectivity.

2.2 Health Promotion

The key groups and issues targeted in this plan are:

- Capacity Building
- Mental Health
- Older People

2.2.1 Capacity Building

Community and Service Profile

- MPHP inclusion of capacity building of IHP for Cardinia, Greater Dandenong and Casey. Not included in this direct language but emphasised with commitments to SEPCP priorities.
- H.A.C.C Annual Plans. Indicate a priority of Coordinated Care with partnerships a key element
- Community Mental Health Plan Priorities for this Plan don't emphasise capacity building but do emphasise workforce development
- Divisions of General Practice – PCP commitment
- Greater Dandenong, Casey and Cardinia Community Health Services all have included Capacity Building for Health Promotion as a priority area of action in their IHP plans.
- SE PCP affiliated agencies have all demonstrated a commitment to IHP and social model of health development.

Priorities for Action

Rationale

Further work indicates the importance of building the organisational environments, systems and cultures that support IHP and partnership development.

To achieve the principles of the social model of health capacity building is a critical element.

Integration has been an identified platform with current and future health service reform eg. H.A.R.P and Neighbourhood Renewal Initiatives.



Strategies

Problem Definition

Goal - To increase the capacity and conditions of local and subregional organisations ie.their systems, staff and environments, to better understand, contribute and support integrated health promotion.

Objectives

- 1a) To increase information exchange on IHP activity over the subregion
- 1b) To increase the opportunity for targeted partnership development across the subregion
2. To increase the organisational environments and work practices that support Integrated Health Promotion

Population Target Group

- The staff, management and systems of key organisations in the Shire of Cardinia, City of Casey and City of Greater Dandenong.
- Staff, management and systems within the South East PCP ie. Integrated Disease Management, Service Co-ordination and Integrated Health Promotion

Solution Generation

Evidence Base Practice

- DHS draft HP guidelines nominate 5 areas integral to successful capacity building inclusive of organizational development, workforce development, resource allocation, leadership and partnership.
- Southern Metropolitan Region Improving Health Promotion document highlights the infrastructure domains and elements for improving health promotion. These domains include, health promotion knowledge, alliances between agency relationships, management skills, agency culture and policy, staff skills, training and principles or practice, community participation mechanisms, data availability and financing arrangements. This document provides guidelines for capacity building and infrastructure development.
- Ways to build and strengthen capacity for effective health promotion are divided into three components in the Eastern Region research document inclusive of workforce development, organisational support (including policy and strategic planning) and resource allocation (financial and human)
- The key stakeholders forum identified eight areas of strategic development to advance health promotion. They include
 - a) Strategy co-ordination and prioritisation
 - b) Financing the health promotion system
 - c) Program planning and delivery structures
 - d) Data collection, analysis and dissemination
 - e) Research, evaluation and evidence based practice
 - f) Workforce training and development
 - g) Communication systems
 - h) Rural health promotion

Although this was a forum viewing and providing recommendations on a statewide basis some of these elements are important considerations for local capacity building.

- Konrad E, (1996) comments on levels of integration from the more informal to the formal, inclusive of information sharing and communication, cooperation, collaboration to consolidation then finally to integration. A continuum of Integration like this helps to guide the IHP plan towards a mix of the more informal and formal levels of integration.

- Characteristics and facilitating factors of Integrated Health Promotion as reported in a case study by CHPE (2002) included:

Agencies working together and developing partnerships as legitimate part of planning HP

The need for building capacity in integrated HP

Being inclusive of the social model of health

Population based approach to health

Skills training in HP targeting managers and HP practitioners and leadership champions

Development of an evidence based HP and consultation with the community at interest.



Relevant Statewide Action

At a State level the Department of Human Services is committed to building health promotion capacity and developing a more coherent and integrated approach to health promotion.

Initiatives included within this are the statewide workforce development program including the health promotion short course and leadership, management development.

VicHealth additionally are committed to building capacity within service systems and leading by example through their policy and funding directions.

Across the State the majority of Primary care Partnerships have identified and prioritised capacity building for health promotion as a key element with some also demonstrating opportunities for integration and capacity within the PCP itself.

Identify the appropriate mix of interventions

Given the above evidence and documentation around indicators and elements for developing capacity, South East PCP will be choosing to provide a mix of interventions based around the key themes or domains identified by the Department and the Health Promotion Guidelines.

ie. organizational development, workforce development, resource allocation, leadership and partnership.

There is also an important emphasis on developing models or initiatives that can be replicated within a range of other organisational environments or systems. A process of developing proposals with consultation from key stakeholders and importantly using existing networks as partners. Then to trial the initiatives, monitor and review.

Building the systems and workforce are priority areas along with creating platforms for shared learning and information dissemination have been highlighted.

Support and Resources

Roles and responsibilities of key stakeholders. This will be varied within each of the interventions.

The SEPCP Integrated Health Promotion Reference Group made up of representatives from affiliated and non affiliated organisations will be the consultative group for the generic development of the proposed models or initiatives.

When the models or initiatives are to be implemented additional short term reference groups reflecting the key players from where the pilot will be conducted will be engaged with a clear terms of reference.

The SEPCP Committee will also be encouraged and supported to foster IHP from a management level.

Administration support will be required to develop such initiatives as the list server.

For further detail please see the summary grid

The resources allocated will be inclusive of SEPCP Health Promotion Worker facilitation investment, administration resources and a range of organisational resources from worker time to worker intelligence to reflective thinking to agenda items on existing networks where the resource is network time.

The timelines for each activity is over a 12 month period with a sense that the interventions being considered and implemented could be continued beyond this time.

Additionally the contracting organisation (Casey CHS) is only secured to March 2004 with review at this time if there is a change of contractor or facilitator this may alter outcomes or proposed timelines.

Plan for review and evaluation

Change in organisational systems, practices and workforce confidence to implement IHP will be monitored by a range of mechanisms including worker investment, contribution from organisations to developmental and pilot work, work practice changes, uptake of partnerships from initiatives, increased understanding of IHP.

The review and evaluation of capacity building objectives will be undertaken by health promotion workers in consultation with Integrated Health Promotion Reference Group.



REFERENCES

Building Capacity for Effective Health Promotion Action in the Eastern Metropolitan Region, Action Plan July 1999 – June 2002, Department of Human Services.

CHPE (2002) A Case Study Approach to Evaluation. Integrated Health Promotion Resource Kit, August 2002

Guidelines for Funding and Planning Health Promotion Programs in Community Health, Overview and Priorities (1996 – 1997), Department of Human Services

Improving Health Promotion, Actions for the Southern Metropolitan Region, Leadership and Infrastructure for Quality Health Promotion, (1998), Department of Human Services.

Jakarta Declaration, Leading Health into the 21st Century, (1997), World Health Organisation

Konrad, E.L (1996) A multidimensional framework for conceptualising human services integration initiatives. Evaluation Initiatives to Integrate Human Services

Primary Care Partnerships, Draft Health Promotion Guidelines, (2000), Department of Human Services.

Strengthening Systems for Health Promotion, Strategic Agenda for Health Promotion Development in Victoria 2000 – 2004, (2000).

2.2.2 Mental Health

Problem Definition

Goal

To identify and model a range of initiatives to increase and sustain the Mental Wellbeing of people living within the SEPCP catchment

Objectives

1. Maintain mental health as a priority for SEPCP Health Promotion activities
2. Develop a coordinated, coherent approach by SEPCP partners to identify and address the primary environmental determinants of mental health problems

Population Target Group

- Older people
- CALD population
- Children
- PCP partners
- Non-PCP partners

Solution Generation

Evidence Based Good Practice

When implementing health policy and planning programs today one of the predominant themes is the necessity for interventions to be based on sound evidence and needs analysis. The examples provided



below highlight the need for intervention in this the area of Mental Health and give example of area's best targeted to influence mental wellbeing.

- Mental health and wellbeing has being identified as a National health Goal and Target (1997)
- Mental health and wellbeing identified as a State Target (1997)
- In the Primary Health (1999 – 2000) Guidelines priority Health Promotion Action Areas include mental health. Identifying in particular youth suicide and depression amongst adults.
- VicHealth have clearly set as one of their priorities mental wellbeing with the focus on building the protective factors including social connectedness.
- VicHealth's mental health plan clearly identifies social connectedness as a determinant of mental health.
- The report the "Pressure Cooker" (Living in the South East Growth Corridor) identified "a need to develop a sense of community and belonging" as a priority and isolated families as a priority.
- Women's Health in the South East Needs Assessment of the Southern Region Report (1999). At a regional level the key issues which emerged from consumer consultations for women were concerns about emotional and mental health including self esteem, depressions, anxiety, isolation and loneliness.
- The Dandenong and District Division of GP's joint health needs analysis (1996) identified the most significant issues included stress and emotional problems, mental health issues and lack of community support amongst others.
- The All for Health Local Government document (1997). Issues for local planning identified included isolation and loneliness, depression and stress.
- South East PCP priorities include mental health with a focus for 2002 – 2003 being on social isolation and older person's.
- The World bank and the World health Organisation estimate that mental health problems contribute 10% of the global burden of disease, with depression alone predicted to be the largest health problem globally by the year 2020 (Murray and Lopez 1996) – VicHealth Rural report
- An individual's level of social integration and social support are powerful predictors of their mental health status and of morbidity and mortality (AHMAC Working Group 1997, Brunner 1997) VicHealth Rural report
- The Burden of Disease Study (2000) shows Great Dandenong having the highest rates for major diseases by LGA (in Victoria), one of the top 3 being mental disorders
- South East Primary Care Partnership – Social Health Report (2001) found that the treatment for acute mental illness within this area to be similar with the Australian norms however most comments provided during report compilation described limited service provision within the community. This report also links social isolation and limited social interaction to Mental disorders.

Relevant Statewide Action

Mental health has long been a priority for statewide organisations and recently more specifically social connectedness has become a priority. With studies showing that those individuals who are isolated or cut off from the community are at risk of poor health.

VicHealth's "Together We Do Better" Campaign is an example of statewide action. Together We Do Better seeks to increase community awareness of the benefits of strong, connected and supportive communities. They suggest that mental distress as a result of social isolation and lack of social support have been shown to increase the likelihood of heart disease, complications in pregnancy and delivery, and suicide. (Syme et al 1996) Social networks can act as a buffer between individuals and the general socio-economic, cultural and environmental conditions over which they have little control and are the most difficult to change.

On a subregional level the South East PCP have also identified mental health, health promotion as a priority.

Mix of Interventions

Given the above evidence and documentation around indicators and elements for Mental Health, SEPCP Integrated Health Promotion Initiative will be choosing to provide a mix of interventions based around the key themes or domains identified by the department and the health promotion guidelines See template



Support and Resources

Identify Roles and Responsibilities of Key Stake holders

Key stakeholders of this initiative will provide a framework for the coordinated development and implementation of programs and initiatives to develop, encourage and support the target population group in the creation and sustainability of Mental Wellbeing.

Partners working together on this priority include representatives from:

Victorian Co-operative on Children's Services for Ethnic Groups (VICSEG)
Dandenong Neighbourhood House
Adult Migrant Education Service
South East Migrant Resource Centre
Greater Dandenong Libraries
Casey Community Health Service
South East Migrant Women's Wellbeing Network
Eastern Regions Mental Health Association Inc (ERMHA)
Action on Disabilities within Ethnic Communities Inc
Bunurong Community Care

Assess and allocate appropriate resources

SEPCP has identified mental health as one of three Health Promotion Priorities. Time will be allocated to this initiative for planning, implementation, monitoring, review and evaluation. The resources allocated will be inclusive of SEPCP Health Promotion Worker facilitation investment, administration resources and a range of organisational resources from worker time to worker intelligence to reflective thinking.

The timelines for each activity is over a 12 month period with a sense that the interventions being considered and implemented could be continued beyond this time.

Additionally the contracting organisation (Casey CHS) is only secured to March 2004 with review at this time if there is a change of contractor or facilitator this may alter outcomes or proposed timelines.

Key Capacity Building Strategies

Workforce development and capacity building is an important component and vital when increasing social connectedness, thus influence Mental Wellbeing in the community. Strategies include:

- Ensuring key individuals who influence mental health policy, programs and environments are provided with the most up to date information on social connectedness and its relationship to health, community well being and the environment.
- Encouraging primary health care professionals to provide advice to clients about social connectedness.
- Raising awareness among community groups, non-government organisations and local government of their important role in providing information, implementing programs and providing supportive, safe environments for social connectedness initiatives.
- Leadership and empowerment within this area will be sought to advocate and be champions for change.

With sustainability being a key focus for any health promotion activity, a primary strategy for increasing the likelihood of maintaining program benefit beyond the life of the various initiatives is to involve the community in the development and implementation.

Proposed Timelines

See grid

Plan for Review and Evaluation

Review of initiatives will be ongoing throughout the 12 month cycle. Implementation of initiatives and the impact on key stakeholders and participants will be evaluated. Documentation of initiatives and frameworks will also be a measure of success.



Feedback is always sought from population groups in a method appropriate to the group structure. Attendance numbers, maintenance rates, observations, feedback from partners in initiatives, maintenance or sourcing of further funding is also used for evaluation.

References

Australian Bureau of Statistics (1996). Census of Population and Housing

Department of Human Services, Southern Health Care Network (2000). Southern Metropolitan Burden of Disease: Mortality and Morbidity. State Government of Victoria.

DHAC & AIHW 1999. National Health Priority Areas Report: mental health 1998. AIHW Cat. No. PHE 13 Canberra: DHAC & AIHW

Mrazek P.J. & Haggerty, R.J. (1994), *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*, National Academy Press, Washington DC

South East Primary Care Partnership (2001), Social Health Research Report, Health Outcomes International, Melbourne.

South East Region Migrant Resource Centre (1999a). Finding their way. Settlement needs of New Arrivals/Refugees in the City of Casey and the Shire of Cardinia

Syme, L. (1996) 'Rethinking disease: where do we go from here? AEP. Vol. 6.5, pp 463-468.

2.2.3 Older People

Problem Definition

Goal

Older people are able to either function independently in the community, or are able to readily utilise existing social and service opportunities.

Objectives

3. To increase the target population and service delivery staff's awareness of health services.
4. To conduct Health Promotion activities to promote social connectedness.
5. To improve transport options to address service access issues.

Population Target Group

- Older People
- PCP Partners
- Non PCP Partners

Solution Generation

Evidence Based Good Practice

When implementing health policy and planning programs today one of the predominant themes is the necessity for interventions to be based on sound evidence of effectiveness. The examples provided below have provided a base for good practice intervention.

There is a growing evidence base to suggest that community participation on various levels is a key element to an individual's sense of wellbeing and to the state of the health of the community generally. Well connected communities with strong social networks are more likely to benefit from lower crime figures, better health, higher educational achievement and better economic growth. (Smith, 2001)



The 2001 SEPCP Community Health Plan identified a range of issues of need within the catchment area, those being, social and geographical isolation; emerging populations/special needs groups; service appropriateness, effectiveness and targeting; underlying socio-demographic health influences.

Further consultation with relevant service providers identified social and geographical isolation as a major over-arching issue, with implications in each of the other areas. The high proportion of older people in the catchment area (Greater Dandenong, Casey and Cardinia) amplifies the issue.

At all levels of government the trend in aged care policy over recent years has been to encourage older people to maintain independence and continue living in the community. This raises a range of social, economic and environmental factors that will effect service development and delivery.

The report the “Pressure Cooker” (Living in the South East Growth Corridor) identified “a need to develop a sense of community and belonging” as a priority and isolated families as a priority.

The Shire of Cardinia stated in their Aged Services Policy, “significant increase in the number of dependent people requiring additional support to remain in their homes will be experienced. Demand on medical, pharmaceutical and other health related services will also increase significantly. Ease of access to these and other services used regularly, including access to shops, will increase the demand for local and community transport services able to respond the needs of a frailer population.”

This provides the basis for the mix of interventions used in order to address the issue of social isolation in older people.

Relevant Statewide Action

Mental health has long been a priority for statewide organisations and recently more specifically social connectedness has become a priority. With studies showing that those individuals who are isolated or cut off from the community are at risk of poor health. VicHealth’s “Together We Do Better” Campaign is an example of statewide action. Together We Do Better seeks to increase community awareness of the benefits of strong, connected and supportive communities. They suggest that mental distress as a result of social isolation and lack of social support has been shown to increase the likelihood of heart disease, complications in pregnancy and delivery, and suicide. (Syme et al 1996) Social networks can act as a buffer between individuals and the general socio-economic, cultural and environmental conditions over which they have little control and are the most difficult to change.

The National Heart Foundation have also entered into the debate and report that depression, social isolation and lack of social support are significant risk factors for CHD (coronary heart disease) that are independent of conventional risk factors such as smoking, high cholesterol and hypertension and are of similar magnitude to these conventional risk factors. (Driscoll & Wood, 1999)

Statewide initiatives have been a partnership of government and non-government organisation which include:

- VicHealth
- National Heart Foundation
- State Government
- PCP

Mix of Interventions

The range of interventions recommended here will form an integrated approach to the promotion of social connectedness. They can provide further direction, coordination and impetus in developing a healthy and active community. There is growing recognition that while some strategies may prove independently effective in increasing social connectedness, a combination of these is optimal for increasing population levels of social connectedness. The main focus will be on individual to group behaviour change and engagement, environmental change and putting health on the agenda of non-health sector and partnerships and collaboration.



Objective 1: To increase the target population and service delivery staff's awareness of health services.

Interventions:

- Disseminating information to the target population about existing services through existing channels of communication.
- Disseminating information to service delivery and administration staff about existing services for referral.
- Establishing closer liaison between existing information services and the SEPCP Health Promotion Officer.
- Forming relationships with non-information services eg. RDNS to encourage information dissemination.
- Training health service staff to identify those at risk of social isolation and to refer them to the appropriate service.

Objective 2: To Conduct Health Promotion activities to promote social connectedness.

Interventions:

- Establishing a consumer advisory group to inform organisations of the target population's need.
- Convening a task group to coordinated multi disciplinary activities around themes of community development and social connectedness targeted at those at risk of social isolation.
- Forming partnerships with non-health organisations to promote benefits of social connectedness.

Objective 3: To improve transport options to address service access issues.

Interventions:

- Liaison between SEPCP Health promotion Officer and HACC district planning group Transport working group to develop advocacy strategies for improving transport options.
- Training health service reception staff to refer clients to transport services if the need is identified.

Support and resources

Key Stakeholders Roles and Responsibilities

Key stakeholders of this project will provide a framework for the coordinated development and implementation of programs and services to encourage and support the population group in the creation and sustainability of social connectedness. Partners working together on this priority include representatives from:

- Cardinia Care MECWA
- Cardinia Shire Council
- Eastern Ranges GP Association
- Cardinia Casey Community Health Service
- HACC
- District Nursing Service
- Local GPs
- Volunteer Transport agencies
- DHS



Appropriate Resources

The SEPCP has Social Connectedness as one of its 3 priorities. Time will be allocated to this initiative for planning, implementation, monitoring, review and evaluation. The resources allocated will be inclusive of SEPCP Health Promotion Worker facilitation investment, administration resources and a range of organisational resources from worker time to worker intelligence to reflective thinking.

The timelines for each activity is over a 12 month period with a sense that the interventions being considered and implemented could be continued beyond this time. Additionally the contracting organisation (Casey CHS) is only secured to March 2004 with review at this time if there is a change of contractor or facilitator this may alter outcomes or proposed timelines.

Capacity Building Strategies

Workforce development and capacity building is an important component and vital when increasing social connectedness in the community. Strategies include:

- Ensuring key individuals who influence mental health policy, programs and environments are provided with the most up to date information on social connectedness and its relationship to health, community well being and the environment.
- Encouraging primary health care professionals to provide advice to clients about social connectedness.
- Raising awareness among community groups, employers and local government of their important role in providing information, implementing programs and providing supportive, safe environments for social connectedness.
- Leadership and empowerment within this area will be sought to advocate and be champions for change.
- With sustainability being a key focus for any health promotion activity, a primary strategy for increasing the likelihood of maintaining program benefit beyond the life of the various initiatives is to involve the community in the development and implementation.

Time Lines

Please refer to grid for time lines.

Plan for Review and Evaluation

The SEPCP, through Casey Community Health Service has a system in place for planning and evaluating all population based programs that is reflective of health promotion principles and practice. There are specialised assessments for social connectedness that can be adapted for each activity/ project that are both objective and subjective. A mixture of process, impact and outcome evaluation methods will be used in determining whether the interventions have been successful. Feedback is always sought from the population group in both written and verbal form. Attendance numbers, maintenance rates, worker observations and feedback from key partners is also sought.

References

Driscoll. K & Wood. L. (1999) Sporting Capital

Smith, M. K. (2001) 'Social capital', the encyclopaedia of informal education, www.infed.org/biblio/social_capital.htm.

Syme, L. (1996) 'Rethinking disease: where do we go from here? AEP. Vol. 6.5, pp 463-468.