Bendigo Loddon Primary Care Partnership

COMMUNITY HEALTH PLAN 2006 - 2009

Primary Care Partnership
BENDIGO LODDON

TABLE OF CONTENTS

Acronyms		3
Acknowledgement		4
Bendigo Loddon PCP members and Executive		4
Bendigo Loddon PCP catchment area		5
SECTION 1	Introduction	7
	References	10
SECTION 2	**Deliverable 1: Partnerships**	
	2.1 Partnership vision	13
	2.2 Achieving the vision	14
	Problem definition	14
	Priority setting	15
	Opportunities and challenges	15
	2.3. Achieving the vision: Capacity Building Plan	16
	2.4. List of PCP agencies	20
SECTION 3	**Deliverable 2: Integrated Health Promotion**	
	3.1 IHP vision	23
	Principles and practice	23
	3.2 Priority setting and problem definition	25
	3.3 Solution generation	27
	Priority goal 1 *Physical Activity*	27
	Priority goal 2 *Mental Health and Well-Being*	34
	Priority goal 3 *Sexual Health*	45
	3.4. Capacity building	50
	3.5. Planning for quality health promotion practice	54
	3.6. Applying an integrated lens to HP planning	56
SECTION 4	**Deliverable 3: Service Coordination**	
	4.1 Introduction	59
	4.2 Flexible Service Coordination Strategies	60
SECTION 5	**Deliverable 4: Integrated Chronic Disease Management**	66
SECTION 6	**Climate change**	76

ACRONYMS

BCHS	Bendigo Community Health Services
BHCG	Bendigo Health Care Group (Bendigo Health)
BLPCP	Bendigo Loddon Primary Care Partnership
CHP	Community Health Plan
CHIPIA	Community Health Plan Implementation Agreement
CDM	Chronic Disease Management
CIV	Community Indicators Victoria
CHUMS	Collaborative Health Unified Messaging System
DHS	Department of Human Services
EliCD	Early Intervention in Chronic Disease
HARP	Hospital Admission Risk Program (*recent name change to "Central Victorian Chronic Disease Management and Complex Care Management Alliance". For brevity will continue to be referred to as HARP in the CHP*)
IHP	Integrated Health Planning
IAWG	Inter Agency Working Group
MOU	Memorandum of Understanding
PAC	Physical Activity Consortium
PPPS	Practices, Processes, Protocols, Systems
PCP	Primary Care Partnership
SCTT	Service Coordination Tool Templates
STIs	Sexually Transmissible Infections
YSAS	Youth Substance Abuse Service
YAN	Youth Arts Network
ST	Strength Training

ACKNOWLEDGEMENT

The Executive Committee of the Bendigo Loddon Primary Care Partnership (BLPCP) would like to thank PCP members and their staff for their interest, enthusiasm, commitment and contributions. This has been demonstrated not only in the preparation of this Community Health Plan (CHP), but also by members' participation during the past three years in collaborative planning, joint projects and service initiatives. The Executive Committee commends members' professionalism, and welcomes their ideas and the impetus for continuing improvement through critical evaluation. We look forward to working with them in 2006 to 2009.

PCP MEMBERS

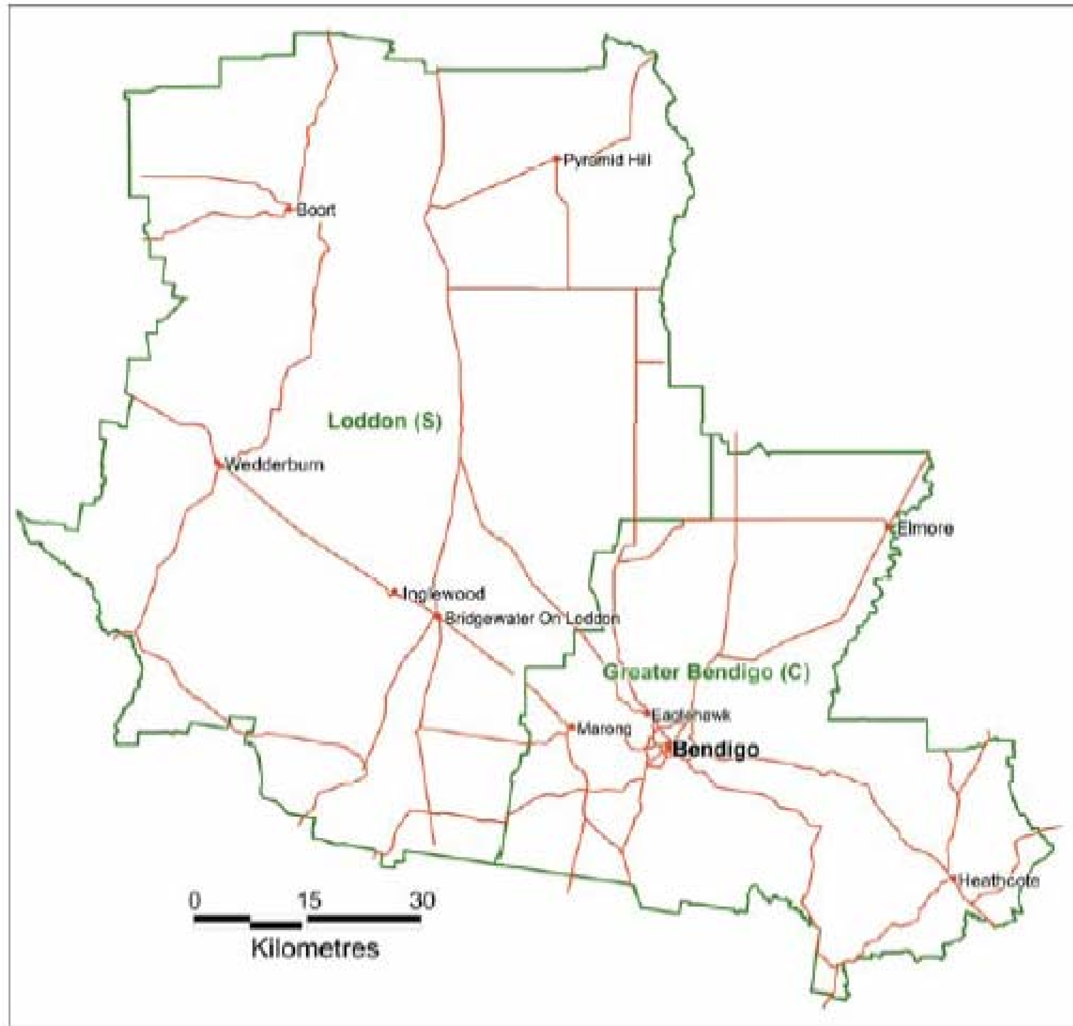
Annie North Inc.
Bendigo & District Aboriginal Cooperative
Bendigo & District Division of General Practice
Bendigo Community Health Services
Bendigo Health
Bendigo Regional Breastscreen Centre
Bendigo Regional Ethnic Communities Council
Bendigo Uniting Care Outreach
Boort District Hospital
Country Awareness Network
Centre Against Sexual Assault
Centacare
City of Greater Bendigo
Dingee Bush Nursing Centre
Future Connections Youth Services
Golden City Support Services
Inglewood & Districts Health Services
Interchange Loddon Mallee Region
La Trobe University
Lifeline Central Victoria
Loddon Mallee Housing Services Inc.
Women's Health Loddon Mallee
Northern District Community Health Service
Richmond Fellowship
Rochester and Elmore District Health Service
The Salvation Army
Sports Focus
St Luke's Anglicare
The OTIS Foundation
Vision Australia
YMCA
Your Employment Solutions
Loddon Shire Council
McIvor Health and Community Services
Monash University School of Rural Health
Murray Plains Division of General Practice

EXECUTIVE COMMITTEE

Sue Clarke	Bendigo Community Health Services (Chair)
Namanita Muss	Bendigo & District Division of General Practice (Deputy Chair)
Barry Secombe	City of Greater Bendigo
Brett Eastwood	Loddon Shire Council
Margaret Brooks	St. Lukes
Jeff Scoble	McIvor Health and Community Services
Jennifer Alden	Womens Health Loddon Mallee
Mike Parker	Inglewood & Districts Health Services
Dan Douglass	Bendigo Health
Peter Abraham	Boort District Hospital
Ann-Maree Conners	Department of Human Services

Formal and informal collaboration also occurs with non PCP members in the government and private sectors

Bendigo Loddon Primary Care Partnership Catchment Area



SECTION 1

INTRODUCTION

The Bendigo Loddon Primary Care Partnership (BLPCP) is a voluntary partnership of health and community care providers in the local government areas of the Shire of Loddon and the City of Greater Bendigo. The Partnership was formed in 2000 in response to the Victorian Government Department of Human Services PCP Strategy. The goals of the Strategy are to improve the health and well-being of people using primary health care services, and to reduce avoidable use of hospital, medical and residential services.

Members of the Partnership are signatories to a Memorandum of Understanding. This outlines definitions and principles for developing a collaborative and integrated approach to population health in the PCP catchment.

BLPCP comprises thirty six members, thirty three of whom are full members and three are Associate members. Six are located in the Shire of Loddon and thirty in the City of Greater Bendigo, although some members operate across both. There is great diversity in the services provided, and in the size of member agencies. Services delivered by members range from specific and multidisciplinary services in health and welfare to sporting programs, arts, transport and local government.

The **BLPCP catchment** is characterised by:

- Widespread dispersion of its population of approximately 105,068 over two local government areas or 9,698 square kilometres, with a number of small towns [1, 2] and approximately 6% of the population in both regions having been born overseas.
- Heavy concentration in services employment within the population of Greater Bendigo in 2001. Manufacturing was also a significant employer. This compares with Loddon, where primary production is diversifying to more intensive forms of agriculture and horticulture.
- Declaration of Bendigo and Loddon as drought regions where exceptional circumstances apply, with consequent short and long term psychological, social and economic impacts on the population, and demands on community services.[3]
- Both local government areas having communities listed in the 30 most disadvantaged postcode areas in Victoria: Heathcote, Marong, Comet Hill and Korong Vale [4]
- Fewer doctors in the Loddon Mallee Region, encompassing the City of Greater Bendigo and the Shire of Loddon, in relation to its population compared to that of Australia as a whole [16]. For example, GP to population ratios are: Bendigo 1:1900; Heathcote: 1: 1300; Elmore: 1: 800; Loddon: 1: 1500. The considerable shortage within the CBD of Bendigo and surrounding suburbs has resulted in 'new to the area' patients in Bendigo having to access GPs from outside of the catchment as far away as Echuca and Melbourne. Many people in Loddon attend a GP in Bendigo.
- An increasing population of older people and people with a disability, especially in Loddon where there is simultaneously a decreasing number of younger people of working age.[5]
- Socio-economic disadvantages compared to the state average such as:
  - Higher rates of unfinished education and unemployment.[6]
  - Higher proportion of single parents.[7,8]
  - Higher proportion of older people living alone.[7]
  - Limited housing options. [8,9]

- Factors contributing most to the burden of chronic disease in the catchment area are[10,11]
  - Cardiovascular disease.
  - Diabetes.
  - Obesity.
  - Cancer.
  - Chronic respiratory conditions.
  - Mental health disorders.
  - The impact of violence.

  Physical inactivity, poor nutrition, excessive alcohol consumption and tobacco use are other factors contributing to the burden of chronic disease in the catchment.
- Demonstrated significantly higher hospital admission rates for diabetes complications, double the rates of other regions in some instances, as indicated by Ambulatory Care Sensitive Conditions data for the Loddon Mallee Region (indicators of avoidable illness).[12, 13]
- Significantly increased annual notifications for all notifiable STIs, which suggests that the incidence of Chlamydia and Syphilis has significantly increased over the past 2 years. This is despite studies suggesting that STI testing is lower in rural areas compared to metropolitan areas. Australian studies have clearly demonstrated that unsafe sex is prevalent amongst young people and that access to sexual health services is inequitable compared to metropolitan areas.[14,15]

These demographic features both enrich and constrain a coordinated approach to planning for community health and well-being. The variety of initiatives attuned to local circumstances, proactive thinking, demonstrated enthusiasm to work together and the recognition that collaboration is essential for quality of services and growth, is enriching. The logistics of balancing commitment to PCP projects alongside distance, human and financial resources, and ever increasing client direct service demands are constraints.

The **current PCP governance structure** of an eleven member Executive and two major Working Groups (Health Promotion and Service Coordination) is to be evaluated. Potential revisions include:

- Review of the Memorandum of Understanding (MOU) to reflect partnership engagement and responsibilities.
- Possible expansion of the membership base to reflect non-public agencies and those outside the health and welfare sectors.
- Ex officio members representing "Networks of Interest" to be invited to participate as new issues emerge.
- Continuation of the Inter Agency Working Group (IAWG).
- Retention of the previous Working Groups under the umbrella of the Health Promotion Working Group (Physical Activity Consortium, Youth Arts Network, Alcohol and Other Drug Working Group, Sexual Health Task Group), with an emphasis on a specific purpose or project rather than operating as a standing committee. These groups will also continue to provide a focus point and resource for other health promotion initiatives in the catchment.
- Disbanding the Service Coordination Working Group in favour of a more direct approach to facilitating service coordination as an integral operating principle for all PCP and member activity.
- An emphasis on time limited task groups convened for a specific project as new issues emerge.

The **2006-2009 Community Health Plan** (CHP) is based on information and input from a range of sources, including:

- Nine forums with members and the PCP Executive, with up to 100 participants.
- Collective information from the Health Promotion, Service Coordination and other Working Groups.
- Feedback from on-going consultations in the field at all levels of organisations and government.
- Participation in policy and service umbrella groups such as the *Bendigo-Loddon Ageing Framework; Transport Connections; PCP Chairs and Managers Forums; Family Violence Network.*
- State and Local government policy directives and reports such as *Care in your community*; *Rural directions for a better state of health; A fairer Victoria; Greater Bendigo +25 Strategy; Shire of Loddon Municipal Plan; Go For Your Life Strategy; Walk For Life Strategy.*
- A consultancy review of the BLPCP model of operation.
- A survey of PCP members about service coordination and IT readiness for e-communication.
- A review of the Service Coordination Working Group.
- Statistical data from *Australian Bureau of Statistics; Burden of Disease data; Your health: a Report on the Health of Victorians; Ambulatory Care sensitive conditions study; Health Service Profiles for Victorian Rural regions; Shire of Loddon Community Profile 2004-2006 and Municipal Health Plan; Know Your Area data sets (DSE); COGB population forecasts; Victorian population health survey; Medicare Data PHCRIS.*

Agreed **strategic directions** for the CHP are:

- Establishing an evidence and knowledge base to inform planning.
- Integrated health promotion, with flexible priority areas to encourage new partnerships and projects and community engagement.
- Service coordination, particularly around chronic disease management and capacity building.
- Addressing local priorities where there are the greatest health inequalities and social and lifestyle disadvantages.
- Developing a positive identity for the BLPCP.

The format of the CHP follows the DHS templates. However the PCP will be flexible as circumstances change, and will engage in additional projects related to PCP strategic directions other than those specified in the objectives and strategies, as further opportunities arise and pending funding. The principles of collaboration and service coordination will underpin PCP activity in all four Deliverables so that programs and initiatives are integrated.

The CHP will be monitored against the objectives in the four Deliverables by the Executive Committee and the Inter Agency Working Group through regular reports, and opportunities for changes will be identified. A process/output/outcome evaluation format will be considered. DHS requirements for formal CHIPIA reports are a further imperative for systematic monitoring of progress.

REFERENCES

1. Australian Bureau of Statisitics (2001) *Census of Population and Housing*. Commonwealth of Australia: Canberra.
2. Australian Bureau of Statistics (2004) *Estimated Resident Population,* June 30th 2004, ABS.
3. Department of Agriculture Fisheries and Forestry http://www.affa.gov.au.
4. Community adversity and resilience - Professor Tony Vinson, March 2004
   Online]http://www.communitybuilders.nsw.gov.au/getting_started/needs/cav.html Jesuit Social Services.
5. Bendigo Loddon Primary Care Partnership. Bendigo Loddon Ageing Framework.
6. Australian Bureau of Statistics, 2003, A*ustralian social trends,*
   economic resources: income distribution: the geography of income distribution. Commonwealth of Australia: Canberra.
7. Australian Bureau of Statistics (1996) ABS Census Data on Family Types and Structure. Commonwealth of Australia: Canberra.
8. City of Greater Bendigo (2003) *Bendigo Health and Wellbeing Framework, City of Greater Bendigo, 27 October 2003*.
9. City of Greater Bendigo Housing Audit 2000 – 2002, November 2002.
10. Department of Human Services [Online] Burden of Disease Estimates – LGAs and Regions
    http://www.health.vic.gov.au/healthstatus/bod/bod_reg.htm Accessed November 2006.
11. Public Health Information Development Unit (2001) [Online] Chronic Disease Estimates http://www.publichealth.gov.au/ Accessed September 2006.
12. Department of Human Services (2004) *The Victorian Ambulatory Care Sensitive Conditions Study, 2001–02*. Public Health, Rural and Regional Health and Aged Care Services Division, Victorian Government Department of Human Services Melbourne Victoria July 2004.
13. Department of Human Services (2005) Your health: A Report on the Health of Victorians.
14. Communicable Diseases Australia. National Notifiable Diseases Surveillance System. Canberra, 2005
    http://www1.health.gov.au/cda/Source/CDA-index.cfm Accessed October 2006.
15. Hocking J, Fairley C, Counahan M, Crofts N. The pattern of notification and testing for genital Chlamydia trachomatis infection in Victoria, 1998-2000: an ecological analysis. Australian and New Zealand Journal of Public Health 2003;27:405-408.
16. Wilkinson and Seymons (2000) Inequitable distribution of General Practitioners in Australia: estimating the need through the Robin Hood Index. Australian and New Zealand Journal of Public Health, vol 24 (1) 71-75.

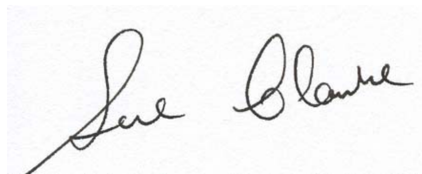
SECTION 2

DELIVERABLE 1: *PARTNERSHIP*

Bendigo Loddon Primary Care Partnership

Community Health Plan 2006 - 2009

Endorsed by PCP Chair:

Name: Sue Clarke Signature:  Date: 28.2.2007

2.1 Partnership vision 2006 - 2009

The Bendigo Loddon Primary Care Partnership (BLPCP) will contribute to the social fabric of a strong community by adopting a health and well-being framework which addresses both health and well-being inequalities and risk, and encourages positive leadership, innovation and advocacy. This aligns with the social model of health defined in the 1986 Ottawa Charter that "*the determinants of health status are not solely individual…and that a range of social and environmental factors have a significant impact on the health status of the community*"

From the individual and group consultations during the development of the Bendigo Loddon Community Health Plan (CHP) and the activities of the PCP Working Groups, a shared vision has emerged: that the BLPCP has the potential and the opportunity to be characterised by a strong and representative membership base. Within this base there will be collaboration, information and resource sharing and a collegial approach to service planning and action on service quality improvement. This will be underpinned by:

- An effective PCP governance structure and processes, with clearly articulated roles and lines of accountability and authority.
- A commitment to consumer participation based on net contributions of member agencies.

The Partnership will:

- Be flexible to suit and progress community health and well-being in the particular Bendigo Loddon environment.
- Incorporate a range of relationships from "Networks of Interest" among members with a shared concern about an issue, or with a common client group and service philosophy, to formal collaborations.
- Build on existing processes and Strategic Plans at local government, agency, state and federal level.
- Draw more broadly on feedback from the community.

2.2 Achieving the vision: *priority setting and problem definition*

Problem definition:

The context for the development of the BLPCP CHP was influenced by two major considerations.

***Composition of the current partnership base. For example*:**

- BLPCP is one of the largest in the state, with 33 heterogenous large regionally-centred and small rural-centred members and 3 associate members.
- The type and scope of services and staffing levels, organizational structures, philosophy, and interest in growth and development are diverse.
- Not all key agencies in the primary health and welfare sectors are current members, and non-public organisations are not well represented.
- There is a history of intermittent engagement of members.

***Catchment area characteristics. For example*:**

- Thirty members are located in the City of Bendigo, and six in the Shire of Loddon.
- Distance impacts on members' budgetary and time capacity to engage with and support PCP activities.
- There is evidence of an increase in the scope and complexity of health and well-being inequalities, and in the numbers of people in isolated areas living with complex or chronic illness.
- The population profile reflects significant increases in the numbers of older people and people with a disability.
- There are emerging mental health service issues because of the drought and predicted rural recession, and the lower socio-economic profile of several of the BLPCP communities.

Priorities:

- A reinforced role for the Executive Committee through developing a governance model that includes and looks beyond the DHS objectives funded under the PCP, and seeks to broaden its areas of interest and influence through knowledge, joint ventures, and advocacy.
- A partnership base reflecting key service delivery decision makers.
- Development of "Networks of Interest" to extend opportunities for addressing areas of community health which, although not specified as core business, are consistent with the social model of health approach.
- Recognition of the PCP as a collective strategic alliance, with a reputable voice and identity that promotes local solutions to local challenges, and best practice in service delivery and innovation.
- PCP and members' planning and practice informed by an evidence and knowledge base.
- Capacity to respond to emerging issues such as drought, pandemic and fire preparedness, domestic violence, and associated outcomes both on a local and regional basis.
- Partnership and workforce professional development to meet changing workforce needs.
- A reinforced role for Local Government through their Municipal Health Plans and Community Plans, as a facilitator and advocate for issues that impact on the community.
- Integrated Health Promotion with a focus on sexual health, mental health and well-being and physical activity.
- Integrated Chronic Disease Management with an initial focus on program and system development in the area of Diabetes management and support.
- Partnership encouragement of members' adoption, as normal quality practice, the DHS protocols for client access, service coordination, integrated health promotion, chronic disease management and continuous improvement in client services.

Opportunities and challenges:

- Communicating with the community about its health and well-being priority issues.
- Continuous reviewing of the alignment of changing funding policy guidelines and planning strategies with community needs.
- Participating in relevant community forums.
- Fostering partnership development in an environment of competing priorities and numerous existing special interest and coordinating groups.
- Building on the Inter Agency Working Group (IAWG) concept to engage staff within member agencies at many different levels.
- Developing the concept of "Networks of Interest" between agencies with common issues, as one means for the PCP to broaden its scope, manage diversity and keep up to date with community concerns.
- Ensuring the PCP is perceived as relevant and useful, adding value to members' core business and to community health and well-being.
- Underpinning all PCP activities by service coordination and collaboration principles.
- Maintaining the engagement of key agency managers at a level of authority, and knowledge of the scope of their agency products, appropriate for decision making about planning and participation in PCP projects.
- Extending member commitment and capacity to release staff for on-going and regular participation in PCP projects.
- Recognising that members' engagement may be intermittent, in accordance with their individual work priorities and interests.
- Strengthening and stabilising relationships with federal and state agencies.

2.3 Achieving the vision: *Capacity Building Plan*

GOAL	***An effective and sustainable PCP that is responsive to members needs; has transparent governance processes; meets funding accountability requirements; and promotes best practice in collaboration, information, resource sharing and a collegial approach to planning.***	
Objective	***Strategies/Interventions***	***Estimated Impacts***
1. Establish a PCP structure and governance that supports the vision and the network of members, and operates at both a strategic and operational level	1.1 Review and document the role, processes and structure of the Executive Committee 1.2 Explore a stronger approach for the Executive Committee, such as portfolios and a more direct involvement with Working Groups and projects 1.3 Develop a process for intra Executive Committee communication about issues in each respective agency and sphere of interest 1.4 Revise the MOU to reflect priorities and partnership engagement and mutual responsibilities 1.5 Conduct periodic snapshot evaluations of members' understanding of and satisfaction with the PCP 1.6 Strengthen PCP administrative support systems to support good governance processes 1.7 Conduct a review of the relevance and inclusiveness of the membership base, to include the potential for representation from non-public agencies and those from non-health and welfare sectors.	Strengthened Executive Committee role and operations All members have a current MOU in place Increased membership satisfaction and participation A membership more reflective of the broader base of agencies and changing socio-economic conditions in the PCP catchment Transparent PCP structure and decision making
2. Establish a reputable and authoritative identity and leadership focus in relation to social and health policy debate, and pursue a stronger advocacy role with government on behalf of the community and member agencies	2.1 Resource the Executive Committee with information to collectively represent broader community issues on behalf of members, and to inform members of relevant emerging policy and funding opportunities 2.2 Develop communication links with government and the wider community through participation in appropriate policy and service forums and special interest community groups 2.3 Strengthen relationships with members through personal contact and cross agency collaboration, to gain a knowledge and evidence base drawn from the field 2.4 Represent and promote local priorities in policy debates 2.5 Encourage, support and sponsor members in presentation of papers at conferences or to government, and in the preparation of funding submissions.	Involvement in policy debate and proposals Active working relationships with member agencies A higher profile for the PCP in the service and wider community

GOAL	***An effective and sustainable PCP that is responsive to members needs; has transparent governance processes; meets funding accountability requirements; and promotes best practice in collaboration, information, resource sharing and a collegial approach to planning.***	
Objective	***Strategies/Interventions***	***Estimated Impacts***
3. Explore methods for strengthening the engagement of current members and broadening the membership base	3.1 The Executive Committee and the IAWG will capitalise on their existing relationships with agencies to broaden interest and participation in PCP initiatives and Networks of Interest 3.2 Networks of Interest will be actively developed, to enable the potential to broaden the membership base and to utilise a wider range of skills and resources 3.3 Capture and promote the vision, optimism and effectiveness of the partnership base through mentoring and coaching 3.4 Actively participate, using a team building approach, with members and Networks of Interest	Engagement with a range of levels in member agencies Broader networking across the PCP catchment Broader understanding of the effectiveness of the power of a partnership Relationships and joint action between agencies developed around a common issue Grass roots ownership of and participation in projects Shared knowledge of best practice improvements
4. Participate in regional, PCP Chair, and Statewide liaison as appropriate to local priorities and PCP and other social and health policy development	4.1 Attend PCP regional and state Chair meetings 4.2 Provide PCP-supported strategic and operational input to and comment on state PCP policy developments 4.3 Foster a collegial relationship with regional PCPs	BLPCP recognised as a key member of and contributor to regional and state policy and collegial groups
5. Support, complement and work in tandem with planning strategies and partnerships already formulated at local government, agency and state level	5.1 Promote cooperative projects with and between members on the basis of its added value to their core business 5.2 Participate in strategic thinking and planning by selective membership of interest groups related to PCP priorities 5.3 Offer PCP support to members where appropriate and relevant in the implementation of individual member agency Strategic Plans	Partnership development Integrated planning

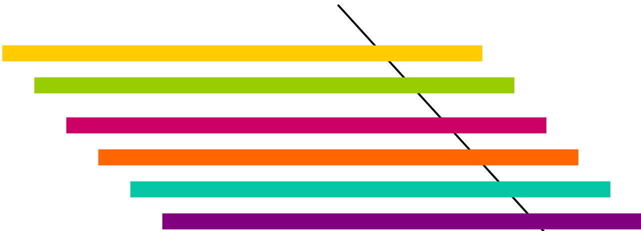
GOAL	***An effective and sustainable PCP that is responsive to members needs; has transparent governance processes; meets funding accountability requirements; and promotes best practice in collaboration, information, resource sharing and a collegial approach to planning.***	
Objective	***Strategies/Interventions***	***Estimated Impacts***
6. Expand and enhance the potential of the skills and resources within the partnership through Networks of Interest, and defining roles and relationships within the Partnership	6.1 Support agencies to continue to develop their capacity to assume representation of their areas in Federal/State initiatives 6.2 Promote members as leaders of Working Groups and projects 6.3 Encourage member leadership in engaging smaller agencies or facilitating funding processes 6.4 Build capacity by providing support funding, encouraging involvement in projects, and resources 6.5 Explore the concept of setting up a pool of funds to assist in delivering initiatives of common interest 6.6 Support and sponsor members in presentation of conference papers and in the preparation of funding submissions	Strengthened capacity of smaller and more rural agencies Resource sharing through mentoring and coaching Contribution to professional development of members
7. Incorporate PCP principles and objectives within agency practices and planning	7.1 Executive and members will embed service coordination principles and practices within their agencies 7.2 Support members to develop a common platform for e-communication 7.3 Work in conjunction with the Bendigo Health Care Group in the rollout of the HealthConnect project for e-referral in discharge and care planning 7.4 Promote the service coordination PPPS protocols 7.5 Build on the concept of managing a pool of funding opportunities to support service coordination in members agencies and PCP service coordination projects	Members accept responsibility for implementing PCP principles Local initiatives modified to suit local conditions Adoption of common procedures Increased use of e-referral.
8. Facilitate networking and professional development and relationships for members, and support for agencies outside the Partnership	8.1 Encourage joint agency approaches to professional development in best practice and the sharing and exchange of staff resources 8.2 Continue to foster input from agencies to the PCP networks of information via 'Newsflash' 8.3 Encourage direct member participation in PCP team projects	Enhanced levels of staff skills Coordination and sharing of professional development opportunities Linkages with state training programs

GOAL	*An effective and sustainable PCP that is responsive to members needs; has transparent governance processes; meets funding accountability requirements; and promotes best practice in collaboration, information, resource sharing and a collegial approach to planning.*	
Objective	***Strategies/Interventions***	***Estimated Impacts***
9. Support the continuing involvement of general practitioners in e-communication with agencies and participation in planning and communication networks	9.1 Work cooperatively with Divisions of General Practice on the CHUMS and managed care networks projects 9.2 Assist agencies to install PKIs 9.3 Cooperate in developing GP protocols with agencies	Improved communication between agencies and GPs Reduction in exchange of paper-based and unsecured client information
10. Encourage member use of the community indicators of health and well-being developed by "Community Indicators Victoria' (CIV) to strengthen PCP members' analytical and predictive capacity	10.1 Maintain an up-to-date Community Profile to provide members with higher order data and demographics interpretation 10.2 Draw on local tertiary student resources to develop and maintain a template for data maps based on CIV and relevant local demographic data 10.3 Publicise availability and distribute demographic data on request	Information for trend analysis Member assistance for planning, and funding submissions
11. Develop a communications strategy for members and the wider community on the PCP	11.1 Sponsor and act as a platform for conferences that enhance members' professional development 11.2 Organise periodic forums with different levels of staff to foster relationships; exchange information about service initiatives and PCP outcomes; and provide an opportunity to promote and celebrate successes and achievements 11.3 Act as a conduit for sharing information of relevance and interest to members, and encourage input and active participation in this process 11.4 Continue the 'Newsflash' information-sharing initiative and trial this medium to promote successes 11.5 Hold an annual meeting or forum for members and Networks of Interest, with a professional development emphasis 11.6 Ensure members understand and can contribute to the PCP governance structure and outcomes 11.7 Identify agency mechanisms for consumer participation	Promotion and encouragement of consumer participation strategies Improved communication and professional development opportunities for members Strengthened role for the PCP in information exchange

2.4 List of PCP member agencies/organisations and explanation of membership types

Agency name	Type of membership
Annie North Inc.	Full
Bendigo & District Aboriginal Cooperative	Full
Bendigo & District Division of General Practice	Full
Bendigo Community Health Services	Full
Bendigo Health	Full
Bendigo Regional Breastscreen Centre	Full
Bendigo Regional Ethnic Communities Council	Full
Bendigo Uniting Care Outreach	Full
Boort District Hospital	Full
Country Awareness Network	Full
Centre Against Sexual Assault	Full
Centacare	Full
City of Greater Bendigo	Full
Dingee Bush Nursing Centre	Full
Future Connections Youth Services	Full
Golden City Support Services	Full
Inglewood & Districts Health Services	Full
Interchange Loddon Mallee Region	Full
La Trobe University	Associate
Lifeline Central Victoria	Full
Loddon Mallee Housing Services	Full
Women's Health Loddon Mallee	Full
Loddon Shire Council	Full
McIvor Health and Community Services	Full
Monash University School of Rural Health	Associate
Murray Plains Division of General Practice	Full
Northern District Community Health Service	Full
Richmond Fellowship	Full
Rochester and Elmore District Health Service	Full
The Salvation Army	Full
Sports Focus	Full
St Luke's Anglicare	Full
The OTIS Foundation	Associate
Vision Australia	Full
YMCAYour Employment Solutions	Full

SECTION 3



DELIVERABLE 2: *INTEGRATED HEALTH PROMOTION*

Bendigo Loddon Primary Care Partnership

Community Health Plan 2006 - 2009

Integrated Health Promotion Catchment Implementation Plan 2006–09

Endorsed by PCP Chair:

Name: Sue Clarke Signature: Date: 28.2.2007

3.1 IHP vision 2006 - 2009

That health promotion practices within the City of Greater Bendigo and the Shire of Loddon are evidence based, build the capacity of local service providers and are responsive to the health and well-being needs of the community.

Guiding principles

Strategies consistent with the World Health Organisation's (WHO) directions for health promotion set out in The Jakarta Declaration on Health Promotion, Leading Health Promotion into the 21st Century 1975, and the Ottawa Charter for Health Promotion 1986. In particular the Bendigo Loddon Primary Care Partnership (BLPCP) strategies reflect the areas of:

- Building healthy public policy.
- Funding appropriate structures for health promotion delivery and development.
- Promoting shared community responsibility for improving health and creating environments that support healthy choices.
- Developing and supporting partnerships for health.
- Increasing the community's skills and resources to promote healthy behaviours and to empower individuals to make informed decisions.
- Developing personal (knowledge and) skills.

Collaborative Practice

The defining characteristics of the collaborative practice relationship are:

- Mutual respect and acknowledgement of each profession's role, scope of practice and unique contribution to health outcomes.
- Clearly stated protocols and guidelines for clinical decision making which comply with relevant legislation and are supported by the health facility and health organisation.
- Clearly defined levels of accountability with an acceptance that joint clinical decision making is an integral component of collaborative practice.
- A belief that the best health outcomes are achieved when well prepared health professionals work in collaboration and partnership in both the practice and the educational setting.

Activities and programs of the BLPCP will adopt principles of social inclusiveness, promote environments free from discrimination and violence and improved access to economic resources.

Strategies and actions will be compatible with PCP and Inter Agency Working Group (IAWG) resources and DHS expectations.

The BLPCP's activities will continue to reflect national and state public health priorities, with a focus on improving the health status of all population groups, while reducing health inequalities. Not all public health priorities can be addressed comprehensively and simultaneously; hence, the BLPCP has identified priority areas for action and capacity building.

The BLPCP is committed to working in collaborative ways with a range of individuals, groups and organisations from many sectors, including sport, health, planning, transport, local government, education, community and the arts to improve health.

The BLPCP will continue to build on our culture of innovation and knowledge exchange to support the development of health promotion leadership and skills within individuals, groups, and organisations.

The BLPCP will seek excellence in meeting all legislative, fiscal and service commitments to ensure a high level of partner, stakeholder and community satisfaction.

3.2 Priority setting and problem definition

The priority setting process involved an extensive review of:

- Available evidence: Burden of Disease data; Your Health: a Report on the Health of Victorians.
- Local municipal health plans: City of Greater Bendigo and the Shire of Loddon.
- Strategic opportunities: National, state and regional health priorities.
- Links with Service Coordination strategies.
- Links with Neighbourhood Renewal strategies/settings.
- Ambulatory Care Sensitive Conditions data.
- HARP initiatives.
- Individual member agency Integrated Health Promotion priorities.
- City of Greater Bendigo +25 strategy.
- Implications and effects of the drought in the region.
- Consultations and three planning workshops with local service providers and member agencies including:
    - The City of Greater Bendigo (+25 Strategy), HACC, Children and Family Services, Community and Cultural Development
    - The Shire of Loddon
    - Bendigo Community Health
    - Bendigo Health
    - Annie North
    - Country Awareness Network
    - Sports Focus
    - Bendigo and District Division of General Practice
    - Centre Against Sexual Assault
    - Lifeline
    - Boort District Hospital
    - Inglewood and Districts Health Service
    - St Luke's Anglicare
    - Women's Health Loddon Mallee
    - Integrated Family Violence Consortium
    - Bendigo Loddon Ageing Framework

IHP agreed priorities

IHP priorities aim to address the broader determinants of health that contribute to the burden of chronic disease in the City of Greater Bendigo and the Shire of Loddon.

Agreed priorities include:

1. Physical activity and active communities.
2. Promoting mental health and well-being.
3. Sexual and reproductive health.

Whilst these agreed priorities form the basis of the IHP Plan, it is acknowledged that as horizon issues present, the PCP will facilitate the opportunity for collaborative responses.

Goals

1. Physical activity and active communities:

   To facilitate increased physical activity within the City of Greater Bendigo and the Loddon Shire.

2. Promoting mental health and wellbeing:

   To improve the mental health of people within the PCP catchment by focussing on the areas for action that impact on mental health: freedom from discrimination and violence; economic participation; and social connectedness.

3. Sexual and reproductive health:

   To raise awareness of sexual and reproductive health issues amongst the community and build the capacity of service providers to respond to sexual health needs.

3.3 Solution generation

PRIORITY GOAL 1: Physical Activity and Active Communities

To facilitate increased physical activity within the City of Greater Bendigo and the Loddon Shire.

Australian studies estimate that obesity rates in Australia have more than doubled over the last 20 years. During the last decade, the prevalence of overweight Australian children almost doubled, while levels of obesity have more than tripled (Booth et al, 2001; Margarey et al, 2001). Conservative estimates indicate that 23% of Australia children are overweight or obese (Booth et al, 2001).

Data from the Victorian Population Health Survey 2001 indicates that almost 50% of adults in Victoria do not participate in levels of physical activity shown to benefit health.

- Locally, levels of participation in physical activity in the Loddon Mallee Region were similar to rates across Victoria, with approximately 60% of adults undertaking sufficient regular activity to achieve health benefits.
- In Victoria, only 61.4% of adult males and 57.6% of adult females are sufficiently active to enjoy the health benefits of physical activity.
- Participation rates are even lower than the average amongst people with disabilities, young people, Kooris, older adults and people from cultural and linguistically diverse backgrounds.
- Environmental, economic, financial, social and cultural factors influence physical activity.
- For many people, one or more of these factors can become a barrier to participating in physical activity.

Proportions of the adult population in Loddon Mallee region who were insufficiently active (30%) or sedentary (8.4%) were similar to the proportions of the Victorian population as a whole (DHS, 2003). Having healthy physical activity habits can assist to improve weight status and reduce the risk of heart disease, stroke, hypertension, type 2 Diabetes and some cancers. Participating in physical activity can also improve mental health and well-being, help manage arthritis, prevent injury from falls and help prevent obesity. Physical activity is ranked second only to tobacco control in being the most important factor in health promotion and disease prevention in Australia.

Physical activity can also make an important contribution to social capital in communities. Participation in a club, group or activity can increase the sense of community identity and belonging, and provide an important source of volunteers. Physically active communities are more likely to be resilient and healthier communities, whilst active people are more likely to experience a better quality of life (Deakin University, 2003).

Through committed and collaborative efforts, organisations and communities can address barriers to inactivity, widen access and opportunity, reduce inequalities and realise the many benefits of diverse participation in physical activity. It is important to acknowledge that encouraging and facilitating people to be physically

active can deliver benefits that relate to the core business of many sectors including transport, local government, education, planning, environment, health and sport and recreation. Establishing partnerships between these sectors is essential to the promotion of physical activity.

It is understood that there is no one strategy that works to address physical inactivity. It is a complex problem that requires comprehensive, multi-strategy solutions combining individual focused and community-wide interventions.

Bendigo Loddon PCP catchment issues and opportunities for physical activity

Since the inception of the BLPCP, the Physical Activity Consortium (PAC) has operated as a task-group of the PCP to 'facilitate increased participation in physical activity within the City of Greater Bendigo and the Loddon Shire'.

Organisations represented on the Physical Activity Consortium (PAC):

Active-After School Communities program
Bendigo and District Division of General Practice
Bendigo Community Health Services
Bendigo Health
City of Greater Bendigo
Department for Victorian Communities (Loddon Mallee)
Inglewood & Districts Health Service
Loddon Shire Council
McIvor Health & Community Services
Sports Focus
Vision Australia
Home and Community Care, City of Greater Bendigo

Bendigo initiatives and opportunities:

- Bendigo + 25 Community Plan
- City of Greater Bendigo Health and Well-being Framework
- Communities for Children initiative
- Eaglehawk and Long Gully Neighbourhood Renewal
- Greater Bendigo Cycling and Walking Strategy
- Greater Bendigo Open Space Strategy

Loddon initiatives and opportunities:

- Health and Well-being Centre, Inglewood

- PAC Loddon
- Dance Your Way to Health, Inglewood and Bridgewater
- Bridgewater-Inglewood Community Building Initiative Project
- Inglewood Walking & Cycling Trails Technical Audit
- Loddon Community Plan and Youth Strategy
- Loddon Recreation Strategy Plan
- Loddon Shire Municipal Public Health Plan

Catchment-wide initiatives and opportunities:
- Bendigo Loddon Ageing Framework

References

Booth MI et al (2001). The epidemiology of overweight and obesity among Australian children and adolescents 1995-1997. Australian and New Zealand Journal of Public Health 25: 162-169.

Deakin University (2003). 'Be Active Eat Well'. Colac Provisional Report, Sentinel Site for Obesity prevention; September 2003.

Department of Human Services (2003) Victorian Population Health Survey 2003, Physical activity, healthy eating and overweight/obesity patterns across Victoria.

Margarey A.M. et al. (2001). Prevalence of overweight and obesity in Australian children and adolescents: reassessment of 1985 and 1995 data against new standard international definitions. Medical Journal of Australia 174: 561-565.

PRIORITY GOAL 1: ***To facilitate increased physical activity in the City of Greater Bendigo and the Loddon Shire***

Objective(s):	1.1 To convene the Bendigo Loddon Physical Activity Consortium (PAC). 1.2 To facilitate the coordinated expansion of Strength Training (ST). 1.3 To enhance physical activity environments and support increased access to physical activity. 1.4 To explore potential for the Inglewood Dance Your Way to Health concept to be extended across the Bendigo Loddon catchment.
Estimated impacts[1]	1.1 Increased communication, partnership development and collaborative action among member agencies. 1.2 Partnership development; coordinated approach to ST; ST opportunities evaluated, enhanced and developed. 1.3 Partnership development; Local Government planning influenced; increased awareness and understanding of physical activity benefits: physical activity environments and opportunities evaluated, enhanced and developed. 1.4 Partnership development; Dance Your Way to Health opportunities enhanced and developed.

Summary of mix of interventions[2]	Key implementation partners[3]	Population target group/s:	Estimated timelines	Estimated reach[4]	Estimated intervention resources per member[5]	Estimated impacts
Objective 1.1: *To convene the Bendigo Loddon Physical Activity Consortium (PAC)* • Facilitate and administer regular meetings of the PAC and the Loddon Physical Activity Development Group • Coordinate the planning, evaluation and reporting of PAC activities	Sports Focus (Lead Agency)	PAC member agencies Active After-school Communities program Bendigo & District Division of General Practice Bendigo Community Health Services Bendigo Health City of Greater Bendigo Department for Victorian Communities (Loddon Mallee) Inglewood & Districts Health Service Loddon Shire McIvor Health & Community Services Sports Focus	Monthly	Average attendance of 8 at meetings Minutes distributed to a minimum of 11 organisations Annual PAC Workplan developed Timely completion of reports Minimum of 4 PAC promotional activities conducted	$10,000 p.a. required from PCP Average PAC member in-kind contribution	Increased communication Improved coordination between member agencies Increased profile of PAC/PCP PAC member agencies report the introduction of at least one staff physical activity initiative in each workplace

Summary of mix of interventions[2]	Key implementation partners[3]	Population target group/s:	Estimated timelines	Estimated reach[4]	Estimated intervention resources per member[5]	Estimated impacts
• Promote PAC • Encourage physical activity participation within PAC member agencies		Vision Australia				
Objective 1.2: *To facilitate the coordinated expansion of Strength Training (ST)* • Facilitate and administer regular meetings of the Strength Training Development Group • Lead the development of a Bendigo Loddon ST Development Plan	Sports Focus Consultant	PAC member agencies Current ST providers/managers Community facility managers ST participants	Monthly plan developed by December 2007	Average attendance of 5 at meetings Minutes distributed to a minimum of 11 organisations ST Development Plan completed	$1,500 required from PCP $2,000 required from PCP for brief development $9,500 for consultant required from PCP	Direction set for the development of ST opportunities and environments for 2007-2010

Summary of mix of interventions[2]	Key implementation partners[3]	Population target group/s:	Estimated timelines	Estimated reach[4]	Estimated intervention resources per member[5]	Estimated impacts
Objective 1.3: *To enhance physical activity environments and support increased access to physical activity* • Facilitate applications for community physical activity initiatives • Provide input into relevant local planning and implementation processes • Facilitate a specific school and community linkages physical activity project	PAC member agencies	Whole of community Schools Local Government Planners, recreation officers & other relevant personel Neighbourhood Renewal and Community Building Initiative Facilitators	Ongoing	Minimum of 5 environments impacted Minimum of 3 funding applications supported School and community linkages project commenced	PAC member agency in-kind contribution	More environments which encourage physical activity New community physical activity initiatives commenced
Objective 1.4: *To explore potential for the Inglewood Dance Your Way to Health concept to be extended across the Bendigo Loddon catchment*	Inglewood & Districts Health Service, supported by PAC member agencies	Older people at risk of isolation and those not participating in adequate physical activity for health benefits. Community Dance instructors	Plan developed by December 2007	Dance Your Way to Health Action Plan developed, assuming there is bus transport assistance	PAC member agency in-kind contribution $2,000 PCP contribution	Direction set for the development of Dance Your Way to Health opportunities for 2007-2009

Summary of mix of interventions[2]	**Key implementation partners**[3]	**Population target group/s:**	**Estimated timelines**	**Estimated reach**[4]	**Estimated intervention resources per member**[5]	**Estimated impacts**
• Disseminate project methodology and evaluation outcomes • Based on project review, develop an Action Plan for the expansion of dance initatives						
Estimated total budget per objective[5]**:**						
Estimated total budget per goal[5]**:** $25,000.00 for priority area						

PRIORITY GOAL 2: Mental Health and Well-being

To improve the mental health of people within the PCP catchment by focussing on the areas for action that impact on mental health: freedom from discrimination and violence, economic participation, and social connectedness.

BLPCP members have focussed on mental health and well-being as articulated in the previous Community Health Plan. Members have demonstrated a further commitment to working together to improve the mental health of the community through participating in development of the Southern Loddon Mallee Community Mental Health Plan 2007-2009, which includes commitments to implement recommendations from all signatory agencies. Given gender differences, such as the difference in interaction with health services, the planning for this priority area has been informed by a gendered perspective, with men's and women's mental health promotion strategies being identified to address the specific needs of these population groups. Data identifying the seriousness and prevalence of this as an issue is available at national, state and local level. The focus has three key elements:

- The prevention of violence against women (including sexual assault and family violence).
- Social connectedness.
- Men's mental health.

Women's Mental Health

There are significant differences in the types of mental illness affecting women and men, and the ways they are prescribed and react to medication. For example:

- The most common mental illnesses experienced by women are depression, bipolar disorder and anxiety (Public Health Group, 2005).
- Eating disorders affect more women than men (Mental Health and Wellbeing Unit, Vic Health, 2005).
- Depression is commonly reported to be twice as common in women as in men (Astbury, 2001).
- Deliberate self-harm is common in adolescents, more so in young women than in young men (De Leo & Heller, 2004).
- 10-15% of women report experiencing depression shortly after childbirth (O'Hara and Swain, 1996).
- Women are more likely to suffer with more than one mental illness at a time (co-morbidity), which is linked to increased severity of mental illness and increased disability (Astbury, 2001).
- Drug trials often exclude women, so when given medications based on knowledge gained from trials on men, women often receive larger doses than are needed (Kulkarni, 2001).

Women are exposed to a wide range of specific risk factors that can increase their risk of poor mental health (Astbury, 2001). Women are at higher risk of developing co-morbidities when these risk factors occur together (Patel, 2005). For example:

- Women are affected unduly by the burden of poverty, and this influences their likelihood of suffering depression (Astbury, 2001).
- Lesbian and bisexual women report worse mental health than other women (Women's Health Australia [Online] and Williams et al, 1995).
- Women are much more likely than men to experience violence. Depression in adult women is between three and four times higher if they have experienced sexual abuse as children or partner violence as adults (Astbury, 2001).

- Women are more likely to work in jobs that are unstable and of low status and to take on the unpaid role of carer (Astbury, 2001 and Patel, 2005).
- Traditional roles expose women to higher stress and make it more difficult for them to change their stressful situations (World Health Organisation, 2001).

Women's mental health outcomes could be improved by addressing the risk factors that specifically impact on women at an individual and societal level (Astbury, 2001). Furthermore, evidence on the impacts of gender and mental health focuses mainly on the differences in frequency of mental illnesses. In the future, research, contributing factors, outcomes, heath seeking behaviours, and the response of health services need to be addressed separately for women and men (Patel, 2005). There is a need for treatment facilities and services to be tailored for the different and specific needs according to gender (Kulkarni, 2001).

Freedom from violence

Members of the PCP have identified the need to focus on prevention of violence against women, which includes sexual assault and family violence. Data identifying the seriousness and prevalence of this as an issue is available at national, state and local level.

Sexual assault is the most under-reported crime and it has the lowest conviction rate. This needs to change to ensure justice and support for victim survivors. A recently conducted personal safety survey found that public education campaigns, as well as changes in legislation and police policy, have a real impact as evident in the fact that reporting to police by women of violence by a previous male partner in the past 12 months has increased from 35% in 1996 to 61% in 2005 (ABS, 2006). This is consistent with the World Health Organisation *World Report on Violence and Health (2002)* that states:

> *"Violence can be prevented and its impact reduced, in the same way that public health efforts have prevented and reduced pregnancy related complications, workplace injuries, infectious diseases and illness resulting from contaminated food and water in many parts of the world. The factors that contribute to violent responses – whether they are factors related to larger social, economic, political and cultural conditions – can be changed."*

This is reinforced in the 2004 Vic Health report on intimate partner violence, which states that this problem is best addressed within human rights, legal and health framework, through the development of multi-level strategies across sectors. Sexual assault, family violence and domestic violence is a serious and prevalent issue in our society. The total annual cost of domestic violence in Australia is estimated at $8.1 billion (Access Economics, 2004).

The recently published Personal Safety Survey (ABS, 2006) has found that:

- One in three Australian women had experienced physical violence since the age of 15.
- Nearly one in five women had experienced sexual violence since the age of 15.
- 16% of women had experienced violence by a current or previous partner since the age of 15.
- In Victoria, it has been found that intimate partner violence contributes to 9% of the disease burden for Victorian women aged 15-44 years, making it the largest known contributor to the preventable disease burden in this group (Vic Health, 2004).

Service figures from Loddon Campaspe Centre Against Sexual Assault (CASA) show that for the period July 2005-June 2006:

1. 1160 clients received counselling.
2. 464 of these clients were new to the service.
3. There were 23 after-hours sexual assault crisis care responses.
4. 98% of perpetrators were male.
5. 40% of clients were children and adolescents.

Social connectedness

The Bendigo Youth Arts Network provides a platform for a coordinated approach to the application of arts in health promotion, to improve the self-confidence and self-worth of at-risk young people, using the arts as a medium for self-expression and well-being. The arts have a well-recognised potential to promote health and well-being. One of the arts most powerful contributions to health is that they reflect and create an inclusive sense of community. There is now considerable evidence that the stronger people feel this sense of belonging, the healthier they are. (Vic health online http://www.vichealth.vic.gov.au) The Youth Arts Network model reflects a very similar philosophy of that of Vic Health's Community Arts Participation program.

The benefits of community participation in the arts are outlined below:

- Participants learn transferable skills such as communication, problem-solving, negotiation, cooperation.
- The arts can provide a powerful tool for advocacy by creating and enlarging understanding of unfamiliar people and issues.
- Arts projects transcend language and cultural barriers.
- A community is created among those working on the project, bolstering individual connections to the community.
- Events allow the general public to gain an appreciation of the talents of people whom they may otherwise never encounter and may hold fears and prejudices about.
- Groups are linked to relevant support services.
- Inter-agency links are created, increasing communication and improving services.
- Organisations outside the arts sector develop an understanding of health promotion through partnership with a Vic Health-funded community arts project.
  (Vic Health website 2007 http://www.vichealth.vic.gov.au)

Men's mental health

Since the early 1990's, men's health has become an increasing area of concern and activity in Australia (Hall, 2003) Promoting men's health. *Australian Family Physician* 2003.

There has been a growing recognition that men's health experiences and their interaction with health services are different from those of women (Draft men's health policy, Commonwealth Department of Human & Health Services 1998). Many of the issues are identified in comparisons made below. Statistical comparisons between men and women need to be treated with some caution. For instance, men complete suicide at a greater rate than women, women *attempt* suicide and commit self harm, and suffer long term consequences at alarmingly high rates. Secondly, generalized comparisons between men and women can obscure the great differences that exist between the various sub groups of men. Attention may be directed exclusively toward disease and diseases, rather than on the health and illness experiences of actual men and women. Finally, an over-emphasis on differences can overshadow the commonalities. The 1996 Draft National Men's Health Policy noted that:

- Men aged 15-24 years are more than three times as likely to die in motor vehicle accidents than young women.
- Men aged 15-24 years are four times as likely to die of suicide than women of similar age.
- Men aged 65 years and older have death rates more than one and a half times that of female contemporaries. Of particular significance are rates relating to lung cancer, bronchitis/emphysema/asthma and suicide.
- Men are just as likely to suffer mental disorders as women. These disorders may be related to alcohol and drug abuse, anti-social behaviour and violence.
- Boys report the following more frequently than girls: chronic illness, serious chronic illness, recent illness, speech impediments, developmental delays, bronchitis and asthma.
- Working men report fewer illnesses in general than women but the same level of serious chronic illness. They report fewer days of reduced activity. Apart from mental health services, they utilize services less than women of similar age. They report greater injury rates, but less circulatory disease.
- Men are disproportionately represented as perpetrators of domestic violence, sexual abuse, rape, assault on strangers, gang violence and theft. They are also significantly over-represented in prisons.
- Men are less likely to access support and GP services for mental health conditions.

When compared with women, Victorian men typically are also more likely to (Public Health, 1995):

- Have higher smoking rates.
- Have a high risk level of alcohol intake.
- Be overweight or obese.
- Be hypertensive and not on medication.
- Be less active after age 35.

These factors provide for different health promotion possibilities. Additionally, different issues impact at different points throughout the lifespan. What is clear from these statistics is that the health of men is an issue that needs to be addressed, hence the development of a specific and multi faceted approach. This evidence identifies the need to maintain a separate organisational health priority.

References

ABS (2006) 2005 Personal Safety Survey, Cat No. 4906.0, Australian Bureau of Statistics, Canberra.

Access Economics Pty Ltd (2004) The Cost of Domestic Violence to the Australian Economy Report prepared for the Australian Government's Office of the Status of Women, funded by the Australian Government under Partnerships Against Domestic Violence.

Astbury J (2001) Gender Disparities in Mental Health. World Health Organisation Round Tables.

Commonwealth of Australia (1996)Draft National Men's Health Policy. AGPS: Canberra.

De Leo D & Heller T S. (2004) Who are the Kids who Self-Harm? An Australian Self-Report School Survey. Medical Journal of Australia; 181(3): 140-144.

Hall, R. (2003) Promoting Men's Health. *Australian Family Physician* 2003; 32(6):401-407.

Kulkarni J (2001) Women and Schizophrenia in Health Sharing Women, 11(4), 17-20.

Mental Health and Wellbeing Unit, Vic Health (2005) Burden of Disease Due to Mental Illness and Mental Health Problems. Vic Health, Carlton.

O'Hara MW and Swain AM (1996) Rates and risk of postpartum depression - A meta-analysis. Rev Psych;8:37-54.

Patel V. (2005) Gender in Mental Health Research. World Health Organisation, Italy.

Public Health Bulletin: NSW Health, 2001.

Public Health Group, Department of Human Services (2005) Victorian Burden of Disease Study: Mortality and Morbidity 2001. Public Health Group, Rural and Regional Aged Care Services Division, Victorian Government Department of Human Services, Melbourne.

Vic Health (2004) The health costs of violence: Measuring the burden of disease caused by intimate partner violence. Victorian Health Promotion Foundation, Carlton, Victoria.

Williams, JB; Spizter, RL; Linzer, M; Kroenke, K; Hanh, SR; deGruy, FV; and Lazev,A (1995) Gender Differences in Depression in Primary Care, American Journal of Obstetrics and Gynaecology Vol 173(2).

Women's Health Australia. The Australian Longitudinal Study on Women's Health: Mental Health. http://www.newcastle.edu.au/centre/wha/Reports/Achievements/achievements-mentalhealth.pdf Accessed on 15/06/2006.

World Health Organisation (2001) World Health Report 2001: Mental Health: New Understanding, New Hope. World Health Organisation, Geneva.

Krug, Dahlberg, Mercy, Zwi and Lozano (eds)(2002) World Report on Violence and Health World Health Organisation, Geneva.

WHO (2004) Preventing Violence: A guide to implementing the recommendations of the World report on violence and health. World Health Organisation, Geneva.

Vic Health (2006) Two steps forward, one step back. Community attitudes to violence against women. Victorian Health Promotion Foundation, Carlton.

PRIORITY GOAL 2: ***To improve the mental health of people within the PCP catchment by focussing on the areas for action that impact on mental health: freedom from discrimination and violence, economic participation, and social connectedness.***

Objectives:	2.1 To increase awareness of issues affecting women's mental health in the Bendigo Loddon catchment area. 2.2 To document existing programs and policies within BLPCP agencies regarding preventing violence against women and children. 2.3 To support both local governments and community based agencies in the Shire of Loddon and City of Greater Bendigo to expand violence prevention programs and policies. 2.4 To ensure opportunities for community and consumer participation through the arts. 2.5 To increase the awareness of men's mental and emotional health issues across the Bendigo Loddon catchment. 2.6 To enhance consumer and agency participation in the Loddon Healthy Minds Network.
Estimated impacts[1]	2.1 Increased awareness of mental health issues affecting women and increased social connectedness for women. 2.2 The mapping process will be an engagement activity to highlight the issue of violence against women and children to PCP members. Preventing violence will be a priority for both local governments, with supporting policies and programs in place. 2.3 Mapping will have formed the basis of an inter-agency violence prevention strategy for the PCP, linked with the regional Family Violence Advisory Committee and its plan. 2.4 Increased youth particpation in Arts for Health programs that strengthen social connectedness to their community, and increased understanding of arts and health promotion practice. 2.5 Increased awareness of mental health issues affecting men and increased social connectedness for men. Increased awareness of men's mental and emotional health issues across the Bendigo Loddon catchment and activities implemented to increase opportunities for men to socially interact. 2.6 Increased participation of agencies in supporting consumers of mental health support services.

Summary of mix of interventions[2]	Key implementation partners[3]	Population target group/s:	Estimated timelines	Estimated reach[4]	Estimated intervention resources per member[5]	Estimated impacts
Objective 2.1: *To increase awareness of issues affecting women's mental health in the Bendigo Loddon catchment area.*	Women's Health Loddon Mallee (WHLM) Neighbourhood Houses	Disadvantaged women	2007-09	Six Neighbourhood Houses in Bendigo Loddon region, 20 women at each over 3yrs= 360 women	$5,760	Increased awareness of mental health issues affecting women
• Implement inaugural Women's Health Week	WHLM (Lead Agency), PCP member agencies, and a Reference Group to be established	Bendigo Loddon population		Women's Health Expos 200 women each year= 600 women. (Primary – 600 women. Secondary - 10,000 women, via media)	$2,000	Increased social connectedness for women at risk Media coverage Participation by member agencies providing women's health services
Objective 2.2: *To document existing programs and policies within BLPCP agencies regarding preventing violence against women and children.*	Bendigo Family Violence Working Group to lead the process.	PCP member agencies	2007-09 .	PCP member agencies	Funds of $60,000 are currently being sought from VicHealth	Service providers have increased awareness of violence in the community and of services addressing this need

Summary of mix of interventions[2]	**Key implementation partners**[3]	**Population target group/s:**	**Estimated timelines**	**Estimated reach**[4]	**Estimated intervention resources per member**[5]	**Estimated impacts**
Objective 2.3: *To support both local governments, community based agencies, the Shire of Loddon and City of Greater Bendigo to expand violence prevention programs and policies.* • To develop an interagency violence prevention strategy for BLPCP.	Bendigo Family Violence Working Group to lead the process.	PCP member agencies	2007-09	PCP member agencies	Further project time is required to collate current activities and formulate an interagency response to violence against women Funds have been sought from VicHealth	Interagency strategy will highlight violence as a priority to be addressed by member agencies and local government

Summary of mix of interventions[2]	Key implementation partners[3]	Population target group/s:	Estimated timelines	Estimated reach[4]	Estimated intervention resources per member[5]	Estimated impacts
Objective 2.4: *To ensure opportunities for community and consumer participation through the arts.* • Development of Youth Fringe Festival • Delivery of workshop series and professional development program • Delivery of Mentoring Program • Responding to needs in the community and engagement of isolated rural youth.	CreateAbility Events Network Inglewood & District Health Services Future Connections DOXA School. Youth Substance Abuse Service Castlemaine Continuing Education Melbourne Fringe Bendigo Regional Institute of TAFE St Luke's BDAC – Indigenous Women's Arts Council Bendigo Community Health Services (BCHS) Bendigo & District Division of General Practice.	Disadvantaged youth.	2007 - 08	No. of participants No. of evaluations completed		Community awareness of benefits of Arts for Health Improved self-confidence of youth using arts as a medium for self-expression and well-being. Increased levels of community engagement and sense of connection to other young people and their community.
• Establish ongoing programs at Specimen Cottage Youth Arts Space that ensure both consumer and community participation in the Arts		Disadvantaged youth Support Workers Community artists	2009	Number of relevant programs developed		Youth Project Steering Committee established Youth Arts resource library established Young people involved in project committee use skills to develop own projects and performances

Summary of mix of interventions[2]	Key implementation partners[3]	Population target group/s:	Estimated timelines	Estimated reach[4]	Estimated intervention resources per member[5]	Estimated impacts
• Strengthen partnerships and build capacity to develop arts based activities that contribute to the promotion of Mental Health and Wellbeing	Youth Arts Network Members	Youth support sector across Arts , Health, Education and Welfare sectors	2007	No. of participants	$15,000 from PCP	Increased programming at Specimen Cottage Art Space Professional development workshop and forum held Increased awareness of benefits to the application of arts in health promotion in Bendigo region Increased capacity of organisations and communities to engage young people in arts and cultural activities
Objective 2.5: *To increase the awareness of men's mental and emotional health issues across the Bendigo Loddon catchment* • Participate in Men's Health Week to increase community awareness of men's health issues and enhance social connectedness	BCHS as the lead agency for Men's Health Week will work in partnership with the Country Awareness Network, local governments, other health services and service clubs and a range of agencies from across the catchment	Men (particularly those in rural locations and disadvantaged communtities) and service providers	September 2007	Impact & Process Questionnaire (Report) Primary 1500 men. Secondary 10,000 men through the media	$2,000 from PCP	Increased awareness of men's health issues Monthly reference group meetings PCP member agencies involved in the implementation of men's health week activities

Summary of mix of interventions[2]	**Key implementation partners**[3]	**Population target group/s:**	**Estimated timelines**	**Estimated reach**[4]	**Estimated intervention resources per member**[5]	**Estimated impacts**
Objective 2.6: *To enhance consumer and agency participation in the Loddon Healthy Minds Network*	Loddon Service Providers Network	Network members and consumers of mental health services	2007 - 09	Loddon Shire PCP members and client groups	Inkind from members PCP contribution $10,240 over two years	
Estimated total budget per objective[5]**:**						
Estimated total budget per goal[5]**:** $35,000						

PRIORITY GOAL 3: Sexual Health

To raise awareness of sexual and reproductive health issues amongst the community and build the capacity of service providers to respond to sexual health needs.

Annual notifications for all notifiable sexually transmitted infections (STIs) - including Chlamydia, Gonorrhoea, Syphilis and HIV - have increased dramatically in Australia over the last five years. Chlamydia notifications have increased from 3,656 in 1999 to 7,878 in 2005, a 115% increase over the seven years (16.5% per annum). In 2004, 58% of Chlamydia notifications in Victoria were diagnosed among women, with 66% of notifications among young women aged 16–24 years (Communicable Diseases Australia, 2005; DHS, 2006). Chlamydia is often asymptomatic but can lead to long term complications: up to two thirds of cases of tubal-factor infertility and one third of cases of ectopic pregnancy may be attributable to Chlamydia infection. Furthermore, Chlamydia and other STIs can increase the risk of HIV transmission (Chen & Donovan, 2004). Human papilloma virus is the most prevalent viral STI and Types 16 and 18 of this virus cause about 70% of cervical cancers [AIHW Online]. The rate of notifications for Syphilis, Gonorrhoea and HIV is unacceptably high and continues to grow. The number of notifications for these three major STI conditions combined has increased by more than 240% over the past six years. Syphilis, which was all but eradicated in Victoria, has increased from two to 80 cases over this period, an alarming 4000% increase, while HIV notifications have increased from 140 in 1999 to 217 in 2004.

Little is known about the prevalence of STIs in young people from rural and regional areas. Most research outside of metropolitan areas in Australia has focused on remote indigenous communities (Miller et. al, 2003). Studies of Australian youth have reached predominantly urban students and predominantly female attendees of medical services, neither of which are likely to provide a true indication of STI prevalence in the wider youth population (Miller et. al, 2001). Males have been particularly overlooked, as many studies of men focus on relatively small sub-populations such as men who have sex with men, sex workers, clients of female sex workers and injecting drug users.

The Australian Study of Health and Relationships found no difference in age at first sex (deVisser et al. 2003), likelihood of having more than one recent sexual partner (DeVissier et al, 2003), lifetime or recent diagnosis of an STI, or knowledge of STIs (Grulich et. al, 2003) between those living within and outside major cities. However those living outside major cities were significantly less likely to have used a condom in the previous 12 months (DeVisser et al, 2003).

Differences in health status and accessibility to health services between metropolitan and non-metropolitan Australia are evident in the consistently higher mortality, disease incidence, hospitalisation and health risk figures reported for rural and remote areas (AIHW, 2005; Poljski et al. 2005). The national rural health report stated that there was a higher rate of Chlamydia and Syphilis notifications in regional and remote Australia compared with major cities, although this was at least partly attributed to the larger indigenous populations in these areas (AIHW, 2005). However, a Victorian based study found that testing and notifications rates for Chlamydia were much lower in Victorian rural and remote areas than in metropolitan areas (Hocking et al., 2003). Coupled with a lack of sexual health services in rural Victoria (Davies et al. 2002), this suggests that there may be differences in access to health care outside metropolitan areas, and that it is likely that the real prevalence of STIs in Victorian rural areas is far higher than notification statistics indicate because of the reduced testing in these areas.

Young people also report various difficulties in accessing appropriate health services in rural and regional areas. High visibility in small towns makes it difficult to seek advice, purchase contraceptives and access abortion services, and there is concern about the maintenance of confidentiality by health service providers, including chemists. A further barrier for youth in rural areas to access health care is lack of transport (Rissel et. al, 2003; Quine et al. 2003; Warr and Hillier, 1997).

References

Australian Institute of Health and Welfare [Online] Cervical Screening in Australia 2003-04. http://www.aihw.gov.au/publications/index.cfm/title/10359 Accessed 12/02/07.

AIHW Rural, regional and remote health: Indicators of health. Canberra: Australian Institute of Health and Welfare, 2005

Chen MY, Donovan B. Genital Chlamydia trachomatis infection in Australia: epidemiology and clinical implications. Sexual Health 2004;1:189-196

Communicable Diseases Australia. National Notifiable Diseases Surveillance System. Canberra, 2005:http://www1.health.gov.au/cda/Source/CDA-index.cfm Accessed 10/10/2005.

Davies L, Jukes J, Hodges C, Crosby J. Rural life of us: Young people and workers with young people in country Victoria: Centre for Adolescent Health, Youth Affairs Council of Victoria, 2002

de Visser RO, Smith AMA, Rissel CE, Richters J, Grulich AE. (2003) Sex in Australia: Heterosexual experience and recent heterosexual encounters among a representative sample of adults. Australian and New Zealand Journal of Public Health 2003;27(2):146-154

Department of Human Services [Online] Infectious Disease Surveillance Reports

http://www.health.vic.gov.au/ideas/surveillance/index.htm Accessed 12/01/07

Grulich AE, de Visser RO, Smith AMA, Rissel CE, Richters J. Sex in Australia: Sexually transmissible infection and blood-borne virus history in a representative sample of adults. Australian and New Zealand Journal of Public Health 2003;27(2):234-241

Hocking J, Fairley C, Counahan M, Crofts N. The pattern of notification and testing for genital Chlamydia trachomatis infection in Victoria, 1998-2000: an ecological analysis. Australian and New Zealand Journal of Public Health 2003;27:405-408.

Miller GC, McDermott R, McCulloch B, Fairley CK, Muller R. Predictors of the prevalence of bacterial STI among young disadvantaged Indigenous people in north Queensland, Australia. Sexually Transmitted Infections 2003;79:332-335

Miller PJ, Law M, Torzillo PJ, Kaldor J. Incident sexually transmitted infections and their risk factors in an Aboriginal community in Australia: a population based cohort study. Sexually Transmitted Infections 2001;77:21-25.

Poljski, C., Atkin, L. and Williams, H. (2005) Review of Clinical Services in Victoria. Family Planning Victoria.

Quine S, Bernard D, Booth M, Kang M, Usherwood T, Alperstein G, et al. Health and access issues among Australian adolescents: a rural-urban comparison. Rural and Remote Health 2003;3.

Rissel CE, Richters J, Grulich AE, de Visser RO, Smith AMA. Sex in Australia: First experiences of vaginal intercourse and oral sex among a representative sample of adults. Australian and New Zealand Journal of Public Health 2003;27:131-7.

Warr D, Hillier L. 'That's the problem with living in a small town': Privacy and Sexual Health Issues for Young Rural People. Australian Journal of Rural Health 1997; 5:132-139

PRIORITY GOAL 3: ***To raise awareness of sexual and reproductive health issues amongst the community and build the capacity of service providers to respond to sexual health needs.***

Objectives:	3.1 Improve collaboration between service providers and promote integrated service planning to address sexual health issues in the Bendigo Loddon catchment. 3.2 Build the capacity of service providers to respond to identified sexual health needs through the provision of locally based training and education. 3.3 Identify consumer needs related to sexual health service provision and implement strategies to address identified needs.
Estimated impacts[1]	3.1 Improved sexual health service delivery in the Bendigo Loddon catchment and Services have an increased capacity to respond to identified sexual health needs. 3.2 Improved knowledge of sexual health services in the catchment area. 3.3 Sexual health needs of consumers are identified and addressed through the delivery of collaborative sexual health projects.

Summary of mix of interventions[2]	Key implementation partners[3]	Population target group/s:	Estimated timelines	Estimated reach[4]	Estimated intervention resources per member[5]	Estimated impacts
Objective 3.1. *Improve collaboration between service providers and promote integrated service planning to address sexual health issues in the Bendigo Loddon catchment.*	Women's Health Loddon Mallee in conjunction with member agencies.	PCP member agencies	April 2007	Member agencies	In kind contribution WHLM	Membership of sexual health task group is re-established
• Map existing sexual health promotion services and programs to identify gaps, duplications and opportunities for service integration and development, and to identify barriers and access issues	Women's Health Loddon Mallee (lead agency) (WHLM) Bendigo Community Health Services (BCHS) Country Awareness Network Bendigo Health Centre Against Sexual Assault City of Greater Bendigo (Maternal and Child Health) McIvor Health and Community Services (MH&CS)	All member agencies of PCP	2007	16-29 year olds in the Bendigo Loddon catchment via member agencies, BRIT, La Trobe University Bendigo and secondary schools	In kind contributions from member agencies $5000 PCP allocation	Updated sexual health services guide Updated Connecting Care website Ability to develop community based projects based on identified barriers and issues related to access

Summary of mix of interventions[2]	Key implementation partners[3]	Population target group/s:	Estimated timelines	Estimated reach[4]	Estimated intervention resources per member[5]	Estimated impacts
• Identify opportunities for STI/Blood Borne Viruses health promotion funding	Inglewood and Districts Health Service Bendigo & District Division of General Practice DHS School Nurses School welfare workers Members of PCP Sexual Health Task Group Women's Health Loddon Mallee BCHS Country Awareness Network McIvor Health and Community Services (MH&CS) Sports Focus Sporting Clubs	16-29 years olds Gay men	Ongoing			No. of successful submissions and resources for projects Partnerships developed through application for funding
• Develop community projects to encourage innovation and improve sexual health promotion practice (e.g review services, resource development)	BCHS WHLM Country Awareness Network Bendigo Health Centre Against Sexual Assault City of Greater Bendigo MCHS Inglewood & District Health Service Bendigo Division of General Practice DHS School Nurses School welfare workers	PCP member agencies and the Bendigo and District Division of General Practice	2007-2009.	PCP member agencies, sexual health technical experts, such as Melbourne Sexual Health and Burnet Institute	$5000 for collaborative projects and building the capacity of the sexual health service sector	Develop collaborative community projects to address needs identified from service provider and community consultation processes Sexual health services are reviewed and opportunities for collaborative practices are identified

Summary of mix of interventions[2]	**Key implementation partners**[3]	**Population target group/s:**	**Estimated timelines**	**Estimated reach**[4]	**Estimated intervention resources per member**[5]	**Estimated impacts**
Objective 3.2: *Build the capacity of service providers to respond to identified sexual health needs through the provision of locally based training and education.* • Support Burnet Institute to implement the Sex and Sport project in the BLPCP region	Women's Health Loddon Mallee BCHS Country Awareness Network Bendigo Health Centre Against Sexual Assault City of Greater Bendigo MCHS Inglewood & Distric Health Service Bendigo Division of General Practice DHS School Nurses School welfare workers	16-29 year olds	12 months to end of 2007	1000 participants	In kind contributions from member agencies via attendance at project reference group meetings. Funded through Burnett	Increased screening for Chlamydia Health education to participants
Objective 3.3: *Identify consumer needs related to sexual health service provision and implement strategies to address identified needs.* • Consultation with the community to identify sexual health needs.	Sexual Health Task group to incorporate principles of consumer participation and consultation with target group to assist in needs identification, planning and implementation of initiatives	PCP member agencies 16-29 year olds.	2007 - 2008	PCP member agencies consulted and a representative sample of 16-29 year olds	In kind contributions from agencies	Sexual health needs of young people are identified and disseminated to member agencies and incorporated into planning activities
Estimated total budget per objective[5]**:**						
Estimated total budget per goal[5]**:** $10,000.00						

3.4 Capacity building

PRIORITY GOAL 1: ***To increase number of people in the catchment area participating in physical activity***

Theme	Objectives	Interventions	What would potentially be changed/different? impacts
Organisational development	To facilitate a coordinated approach to physical activity	Regular PAC meetings convened Annual PAC workplan developed and reviewed	Continuous planning cycle Integration of organisational/ community plans related to physical activity
Partnerships	To establish interaction between sport and recreation, local government and health sectors to ensure a collaborative approach to physical activity promotion.	Facilitate regular PAC meetings to be attended by representatives from the range of agencies and sectors Identify opportunities for sectors to work together eg. Strength Training and dance PAC to support relevant funding initiatives PAC to facilitate physical activity planning at a PCP level	PAC Terms of Reference reviewed The range of sectors represented as members of PAC PAC task groups convened Physical activity initiatives supported by PAC New partnerships developed
Leadership	To establish PAC as a key facilitator of physical activity across the catchment	Ensure PAC membership is representive of all relevant agencies and sectors Support and coordinate catchment wide physical activity initiatives	Increased profile and influence of PAC Service Coordination (SC) and IHP leadership embedded within organisations
Workforce development	To support physical activity promotion and participation within PAC/PCP member agencies	PAC members to promote and participate in relevant industry forums Networking and peer support provided to workers through regular PAC meetings PAC member agencies encouraged to adopt initiatives that support staff being physical active	Increased awareness of and participation in professional development activities that enhance staff skills and capacity to support physical activity initiatives Increase in number of agencies with workplace physical activity initiatives

PRIORITY GOAL 2: ***To increase awareness and knowledge of mental health and wellbeing amongst service providers and the community***

Theme	Objectives	Interventions	What would potentially be changed/different? impacts
Organisational development	Develop gendered interagency violence prevention strategy for the Bendigo Loddon catchment	Consult with PCP member agencies to develop violence prevention strategy	Continuous planning cycle to address violence against women and children
Partnerships	Establish Mental Health IHP Working Group for the Bendigo Loddon catchment Establish Special Interest Groups according to identified needs e.g. Women's Health Week	Hold regular meetings and review membership of Working Group	Integration of strategies that address violence against women and children, use the arts as a method to improve young people's health and respond effectively to Mens Mental Health issues Forums for disseminating information about mental health issues are established
Leadership	Develop organsiational policy for PCP member agencies related to violence against women and using the arts to improve the health of young people and men. Bendigo Family Violence Working Group to lead the process	Consultation with service providers	Policy development
Workforce development	Increase awareness of existing programs and policies regarding violence against women and children Improve the capacity of service providers in the region to respond to drought affected community needs	Map existing service and programs to identify gaps and opportunities in violence against women programs and services PCP member agencies to evaluate and document at least one project/model in the Loddon Shire	Improved knowledge of programs and policies that address violence against women, leading to improved service coordintation An evidence base developed to determine what makes a difference in communities in transition, to inform future planning and program development

PRIORITY GOAL 3: ***To raise awareness of sexual and reproductive health amongst the community and build the capacity of service providers to respond to sexual health needs***

Theme	Objectives	Interventions	What would potentially be changed/different? impacts
Organisational development	To integrate sexual health services in the catchment Develop and implement organisational policy regarding best practice in sexual health.	Map existing sexual health services in the Bendigo Loddon catchment Identify gaps and duplications in sexual health service delivery Develop strategies to address gaps and duplications in service delivery	PCP member agencies are aware of services available, including hours of operation, elibility and referral processes Improved agency referral to sexual health services Organisaional plans and community plans around sexual health are more integrated
Partnerships	To re-establish membership of the BLPCP Sexual Health Task Group Develop Special Interest Groups according to identified needs	Establish working group from a range of member agencies to address sexual health needs	Opportunities for collaborative work are identified Service providers have a forum for the exchange of information and to participate in collaborative catchment wide projects
Leadership	BLPCP to faciliate collaborative projects to address sexual health needs Review existing sexual health services to identify gaps and opportunities in service provision	Identify opportunities for collaborative projects to increase impact of sexual health projects and strategies, such as Chlamydia screening and a review of sexual health service delivery in the catchment	Improved service coordination and integration
Workforce development	To build the capacity of sexual health services to respond to identified needs	Consult with sexual health service providers to determine professional development needs Develop strategies, such as locally based training and support systems to meet the professional development needs of sexual health service providers, including GPs	Locally based training and support provided to sexual health service providers/GPs.

Additional role for the IHP working group

The Integrated Health Promotion Working Group has agreed to facilitate the planning and implementation of the Health and Well-being component of the City of Greater Bendigo +25 Strategy. This will involve the following:

- Broadening the membership of the IHP working group to include other interested agencies and individuals.
- Forming a task group to oversee the development and implementation of an agreed action plan.
- Supporting the implementation of the Health Promotion component of the Bendigo Loddon Ageing Framework.

3.5 Planning for quality health promotion practice (Evaluation of mix of interventions)

Evaluation of priority goals (PCP facilitation and support of agencies)

The processes the PCP will employ to facilitate and support evaluation processes conducted by the agencies around the priorities include:

a) Process mapping

- The BLPCP will map processes and activities involved in evaluating the Integrated Health Promotion Plan to demonstrate the workflows and relationships between agencies, Working Groups and Special Interest Groups. This will improve understanding of evaluation processes of IHP work (detailing data and information to be collected), assist with identifying areas for improvement and demonstrate how processes and activities may change from time to time. The PCP will aim to establish links to agency IHP planning cycles as part of process mapping.

b) Information and support

- The PCP will develop a central repository of health promotion evaluation frameworks and tools for agencies to utilise in evaluating their IHP work.

The processes the PCP will employ to obtain an evaluation of the work around the priority across the whole of the PCP catchment include:

a) Evaluation plans for priority areas

- Evaluation indicators are established in the IHP. It is envisaged that each key area /objective of the IHP plan will develop an evaluation plan based on the 'Planning for effective evaluation resource' (DHS, 2005) process and framework.
- This task will be one of the initial actions for the various partnership groups and shall be led by the lead agency for each priority area. Each Working Group for individual priority areas will define for each key strategy and action the relevant evaluation questions; expected reach and impacts; the key performance indicators; the appropriate measuring tool; data source, and the timing of the measurement.
- This will also include an annual reporting schedule with bi-monthly monitoring to the PCP IHP Working Group via face to face meetings.

b) Project support

- A project support worker resourced by PCP will be allocated bi-annually to support agencies to monitor their progress on and assist with reporting against the IHP Plan.

c) Annual evaluation and continuous improvement planning workshops

- Annual workshops will be conducted to assist agencies with reporting their progress against the IHP plan. This will assist to build the capacity of agencies to evaluate health promotion projects and to identify opportunities for improvement in processes and activities.

d) Resources

- At least 10% of IHP resources will be allocated to agencies to assist with the evaluation of IHP priority areas.

Evaluation of capacity building strategies

The processes the PCP will employ to measure progress towards achieving the capacity building objectives detailed in the previous section include:

- Each of the capacity building objectives that relate to particular key areas will be included in the processes listed above.
- Members will report on their progress on the IHP and bi-monthly IHP Working Group meetings.
- Ongoing process evaluation will occur at IHP Working Group meetings to identify additional opportunities for related work, potential links between priority areas and opportunities for improvement.

The PCP will identify when the capacity building objective(s) have been achieved by:

- The PCP IHP Working Group will develop an evaluation plan based on the process listed above for the specific capacity building objectives.
- The number of successful collaborative submissions will be a key indicator.
- New partnerships developed, such as special interest groups.
- Number of successful submissions.
- Number of workforce development initiatives developed across the catchment.
- Evidence that interagency and organisational policy has developed and been implemented.
- The Vic Health Partnerships Analysis Tool will be used to assess the level of integration between agencies for each priority.

The PCP will facilitate the dissemination of learning, including unexpected results, by:

- Central repository of information, including plans, submissions and impacts/outcomes.
- Regular monthly newsletters.
- IHP Working Group meetings (all priority area working groups).
- Working Group meetings.
- Annual reporting.

3.6 Applying an Integrated Disease Management 'lens' to IHP planning

Many of the indicators used to ascertain key priority areas are based on disease, such as the Ambulatory Care Sensitive Conditions study and the Burden of Disease study. The BLPCP's IHP priority areas, physical activity, sexual and reproductive health and promoting mental health, are demonstrative of preventing or delaying chronic conditions.

IHP approaches and interventions are used to prevent and/or delay chronic illness in the catchment through creating supportive environments to promote health, increasing opportunities for physical activity, social inclusion and connectedness. Chronic Disease Management initiatives will be linked with priority areas outlined in the IHP.

Specific chronic conditions and underlying social determinants being addressed within priority approaches include cardiovascular disease, diabetes, mental health conditions, HIV and Chlamydia.

People experiencing disadvantage and inequalities in communities throughout Bendigo Loddon are a major focus of the IHP. These community groups include drought affected communities, people with a chronic illness, people from lower socio-economic areas and high unemployment (such as Neighbourhood Renewal site areas) and women and children experiencing violence.

Isolation is one of the broader impacts on people with a chronic illness in Loddon. This has been a major consideration in ensuring that interventions and strategies encompass outlying areas within the catchment in addition to major centres.

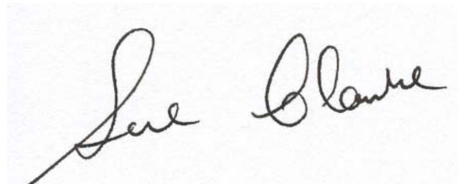
SECTION 4

DELIVERABLE 3: *SERVICE COORDINATION*

Bendigo Loddon Primary Care Partnership

Community Health Plan 2006 - 2009

Endorsed by PCP Chair:



Name: Sue Clarke   Signature: Date: 28.2.2007

4.1 INTRODUCTION

Service Coordination for the BLPCP will have four directions:

1. *Catchment-wide strategic planning for a common issue or client group.*
2. *Agency-initiated action on a particular issue or client group.*
3. *PCP-initiated action where there is potential for efficiencies through collaboration.*
4. *Information exchange between agencies.*

It is recognised that agencies will engage in different aspects of service coordination depending on their target group or service focus, and are most likely to collaborate on issues which have direct relevance and add value to core business. However service coordination as accepted best practice across the region will only be reinforced if individual agencies put in place working principles and an organisational structure which emphasises collaboration and partnerships.

Broad service coordination priorities were identified through community consultations on the CHP as:

- Communication and relationships between agencies.
- Information about services and initiatives in the PCP catchment.
- E-communication.
- Chronic disease management.
- Capacity building.

BLPCP will support and facilitate service coordination through:

- The PCP Executive Committee and IAWG promoting and embedding service coordination practices in their own organisations.
- Establishing regular and systematic information exchange to and between agencies.
- Support for incorporating service coordination in agency workplans.
- Support for the adoption of e-referral, the SCTT tools and use of service directories within each partner organisation.
- Fostering inter-agency working relationships and "Networks of Interest".

4.2 Flexible service coordination strategies that accommodate agencies' capacities.

GOAL	*Implement the Better Access to Services (BATS) framework by progressing common practices, processes, protocols and systems for initial contact, initial needs identification, referral, assessment and care planning by member organisations.*	
Objective	**Strategies/Interventions**	**Estimated Impact**
1. Encourage the use of referral and client service coordination tools and strategies	1.1 Continually reinforce service coordination principles as normal agency practice through partnership contacts 1.2 Executive Committee and IAWG members actively advocate through their positions in and relationships with agencies 1.3 Market service coordination successes through 'Newsflash' items 1.4 Encourage 'best practice agencies' to act a coaches or mentors 1.5 Engage with key agency managers so that activities of IHP and CDM Working Groups are linked 1.6 Membership of Working Groups to reflect appropriate authority for decision making on service coordination proposals and systems development in CDM	Members increasingly adopt a streamlined client pathway for service and referral in place Agencies are informed and trained about service coordination
2. Input to systems and relationships which develop and support coordination and encourage a disease-specific focus where appropriate e.g. CDM	2.1 Participate with agencies in workforce skilling through professional development forums, and inputs to staff orientation and training 2.2 Ensure agencies are updated with the latest service coordination material.	Service coordination information is regularly exchanged about successes, initiatives and policy and funding changes, possibly through the use of a PCP Web Portal

GOAL	*Improve communication about clients (especially those with chronic disease and complex needs) with general practice, leading to more active GP participation with other service providers involved in the client's care.*	
Objective	**Strategies/Interventions**	**Estimated Impact**
3. Participate in relevant service coordination umbrella groups such as HARP/EliCD governance and working groups	3.1 Explore potential for a PCP web portal hosting a confidential peer support group to discuss problems or difficult client issues, possible data respository	Improved communication between agencies and GPs
4. Work with the Division of General Practice on building links with GPs • Work cooperatively with the Division of General Practice on the CHUMS and managed care networks projects • Facilitate a feedback system to GPs post referral	4.1 Use 'Newsflash' to circulate information on GP issues and initiatives 4.2 Support the mapping of self-management interventions with GPs and agencies 4.3 Explore potential for a pilot on e-referral in the Shire of Loddon between GPs, agencies and hospitals 4.4 Cooperate in developing GP protocols with agencies, for referral and feedback and self-management interventions	Reduction in exchange of paper-based and unsecured client information
5. Lead and advise the rollout of the HealthConnect pilot	5.1 Assist agencies to install PKIs	Reduction in exchange of paper-based and unsecured client information

GOAL	*Successful implementation of the Victorian Service Coordination Practice Manual and subsequent versions of the Service Coordination Tool Templates.*	
Objective	**Strategies/Interventions**	**Estimated Impact**
1. Executive Committee and IAWG will promote Service Co-ordination practices in their agencies • Facilitate members' adoption of PPPS, SCTT and e-communication tools • Change management support for implementation of e-referral	1.1 Offer support, and input to staff professional development and orientation and staff meetings 1.2 Share information on successful adoption of SCTT and e-referral for possible mutual agency support 1.3 Explore links with tertiary resources in service coordination projects such as a referral pathway analysis for agencies 1.4 Input to reviews of SCTT tools and other statewide referral/review processes, either directly or via regional representation 1.5 Support the use of SCTT and other tools to identify clients requiring inter-disciplinary care planning 1.6 Investigate direct support to agencies through an IT consultant 1.7 Cooperate with the implementation of local government and agency e-communication plans 1.8 Explore special purpose funding and resource sharing opportunities for IT support 1.9 Encourage joint agency approaches to professional development in IT best practice and the sharing and exchange of staff resources 1.10 Encourage members to submit 'Newsflash' articles on their e-referral experience, and incorporate as standing items for Executive Committee and IAWG updates on e-communication in the catchment area.	Agencies' increased use of the SCTT tools Agency training incorporates use of the SCTT tools and e-referral Key staff are skilled and motivated to use e-referral and SCTT to support effective and efficient practice Member agencies have appropriate internal business systems in place Information and resource sharing strengthens and extends inter-agency relationships

<table>
<tr><td>GOAL</td><td colspan="2">Improved amount and accuracy of information to support referral through the Human Services Directory.</td></tr>
<tr><td>Objective</td><td>Strategies/Interventions</td><td>Estimated Impact</td></tr>
<tr><td>1. Liaise with ConnectingCare about member usage rates and issues
• Contribute usage issues for agencies to service directory changes and developments
• Transmit ConnectingCare changes to members through ‘Newsflash”</td><td>1.1 Usage issues are addressed by the ConnectingCare Users’ Group
1.2 Agencies regularly update their service information
1.3 Briefing/training programs for agency staff to become familiar in the use of ConnectingCare and other information exchange innovations</td><td>Increased use of service directories for service information
Increasing use of ConnectingCare and the Human Services Directory for e-referrals
Service directories maintain information currency</td></tr>
</table>

SECTION 5

DELIVERABLE 4: *INTEGRATED CHRONIC DISEASE MANAGEMENT*

Bendigo Loddon Primary Care Partnership

Community Health Plan 2006 - 2009

Endorsed by PCP Chair:

Name: Sue Clarke   Signature: Date: 28.2.2007

Integrated Chronic Disease Management

Goal	Objective	Strategy	Planned Impact
1. *Completion of a mapping of self-management interventions (provided by agencies within the catchment). Facilitate planning processes to develop self-management interventions within member agencies that respond to gaps identified in the mapping process.*	Identify the range of services which curently provide self-management interventions	Review previous work regarding the mapping of self-management activities determining the individual agencies understanding of self-management	Increased awareness of self-management programs across the catchment
	Identify the range of models of self-management interventions utilised by agencies	Engage key stakeholders and determine an agreed process for mapping activities Embed the process in the activities and work plan of the cross agency HARP EliCD reference group Conduct the mapping exercise using relevant methodological framework Produce and disseminate a report of the findings of the mapping exercise for consideration and analysis by the HARP EliCD reference group	Increased awareness of self management programs across the catchment Report complete Report informs the actions and planning of the HARP EliCD reference group
	Increase knowledge and skills of member agencies in self-management practice within BLPCP	Assist member agencies identified in the mapping process to develop a capacity building plan to embed self-management activities across programs	Bendigo Loddon Self-Management Program Capacity Building Plan agreed and actioned Increased number of programs incorporating self-management strategies

Goal	Objective	Strategy	Planned Impact
2. *Facilitation of a process for agencies to define their roles and responsibilities, especially acute and community health services, in relation to providing self-management interventions for people with chronic disease.*	Consider the current roles and responsibilities undertaken by individual agencies in the provision of self-management interventions	Conduct a forum of relevant service providers focussing on: • Current models • Evaluation of findings and learnings gathered to date • Review of current roles and responsibilities checking duplication or service gaps	Forum facilitates the opportuntiy for agencies to engage in discussion identifying duplication or service gaps
		Review and critique contemporary self-management literature	Literature review completed and disseminated to agencies within the catchment who either provide self-management or have an interest in self management
	Develop and implement a collaborative planning approach to the development and implementation of self-management interventions across the catchment	Develop an action plan for the provision of self-management interventions using the HARP Chronic Disease model as a foundation for further work	Action plan in place
		Link the activities and workplans of the Health Promotion, Service Coordination and EliCD cross agency working groups	Links between IHP, Service Coordination, HARP and EliCD are evident and reflect a collaborative and coordinated approach to planning
	Support member agencies to embed self-management interventions within the locally agreed PPPS framework	Employ a mentoring approach between agencies and include the activities as a key element of the Service Coordination plan	An increase in the number of agencies able to demonstrate self-management interventions embedded in the agreed PPPS framework

Goal	Objective	Strategy	Planned Impact
3. *Successful implementation of the Better Access to Services (BATS) framework by progressing common practices, processes, protocols and systems for initial contact, initial needs identification, referral, assessment and care planning by member agencies, particularly as it relates to people with chronic disease.*	Strengthen local implementation of common practices, protocols, processes and systems Apply a disease specific focus to service coordination system development across the catchment	Review status of PPPS implementation across member agencies Determine referral processess and systems currently used across member agencies, exploring the viability of a Single Entry Point (SEP) Review local protocols and check for congruence with statewide PPPS Identify barriers to implementation Support member agencies to improve the uptake and application of PPPS implementation through education and orientation to tools Use learnings from the local HARP program around service coordination system development to inform the development of a disease specific approach to establishing consistent systems in the EliCD program Link the activities and workplans of the Health Promotion, Service Coordination and EliCD cross agency working groups Embed CDM service coordination system development within a Bendigo Loddon Service Coordination Agreement	Reported improved client access to appropriate programs Inproved access for clients to sevices in an appropriate time-frame A smooth transition of clients between member agencies, specifically EliCD and HARP CDM Consistent evidenced based approach to chronic disease management
4. *Developed and defined local agreements and systems to identify clients with chronic disease who require comprehensive assessment, by working with PCP member agencies, particularly GPs.*	Identify current practices and systems used by member agencies for the identification of clients with chronic disease Apply a disease specific focus to system development of a consistent approach to comprehensive assessment	As above Gather evidence and review current literature related to comprehensive assessment tools and their application and effectiveness in similar settings	Consistent comprehensive assessment tool adopted and implemented across member agencies (those dealing with CDM)

Goal	Objective	Strategy	Planned Impact
	Identify the issues affecting the application of comprehensive assessment as it relates to GP practice	Identify and agree on the implementation of a common assessment tool across member agencies eg InterRAI Develop a process with Divisions of General Practice to seek a GP perspective and incorporate findings in future planning	Issues related to comprehesive assessment and GP practice are identified and considered in all elements of planning and application of comprehensive assessment tools. An increased number of GPs using consistent comprehensive assessment tools across the catchment
5. *Developed and defined local agreements and systems to identify clients with chronic disease who require cross-disciplinary/multi-agency (including GP) care planning, by working with PCP member agencies, particularly GPs.*	Develop a disease specific integrated service model for chronic disease management (this will extend to a broader range of chronic disease in year 3) Ensure the links between the local HARP and EIICD programs are strengthened and provide a consistent aproach to cross discipline/multi agency care planning.	Acknowledged as a key element of the EliCD program (see implementation plan) including: • System and service development • Organisational capacity building re CDM • Support and resourcing of GPs to undertake care planning Implement strategies learned from the 2005 BLPCP and HARP CDM Case Conferencing and Care Coordination Project Develop and implement a tool that will readily identify clients that require interdisciplinary care planning	Integrated care planning and case conferencing with appropriate health service providers
6. *Developed and defined local agreements and systems around initiating and coordinating care planning for people with chronic disease by working with PCP member agencies, particularly GPs.*	As above	As above recognising the importance of GP involvement in cross agency HARP EliCD reference group In conjunction with key stakeholders, plan and implement appropriate training, and provide support for service providers from a range of disciplines to build systems and resources for coordinated care planning	Local agreements and systems in place across the catchment An increase in the number of coordinated care plans for patients with chronic disease across the catchment

Goal	Objective	Strategy	Planned Impact
7. *Strengthened approaches to address disadvantage and health equality in Integrated Health Promotion initiatives, including barriers to participation such as chronic disease.*	Ensure the issues facing disadvantaged people within the catchment area are considered, and inform the planning of IHP and CDM activities and intervention	Ensure linkages between IHP and EliCD programs and local neighborhood renewal programs Conduct appropriate consultations to identify need through avenues such as Neighbourhood Renewal, Primary Care Clinics and the HARP program Ensure the needs of those people affected by the barriers of rural isolation, lack of transport and decreased mobility are identifed through consultations with relevant service providers and consumer involvement. e.g. focus groups Incorporate findings of consultations together with a review of the literature evidencing contempory practice and interventions focussed on addressing barriers to access and participation in a paper for discussion within IHP, Service Coordination and EliCD /HARP groups Build on the foundation work of the Physical Activity Group and Youth Arts Network addressing the barriers to participation	Increased access and participation in programs and activities by people who are affected by social and economic hardship, or geographical isolation

PCPs working with CHSs funded under the EliCD initiative

Goal	Objective	Strategies/Interventions	Estimated Impact
8. *Successful implementation of workforce development strategies for self-management, particularly for community health services and GPs.*	Increase the knowledge of self-management practice within the catchment Build the capacity and skills of service providers from a range of agencies and disciplines in the development and implementation of self-management models and practice Increase the number of service providers within the cathcment who utilise a self-management framework as a key intervention in chronic disease management	Develop an electronic respository of information and educational resources focussed on self-management. Develop a multi disciplinary training and development program focussed on self-management including: • Learning sets • Self paced packages • Forums • Mentoring program Identify opportunties for recruitment across agencies of personnel with key interests and expertise in self management practices	An increase in the number of service providers using evidence based self-management programs across the catchment
9. *Successful implementation of communication and marketing strategies (developed in conjunction with the Divisions of General Practice) that promote the benefits and availability of local self-management interventions to GPs.*	Enhance the awareness, understanding of, and access to local self-management programs across the PCP and the broader GP population	Develop and implement a communication and marketing plan designed to reach a range of audiences, with a particular focus on GPs	Increased awareness of local self-management programs Increased referrals by GPs to self-management programs across the catchment Increased numbers of patients participating in self-management programs across the catchment

Goal	Objective	Strategies/Interventions	Estimated Impact
10. *Improved communication and collaborative care planning (by working closely with the Divisions of General Practice) between GPs and community health services.*	Increase the uptake of collaborative care planning for patients with chronic disease Improve the systems to support collaborative care planning between agencies, service providers and GPs Ensure appropriate referral/feedback between GPs and other service providers	Development of communication plan (in conjunction with Divisions of General Practice) Identified as a key activity of EliCD implementation plan Resource the Bendigo Division of General Practice to support the development of a GP liaison role, and engage in collaborative system and model development Ensure GP input to all planning processes through involvement in HARP/EliCD cross agency reference group	Increased uptake of collaborative care planning between GPs and community health services particularly in the areas of Bendigo, Elmore and Heathcote
11. *Development and adoption of disease-specific care pathways to ensure that clients get the right care in the right place, regardless of where they enter the service system.*	Identify evidence based care pathways for patients with a diagnosis of Diabetes Increase the application of care pathways across the catchment	Gather data from a range of sources including peak bodies, national, state organisations focussed on the managment of Diabetes and the identification of practice guidelines inclusive of a range of disciplines Conduct a workshop with service providers from across the catchment to consider and agree on the implementation of a consistent care pathway for patients with Diabetes	Evidence based care pathway for patients with Diabetes identified and implemented Greater access for patients with Diabetes to the most appropriate care in the most appropriate place Reported ease of access by patients/clients utilising a range of entry points across the catchment
12. *Support for change management provided to agencies, particularly community health services, which are implementing new systems or strengthening existing systems to provide proactive care rather than reactive care for clients with chronic disease.*	Ensure that change management issues are identified and responded to in a planned and timely manner	Support the collaborative development and implementation of a comprehensive change management plan Identify and provide resources to build knowledge and confidence in proactive care	Effective change management process results in a smooth transition from existing systems to the provision of proactive care for patients/ clients with Diabetes Service providers report an increase in knowledge, confidence and application of proactive care for patients and clients with Diabetes

Goal	Objective	Strategies/Interventions	Estimated Impact
13. *Facilitation of a process for agencies to develop and implement consistent approaches to the use of decision support tools to support ICDM.*	Use an evidence based approach to identifying relevant decision support tools designed for ICDM Increase the understanding of, and access to, decision support tools across key agencies Gain agreement amongst key agencies for the use of a consistent set of decision support tools	Development of multidisciplinary evidence based clinical guidelines for the management of Diabetes Engagement of a clinical "champion" to provide education in relation to the clinical guidelines to other clinicians in the EliCD team Integrate specialist expertise into agencies across the catchment setting and create an agreed management plan	Increased application of agreed and consistent decision support tools to support the management of patients/clients with Diabetes across the catchment
14. *Dissemination of transferable change management lessons in relation to ICDM.*	Ensure all agencies involved in, or who have an interest in CDM are appropriately informed of the learnings generated from the change management experience	Identify dissemination of findings as a key element of the change management plan utilising a range of communication methodologies	Knowledge of findings shared across the partnership and beyond where appropriate Findings used to identify future planning Findings evident in local evaluation strategy
15. *Completion of the statewide evaluation tools for EliCD.*	Data collection is identifed and accepted as a key responsibility of the team and individuals	The lead agency Project Manager and Care Coordinator will be responsible for completion of the management reports, due at six monthly intervals Key workers will be responsible for Key Worker reports, due at six monthly intervals (administered in parallel with management reports) Discontinuing clients telephone surveys will be administered by the key worker as required. Data will be analysed and reported in the six monthly management reports The client survey will be administered by the Care Coordinator on admission to the program and will then be administered at six monthly	Comprehensive process in place providing data in a timely manner to state wide evaluation

Goal	Objective	Strategies/Interventions	Estimated Impact
		intervals from the date of admission Clinical indicators will be collected every twelve months (in parallel with the client survey) and in close collaboration with the clients GP. Clinical indicators for diabetes are in line with the annual cycle of care for diabetic clients	

SECTION 6

6. CLIMATE CHANGE

A substantial body of evidence has emerged on the effects of climatic change and drought on rural economies and the natural environment. As the community moves to accept the influence of altered climatic circumstances being more than 'exceptional circumstance' of a singular and unique nature, it has been recognised that continuous drought can reduce the physical and mental health of individuals, as well as the health and well-being of both families and regional and rural communities.

Problems hitherto latent may now emerge at a crisis level because of the economic and social issues that come to the forefront. These include structural changes to industry (primary, secondary and small business), community cohesion, and differing impacts on age cohorts such as older people and youth.

BLPCP's constituency is a community which is dealing with environmental and socio-economic change. The CHP is a plan about and for this community. Hence it must be flexible because of the evolving impacts of:

- Demographics
- Climate
- Cultural/social changes
- The requirement to integrate ICT tools to manage client information and service access.
- The requirement to share information between service providers electronically

BLPCP, through integrated planning and service integration, will support coordination and facilitation of training packages such as Mental Health First Aid. Drought responses will be integrated within core health promotion and service coordination roles, collaborating with primary health services, local government and other relevant sectors.

BLPCP will use a health promotion approach that recognises the social determinants and the broader community context of drought impacts. Engagement and support for community leadership in identifying strengths and needs, shaping of priorities, planning, implementation and evaluation will be vital for building sustainability of action and the resiliency of communities.

Climate change has been identified as the preferred reference for drought activities by the BLPCP Executive and IAWG. The contribution to this section has been generated from the State Wide Drought Recovery Strategy, to which partners are working. A Special Interest Group: Drought Recovery Working Group (which may operate on the basis of a Network of Interest) is being considered, structured as follows:

Rationale

Drought has been associated with:

1. Serious impacts on physical and mental health.
2. Increased unhealthy behaviours.
3. Decreased health enhancing behaviours.
4. Increased risk of injury.

1.1 Physical and mental health

- Increased risk of heart attack, stroke and social isolation.
- Decrease in exercise and commitment to staying well
- Difficulties self motivating.
- Farmers already have a higher incidence of CVD, cancer and injury.
- Farmers wait before seeking assistance.
- Stress and immune responses.
- Increased risk of depression, anxiety and suicide.

1.2. Increased unhealthy behaviours

- Increased consumption of alcohol (rural people high alcohol base).
- Linkage with suicide, domestic violence, car accidents.
- Substance abuse (prescribed or unprescribed).
- Less likely to keep up social activities, sporting and leisure activities.

1.3. Decreased health enhancing behaviours

- Lost motivation to monitor illness.
- Decreased commitment to routine assessments.
- Less commitment to exercise and diet that controls illness.
- Poorer working conditions: temperatures over 30 degrees Celsius.
- Dehydration.
- Increased dust and effects on respiratory conditions.

1.4. Increased risk of injury and accident. Heavy physical demands due to:

- Stock feeding and watering.
- Less help.
- Unfamiliarity with new ways of doing things.
- Worn machinery not replaced or maintained.
- Breakages or maintenance not attended to.
- Fatigue management - long hours, stress's.
- Family labour not familiar with machinery.

Centre for Rural and Remote Mental Health (2005).

Best practice in reducing the impacts of drought

The key message for agencies to give to farmers is that health (their own and their families) is their most important asset. There is a need to destigmatise mental health and to encourage people to monitor their own health. Participation in social activities also needs to be encouraged.

The Centre for Rural Mental Health advocates the following approaches to address the impacts of the drought:

- Provide a variety of ways to access information.
- Do not underestimate the value of social activities.
- Farm family gatherings worked well in NSW.
- Increase interagency partnerships.
- Improve access to services (e.g. visit sale yards, do farm visits, and provide drought updates).
- Do not presume males won't discuss things. Sustainable Farm Families found that both males and females would discuss, seek assistance and plan if they:
  - knew where to go
  - knew how to go about it
  - knew what was likely to happen
  - were involved in the referrals and what was written
  - were provided information that worked for them.
- Do value the strengths of community.
- Promote the protective factors that help build resilience (Evidence based mental health promotion resource Keleher & Armstrong 2005)
  - Expressing emotions and feelings
  - Good problem solving skills
  - Self-worth or self –esteem
  - Sense of belonging
  - Knowledge of available supports
  - A realistic view of the world
  - Positive interests of hobbies
  - Sense of fun/humour

Membership of the Drought Recovery Working Group

- Inglewood & Districts Health Service
- Boort District Hospital
- Northern Districts Community Health Service
- Dingee Bush Nursing Centre
- Loddon Shire
- Bendigo Community Health Service
- Loddon Neighbourhood House
- Inglewood Community Resource Centre

- Community members

- Loddon Shire counsellor
- Centacare
- VFF
- Boort Resource and Information Centre (BRIC)
- Department Victoria Communities – Womens Drought Network Facilitator

Purpose

To reduce the impacts of drought and encourage recovery for individuals, families and communities

Objectives

- To provide drought program linkage and dissemination of the information
- To convene and facilitate local training activities for the community and workforce in relation to drought
- To increase health promotion capacity in communities and organisations
- To encourage community participation
- To share resources and information
- To evaluate projects/programs and disseminate information
- To identify service gaps and identify means to address them.

Strategies

A Bendigo Loddon Climate Change Action Plan will be developed and will be inclusive of the following strategies:

1. Convene a Drought Recovery Working Group.
2. Conduct a community (service providers and community) needs assessment to identify the impact of the drought and strategies to address them.
3. Roll out workforce development workshops across the catchment according to identified needs of service providers.
4. Develop and implement Health and Well-being expos (x 4) for service providers and rural communities. The community activities must be planned and implemented with the communities and linked to the Shire of Loddon's coordination of drought response programs. (Mental Health First Aid training, Leading the Way, VicHealth HP Short Course).

Evaluation

- Member agency participation in the Drought Recovery Working Group
- Action plan that identifies service provider and community needs is implemented.
- Number of organisations that participated in the health promotion short course, Mental Health First Aid training and other needs based capacity building initiatives.
- Agency and community participation in Health and well-being expos
- Information is disseminated using a variety of mediums to member agencies to build their capacity to respond to the impacts of the drought.

Resources:

A budget inclusive of funding sources will be prepared.

Conclusion:

The CHP must continually be referenced back to what is happening in the community, to build agency capacity to predict and respond to emerging issues through an iterative process of consultation, encouragement of networks of interest, and an evidence base from data collection and analysis.

The challenge for the CHP is to balance maintaining its integrity as a forward plan so that its momentum is not lost, alongside gearing for change and the management of diversity and immediate crisis issues.

References

Centre for Rural and Remote Mental Health (CRRMH) 2005 *Wisdom from the Drought:*

A consultative conference December 2003. Orange: The University of Newcastle.

'Tackling Mental Health' Drought Initiatives 2006 -07. Dept of Human Services. General information December 2006.

Countering Drought. Manual of Creative Community Solutions. December 2006. Deakin University.