



Alfred Health

Population Health
Scoping Report 2018

Compiled by K Fallon

Inside cover

Aboriginal Acknowledgement

We acknowledge the people of the Kulin Nation who are the custodians of the land and waters, and pay our respect to Elders past and present.

Star Health Acknowledgement

This paper has been developed as a direct extension of the Star Health Integrated Health Promotion Planning 2017 – 21 Scoping Paper. Sections of this paper, in particular background data on each of the priority areas, has been utilised directly from the Star Health report with no changes other than updated data where available.

Alfred Health acknowledges and thanks Star Health for allowing the use of the above mentioned document to develop this Population Health Scoping Report.

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1. Introduction

Alfred Health is the main provider of public health services to over 778,000 people residing in the inner southeast suburbs of Melbourne and incorporates three main hospital campuses: The Alfred, Caulfield Hospital and Sandringham Hospital. The primary catchment is a highly diverse population with pockets of disadvantage, interspersed with areas of relative financial and socioeconomic advantage.

This paper draws and expands the Star Health, Integrated Health Promotion Planning 2017-21, scoping paper and Alfred Health acknowledges the use of that document as the basis for this report.

The paper includes demographic and population health data relevant to the four life stages and six priority areas outlined in the 2015-2019 Victorian Public Health and Wellbeing Plan.

Life Stages

2. Starting well
3. Resilient adolescence and youth
4. Healthy adulthood
5. Healthy and active ageing

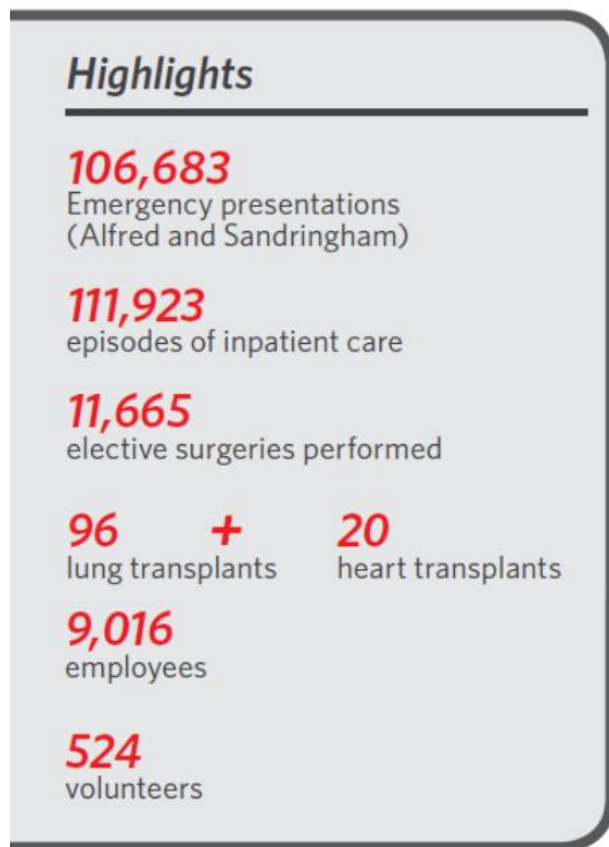
Priority areas

1. Healthier eating and active living
2. Tobacco-free living
3. Reducing harmful alcohol and drug use
4. Improving mental health
5. Preventing violence and injury
6. Improving sexual and reproductive health

Alfred Health provides a comprehensive range of health services from prevention, early intervention and primary care to complex acute and tertiary services, aged care and psychiatric services to the residents of Victoria.

2. Who are we and who do we service

2.1 About Alfred Health



Alfred Health is one of Australia's major health services, with three hospital campuses – The Alfred, Caulfield Hospital and Sandringham Hospital – as well as a ranges of community -based services.

We care for people, from children to the elderly, across Victoria. With a broad range of statewide programs, our services reach far beyond our local community of southern and Bayside Melbourne to care for Victorians.

With a growing population throughout the state, we are constantly expanding our care – in the community, in the home and in hospital. Our work is not confined to lifesaving procedures; it extends to intensive rehabilitation to help our patients regain as much function, independence and wellbeing as possible.

Three hospital campuses

The Alfred, a major tertiary referral hospital, is best known as one of Australia's busiest emergency and trauma centres and home to many statewide services including the Victorian Adult Burns Service, Heart and Lung Transplant Service, and Psychiatric Intensive Care Service. This site is also home to the Alfred Medical Research and Education Precinct.

Caulfield Hospital specialises in community services, rehabilitation, aged care and mental health. The hospital delivers many services through outpatient and community-based programs and plays a statewide role in providing rehabilitation services, which includes the Acquired Brain Injury Rehabilitation Centre.

Sandringham Hospital is community focused, providing hospital healthcare needs for the local area through emergency, paediatrics, general medicine and outpatients services. The hospital works closely with the Royal Women's Hospital onsite and local community healthcare providers.

Community services and clinics

Melbourne Sexual Health Centre has dedicated clinics for men and women, onsite testing for sexually transmitted infections and provides counselling, advice and health information.

Community Clinics meet the growing expectations of our patients for treatment in their communities or at home. We have developed numerous clinics to deliver this care, including new services such as Hope (a psychiatric program aiming to reduce suicide rates), a new drug and alcohol service.

2.2: Our catchment

Alfred Health's catchment reflects our role in the provision of tertiary, statewide and specialised health services. Our local catchment includes the local government areas of Bayside, Glen Eira, Melbourne, Port Philip, Kingston and Stonnington.

Figure 1. Alfred Health catchment with LGA boundaries and Alfred Health service sites.



3. Life Stages

3.1 Stage 1 - Starting Well (0-12 years)

3.1.1 Overview of this life-stages importance for health

The “Starting Well” years are defined within the Victorian Public Health and Wellbeing Plan 2015 – 2019 as children 0 – 12 years old. This encompasses the pre-natal period, the early years (generally 0 – 8) and the middle years of childhood (generally 8 – 12).

In recent years’ childhood, and in particular early childhood, has been identified as the critical window to influence the health and wellbeing of the community. The Marmot review of health inequalities in the UK stated that “The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing”. As a result of this the Review made ‘giving every child the best start in life’ its highest priority recommendation for reducing health inequalities, stating that ‘later interventions, although important, are considerably less effective where good early foundations are lacking’.¹

A child’s development is heavily impacted by the antenatal, family, and social environments.² A woman’s health before she becomes pregnant can affect the pregnancy and birth outcomes.³ The effects of low birth weight can also have damaging consequences that continue into adulthood.⁴ Research identifies that adults born of low birth weight have an increased risk of Type 2 diabetes, obesity, high blood pressure and metabolic and cardiovascular disease in later life.⁴

The quality of the parenting a child receives and the nature of a child’s home learning environment are the strongest influences on their development, with effects demonstrated in the areas of self-esteem, academic achievement, cognitive development and behaviour.²

The following five early childhood experiences and circumstances are defined by Moore and McDonald to have life-long negative consequences:

- Sustained poverty
- Child abuse and neglect
- Early mental health problems
- Conduct problem
- Poor health and nutrition

Protective factors within the early years include:

- Optimising parent-child relationships and home learning environments.² The attachment relationship between the infant and their primary care giver is the most important experience for an infant to help shape the developing brain.⁵
- Efforts focusing on developing children’s and younger people’s knowledge, skills, physical literacy and behaviour.
- Immunisation, breastfeeding, Maternal Child Health service use, early education services use such as kindergarten participation social competence.⁶
- School dental programs ensure that all children and young people have every opportunity to optimize oral health³

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Researchers state that the foundation for the future mental health is based on the capacity to emotionally regulate during the early weeks and months of an infant's life.⁵ Additionally, wellbeing and engagement issues that arise during middle childhood and adolescence can have a long lasting effect into adulthood.⁶

Toxic stress during the early years of a child's life has been linked to damaging brain development and is defined as physical or sexual abuse, neglect or lack of affection, parental mental illness, family violence, poverty, and lack of adequate housing.⁷

The *Picture of Australia's Children* reports that areas of work are needed to address the following findings³:

- 15% of parents were affected by mental health problems
- AN estimated 45% of 6-year-old children experienced dental decay
- Almost a quarter of children were developmentally vulnerable on one or more domains of the Australian Early Developmental Index at school entry.

The population groups highlighted by the Headline Indicators for Children's Health, Development and Wellbeing as having considerable variations in results are⁸:

Indigenous children were:

- 2-3 times as likely to die as infants or due to injury, to be born with low birth weight, or to be developmentally vulnerable at school entry.
- 5 times as likely to be born to a teenage mother.
- 8 times as likely to be the subject of a child protection substantiation.
- Between 20 – 30% less likely to meet national minimum standards for reading and numeracy.

The majority of Indigenous children in their first year of full-time schooling were developmentally on track (57% in 2012). However, they were more than twice as likely as non-Indigenous children to be developmentally vulnerable in 1 or more areas (43% and 21%, respectively). The proportion of Indigenous children who were developmentally vulnerable in 1 or more areas declined between 2009 and 2012 (from 47% to 43%).⁹

Children living in the lowest socioeconomic status areas, compared to those in the highest socioeconomic status areas, were:

- Almost twice as likely to die as infants and nearly 3 times as likely to die due to injury.
- 30% more likely to be born with low birth weight.
- 60% more likely to have dental decay.
- 70% more likely to be overweight or obese.
- More likely to be developmentally vulnerable at school entry.

3.1.2 Stage 1 Our Local Picture

Children between the ages of 0 – 14 make up 14% of the catchment population. Victorian children of the same age group make up 12.7% of the population (ABS, 2016).

Table 1: Population by Age Group 0 -14 years

Population by age group		
LGA Name	0 – 14 years	% of total population
Melbourne	9,759	7%
Port Philip	12,796	12%
Bayside	19,626	19%
Glen Eira	27,422	18%
Stonnington	13,940	12%
Kingston	28,412	18%
Total	111,955	14%
Total Victoria	788,868	12.7%

The Australian Early Development Census (AECD) found that in 2015 75.7% of Melbourne, 81.8% of Port Phillip, 88.5% of Bayside, 84.9% of Glen Eira, 85.6% of Stonnington and 84.5% of Kingston children were developmentally on track for the Physical Health and Wellbeing domain, all above the Victorian average of 80.9% except Melbourne.

The following table illustrates how healthy children are in the catchment compared to the Victorian averages, based on the Children's Headline Indicators.⁴

Table 2: Comparison Children's Headline Indicators

	Melb %	Port Phillip %	Bay- side %	Glen Eira %	Ston'n %	King'n %	Victoria %
Children with development delays/vulnerable on 1> domain 2015	22.8	14.1	10.1	14.1	11.9	13.7	19.9
Children with development delays/vulnerable on 2> domain 2015	12.2	5.9	4.3	5.6	3.7	6.3	9.9
Early childhood physical health and wellbeing – children vulnerable (2015)	10.1	5.5	3.8	5.0	5.8	5.3	7.9
Early childhood physical health and wellbeing – children at risk (2015)	13.3	12.9	7.7	10.0	7.9	10.0	11.2
Low birth weight babies (2012 – 14)	7.1	5.7	5.9	5.8	5.8	5.9	6.3
Mothers smoking during pregnancy (2012– 14)	7.3	7.0	4.3	4.7	5.7	6.8	15.0
Children immunised fully by age 1 (2015)	88.9	92.4	92.8	92.8	92.4	92	92.2

	Melb %	Port Phillip %	Bay- side %	Glen Eira %	Ston'n %	King'n %	Victoria %
Children immunised fully by age 5 (2015)	87.2	91	93.3	92.8	92.3	92.6	93

Data retrieved from Social Health Atlas of Australia 2018 (PHIDU)

The following table identified the proportions of high risk groups across the catchment.

Table 3: Proportions of High Risk Groups 0 -14 years

	Melb %	Port Phillip %	Bay- side %	Glen Eira %	Ston'n %	King'n %	Victoria %
Indigenous children 0-4 years (2016 usual resident population (URP))	3.0	4.3	6.3	8.4	6.6	9.6	11.5
Indigenous children 5-9 years (2016 URP)	2.3	3.6	9.0	8.8	6.0	8.7	11.3
Indigenous Children 10-14 years (2016 URP)	1.5	6.6	9.5	8.4	5.0	9.2	10.5
Single parent families (2016)	19.1	17.4	12.3	12.3	14.0	15.2	18.3
Low birth weight babies (2012 – 14)	7.1	5.7	5.9	5.8	5.8	5.9	6.3
Jobless families with children aged <15 years (2016)	13.6	7.1	4.9	4.8	6.2	6.6	11.0
Dwellings rented from government housing authority (2016)	4.4	4.4	2.3	0.8	2.7	1.6	2.5

Data retrieved from Social Health Atlas of Australia 2018 PHIDU

3.1.3 Stage 1 National and state strategies.

The National Strategic Framework for Child and Youth Health details five priorities¹⁰:

1. Equip children and young people with the foundations for a healthy life.
2. Support children and young people to become strong and resilient adults.
3. Ensure children and young people live in healthy and safe homes, communities and environments.
4. Children and young people have equitable access to health care services and equitable health outcomes.
5. Improve systems to optimise the health outcomes of children and young people.

The Early Years Strategic Plan: Improving outcomes for all Victorian children 2014 – 2020 aims to improve outcomes and better support all Victorian children from pregnancy up to eight years of age, with a focus across three areas¹¹:

-
1. Supporting parents and communities to give children a great start
 2. Early and sustained support for those who need it most
 3. All children benefiting from high-quality early learning

The strategic plan also details an *Early Years Outcomes Framework* to support services in their own planning, improvement and accountability.¹¹ The outcomes are identified in four key domains:

1. Being Healthy
2. Building Wellbeing
3. Learning and Developing
4. Staying Safe

Key Priority 1 of Koolin Balit, Victorian Government strategic directions for Aboriginal health 2012– 2022¹² is a healthy start to life.

The aims for this priority are to:

- Reduce the rate of Aboriginal perinatal mortality
- Decrease the percentage of Aboriginal babies with a low birthweight
- Reduce smoking in pregnancy by mothers of Aboriginal babies
- Increase breastfeeding rates for mothers of Aboriginal babies.

The actions to achieve this include:

- Increasing the number of Aboriginal mothers accessing antenatal care early in their pregnancy.
- Supporting programs that aim to improve positive lifestyle behaviour during and after pregnancy to help provide an optimum environment for the baby to grow.
- Enhancing links between programs and initiatives across departments.
- Supporting local initiatives focused on the physical and mental health and wellbeing of Aboriginal babies and their mothers before and after birth.

Key Priority 2 of Koolin Balit is Healthy Childhood.

The aims for this priority are to:

- Increase the proportion of Aboriginal children attending maternal and child health services at key age milestones.
- Reduce the proportion of Aboriginal children and young people living in households with a current daily smoker.
- Improve the oral and nutritional health of Aboriginal children and increase their physical activity.
- Improve ear health to ensure it does not provide a barrier to educational achievement.

The actions to achieve these aims include:

- Improving access to, and care pathways between, immunisation, screening, assessment and follow-up services for Aboriginal children, including those in statutory services such as out-of-home care.
- Ensuring that Victorian Aboriginal communities have access to appropriate information about healthy behaviour and lifestyles, and support in acting on that information.
- Strengthening links between programs and initiatives across departments.
- Supporting local initiatives focused on the physical and mental health and wellbeing of Aboriginal children.

3.2. Stage 2 Resilient Adolescence and Youth (12 – 25 years)

3.2.1 Why is this life stage important?

Adolescence and young adulthood is a period marked by key transition points including puberty, starting and leaving secondary school, starting work or being unemployed, negotiating romantic and sexual relationships, driving, drinking alcohol and using drugs, starting higher education and leaving home.³ Whilst definitions of the age range of adolescence and youth vary, the ages 12-25 are commonly used to denote this group.

Many of the physical, emotional and neural changes and development that occur during adolescence and young adulthood can impact on health and wellbeing. The brain continues to develop until the early 20s and improved self-control, judgement and decision-making appear late in adolescence.

Adolescence and young adulthood is a period of significant vulnerability:

- Around 1 in 4 (26%) young people aged 16-24 in Australia experience a mental disorder, with the most common disorders being anxiety disorders (15%) and substance use disorders (13%).⁹ Three-quarters of people suffering mental illness first experience symptoms between the ages of 16 and 25 years (VicHealth 2014).
- In 2013 around 1 in 5 Australian young people aged 18–24 drink alcohol at risky levels for lifetime harm.
- In 2013–14 across Australia there were around 46,500 hospitalisations of young people aged 15–24 for mental and behavioural disorders, a rate of 1,493 per 100,000 population.
- 26% of occasions of accessing homelessness services were for 18-24 year olds.⁹

Groups that have higher vulnerability for poor outcomes include Indigenous youth, young people with low socioeconomic status backgrounds and/or poor academic performance. Other vulnerable groups include youths with disability or other long-term physical or mental health conditions, youths in the child protection and youth justice systems, and those experiencing homelessness.⁹

Data indicates high levels of health risk amongst Indigenous young people in Victoria¹²:

- Almost half (43 per cent) of Victorian Aboriginal people aged 15–24 years are current smokers, which is more than double the rate of the general population for that age group (19 per cent).
- Excessive alcohol consumption accounts for the greatest proportion of the burden of disease and injury for young Aboriginal males (aged 15–34 years) nationally and the second highest for young Aboriginal females. Rates of short-term risky drinking are at their highest in the 18–24 age group.
- Rates of illicit drug use for young people are higher among Aboriginal than non-Aboriginal Victorians.
- Young Aboriginal people report racism, bullying and discrimination within schools and other settings, which is likely to impede their wellbeing and their educational engagement and retention.
- The rate of emergency department presentations for self-harm for Aboriginal people in Victoria in 2009–10 was three times the rate for non-Aboriginal people, with 70 per cent of self-harm presentations being in the 15–17-year age group.

The risk and protective factors for wellbeing in children and young people have been mapped by Communities That Care across four domains: community, family, school and peer/individual.¹³

Risk factors predictive of higher levels of school drop-out, depression/anxiety, youth violence, antisocial behaviour, and alcohol and drug abuse are outlined in table 4 below:

Table 4: Care Domains and Risk Factors

Domains	Risk factors
Community Risk Factors	<ul style="list-style-type: none"> • Perceived availability of drugs • Community laws and norms favourable to drug use and crime • Low neighbourhood attachment • Community disorganisation • Transitions and mobility • Extreme economic deprivation
Family Risk Factors	<ul style="list-style-type: none"> • Family history of problem behaviour • Family management problems • Family conflict • Favourable parental attitudes and involvement in the problem behaviour
School Risk Factors	<ul style="list-style-type: none"> • Academic failure beginning in late primary school • Low commitment to school
Peer/Individual Risk Factors	<ul style="list-style-type: none"> • Early and persistent antisocial behaviour • Rebelliousness • Friends who engage in problem behaviour • Early initiation of the problem behaviour • Constitutional factors

3.2.2 Stage 2 Our Local Picture

Children and young adults between the ages of 15 – 24 make up 15% of the catchment population. Victorian's of the same age group make up 13.2% of the population (ABS, 2016).

Table 5: Population 15-24 years

Population by age group		
LGA Name	15 - 24 years	% of total population
Melbourne	43,704	30%
Port Philip	10,590	10%
Bayside	11,954	12%
Glen Eira	19,103	13%
Stonnington	15,713	14%
Kingston	18,358	12%
Total	119,422	15%
Total Victoria	822,788	13.2%

Demographics of this age group are detailed in the table below

Table 6: Demographics 15-24 years

	Melb %	Port Phillip %	Bay- side %	Glen Eira %	Ston'n %	King'n %	Victoria %
'Learning or earning' (2016)	86.6	84.6	91.7	91.1	89.8	89.6	86.2
Children 15 years and under in jobless families (2016)	10.7	5.9	3.9	4.2	5.3	6.0	10.5
Estimated number of children 2-17 years who are obese (2014 – 15) *modelled estimates	7.6	5.5	4.8	5.5	4.8	6.4	7.6
Estimated number of children 2-17 years with adequate fruit and vegetable intake (2014 – 15) *modelled estimates	68.8	65.5	72.2	65	69.6	64.9	64
People who left school below year 10 (2016 URD) *ASR/1000	8.9	12.6	14.1	15.4	11.0	22.8	26
Full time participation in Secondary School at age 16 (2016 URP)	64.6	88.5	92.3	91.9	90.1	90.3	86.1

3.2.3 Stage 2 National, state and local strategies. (to be completed post AH forum 6 April 2018)

The National Strategic Framework for Child and Youth Health outlines 5 strategic priorities, with 27 objectives and 64 actions. The strategic priorities are:

- Equip children and young people with foundations for a healthy life.
- Support children and young people to become strong and resilient adults.
- Ensure children and young people live in healthy and safe homes, communities and environments.
- Children and young people have equitable access to health care services and equitable health outcomes.
- Improve systems to optimise health outcomes

The Victorian Public Health and Wellbeing Plan 2015 – 19 outlines the importance of this life-stage for wellbeing, and outlines a number of strategic directions impact this age group across the six priorities listed in the plan. Schools are highlighted as healthy settings. The statewide Healthy Together "Achievement Program" for schools is one way in which this is supported by the Victorian Government. The whole of organisation framework outlined in the Achievement Program addresses eight areas: alcohol and other drug use, safe environments, sun protection, tobacco control, mental health and wellbeing, physical activity, healthy eating and oral health, and sexual health and wellbeing (www.achievementprogram.healthytogether.vic.gov.au).

VicHealth has prioritised young people's mental wellbeing in its Mental Wellbeing Strategy 2015-19. The strategy prioritised building resilience and social connection. It aims to target environments where young people live, work, learn, play and build relationships with one another.¹⁴ Key Priority 3 of Koolin Balit, Victorian Government strategic directions for Aboriginal health 2012– 2022¹² is healthy transition to adulthood.

The aims for this priority are to:

- Reduce the take-up of high-risk behaviours such as smoking, excessive alcohol consumption and use of illicit drugs

- Reduce the rate of young Aboriginal people with sexually transmitted diseases
- Reduce the rate of presentations of young Aboriginal people to emergency departments for injury and self-harm.
- Improve access to mental health services earlier for young Aboriginal people.

The actions to achieve this include:

- Supporting initiatives that promote healthy lifestyles and reduce risks.
- Supporting initiatives that strengthen young Aboriginal people's connection to community, culture, positive social norms and healthy behaviours.
- Improving early identification, referral and access to clinical and support services.
- Supporting local initiatives focused on the physical and mental health and wellbeing of young Aboriginal people.

3.3. Stage 3 Healthy Adulthood

3.3.1 Overview of this life-stage's importance for health

The Victorian Public Health and Wellbeing Plan 2015-19 notes that adulthood is a time of major life transitions, which can include: establishing or ending intimate relationships, the birth of children, changes in housing, employment, income and physical and mental capacity, and the death of parents, family members or partners.¹⁵

The AIHW classifies adults aged 25-64 as being of 'working age'. As the nature of the health issues people face changes significantly during this period, Australia's health 2014 presented a summary of the health issues faced by working-age people in two cohorts: 25-44 year olds and 45-64 year olds.

25-44 year olds

25-44 years olds tend to have good health. 90% rated their health as excellent, very good or good in the Australian Health Survey 2011-12. Long-term health conditions are less common in this group. However, issues worth noting include:¹⁶

- 10% report having a disability, and 67% of these had a disability that restricts their employment participation.
- 13% of women and 10% of men in this group have high or very high level of psychological distress.
- Mood problems such as depression affected 12% of this age group
- 15% have back pain, back problems or disc disorders

Key behavioural risk factors for chronic conditions are common in this age group. In the 2011-12 AHS:

- 96% did not meet the recommended levels of fruit and vegetable consumption
- 60% of men and 70% of women were sedentary or have low levels of physical activity
- 70% of men and 49% of women were overweight or obese
- 20% were daily smokers
- 61% of men and 43% of women had consumed alcohol at short-term risk levels (more than 6 standard drinks in a single episode)
- 14% of men and 10% of women regularly consumed alcohol at more than 4 standard drinks a day (long-term risk levels)

The leading causes of death in this age group are suicide, drug overdoses and transport accidents.¹⁶

45-64 years olds

Poor health and disability are more common in this older age group.¹⁶

- 23% report having a disability, and 69% of these had a disability that restricts their employment participation
- 45-64 years olds are 1.7 times more likely to rate their health as fair or poor than 25-44 year olds
- Levels of psychological distress are similar to those in 25-44 year olds, mood disorders affect 14% of 45-64 year olds
- Back pain affects 20%
- 73% of 45-64 year olds are overweight or obese

Cancer and coronary heart disease are the leading cause of death in both men and women in this age Group.¹⁶

Employment

Employment is recognised as a major determinant of the health of the working age population, whilst health also has a major impact on employment status. Australians who are in good health are more likely to participate in the labour force, whilst those who are not employed may experience poorer health. Across Australia 79% of 25-44 year olds were employed according to the 2011 census. 71% of men and 38% of women worked full time. 71% of 45-64 year olds were employed in 2011.¹⁶

Indigenous health

Indigenous Australians continue to have lower life expectancy, higher rates of chronic and preventable illnesses, poorer self-reported health, and a higher likelihood of being hospitalised than non-Indigenous Australians. There are many dimensions to the poorer health status of Indigenous Australians compared with other Australians and a complex range of factors are behind these differences. These include:

- Differences in the social determinants of health, including lower levels of education, employment, income and poorer quality housing, on average, compared with non-Indigenous Australians
- Differences in behavioural and biomedical risk factors such as higher rates of smoking and risky alcohol consumption, lack of exercise, and higher rates of high blood pressure for Indigenous Australians
- The greater difficulty that Indigenous people have in accessing affordable and culturally appropriate health services that are in close proximity.

The impacts of these factors are demonstrated in a range of health indicators including:

- Nearly 4 in 10 (39%) Indigenous Australians aged 15 and over reported their health status as 'excellent' or 'very good' in 2012-13—a decrease from 44% in 2008 and 43% in 2004-05. A further 37% reported their health as 'good', and 24% as 'fair' or 'poor' in 2012-13. Adjusting for differences in age structure, 29% of Indigenous Australians rated their health as 'fair' or 'poor', which was more than double the non-Indigenous rate of 14%.
- In 2012-13, 36% of Indigenous Australians (an estimated 228,000 people) had some form of disability. Based on age-standardised rates of 44% and 29%, this is 1.5 times the rate experienced by non-Indigenous Australians. Indigenous Australians were twice as likely to have a severe or profound form of disability (with age-standardised rates of 7.9% and 3.9%, respectively).
- In 2012-13, two-thirds (67%) of Indigenous people reported at least one chronic health condition, with 33% reporting three or more. The proportion of Indigenous people reporting at least one health condition was similar to that of non-Indigenous people.

3.3.2 Stage 3 What's the local picture

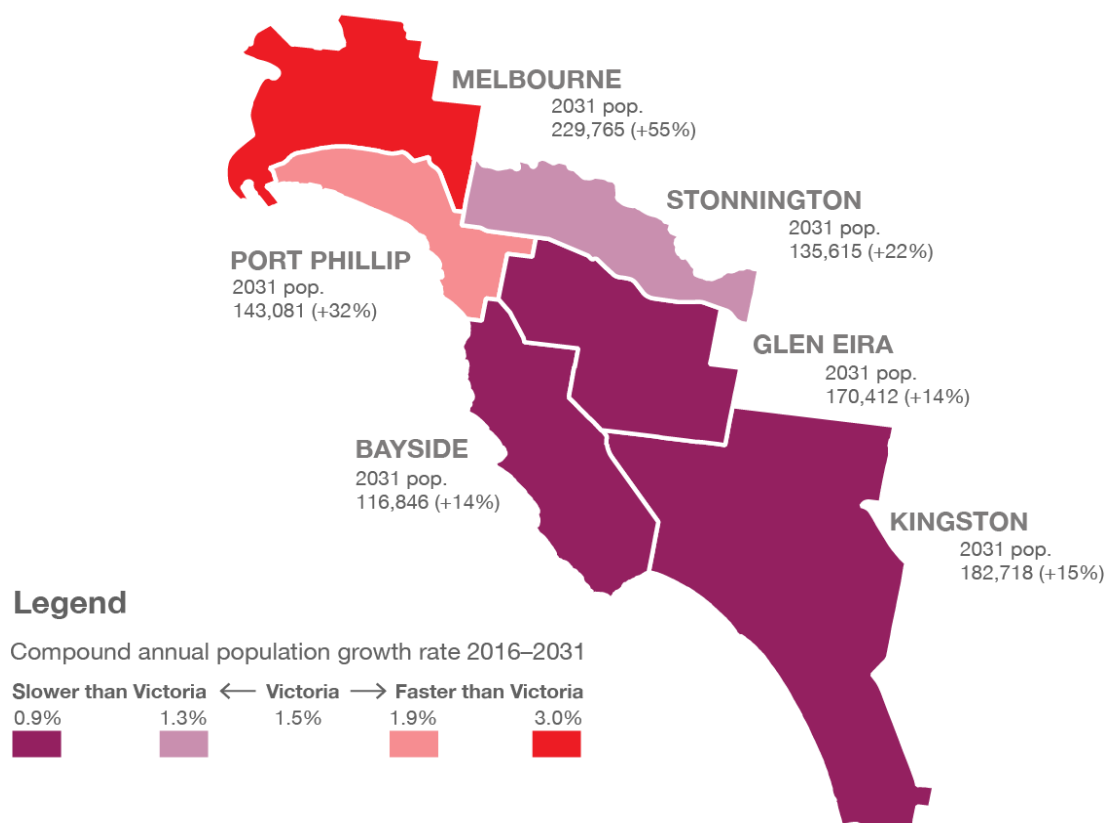
There is some variation across the catchment between the two age groups with Melbourne and Port Philip having the highest percentage in the 25 – 44 year olds and Bayside having the highest percentage in the 45 – 64-year-old group.

Table 7: Comparison Populations 25-44 years and 45-64 years

Population by age group				
LGA Name	25 – 44 year olds	% of total population	45 – 64 year olds	% of total population
Melbourne	64,976	44%	19,614	13%
Port Philip	47,636	44%	25,138	23%
Bayside	22,480	22%	29,529	29%
Glen Eira	45,287	30%	35,359	24%
Stonnington	41,918	38%	23,538	21%
Kingston	45,269	28%	40,427	25%
Total	267,566	34%	173,650	22%
Total Victoria	1,797,219	29.08%	1,489,745	24.1%

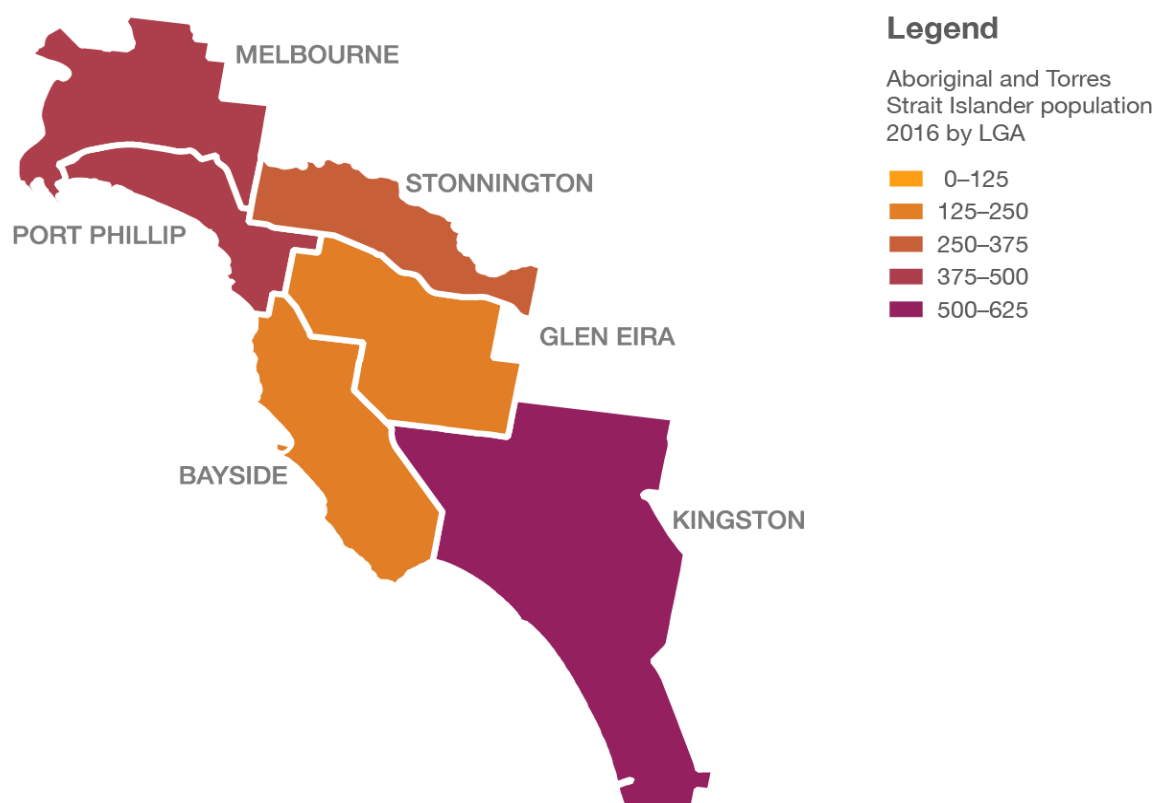
Population growth data below shows the predicted growth across all areas in relation to Victorian average growth rates.

Figure 2: Predicted Growth Across Catchment

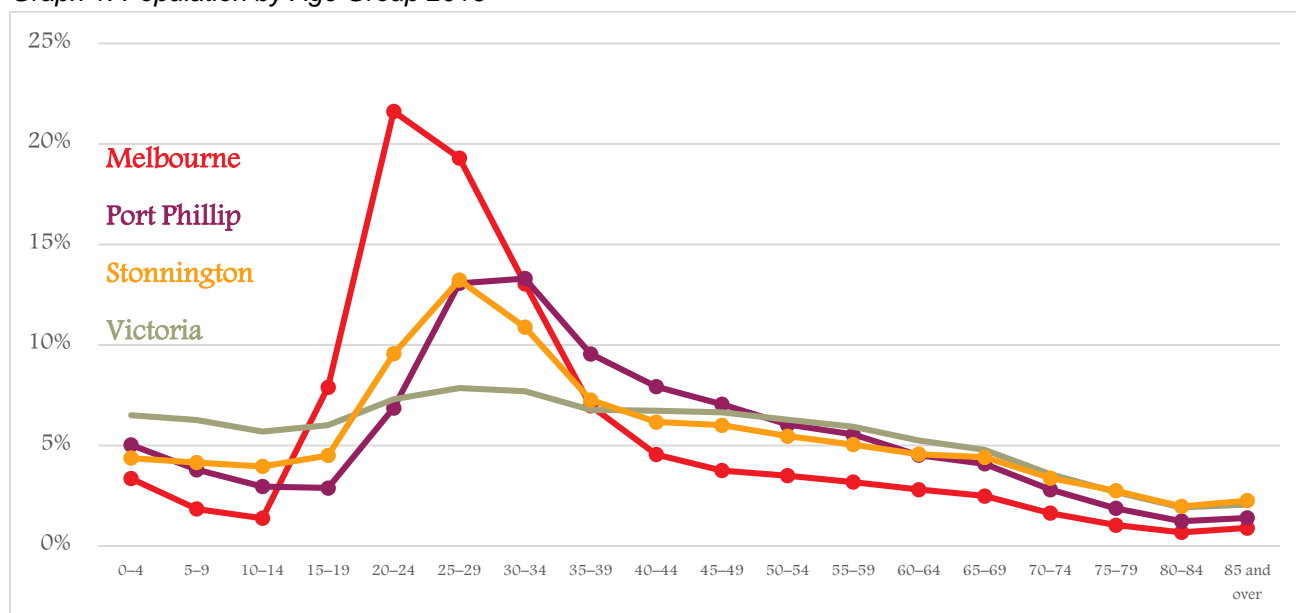


Source Australian Bureau of Statistics ERP for 2016
Department of Environment, Land, Water and Planning Victoria in Future 2016 (2031 forecast data)

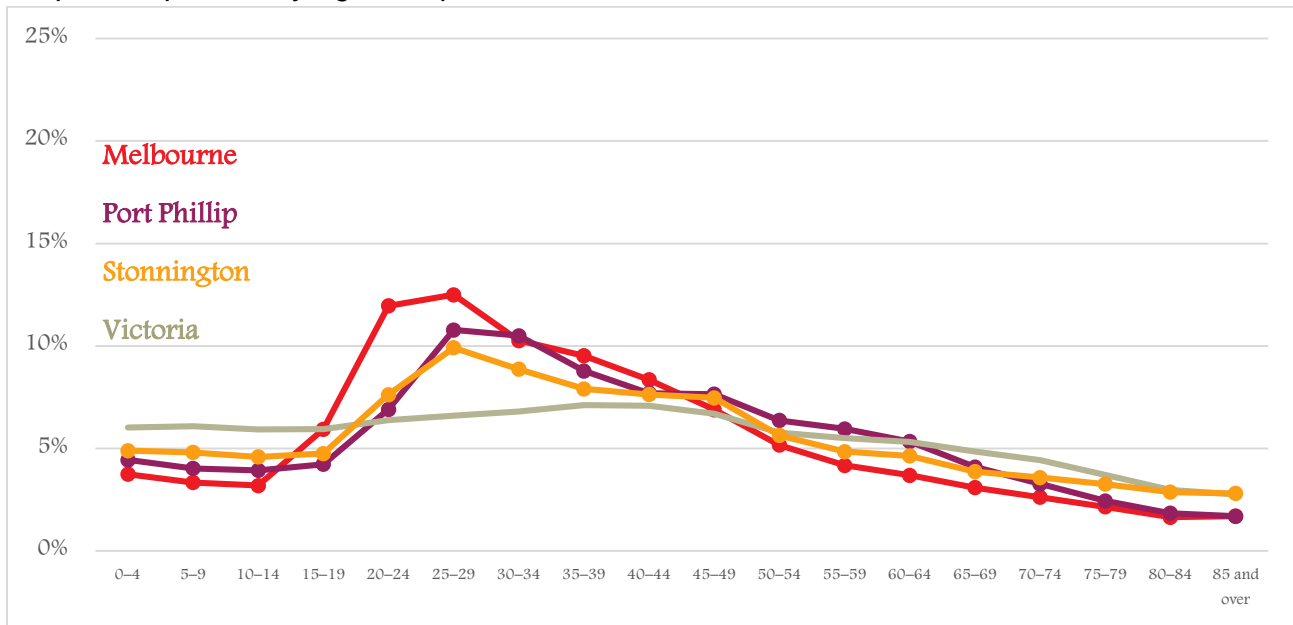
Figure 3: Aboriginal and Torres Strait Islander population



Graph 1: Population by Age Group 2016



Graph 2: Population by Age Group 2016



Sources:

Australian Bureau of Statistics ERP for 2016

Department of Environment, Land, Water and Planning *Victoria in Future 2016* (2031 forecast data)

The age profile of the South Eastern part of the catchment (Bayside, Glen Eira and Kingston) is similar to that of Victoria as a whole, both in current and forecast years.

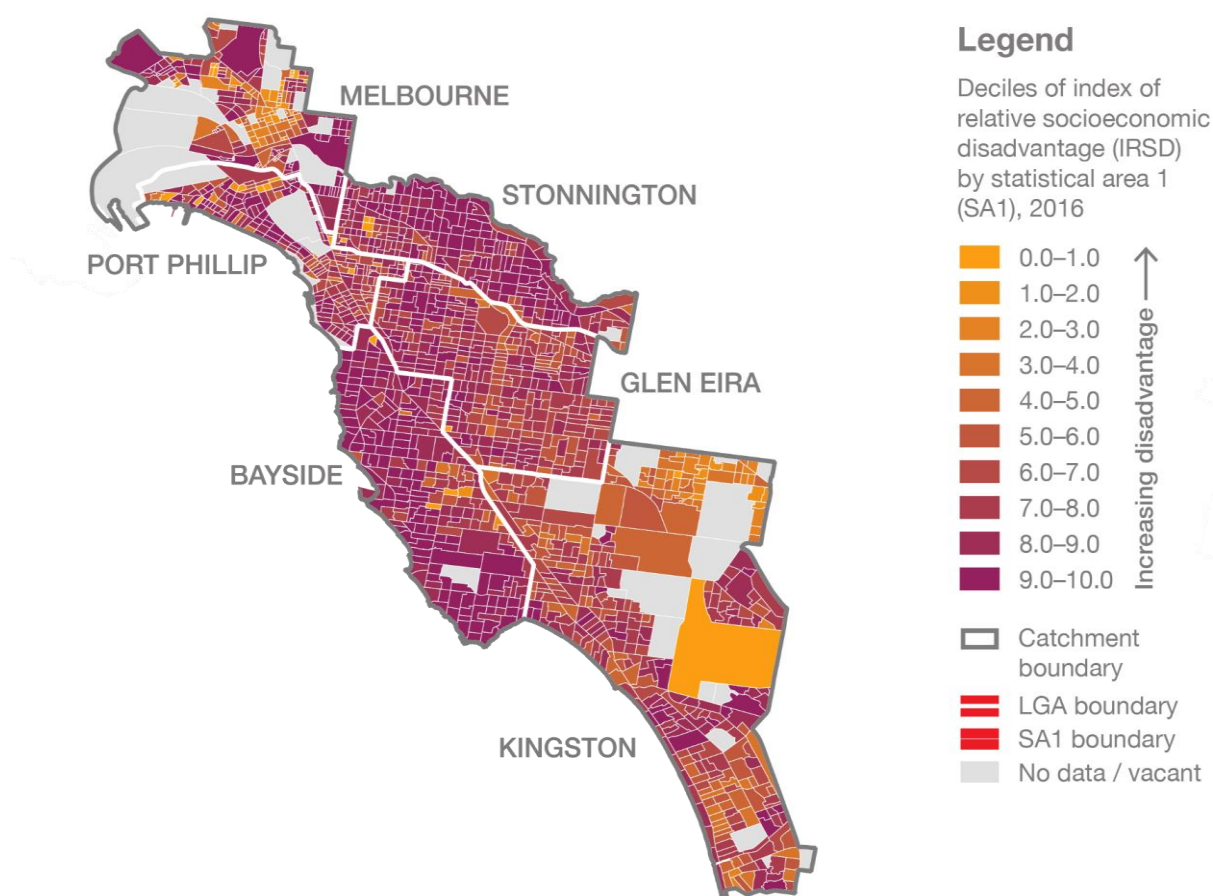
Melbourne, Port Phillip and Stonnington, however, have a significantly larger proportion of their population in the 20–35 year old age groups. Though to 2031, this will flow through into the 35–50 year old age groups.

An understanding of the distribution of disadvantaged communities is important in planning population based health services as there is a well demonstrated gradient in the prevalence of health risk factors and disadvantage.

Disadvantaged communities have higher prevalence of smoking, obesity, low exercise, poor diet (fruit and vegetable), but have lower prevalence of problem alcohol use. Overall, the Alfred Health catchment has a low level of disadvantage. However, when viewed at a finer level of detail, pockets of disadvantage are apparent in parts of the catchment, including: inner Melbourne, some parts of Stonnington, Port Phillip and Bayside, and many parts of Kingston.

Many of these low socioeconomic areas contain large proportions of public housing. (NOTE: most vacant areas correspond to industrial/commercial zones or parkland/reserves.)

Figure 4: Socioeconomic profile (deciles of index of relative socioeconomic disadvantage, 2011)



Source:

Australian Bureau of Statistics 2033.0.55.001 - Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia, 2016 (Released at 11.30am (Canberra time) 27 March 2018)

3.3.3 Stage 3 National and state wide strategies

Unlike other population groups, strategies that specifically target the health of adults of working age are rare. The Victorian Population Health and Wellbeing Plan 2015-19 recommends a life-course approach to promoting health and wellbeing. The 6 priorities of the plan are all relevant to adults. Efforts directed towards these priorities have been outlined in the relevant topic fact-sheets. The plan recommends place-based and person centred approaches to promoting health.

Place-based approaches that are relevant to working age adults include:

- Healthy workplaces – for example through the Achievement Program for workplaces (see below)
- Communities
- Liveable neighbourhoods

Person-centered approaches include:

- Person-centered health services
- Empowerment and education

The Achievement Program for workplaces is a Victorian Government initiative based on the World Health Organisation's Healthy Workplaces Model. The Healthy Workplaces Framework incorporates four elements: healthy culture, healthy physical environment, healthy community connections, and health and wellbeing opportunities. The program's benchmarks cover smoking, physical activity, mental health and wellbeing, healthy

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eating and alcohol. Local services are able to register to provide support to workplaces in their local area (as well as schools and early childhood services) in becoming a health promoting setting.

Koolin Balti, Victorian Government strategic directions for Aboriginal health 2012–2022¹² includes a range of health promotion objectives for adults under the addressing risk factors priority.

The aims under this priority are to:

- Reduce the proportion of Aboriginal adults who are smokers.
- Reduce the proportion of Aboriginal adults who are obese.
- Reduce the rate of emergency department presentations due to alcohol consumption among Aboriginal people.
- Reduce the proportion of Aboriginal Victorians drinking at risky and high-risk levels.
- Reduce the prevalence of oral diseases, including tooth decay and gum disease, among Aboriginal adults.

Actions to achieve these aims include:

- Supporting the implementation of planned, evidence-based health promotion initiatives in partnership with Aboriginal communities and local government in relation to smoking and other risk factors.
- Improving Aboriginal people's access to culturally relevant information about healthy behaviour and lifestyles in relation to smoking and other risk factors, and improving support to act on that information.
- Identifying and developing ways to address health issues that are impacting specifically on Aboriginal men and Aboriginal women.
- Supporting initiatives that foster emotional wellbeing within Aboriginal communities and promote individual and community resilience.
- Strengthening service delivery and links across services and programs.
- Supporting local initiatives focused on physical and mental health promotion for Aboriginal people.

3.4. Stage 4 - Healthy and Active Ageing

3.4.1 Overview of this life-stage's importance for health

The World Health Organization's World Report on Ageing and Health (2015)¹⁷ defines healthy ageing as "the process of developing and maintaining the functional ability that enables well-being in older age".

The Victorian Public Health and Wellbeing Plan 2015-19³ outlines the important role that low intensity and low cost interventions focused on wellness can play in achieving improvements in wellbeing and morale for older adults. Participating in leisure, social, cultural and spiritual activities with family or in the community enables older adults to continue to use their skills, enjoy respect and esteem, and to maintain or establish supportive and caring relationships. The VPHWP outlines key transition points for older adults, including changes in employment circumstances, taking on a grandparent or carer role, ceasing driving, deterioration of mental or physical health and the impact on carers, death of partners or family members and changes in housing circumstances.

Older Victorians now account for an increasing share of the population. For population health status reporting, 'older' is conventionally defined as people aged 65 and older, based on the original qualifying age for the Age Pension. People are living longer: at 65 years of age Victorian males can expect to live another 19.2 years and females 22.1 years.

The Australian Institute of Health and Welfare (2014) outline two key challenges associated with Australia's over-65 population

- A rapidly growing group of 'old' (85 and over) people who have a range of typical age-related health problems (for example, arthritis, dementia and cancer)
- A younger cohort entering the '65 and over' age bracket with a larger burden of lifestyle-related diseases (for example, type 2 diabetes) than previous generations.

Some of the key health challenges associated with an ageing population include:

- Increased risk of many health conditions, disability and dependency. Lifetime prevalence of arthritis was 52%, 18% for osteoporosis, 18% for cancer and 22% for heart disease.
- Falls often result in fractures or other serious injuries and are common among older adults. In Victoria there were about 45,000 hospitalisations, or about 900 per week, for injuries due to falls for older people in 2011–12. Older women sustained about twice the number of hospitalised fall injuries than men, and the rate of fall injuries increased with age in both sexes.
- In 2011 an estimated 1.3% of Australians had dementia – about 72,000 Victorians of all ages. The prevalence of dementia increases with age from 3% of 65–74 year olds to 30% of those aged 85 years and older. Females are more likely to develop dementia than males.
- Older adults are more vulnerable to heatwaves, particularly those living alone in private residences.
- Older Victorians are at greater risk of social isolation than younger adults. Older adults were half as likely to speak to 10 or more people in a day as 18–24 year olds. Compared with those aged 55–64 years, older adults were about one-third less likely to speak to this number of people.
- The OECD reported that one-third of older Australians in 2012 were relatively poor.
- Over a quarter of Australians aged 50 years and older in 2014 indicated that they had experienced some form of age discrimination on at least one occasion in the workplace in the preceding two years.
- In 2011–12, 49% of Victorians aged 65 years and older did sufficient physical activity for health benefit, with males 21% more likely to meet the guideline. One in 10 older adults was completely sedentary.

Victoria's Aboriginal population is young, however the rate of increase in the Aboriginal population aged over 55 years is three times the rate in the non-Aboriginal population. The need to strengthen responses for older Aboriginals in Victoria was recognised in the Koolin Balit plan (Department of Health 2012) which made caring for older a priority.

3.4.2 Stage 4 What is the local picture

There is again a spread of distribution across the catchment with some local areas Bayside (19%) and Kingston (17%) having a higher than Victorian average (15%) number of people over 65 years residing in the catchment. Conversely Melbourne (7%) and Port Phillip (11%) have a lower than Victoria average number.

Table 8: Population Over 65 years

Population by age group		
LGA Name	Over 65 years	% of total population
Melbourne	9,986	7%
Port Philip	12,398	11%
Bayside	29,529	19%
Glen Eira	21,841	15%
Stonnington	16,497	15%
Kingston	26,512	17%
Total	106,382	14%
Total Victoria	929,214	15%

Indigenous populations in the >65 age group are low across the catchment with estimated numbers outlined below. Stonnington are noted to have the lowest representation (0.03%).

Table 9: Indigenous Population >65 years

	Melb	Port Phillip	Bay-side	Glen Eira	Ston'n	King'n	Victoria
Indigenous Status, 65 years and over (URP 2016) % of total persons >65 years	18 (0.2%)	23 (0.2%)	16 (0.1%)	20 (0.1%)	5 (0.03%)	41 (0.2%)	2,518 (0.3%)

Age related demographics across the catchment, variation can again be seen across the various local government areas in regards to age and disability profile.

Table 10: Aged Related Demographics

	Melb	Port Phillip	Bay-side	Glen Eira	Ston'n	King'n	Victoria
	%	%	%	%	%	%	%
Aged pensioners as a total of >65 age group (2016)	39.6	50.7	42.9%	56.2	39.0	69.0	69.5
Disability Support pensions (16 – 64 yrs) 2016	1.9	4.0	2.6	2.9	2.3	4.1	4.9
Unpaid assistance to people with a disability >15 yrs.(2016)	5.5	8.7	12.5	11.6	9.5	11.7	11.6
People with profound or severe disability in long term accommodation >65 years (2016)	14.4	18.1	17.4	21.3	16.6	19.0	19.4
People with profound or severe disability living in community >65 years (2016)	9.8	13.3	11.1	15.8	12.8	15.1	14.9

3.4.3 Stage 4 National and state wide strategies

The Victorian Department of Health & Human Services (2016) has integrated a range of discrete healthy ageing programs (which focus on specific issues in specific settings) into one broader healthy ageing approach.

Features of this new approach include:

- Healthy ageing advisers: a small number of healthy ageing advisers have been appointed across the state. The positions will focus on organisational change, workforce development and partnerships to maximise sustainability and impact.
- Healthy Ageing Online Network (HANet): an online, interactive network for health professionals and service providers to work together, share information and resources, and discuss best practice strategies to support Victorians as they get older.
- Well for Life: The Well for Life toolkit is a resource to educate and support management and staff working with older people in a variety of settings.

Key Priority 2 of Koolin Balit is Caring for older people.

The aims for this priority is to:

- Enable all older Aboriginal people to access the information, support and culturally responsive services that will maximise their health and wellbeing

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The actions to achieve these aims include:

- Improving access to a wide range of high-quality culturally responsive services for older Aboriginal people
- Improving coordination of the range of services for older Aboriginal people
- Supporting local initiatives focused on the physical and mental health and wellbeing of older Aboriginal people.

4. Priority Areas

4.1. Priority 1. Healthier Eating and Active Living

4.1.1 Overview of the issue

Healthier eating

The food and beverages we eat and drink play an important role in our overall health and wellbeing. The conditions often affected by our diet include coronary heart disease, stroke, high blood pressure, atherosclerosis, some forms of cancer, type 2 diabetes, dental caries, gall bladder disease and nutritional anaemias.¹⁸

Minimal consumption of discretionary foods—foods and drinks not necessary to provide the nutrients the body needs, and often high in saturated fats, sugars, salt and/or alcohol—and sufficient consumption of fruit and vegetables (recommended intake of 2 and 5–6 serves per day, respectively) are good indicators of a healthy diet:

- In 2014–15 in Australia, nearly one in two (49.8%) adults met the Australian Dietary Guidelines for recommended daily serves of fruit (2 per day), while 7.0% met the guidelines for serves of vegetables (5 per day). Only one in twenty (5.1%) adults met both guidelines¹⁹.
- Discretionary foods contributed 35% of energy intake for Australian adults, and 39% for children and young people aged 2–18 in 2011–12.²⁰

Active living

Regular physical activity is widely considered a means to protect against a range of poor health outcomes including cardiovascular disease, hypertension, type 2 diabetes, osteoporosis, musculoskeletal complaints, obesity, some cancers and poor mental health.

- In 2014–15, 55.5% of 18–64 year olds participated in sufficient physical activity in the last week (more than 150 minutes of moderate physical activity or more than 75 minutes of vigorous physical activity, or an equivalent combination of both, including walking). Nearly one in three (29.7%) were insufficiently active (less than 150 minutes in the last week) while 14.8% were inactive (no exercise in the last week) (ABS 2015). The proportion of the population inactive or insufficiently active increased with age in 2014–15, from 40% for those aged 18–24 to 59% for those aged 65 and over.
- Among children and young people aged 5–17 years in 2011–12, 80% did not meet physical activity recommendations on all 7 days of the week. Rates increased from 64% for those aged 5–8 to 94% for those aged 15–17.¹⁹

Increasing participation in physical activity and reducing time spent sitting can deliver a number of benefits (VicHealth 2012a):

- Promote health and prevent the onset of disease
- Improve individuals' self-confidence and number of social connections
- Improve the wellbeing of local workforces and their productivity through less absenteeism
- Reduce local traffic congestion, especially when walking or cycling replaces car trips

- Generate economic benefits for businesses in the area (e.g. sporting events)
- Contribute to safer communities (e.g. more pedestrians on the streets at night)

Health impacts

10.5 per cent of Australia's burden of disease is due to dietary risks, 8.5 per cent is due to high body mass (excess weight for height) and 4.6 per cent is due to physical inactivity. 22% of the diabetes national burden and 79 per cent of the coronary heart disease burden is due to dietary risks.¹⁷

Poor diet and inadequate physical activity are the main factors influencing overweight and obesity.

- In 2014–15, 63% of adults in Australia were overweight or obese—35% were overweight and 28% were obese.
- One in 4 children aged 5–17 (27%) were overweight or obese.
- Overweight and obesity was greater among men (71%) than women (56%), and increased with age from 39% of people aged 18–24 to 74% for those aged 65–74.
- Adults living in the lowest socioeconomic areas were more likely to be overweight or obese than those in the highest socioeconomic areas (66% compared with 58%).²⁰

The combination of overweight or obesity, poor dietary intake and/or insufficient physical activity further increases the risk of chronic disease. In 2011–12, most adults who were overweight or obese were also inactive or insufficiently active, and/or had inadequate fruit and vegetable consumption. Almost one-third (31%) of adults had all three risk factors. This increased to over half (54%) for those with diabetes and 42% for those with cardiovascular disease.²⁰

Poor diet and consumption of sugar-sweetened drinks are also important contributors to poor oral health.

Indigenous health

Data reported in The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015²¹ provides the following information in relation to obesity, physical activity and diet for Indigenous Australians:

Obesity

Across Australia, in 2012–13, 10.2% of Indigenous children aged 2–14 were obese; Indigenous children were significantly more likely than non-Indigenous children (6.5%) to be obese (1.6 times as likely). Almost 2 in 5 (37%) Indigenous people aged 15 and over were obese in 2012–13. They were 1.6 times as likely as their non-Indigenous counterparts to be obese (based on age-standardised rates).

Physical Activity

In 2012–13, among Indigenous children aged 2–4 living in non-remote areas:

- 82% met the physical activity recommendation for children in this age group of at least 3 hours of activity each day in the 3 days prior to interview
- an average of 6.6 hours per day was spent on physical activity, which was similar to the non-Indigenous average of 6.2 hours per day
- there was no difference between boys and girls in the proportion who met the recommendation or the average amount of time spent being physically active.

In 2012–13, among Indigenous children aged 5–17 in non-remote areas:

- almost half (48%) met the physical activity recommendation—this was significantly higher than the proportion for non-Indigenous children (35%)

- an average of 2 hours per day was spent on physical activity, which was more than the average for non-Indigenous children (1.6 hours)
- boys were more likely than girls to meet the recommendation (54% compared with 41%) and spent more time being physically active per day (2.2 compared with 1.7 hours).

In 2012–13, among Indigenous adults in non-remote areas:

- about 3 in 5 (61%) reported that they had been sedentary or had exercised at low intensity in the week before the survey
- almost 3 in 10 (29%) had exercised at moderate intensity
- 1 in 10 (10%) had exercised at high intensity

Fruit and vegetable consumption

In 2012–13, among Indigenous children aged 2 to 14:

- 85% did not consume an adequate amount of fruit and/or vegetables daily
- More were likely to consume an adequate amount of fruit daily (78%) than an adequate amount of vegetables daily (16%)
- 9% consumed no fruit or less than 1 serve daily, and 10% consumed no vegetables or less than 1 serve daily
- There was no significant difference between remote and non-remote areas in the proportion who consumed an adequate amount of fruit and vegetables (13% and 15%, respectively).

In 2012–13, among Indigenous people aged 15 and over:

- 97% did not consume an adequate amount of fruit and/or vegetables daily
- 42% consumed an adequate amount of fruit and 5% consumed an adequate amount of vegetables
- Adequate daily fruit and vegetable intake was highest among those aged 55 and over (6%)
- Those living in remote areas were significantly more likely to consume an adequate amount of fruit daily than those in non-remote areas (46% compared with 41%), and significantly less likely to consume an adequate amount of vegetables daily (3% compared with 5%)

Indigenous people aged 15 and over were significantly less likely than non-Indigenous people to consume an adequate amount of fruit daily (0.9 times as likely, based on age-standardised rates) and an adequate amount of vegetables daily (0.8 times as likely, based on age-standardised rates)

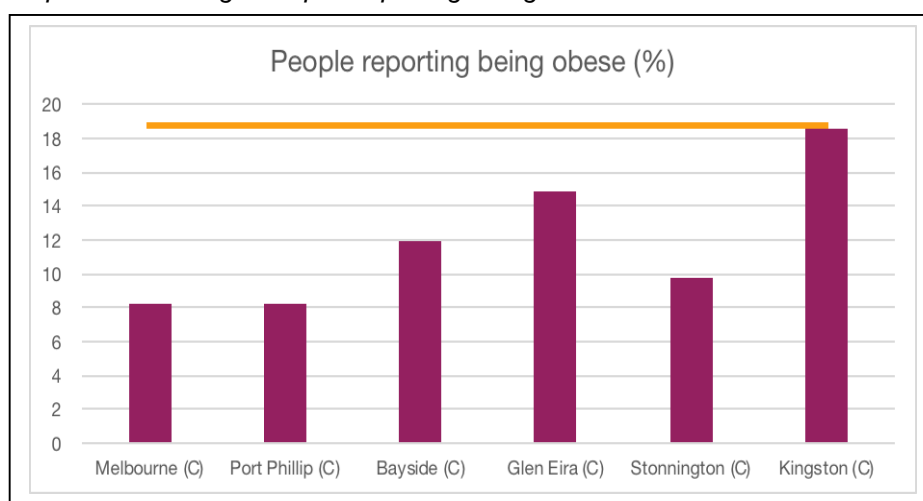
4.1.2 What's the local picture?

Inactivity at the workplace across all areas except Kingston was well above the Victorian average, with the daily intake of sugar sweetened beverages on average falling below the Victorian average except for Kingston.

Table 11: Comparison Healthier Eating and Active Living

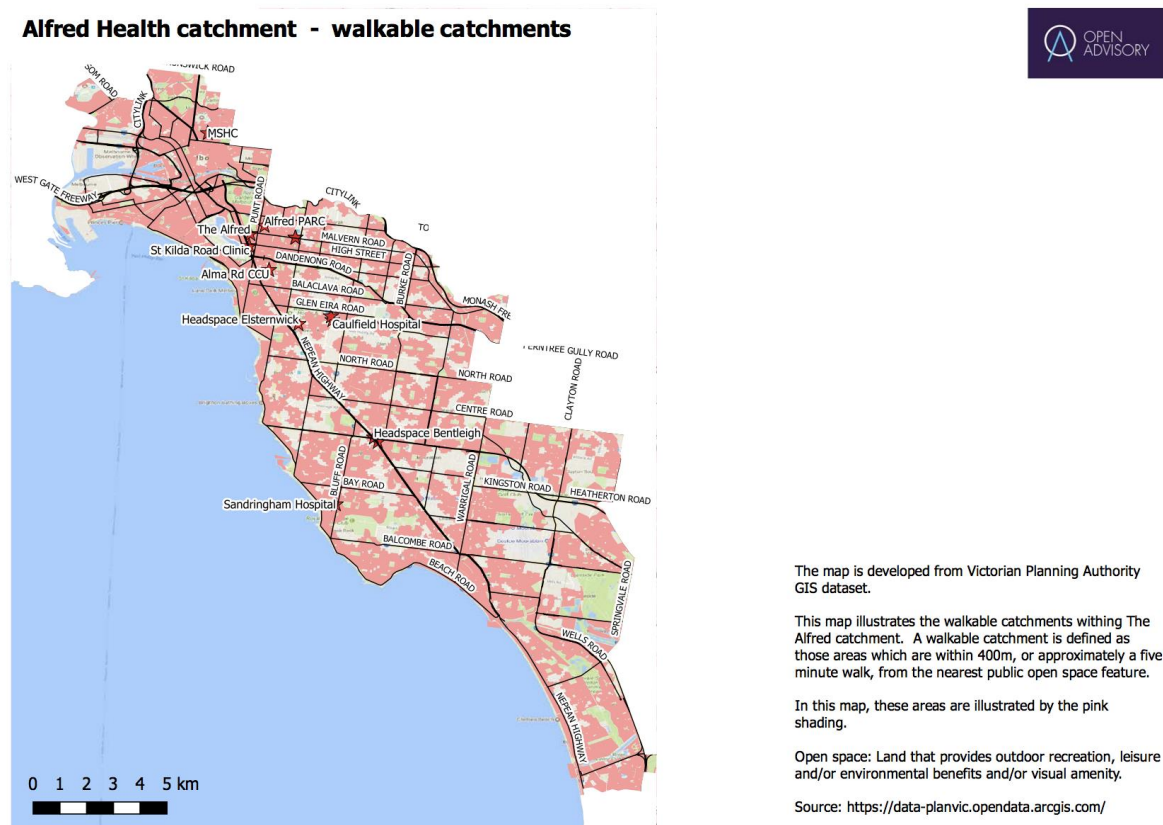
	Melb %	Port Phillip %	Bay- side %	Glen Eira %	Ston'n %	King'n %	Victoria %
Compliance with fruit and vegetable consumption guidelines (2014)	5.6	5.6	5.8	3.2	6.1	2.8	4.4
Proportion of adult population eating take away meals or snacks >1 to <3 times /week (2014)	10.6	5.0	6.1	5.9	4.9	11.7	9.9
Prevalence of daily intake sugar sweetened beverages	6.9	5.3	3.1	5.6	8.9	11.4	11.2
Proportion of adults reporting sedentary behaviour (2014)	2.5	1.2	0.6	1.6	1.2	3.5	3.6
Proportion of Adults who reported being mostly inactive at work (2016)	77.2	64.3	60.5	60.7	70.2	43.5	49.6
Proportion of adults who were overweight or obese	35.8	38.2	42.3	44.9	40.8	56.8	50.0

Graph 3: Percentage People Reporting Being Obese



Availability of green spaces or walkable catchments is shown in the figure below. The largest residential areas not within 400m of public open space is around the Caulfield area.

Figure 5: Available Green Spaces and Walkable Catchments



4.1.3 National and state wide strategies.

Strategic directions for the healthier eating and active living priority of the Victorian Public Health and Wellbeing Plan 2015-19³ include:

- Promote consumption of healthy, sustainable and safe food consistent with the Australian dietary guidelines. Support healthy food choices to be the easier choices for all Victorians by working across the entire food system.
- Encourage and support people to be as physically active as often as possible throughout their lives. Strategies may include active transport (such as walking or cycling to work), neighbourhood design that promotes activity and social connectedness and participation in sport and recreation.
- Encourage interaction with nature in Victoria's parks and open spaces.

VicHealth's Action Agenda for Health Promotion 2016-19²² includes promoting healthy eating and encouraging regular physical activity as two of its five strategic imperatives.

The VicHealth priorities for promoting healthy eating are to:

- Make water the drink of choice, instead of sugar-sweetened beverages.
- Generate public awareness and debate about reducing salt consumption, and driving policy and food industry action.
- Build partnerships for healthier food environments, with an emphasis on sporting stadiums and facilities.

The VicHealth priorities for encouraging regular physical activity are to:

- Advance gender equality in sport.
- Create more opportunities for less active Victorians to participate in sport.

- Enable and encourage walking, active travel and recreation.

Key Priority 5 of Koolin Balit, Victorian Government strategic directions for Aboriginal health 2012–2022¹² aims to address risk factors for poor health amongst the Victorian Aboriginal population.

This includes aims to:

- Reduce the proportion of Aboriginal adults who are obese.
- Reduce the prevalence of oral diseases, including tooth decay and gum disease, among Aboriginal adults.

The actions to achieve this include:

- Supporting the implementation of planned, evidence-based health promotion initiatives in partnership with Aboriginal communities and local government in relation to smoking and other risk factors.
- Improving Aboriginal people's access to culturally relevant information about healthy behaviour and lifestyles in relation to smoking and other risk factors, and improving support to act on that information.

4.2. Priority 2. Tobacco-Free Living

4.2.1 Overview of the issue

Tobacco smoking is a leading risk factor for chronic disease and death, including many types of cancer, respiratory disease and heart disease. In Australia in 2011, it was estimated that 80% of lung cancer burden and 75% of chronic obstructive pulmonary disease burden were attributable to tobacco smoking. In total smoking was responsible for 11% of the total burden of disease and injury. In Victoria alone, approximately 4,000 lives are lost and an estimated \$2.4 billion is incurred in direct healthcare costs and lost productivity annually.²³

Compared to international levels, the rate of daily smoking amongst Australians is low at 13% of people aged 14 and over. The recent fall in smoking prevalence is strongly influenced by fewer young people taking up smoking and fewer adults aged up to 45 smoking daily. People aged 45–54 smoke on average the largest number of cigarettes compared with other age groups (about 130 per week).²⁴

The Victorian Public Health and Wellbeing Plan 2015-2019 asserts that the decline in smoking prevalence is not equal across the state. People living in disadvantaged population groups, Aboriginal people, people with psychological distress, people with a low education level, people living rurally, unemployed people or low income earners have been highlighted as having a greater smoking prevalence in Victoria.³ In Victoria, one in eight women smoke while pregnant.³

Second-hand smoke is highlighted by VicHealth to affect children, infants and unborn babies, with associated health risks including sudden infant death syndrome (SIDS), lower birth weight, and lung and respiratory infections.²⁵

In 2012–13, among Indigenous people aged 15 and over in Australia²¹:

- 44% reported being current smokers—42% smoked daily and 2% smoked weekly or less than weekly
- 20% were ex-smokers
- 36% had never smoked
- Rates of daily smoking were significantly higher among those living in remote areas compared with non-remote areas (50% and 39%, respectively) (ABS 2014d).
- Indigenous people aged 15 and over were 2.6 times as likely as their non-Indigenous counterparts to smoke daily in 2012–13, based on age-standardised rates
- Indigenous young people were significantly more likely than non-Indigenous young people to smoke:
 - those aged 15–17 were 4.5 times as likely to smoke daily (18% and 4%, respectively)
 - those aged 18–24 were 2.7 times as likely to smoke daily (43% and 16%)

In 2011 across Australia Indigenous mothers were 4 times as likely as non-Indigenous mothers to have smoked during pregnancy (age-standardised rates of 49% and 12%).²¹

Cancer Council Victoria (2013) has identified factors that encourage smoking and factors that are barriers to quitting amongst disadvantaged population groups:

Table 12: Enablers to Smoking and Barriers to Quitting

Enablers to smoking	Barriers to quitting
Parental and peer smoking	Lack of support for quitting amongst family and friends
Financial pressure	Lower levels of confidence in their ability to quit
Unemployment	Unsupportive service environment
Nicotine exposure during and before childhood	Perceived cost of nicotine replacement therapy (NRT)
Limited opportunities for enjoyment and recreation	Perceived role of smoking in relieving boredom
Specific marketing by tobacco companies	Using smoking as a form of self-medication
Higher density of tobacco outlets	Unaware or misconceptions about cessation services
Living in unsafe environments	Heavier nicotine dependence
Daily Stress	
Inadequate or unstable housing	

4.2.2 What's the local picture?

Table 13: Smoking and Alcohol Risks

	Melb %	Port Phillip %	Bay- side %	Glen Eira %	Ston'n %	King'n %	Victoria %
Smoking status – current smoker (2014)	8.0	7.4	9.5	18.2	7.9	13.9	13.1
Frequency of smoking - daily	7.1	4.4	5.6	13.2	4.2	8.2	9.8
Lifetime risk of alcohol-related harm, by risk category – increased lifetime risk (2014)	69.1	68.8	72.7	65.6	76.7	61.7	59.2

All areas are at higher than state average for lifetime risk in relation to alcohol consumption. Glen Eira is above the state average for all measures. The data for smoking prevalence by LGA are reported from the

Victorian Population Health Survey 2014. Except for Glen Eira, all areas have reported a decline in smoking rates from the previous survey in 2008

4.2.3 National and state wide strategies.

The Victorian Public Health and Wellbeing Plan 2015-19 has tobacco-free living as a priority. Strategic directions for the priority include:

- Continue to further reduce smoking rates with the ultimate aim of achieving a tobacco-free Victoria.
- Continue legislative and non-legislative approaches to tobacco reform, such as smoking cessation support, in order to continue the downward trend in smoking rates.
- Focus on smoking cessation support at the community level (via hospitals, GPs and community health services).
- Target smoking cessation measures for those groups with disproportionately high smoking prevalence, particularly Aboriginal Victorians.

Quit Victoria are the lead agency in tobacco control at the state-wide level. Their 2016-2019 strategic plan recognises five priority areas to end the tobacco toll:²⁶

- Create a tobacco-free environment
- Prevent new nicotine addictions
- Support people who smoke to become tobacco-free
- Enhance and tailor efforts for priority populations
- Lead and facilitate Victoria's efforts to end the tobacco toll

Preventing tobacco use is one of VicHealth's strategic priorities. Priority actions for VicHealth over the period 2016-19 are to:

- Support Quit Victoria's delivery of impactful anti-smoking campaigns
- Fund critical cessation services for smokers
- Trial innovative approaches in settings and groups where smoking rates remain high.

Key Priority 5 of Koolin Balit, Victorian Government strategic directions for Aboriginal health 2012– 2022¹² aims to address risk factors for poor health amongst the Victorian Aboriginal population.

This includes aims to:

- Reduce the proportion of Aboriginal adults who are smokers.

The actions to achieve this include:

- Supporting the implementation of planned, evidence-based health promotion initiatives in partnership with Aboriginal communities and local government in relation to smoking and other risk factors.
- Improving Aboriginal people's access to culturally relevant information about healthy behaviour and lifestyles in relation to smoking and other risk factors, and improving support to act on that information.

4.3. Priority 3. Reducing Harmful Alcohol and Drug Use

4.3.1 Overview of the issue

The health and social impacts of harmful and hazardous consumption of alcohol and drugs are considerable. One study estimated costs including crime, loss of life, loss of production, road accidents and health care are about \$24.6 billion per year in Australia.

Alcohol

Alcohol use was responsible for 5.1% of the total burden of disease and injury in Australia in 2011. It was responsible for 28% of the burden due to road traffic injuries (motor vehicle occupants), 24% of the burden due to chronic liver disease, 23% of the burden due to suicide and self-inflicted injuries, and 19% of the burden due to stroke.

In 2011-12, 1 in 5 (20%) Australians aged 18 and over drank more than 2 standard drinks per day on average, 29% of men were drinking at this level compared to 10% of women.²⁷ People in their 40s are more likely to drink at lifetime risky levels than any other age group.

9% of adult's drink at risky or high-risk levels for short-term harm at least weekly (drinking more than four standard drinks on a single occasion). 15% of Victorian 18–24 year olds drink alcohol at risky or high-risk levels for short-term harm at least weekly.²⁸

The risk factors contributing to higher alcohol and drug use include: remoteness, socioeconomic disadvantage, indigenous status, unemployment, sexual orientation, mental illness and high levels of psychological distress (AIHW, 2014). Cultural and social attitudes about alcohol have been identified as influential on the reduction of alcohol use particularly in teenage populations.²⁹

Illicit drugs

Illicit drugs can mean any drug that is prohibited from manufacture, sale or possession in Australia or the misuse of pharmaceuticals or other psychoactive substances, legal or illegal in a harmful way.²⁷ Illicit drug use contributed to 1.8% of the total burden of disease and injury in Australia in 2011. This included the impact of injecting drug use and cocaine, opioid, amphetamine and cannabis dependence.

14% of people in Victoria used an illicit drug in the previous 12 months. The highest proportion of recent drug use across all subpopulations in Australia was for people who identified as homosexual/bisexual (35.7%) and significantly higher illicit drug use is also seen among single people without children, those with lower socioeconomic status, and those who mainly speak English at home and among Indigenous Australians.³⁰

Health impacts can include: poisoning, infective endocarditis, mental illness, self-harm, suicide and death. Injecting can result in blood-borne viruses, including HIV/AIDS, hepatitis C and hepatitis B. Drugs are a contributor to crime, road accidents and violent injury and there have been increased hospitalisations due to antidepressant, antipsychotic and pain-killer drug misuse. Families can be affected by drug use including through domestic violence, child abuse, assaults and crime.

Individual behaviour, family, school, community, peers and attitudes towards the behaviour can all have a positive or negative influence on whether a young person uses illicit drugs.

In 2012–13 in Australia, almost 3 in 4 (72%) Indigenous people aged 15 and over reported that they had consumed alcohol in the previous 12 months, 13% had consumed alcohol 12 or more months ago, and 14% indicated they had never consumed alcohol. Indigenous people aged 15 and over were:²¹

- Significantly less likely than non-Indigenous people to report having consumed alcohol in the previous 12 months (age-standardised rates of 71% and 81%, respectively).
- Significantly more likely than non-Indigenous people to report they had never consumed alcohol (age-standardised rates of 13% and 11%).

In 2012–13, among Indigenous people aged 15 and over:²¹

- 54% reported consuming more than 4 standard drinks on a single occasion in the previous year,
- Exceeding the guidelines for single occasion risk
- Males were significantly more likely to report drinking at these levels than females (64% compared with 44%)
- The proportion of 15–17 year olds exceeding the guidelines for single occasion risk was 24%; this rose to 68% among those aged 18–24 and then fell with age to 31% among those 55 and over
- Those living in non-remote areas (55%) were significantly more likely to consume alcohol at single occasion risk levels than those living in remote areas (48%)
- 18% reported drinking more than 2 standard drinks per day on average over the previous year, exceeding the guidelines for lifetime risk

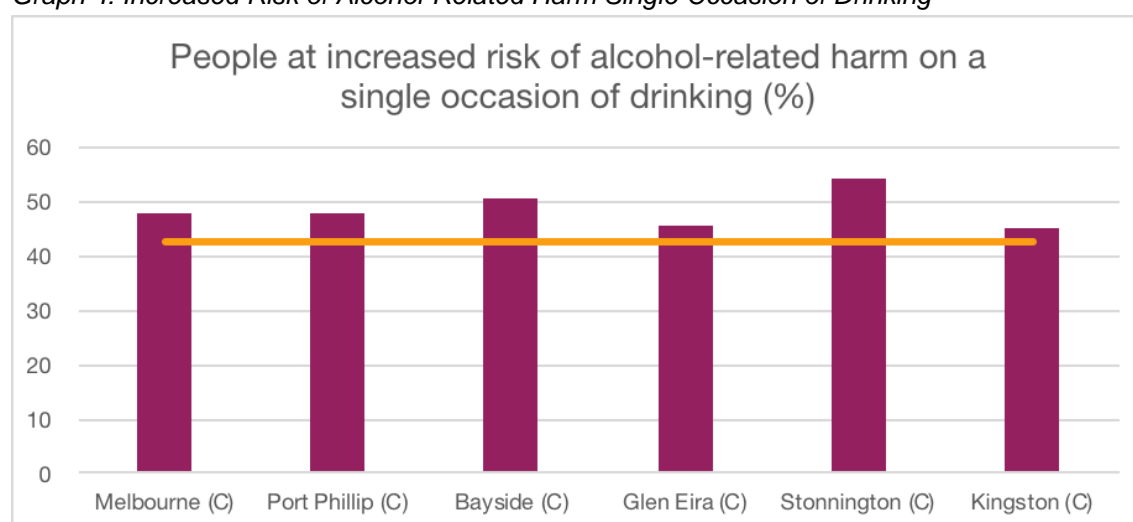
- Males (26%) were significantly more likely than females (10%) to have exceeded these guidelines
- Lifetime risky alcohol consumption peaked at 23% among those aged 35–44 and was lowest among those aged 15–17 (3%) and those aged 55 and over (16%); these differences were statistically significant
- There was no statistically significant difference between the proportion of people living in non-remote (18%) and remote (17%) areas who drank at levels exceeding the guidelines for lifetime risk
- Age-standardised rates of lifetime risky alcohol consumption were not significantly different from those for non-Indigenous people (18% and 19%, respectively)

4.3.2 What's the local picture?

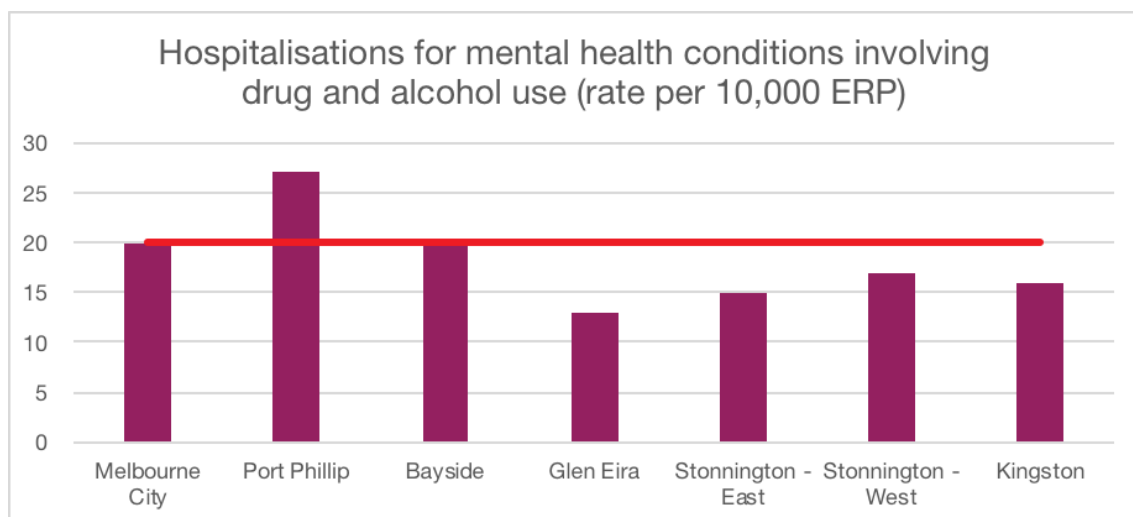
Table 14: Lifetime Risk of Alcohol-Related Harm

	Melb %	Port Phillip %	Bay- side %	Glen Eira %	Ston'n %	King'n %	Victoria %
Lifetime risk of alcohol-related harm, by risk category – increased lifetime risk (2014)	69.1	68.8	72.7	65.6	76.7	61.7	59.2

Graph 4: Increased Risk of Alcohol-Related Harm Single Occasion of Drinking



Graph 5: Hospitalisations for Mental Health Conditions involving Drug and Alcohol Use



The population of the Alfred Health catchment generally reports more positively on key determinants of health than Victoria overall.

Exceptions are high rates of smoking reported in Glen Eira, hospitalisations for mental health conditions involving drug and alcohol use in Port Phillip, and risk of alcohol-related harm which is higher than the Victorian average across the entire Alfred Health catchment.

4.3.3 National and state wide strategies.

The Victorian Public Health and Wellbeing Plan 2015-2019³ outlines a number of strategic directions for the priority of reducing harmful alcohol and drug use:

- Develop strategies across government to reduce the risk of short-term harms due to the misuse of alcohol, and minimise the chronic health problems associated with long term unhealthy drinking patterns.
- Address the impacts of illicit drug use, including through the Ice action plan.
- Develop a Victorian pharmaceutical misuse strategy and education program to reduce problematic use of prescription medicines.
- Improve alcohol and drug education in schools and access to early intervention services for people with alcohol and drug use issues.

Preventing harm from alcohol is one of the five strategic imperatives in VicHealth's Action Agenda for Health Promotion 2016-19.²² VicHealth have adopted three priorities to address this over the period 2016-19:

- De-normalise risky drinking in high-risk groups, settings and subcultures.
- Better understand how we can reduce harm from alcohol in vulnerable groups.
- Increase public, government and industry support for evidence-based alcohol control policies and practices.

The draft National Drug Strategy 2016-25³¹, released for consultation in 2015, outlined three pillars of harm minimisation:

- Demand reduction
- Supply reduction
- Hard reduction

Key Priority 3 of Koolin Balit, Victorian Government strategic directions for Aboriginal health 2012– 2022¹² aims to ensure a healthy transition to adulthood. This includes an aim to reduce the take-up of high-risk behaviours such as smoking, excessive alcohol consumption and use of illicit drugs.

The Koori alcohol action plan 2010-2020³² outlines four broad aims, each with a set of actions:

1. To reduce the harms associated with alcohol use by building on and developing partnerships that strengthen Aboriginal communities.
2. To address access-to-alcohol issues, focusing on young people, with the aim of preventing and reducing alcohol-related harms.
3. To improve the provision of information and understanding regarding alcohol and associated harms to encourage safer consumption and patterns of use.
4. To improve responses and services with a focus on proactive and partnership approaches.

The Alcohol and Drug Foundation delivers a range of programs that aim to reduce harm from alcohol and drug use. A major focus is the Good Sports program, which aims to make community sporting clubs healthier, safer and more family-friendly places. The program supports clubs to introduce practices and policies that create a culture of responsible drinking within the club.³³

Harm Reduction Victoria has a range of programs including Pharmacotherapy, Advocacy, Mediation and Support (PAMS) service, health promotion workshops in safer using, vein care and blood borne viruses, brief interventions, peer networker project, overdose prevention education workshops and DanceWize, a harm reduction, peer education outreach program.

4.4. Priority 4. Improving Mental Health

4.4.1 Overview of the issue

Mental health is a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her. ³⁴ The term 'mental disorder' describes a spectrum of conditions that can vary in both severity and duration.²³ The most common mental disorders are depression, anxiety and substance use disorders, with less common, and often more severe disorders identified as schizophrenia, schizoaffective disorder and bipolar disorder.²⁴

In Australia, mental disorders are one of the top burdens of disease.³⁵ Survey data reveals that 45% of the Australian population have experienced a mental disorder during their lifetime (16-85 year olds). In Victoria, it is estimated that 1.2 million (one in five) people experience mental illness each year. ³⁶

The impacts of mental health disorders are summarised by the Australian Institute of Health and Welfare²⁴ as:

- High levels of psychological distress
- Impairment in people's ability to care for themselves
- Feeling socially isolated and lonely
- Suicidality

Australians with affective (mood) disorders can experience severe levels of interference with life, including home responsibilities, work or study, close relationships and social life.³⁷

The World Health Organisation defined the following groups as more susceptible to experiencing mental health disorders: members of households living in poverty, people with chronic health conditions, infants and children exposed to maltreatment and neglect, adolescents first exposed to substance use, indigenous populations, older people, people experiencing discrimination and human rights violations, lesbian, gay, bisexual, and transgender persons, prisoners, and people exposed to conflict, natural disasters or other humanitarian emergencies.³⁸

Women have increased risk to their mental health during pregnancy and following child birth³⁶ and also experience disproportionate rates of domestic violence and sexual abuse, significantly impacting their mental health status. ³⁶ Men are less likely to seek treatment or other support for a mental health problem and are over three times more likely to die by suicide than women.

Research identifies that 75 per cent of mental illnesses begin before the age of 25³⁹, highlighting the need for early intervention. Current data from the Australian Child and Adolescent Survey of Mental Health and Wellbeing reveals 560,000 Australian children and adolescents have experienced a mental health disorder in the 12 months prior to the survey.⁴⁰

The Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders (2008), outlined a comprehensive list of protective and risk factors for mental health and wellbeing.

Table 15: Protective and Risk factors for Mental Health

Protective factors for mental health and wellbeing	Risk factors for mental health and wellbeing
<ul style="list-style-type: none"> • Arts and cultural engagement • Childhood: positive early childhood experiences, maternal attachment • Cultural identity • Diversity: welcomed/shared/ valued • Education: accessible • Environments: safe • Empathy • Empowerment and self determination • Family: resilience, parenting competence, positive relationship with parents and/ or other family members • Food: accessible, quality • Housing: affordable, accessible • Income: safe, accessible employment and work conditions • Personal resilience and social skills • Physical health • Respect • Social participation: supportive relationships, involvement in group and community activity and networks • Sport and Recreation: participation and access • Transport: accessible and affordable • Services: accessible quality health and social services • Spirituality 	<ul style="list-style-type: none"> • Alcohol and drugs: access and abuse • Disadvantage: social and economic • Displacement: refugee and asylum-seeker status • Disability • Discrimination and stigma • Education: lack of access • Environments: unsafe, overcrowded, poorly resourced • Family: fragmentation, dysfunction and child neglect, post-natal depression • Food: inadequate and inaccessible • Genetics • Homelessness • Isolation and exclusion: social and geographic • Natural and human-made disasters • Peer rejection • Political repression • Physical illness • Physical inactivity • Poverty: social and economic • Racism • Unemployment: poor employment conditions and insecure employment • Violence: interpersonal, intimate and collective; war and torture • Work: stress and strain

Indigenous health

Poor mental health and suicide is one of the leading contributors to the burden of disease for Aboriginal people of all ages. In 2008, 22 per cent of Aboriginal Victorians reported high or very high levels of psychological distress, about twice that of non-Aboriginal Victorians.

In 2012–13 across Australia, Indigenous adults were significantly more likely to have high or very high levels of psychological distress than non-Indigenous adults 2.7 times as likely, based on age- standardised rates). Among Indigenous adults:

- 30% had high or very high levels of psychological distress in the 4 weeks prior to the survey.
- Women had significantly higher rates of high or very high levels of psychological distress (36%) than men (24%).
- Those in non-remote areas were significantly more likely to have high or very high levels of psychological distress than those in remote areas (32% compared with 24%).²¹

The Australian Institute of Health and Welfare's 2014 report, Determinants of wellbeing for Indigenous Australians⁴¹ found that compared with non-Indigenous Australians, Indigenous people tended to report lower levels of emotional wellbeing but they were more likely to say that they were satisfied with life.

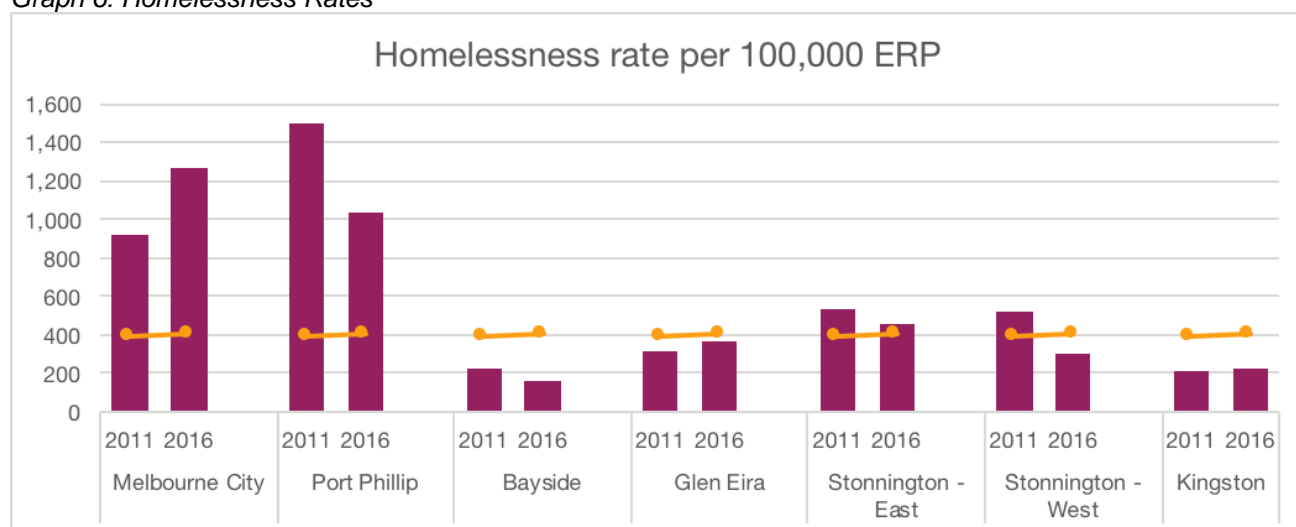
4.4.2 What's the local picture?

Table 15: Proportions of Psychological Distress and Anxiety or Depression

	Melb %	Port Phillip %	Bay- side %	Glen Eira %	Ston'n %	King'n %	Victoria %
Proportion of adult population with high or very high psychological distress (2014)	11.1	12.6	3.6	8.9	8.4	12.9	12.6
Anxiety or depression (2014)	27.1	31.2	15.9	25.5	25.2	21.7	24.2

The proportion of population experiencing high to very high psychological distress are higher than the state average in Kingston (12.9%) with Port Phillip being the next highest and equal to the state average of 12.6%. High rates of homelessness in Melbourne and Port Phillip are notes with a general swing away from Port Phillip to Melbourne areas over time. This reflects the recent observable increase in homelessness in the city centre.

Graph 6: Homelessness Rates



4.4.3 National and state wide strategies.

The Victorian Public Health and Wellbeing Plan 2015–2019 has highlighted the following 5 strategic directions to reduce the burden of mental health illnesses:

- Enhance and develop strategies to promote mental health and wellbeing and reduce current high levels of psychological distress. Examples include addressing discrimination, encouraging interaction with the natural environment, promoting positive body image, reducing disordered eating, preventing violence against women, tackling stress in the workplace, increasing physical activity and sporting participation and promoting acceptance of diversity and social inclusion to build resilient and connected communities.
- Increase the intensity of targeted action for those who experience greater social and economic disadvantage. Specifically consider and support the social and emotional wellbeing of Aboriginal Victorians.
- Invest in early identification and intervention with vulnerable children and families.
- Focus on promoting wellbeing and preventing suicide in at-risk populations including Aboriginal Victorians, young Victorians and those living in low socioeconomic areas.

VicHealth aims by 2023 to have “one million more Victorians with better health and wellbeing, including 200,000 more people resilient and connected” and has prioritised the following areas of work:

- Prevention of violence against women
- Youth resilience and connectedness
- Arts and social connections
- Resilient elderly
- Racism and young people health

VicHealth’s Mental Wellbeing Strategy 2015–2019, places strong emphasis on youth resilience and connectedness.

4.5. Priority 5. Preventing Violence and Injury

4.5.1 Overview of the issue

Violence

Violence is defined as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation.” This includes neglect and all types of physical, sexual and psychological abuse, as well as suicide and other self-abusive acts.⁴²

Violence against women:

One in three Australian women has experienced physical violence since the age of 15. Almost one in five have experienced sexual violence. Violence was the leading risk factor contributing to death, disability and illness in Victorian women aged 15 to 44 years⁴³ and 3% of the Indigenous burden of disease is due to intimate partner violence. Data on hospitalisations for assault suggest that rates of assault in the Indigenous population are relatively high, especially among females. In 2012–13 the age-standardised rate of hospitalisations for assault among Indigenous females was 31 times as high as for non-Indigenous females (1,204 and 39 per 100,000 females, respectively).

Family violence is generally underpinned by a pattern of coercion, control and domination by one person over another. It can occur in a variety of contexts, the majority of which are intimate partner relationships, with the violence being perpetrated by a man against a woman. It has long-lasting and serious effects on both physical and mental health, including increased risk of self-harm, depressive disorders, poorer health and higher health service use, increased homelessness in women and profound negative effects for children.

Risk factors for family violence include gender inequality, alcohol and drug use, past experience of violence, pregnancy, separation and divorce, young women, indigenous women, living in rural and remote areas, living with disabilities, CALD women, financial stress and same-sex intimate relationships.⁴⁴

Protective factors include: strong cultural identity, social inclusion and respect for diversity across society; safe, affordable and accessible housing and employment; and accessible and affordable transport. For Aboriginal people, connection to land, family, ancestry, culture and spirituality are protective factors that can provide a source of strength, resilience and empowerment.

Change the story: A shared framework for the primary prevention of violence against women and their children in Australia (Our Watch 2015) asserts that particular expressions of gender inequality consistently predict higher rates of violence against women:

- Condoning of violence against women
- Men’s control of decision-making and limits to women’s independence in public and private life
- Rigid gender roles and stereotyped constructions of masculinity and femininity
- Male peer relations that emphasise aggression and disrespect towards women.

The framework also highlights reinforcing factors that can increase the frequency or severity of violence:

- Condoning of violence in general
- Experience of, and exposure to, violence
- Weakening of pro-social behaviour, especially harmful use of alcohol
- Socio-economic inequality and discrimination
- Backlash factors (increases in violence when male dominance, power or status is challenged).

Other forms of violence

In 2012, Victorian men were around 90 per cent more likely than women to have experienced physical assault in public, robbery and homicide in the previous 12 months. Alcohol and substance use are linked to higher rates of violence amongst men.

Injury

Injuries can be caused by car crashes, inter-personal violence, self-inflicted violence, sporting, recreational activities, work and war; and can include drowning, poisoning, falls and burns. Injury has a major, but often preventable, impact on the health of Australians of all ages:

- It is the largest cause of death for those aged under 35, and leaves many with serious disability or long-term conditions.
- Each year, approximately 250 Australian children are killed and 58,000 hospitalised by unintentional injuries.⁴⁵ Injuries sustained during childhood can have profound and lifelong effects on health and development, by causing permanent physical disabilities or long-term cognitive or psychological damage.⁴⁶
- In adolescence and early adulthood, young people tend to engage in riskier behaviours, which resulted in 84,560 injuries of 15-24 year olds in 2011.⁴⁷
- Falls can cause joint fractures, dislocations, bruises, sprains, head injuries and abrasions and can result in a lack of confidence and a restriction of activities due to a fear of falling. One-third of male injury deaths and almost two-thirds of female cases occurred at ages 65 and older.⁴⁷ The age group with the highest number of injury-related hospitalisations was people aged 85 and older, at 10,945 hospitalisations per 100,000 population.⁴⁷

Risk factors for injury include:

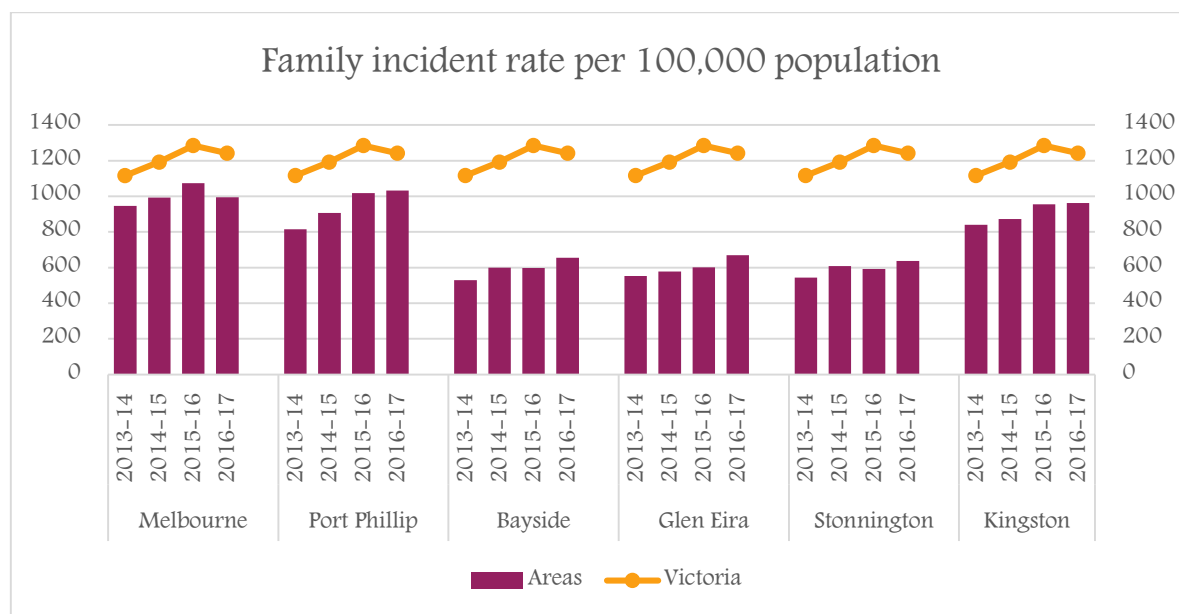
- Remoteness and socio-economic status
- Risky drinking for example leading to falls, assault or road accidents
- Males were more likely than females to be hospitalised for most types of injury including sports injuries⁴⁸
- Occupational exposures & hazards were responsible for 1.9% of the total burden of disease and injury in 2011. Males are more prone to workplace injury.
- Risk factors for falls include low bone mineral density, alcohol and drug use, occupational hazards, age, gender, living alone, ethnicity, medicines, medical conditions, impaired mobility, sedentary behaviour, psychological status, nutritional deficiencies, impaired cognition, visual impairments and foot problems.⁴⁹

Aboriginal and Torres Strait Islander people continue to have a higher rate of injury-related hospitalisation per 100,000 (3,838) compared to other Australians (1,897). Aboriginal and Torres Strait Islander children are 3 times more likely to suffer death as a result of injury. Injury and poisoning was the second leading cause of hospitalisation for Indigenous Australians in 2012–13, accounting for 27,653 (7.2%) hospitalisations of Indigenous people. Of these hospitalisations, 23% were due to assault and 19% were due to accidental falls. In 2008–2012, external causes of injury and poisoning accounted for 15% of deaths of Indigenous people compared with 6.1% of deaths of non-Indigenous people. The most common external causes of death for Indigenous people were suicide (4.8% of all deaths) and transport accidents (3.9%).

4.5.2 What's the local picture?

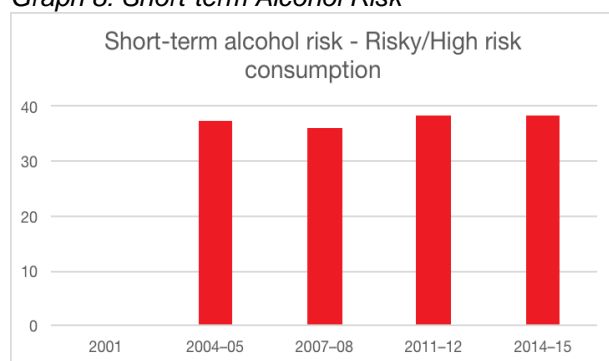
Incidence of family violence is lower than the Victorian average across all areas of the catchment. Increasing rates across all areas is evidence and reflects the state trend in growing incidence rates.

Graph 7: Incidence of Family Violence



Determinant of Health over time (data for Victoria Overall)

Graph 8: Short-term Alcohol Risk



Graph 9: Longer term Alcohol Risk



In relation to potential injuries the short term alcohol risk is far higher and stable across time than the overall long term risk.

4.5.3 National and state wide strategies.

The strategic directions in the Victorian Public Health and Wellbeing Plan 2015-19 to prevent violence and injury are:

- Prioritise strategies that support Victoria to be a respectful society that does not tolerate family or sexual violence, community violence or violence associated with abuse, racism, discrimination or bullying.
- Implement strategies to reduce family and sexual violence consistent with the recommendations of the Royal Commission into Family Violence.

- Continue to reduce the injury-related mortality and morbidity from transport-related injury, workplace hazards, falls (particularly for older Victorians) and sports.

The Victorian Government has committed to implementing the Royal Commission into Family Violence recommendations for preventing family violence. The Commission's prevention recommendations included:

- The Victorian Government ensure that the Commission's recommended Statewide Family Violence Action Plan includes a primary prevention strategy [within 12 months] that should: be implemented through a series of three-year action cycles; guide and be guided by the Victorian Government's Gender Equality Strategy; be supported by dedicated funding for family violence primary prevention.
- The Victorian Government resource an initiative [within 18 months] to: oversee prevention of family violence activities in Victoria; provide policy and technical advice to policy makers—including government—on primary prevention; provide to organisations technical advice and expertise on building primary prevention in their organisations and within communities; coordinate research that builds evidence around the primary prevention of all forms of family violence; ensure that accredited workforce development training in primary prevention is available through registered training organisations.
- The Victorian Government mandated the introduction of respectful relationships education into every government school in Victoria from prep to year 12. Implementation should be staged to ensure school readiness and to allow for ongoing evaluation and adaptation. It should be delivered through a whole-of-school approach and be consistent with best practice [within five years].

Strong Culture, Strong Peoples, Strong Families. Towards a safer future for Indigenous families and communities⁵⁰, Victoria's 10-year plan for Indigenous Family Violence has 8 objectives:

1. Cultural Safety: Make Victoria a safer place for all Indigenous Victorians.
2. Healthy Families: Support strong, robust and healthy families that provide a safe nurturing environment.
3. Education, Awareness, Prevention: Intervene early to improve education, awareness and prevention of family violence.
4. Safety for Victims: Increase the safety of Indigenous families and individuals, especially women and children.
5. Accountability: Increase the accountability and personal responsibility of perpetrators of family violence within Indigenous communities.
6. Healing: Increase opportunities for healing for victims and perpetrators.
7. Service Capability: Increase the cultural competency and capacity of the service system to improve responses to Indigenous family violence.
8. Research and Evaluation: Improve the effectiveness and efficiency of responses to Indigenous family violence through ongoing research and evaluation.

The Royal Commission into Family Violence recommended that the Victorian Government implement the recommendations of the mid-term evaluation of this plan, which was completed in 2015.⁵¹

The National Plan to Reduce Violence against Women and their Children 2010–2022⁵², includes six national outcomes and a range of strategies. The first three outcomes have a primary prevention focus include:

- Outcome 1: Communities are safe and free from violence. Strategies: promoting community involvement, focus on primary prevention, advancing gender equity.
- Outcome 2: Relationships are respectful. Strategies: build on young people's capacity to develop respectful relationships, support adults to model respectful relationships, promote positive male attitudes and behaviours.
- Outcome 3: Indigenous communities are strengthened. Strategies: foster the leadership of Indigenous women within communities and broader Australian society; build community capacity at the local level and improve access to appropriate services.

In 2016 the Council of Australian Governments launched the Violence Against Women. Let's Stop It At The Start campaign. The national campaign aims to help break the cycle of violence by encouraging adults to reflect on their attitudes, and have conversations about respect with young people. The campaign is aimed at parents and family members of children aged 10–17, as well as teachers, coaches, community leaders and employers

of young people. Campaign activities run until 2018 and will include advertising and online tools and resources. See: www.respect.gov.au.

Other national or state-wide initiatives include:

- White Ribbon, a national, male-led campaign to end men's violence against women.
- Victoria Legal Aid (VLA) is undertaking the Settled and Safe - to prevent family violence in newly arrived communities by increasing the knowledge of family violence laws in newly emerging communities in Victoria.

4.6. Priority 6. Improving Sexual and Reproductive Health

4.6.1 Overview of the issue

The World Health Organisation's working definitions of sexual and reproductive health are:

- Reproductive health refers to a state of physical, mental and social wellbeing – and not merely the absence of disease or infirmity – in all matters relating to the reproductive system and to its functions and processes, and across all stages of life.
- Sexual health refers to a state of physical, emotional, mental and social wellbeing related to sexuality; it is not merely the absence of disease, dysfunction or infirmity.⁵³

The impacts of sexual and reproductive health are human and economic, and direct and indirect. Unwanted pregnancy, sexual violence, sexually transmissible infections (STIs) and infertility are major contributors to morbidity and associated costs in Australia. The incidence and impacts of poor sexual and reproductive health in turn varies among different population groups and according to age, sex, socioeconomic background and geographic location.⁵⁴

Sexual health includes the prevalence of sexual problems and sexually transmissible infection rates. Sexually transmissible infections and blood-borne viruses place a significant burden on the Victorian community.

- Chlamydia is the most commonly notified infectious disease and sexually transmissible infection in Victoria with 19,591 cases in 2013.
- Of the 12,607 notifications for sexually transmitted infections among Victorian 15–24 year olds in 2014, 90 per cent were for chlamydia.
- There were 306 notifications of diagnosis of HIV in 2013, with the highest rates being for 25–29 year olds. The rate was stable for a decade, with increases in 2013 and 2014.
- 660 cases of infectious syphilis were notified in 2013, the highest since 1991. In 94 per cent of cases the route of transmission was males (mostly 40–44 years), with 76 per cent due to male-to-male sex.
- There were 139 cases of newly acquired hepatitis C infections in 2013, which has decreased since 2009. Injecting drug use was the main risk factor, causing 81 per cent of infections.

Risk factor data collected through the surveillance system in 2011 showed that chlamydia transmission occurred primarily through heterosexual sex. Among men, the infection was mostly reported as acquired through sexual contact with casual partners, whereas among women, it was mostly reported as acquired through sexual contact with regular partners.⁵⁵

Young people who engage in risky health behaviours place themselves at an increased risk of acquiring a sexually transmissible infection. Sexually transmissible infections (STIs) were twice as prevalent among those who had used an illicit drug in the last 12 months or who reported having consumed more than 4 standard drinks on 1 occasion at least once a week (4% respectively compared with 2% of all 15–24 year olds).²⁴

Problematic alcohol and substance use, depression, domestic violence, and childhood and adult sexual violence and abuse are consistently associated with poorer sexual and reproductive health outcomes. Insecure housing, unsupportive social relationships, limited literacy and low levels of education are also common determinants. Cultural and social attitudes and expectations can also contribute to unhealthy or risky sexual behaviours, including sexualised media representations of girls and women, stigma associated with STIs,

stereotypes about masculinity, and stigma surrounding the sexual needs or preferences of older people and people living with disabilities.⁵⁴

According to the Australian Medical Association (2014) Aboriginal people and Torres Strait Islanders experience poorer sexual and reproductive health outcomes than other Australians, including substantially higher rates of STIs, particularly for chlamydia, gonorrhoea, syphilis and hepatitis B. Among teenage Aboriginal and Torres Strait Islander women, the birth-rate is more than five times that of all teenage women, and more than half of all hospitalisations are related to pregnancy complications; the proportion of low birth weights and rates of infant mortality are double the non-Indigenous rate. Cervical cancer mortality is five times that of non-Indigenous women, in part reflecting lower cervical cancer screening rates, while the ovarian cancer mortality rate is nearly 40 percent higher than the rate for non-Indigenous women. There are also major disparities between the sexual and reproductive health of Aboriginal and Torres Strait Islander men and non-Indigenous men, with low levels of screening and help-seeking behaviour for sexual and reproductive health disorders.

Epidemiological studies have consistently shown that sex workers in Australia have lower rates of STIs than the general population, and very high rates of condom use.⁵⁴

4.6.2 What's the local picture?

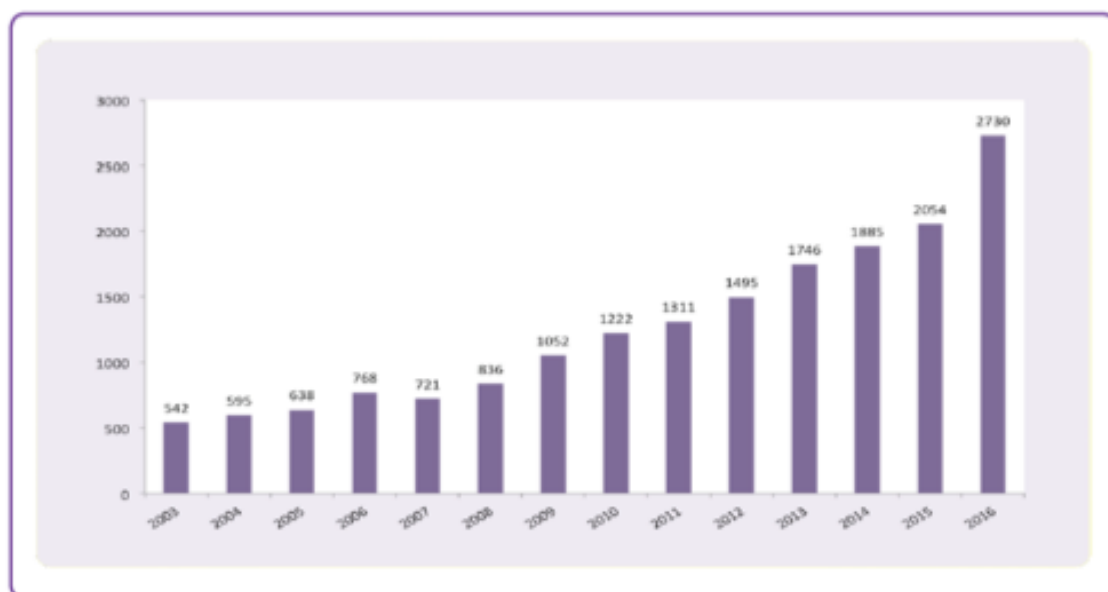
Table 16: STIs Rates

Rates per 100,000	Melb %	Port Phillip %	Bay-side %	Glen Eira %	Ston'n %	King'n %	Victoria %
Chlamydia 2011-12	784	628.1	271.4	342.7	14.9	N/A	N/A
Gonococcal Infection 2011-12	164.7	107.8	27.8	63.9	197.3	N/A	N/A
Syphilis – infectious 2011-12	43.5	30.8	5.1	16.7	40.9	N/A	N/A

Source – Department of Health, 2012

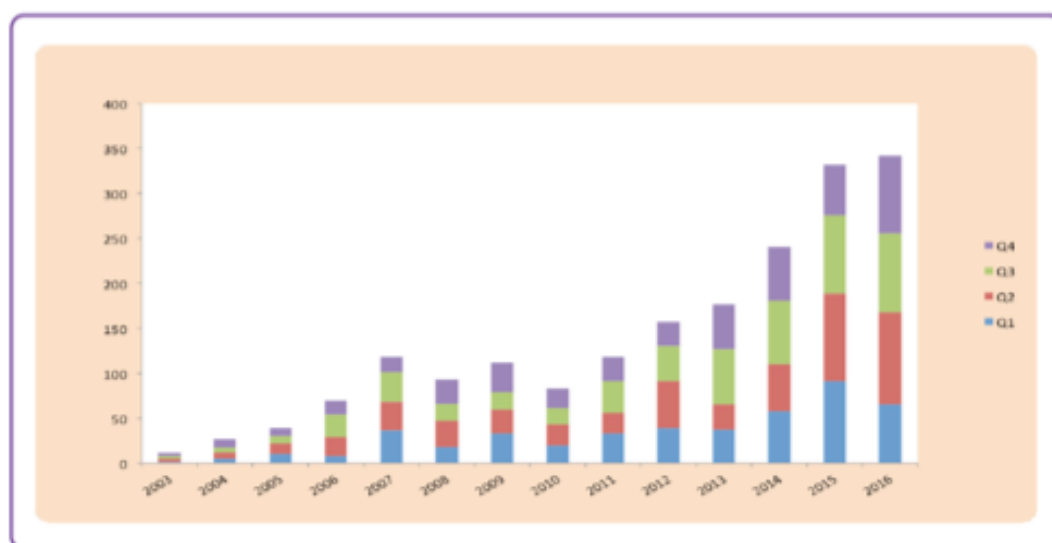
Data is not available for all areas at time of reporting however to note the overall increases in sexually transmitted diseases reported by Melbourne Sexual Health Centre in the 2016 Annual Report.

Figure 6: Number of Positive Gonorrhoea Tests 2003 - 2016



Source:
Melbourne Sexual Health Annual Report 2016

Figure 7: Number of Infectious Syphilis Cases by quarter 2003 - 2016

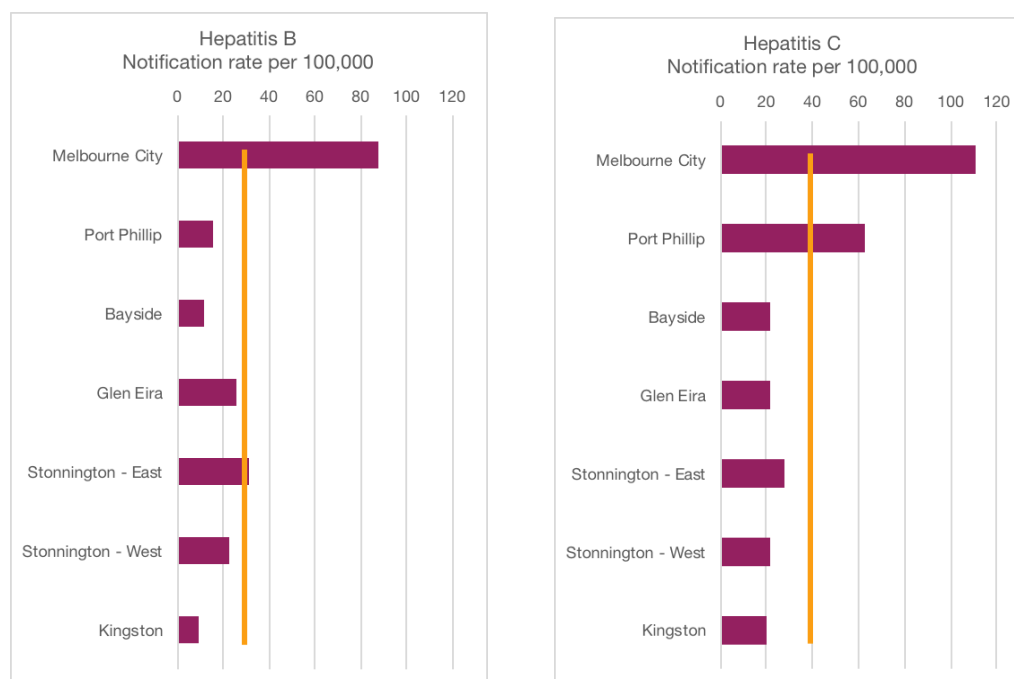


Source: Melbourne Sexual Health Annual Report 2016

The overall increases in activity and reportable cases noted at Melbourne Sexual Health Centre could be extrapolated across the State in terms of growth in incidence.

Hepatitis

Figure 8: Hepatitis B and C Notification Rates



Source:

National Notifiable Diseases Surveillance System

Across the Alfred Health catchment generally, the Hepatitis B notification rate is close to or below the overall rate for Victoria, with the exception of Melbourne, which is significantly higher.

For Hepatitis C, notification rates are well below the rate for Victoria as a whole, except for Melbourne and Port Phillip.

4.6.3 National and state wide strategies.

Strategic directions outlined in the Victorian Public Health and Wellbeing Plan 2015-19 (Victorian Government 2015) are:

- Promote and support positive, respectful, non-coercive and safe sexual relationships and reproductive choice (including planned, safe and healthy pregnancy and childbirth).
- Actions to reduce sexually transmissible infections and blood-borne viruses will focus on prevention, testing, management, care and support, surveillance, research and evaluation, in line with national strategies.
- Work towards eliminating HIV and viral hepatitis transmission and significantly increase treatment rates.

Victoria is a signatory to five national strategies for blood-borne viruses and sexually transmissible infections:

- Second National Hepatitis B Strategy 2014–2017
- Third National Sexually Transmissible Infections Strategy 2014–2017
- Fourth National Hepatitis C Strategy 2014–2017
- Fourth National Aboriginal and Torres Strait Islander Blood-Borne Viruses and Sexually Transmissible Infections Strategy 2014–2017
- Seventh National HIV Strategy 2014–2017

Family Planning Victoria (FPV) has a focus on reproductive and sexual health care, education and advocacy. FPV works to strengthen the primary care and community-based service system to deliver reproductive and sexual health services and support people to make decisions about their reproductive and sexual health and wellbeing that are right for them. FPV promotes reproductive and sexual health for all Victorians by providing:

- Reproductive and sexual health care and training clinics
- Training programs and professional development for health and human service professionals
- Professional development for teachers and youth/community workers
- Relationships and sexuality education for schools
- Education and health care resources
- Research and advocacy.

FPV's Integrated Health Promotion goals for 2013-17 are to:

- Improve the sexual and reproductive health literacy of young people.
- Provide expert advice, consultancy services and support, on young people's sexual and reproductive health, to primary care providers.

Key Priority 3 of Koolin Balit, Victorian Government strategic directions for Aboriginal health 2012– 2022¹² aims to ensure a healthy transition to adulthood.

This includes an aim to reduce the rate of young Aboriginal people with sexually transmitted diseases. Sexual and reproductive health is one of Women's Health in the South East's (WHISE) priority areas. WHISE is committed to addressing the social determinants that impact women's sexual and reproductive health across the lifespan with a particular focus on women aged 50 and over by developing initiatives based upon advocacy, capacity building, education and community development.

5. Local Priority Areas

The local government areas across the catchment all have the priority areas incorporated into their strategic plans outlined below are the focus areas highlighted in the local government areas. The detail was derived from the various areas local plans.

City of Bayside Wellbeing for All Ages and Abilities Strategy

The *Wellbeing for All Ages and Abilities Strategy 2017-2021* outlines three goals and twelve objectives:

- Goal 1: An engaged and supportive community
 - Objective 1.1 Improve mental health and resilience.
 - Objective 1.2 Support opportunities that build social networks and community connections.
 - Objective 1.3 Strengthen volunteerism.
 - Objective 1.4 Improve access to affordable, appropriate and inclusive services.
- Goal 2: A healthy and active community
 - Objective 2.1 Increase physical activity opportunities.
 - Objective 2.2 Increase healthy eating.
 - Objective 2.3 Increase participation in health assessments and self-care.
- Goal 3: Safe and sustainable environment
 - Objective 3.1 Reduce family violence.
 - Objective 3.2 Reduce consumption of alcohol and other drugs.
 - Objective 3.3 Improve community safety.
 - Objective 3.4 Improve environmental sustainability.
 - Objective 3.5 Improve community resilience to extreme weather events.

City of Melbourne Council Plan

The City of Melbourne has identified five priority areas for 2017-2021:

- Active living
- Healthier eating
- Preventing crime, violence and injury
- Planning for people
- Social inclusion

Glen Eira Municipal Public Health and Wellbeing Plan

There are six priority areas of the Public Health and Wellbeing Plan 2017–2021:

- Demonstrate leadership, advocacy and collaboration
- Promote active lifestyles and healthy eating
- Respond to family violence
- Reduce tobacco, alcohol and other drug consumption
- Improve mental health and community connection
- Enhance public health protection

Stonnington Public Health and Wellbeing Plan

There are five overarching priority areas or pillars included in the 2017-2021 Public Health and Wellbeing Plan:

- Active and healthy lifestyle
- Community safety
- Vulnerable communities
- Harmful alcohol and other drug use (inc. tobacco, pharmaceutical and illicit substance)
- Violence and injury

City of Kingston Municipal Public Health and Wellbeing Plan

The six priority areas of the Municipal Public Health and Wellbeing Plan 2017–2021 are:

- A healthy and well community
 - Increase participation in physical activity
 - Increase healthy eating habits
 - Improve mental wellbeing
 - Reduce harm from consumption of alcohol and other drugs, smoking and gambling
- A safe and secure community
 - Improve community safety
 - Improve perceptions of safety
 - Reduce prevalence of family violence
- A connected community that participates
 - Increase participation in community activities and volunteering; and reduce social isolation
 - Improve social cohesion
 - Ensure facilities, services and open spaces are accessible and equitably provided
- A liveable community
 - improve environmental resilience and sustainability
 - increase the availability of affordable housing
 - increase participation in the workforce and local economy
 - increase participation in learning and education

City of Port Phillip Council Plan

The single, integrated plan delivers our council plan 2017-2027, municipal public health and wellbeing plan, strategic resource plan, 10-year financial outlook, and annual budget.

There are 6 strategic directions:

- We embrace difference and people belong
- We are connected and it's easy to move around
- We have smart solutions for a sustainable future
- We are growing and keeping our character
- We thrive by harnessing creativity
- Our commitment to you

Caulfield Community Health Service

The Integrated Health Plan 2017-2021 will address the following health priorities:

- Active living
- Healthier eating
- Prevention of family violence
- Mental health

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