COMMUNITY HEALTH FIRST

COMMUNITY HEALTH:
People, place, and partnerships

IMPACT REPORT 2024-25

COMMUNITY HEALTH FIRST

Community Health First expresses gratitude to all partner organisations, for sharing the stories and insights that highlight the collective work of our sector and showcase the immense breadth and depth of our work across Victoria.

Access Health and Community

Ballarat Community Health

Bellarine Community Health

Bendigo Community Health Services

Better Health Network

cohealth

DPV Health

Each

Gateway Health

Gippsland Lakes Complete Health

Grampians Community Health

healthAbility

IPC Health

Latrobe Community Health Service

Holstep Health

Nexus Primary Health

North Richmond Community Health

Northern District Community Health

Primary Care Connect

Sunbury and Cobaw Community Health

Sunraysia Community Health Services

Your Community Health

Foreword

Community Health First is proud to share the achievements, innovations and outcomes of the registered, independent community health sector over the past year.

Amid ongoing reforms and growing health needs in our communities, independent registered community health services remain vital to Victoria's health system, serving as a critical safety net for over 670,000 – 1 in 10 – Victorians.

The number of people accessing community health services grew by 11% last year, showing more Victorians than ever before are seeking support through our organisations. However, demand for services continues to exceed available funding, with all community health organisations managing active waitlists across a range of services and programs.

Around the state, our communities have faced new and ongoing challenges: from cost-of-living pressures continuing to impact health care access to the increased prevalence of vaping, the ongoing impacts of chronic disease and communities still recovering from last year's climate disasters now facing new bushfires and drought.

Through it all, community health has been there providing support and services. Rolling out new services to meet increasing demand and ensuring community health remains a welcoming space for new clients..

Community health has continued to build on a legacy of genuine partnerships with communities, working together to deliver care that is equitable and directly addresses changing needs. Our organisations have established new partnerships and built on existing ones with hospitals, schools, youth justice centres, housing services and local councils to design and deliver effective health and wellbeing programs.

The past year has shown that innovative solutions and robust, purpose-led collaborations continue to make a real difference to people's lives and deliver tangible savings to the health system. This is a testament to the powerful collaboration within the community health sector.

The Community Health First Steering Committee would like to thank the leaders and teams of all our partner organisations for their steadfast commitment to our shared goal: improving the health, wellbeing and quality of life of our communities. It is because of this unity and shared purpose that we can achieve so much more together.

communityhealthfirst.org.au

Community Health First acknowledges the Traditional Owners of the land on which we live and work. We pay our respects to Elders past and present and recognise that sovereignty was never ceded.

* Names and identifying details have been changed in some instances to protect privacy. Where appropriate, names are used with permission.

Our impact

674,375
Victorians supported in the past year, which is

1 in 10 **Victorians accessing community services**

11%
growth in people reached

Connection

76% of clients say the support they get from community health makes them feel **more connected and less alone**

88% of clients say the support they get from community health is **personalised to their needs**

Support

92% of clients say the support they get from community health helps them **better manage** their health and wellbeing

89% of clients said their local community health organisations **makes it easier** to get the care and support they need

Innovation

New programs demonstrated that **for every $1 spent, an estimated**

$8 to $13
will be saved
on future health system costs

Chronic disease programs **reduced Emergency Department presentations from**

85% to 32%

“The support & help I got was wonderful. I was listened to and not judged.”

Community health client

The value of community health

We ask clients across the state what they valued most about community health.

1
Community health is affordable

2
The service is close to where I live

3
The care is personalised

“If I had one ask for the government, it would be to find funding for [community health] programs like these. They are life changing. It’s programs like these that will help us, as a society move forward – especially kids. It’s that early intervention that we need to help them with, and without that funding, we can’t help them. ”

Adam, Community health client

Our sector

Community health organisations are a vital part of Victoria's health and social services system. Independent and locally embedded, they are a driving force for change – delivering care where it's needed most.

Across Victoria, 22 independent registered community health organisations work in partnership to deliver integrated, place-based care tailored to the needs of their communities.

Together, we employ almost 11,000 staff across over 250 sites in metropolitan, regional and rural areas, supporting more than 670,000 Victorians each year.

Operating at three levels: with individuals and families, within communities, and across systems, we work to improve health outcomes, strengthen social connection, and create lasting impact.

Community health plays a vital early role in preventing health and social issues from escalating, helping to ease pressure on Victoria's hospitals and acute services.

22
organisations

10,933
staff

1,968
volunteers

Our funding

Community health is funded through multiple state and federal government sources. This diverse funding base allows organisations to respond flexibly and efficiently to local needs. It also supports innovation and tailored service delivery across different communities.

Victorian State Government Funding
49%

Federal Government Funding
36%

Other Funding
15%

Our approach

Community health is built on a model of care that recognises health and wellbeing issues do not exist in isolation.[1, 2] To truly meet the needs of our communities, we must move beyond single-issue responses and embrace the full context of each person's life.

Our work is grounded in the social model of health, which recognises that factors such as economic stability, living conditions and access to education all influence a person's health and wellbeing . There is no one-size-fits-all approach; our services are designed to reflect the unique needs of each person and community.

By combining expert clinical care with a range of social services and population health programs **together in one place**, we address both health and social factors simultaneously, delivering better outcomes – immediately and over the long term.

"The care and attention I have received since attending the clinics has literally turned my health around. It is a vital community health service."

Community health client

Two thirds of clients

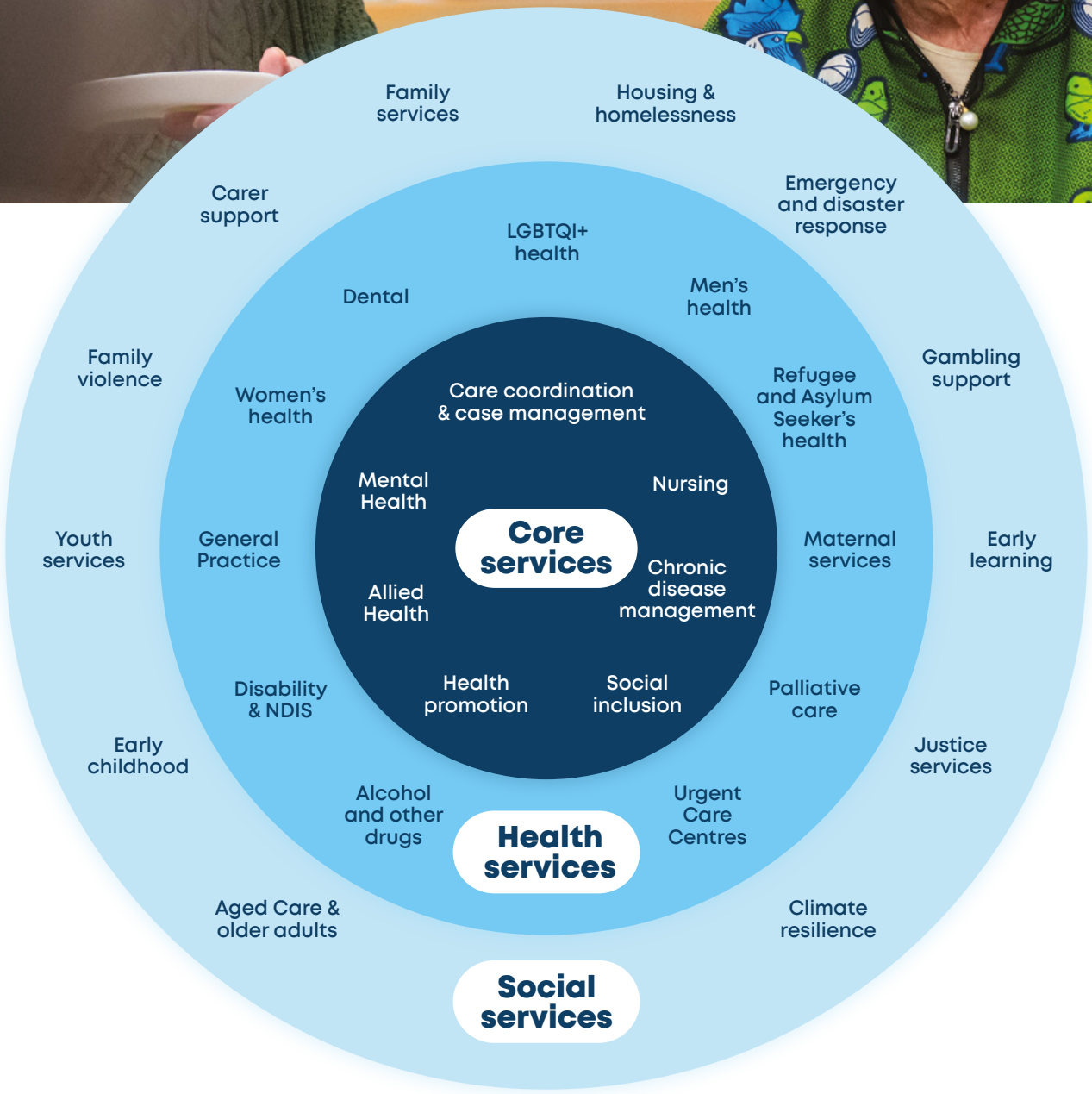
say compared to other health or wellbeing services they use, community health is better

"All the staff and treating professionals are fantastic and very helpful, friendly and knowledgeable. They are willing and able to help with any concerns you have. They have access and knowledge about a lot of different support services. And very non judgemental. Leaving there always fills me with hope that people are caring. I feel heard and well cared for by everyone there."

Community health client

"I honestly don't know where else I could go for help and the information and support I get here. The people are kind and supportive."

Community health client



Community health provides a wide range of support and services to address the diverse needs of all Victorians. All community health organisations provide the core services that form the foundation of community health. Each organisation then builds on the core services offering a range of additional health and social support tailored to local needs. This unique service model allows community health organisations to deliver holistic, wrap-around support for clients.

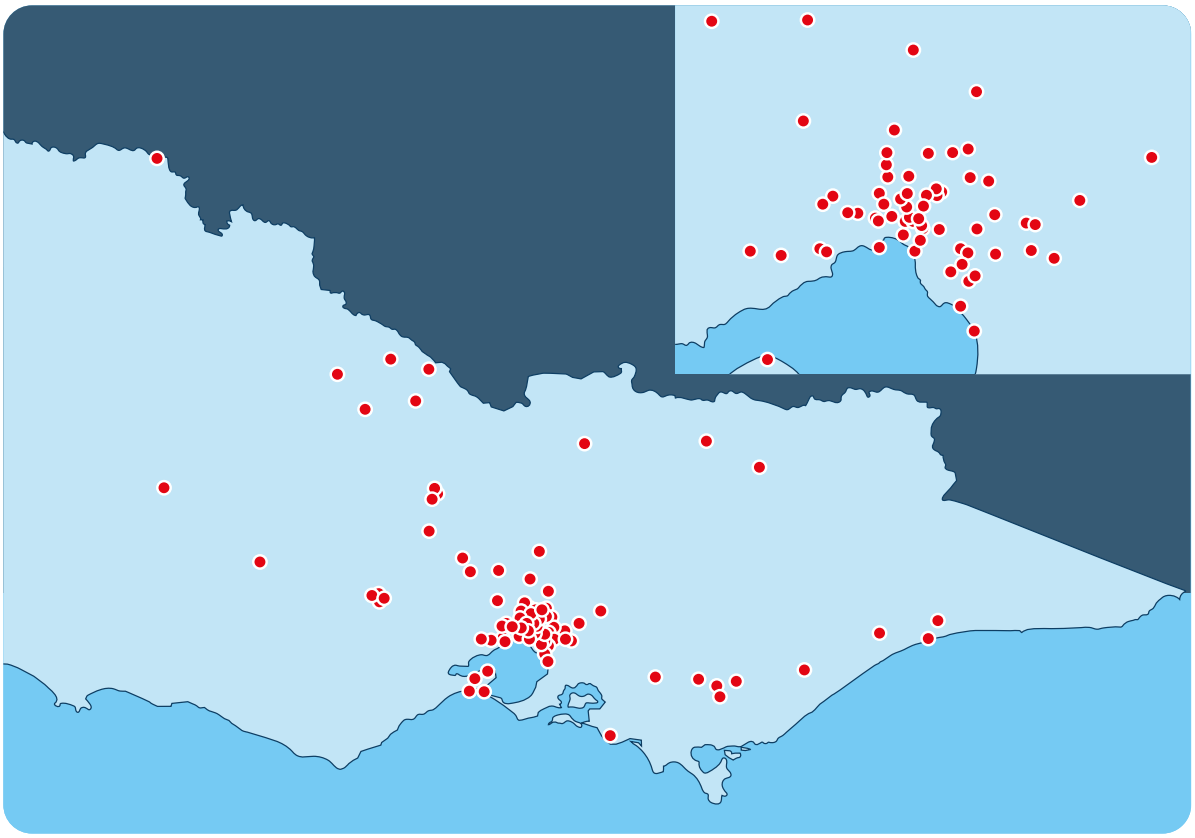
Over 45%
of clients access multiple services through their local community health organisation

Where we work

Community health services are delivered from **more than 250 locations** across Victoria, including metropolitan and regional areas. Where possible, services are co-located to create a 'one-stop-shop' – making care more coordinated, accessible and efficient.

Co-location provides a single point of entry into the health system. It simplifies the client's journey, improves referrals between practitioners and supports doctors, nurses, allied health professionals and social support teams to collaborate more effectively.

Map 1: Independent registered community health service locations that offer 3 or more services



Community health organisations also deliver through outreach, mobile clinics and virtual models of care to ensure more people can access support, regardless of where they live.

However, aging and inadequate infrastructure limits the sector's ability to meet growing demand. Registered community health receives just 0.3 per cent of the $2 billion the Victorian Government spends on heath infrastructure each year.[3] Without increased investment, organisations cannot expand services or reach more people, leading to higher long-term costs for government and poorer community outcomes.

With smarter planning and a small increase in infrastructure funding, community health organisations can play a greater role in keeping vulnerable Victorians healthy and reducing demand on ambulances, emergency departments and hospitals.[4]

People

The life-changing difference of connected, wrap-around care and support

What we do

Community health is about people – supporting Victorians to live healthier, more connected lives. Our services are designed around the individual, not their health issues. We provide care that sees the whole person in the context of their life, recognising that health and wellbeing are shaped by a range of social, economic and environmental factors.

Across Victoria, community health organisations deliver tailored support at every age and stage of life. From health promotion and early intervention to clinical care and recovery, our holistic approach meets people where they are – bridging the gap between primary and tertiary care and reducing pressure on the hospital system.

Why it matters

When people receive care that reflects their full life context, outcomes improve – not just for individuals, but for the whole health system. Community health's wrap-around approach helps people manage complex and chronic conditions, navigate life challenges and stay connected to the support they need. Community health provides more than just services: we offer hope, dignity and a chance to thrive.

The community health model reduces avoidable hospital admissions, improves continuity of care and supports recovery and independence. Wrap-around care is more effective for people who face multiple barriers to accessing traditional health services – such as those experiencing homelessness, family violence, disability, or mental ill-health.

By meeting people where they are and tailoring care to their circumstances, community health delivers better health and wellbeing outcomes and stronger social connections.

Holistic care that makes a real difference to the whole family

A streamlined approach means faster access and better care

When Rachel and Adam sought out **IPC Health** for help for their daughter, Trinity, they were already familiar with the challenges of navigating the health system. Years earlier, their eldest son's epilepsy and autism diagnoses had required countless appointments across multiple locations, extensive paperwork, and long delays. Trinity was experiencing anxiety and handwriting difficulties. The family needed timely assessments and practical support – but with both parents working and another child at home, the prospect of repeating the exhausting process was overwhelming.

Through the **IPC Health** Brimbank Melton Children's Health and Wellbeing Local, the family accessed a coordinated, multidisciplinary team under one roof. Within a week of their first call, Trinity had an intake appointment and soon after received an autism diagnosis, occupational therapy and mental health support, all delivered in the same location.

"Everyone's in the same place, talking to each other. I don't have to tell our story 100 times, and all the different practitioners can share info on what the best care plan would be."

Rachel

The family also connected with a lived experience worker, who provided guidance on building independence, future employment pathways, and navigating housing challenges. The empathy and compassion from someone with lived experience of these challenges was invaluable.

"When your child has complex needs, you need a lot of support. Having it all in one place makes a huge difference. Not just for my daughter, but for the whole family."

Adam

Breaking barriers to early support for children like Isla

In Victoria, 1 in 5 kids under five experience some form of developmental delay.[5] For families facing complex challenges, accessing timely support can be difficult — but early intervention is critical.

Isla*, a 2-year-old referred to **Holstep Health**'s Integrated Family Services, reflected this need. She showed developmental concerns in speech and feeding and experienced anxiety when separating from her mother.

Isla's family environment was complex, shaped by trauma and intellectual disability. While the team's initial goal was to understand her developmental needs and identify the best pathway forward, they also recognised the likely need for ongoing support for Isla and her family.

An Integrated Family Services practitioner and a Complex Disability Practitioner worked collaboratively to visit Isla's family at home.

Meeting in a familiar environment helped reduce stress and build trust. By listening to the family's concerns and taking a culturally sensitive approach, trust grew stronger. Holding the visits at home also gave the team flexibility to adapt to challenges like sleep difficulties, which had previously caused cancelled appointments.

After the first assessment, **Holstep Health** made timely referrals to audiology and dietetics, and supported access to a tailored NDIS plan. Over several months, the team worked with Isla's mother, modelling child-led play, communication strategies, and routines to support her development. Isla was successfully enrolled in a local childcare centre, encouraging socialisation and long-term developmental progress.

From lifeline to a new beginning

Van Nawl Peng, Fung Nei Men and their daughter Daisy moved to Australia in 2024 hoping for a fresh start having already had to move from Myanmar to Malaysia. But stepping onto Australian soil wasn't the fresh start they had imagined. They had no friends, spoke very little English and felt quite disconnected from the community, with little support to help them navigate this unfamiliar world . Then a neighbour introduced them to **Each**, and everything changed.

Each stepped in – not just as an organisation but as a lifeline. The clinical and complex care team helped the family with paperwork and securing a pension card for Fung Nei Men. They provided access to a dietitian, an occupational therapist and a taxi card for much-needed mobility. The team worked closely with the family, ensuring they had the tools to navigate life in their new home. Daisy was able to return to school and go on to study at TAFE, rebuilding the dreams she had once set aside.

Honouring final wishes with compassion and courage

The **Bellarine Community Health** Palliative Care Team are a deeply committed interdisciplinary group, comprising four specialist palliative care nurses, a social worker, an occupational therapist, and a dedicated manager. Over the past 18 months, the team has shown leadership, collaboration, and innovation in delivering high-quality, patient-centred care.

One extraordinary example was the care of Fraser Cahill, a 37-year-old man with advanced duodenal cancer. After moving from Melbourne to his parents' home in Point Lonsdale, Fraser expressed a clear and heartfelt wish: to access Voluntary Assisted Dying and spend his final moments overlooking his favourite beach.

Despite the complexities of delivering Voluntary Assisted Dying in a public setting, the **Bellarine Community Health** team embraced the challenge with compassion and courage. They coordinated with local authorities, arranged safe transport, and supported Fraser and his family through every step. On the chosen day, Fraser was surrounded by loved ones, listening to music and gazing out over the ocean.

With around 60 per cent of clients supported to die at home or in their place of choice – well above the national average – the team continues to redefine what compassionate end-of-life care can look like.

“Fraser was very clear about what he wanted – he wanted to die with dignity at his favourite beach, and our role was to make that happen safely and peacefully.”

Beth, Palliative Care Nurse

Inroads: Reconnecting people with health services

Inroads, launched in early 2025 through **Bendigo Community Health Services**, connects people experiencing or at risk of homelessness with health and other services. The 2021 Census found 571 people were experiencing homelessness in City of Greater Bendigo: a 94 per cent increase since 2016 and four times the state average.[6]

Bendigo Community Health Services Community Connectors, are based in the CBD and the Bendigo Library, where they have established trusted relationships with community members and library staff.

Inroads recognises that trauma may lie just beneath the surface – and that many individuals have already been let down by the system. There is a common and harmful assumption that people experiencing homelessness are to be feared, often equating homelessness with criminality. But context is important. Most people experiencing homelessness come from low socioeconomic backgrounds, live with a cognitive or psychosocial disability, have experienced trauma, face episodic mental ill-health – or a combination of these factors.

Community Connectors work closely and respectfully with local service providers to shift this lens. They encourage staff to see things from the individual's perspective and understand the context of their life, resulting in 80 per cent of program participants attending appointments.

The success of the program comes from the Community Connectors practical, relationship-based support model:

- **Connection** – working at an individual's pace to build rapport and explore health needs.
- **Health access** – supporting people to connect with healthcare.
- **Attending appointments** – assisting with bookings, reminders, preparation, and attending appointments.
- **Navigation** – helping people move through complex systems.
- **Central coordination** – acting as a central point of contact across health, housing, and other support services.
- **Engagement** – guiding gentle re-entry into healthcare via Bendigo Community Health Services Nurse Practitioners and GPs.

"For the community we support, food and shelter are their main priorities, so health drops off. When you haven't had the privilege of a safe place to call home you are forced to feel your feelings in public which makes it hard to meet society's expectations around behaviour. Or just simple things like being contactable is hard. So, we become the point of contact for all the services engaged with a person."

Clare, Inroads Community Connector

No judgement. No stigma. How anonymity and open doors are saving lives.

Providing a gateway to recovery in Richmond

Society often stereotypes and stigmatises people who use drugs, fostering discrimination and creating barriers to care and other critical services. The Medically Supervised Injecting Room understands that addiction is not a choice and works to provide a supportive environment for people who use drugs to do so in a safe way.

Delivered by **North Richmond Community Health** and acute health partner, St Vincent's Hospital Melbourne, the Medically Supervised Injecting Room provides a wrap-around service that connects people with health and social support services on site, including primary care, oral health, hepatitis testing, drug treatment, housing services, and legal support.

With the right support, people can shape their lives, find hope, and rebuild their futures. Facilities like the Medically Supervised Injecting Room are more than just safe injecting spaces – they are gateways to recovery, understanding, and life-changing care one person at a time.

MJ, a 32-year-old criminology student, is a current client of the Medically Supervised Injecting Room. MJ started visiting after a rare neuromuscular condition caused her to experience excruciating amounts of pain. After morphine, she eventually turned to heroin to self-medicate and avoid constant hospital visits.

The injecting room has provided her with a safe place, non-judgemental place to inject. With the support of the wrap-around services available from **North Richmond Community Health**, MJ has secured public housing, a psychologist, access to methadone and the long-term goal of a future without heroin.

Supporting long term recovery one step at a time

Latrobe Community Health Service's Community Recovery Program and Alcohol and Other Drug counselling services are built on the idea that the road to recovery is one you shouldn't have to walk alone. Chantelle* was a new client who started counselling in 2025. At her first counselling session she demonstrated a strong commitment to change despite a long history of substance use and instability; Chantelle spoke about how she'd never experienced safe or stable housing and was at risk of ongoing disconnection from her child.

After successfully working with a **Latrobe Community Health Service** specialist counsellor, Chantelle transitioned into the Care and Recovery Coordination program, where her goals focused on building recovery plan, securing housing and strengthening her role as a parent. **Latrobe Community Health Service** connected her with a community housing program designed for people in recovery, and she was able to secure the first stable accommodation of her life. This milestone became the foundation for Chantelle to continue her substance-free journey and provided a base from which she could build hope for the future. Having stable housing, combined with intensive therapeutic and practical support, allowed her to maintain abstinence, rebuild her confidence and establish a safe environment for her family. Over time, she achieved reunification with her young child: a life-changing outcome.

> **"My counsellor never saw me as an addict; she always saw me as a human being… she helped me restore my faith in humanity and in myself."**
>
> Chantelle

Embedding specialist opioid treatment within trusted organisations

The Opioid Management Clinic (OMC) at **Ballarat Community Health** is the only service of its kind in Victoria. Led by Orticare, the Grampians Loddon Mallee Pharmacotherapy Network, and Addiction Medicine Physician Dr Adam Straub, the clinic currently operates 15 hours per week and has received referrals from more than 220 medical practitioners in the region. Around 75 per cent of appointments are delivered via Telehealth, making treatment accessible across regional and rural areas while maintaining a 95 per cent attendance rate.

Pharmacotherapy is an effective medical treatment to reduce people's use of opioids such as heroin, Oxycontin and fentanyl. Opioid dependence is a complex health condition that affects people from all walks of life – not only injecting drug users but also people who become dependent upon pain relievers because of a range of different circumstances.

The OMC has established itself as both a treatment hub and a centre for education. Medical students are now undertaking placements, and training and collaboration extend to services such as **Sunraysia Community Health Services**, **Bendigo Community Health** and **cohealth**. This not only improves outcomes for clients but also strengthens statewide capacity by equipping health professionals with knowledge, confidence and networks to deliver safer, evidence-based care.

For regional Victoria, the impact is profound. By embedding specialist opioid treatment within the trusted community health system, the OMC addresses geographic barriers, builds local workforce capability, reduces stigma and ensures that people can access the care they need close to home.

Place

A commitment to local services who engage communities in the design and delivery of care that meets their needs

What we do

Community health services are deeply embedded in the communities they serve. Our commitment to place ensures that local people are actively involved in the governance, design and delivery of services — making care more relevant, responsive and trusted. With a strong focus on health equity, we work to reach and engage those who are often missed by mainstream services. This includes people facing barriers due to geography, culture, language, disability or disadvantage — ensuring no one is left behind.

Our deep community roots, long-standing relationships and understanding of local needs enable us to respond swiftly to emerging health challenges. Our place-based approach allows us to adapt services in real time, ensuring care is relevant, accessible and effective and tailored to local circumstances.

Why it matters

Place-based approaches to care strengthens communities and provide a framework for responding to complex challenges and better meet local needs.[7] When services are designed and delivered locally, they reflect the realities of the people they support — building trust, increasing engagement and improving health equity.

By embedding care within communities, we reduce barriers, improve continuity, and ensure people receive the right support at the right time.

Place-based care also enables early intervention and prevention — reducing demand on hospitals and acute services and delivering long-term savings to the health system.

The life changing power of having support in the one place

Supporting safety, stability and access to disability support: Anna and Tom's story

When Anna arrived for counselling at **Gippsland Lakes Complete Health**, she had just left a relationship marked by family violence. She was navigating the trauma of that experience while facing housing instability and caring for her son, Tom, who lives with disability.

In partnership with her counsellor, Anna began to explore her goals and priorities. As part of her care plan, she was introduced to the Homelessness Support Team, who were able to provide temporary accommodation for her and Tom.

During the assessment process, it became clear that Tom had a NDIS support package – but it was minimal and largely unused. Anna's previous partner had actively blocked access to support, refusing to acknowledge Tom's disability.

Recognising the need for specialist input, Anna was referred to the **Gippsland Lakes Complete Health** NDIS Specialist. Working closely with the East Gippsland Specialist School, Tom underwent reassessment, which led to a comprehensive review of his NDIS plan and a package that better reflected his needs.

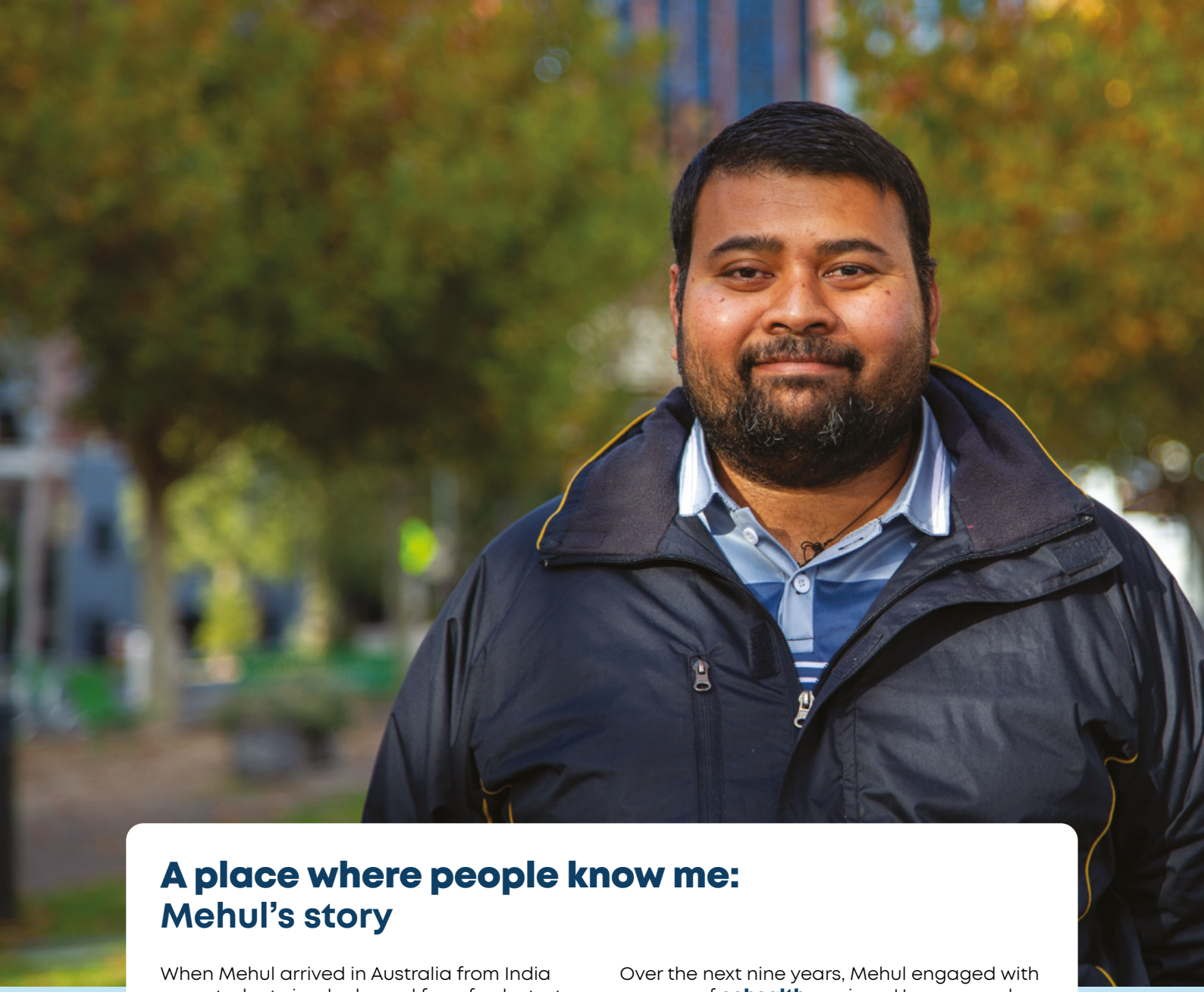
With the combined support of **Gippsland Lakes Complete Health Counselling**, the NDIS Specialist and the Homelessness Support Team, Anna and Tom were eventually placed in permanent, secure housing. Tom now receives the support he needs, and Anna is developing the skills and strategies she needs and has begun to rebuild her life with greater stability and confidence.

Chronic disease nursing supporting older clients in rural communities

In rural areas, managing chronic disease in older clients requires a multidisciplinary, client-centred approach to connect the often-disparate services and ensure clients are supported. Many older people struggle to manage emerging health issues and may not feel confident seeking help early. **Northern District Community Health** Chronic Disease Nurses work to overcome these barriers and support clients to stay well and at home, where they want to be. Using the 4 Ms Assessment – Medications, Mobility, Mental Health, and What Matters – nurses work towards understanding clients' priorities, identifying needs, building trust and coordinating care. Chronic Disease Nurses offer home visits that can provide further insight into how clients are coping and what support is needed.

Nurses help clients navigate the complexities of the health system, are available to attend GP appointments, assist with My Aged Care registration and ensure they feel supported along the way. Knowing there can be limited services available across the region, the **Northern District Community Health** team also assist with follow up during long wait periods, making sure to monitor for deterioration and advocate for faster assessments. Once services are approved, clients can access podiatry, physiotherapy, dietetics, diabetes education, counselling, and community care supports.

The wrap-around care model extends beyond just treating a chronic health condition. Client's mental wellbeing is also closely monitored, as chronic illness increases the risk of anxiety and depression. Nurses refer clients to appropriate services and involve family and carers in care planning. The service also addresses social isolation, with nurses connecting clients to local groups such as Men's Sheds, U3A, volunteer groups and Neighbourhood Houses – improving health outcomes and quality of life.



A place where people know me: Mehul's story

When Mehul arrived in Australia from India on a student visa, he hoped for a fresh start. But after struggling to find work, he soon faced housing insecurity and eventually became homeless. With no stable income, no Medicare access, and no support network, Mehul found himself navigating multiple challenges – including food insecurity, debt, and a gambling problem. He connected with **cohealth** through a drop-in service in Melbourne's CBD. There, he was able to access necessities – a hot meal, a shower, and someone to talk to. It was the beginning of a long-term connection.

> **"At that time, I didn't have Medicare, so whenever I needed anything, I came to cohealth. It's good to have everything in one place, where people know my story."**
>
> Mehul

Over the next nine years, Mehul engaged with a range of **cohealth** services. He accessed primary care, allied health, and social supports all in one place. After a hospital admission for a leg injury, he continued his rehabilitation with cohealth physiotherapy.

> **"Now from being homeless I have a stable house, and I feel very safe at home. It's such a beautiful thing. cohealth do amazing work. Really amazing work."**
>
> Mehul

Through a partnership with Launch Housing, **cohealth** supported Mehul to find stable accommodation. For the first time in years, he had a safe place to call home.

Community health in schools

Empowering students to say no to vaping

Bendigo Community Health Services is tackling youth vaping through its Prevention of Vaping program for Grade 5 and 6 students. Already delivered in 5 schools, with 7 more booked, the program uses interactive sessions and creative activities to build awareness and confidence. Survey data shows students gained knowledge about vaping harms, support services and how to say 'no', and is helping young people make informed, healthy choices.

Nurses in schools

Latrobe Community Health School Nurses deliver healthcare and wellbeing education to children and families in schools across the Latrobe Valley.

Nurses are embedded in schools and work on-campus to respond to the health and wellbeing needs of students. Nurses also provide guidance and support on how to access other health services, hearing, eye and dental checks, health and wellness education, and management support for chronic conditions such as asthma or diabetes.

In 2025, the Nurse in Schools program expanded to include preschools and childcare centres, with 90% of families already signed up to participate.

ICAN Imagination Club

The ICAN Imagination Club, run by **Sunbury and Cobaw Community Health**, is a transformative 10-week program for neurodivergent students. Paired with lived experience mentors, participants build confidence, social skills, and a sense of belonging. Educators reported life-changing outcomes for students previously disengaged due to anxiety or lack of support. With accompanying teacher training, local schools are now better equipped to re-engage neurodivergent learners and foster inclusive learning environments.

Hands-On Learning

Sunbury and Cobaw Community Health partnered with Castlemaine Community House to deliver Hands-On Learning at Castlemaine Secondary College. Designed for students at risk of disengaging, the program focuses on practical skills, teamwork, and real-world projects. Students are currently developing a community caf and leading school landscaping initiatives. These hands-on experiences help students reconnect with learning in a supportive, meaningful way – building confidence, purpose, and pathways to future opportunities.

Big Sister Program

Grampians Community Health delivers the Big Sister Program aimed at primary school students to build resilience, self-confidence, social skills and school engagement. Students are highly engaged, with improved understanding of mental health, body image, and the importance of friendships, personal happiness and self-care practices. One student, previously disengaged and anxious, now attends school regularly, participates in class, maintains friendships and shows reduced anxiety and increased resilience.

> **“Loved how hands-on they were with us. I’m going through a lot, and I think it will really help me. Thank you so much.”**
>
> The Big Sister Program participant (Grade 6 student)

A borderless approach to community wellbeing

Community health organisations are central to delivering the Victorian Cross Border Strategy's vision of "a borderless approach to healthcare and community wellbeing."[8] **Gateway Health** ensures people living in the cross-border community of Albury-Wodonga receive consistent, person-centred support – regardless of which side of the border they live on.

A 27-year-old woman from Albury accessed Head to Health, provided by **Gateway Health**, during a period of acute mental ill-health, following a distressing hospital discharge.

Gateway Health played a crucial role in supporting her transition back to community-based care and facilitated re-entry to acute care when her risk escalated. Through this support, she reported feeling more understood, less alone, and better equipped to manage her mental health needs.

Her experience highlights the importance of accessible, coordinated, face-to-face care – especially for border communities who often need to navigate multiple systems and services during acute health episodes.

Mary, a 52-year-old First Nations woman living in Wodonga, receives care from providers across both NSW and Victoria. Her multidisciplinary team includes an ACCHO GP in Albury, **Gateway Health**'s Alcohol and Other Drugs (AOD) team, cancer and palliative care clinicians from both states, and a Hepatitis C nurse in Albury.

The team at **Gateway Health** plays a central role in coordinating and integrating Mary's care across these services. This collaborative, culturally safe approach supports her health literacy, treatment stability, and continuity of care – addressing her physical, mental, and cultural health needs with respect and compassion.

A 26-year-old man engaged with **Gateway Health** to manage complex mental health challenges. He was seeking support that felt safe and confidential. Halfway through his treatment he moved house and was able to continue receiving care without interruption.

Continuity across borders was crucial, cross-border continuity proved crucial, helping him stay engaged in therapy where he had built trust with his clinician.

Exploring masculinity and relationships

DPV Health's Gender Equity and Prevention of Gender-Based Violence team conducted consultations with 70 culturally diverse men across Hume and Whittlesea to explore masculinity, gender roles, relationships, and violence prevention.

Findings revealed strong social expectations for men to be providers, suppress emotions, and conform to traditional roles – often at the cost of mental health. Many participants reported feelings of stress, depression, and isolation, yet feared seeking help due to stigma. It highlighted generational shifts, with younger men expressing more progressive views on gender roles and emotional openness.

The project centered men's lived experiences to inform inclusive, community-led prevention strategies and developed recommendations to further foster culturally safe spaces, normalise help-seeking, and engage men in schools and community settings.

> **"It can break a man if he can't achieve what's expected of him."**
>
> Participant

Early intervention dental programs helping kids and adults

Good oral health is fundamental to overall health and wellbeing. When oral health deteriorates it can greatly impact people's ability to eat and speak, and can have a knock-on effect that reduces socialising and quality of life. Tooth decay is a leading preventable health issue among young children, often caused by high sugar intake and inadequate dental care, sometimes brought on by anxiety around dental visits. Oral health also deteriorates with age and is associated with several chronic diseases, including stroke and cardiovascular disease.

Little Chompers

A free oral health education and screening program, delivered by **HealthAbility**, is designed to promote healthy eating and dental hygiene in children up to 5 years of age. Little Chompers is delivered locally in early childhood settings; the program aims to make oral health fun and accessible while reducing fear of dental visits. The program uses interactive games to teach children about sugar consumption and making healthy food choices. It also provides free dental checks, and goodie bags for each child to continue practicing good dental hygiene at home, and has led to meaningful change for the children and their families.

Adult oral health classes

Bellarine Community Health delivers oral health therapy sessions to improve adults' dental education and assist with the most common barriers to dental care, including the complexity of navigating public dental pathways. The classes are run by an oral health therapist and provide comprehensive information that explores the connections between oral health and overall health, provides advice on proper oral health and tooth brushing, demystifies the process to seek dental care and empowers patients to make informed decisions about their oral health care.

By investing in prevention-focused programs and education before problems arise, community health reduces emergency presentations, prolongs oral health, and ultimately improves quality of life for our clients.

Partnerships

Purpose-led collaborations that create meaningful change

What we do

Our deep community roots and understanding of local needs make us highly responsive and able to adapt quickly to emerging health challenges in partnership with others to deliver better outcomes. Our services are strengthened by the ability to share knowledge and evidence, learning from our peers to uplift our collective capabilities.

Through purposeful collaboration, innovation, research, evaluation and workforce development, we deliver work that creates lasting impact. We don't just respond to need; we proactively build partnerships that lead to a stronger, more resilient health system.

Why it matters

This proactive approach is not simply good for people; it's smart for the system. By stepping in early to prevent health and social issues from escalating, we play a key role in reducing the burden on our hospitals and ambulance services.

For every dollar invested in preventative health, $14 is avoided in future acute care costs.[9] It's a proven model that helps address long-term acute service challenges and downstream expenditure, making the entire health system more efficient and effective.

From the Top End to Richmond, supporting students

In 2024 **Access Health and Community** partnered with the Melbourne Indigenous Transition School (MITS), a transition school and boarding program for Aboriginal and Torres Strait Islander students, to support studying in Richmond, Melbourne.

MITS creates pathways to greater opportunity for Year 7 and 8 students from remote and regional communities across the Top End of the Northern Territory and Victoria. By working with local schools, MITS provides culturally safe education opportunities for students with a range of learning needs and is committed to empowering young First Nations people.

Together, **Access Health and Community** and MITS developed the Cycle of Care program, launched in February 2025, to provide culturally safe, continuous healthcare throughout the school year for MITS students living in Richmond.

Cycle of Care aims to reduce barriers and improve short and long-term health outcomes for MITS students. The program is led by a specialist GP with over 20 years' experience working with Aboriginal communities, and meets students and families informally throughout the term whenever possible to, to build trust and connection.

There is a focus on early communication, so students know where to go for support when needed. Families are supported to understand their children's health needs and feel confident in the care provided while their children are away from home.

The program ensures students receive care throughout the school year, with relevant health information shared with families and providers in their home communities whenever possible, for continuity of care between school terms.

Artwork at the new **Access Health and Community** Richmond Hub supports students and their families to feel culturally safe when accessing the health services. The MITS students exhibit artwork in an on-site rotating student gallery.

A feature of the hub is Access Health and Community Reconciliation Action Plan artwork created in 2023 by Wurundjeri/Yorta Yorta artist Simone Thomson titled Ngi-A-Gat Yirramboi - Build tomorrow, curated and culturally governed by trusted consultants Dreamtime Art Creative Consultancy.

26 Health assessments

9 Case Conferences

40 Referrals to the MonashHeart program

20+ Mental health and psychology referrals

Creating an Employee Assistance Program for farmers

A period of prolonged climate impacts across the Grampians region, including successive years of devastating bushfires and drought, combined with shifts in agricultural practices and changes in land use, has taken a toll on the mental health of many farmers in the region. Rates of suicide in rural communities across Australia have been increasing over the past decade, with farmers twice as likely to die by suicide compared to the general population.

In the Grampians, local agricultural business and traders had noticed farmers were struggling with their mental health and recognised that in some cases these businesses were often the only point of contact for some men in the area. In response, a group of businesses established a series of social groups and activities to bring men together, giving them a space to talk about things other than farming, and providing an opportunity for connection. The farming community's response was positive and the activities were well attended, but the business group recognised that more specialised mental health support was needed and approached **Grampians Community Health**.

Working in collaboration with local business owners and North Grampians Shire, **Grampians Community Health** established a Farmers Employee Assistance Program (EAP). EAP programs are commonplace to millions of employees around Australia, and the local community wanted to see farmers given the chance to access the support they need.

Previously some famers had sought support from other services and felt invalidated and not listened to. These experiences were greater with visiting and locum GPs and mental health workers, who didn't understand the compounding impacts of drought, the long hours farming families work, the isolation that the job can create, and the mounting financial pressure of multiple bad seasons.

The Farmers EAP provides a dedicated counsellor who is available for a drop-in chat, structured counselling, or assessments and referrals when needed. Most importantly, the counsellor is locally based and sensitive to and understanding of the complexities of farming and living in rural and regional areas. This new trial program, working in partnership with the local community, has been well received and already has a three-month waiting list.

Strong cross sector partnership improves chronic condition management

Health@Home, delivered by **Each**, supports people living with chronic and complex health conditions to improve their capacity to manage their health and reduce their need to go to hospital. The program was pioneered over a period of 4 years by **Each**, in collaboration with Eastern Metropolitan Health Alliance and delivered in partnership with Eastern Health, ahead of scaling in 2025.

The number of Victorians living with long term health conditions is growing, with 80 per cent of Victorians having at least one long term health condition . Chronic diseases can be debilitating for individuals and their families. They also place a significant and growing burden on the Victorian healthcare system, with one third of all hospitalisations related to chronic conditions such as heart disease or diabetes.

Health@Home is an evidence-based, stepped care model that bridges the gap between primary care services and the acute healthcare system to improve long term health outcomes. When chronic conditions are treated in an acute setting, the focus is typically on the most immediate health issue, with limited capacity to address ongoing concerns or ensure continuity of care. Health@Home works to overcome this by providing tailored health support and education in a community setting to improve clients' long term health outcomes and quality of life. It helps them improve care coordination, navigate the health system, better understand their condition, and build their confidence to manage their health. The program is delivered by a multidisciplinary team of chronic disease nurses, health coaches and allied health clinicians from **Each**, Eastern Health and local primary health partners.

> **"By placing patient needs at the forefront and providing tailored support and education for self-management, our goal is to continually improve health outcomes and quality of life while bridging the gaps between healthcare sectors."**
>
> Health@Home Clinician

Over 90 per cent of clients participating in the Health@Home program have multiple chronic health conditions and report they felt supported, respected and empowered to manage their health by participating.[10] Clients gained confidence in looking after their health and increased social contact and personal care and improved health outcomes as a result.

The impact of Health@Home goes beyond the individual client to deliver significant economic benefits to the health system through reduced emergency department presentations and reduced length of hospital stays, demonstrating that for every $1 invested in the program, and estimated $8–$13 will be avoided on future health system costs.[11]

Emergency department presentations reduced from 85% prior to engaging with the program to

32% **during program**

For every $1 spent, up to $13 will be avoided on future health system costs

Hospital admissions went from 85% prior to participation to

37% **in the six months following participation**

Over 85%

of clients felt supported, respected and empowered to manage their health

100%

of Hospital Admission Risk Program clinicians reported that the program improved the capacity of their service

Weekly drop-in centres supporting hard to reach communities

Regional and rural community health organisations have continued to strengthen community-based connected care models through the CP@ pilot project. This successful outreach model – pioneered by **Sunraysia Community Health Services** in Mildura and now offered in several regional locations through **Primary Care Connect**, **Gateway Community Health**, and **Grampians Community Health** – provides pop-up clinics for preventative health screening and supports people to connect with and navigate the health system. This program reaches thousands of Victorians, reducing ambulance callouts by 19–25 per cent and emergency department presentations in pilot communities.

Maude's Story:

Maude, 71, lives in social housing and was largely confined to her home due to chronic pain. Having recently moved to the area following a separation, she had few social connections and limited support. She first attended **Sunraysia Community Health Services**' CP@clinic seeking help with pain management and other health concerns. Her GP had referred her for an MRI, but the cost was prohibitive.

Over time, the CP@clinic community paramedics built trust and worked closely with Maude to identify and access the support she needed. They connected her with **Sunraysia Community Health Services**' pain clinic, rehabilitation team and a nurse practitioner specialising in mental health. Externally, they linked her to financial counselling, the Aged Care Assessment Service (ACAS) and a new GP who arranged a free CT scan instead of the MRI.

Initially, Maude didn't disclose that she had a cochlear implant, which made phone communication difficult. Once her hearing challenges were understood, the team installed talk-to-text apps on her phone, transforming how she engaged with health services. Maude now attends regular health monitoring appointments, has set new health goals, and participates in centre activities including regular exercise. This, combined with referrals to the pain rehabilitation team, means Maude's arthritis is better managed and is less of a barrier to her engaging in activities she wants to do.

These coordinated supports have greatly improved Maude's mental and physical health, reduced hospital visits, and helped her regain her independence. She now confidently manages her appointments and leaves the house regularly.

More than moving house

Moving house is often stressful but for long-term tenants of a Melbourne public housing complex, relocation as part of Victoria's Big Housing Build brought added challenges. Many residents, older and culturally diverse, had lived in their current residence for decades and face barriers navigating complex relocation systems and accessing clear, consistent information.

In response, **Better Health Network** partnered with Homes Victoria and the Department of Families, Fairness and Housing, to co-design the Better Homes Better Health program for the planned relocation. Using the evidence-based OPHELIA (Optimising Health Literacy and Access) approach, the program was built on respect, inclusion and sensitivity to trauma.

Feedback from residents informed the Resident Relocation Roadmap – a practical guide that kept people informed, supported, and confident throughout the move. Grounded in strong relationships and deep engagement, the roadmap offers a model that can be adapted to support other community relocations.

When asked about their hopes and dreams in their new homes, one resident said that "being with family, friends and neighbours was the most important thing". Having lived locally for decades, what really mattered was the close social connections and belonging with others.

Better Homes Better Health had near-total participation from residents. By building residents' confidence and providing clear, consistent communication, the program helped people prepare to move, eases the stress of transition and provided support during settlement in a new location.

Residents were also connected with **Better Health Network**'s local health and wellbeing services – including mental health and AOD programs, child, adult and family services, allied health, primary care, dental, and community transport – ensuring continuity of care and a pathway to ongoing wellbeing after the move.

Collaborating for healthier communities

14
initiatives scaled across inner east communities

21
sporting clubs engaged

35
early years services supported

Model expanded to all Community Health services in Eastern Metropolitan Region for unified preventionv

Connected, active, and inclusive communities

The Inner East Prevention Partnership (IEPP) united four community health organisations – **healthAbility**, **Access Health and Community**, **Latrobe Community Health Service**, **Each** – along with Eastern Health to tackle pressing public health challenges in Melbourne's Inner East. Through a systems-thinking approach and cross team collaboration, the partnership scaled up programs in schools, early childhood services and sports clubs that promoted health and wellbeing.

The partnership created healthier environments by increasing access to nutritious food and opportunities for active living, reducing tobacco and e-cigarette use, and advancing gender equity, particularly in communities facing socio-economic disadvantage. Fourteen initiatives were rolled out, including Vic Kids Eat Well, the Achievement Program, Menu Planning Guidelines, the Cook's Network and the Student Leadership Project. Collaboration with local governments and regional partners strengthened advocacy and ensured unified, evidence-led action.

The Inner East Prevention Partnership work led to rapid and tangible change, driving improved health equity across the Inner East. Sporting clubs like Waverley Hockey Club revamped their food offerings in just 6 weeks. Healthier policies and environments emerged across sectors, while initiatives such as the Cook's Network and climate and health pathway grants supported long-term, sustainable change. The outcomes continue to demonstrate that the places where people live, work, learn, connect and play are places to positively influence health and wellbeing.

Eat Well, Live Well

The Eat Well, Live Well project is resident-led initiative co-designed by **Your Community Health**, Housing Choices Australia, Neami National, and Darebin Information Volunteer Resource Service to enhance Housing Choices Australia residents' health and well-being through connection, while also improving nutrition and food security.

Delivered in a community space, the project met residents where they lived – making participation accessible. Activities like shared lunches, walking groups, and cooking workshops fostered connection, improved food literacy, and supported physical and mental health.

Residents reported stronger relationships with neighbours, greater confidence in cooking skills, and increased awareness of local services.

"My life is better because people in the group are in my community. It gives me a sense of belonging… It's life long."

Program participant

Future outlook

The Victorian Government has set a bold vision: for Victorians to be 'the healthiest people in the world'.[12] One where our communities are free of the avoidable burden of disease and injury, so that all Victorians can enjoy the highest attainable standards of health, wellbeing and participation at every age.

Victoria is Australia's fastest-growing state, with Melbourne's growth areas alone expected to welcome 850,000 new residents by 2036.[13] With rapid growth comes continued pressure on health services. People living in growth areas continue to have far less access to services near their homes than those in inner and middle Melbourne and access to healthcare in regional areas continues to be a postcode lottery .

The community health sector is poised and ready to help tackle these challenges and improve Victorians access to much needed, local health and wellbeing services – with scalable solutions available that can help tens of thousands more Victorians access care when and where they need it and improve health equity for rural, regional, and vulnerable communities across the state.

However, the sector continues to face a tough landscape with funding not keeping up with demand, failing infrastructure and lack of investment in maintaining and scaling programs that have demonstrated impact. Currently, less than 0.5 per cent of Victoria's $27 billion health budget is directed to community health – despite it being one of the most effective ways to improve outcomes and reduce pressure on hospitals.[14]

Waitlists for the Community Health Program are a common reality across all community health organisations, with wait times averaging between three to six months, and in some cases, extending beyond nine months or waitlists being closed altogether. There have been no funding increases beyond annual indexation over the last twenty years despite population growth.

Beyond funding, a lack of infrastructure investment has also been a major barrier.[15] Many services operate from outdated facilities that require urgent repairs and limit the ability to scale services to meet demand. Up to 45 per cent of eligible Victorians are missing out on community-based services close to where they live. This gap in infrastructure creates more demand on hospitals, with over 550,000 potentially preventable emergency department presentations each year that could be avoided if these people were treated in a community setting.[16] These avoidable visits are estimated to cost the health system approximately $500 million annually.[17] With the right investment and government support, community health is ready to scale and address these challenges by elevating its role in Victoria's healthcare system.

Over the past two years record investments have been made in acute health services and health service reform is now well underway. With these foundations in place now is the time to amplify that impact by investing in the community health.

This is a defining moment to strengthen our health care system – making care more connected, more accessible, and more effective.

Partners

Community Health First is an initiative led by all 22 registered independent community health services in Victoria united by one shared goal – improving the health, wellbeing and quality of life for all Victorians.

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Photo credits

Community Health First sincerely thanks the organisations who contributed images to this publication, helping to visually reflect the stories and impact of community health.

For more details on images included see:

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