



Australian Government

Department of Health

phn

An Australian Government Initiative

Primary Health Network Needs Assessment Reporting Template

Name of Primary Health Network

Australian Capital Territory

Section 1 – Narrative

Needs assessment is a crucial step in the commissioning process. A good understanding of the current and likely future needs of the local population is critical if a suitable strategy to meet those needs is to be produced and put into practice economically, efficiently and effectively. The process for the 2016 needs assessment has been guided by the provided framework and has built on the work undertaken for the ACTML 2014 Comprehensive Needs Assessment (CNA), which has provided a good foundation.

A more strategic approach to stakeholder engagement was undertaken for the 2016 Baseline Needs Assessment (BNA). Phase one involved consultation with government and peak bodies, focusing much of the engagement on the major issue areas identified in the 2014 CNA as well as the six key priority areas that the Department has set PHNs for targeted work: mental health, Aboriginal and Torres Strait Islander health; population health; health workforce; eHealth and aged care, most of which were in the 2014 CNA. Additionally, we have tried to focus on efficiency and effectiveness of health services for patients and opportunities to improve coordination.

Working in a single PHN jurisdiction also has meant that we have had a particular emphasis on whole-of-system issues, as there are often common barriers that need to be addressed and particularly across the acute-primary care interface.

Phase two involved consultation with non-government organisations, consumers and community, health professionals and other stakeholders, increasing our level of engagement with guidance from the Community Advisory Committee, which has played a key role in providing advice on priority issues for the needs assessment. A snowball approach was utilised to locate networks of information-rich key informants.

Quantitative data was obtained from many sources, including the Australian Bureau of Statistics (ABS), Australian Institute of Health and Welfare (AIHW), Report on Government Services (ROGS), PHN website, MBS online, Emergency Department Information System (EDIS), the ACT Chief Health Officer's Report and the National Health Performance Authority Healthy Communities reports. Latterly, information from the PHN data portal has also been accessed.

We also considered it important to collect information about health inequalities in the ACT population and to have a focus on those groups who are disadvantaged or vulnerable. We were interested in exploring those groups who have unmet needs in the community and who may not have access to mainstream primary health care services. The groups we have focused on include the homeless, refugees, those from a CALD background, the LGBTIQ community and those experiencing domestic violence. This was in addition to our focus on the Aboriginal and Torres Strait Islander population, older people, early childhood (vulnerable children), those with a mental health issue and those affected by alcohol, tobacco and other drugs.

Issues and needs arising from the data and/or identified through the community, professional and stakeholder consultations were progressively summarised into consistent themes. The information was compared and cross-checked (triangulation process) where possible. On the basis of synthesizing and triangulating evidence from consultations and the

analysis of the health and service need components, opportunities for further consideration or development were identified.

Feedback and consultation has been undertaken at a number of levels. We have tapped into issue-based networks (providers and consumers) where these exist, and/or utilised key informants to provide information or seek validation around the articulation of issues. We also utilised the Health Care Consumers Association (HCCA) in the ACT, to consult on draft priority areas and key issues within its networks and to provide information to incorporate into the BNA. Consumer forums were also organised and undertaken in partnership with the peak body for older people in the ACT (Council on the Ageing, COTA) and the peak body for mental health consumers in the ACT (Mental Health Consumer Network, MHCN). In other cases, such as the drug and alcohol sector, existing provider forums were utilised for input into the BNA.

A comprehensive commissioning process has been established with key government and NGO stakeholders on the mental health model of care with the establishment of a Primary Mental Health Strategic Reform Group to oversee the commissioning process. Mental Health needs assessment has been at the front end of that process, with feedback being provided from that group.

Similarly, a comprehensive commissioning process was established with the AOD sector involving the peak body ATODA and ACT Health. A partnership arrangement was established with these two bodies and ATODA was commissioned to provide ACTPHN with a comprehensive needs analysis as part of the process.

We had to keep in mind ACT Government priorities so that local priorities reflected these priorities as well as issues/needs identified by local stakeholders. We are working closely with the ACT Government (both Health and Community Services) to ensure that we have maximum alignment of priorities where possible.

Effective engagement with the Aboriginal and Torres Strait Islander stakeholders is still developing and because of the absence of advice as to the level of quaranteed funds for this sector in both the mental health and AOD programs, we consider that it would be counterproductive at this stage to commence specific engagement on the issues and possible approaches with the key stakeholder, the AMS.

Finally, in the development of Sections 2-4, the CHN Board undertook a workshop to work through key issue areas and determine what priority areas and broad interventions should be included in Section 4.

For the ACT population, the vast majority of available data about risk factor, disease prevalence and services is presented at territory level, and this includes the data available on the PHN website. This creates challenges for obtaining comprehensive data on target populations at the sub-regional level. Another challenge has been the ability to access relatively recent data. As a territory-wide PHN, however, we are fortunate to have a number of data sources to access. We note that there has been a very significant and welcome improvement in the release of Commonwealth data to assist PHNs.

We have started to build partnerships with stakeholders in relation to the collection of and access to population health data. We have collaborated with ACT Government (Health and

Community Services) and The Centre for Research and Action in Public Health (CeRAPH) at the University of Canberra in relation to data issues that we have in common. These include a revision of the ACT Health Survey and consideration of more effective ways to undertake separate surveys for education, health, community services etc; exploring the potential of data linkage and data access (including discussions with the ACT Government Chief Digital Officer); the possibility of having an ACT community of practice for GIS interested parties and an assessment of what data is collected and available from ACT Government.

We have also been involved in discussions in relation to data scoping for the ACT Government Better Services Initiative, which is a component of the Human Services Blueprint (a whole of system reform agenda to better utilise government investment in social outcomes and which will enable community, health, education and justice systems to work in alliance to join up support to vulnerable people and families).

An ongoing challenge in engaging in data-supported decision making has been the need for additional resources, especially staff support and time.

The tight timeframe around the needs assessment process (particularly for drug and alcohol and mental health) has made it difficult for in-depth engagement with those sectors. Having said this, we consider our engagement with stakeholders to be an ongoing process in this and other areas. We have also acknowledged the need for in-depth and ongoing consumer/community engagement as an essential part of a sustainable health improvement process.

As indicated in our response to the guidelines in October 2015, the analysis of health needs and service needs separately is an artificial construct (ie. a service need is a result of a health need) and these were brought together at the front end of our needs assessment process rather than at a later stage. Consequently, we have combined Sections 2&3 as this more accurately reflects the key issue-based approach that we have utilised in the needs assessment.

Some of the possible performance measurements provided in Section 4 are process and output rather than outcome measures at this stage and many are proxy measures for outcome measures. This is because many of the expected outcomes are long term rather than short term ones.

Sections 2-4 that we have submitted in this document do not provide comprehensive information and context for the priorities and issues that have been selected. Nor do they address the social determinants of health. We are in the process of completing a much more comprehensive document which provides a greater level of detail and context around the issues and will be a much more palatable document for stakeholders. This comprehensive document will accompany the Section 2-3 tables on our website when completed.

Sections 2 & 3 – Outcomes of the health & service needs analysis

Outcomes of the health & service needs analysis		
Priority Area	Key Issue	Description of Evidence
Transitions of care	Poor communication between different parts of the health system often results in delays in appropriate treatment or community supports, duplication of diagnostic tests and in some cases re-hospitalisation	<p>33% of GP survey respondents said that it was rarely or never clear who was responsible for following up results and 47% said that this usually resulted in clinical consequences to the patients.</p> <p>Outpatient clinic communication issues were particularly prominent with GP comments about delays in receiving responses, difficulties in accessing clinicians required and the general sense that the system was overburdened and unable to respond effectively.</p>
	Lack of consistency in discharge planning processes	<p>Lack of clearly articulated arrangements with regard to follow-up post discharge highlights poor systems that appear to be in place in at least some clinical units.</p> <p>Audits show significant quality issues with discharge summaries around timeliness, recording of principal diagnoses, complications and medications.</p> <p>33% of Canberra Hospital and 43% of Calvary Hospital discharge summaries are rated average or below average</p>

Outcomes of the health & service needs analysis		
		This level of performance with regards to discharge information poses safety and quality risks for patients and makes continuity of care a major challenge.
	Variable access to Outpatient Services leading to suboptimal management of a particular condition or delayed diagnosis.	<p>Current growth in demand for outpatient services is unsustainable and is already well beyond capacity.</p> <p>ENT, urology, vascular, general surgery, orthopaedics and plastic surgery currently have the largest waiting lists.</p> <p>Variability evident in how referrals are organised, lack of an effective e-referral system, quality of GP referrals, multiple referral pathways, timely referral of patients back to GPs have been highlighted as significant issues.</p>
	Lack of knowledge and awareness of support services	<p>This issue has been raised by GPs, specialists, allied health providers, alcohol and drug service stakeholders, mental health providers, Aboriginal and Torres Strait Islander community representatives and refugee advocates.</p> <p>Accurate information is a fundamental building block for coordination of care and the development and up-to-date maintenance of referral pathways</p> <p>There is significant evidence highlighting that active integration of community and social support networks addressing needs of patients discharged from hospital was one of the top three interventions associated with success in reducing re-admissions</p>

Outcomes of the health & service needs analysis		
	Poor information infrastructure to support shared care planning and transition of care	<p>Key underlying theme in the 2013 ACTML ACT Health Interaction Survey was the need for improved communication across health sectors and between clinicians.</p> <p>There is significant evidence of the importance of multi-disciplinary care for chronic disease management. Very low uptake in ACT of shared care and allied health MBS items or utilisation of My Health Record.</p> <p>Development of ACT Health e-health systems to date have failed to adequately respond to the needs of GPs in terms of shared medical record requirements or seamless e-referrals.</p>
Older people	Better admission and discharge planning and communication processes	<p>It is well established that older people are more likely to:</p> <ul style="list-style-type: none"> - Be admitted with existing health or community services needs or require step-down to these services on discharge - Experience delayed transfers of care - Report uncertainty, lack of confidence and lack of support on discharge from hospital - Be at high risk of re-admission because of their complex needs and frailty <p>RACFs report significant issues around discharge processes from EDs and acute wards.</p>
	Poor hydration and nutrition in older people in hospital care	Poor nutritional status has a negative impact, particularly on older patients; increasing morbidity, mortality and length of hospital stay.

Outcomes of the health & service needs analysis		
		<p>According to best evidence routine screening of hospital patients for nutrition risk early in admission is essential, although not a widely adopted practice.</p> <p>Consultation with the aged care sector indicated ACT hospitals have inadequate understanding of the significance of integrating medication with effective management and support of hydration and nutrition.</p>
	Need for improved chronic pain management and treatment by GPs	<p>Limited knowledge about multidisciplinary approaches to the assessment and treatment of persistent pain.</p> <p>Chronic pain is associated with increased hospitalisation, GP visits and ED presentations.</p> <p>Chronic pain is generally more common with increasing age, with prevalence peaking in the 65-69 year age group for males and in the 80-84 year age group for females.</p> <p>The average GP has 260 osteoarthritic patients in their care and arthritis is one of the top 5 most commonly reported long term conditions</p>
	Avoidable ED attendances and hospitalisation	<p>Older people constitute around 36% of hospital separations and 18% of ED presentations and per capita hospitalisation rates have increased by 23% and ED presentation rates by 14% over a decade.</p> <p>ED is a challenging environment for older people, particularly those with dementia. RACF residents are a particularly vulnerable group.</p>

Outcomes of the health & service needs analysis

		<p>Between 2004-2013, the proportion and rate of ED presentations for older persons in the ACT increased by 14.4%, with the increase driven by those 85 years and over.</p> <p>Of the 85+ cohort, 400 per month present to Canberra Hospital ED; of the 100 not admitted 70% re-present to ED within 28days, with 80% of these being admitted.</p> <p>Some older patients have spent over a year in ACT hospitals. Some of this has been attributed to the lack of adequately resourced RACFs capable of administering continuous morphine infusions.</p>
	<p>Improved medication management (discharge medication; new medication; over medication; medication in RACF setting; closer involvement of GPs and pharmacists in medication reviews)</p>	<p>Older people are more at risk of experiencing side effects from their medicines. They may also experience difficulties with vision, hearing, memory or cognitive functions that can make managing medicines safely a lot harder.</p> <p>Approximately 50% of patients don't take their medication as prescribed by their healthcare professional. This medication non-adherence compromises the effectiveness of treatments, increases the risk of medication incidents and reduces quality of life.</p> <p>There is also limited knowledge and understanding about the ongoing interface and interaction between medications and nutrition.</p>
	<p>Improving the integrity and uptake of end of life care planning</p>	<p>It is widely accepted that hospitals remain the last preferred place of death but still remain the most common places to die, with</p>

Outcomes of the health & service needs analysis

		<p>many being actively treated right up to the moment of their death, in some cases involving expensive and futile treatment.</p> <p>Many of the problems associated with the effective provision of end of life care relate to barriers that occur at the interfaces between settings, services and health care professionals.</p> <p>Advance Care Planning should be a part of routine health care and GPs can play a guiding role in this process.</p> <p>Consultation highlighted the need for more effective doctor-patient communication, which is likely to have specific benefit (such as patients being more likely to adhere to treatment, have better outcomes and express greater satisfaction with treatment). Education for families, carers and RACF staff in end of life care and support during difficult times, has also been raised by stakeholders.</p>
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Outcomes of the health & service needs analysis		
Priority Area	Key Issue	Description of Evidence
<p><i>Vulnerable populations</i></p> <p><i>People who are homeless or at risk of being homeless</i></p>	Access to primary health services - ongoing need for outreach services	<p>Homeless people encounter substantial barriers to accessing mainstream primary health care services, including long waiting times, inflexible scheduling and inadequate service options.</p> <p>Poor access can lead to delayed clinical presentation, increased reliance on emergency departments and higher rates of hospitalisation, often for preventable conditions.</p>
<p><i>People experiencing domestic violence</i></p>	A more pro-active role of GPs in screening, risk assessment and referral and a need for information and training	<p>According to the ABS Personal Safety Survey 2012, in the 12 months prior to the survey, around 8,900 ACT women had experienced some form of violence; 6900 had experienced physical violence and 3200 had experienced sexual violence</p> <p>Key themes in the Domestic Violence Prevention Council Report (2015):</p> <ul style="list-style-type: none"> - clinicians can miss domestic violence as they tend to be very focused on symptoms and interventions and that some clinicians are hesitant about asking questions as they are unsure about what they can do and to whom they can refer - there is a need for information on domestic violence and skills development on how to talk to clients, how far to go to elicit more information, what to do with disclosures, when to refer, who to refer to and how far to go with the client.
<p><i>CALD populations / Refugees</i></p>	Lack of interpreters and bilingual staff and need for their appropriate use	<p>Use of interpreters is essential in facilitating access to care and delivering quality of care.</p> <p>Low levels of English proficiency and access to qualified interpreters is a systemic problem compounded by providers</p>

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		reluctant to use interpreter services and/or insufficient interpreters for certain language groups.
	Health literacy/language barriers	<p>Language barriers impede access to healthcare, can compromise quality of care and may increase the risk of adverse health outcomes among patients with limited English proficiency.</p> <p>People with inadequate health literacy have limited ability to search for and use health information, make informed decisions or maintain their basic health.</p> <p>Research demonstrates that there are strong correlations between low health literacy and less healthy behaviours, poorer self-management of chronic conditions, higher rates of hospitalisation, difficulty communicating with providers and poorer health status in general.</p> <p>A culturally competent healthcare system is essential to improved health literacy in CALD communities.</p>
<i>Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) population</i>	Lack of LGBTIQ inclusive referral options and access to a health service sector which can often be very heteronormative	Consultation undertaken by Health Care Consumers' Association in 2013 highlighted that the search for an appropriate GP becomes crucial for LGBTIQ consumers as the GP needs to possess both adequate knowledge and sensitivity to assist them in treating/managing their condition and navigating through the system. Consumers stated that for transgender people, the GP is the gatekeeper to the very first elements of their transition, usually access to hormone therapy.

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Aboriginal and Torres Strait Islander health	High rates of smoking during pregnancy	<p>Indigenous women are 4.9 times more likely to smoke during pregnancy than non-Indigenous women.</p> <p>There is a dose-response relationship between number of cigarettes smoked and the likelihood of giving birth to a low-birthweight baby.</p> <p>A significant proportion of babies born to Aboriginal and Torres Strait Islander women in the ACT are of low birth weight with a figure that is approximately two and a half times higher than the figure for non-Aboriginal and Torres Strait Islander mothers.</p>
	Social, emotional and cultural wellbeing	<p>In ACT, almost one third of Aboriginal and Torres Strait Islanders reported having a high level of psychological distress and the percentage is 3.4 times higher than the non-Indigenous population.</p> <p>The ACT rate of hospitalisation for principal diagnosis of mental health related conditions is 2.3 times higher than the non-Indigenous population.</p> <p>The Aboriginal and Torres Strait Islanders in ACT accessed the community mental health services at a rate 2.6 times higher than the non-Indigenous population.</p>
	Difficulty accessing non-Aboriginal and Torres Strait Islander-specific services	<p>Indigenous patients and families experience barriers when trying to access mainstream primary health care services (i.e. non-Aboriginal and Torres Strait Islander-specific services), including:</p> <ul style="list-style-type: none"> - Long wait times

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		<ul style="list-style-type: none"> - Lack of bulk-billing in the majority of practices - Lack of information about which practices are “incentivised” to provide primary care to this population group - Lack of transport <p>Some GPs may not provide the types of services required by many Aboriginal clients with complex needs, resulting in clients needing to travel some distance for appropriate services</p>
	<p>Need for an integration of early childhood services</p>	<p>Aboriginal and Torres Strait Islander children and youth are over-represented in statistics that include living in poverty, statutory child protection, out-of-home care, juvenile justice and leaving school early, compared to their non-Indigenous peers.</p> <p>Children in out of home care are a vulnerable and at-risk group in the population, and although existing data is limited, they are likely to have poorer physical, mental and developmental health than their peers. Trauma in these children and youth (as a result of being removed from families, family violence and family breakdown) is an issue often overlooked.</p>
<p><i>After Hours</i></p>	<p>More cost-effective deployment of after hours primary care resources for urgent care</p>	<p>Significant resources are provided by governments for after hours care but could be more effectively targeted and integrated, particularly for urgent care.</p> <p>Little knowledge of services provided by primary after hours care providers, patient profiles, patient or provider motivations and provider referral reasons to ED.</p>

Outcomes of the health & service needs analysis		
	Residential Aged Care Facilities & housebound patients – access to GPs in After Hours period	<p>RACFs have reported difficulty in accessing GPs during the after hours period, particularly for rapid responses for deteriorating patients.</p> <p>MBS data indicates a low per capita number of RACF GP visits in the after hours period.</p> <p>High rates of ED re-presentation and readmission from RACFs and home-based elderly.</p>
	Access to diagnostic services	Limited access to diagnostic services such as radiology and pathology during the after hours period (particularly co-located with general practice).
	Awareness of After Hours services (both in the community and profession)	<p>Data from a 72 hour ED snapshot survey undertaken by ACTML in 2013 shows that when respondents were asked about their knowledge of after hours services available, there were significant gaps (ie. fewer than 50% of participants were aware of extended hours general practice).</p> <p>The Health Care Consumers Association have identified ‘navigating the system and identification of the right service for the consumer’s needs’ as a significant barrier to access in the ACT.</p>
Early childhood	Healthy growth and development	The Australian Health Survey reported that around a quarter of children aged between 2 and 17 years were overweight or obese (25.5%).

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		15.7% of kindergarten children in the ACT in 2012 were measured as overweight or obese (ACT Kindergarten Screening Program) compared to 17.3% in 2011 and 15.7% in 2010.
	Access to early intervention services	<p>It has been recognised by the ACT government that identification and access to early intervention services around developmental delay and mental health is complex and difficult to navigate for consumers.</p> <p>The introduction of the NDIS and the reduction of services provided by the Child Development Service (formerly Therapy ACT) has contributed to this complexity.</p>
Workforce	Need to support sustainable workforce supply	<p>Changing nature of primary care influenced by ageing population, marked increase in chronic diseases, increased use of telemedicine, more informed consumers.</p> <p>Increased need for team based care and care coordination.</p> <p>Fall in average hours worked by GPs and increased female workforce participation.</p> <p>Increased pressure on practices for training places for medicine, nursing and allied health disciplines.</p> <p>Limitations to GP infrastructure to accommodate growing team numbers.</p> <p>Uneven distribution of the GP workforce.</p>
	Increased demand for more complex multidisciplinary primary care services	There is a growing burden of chronic illness in the ACT which has resulted in an increasing role for general practitioners in

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		<p>conjunction with other health care practitioners to deliver multidisciplinary team based care.</p> <p>Multidisciplinary care provides a more diverse range of skills and experience than care delivered by a single provider and its importance in chronic care has been well established. The multidisciplinary team requires specific skills in coordination and continuity of care and clinical team leadership, in order to meet the comprehensive needs of patients with chronic and complex conditions.</p>
<p>Chronic conditions</p>	<p>The need for ‘activated’ consumers: Education of consumers and carers using principles of health literacy, teach-back, self-advocacy and self-management and decision support</p>	<p>Target populations include: people of low SES status, marginalised and disadvantaged communities (ie: those at risk of developing a chronic condition).</p> <p>Health literacy is considered a primary preventative and quality and safety measure (NSQSH). 60% of Australians aged 15–74 years do not have adequate health literacy (circa 45% of ACT pop). Low health literacy is associated with less healthy behaviours and poorer health status, higher rates of PHC utilisation, avoidable ED presentation and hospitalisation, and increased health care cost.</p> <p>Targeted health literacy initiatives in the ACT are limited. The now defunded HCCA Health Literacy for All program demonstrated greater understanding of health system and 71% increase in confidence to self-manage personal and family health.</p>

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		<p>The ACT has a range of self-management and health coaching (ie: behaviour change) and supported decision making programs for people with chronic conditions and disability. However, there is limited awareness of these amongst consumers and clinicians; eligibility criteria and access routes are unclear; programs are not integrated into care planning nor health pathways.</p> <p>Educated and empowered consumers achieve better health outcomes, reduce demand on both primary health care and hospital services when, the culture is supportive, consumer centred education programs and supports are fully integrated into the CD management system and ongoing therapeutic relationships established with a single health care provider responsive to multiple patient needs (eg: GP).</p>
	<p>Increasing the capacity of general practice – early identification, assessment and intervention</p>	<p>Advanced or high performing primary health care is the foundation of an effective and efficient health care system. Evidence confirms that health care home initiatives (encompassing voluntary enrolment) have the potential to: increase consumer satisfaction and health outcomes; reduce health care costs associated with unnecessary use of ED, hospital and specialist services. (Note: most frequent avoidable ED presentations and hospital admissions relate to diabetes, heart disease, COPD and mental illness).</p> <p>The QiData initiative strengthens general practice ability to identify those at risk of poor health outcomes and enhance quality and</p>

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		<p>safety through appropriate call/recall (ie: CD screening, assessment and management) capability.</p> <p>Timely diagnosis and treatment – see <i>Whole of System</i>. (Issue: TCPH wait lists and times).</p>
	<p>Need for shared and coordinated care</p>	<p>Ineffective management of chronic conditions leads to worse health outcomes and higher costs.</p> <p>GP Management Plans and Team Care Arrangements are undertaken at 47% the Australian per capita rate. CDM podiatry and physio referrals are at 18% and 23% of the national per capita rate.</p> <p>12.9% of GP-attenders are responsible for 41% of Medicare expenditure. High users: tend to have more chronic conditions, lower levels of health literacy and greater levels of disadvantage than low-attenders; and they need multi-disciplinary and coordinated care to address health needs.</p> <p>Chronic disease management is complex and multifaceted, many consumers requiring multiple, contingent and/or complementary services, spanning a complex and disconnected health system.</p> <p>Health systems are stronger if they are more comprehensive, coordinated, community focused, universal, affordable and person/family oriented:</p>

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		<ul style="list-style-type: none">- Both shared care and care co-ordination are critical components of all best practice chronic care arrangements and advanced primary health care.- A consistent approach to clinical care protocols and pathways for specific chronic diseases can make a real difference to health outcomes (eg: CHF and COPD)- Responsive step up/step down capability spanning PHC/Community/Sub-acute (re-ablement and rehabilitation)/Acute and specialist services achieve better health outcomes- Digital technology, electronic health records and information sharing tools are key system enablers - enhancing service quality and safety, reducing duplication and waste- Person focused and integrated care spans holistic health and social care needs of individuals
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Mental Health

Outcomes of the health & service needs analysis		
Priority Area	Key Issue	Description of Evidence
Mental Health	<p>Early intervention in life; in illness; and in episode</p> <ul style="list-style-type: none"> - Lack of appropriate, evidence based early intervention and prevention services - Barriers to accessing early intervention services 	<p>Early intervention promotes more effective recovery, and can reduce the duration of an illness and decrease the negative impact of mental illness on people, families and the community over the course of their life.</p> <p>Prevention and early intervention can also reduce the need for hospitalisation and inpatient facilities.</p> <p>Stakeholder feedback has highlighted the importance of a focus on appropriate, evidence based early intervention and prevention based services for those suffering from a mental health disorder.</p>
	<p>Physical Health</p> <ul style="list-style-type: none"> - Lack of awareness of the physical health outcomes for people experiencing severe mental ill health - Lack of General Practitioners willing to manage people with mental ill health in the community 	<p>There is strong evidence to indicate that people who experience severe mental ill health have poor physical health outcomes. This is the result of a lack of physical care at the right time and side effects of psychotropic medication, often leading to chronic diseases such as Type 2 Diabetes and Cardiovascular Disease.</p> <p>Stakeholder feedback has highlighted the importance of improved awareness of Metabolic Disorder, education for GPs and the importance of people who experience mental ill health having a regular GP in the community.</p>

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	<p>Services for moderate to severe presentations</p> <ul style="list-style-type: none"> - Lack of services focusing on psychological interventions for people with moderate to severe presentations - Lack of integration between primary mental health care services and tertiary services 	<p>Lack of services focusing on psychological interventions for people with moderate to severe presentations, who require more than 10-12 sessions with a mental health clinician in a calendar year.</p> <p>Stakeholders highlight need for better primary mental health care services, following a stepped care model with low intensity through to high intensity services.</p> <p>Stakeholders highlight need for better integration between primary mental health care services and tertiary services and stepping up and down between these.</p>
	<p>National Disability Insurance Scheme (NDIS) – Psychosocial Disability</p> <ul style="list-style-type: none"> - Uncertainty surrounding system capacity to support people who are not NDIS eligible - Lack of GP awareness in regards to NDIS and the pre-planning process - Lack of care coordination services for people who do not transition to NDIS 	<p>With the commencement of the Psychosocial Disability component of the NDIS in the ACT, stakeholders have expressed uncertainty in regards to future system capacity to support those who are eligible for Psychosocial Disability Packages of care through the NDIS and for those who are not.</p> <p>Stakeholders have highlighted the importance of the need for a continuing care coordination service for those with severe mental ill health who do not transition to the NDIS.</p> <p>Stakeholders have expressed the need for GPs to be educated around the NDIS, including provision of documentation for package planning.</p>

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	<p>Vulnerable populations</p> <ul style="list-style-type: none"> - Lack of specialist multidisciplinary services for Transgender population - Barriers to accessing services for people who are homeless or at risk of homelessness - Lack of trauma informed care - Access barriers for Aboriginal and Torres Strait Islander People 	<p>Evidence suggests that vulnerable groups experience higher rates of mental ill health. Stakeholders have highlighted the following areas of need:</p> <ul style="list-style-type: none"> - An increase in the provision of specialist psychiatric support for Transgender population - Improved accessibility and provision of mental health services for people who are at risk of homelessness or who are homeless - An increase in the provision of specialised mental health services for refugees, particularly in regards to trauma informed care - Specialist service provision for Aboriginal and Torres Strait Islander People focusing on their social and emotional wellbeing (including mental health)
	<p>Suicide prevention</p> <ul style="list-style-type: none"> - Lack of community based support services for people discharged from hospital following a suicide attempt - Lack of primary mental health care services for people with suicidal ideation - Access barriers to existing primary mental health care services, e.g. requiring a GP or Tertiary Service referral 	<p>There is currently a perceived lack of support and primary mental health care services for suicide prevention in the ACT. Stakeholders highlighted the following areas of need:</p> <ul style="list-style-type: none"> - Improved support services for people discharged from hospital following a suicide attempt - Increased access to primary mental health care services for people with suicidal ideation - Increased understanding of referral pathways for people with suicidal ideation who are not at immediate risk of self harm - Improved ease of access to primary mental health care services and community based services for people with suicidal ideation, for example, self-referral.

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	<p>Peer Participation</p> <ul style="list-style-type: none">- Lack of meaningful peer participation in service development, implementation, delivery and evaluation	<p>People with lived experience of mental illness offer perspectives that enrich how services are delivered.</p> <p>Stakeholders stated that there is a lack of peer participation in primary mental health in all phases of commissioning.</p>
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Alcohol, Tobacco and Other Drugs

Outcomes of the health & service needs analysis		
Priority Area	Key Issue	Description of Evidence
Dependent / high risk / severe drug and alcohol use and related harms	Increased alcohol and other drug (AOD) related harms (e.g. dependency, changing drug trends, complexity, overdose, family problems, blood borne virus infection) and their disproportionate impact on Aboriginal and Torres Strait Islander people in the ACT region	<p>Relatively rapid change in ACT drug trends are consistent with national trends (National Drug Strategy Household Survey, 2013)</p> <p>Increased AOD related harms including, e.g.:</p> <ul style="list-style-type: none"> - Almost doubling people who are dependent drug users (i.e. methamphetamine) over a relatively short period (3 years) - Increased demand on specialist AOD treatment and support services (e.g. increased presentations to specialist AOD services where amphetamines is a drug of concern) - ACT opioid overdose rates highest in 10 years <p>Disproportionate burden of alcohol and other drug related harms experienced by Aboriginal and Torres Strait Islander people in the ACT region</p> <p>Expert advice from ACT specialist AOD treatment and support services, consumer organisation, ACT Health, ATODA (the peak body) and Aboriginal and Torres Strait Islander community-controlled services, external ACT AOD research expertise</p>
Strengthen existing specialist AOD treatment and support services for people experiencing	Significant unmet need and demand for specialist AOD treatment and support services for the ACT region	<p>Need to double AOD treatment places</p> <p>36% increase in demand for specialist AOD non-government services from 2010-2014</p>

Outcomes of the health & service needs analysis

<p>dependent / high risk / severe drug and alcohol use and related harms and their friends and families</p>	<p>Treatment and support that is culturally safe for Aboriginal and Torres Strait Islander people Lack of capacity in existing specialist AOD treatment and support services in the ACT to provide:</p> <ul style="list-style-type: none"> - Opportunistic assertive outreach to engage ‘hard to reach’ sub-populations to prevent and reduce AOD related harm and provide supported referrals to treatment - The intensity and duration of treatment required (at all points of treatment pathway, including after care) <p>Need to increase the quality of existing specialist AOD treatment (e.g. consumer and friend/family participation) particularly for clients experiencing complexity and multiple morbidities (e.g. hepatitis C, risk of opioid overdose, use of methamphetamine)</p>	<p>Harm reduction services have a strong evidence base and have been used effectively in the ACT, including peer based approaches</p> <p>If people who need AOD treatment don’t get a specialist AOD response when they seek it they may not re-engage for significant periods of time and may remain at high risk Sustained positive AOD treatment outcomes over the longer term are more common for those who have experienced severe and complex AOD problems with longer treatment duration and more intensive treatment modalities</p> <p>Current ACT AOD treatment population experiencing significant complexity (e.g. 70% unemployment) (Service User Satisfaction and Outcomes Survey, 2015)</p> <p>25% of the current ACT AOD treatment population identify as Aboriginal and Torres Strait Islander (Service User Satisfaction and Outcomes Survey, 2015)</p> <p>Expert advice from ACT specialist AOD treatment and support services, consumer organisation, ACT Health, ATODA (the peak body) and Aboriginal and Torres Strait Islander community-controlled services, external ACT AOD research expertise</p>
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