Australian Capital Territory PHN
Needs Assessment 2020-2021

Process summary

Priority Areas

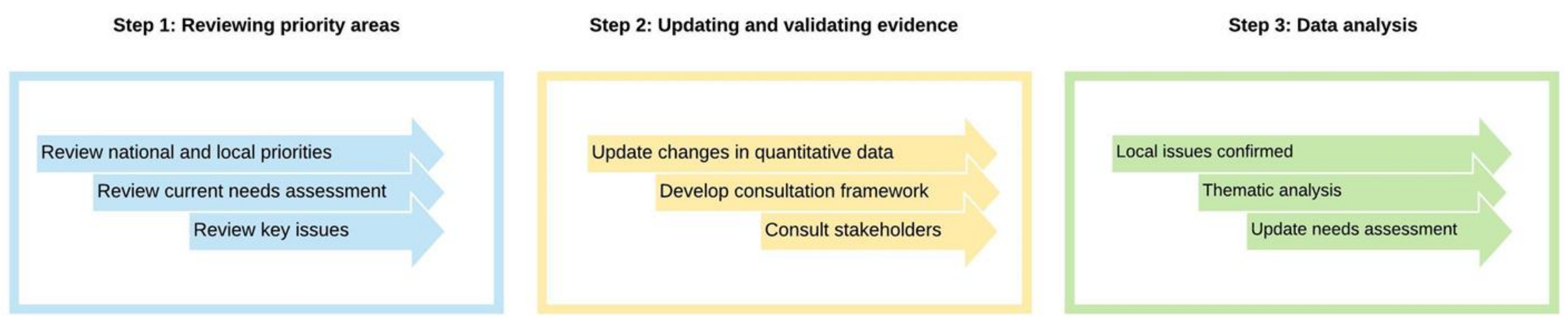
The Australian Capital Territory Primary Health Network (ACT PHN) has undertaken a thorough review of its previous Needs Assessments and has updated all priority areas with relevant data and feedback from community consultation. ACT PHN has identified priority areas aligned with the Department of Health's Primary Health Network focus areas as well as locally identified priority populations. The nine priority areas are:

1. Care across the continuum
2. Aboriginal and Torres Strait Islander health
3. Digital health
4. Alcohol and other drugs
5. Mental health
6. Chronic conditions
7. Aged care
8. At-risk populations
9. Workforce

The process for this Needs Assessment update has involved a review of the quantitative information contained in the previous Needs Assessment and further collection of qualitative data via consultation. We continue to utilise existing networks (providers and consumers) and key informants to provide information, or seek validation, around the articulation of issues. This has included the Community Advisory Council, the ACT Clinical Council, the General Practice Advisory Committee, staff and other local stakeholders and subject matter experts. Due to social distancing restrictions, we held video consultations and online surveys this year to obtain feedback from a wider group of stakeholders that included consumers, carers, service providers, and peak bodies, with respondents asked a series of questions regarding their perceptions of what is happening locally within that priority area. Importantly, this Needs Assessment update has explored the impact of COVID-19 in each of the nine priority areas. ACT PHN also provided stakeholders the opportunity to provide feedback via video consultations if requested. As with the previous Needs Assessment, the consultation data was analysed thematically alongside local data where available. The consultation data has added invaluable anecdotal evidence to the overall picture provided by the quantitative data.

The overall process for developing the Needs Assessment is mapped below:

Figure 1: Updating Needs Assessment Process Map



The 2020 updated Needs Assessment provides a summary of findings against all priority areas. It is important to note that while there is a summary for Priority 9 – Workforce, due to the importance of this issue in the ACT, issues of workforce will appear throughout the document. In addition to the updated relevant data and community consultation findings, we have also included a section regarding COVID-19 within each priority area summary. There has been no change against the identified themes from the current Needs Assessment or with the identified potential strategies and opportunities to take action. These high-level strategies are:

Commission services	**Procure services or programs to provide direct support to people with identified health needs.**
Capacity building	Provide training and other supports to health professionals and primary health care organisations to improve their capability to provide high quality care.
System improvement projects	Work with key stakeholders in the health care system to enable better communication and connection between parts of the system such as improving referral pathways.
Awareness raising	Raise awareness among consumers, carers, health professionals, and other stakeholders about emerging needs.
Strategic partnerships	Work with strategic partners to address needs that do not solely fit within the PHN's sphere of influence.
Planning	Undertake scoping, background research, and/or community consultation to better understand needs in this area.

The themes, focus areas and strategies were finalised with consideration for the role of ACT PHN in the local health sector as well as the guidelines of the PHN program.

The needs assessment drives planning activities throughout the year. Ongoing planning activities will focus on:

- Continuous review of new and updated data across the 9 priority areas
- Further research and planning around emerging themes that have been identified across multiple priority areas such as health literacy, medication management, and integration

- Detailed planning and consultation around ACT PHN’s identified at-risk priority populations
- Emerging issues identified by the Department of Health and/or the ACT community
- How as a PHN we can contribute to the ongoing delivery of services to meet the community’s needs in the new ‘COVID normal’ environment.

Australian Capital Territory PHN
Needs Assessment 2020-2021

1. Care across the continuum

This priority area focuses on:

- How people use and move between health services
- People's experience of the health system as a whole
- How primary, secondary, and tertiary services work together.

Key themes and issues for PHN action

Theme	Focus areas	Strategies & opportunities to address
Affordability of services	1.a. High out-of-pocket costs limit access to health services, including primary care, specialists, and allied health 1.b. Additional costs of accessing ongoing care such as transportation and time off from work are often overlooked and not assessed as part of care planning.	Raise awareness Commission services
Health literacy including awareness, navigation of services, and confidence in seeking and participating in health	1.c. Lack of awareness and understanding of service options among consumers especially including after-hours services. 1.d. Lack of support in navigating services, particularly for vulnerable groups.	Commission services System improvement
Early assessment, diagnosis, access, and care planning	1.e. Lack of early assessment diagnosis, and care planning 1.f. Lack of opportunistic screening in general practice 1.g. Long wait times to access specialist services 1.h. Lack of multidisciplinary and/or shared care.	Capacity building Commission services
Integration of services and systems	1.i. Transition points across the system are a high-risk area where consumers and carers experience significant barriers and are at risk for poor outcomes or becoming disconnected from services.	System improvement Strategic partnerships
Preventable use of ED and Hospitalisation	1.j. Continued use of the ED for low-urgency or preventable conditions.	Commission services Capacity building
Impact of COVID-19	1.k. Address emerging needs from COVID-19	Capacity building System improvement Planning

Intended outcomes

- People can find and access services they need
- People receive care at the right time and the right place.

How people use and move between health services

According to AIHW, 88% of ACT residents rated their health as excellent or very good (1). This figure has increased steadily since 2001. Approximately 83% people in the ACT saw a GP in 2017-18, compared to the national average of 84.3% (1). While nation-wide figures suggest 12.6% Australians saw a GP more than 12 times in the year, only 9% of the ACT population did so (1). The Productivity Commission reports that on average, in 2017-18, ACT residents used GP-type services 5 times per year, the lowest in Australia (national average: 6.5 times per year) (2). The number of full service equivalent (FSE) GPs services used per 100,000 people is 76, lowest in Australia and significantly lower than the national average (101.5 FSE GPs services per 100,000 population) (2). Canberrans are more likely to see a GP for urgent medical care (12% compared to 11% nationally) and have a relatively higher rate of GP after-hours visits (9% compared to 8.3% nationally) (1). However, the proportion of GP management plans and team assessment plans reviewed in 2018-19 were the second lowest in Australia (70.8% plans reviewed compared to 74.1% nationally) (2).

In 2017-18, the number of children in the ACT who were fully immunised in 2018-19 was above the national average in most age groups, except for children aged 60 months to less than 63 months (94.7% compared to 94.9% at the national average) (2). The rates of participation in Breast Screen and National Bowel Cancer Screening program were above the national average, while that of cervical screening programs was the lowest in Australia (around 49.1% compared to 54.1% for people aged 25-74) (2).

Use of ED for low urgency care in the ACT reduced from 133.4 to 127.4 per 1000 population from 2016 to 2018 but remained the highest among all states and territories (national: 117 per 1000 persons in 2017-18) (3). The rates of after-hours lower urgency care in the ACT were higher than the national average for people aged 15-24 (77.1 compared to 73.7 presentations per 1000 population), people aged 65+ (33.9 compared to 31.7 presentations per 1000 population) and people aged 25-44 (55.6 compared to 54.7 presentations per 1000 population) (3). Children below 15 years old were most likely to use low urgency care in ED, followed by young adults (15-24 years old) (3). Children and young people in Tuggeranong and Belconnen had the highest rate of emergency use for low urgency care in both per 1000 population and real number. In 2017-18, people from Canberra East (the most social-economically disadvantaged area in the ACT) had the highest rate of use of ED services for low urgency care (183.9 per 1000 populations) (3).

There was a slight decrease in the number of potentially preventable hospitalisations (PPHs) for acute conditions (from 1081 to 1017 per 100,000 population) and a significant decrease in that of chronic conditions (from 1045 to 891 per 100,000 population) from 2016-17 to 2017-18 (4). The number of PPHs for acute conditions was considerably high in Tuggeranong, Belconnen, South Canberra and Weston Creek (all more than 1000 per 100,000 population) (4). The figure for chronic conditions was remarkably high in Belconnen (more than 1000 per 100,000 population) and high in Gungahlin, Tuggeranong and Molonglo (more than 950 per 100,000 population) (4). Most common conditions for potentially preventable hospitalisations in the ACT were Chronic Obstructive Pulmonary Disease (COPD), dental conditions, heart disease and cellulitis (4).

HealthMap data during the first quarter of 2020 notes 7071 Healthdirect Helpline calls in the ACT (5). Although its population is smaller, the ACT has a higher number of episodes than Queensland and Victoria. The heaviest usage of Nurse triage was during T1 (6pm – 11pm) and T4 (Sundays or public holidays), and the most calls concerned young children, aged 0-4 years (5). The same goes for After-hour GP Helpline (5). Although the estimated population of Aboriginal and Torres Strait Islander was just 1.9% of the total population (as of June 2019), they represented 3.8% of the total number of calls (5).

Based on our consultations, issues around early assessment, diagnosis and care planning need more attention, especially for chronic diseases, dementia, and chronic pain. Stakeholders all acknowledged that these things are often not managed until they are quite severe and taking a significant toll on quality of life, or when people end up in hospital.

People's experience of the health system as a whole

In 2017-18, 17% Canberrans needed to see a GP but did not, which was higher than the national average at 15.2% (1). Concurrently, during the same period, the ACT reported high levels of people seeing GPs for urgent medical care (12% compared to 11% nationally) (1). Canberrans regularly report experiencing long wait times to access medical services:
- In 2017-18, 27% were referred to a medical specialist and waited longer than they felt acceptable to get an appointment (national average: 21.6%) (1).
- In 2018-19, 19.2% of people who saw GP in the previous 12 months who waited longer than felt acceptable to get an appointment (an improvement from 22.5% in 2017-18, but still higher than the national average at 18.8%) (2).
- In 2018-19, 58.2% waited four or more hours after making an appointment to see a GP for urgent care (the highest in Australia, national average: 38.9%), an increase from 53% in 2017-18 (2).

Our consultations also informed that long wait times often inhibit care and people accessing services, even with timely assessment and referral.

Whilst wait times are a barrier to accessing services, so is affordability of services. Although there have been improvements over time, there are a number of indicators demonstrating the ACT is falling behind the national average. Data has shown that:
- In 2018-19, around 5.6% of people in the ACT deferred seeing GPs due to cost. Although this was an improvement from 8% in 2017-18, the figure was still significantly higher than the national average (3.4%) (2).
- In 2018-19 around 6.8% people in the ACT delayed filling a prescription because of cost, an improvement from 7.1% in 2017-18 (2).
- In 2017-18, around 17.3% Canberrans delayed seeing a dentist, hygienist or dental specialists because of cost (1)
- In 2016-17, the ACT had the highest out-of-pocket expenditure for all non-hospital Medicare services (69.3%, national: 49.8%), diagnostic imaging tests (43.7%, national: 23.5%), GP attendances (63.7%, national: 33.8%) (6).
- Annual Medicare Statistics note that the ACT remained the state/territory with lowest bulk-billing rates in key primary care areas (7).

According to our consultations, the social determinants of health were highlighted as a significant barrier to navigating services in the ACT. Stakeholders discussed the need to improve health literacy, including awareness of services, navigation of services and empowering consumers. Awareness of options and support to navigate the right service are required, particularly for vulnerable groups.

Despite the issues with wait times and accessibility, Canberrans' satisfaction with the way their GP interacted with them was higher than the national average:
- In 2017-18, 93% Canberrans reported that their GP always or often listened carefully (national: 91.8%) (1).
- In 2017-18, 95% reported that their GP always or often showed respect (national: 94.1%) (1).

Additionally, while perceptions of health professionals were high, they were not as high as perceptions from patients from other states and territories:
- In 2017-18, 19% of Canberrans saw three or more health professionals for the same condition (national: 17%) (1).
- In 2016, around 90.1% Canberrans said there was a health professional who had a good understanding of their health (second lowest nationally) (8).
- In 2016, around 91.9% patients received enough information from a health professional about their care or treatment (ranked fourth lowest nationally) (8).

How primary, secondary, and tertiary services work together

Communication and information exchange among health professionals seem problematic. For example in 2014-15 (9):
- Around 89.8% Canberrans said that tests, X-ray or scan results were not available at scheduled appointment (second lowest nationally).
- Around 10.6% Canberrans had at least one time when specialist doctor did not have their medical information or test results (second highest nationally).
- Around 86.7% said GPs or their usual health providers seemed informed about a patient's care after their most recent visit to a specialist (second lowest in Australia).
- Only 72.6% said their usual health providers seemed to be informed about a change of medication after their visit to ED (second lowest nationally), and 16.8% did not know until the patient told them (highest in Australia).
- About 68.4% said that their GP or other usual place of care seemed informed about care provided by an allied health professional for physical health (lowest and significantly lower than other states and territories; the next was Northern Territory at 70.5%).
- About 79.3% said that their GP or other usual place of care seemed to be informed about care provided by an allied health professional for emotional or psychological health (second lowest, more than Western Australia at 78% and Northern Territory not reported).

According to our previous consultations, there is an increasing need to build strong partnerships within the health system and across health sectors such as primary, community and acute care; specialist and generalist care; mental health, aged care, and disability services; as well as public, private and not-for-profit providers. All relevant parts of the system should work to facilitate better integration or coordination of services to enhance health service delivery centred on the needs of the individual. Making transition points as navigable and as seamless as possible minimises handover risk, avoids duplication and treatment delays, and ensures the provision of high-quality, consistent care

The impact of COVID-19 on care across the continuum

Our consultations with stakeholders inform us that COVID-19 has brought many challenges to continuity of care. Reduced face-to-face access to GPs can be prohibitive to diagnosis/monitoring of conditions (i.e. cervical cancer screening and chronic disease management). There have been signs of increased impacts for people who use recreational facilities to manage chronic conditions, such as gymnasiums and swimming pools. There is a fear of accessing in-person health services which in turn can exacerbate conditions due to not seeking services - this includes preventative health screening for a range of cancers.

Additionally, with increased physical distancing measures limiting access to outpatient clinics and a reduction of face-to-face services, there were increased concerns and challenges around access to screening (i.e. breast screen) and outpatient services as reported by many stakeholders. Access for consumers and clear communication to GPs were disrupted. While a rapid implementation of telehealth services for many outpatient specialities occurred, GPs reported being unclear around referral pathways and requirements and remained concerned that clients would not have access. Opportunities to leverage telehealth to improve continuity of care were identified (i.e. through brief consultation and case conferencing between general practices and specialists) but ongoing work is required to ensure that workflows meet the need for consumers, specialists, and GPs.

Update on stakeholder perceptions on care across the continuum

Stakeholders emphasized the importance of co-design, better implementation, monitoring and evaluation practices to create meaningful and sustainable changes for improvements. Beside better integration and easy navigation, affordability remains a strong theme in our consultations. As people cannot afford to access services for early interventions and better monitoring, their conditions got worse and demands more advanced care. Improving access to specialists was mentioned as important to improve continuity of care.

2. Aboriginal and Torres Strait Islander health

This priority area focuses on:

- Ensuring access to culturally appropriate care
- Improving physical health and wellbeing of Aboriginal and Torres Strait Islander people
- Improving the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.

Key themes and issues for PHN action

Theme	Focus areas	Strategies & opportunities to address
Supporting the primary care workforce to provide culturally appropriate care	2.a. Improving identification of Aboriginal and Torres Strait Islander people and supporting them to access culturally appropriate care pathways 2.b. Reducing barriers to access	Capacity building Commission services
Access to culturally appropriate services	2.c. Supporting mainstream workforce to provide culturally appropriate care 2.d. Enabling and supporting the Aboriginal and Torres Strait Islander workforce	Capacity building
Improving health outcomes for Aboriginal and Torres Strait Islander people	2.e. Coordinating care and supporting people to navigate services 2.e. Providing high quality assessment, diagnosis, and management for chronic disease 2.f. Providing care coordination for chronic conditions, mental health, social and emotional wellbeing services, and AOD services	Commission services Capacity building
Impact of COVID-19	2.g. Address emerging needs from COVID-19	Capacity building Planning Strategic partnerships

Intended outcomes

- Aboriginal and Torres Strait Islander people in the ACT experience positive social and emotional wellbeing
- Aboriginal and Torres Strait Islander people in the ACT experience improved health
- The health care workforce is delivering culturally appropriate care.

Ensuring access to culturally appropriate care

According to ABS in 2018, there were 7,513 Aboriginal and Torres Strait Islander people in the ACT, accounting for 1.8% of the total population (10). According to AIHW's data on cultural safety health care framework in 2017-18 (11), the ACT had some of the lowest rates for several indicators of culturally safe services. The indicators examine an organisation's: provision of interpreter services, provision of cultural orientation for non-Indigenous staff, mechanisms for client and community feedback, and the presence of cultural safety policies developed in consultation with communities and Indigenous staff. NSW/ACT also had the second lowest rate (69%) of primary health care services that had formal cultural safety policies nationwide, 69% compared to South Australia who had the highest at 88% (11).

Cultural appropriateness and trust are major barriers to access services. In 2014-15, 83.8% Indigenous patients felt doctors showed respect for what patients reported (the lowest in Australia), 8.3% believed they were treated unfairly by healthcare providers (ranked third nationally) and only 64.4% of Aboriginal and Torres Strait Islander patients in the ACT had trust in hospitals (11). The cultural appropriateness of services is important as Traditional healing programs are not easily accessible in the ACT, with the ACT/ NSW having the lowest proportion of primary health services offering traditional healing, bush medicine and bush tucker (7%, 4% and 5% compared to 75%, 44% and 29% of South Australia – the highest in Australia) (11).

Cost is also a barrier to accessing care. Approximately 25% of Aboriginal and Torres Strait Islander people said they needed to go to a doctor (at least once) in the last 12 months but did not (12). For Indigenous Australians of all ages, services that were not accessed when needed included dentists (25%); doctors (21%); other health professionals (13%); and hospitals (7%). Additionally, our previous consultations note transportation as another major issue in the ACT for people to access services.

Consultations also highlighted a range of services that are in demand for the local Aboriginal and Torres Strait Islander population, but are in short supply:
- Men's rehabilitation and men's services with better visibility.
- Mental health programs with Aboriginal workers – especially for adolescents (ex. headspace).
- Services for Aboriginal and Torres Strait Islander women incarcerated in the ACT (the ACT had the highest rate of women incarcerated in the nation) and alcohol and other drug services for women
- Trauma healing/informed programs
- Culturally appropriate aged care facilities
- An Aboriginal Community Controlled Legal Service
- Indigenous Children's Commissioner
- A service directory listing all culturally appropriate and Community Controlled services in the ACT (and cross border).

Improving physical health and wellbeing of Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people who had seen a GP or specialist was higher for the ACT (94%) than any other state and territory, except Victoria and Tasmania (12). However, AIHW's report on Indigenous primary care results from Online Services Report (OSR) and the national Key Performance Indicators (nKPIs) in 2020 reports a sharp decrease of 9% in the rates of uptake for MBS General Practitioner Management Plan (MBS item 721), and 9% in Team Care Arrangements among Aboriginal and Torres Strait Islander people aged 35-44 years in the ACT (13). Among the states and territories, the proportion of Indigenous people with one or more selected chronic conditions in the ACT was the second highest in Australia in 2018-19 (57%) (12). Recent data from the 2018-19 National Aboriginal and Torres Strait Islander Health Survey states the most common chronic health problems among Indigenous populations were eye/sight problems, mental and behavioural conditions, asthma, ear/hearing problems and back problems (12). The gaps between Indigenous and non-Indigenous populations in the ACT in terms of asthma, mental and behavioural conditions were most significant, with the rates of Indigenous populations being about twice as much as those of non-Indigenous (12).

The age-standardised hospitalisation rate (excluding dialysis) for Indigenous Australians in the ACT in 2013-15 was 326 per 1,000 population (14). This was 1.3 times the rate for non-Indigenous Australians, and the rates were higher for females than for males (14). In the same period, some numbers that need attention were (14):
- The age-standardised rate of hospitalisation for injury and poisoning were higher than that of non-Indigenous Australians (29 compared with 22 per 1,000) (14). The rate was lower for Indigenous males compared to females (24 per 1,000 compared with 33 per 1,000)
- The age-standardised hospitalisation rate for respiratory diseases was 1.8 times the rate for non-Indigenous Australians (14 per 1,000)
- The age-standardised hospitalisation rate for Indigenous Australians for mental health-related conditions was 16 per 1,000. This is 1.9 times the rate for non-Indigenous Australians (8.8 per 1,000)
- The age-standardised rate of hospitalisations where Indigenous patients left against medical advice, or were discharged at their own risk, was 5.2 times the rate for non-Indigenous patients (1.8% compared with 0.3%).

Improving the social and emotional wellbeing of Aboriginal and Torres Strait Islander people

According to ABS National Aboriginal and Torres Strait Islander Health Survey in 2017-18, the proportion of Indigenous people with a mental or behavioural condition was highest in the ACT, 40% compared to national average of 24% (12). Indigenous youth in the ACT had the highest rate of psychological distress in comparison to their peers in other states and territories between 2012-18 (12). The proportion of people with high or very high psychological distress was double that of non-Indigenous population (12). According to AIHW's report on Aboriginal and Torres Strait Islander health performance framework in 2017, the average annual change in the number of community mental health service contacts in the ACT for Indigenous population kept rising overtime and was significantly higher than that of non-Indigenous population (6.9% compared to 0.7%) (15). In 2013-15, the age-standardised hospitalisation rate for Indigenous Australians in the ACT for mental health-related conditions was 16 per 1,000, which was 1.9 times the rate for non-Indigenous Australians (8.8 per 1,000 population) (14).

The impact of COVID-19 on Aboriginal and Torres Strait Islander health

Nationally, as of 13 October 2020, there were 146 cases of COVID-19 reported in Aboriginal and Torres Strait Islander people. Almost 80% of these cases were locally acquired, 75% of these reported in major cities across Australia (16). There has been a large and successful public health response by Aboriginal and Torres Strait Islander communities, Aboriginal Community Controlled Health Sector and health services evidence by these low numbers. Comparatively, the number of cases among Aboriginal and Torres Strait Islander people is six times lower, than if the population was impacted at the rate as the rest of Australia (16).

Locally, ACT PHN worked closely with Winnunga Nimmityjah Aboriginal Health and Community Services in setting up a GP Respiratory Clinic. Additionally, ACT PHN collaborated with ACT Health and members of the local community to co-design and develop a COVID-19 brochure for the local Aboriginal and Torres Strait Islander community. Consultations have told us that COVID-19 had a negative impact of services for Aboriginal and Torres Strait population. It has also delayed consultation activities from other organisations with the local community to inform future service design.

Update on stakeholder perceptions on Aboriginal and Torres Strait Islander health

Stakeholders have informed us that the health of Aboriginal and Torres Strait Islander people remains a multifactorial and complex space. Mental ill health of Aboriginal and Torres Strait Islander people is made more complex due to comorbid substance use issues. Stakeholders have noted some improvements from the "Closing the Gap" initiative. However, there still needs to be more funding for Aboriginal and Torres Strait Islander specific services, improved navigation, and more representation of Aboriginal and Torres Strait Islander people in decision making bodies, service design, implementation, and evaluation.

3. Digital health

This priority area focuses on:

- The utilisation of digital health tools to improve care, coordination, and communication
- The experience and opportunities to use digital health to improve care
- Consumer use of digital and e-health tools

Key themes and issues for PHN action

Theme	Focus areas	Strategies & opportunities to address
Integration of digital health systems	3.a. My Health Record (MHR) is not being fully utilised across the continuum of care. 3.b. Digital health systems within the health sector and community are not compatible and are therefore burdensome to use.	Capacity building System improvement Strategic partnerships
Digital health use among consumers	3.c. Lack of health literacy around the use of digital health tools and systems by consumers. 3.d. Lack of understanding of how consumers and carers use digital health or what they want from it.	Planning Awareness raising
Digital health use among health care professionals	3.e. Opportunities to use of digital health systems including e-referrals and secure messaging to improve coordination and communication. 3.f. E-prescribing in the ACT is an opportunity to improve medication safety and management. 3.g. Support for health professionals to engage consumers in using digital health tools.	Capacity building Strategic partnerships System improvement
Impact of COVID-19	3.h. Address emerging needs from COVID-19	System improvement Planning Capacity building

Intended outcomes

- Digital health tools enable better care and communication across the health system
- Digital health tools are used consistently and are integrated into service provision
- Digital health tools enable improved health literacy among consumers

The utilisation of digital health tools to improve care, coordination, and communication

A GovDEX review for the ACT in 2019 over the preceding year and a half showed a steady increase in the number of providers registering for My Health Record (MHR). The highest increase was amongst Pharmacists, from 4 in January 2018 to 61 in May 2019. Pharmacists also contribute the most to the document uploads to the records. The number of uploads by GPs doubled during the same period, and GPs are the professionals with the most viewings of MHR documents (17). Consultation informed us that consumers experience challenges and barriers in using MHR, some of which include access to digital platforms, the health literacy to understand the record and concerns around privacy, confidentiality, and accuracy. It was also commented that MHR does not look holistically at individuals, which people feel is a concern when receiving health care.

Canberra Health Services rate as 1.5 on a scale of 0 -7 for their Electronic Medical Records capability. Areas for improvement are required in the digital health space as a result of siloing of information in individual systems, an increase in the number of systems, decentralised system management, multiple sources of patient information, reliance on paper-based records and an ageing infrastructure requiring investment(18). While this is specific to Canberra Health Services, it highlights some of the challenges around integrating digital health systems. There is limited data available around the use of other digital health tools and resources by health care professionals such as e-referrals and secure messaging.

The experience and opportunities to use digital health to improve care

It is perceived by the community that using MHR is burdensome for health practitioners and there is little incentive for them to spend their time engaging with the system. Therefore, the information contained is not comprehensive and the system itself is deemed less useful. A gap has been identified in the communication flows between primary and tertiary healthcare providers, especially within aged care facilities. This communication deficit is also recognised between health and community services. My Aged Care does not talk to My Health Record, another example of disconnected digital systems.

Despite the challenges in implementing the use of digital health tools, digital health was largely seen as a solution to many problems across the health system, and several opportunities were discussed during our consultations, including:
- An increase in the use of e-prescribing to improve medication safety
- The use of digital health to help consumers track and manage their health, improve health literacy, and lead to greater independence
- Digital transformation to improve health outcomes for patients and address health system challenges, whilst supporting clinicians through the opportunity for improved shared care.

According a survey conducted by ACT PHN in 2020, 50% of the practices surveyed told us that they were not fully aware and prepared for the new electronic prescriptions arrangements that are coming into effect (19). Just around 1/3 of practices were connected to Prescription Exchange Service and less than 1/3 update the service as part of onboarding process for new doctors (19). However, 24/39 practices informed us that they were planning to move to the version of clinical information system that is more conformant with electronic prescriptions.

The impact of COVID-19 on digital health

During the COVID-19 pandemic, the CHN's commissioned service providers were able to quickly transition away from face-to-face service delivery toward digital platforms such as video, phone and other media communications with their client cohort. Providers were utilising mediums such as email, texts, phone and video calls, social media and apps to maintain communication with clients and also staff during the period of social isolation. Whilst nearly all providers were able to adjust to this rapid transition, it brought many challenges in the continual strive to maintain engagement with community members during this stressful period. Challenges such as decreased client input through video or phone sessions (although some providers stated that youth clients were engaging better through video), clients not having access to the required level of quiet space, technology or internet to facilitate sessions and the reduced ability to build rapport with non-face-to-face mediums, particularly during group work. Benefits to the increased uptake of digital platforms as a medium to deliver services include decreased DNA rate for some programs and higher accessibility for clients were transport and time were an obstructing barrier.

Due to COVID-19 physical distancing requirements, the uptake of telehealth was high across all 97 general practices in the ACT based on engagement and feedback from the sector. A survey was conducted across general practice to assess uptake of telehealth and 36/39 respondents used telehealth to deliver services (19). However, a majority of responding practices reported that they were using telehealth for less than 50% of their appointments during the first several months of the pandemic and the primary mechanism for delivering telehealth was by telephone (19). Reflecting the survey results, stakeholder feedback has suggested that use of video-conferencing to conduct telehealth has been limited, with some GPs reporting that video calls took longer to establish/set up, created more burden for clients as it required access to a camera. Overall stakeholders have endorsed telehealth as a valued addition to their services but agree it should be delivered in conjunction with in-person care.

COVID-19 also brought in a very rapid implementation of electronic prescribing. Initial challenges including ensuring readiness across both community pharmacy and general practice and establishing new business workflows. To date a large majority of community pharmacies, have the systems in place and are able to accept electronic prescriptions based on feedback from key peak organisations. Ongoing cross sector engagement and uptake of digital health tools such as e-prescribing are required to support effective implementation.

Update on stakeholder perceptions on digital health

Stakeholders told us that while there is great value in video services for telehealth, there is still a strong reliance on audio only telehealth. My Health Record is potentially addressing a range of issues around coordination of care but is yet to meet the needs of the community. Awareness of e-prescriptions is low among both consumers and health professionals due to the lack of communication and engagement. Improved communication between acute and government sectors (e.g. hospital) and community providers (e.g. GPs, allied health practitioners) need to be improved.

4. Alcohol, tobacco and other drugs

This priority is about:

- Improving access to specialist alcohol and other drug (AOD) services
- Preventing alcohol, tobacco, and other drug (ATOD) related harm
- Building workforce capacity.

Key themes and issues for PHN action

Theme	Focus areas	Strategies & opportunities to address
ATOD in primary care	4.a. Assessment of ATOD use and related harm in general practice 4.b. Managing the physical health care needs of people experiencing or at risk of ATOD-related harm 4.c. Ensuring appropriate information and referral pathways are in place for GPs, including self-help resources, early intervention support, and specialist services 4.e. Increasing the number of GP prescribers for pharmacotherapy.	Capacity building System improvement Strategic partnerships
Delivering specialist AOD services	4.f. Ensuring an appropriate mix of service types in the ACT 4.g. Increasing access to specialist services that meet the needs of the community 4.h. Ensuring the availability of culturally appropriate services for Aboriginal and Torres Strait Islander clients.	Commission services
Social determinants of health	4.i. Ensuring that primary care and specialist services recognise and respond to the holistic needs of clients, including the social, legal, and health needs of people who are experiencing ATOD related harm.	Capacity building System improvement
Impact of COVID-19	4.j. Address emerging needs from COVID-19	Capacity building System improvement Planning

Intended outcomes

- AOD related harm is prevented and managed appropriately in the ACT
- people using ATOD have access to information, support, and services to reduce harm or risk of harm
- the primary care and AOD specialist sector are well supported to provide high quality care.

Current landscape of alcohol, tobacco, and drug use in the ACT

The consumption of alcohol, tobacco and other drugs is a major cause of preventable disease and illness in Australia. The health burden of alcohol and other drug use is considerable and includes hospitalisation from injury and other disease, mental illness, pregnancy complications, injection-related harms, overdose and mortality (20).

The 2019 National Drug Strategy Household survey reports the proportion of daily smokers in the ACT has declined overtime, from 9.7% of people aged 14 and over in 2013 to 8.2% in 2019 (21). Conversely, alcohol was among the most consumed drugs in the territory, with Canberrans drinking roughly 1.6 standard drinks per person per day (22). According to National Health Survey 2018-19, 15.8 % of people in the ACT exceeded lifetime risk guidelines and 43.9% exceeded single occasion risk guidelines for alcohol consumption (23). In regards to illicit drugs, the 2019 National Drug Strategy Household Survey notes the proportion of people aged 14 and over having recent illicit use has reduced from 15.3% in 2013 to 14.6% in 2019 (21). Analysis of the ACT's wastewater in 2019 by the Australian Criminal Intelligence Commission (ACIC) found Canberrans were among the highest opioid users (fentanyl and oxycodone) in the nation (22).

There is a clear trend towards the increasing use and accessibility of amphetamine type stimulus drugs. A majority of people who inject drugs and use methamphetamine or cocaine reporting that it is ‘easy’ or ‘very easy’ to obtain those substances (20). The negative impacts of drug use are significant. Nationally, amphetamine use contributed to 28% of drug use disorders (excluding alcohol), 5% to poisoning and suicide, 4.3% to self-inflicted injuries and road traffic injuries (24). Locally, 47% of the ACT Illicit Drug Reporting System sample self-reported a mental health problem in the preceding six months, most commonly depression (62% of respondents) and/or anxiety (41% of respondents) in 2017 (24). Many (65%) of those who had experienced a problem reported attending a mental health professional (24). Higher levels of psychological distress were reported, with 29% reporting very high distress (compared to 3% in the general population) and 29% reporting high distress (compared to 7% in the general population). Other mental health issues identified among a sample of crystal methamphetamine (ice) users in the ACT include anxiety, depression, perceptual disturbances, thought disorder, delusions, paranoia, hallucinations and psychosis (25). The number of contacts with ED from ACT ice users was particularly high compared to the general population: 43% of participants had attended ED in 2017 (25).

The AOD specialist sector in the ACT provides a variety of services, including counselling, assessment, support and case management, withdrawal management, information, education, and rehabilitation. According to the most recent reporting from the AODTS National Minimum Data set in 2018-19, there were 6,700 closed treatment episodes provided to clients in the ACT (26). People aged 30-39 years old had the highest number of closed episodes (1926), followed by people aged 20-29 (1588 closed episodes) and people aged 50-59 (1565 episodes) (26). There were 956 closed episodes of people identified as Aboriginal and Torres Strait Islander, accounting for 14.27% of total episodes (26). Alcohol had the greatest number of closed episode (42.8% of all episodes), followed by amphetamines (22.6%), cannabis (12.7%) and heroin (10.5%) (26).

There is a low uptake of opportunistic AOD screening/ assessment at potential services (e.g. domestic and family violence or mental health services) to identify a window for early intervention. Through our consultations, the reasons for low uptake are:
- Services tend to have a speciality/narrow focus and therefore do not prioritise people with or screen for alcohol use
- There is nowhere to refer clients to or they have to wait long periods of time, which results in the assessment becoming irrelevant
- Staff in mental health and primary care services are not equipped to deal with AOD issues, stigma, trauma, creating safe place for disclosure, lack of knowledge of opportunities for direct intervention (e.g. nicotine replacement) and knowledge of suitable referral pathways
- Lack of a simple screening and assessment tools to enable identification and referral.

Although alcohol and substance abuse issues are common comorbidities of mental health issues, services are not well-integrated and cannot provide a holistic approach to help clients recover effectively. According to ATODA’s survey in 2018, mental health was the most frequently received type of support within the organisation (27.2%), which means AOD service organisations may be under pressure to deal with mental health issues (27).
Stakeholders have told us that:
- There is no existing opportunity to bring all the sector partners together
- There is an assumption that all the pieces already exist
- The thing left to be done is to integrate services effectively.

Wait times to access needed services in the ACT are significant and detrimental to people’s health. According to ATODA’s Service Users’ Satisfaction and Outcomes Survey in 2018, 40.7% service users wishing to enter residential AOD programs had to wait between 1 to 3 months (27). Other barriers to accessing services as noted in our previous consultations were:
- Access times to see a GP for such things as urgent prescriptions for antibiotics
- GPs have access to treatments they can prescribe (hepatitis treatment, naloxone, nicotine, etc.) but do not always do so as early as they could be
- Cost; the lack of bulk-billing GPs in the ACT as well as out-of-pocket costs, transport, housing, and resourcing problems
- Lack of information regarding available services within the ACT as well as what accessing services, or treatment, means for the client
- Hospital is a no-go zone for AOD community because of stigma and discrimination
- Services are not client-centred
- Primary care practitioners do not know the current capacity of services
- For children and youth services, staff conflating issues and confidentiality breach are significant concerns
- The residential rehabilitation program structure does not suit everyone
- Lack of culturally-secure services for Aboriginal and Torres Strait Islander people, especially non-residential rehabilitation
- Lack of services to improve health literacy and understanding of the system are needed to help people better access the services they need
- Lack of AOD specialists
- Lack of harm reduction strategies and early intervention supports from other sectors that deal with important co-morbidities and social determinants including housing and child protection (ancillary services)
- Lack of graded interventions that suit different levels of issues
- Lack of opioid maintenance treatment prescriber program
- For ice, lack of access to rural women's treatment
- Need for increased community pharmacy dosing
- Need for extended opening hours.

Impacts of COVID-19 on alcohol, drugs and tobacco consumption

Nationally, there are early indications of increasing demands for online AOD supports, increased incidence of family violence, and increased involvement of alcohol in family violence situations (28). A number of potentially problematic alcohol use behaviours during COVID-19 were recorded in a survey conducted by the Foundation for Alcohol Research and Education (FARE) in April 2020, including nearly one in seven (13%) Australian drinkers being concerned about the amount of alcohol they or someone in their household is drinking, 11% reporting drinking to cope with anxiety and stress and 14% reporting they have been drinking daily (28). Consumer spending data on alcohol and sales results from alcohol retailers indicate there has been significant increases in packaged liquor sales since the beginning of COVID-19 lockdowns in Australia, particularly for online sales and home delivery (28).

Based on national data, the most commonly reported reasons for drinking more during COVID-19 were boredom, anxiety or stress, being tempted due to more time at home, to keep spirits up and loneliness (28). Younger Australians are more likely to be drinking to cope with anxiety and stress when compared to those aged over 50 (28).
Locally, almost one-third of men (31%) in the ACT have reported wanting to cut down their alcohol consumption in the next 12 months (28). This could be due to the impacts of COVID-19, when:
- Home is the most common place where Australians drink (29)
- Drinking at home is highly habitual (30)
- Drinking to cope is common among those seeking treatment for problematic alcohol use and it is likely that people are drinking to cope with all the stresses associated with the pandemic (31)
- On-demand delivery of alcohol to people's homes (as businesses try to keep their earning) is linked to a higher likelihood of risky drinking (32).

Stakeholders have informed us that reduced services due to social distancing has resulted in negative impacts on current clients. There were concerns regarding on how to deliver quality services via telehealth and how to deliver medications (e.g. methadone) to clients. They have also confirmed the increases in alcohol-related problems, with an addition of greater oversight of opioid and pharmaceutical drugs to manage anxiety, pain, and mental health issues. Stakeholders also informed us that due to social distancing restrictions and border closure, the drug market has changed significantly, thus might have affected drug use pattern.

Update on stakeholder perceptions on alcohol, tobacco and other drugs

Shortage of service options and lack of Aboriginal community-controlled drug and alcohol services remained the main themes of our consultations. More attention should be paid to populations with intersecting risks (e.g. polysubstance issues, mental health issues) and alcohol consumption issues. Stakeholders continue to note that there is a need for accurate and timely information about AOD services across the sector, along with how patients can access these services. It has also been noted that there are a number of GPs who are qualified to prescribe opioid maintenance therapy but choose not to. As a result, the small number of GPs who do prescribe are seeing the majority of patients.

5. Mental health

This priority area focuses on:

- The mental health and wellbeing of people in the ACT
- The psychosocial needs of people living in the ACT
- Access to services.

Key themes and issues for PHN action

Theme	Issues/Needs identified	Strategies & opportunities to address
Improving access and outcomes for people with mental illness	5.a. Awareness of services and communication about how to access services 5.b. Addressing barriers to accessing care such as wait times and affordability 5.c. Culturally appropriate, safe, and responsive services 5.d. Tailored services for at-risk populations 5.e. Clinical services for people with mild-to-moderate and severe mental illness.	Commission services System improvement Capacity building
Integrated mental health services	5.f. Availability of services across the stepped care continuum and effective referral pathways between steps 5.g. Availability of information for consumers and health professionals to support service navigation.	Commission services System improvement
Whole-of-person care	5.h. Holistic, wrap-around services including mental, physical, and social health 5.i. Consideration for social needs during assessment and care planning 5.j. Ongoing, consistent, and comprehensive psychosocial services for people with severe mental illness.	Commission services Capacity building
Supporting the mental health workforce	5.k. Limited workforce and skill mix 5.l. Effectively supporting a peer workforce 5.m. Supporting the workforce to provide culturally appropriate, safe, and responsive care.	Capacity building
Suicide prevention	5.n. Providing integrated suicide prevention services and initiatives.	Commission services Capacity building
Early intervention in life, illness, and episode	5.o. Early identification and assessment of ill mental health 5.p. Provision of preventative support during stressful life transition periods 5.q. Provision of low intensity services earlier in illness or episode 5.r. High rates of mental illness and psychological distress among children and young people.	Commission services System improvement
Impact of COVID-19	5.s. Address emerging needs from COVID-19	Capacity building System improvement Planning Commission services

Intended outcomes

- People experience improved mental health and wellbeing
- People experience mental health services as integrated and seamless
- The mental health workforce is supported and able to deliver high quality care.

Mental health and wellbeing of people in Canberra

Mental illness is a leading cause of chronic disease in the ACT. According to National Health Survey 2017-18, around 20.8% people aged 15 and over in the ACT had mental and behavioural issues (23). Local data from 77 general practices as at end of January 2020 shows that 12.3% of their total patient population were diagnosed with at least one mental health disorder (33). Of data from ACT Government, the two most common conditions were anxiety (68% of affected population) and depression (57% of affected population). Evidence from the Primary Mental Health Care Minimum Data Set highlights that the most common mental health conditions in the ACT from 2017-18 were major depressive disorder, generalised anxiety disorder, mixed anxiety and depressive symptoms and post-traumatic stress disorder(34). Anxiety disorders contribute to 5.1% of the burden of disease and depressive disorders contribute to 2.7% of the burden of disease (35). Data from the AIHW Mental Health Services report show that compared to national data, in 2017-18 the ACT had a higher percentage of population receiving clinical mental health care in the following group: females, Indigenous, people aged 25-64, most disadvantaged and least disadvantaged (23)

In the ACT, the death rate by suicide has increased over the last 10 years; however, this may be due to changes in how deaths by suicide are reported. According to ACT Health, deaths by suicide were three times higher among ACT males than females in 2015, and this has been consistent over time (35).

The suicide death rate in the ACT in 2018 was 11 deaths per 100,000 people (compared to 12.1 nationally). The ACT Chief Health Officer's Report 2018 notes 76% of self-harm hospitalisations in 2015-16 were female and almost 50% of self-harm hospitalisations in 2015-16 were young Canberrans aged 10 to 24 years (35).

Access to mental health services

According to Mental Health Community Coalition in 2018, there were 110 services with 122 main types of care (36). Most of the types of care were directed at adults (62%) with much smaller numbers specifically directed to children and adolescent (9%) or those transitioning to adulthood services (5%). Although the number of new clients tends to reduce overtime, the demand of services is increasing in duration, complexity, severity, and quality. According to our consultations, access to mental health services is a serious issue in the ACT, including wait times, service accessibility and availability for vulnerable populations, service effectiveness, cultural appropriateness, and the broken links with AOD and other health services. The gaps in primary and community services have led to high demands in mental health presentations, increased burden on hospital mental health care.

In 2017-18, the ACT had the highest rate of service contacts for community clinical mental health care services (767.5 persons per 1,000 population) – twice the Australian average (37), with 37.8% of the ACT consumers receiving mental health services being new clients (38). Although the percentage of new clients reduced, the number of mental health service contacts increased significantly overtime (37). From 2013-14 to 2017-18, the number of service contacts increased by 1.8%, the number of patients increased by 2.3% and the number of treatment days increased by 2.5% (37). These increases ranked third among all states and territories and suggest that mental health issues in the ACT are increasing in both number and complexity. The three most common principal diagnosis that contact community mental health services in the ACT in 2017-18 were schizophrenia, schizoaffective disorders and bipolar affective disorders (37). Beside mental health diagnosis, issues relating to substance use, alcohol consumption and eating disorders lead to a significant proportion of community mental health service needs in the ACT (37). Within primary care, there were 39,606 people in the ACT receiving Medicare-subsidised services, with the majority of services provided being GP mental health specific services (120.9 services per 1,000 people) (39).

All areas in the ACT had increases in mental health service contacts from 2016-17 to 2017-18, except for Canberra East (37). Areas that experienced a significant surge in service contacts were Tuggeranong (223%), Belconnen (191.8%), South Canberra (191%) and Weston Creek (164.6%). North Canberra had the highest contacts per patient ratio (31 contacts per person), followed by Belconnen and Gungahlin (28 and 27 contacts per person respectively). Tuggeranong, Belconnen and North Canberra were the areas with the highest number of mental health contacts for the Aboriginal and Torres Strait Islander population (37). The greatest increases were in Weston Creek (311%), South Canberra (257%), Tuggeranong (241%), Woden Valley (238%) and Gungahlin (166%) from 2016-17 to 2018-19 (37). The highest number of contacts per Aboriginal and Torres Strait Islander per person was in South Canberra, followed by North Canberra, Canberra East, Weston Creek and Tuggeranong (37). There were 111.2 per 10000 population (4,626 people) mental health ED presentations and in 2017-18, double the rate in 2004 (40).

Issues regarding access to appropriate services was a prominent theme from our previous consultations. Concerns were raised regarding wait times for people to have an appointment with a medical specialist, transportation to and from appointments, as well as affordability. Challenges regarding service navigation for clients and their families/carers were also raised as problematic during our previous consultations, as was finding appropriate housing options for both crisis and non-crisis situations.

Other gaps in services identified from previous consultations include:
- Lack of qualified knowledgeable peer-led services and understanding of the importance of a peer-led community-controlled workforce for mental health
- Lack of services for the missing-middle – people who are often too unwell for primary care, but not unwell enough for state-based services, as defined by Orygen (41)
- There is a need to fill the gaps during waiting periods between appointments and referrals
- Improved services and resources across the lifespan are required, particularly at transition point ages such as 8, 12, 18, 25, 65
- Lack of acute and non-acute alternatives to hospitalisation, acute and non-acute health-related day programs, employment-related services
- Mental health specific services for specific vulnerable populations, including older people with an intellectual disability, refugee population, carers, children, and people with complex comorbid disabilities
- Lack of continuity of care between and among services within the broader ACT health system.

Psychosocial needs

ACT PHN also funds a range of psychosocial services for people with severe and complex mental illness, while not a separately identified priority this section draws on findings from the mental health priority with a specific focus on psychosocial needs of people with severe and complex mental illness. This section summarises the specific needs of this population and aligns with many of the findings under the Mental Health priority.

This priority area focuses on:

- Ensuring access to psychosocial supports for people with severe mental illness
- Improving the continuity of care for people with severe mental illness.

Key themes and issues for PHN action

Theme	**Issues/Needs identified**	**Strategies & opportunities to address**
Improving access and outcomes for people with complex mental illness and psychosocial disability	5.a. Awareness of services and communication about how to access services 5.b. Addressing barriers to accessing NDIS and/or other psychosocial services.	Commission services System improvement Capacity building

Whole-of-person care for people with complex mental illness and psychosocial disability	5.h. Holistic, wrap-around services including mental, physical, and social health 5.j. Ongoing, consistent, and comprehensive psychosocial services for people with severe mental illness.	Commission services Capacity building
Supporting the workforce to deliver psychosocial services	5.k. Limited workforce and skill mix 5.l. Effectively supporting a peer workforce.	Capacity building
Impact of COVID-19	5.m. Address emerging needs from COVID-19	Capacity building System improvement Planning Commission services

Intended outcomes

- Psychosocial support services support recovery
- People with severe mental illness have access to and receive an appropriate level of psychosocial services.

The psychosocial needs of people living in the ACT

According to National Health Survey in 2017-18, females in the ACT had a much higher rate of having high or very high psychological distress compared to males (13.6% compared to 8.6%) (23). As of June 2019, the ACT had the second highest percentage of NDIS participants with psychosocial disability, at 12.7 % (Vic 13.2%) (42). Its average spend in plans is slightly above the national, at $65,000 compared to $63,000 (43). These figures do not include people with psychosocial disability who have been found to be ineligible for the scheme. Of the 50% of current Commonwealth Community Mental Health Program clients that have applied for the NDIS, half have been found eligible, one-quarter have been found ineligible and the remaining quarter are awaiting an outcome in 2019 (43). The greatest number people receiving psychosocial therapies belonged to the adult age group (25-64) (369 people), around 4 to 5 times higher than that of people from 18-24 and people aged 65+ (34). When considering the proportion of people accessing services in each age group, people aged 18-24 were more likely to access low intensity services, followed by people aged 12-17 (34).

Ensuring access to psychosocial supports and improving continuity of care for people with severe mental illness

According to national rates, it is estimated that approximately 3% of the population have severe mental illness, many of whom require a mix of clinical and non-clinical psychosocial supports and coordination of these services (42). A smaller number will require ongoing support for chronic and enduring needs while others may need more episodic care (42). The most recent Disability, Ageing and Carers Survey from the ABS found that almost a quarter of all people with disability reported a mental or behavioural disorder as their main condition (44).

In the ACT about 68% of access decisions for people with psychosocial disability have been found to meet the requirements which is on par with the national rate of 67% (42). The ACT has the third highest rate among states and territories (42). Local program data also suggests there are a number of people in the ACT who choose not to test for the NDIS and so they are not represented in this data. While there has been good uptake of the NDIS by people with psychosocial disability in the ACT, issues and barriers to access services present, including:

- The current suite of funded programs continues to leave gaps, specifically where a person chooses not to test for the NDIS
- Accessing assessments and obtaining proof of need for the NDIS application process is often costly and requires a high level of support or capability to navigate
- A major impediment to the successful transition to the NDIS continues to be that the Scheme fails to cater adequately for the complexities and specificities of psychosocial disability as compared to general disability
- Support for alcohol and other drug use, transportation, accessing education or volunteering, the provision of personal and domestic care, and accessing services such as Centrelink are common needs of people accessing psychosocial services
- People with disabilities who are on NDIS Supported Independent Living (SIL) money will not be supported to find housing.

Impacts of COVID-19 on service and mental wellbeing

Generally, people's mental health is negatively impacted by COVID to a significant extent. In July 2020, Lifeline Canberra answered 4,400 calls — almost 900 more than any single month previously (45). This is a 35% increase in calls compared to July last year. Of those callers, 43 had immediate safety risks and emergency services were needed to give them immediate assistance. Lifeline data also revealed that 406 of the callers were either experiencing suicidal thoughts or had a suicide plan and had to work with the crisis supporter to keep safe. A further 111 callers were in domestic violence situations.
In early April 2020, the Youth Coalition of the ACT conducted a survey of service providers working with young people and families to examine the early impact of COVID -19 (46). The submission found that young people and their families were experiencing higher levels of stress, anxiety and depression, as well as increased alcohol and other drugs use. Services were reporting higher demand from existing clients seeking emotional support. Online and phone-based mental health providers reported an increasing demand for counselling (47).

According to our consultation with local service providers, service closures or reduced capacity in both quantity and quality have had significant impacts on vulnerable populations, people with complex conditions and older people, who were unable to use or did not have access to digital alternatives. Telehealth was challenging for both clients and service providers. Services have witnessed a surge in presentations for mental health care with increased complexity. Stakeholders informed us that the reasons for increased mental health presentations was due to greater economic and occupational uncertainty and worsening chronic illness burden. On a national scale, Sydney University's Brain and Mind Centre has estimated that there was a 14% increase in overall suicide rates due to COVID-19 restrictions and the subsequent social dislocation and economic fall-out nationally (48). The real drivers of these substantive health risks are job losses, social disconnection and, for young people, the availability of support for ongoing education and training.

Key stakeholders have indicated that mental health and wellbeing is a primary concern emerging out of COVID-19 with increased isolation, limited access to services and increased stress. A survey of local general practices about needs emerging out of COVID-19 indicated that 38% of respondents were concerned about the availability of mental health services for patients and 41% indicated concern about the mental health and wellbeing of their staff. GPs have reported increased mental health presentations and long wait-lists for services.

Update on stakeholder perceptions on service and mental wellbeing

There was a strong emphasis on the importance of peer supports. Stakeholders also stated that service providers need additional resourcing to increase program capacity, workforce needs to be grown and there needs to be an increased level of capital investment in the establishment and maintenance of facilities to provide services. The gaps in appropriate services for teenagers and the “missing middle” (people with psychosocial disability who were not eligible for NDIS and/or people with mild-moderate depression and anxiety) were highlighted. Mental health services should shift from crisis-response to prevention and early intervention. Speech pathologists should be key members of early intervention programs as many mental health difficulties are masked by undiagnosed speech, language and communication needs. Intersecting needs are once again noted, especially as the impacts of substance use on psychosis which then leads to a mental health admission. There is a major overlap between chronic trauma and domestic violence, resulting in additional complexity for service providers in managing clients and referring them to the most appropriate services.

6. Chronic Conditions

This priority area focuses on:

- The prevention and management of chronic conditions
- Quality of care for chronic conditions.

Key themes and issues for PHN action

Theme	Issues/Needs identified	Strategies & opportunities to address
Prevention and management of chronic conditions	6.a. Focus on limiting risk factors and improving prevention 6.b. Building health literacy to support self-management 6.c. Need for integrated and multidisciplinary care 6.d. Coordination of care and navigation of services including discharge planning, team care arrangements 6.e. Understanding the impact that social determinants have on chronic conditions.	Capacity building Commission services Raise awareness
Access to multidisciplinary and team-based care	6.f. The management and care of chronic conditions requires coordination, flexible service delivery, and team-based care 6.g. Innovative models of care that improve access to integrated services for chronic conditions.	Capacity building Commission services
Support for workforce	6.g. Primary health care professionals should be adequately equipped to identify and address risk factors for chronic conditions 6.h. Primary health care professionals need to be supported by effective specialist and allied health referral pathways 6.i. Primary health care professionals should be supported to participated in team-based and shared care.	System improvement Capacity building
Impact of COVID-19	6.j. Address emerging needs from COVID-19	Capacity building Planning Raise awareness

Intended outcomes

- People experience improved health outcomes for chronic conditions
- Chronic conditions are prevented where possible and are managed effectively
- Primary health care professionals are supported to provide high quality care for chronic conditions.

The prevention and management of chronic conditions

According to ABS in 2017-18, approximately 49% people in the ACT had at least one chronic condition(23). Chronic conditions in the ACT increased in both prevalence and complexity, with a 3%, 6.4% and 7% increase in the number of people that had one, two and three or more conditions respectively (23). The most common conditions were hay fever and allergic rhinitis, mental and behavioural conditions, back problems, and arthritis (23). The conditions with the fastest increase in prevalence were Osteoporosis (31% increase); followed by heart, stroke, and vascular diseases (29.3%), cancer (22%), hay fever and allergic rhinitis (21%) and mental and behavioural conditions (21%) (23).

The ABS National Health Survey shows that Canberrans are worse than the national average for a range of health risk factors for chronic conditions despite the ACT having lower rates of adults who were obese compared with Australia (26.4% compared with 31.3%) and higher rates of adults in the healthy weight range (35.1% compared with 31.7%)(23). The main areas of risk were dietary, accompanied by higher rates in inactivity and exceeding alcohol consumption guidelines on a single occasion (23).

The air quality in the ACT was greatly affected by the widespread bushfires burning in 2019–20 (49). On January 1, 2020, a PM2.5 reading of 1197µg/m3 was recorded at Monash in the ACT—a reading almost 48 times the PM2.5 advisory standard of 25µg/m3 (49). Modelled data from a range of sources estimates that, during the 19 weeks of continuous bushfire activity from September 2019 to February 2020, bushfire smoke was responsible for 417 excess deaths; 1,127 hospitalisations for cardiovascular problems; 2,027 hospitalisations for respiratory problems; and 1,305 presentations to emergency departments for asthma across NSW, Queensland, Victoria and the ACT (49).

Quality of care for chronic conditions

According to our consultations, highlighted issues in the ACT in delivering quality care for chronic conditions are integration and continuity of care, including the need for systematic approaches to the diagnosis, care planning and service coordination of chronic diseases across the ACT. There is limited capability of the service system and the health workforce to respond to the demand for chronic disease integrated care. Discharge planning from acute services needs to have better alignment and coordination with primary care in a way that connects patients to general practice, allied health and community support structures that will help mitigate readmission. On the contrary, primary care should include close coordination with, and referral to, speciality or tertiary care services as needed. Management and care for people with chronic conditions requires coordination, flexible service delivery and team-based care. This should be underpinned by a well-resourced health workforce with the capability to communicate effectively across sectors and work in flexible team-based care arrangements. Innovative models, such as the use of MBS-funded allied health services, could also be implemented to support the delivery of services to people with chronic conditions and complex needs.

It was highlighted through consultation that there needs to be a strong focus on the proactive prevention and management of chronic diseases, health literacy and self-management. Providing support to patients and the health workforce in managing chronic conditions not only leads to improved care outcomes but also enables hospitals to save money in the form of preventable hospital readmissions. Early intervention of pain management strategies that incorporate diet, exercise and psychological support could also help slow down debilitation caused by chronic disease. Improving health literacy will empower people to take greater control in managing their health and will improve their overall healthcare experience. Family-centric health literacy and empowerment, including ongoing campaigns, could assist consumers to access appropriate resources in the community earlier and build resilience, which could keep them healthier longer and potentially reduce costs associated with unplanned disease exacerbations.

The impact of COVID-19 on chronic conditions

COVID-19 has led to an increase in use of telehealth to support patients to better manage their conditions. Stakeholders told us that webinars on how to guide patients on managing their own conditions were welcomed. As noted earlier, COVID-19 has had an impact on people with chronic conditions maintaining their ability to self-manage their condition and keep regular medical appointments.

Update on stakeholder perceptions on chronic conditions

Care coordination and challenges to access specialists, especially for people with multiple morbidities, continue to be strong themes in the most current consultation. Prevention and self-management were emphasised as an important focus to maintain health and wellbeing of patients with chronic conditions. There needs to be programs to promote people’s health literacy to manage their conditions and prevent the progression of conditions. Co-location is emphasised as an essential way to maintain continuity of care for patients. Discharge pathways need to be better structured and coordinated, with clear procedures to review patients’ conditions in the community.

7. Aged Care

This priority area focuses on:

- The health and wellbeing of 65+ years old Canberrans
- Older Canberrans living in residential aged care facilities
- Older Canberrans living in the community.

Key themes and issues for PHN action

Theme	Issues/Needs identified	Strategies & opportunities to address
Inadequate access to primary health services and multidisciplinary care	7.a. Access to primary care, including GP, allied health (including mental health) and dental 7.b. High rates of preventable hospitalisation among older Australians	Commission services System improvement
Integration of aged care and health services	7.c. The aged care system and health system are siloed and do not work together 7.d. Improved communication between hospitals and aged care facilities on discharge	System improvement
Medication management	7.e. Improved health literacy around medications for older Canberrans. 7.f. Improved medication management and medication safety in residential aged care facilities.	Commission services
Supporting the aged care and health workforce	7.g. Health sector and aged care workforce require support to better work together 7.h. Ongoing training and support for aged care and health workforce in Advanced Care Planning, medication management 7.i. Ongoing support to delivering culturally appropriate care to a diverse group of older people including LGBTQI+, CALD, and Aboriginal and Torres Strait Islander people	Capacity building System improvement
Impact of COVID-19	7.j. Address emerging needs from COVID-19	Capacity building System improvement Planning Strategic partnerships

Intended outcomes

- Older Canberrans experience improved health and wellbeing
- The health and aged care workforce are supported to work together to care for older Australians.

The health and wellbeing of 65+ years old Canberrans

According to the ABS in 2018, there were nearly 53,639 older (65+ years) people in the ACT (12.75% of the total population) (50). According to the ACT Healthy Aging Report Card in 2018, the ACT population will almost double in the next 40 years, with the greatest increase in people aged 85 and over (from 13% in 2017 to 22% in 2059) (51). The life expectancy ACT residents has increased over the last ten years and is the highest in Australia (51). The ACT older persons population is diverse, with 57% born in Australia, 29% Europe, 0.3% Aboriginal and Torres Strait Islander, and 25.6% with a CALD background. Suburbs with the highest proportions of people aged 65 and over were Yarralumla and Page (25% in each suburb) (52). Belconnen and Tuggeranong are the areas with the fastest growth in the number of older residents, and it is estimated that by 2021 almost half of the ACT's older people will be living in these areas (52).

Approximately 80.8% of older people in the ACT in 2018 had at least one or more long term physical health condition (53). According to ABS Disability, Aging and Carers Survey in 2018, about 24,500 older people in the ACT reported to have disability and around 11,400 had profound or severe core activity limitation (53). Around 22.2% older people in ACT need assistance with at least one activity (53). The highest areas of need were in property maintenance (12.5% of older ACT population), health care (11.2%), mobility (10%) and transport (9.7%). The ABS also reports that there were 49,200 people aged 65+ in the ACT in 2017-18 suffering from psychological distress (54% were female), and 8300 (16.9%) people aged 65+ had mental and behavioural problems (37). Males over 65 have high or very high levels of psychological distress compared to 7.4% of women (37). Older people in the ACT are over-represented in community mental health and hospital out-patient services with depression and anxiety being most common. There were 21,420 mental health services contacts of people aged 65+ in the ACT in 2017-18 (37). While the length of acute inpatient stay reduced nationally, that of older people in the ACT increased significantly over time (13.6% compared to -0.3% nationally) (38) .

Total potentially preventable hospitalisations (PPHs) of older people in the ACT in 2017-18 was 3795, equivalent to 7351 PPHs per 100,000 people (54). Among those, the most common type of PPH was due to chronic conditions (57.9%, average length of stay: 5.3 days), followed by acute conditions (30%, average length of stay: 5.2 days) and vaccine preventable (12.8%, average length of stay: 7.8 days) (54). The areas had the highest PPHs in 2017-18 were Belconnen (1005 PPHs) and Tuggeranong 795 (PPHs) (54). However, older people in North Canberra had the highest PPHs per 100,000 people (8200 hospitalisations), followed by older people in Weston Creek (7694 hospitalisations), Belconnen (7403 hospitalisations) and Tuggeranong (7362 hospitalisations) (54).

There were 4,340 lower urgency ED presentations of older people in the ACT in 2018-19, which was an improvement from 4,558 presentations in 2017-18 (55). The rate for lower urgency ED presentation for older people in the ACT per 1,000 was higher than the national average (80.9 compared to 79.8) (55). This figure was highest in Belconnen (91.8 presentations per 1,000 population), followed by Gungahlin (86.7 presentations per 1,000 population) (55). According to Women's Centre for Health Matters, women aged 75+ advised that they went to ED (for emergency purposes) at twice the rate of the other age groups, but were least likely to attend the Walk-in Centres in the last 12 months (56).

Older Canberrans living in residential aged care facilities

In 2017-18, there were 3176 older people in RACF in the ACT (57). Approximately 80% of aged care residents were aged 80 years or more, with more women living in permanent residential care than men (57). Stakeholders informed us that the quality and continuity of care for RACF residents are affected by the continuous change in visiting health practitioners. There has been an increase in reliance on community primary care practitioners to provide episodic care, as there are not enough trained staff in RACFs that can support the care of individuals around the clock. This can impact negatively on residents as they prefer (and need) continuing relationships with their usual care providers. This is particularly the case for those in cognitive decline who may find it difficult to sufficiently explain their health conditions to a new practitioner. Additionally, issues with consistent and reliable communication and documentation, visiting practitioners may difficulties to keep track of the progress of the residents in their care, resulting in the providers having to ask the same questions again, or cannot provide quality patient-centred care as needed.

According to our previous consultations and findings from other studies, most residents in RACFs have higher care needs, but there are issues related to workforce to address increasing demands. The gaps persist in basic needs like core activity (e.g. communication, mobility and self-care) to more advanced needs like mental health, cognitive and behavioural supports. Other areas include medication management, better awareness, and use of resources (pain management, palliative care) and better communication between EDs and acute wards to RACFs regarding discharge.

Older Canberrans living in the community

In 2017-18, around 96% older persons in the ACT lived at home and 63% of ACATs clients are suggested to continue living in community (57). There were 1,464 people using home care and 11,524 using home support (57).

Our consultations have identified issues around early assessment, diagnosis, and care planning especially for chronic diseases, dementia, and chronic pain. Stakeholders all acknowledged that these things are often not managed until they are quite severe and taking a significant toll on quality of life or people are ending up in hospital. This means there are big gaps in community services for older people, especially those of early and low-intensity interventions to prevent people from the needs for more advanced care. Low uptake of the annual Health Assessment for Older Persons is also a major obstacle in providing timely preventive care for older people. Consultations have also noted that the current process to navigate services is hard to understand and difficult. The confusion usually led to delayed diagnosis. Clients and/or their carers receive inconsistent messaging from My Aged Care. From the perspective of health professionals, it was reported that many of the people they interact with avoid My Aged Care and acquire their own services privately to avoid the disempowering process of interacting with My Aged Care.

Another need identified through our consultations was access to multidisciplinary care for older Canberrans. Links between aged care providers and the health system to enhance and expand access to multidisciplinary services and improve care coordination would improve health outcomes for aged care recipients. This could include subsidised visits to allied health providers and mental health under the MBS, and better transition from NDIS to aged care services. With the increasing diversity of older people in the ACT in terms of genders and cultural backgrounds, it is recommended from our consultations that aged care services should be person-centred to cater to the increasingly diverse needs.

Finally, poor quality and low uptake of advance care planning was also a major theme identified through our consultation. Advance care planning usually happened late, were mostly crisis-responses and brought negative experience to patients. The recommended solutions were to enhance staff's skills to initiate the conversation, improve the administrative process around advance care planning and improve the awareness of patients about advance care planning options.

The impact of COVID-19 on older persons health

Services for older people have been negatively impacted by COVID-19. Reduced visits to RACFs due to social distancing restrictions, increased anxiety among older population and reduced capacity to conduct cognitive assessment are major examples. However, the number of hospitalisations for respiratory conditions reduced due to the low prevalence of other viruses, influenza included.

Stakeholders have highlighted concerns around mental health for older people due to increased levels of isolation both in RACFs and the community. Within the community, it has been raised by stakeholders that there is a concern about older people delaying care out of fear or worry about COVID-19.

Specifically, regarding people living in RACFs, stakeholders continue to raise issues around access to general practice and allied health within aged care settings. COVID-19 has raised a range of concerns as:
- Access: Access to general practice and allied health is already limited. In the case of additional outbreaks or access restrictions, this may be further limited
- Ensuring ongoing regular care: Residents in RACFs have a range of physical and mental health needs. In the case of an outbreak, ensuring usual health care needs are monitored and managed

- Advance care planning: Ensuring that advanced care plans are in place, updated, and that residents and carers are engaged in an ongoing way around advanced care planning.

Update on stakeholder perceptions on older persons health

Mental health for older people remains a strong theme in this year's consultation. It is noted that people with a dual diagnosis of dementia and mental health issues were likely to be excluded from services. Medication management was also mentioned as an area that needs to be addressed. The increasing acuity of people entering aged care facilities needs more responsive GP services. There is a shortage of supports and services for neuro-degenerative diseases in the north side of Canberra. Coordination and continuity of care was disrupted due to low uptake of e-prescribing from GPs and fractured referral pathways. It is suggested that GPs should be promoted as the coordinator of care.

8. At-risk populations

This priority area focuses on:

- The health and wellbeing of population groups that may be at higher risk of poor health outcomes
- Access to primary health care services for populations that may be experiencing disadvantage.

We know that social determinants of health have a significant impact on the health and wellbeing of individuals and communities. We know that due to social and economic disadvantage, discrimination, social exclusion, limited access to education and employment, and other factors can place individuals and communities at higher risk for poor health outcomes. In ACT PHN's baseline Needs Assessment and through subsequent planning activities and needs assessments, ACT PHN identified a set of priority populations including:

- People from culturally and linguistically diverse backgrounds
- Refugees
- People who are experiencing homelessness
- People experiencing family violence
- People who are LGBTIQ+
- Children and young people
- People with disability
- Carers
- Families experiencing complex social and health needs
- People exiting prison and
- People living with blood-borne illness.

Given the diversity of experience and needs of these populations, this section captures cross-cutting themes and specific insights gained from consultation.

Theme	Issues/Needs identified	Strategies & opportunities to address
Health literacy including awareness, navigation of services, and confidence in seeking and participating in health	8.a. Having information and services available in a variety of formats that are easy to read, in your own language, and relevant. 8.b. Need for increased support around navigating services.	Commission services System improvement
Access to and quality of care for at-risk-populations	8.c. High out-of-pocket costs limit access to health services including primary care, specialists, and allied health 8.d. Additional costs of accessing ongoing care such as transportation and time off from work are often overlooked and not assessed as part of care planning 8.e. Services should be delivered flexibly and through alternative settings such as in-reach and outreach. 8.f. Access to integrated and multidisciplinary care including physical and mental health.	System improvement Commission Services.
Stigma and minority stress	8.g. Many at-risk populations experience high levels of stress 8.h. Experiencing stigma and discrimination in health care settings.	Capacity building System improvement
Inclusive and responsive care	8.i. Services need to be trauma informed 8.j. Upskilling the primary health care workforce to provide inclusive, responsive, and affirming health care 8.k. Ensuring there is shared decision making between consumers and health care providers 8.l. Holistic, wrap-around services to support complex health and social experiences.	Capacity building System improvement
Data and consultation	8.m. In-depth consultation and data review will be undertaken against each of the identified at-risk populations over the next 24 months to ensure a comprehensive review of needs.	Planning
Impact of COVID-19	8.n. Address emerging needs from COVID-19	System improvement Capacity building Planning

People from culturally and linguistically diverse backgrounds

Although older people from culturally and linguistically diverse background accounted for around one-fifth of older population in the ACT (52), they may experience undesirable health outcomes due to lack of access to culturally appropriate support services. Older culturally and linguistically diverse (CALD) adults are less likely to use services and supports than other Australians (58). Residential aged care options may be viewed negatively by this population, with home care options preferred (58). Some providers are unaware of the availability of translating and interpreting services or may decide not to use them – potentially leading to miscommunication, misdiagnosis, dissatisfaction with services and other adverse outcomes (58).

Refugees

Many refugees and asylum seekers have experienced traumatic events such as physical and psychological trauma or torture, deprivation and prolonged poverty, periods in immigration detention and poor access to health care prior to arrival. As a result, many people from a refugee background have multiple and complex physical and psychological health problems on arrival, including high levels of avoidable illness and associated mortality (59). Our stakeholders advised that refugee populations experienced major disadvantages during COVID-19 due to loss of employment, being ineligible for government supports and stresses from financial/ housing issues. This has largely impacted on this population's mental health and wellbeing.

People who are experiencing homelessness

Mental health needs are prevalent among people who are experiencing homelessness. In 2018-19, 47.3% of the 3223 people who sought assistance from the specialist homelessness services in the ACT experienced mental health issues (60). This direct relationship is also demonstrated in the AIHW's Sleeping Rough Report which states that people who present sleeping rough and persistently receive homelessness services over extended periods report high levels of mental ill-health (78%), a mental health diagnosis (69%), and/or problematic drug/alcohol use (63%) (61).

People experiencing family violence

According to data from the Personal Safety Survey undertaken in 2016, around 7,400 ACT women had experienced some form of violence and abuse in the 12 months prior to the survey (62). The most common type of abuse was emotional abuse, followed by any violence, physical violence, and finally sexual violence. While the number of other forms of violence and abuse reduced overtime, the prevalence of emotional abuse rose. The severity of domestic violence has increased during COVID-19, when people's movements outside of their home were restricted, thus spending time in their house more often and for longer. Lifeline data has witnessed a great increase in support for domestic violence supports.

In 2018-19, 8.9 per 1,000 ACT children were in out-of-home care, below the national average of 9.8 and the third lowest rate in Australia (63). In the ACT, the most common type of abuse was emotional abuse, followed by neglect, physical abuse, and finally sexual abuse. Boys were more likely than girls to experience physical and emotional abuse whereas girls were more likely to experience sexual abuse and neglect. The rates of physical abuse and emotional abuse are much higher than the national average (63). Children in the ACT were more likely to have recurring experiences of family violence, with the percentage of children receiving more than one child protection service (68.4%), care and protection order (95.7%) and placements in out-of-home care (94.9%) higher than those of national average (67.6%, 94% and 93,9%) (63).

Domestic violence against children among Indigenous communities is a serious health risk. In 2017-18, the rate for Indigenous children (aged 0–17) receiving protection services was 178 per 1,000 children. This rate was the third highest in Australia and 8.9 times the rate for non-Indigenous children on care and protection orders (6.4 per 1,000) (63). Compared to non-indigenous children and national average of indigenous children, the most common type of abuse to indigenous children in the ACT is neglect (47.7%), then followed by emotional abuse (35.1%) (63).

According to local stakeholder consultation, interventions to reduce the rate and impacts of family violence against children should be more child-centred, culturally appropriate and trauma-informed. Services should be able to address inter-generational trauma, adopt a collaborative and strength-based approach, have easy access and focus on early interventions. Capacity building for service providers to be able to meet these needs is required.

People who are LGBTIQ+

In the ACT, 16,900 people have a sexual orientation other than heterosexual and ACT couples are 50% more likely to be same-sex couples than couples elsewhere in the country (52). Research has demonstrated that a disproportionate number of LGBTIQ+ Australians experience poorer mental health outcomes and have higher risk of suicidal behaviours than their peers (64). Nationally, mental health disparities between LGBTIQ+ people and the wider population are more pronounced in younger age groups, with LGBTIQ+ young people aged 16-27 having the highest levels of psychological distress across all age groups and five times more likely to attempt suicide (65). The LGBTIQ+ population is at higher risk of mental ill health due to disproportionate exposure to discrimination, stigma, social exclusion, and violence (64).

Heteronormativity was discussed among Canberra LGBTIQ Community Consortium as a key barrier to accessing services (66). This was demonstrated by services requiring gender markers but not providing appropriate options for sex and gender diverse people, requiring the disclosure of relationship status disclosures but with no options for people in same sex relationships (66). The low rates of support-seeking for same-sex couples' violence as reported in Australian Trans and Gender Diverse Sexual Health Survey in 2018 suggest that there may be a lack of appropriate support services following an experience of sexual violence or coercion (67).

Children and young people

Mental health is a major health issue among children and young people in the ACT. ACT residents aged 18-24 years old reportedly have the highest levels of psychological distress in comparison to other age groups in the ACT (23). The number of community treatment days of child and adolescent in the ACT were the highest among all states and territories from 2007 to 2018, ranging from 1.4 to 1.6 times higher than the national average (38). In the ACT, the top three identified mental health issues for those under 25 years were anxiety/stress (coping), school or study problems and experiencing bullying (47). The top three barriers were affordability, wait times for access and the stigma associated with mental health (47).

Availability of services for young children is another major issue. There are long wait times for young people to access specialist appointments in the ACT. A question on notice from The Canberra Liberals spokeswoman for health to the ACT Government in 2020 revealed that children across a range of specialists needs face significant wait times, anywhere up to: 1,500 days for a dermatology, 1,200 days for a urology, 870 days for gastroenterology, 600 days for ear, nose, throat (ENT), and 149 days for paediatric surgery (68). This shortage was echoed in our consultation with stakeholders.

People with disability

The number of people having disability in the ACT increased rapidly over time, from 62,000 in 2015 to 80,000 in 2018, equivalent to 19.2% of the total population (53). As at 30 Sep. 2019 while 8,449 people in the ACT had funded supports, more than 10,000 people in the ACT are identified as requiring assistance with core activities of daily living and are not receiving funded supports through NDIS or My Aged Care (69). Currently, 80% of care for people with disabilities is provided by carers rather than by formal services (70). According to National Aboriginal and Torres Strait Islander Health Survey in 2017-18, approximately 32.5% Aboriginal and Torres Strait Islander people has a disability or restrictive long-term condition (12), which was much higher than the national average at 27.1% (12).

According to 2017-18 data, people with disability of restrictive long-term conditions had a much higher rates of having high or very high psychological distress compared to population without (28.4% compared to 6%) (39). Roughly one-third of LGBTIQ people who have a disability describe it as being primarily psychiatric (64). There is a high prevalence of alcohol and drug use among people with disability. According to ATODA's Service Users' Satisfaction and Outcomes Survey in 2018, one-in-five (20.4%) of the respondents identified that they had a physical or intellectual disability of some sort (27). More than one-quarter of service users who identified a disability (28.8%) indicated that they identified as someone with a mental health disorder (27).

Carers

In 2018, it is estimated by the ABS that approximately 50,200 ACT residents (12.2% of the ACT population) provided unpaid care to family members or friends who needed assistance with daily living due to a disability, chronic illness, mental illness, or frailty due to ageing (53). Around 33.5% of them are primary carer (53). The majority of carers are aged over 45 years (28,000 over 45 years and 16,000 under 44 years), with the highest number belonging to the group from 35 to 54 years old (53). Around one-third of carers care for 40 hours or more each week (71).

Research has demonstrated that informal carers in Australia experience low mental and social wellbeing. The poorest wellbeing was reported by those who were caring for people with drug or alcohol addiction or dependency, followed by those caring for people with mental illness (72). Locally, in 2016, 36% of carers were caring for someone with a medical condition such as a long-term illness; 34% were caring for someone with old-age related health problems, 33% were caring for a person with a permanent disability other than mental illness or dementia; 27% were caring for someone with a mental illness; 12% were caring for a person with dementia, and 7% cared for a person with drug or alcohol addiction/dependency (72). According to the Carers ACT Annual Report in 2018, 47% unpaid carers experience anxiety or depression, 16% of carers of people with dementia have contemplated suicide more than once in a year and carers are more likely to experience chronic pain and highly likely to carry an injury (71).

Families experiencing complex social and health needs

People making contacts to community mental health services in 2017-18 were predominantly in the least disadvantaged social quintiles, 121,843 and 136,612 for Quintiles 4 and 5 (37). In 2017-18, people in the most disadvantaged group had the worst community follow-up within first 7 days of discharge from psychiatric admission nationally (35.7% compared to 76.6% of national average) (39). People in more disadvantaged quintiles tend to have more complicated mental health conditions (38). Although the most disadvantaged quintiles had the greatest reduction in the percentage of new clients, the percentage of new clients was still higher than the national average. According ATODA's to Service User's Satisfaction and Outcomes Survey in 2018, socio-economic disadvantage is clearly a characteristic of the AOD service user population and has implications for AOD service delivery (27).

People experiencing socio-economic disadvantage have a higher prevalence of chronic conditions and a greater burden of disease. Considerations for cost-effective treatment and management options and different funding approaches to health service delivery in the ACT could ensure equity of access to care. Addressing the social determinants of health, including social connection, and improving health workforce knowledge of the impact of social determinants would be a step towards improving outcomes for disadvantaged Canberrans.

People in detention

In the ACT, the 2016 ACT Detainee Health and Wellbeing Survey was completed by 23% of the detainee population and 54% reported a current and/or previous diagnosis of a mental health concern and 21% of respondents reported a previous mental health inpatient admission (73). It is important to note that the social stigma against seeking support is likely to be amplified in the custodial environment. There is a need to continue activities that aim to reduce stigma and encourage help-seeking behaviours.

According to AIHW's report on Prisoner's Health in Australia in 2018, ACT's entrants have high rates of alcohol and illicit drug use within 12 months before being incarcerated, and have high prevalence of chronic conditions, especially asthma (74). The interplay between mental health and alcohol and drug usage affects a person with a mental illness's engagement in the justice system. These people often require specialist support that needs to transition with the person through their entry to and exit from custody. They may also be vulnerable in prison populations and may engage in crime to support alcohol and drug habits and social connections. The breaking of this cycle can be challenging and require ongoing, professional supports of significant duration.

People living with blood-borne illness

Major blood-borne illness in the ACT include Hepatitis B, Hepatitis C and HIV. Stakeholders informed us that only about 20% of people with chronic Hepatitis B are currently engaged in care. Older residents living with HIV, many of whom are gay, experience increased discrimination associated with their HIV status (64). This discrimination is informed by the persistence of inaccurate and prejudicial stereotypes about HIV (75). The number of older people living with HIV and entering aged care facilities is increasing, which demonstrates the urgency of producing better health and wellbeing outcomes for this group. It is important that healthcare workers understand the sensitivities of living with HIV and do not disclose the HIV status of people living in aged care facilities.

The impact of COVID-19 on at-risk populations

Stakeholders have informed us that COVID-19 has significantly reduced service capacity, increasingly marginalised at-risk populations. Some stakeholders were able to identify arising needs early and quickly created temporary services to adapt to those needs (e.g. financial supports for LGBTIQ refugee groups when they lost their employment during the pandemic). Because of this work, there are some clients that have an expectation that these supports are continued, despite the reduced impact of COVID-19 on usual service delivery.

Update on stakeholder perceptions on at-risk populations

There is a strong emphasis on peer support for better service navigation among all at-risk groups. The discussion about peer support was not only about workforce, but also the need for a systems-based framework that facilitates a peer-informed approach. Discussions also highlighted the importance of more appropriate service design, easier service access and continuity of care among service providers for at-risk populations. Infrastructure was also noted as important regarding housing affordability for those experiencing homelessness, as well as services and supports for the local aging population.

9. Workforce

This priority area focuses on ensuring:

- The primary care workforce in the ACT is skilled and supported
- The ACT has a sustainable primary care workforce.

This table draws on the needs identified across the other priority areas as well additional needs.

Theme	Issues/Needs identified	Strategies & opportunities to address
Culturally appropriate care for Aboriginal and Torres Strait Islander people	2.c. Supporting mainstream workforce to provide culturally appropriate care 2.d. Enable and support the Aboriginal and Torres Strait Islander workforce. 2.e. Providing high quality assessment, diagnosis, and management for chronic disease.	Capacity building
Digital health	3.g. Support for health professionals to engage consumers in using digital health tools.	Capacity building System improvement
Alcohol and other drugs	4.a. Assessment of ATOD use and related harm in general practice 4.b. Managing the physical health care needs of people experiencing or at risk of ATOD-related harm 4.c. Ensuring appropriate information and referral pathways are in place for GPs, including self-help resources, early intervention support, and specialist services 4.e. Increasing the number of GP prescribers for pharmacotherapy.	Capacity building System improvement Strategic partnerships
Mental health	5.k. Limited workforce and skill mix 5.l. Effectively supporting a peer workforce 5.m. Supporting the workforce to provide culturally appropriate, safe, and responsive care.	Capacity building Strategic partnerships
Chronic conditions	6.g. Primary health care professionals should be adequately equipped to identify and address risk factors for chronic conditions 6.h. Primary health care professionals need to be supported by effective specialist and allied health referral pathways 6.i. Primary health care professionals should be supported to participate in team-based and shared care.	System improvement Capacity building
Aged care	7.g. Health sector and aged care workforce require support to better work together 7.h. Ongoing training and support for aged care and health workforce in Advanced Care Planning, medication management 7.i. Ongoing support to deliver culturally appropriate care to a diverse group of older people including LGBTQI+, CALD, and Aboriginal and Torres Strait Islander people.	Capacity building System improvement
At risk populations	8.i. Services need to be trauma informed 8.j. Upskilling the primary health care workforce to provide inclusive, responsive, and affirming health care.	Capacity building System improvement
General primary health care workforce	9.a. Ensuring an appropriate skill mix across the primary care workforce 9.b. Supporting multidisciplinary and interdisciplinary care 9.c. Enabling a high performing primary care sector.	System improvement Capacity building
Impact of COVID-19	Address emerging needs from COVID-19	Planning Raise awareness System improvement Strategic partnerships Capacity building

In addition to the workforce needs identified throughout the specific priority areas, we know that the ACT's primary care workforce looks quite different to Australia as a whole.

Health professional	ACT	Australia
GP full-service equivalents per 100,000 population (2)	88.5 (the lowest in Australia)	113.4
Female GPs per 100,000 females (2)	81.9	87
Dentists per 100,000 population (2)	5	5.7
Occupational therapists per 100,000 population (2)	23.3	26.3

Psychologists per 100,000 population (2)	52.3 (the highest in Australia)	26.5
Nurses and Midwives full-time equivalent per 100,000 population (76)	1,274.2	1,197.4
Pharmacists full-time equivalent per 100,000 population (77)	107.9 (the highest in Australia)	94.1
Aboriginal and Torres Strait Islander Health Practitioner average hours worked (11)	36	40.5
Indigenous health professionals employed per 100,000 population (11)	38.8 (significantly below the national average)	59.8

According to our consultations with local stakeholders, the high turnover rate of staff in the Indigenous sector has caused disruption to continuity of care for patients. There needs to be strategies in place to develop and retain Indigenous staff to able to build trust and relationship with clients; therefore, to better engage patients in care. The number of Indigenous students in health-related courses in the ACT was the lowest nationally (14/18 students passed in 2015). The rate of success was the second lowest among all states and territories (11). In 2018, the number of Indigenous people receiving government funded health-related vocational education and training per 10,000 population was the third lowest in Australia, but the completion rates were the lowest, 1.3 per 10,000 population (national: 11 per 10,000 population) (11).

The impact of COVID-19 on the primary care workforce

The COVID-19 pandemic (off the back of the 2019-2020 bushfire season) has a significant impact on the local primary care workforce. Early in the pandemic it was identified that the sustainability of general practice and business continuity was a significant issue as practices saw a significant decrease in people making and attending appointments. This led to impacts on the mental health and wellbeing of staff and reduction in staff levels. In a general practice survey with 39 respondents, when asked what support would be most valued, practices responded that support for workforce and business continuity would be the most useful (19). Anecdotally, mental wellbeing of staff continues to be a major concern.

It has also been identified that access to a locum workforce has been limited with travel restrictions and other COVID-19 restrictions. Key stakeholders have reported that this has increased pressure on general practices to work longer hours and impact their ability to take breaks. There is a concern that this will impact access to primary care services over the holidays and summer period as there is limited back-up workforce to step in.

Update on stakeholder perceptions on workforce

Stakeholders informed us that the ACT has a good mix of services but lacks in volume. The priority should be to increase the number of health workforce in the ACT, especially in areas of alcohol and other drugs, mental health and Aboriginal and Torres Strait Islander health. Throughout the assessment of other priorities, there is a strong emphasis on improving workforce capacity in areas such as risks assessment (e.g. substance abuse, family/domestic violence), services for people with complex and intersecting needs (e.g. mental health and substance abuse), trauma-informed care, culturally-appropriate care, and appropriate referral pathways. With the emergence of COVID-19, stakeholders have also identified the needs to improve capacity in delivering quality care via digital tools.

References

1. AIHW. Patient experiences in Australia by small geographic areas in 2017–18. 2020.
2. Productivity Commission. Report on Government services - Primary and community health. 2020.
3. AIHW. Use of emergency departments for lower urgency care: 2015–16 to 2017–18. 2020.
4. AIHW. Disparities in potentially preventable hospitalisations across Australia, 2012-13 to 2017-18. 2020.
5. Healthdirect Australia. Healthmap. 2020.
6. AIHW. Health & welfare expenditure. 2018.
7. The Department of Health. Annual Medicare Statistics. 2020.
8. AIHW. Coordination of health care: experiences of barriers to accessing health services among patients aged 45 and over in 2016. 2020.
9. AIHW. Coordination of health care: experiences of information sharing between providers for patients aged 45 and over 2016. 2019.
10. ABS. Australian Demographic Statistics 2018. 2019.
11. AIHW. Cultural safety in health care for Indigenous Australians: monitoring framework. 2019.
12. ABS. National Aboriginal and Torres Strait Islander Health Survey 2018-19. 2019.
13. AIHW. Aboriginal and Torres Strait Islander-specific primary health care: results from the OSR and nKPI collections. 2020.
14. Australian Health Ministers' Advisory Council. Aboriginal and Torres Strait Islander health performance framework 2017 report. 2017.
15. AIHW. Mental health services in Australia. 2020.
16. NACCHO. Aboriginal and Torres Strait Islander Advisory Group on COVID-19, 15 October 2020. 2020.
17. Digital Health Data2019. Available from: https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHN-Digital_Health.
18. Digital Health Strategy 2019-2029: Enabling exemplary person-centred care through digital innovation. Canberra, Australia: ACT Government; 2019.
19. Capital Health Network. General Practice COVID 19 Impact Survey results' 2020.
20. AIHW. Alcohol, tobacco & other drugs in Australia. 2020.
21. AIHW. National Drug Strategy Household Survey 2019. 2020.
22. Australian Criminal Intelligence Commission. National Wastewater Drug Monitoring Program—Report 10. 2020.
23. ABS. National Health Survey 2017-18. 2018.
24. National Drug and Alcohol Research Centre (UNSW). ACT Drug trends 2017 - Findings from the Illicit Drug Reporting System (IDRS). 2018.
25. Alexandra Voce Rebecca McKetin, Richard Burns. Research into Methamphetamine Use in the Australian Capital Territory. 2017.
26. AIHW. Alcohol and other drug treatment services in Australia, 2018–19. 2020.
27. ATODA. Service Users' Satisfaction and Outcomes Survey 2018. 2020.
28. Foundation of Alcohol Research and Education. Alcohol use and harm during COVID-19. 2020.

29. Ph.D. Sarah Callinan , Michael Livingston , Ph.D., Robin Room , Ph.D., & Paul Dietze , Ph.D. Drinking Contexts and Alcohol Consumption: How Much Alcohol Is Consumed in Different Australian Locations? Journal of Studies on Alcohol and Drugs. 2016;77(4).
30. Jonathan Ling Lyn Brierley-Jones, Karen E McCabe, Graeme B Wilson, Ann Crosland, Eileen F S Kaner, Catherine A Haighton. Habitus of home and traditional drinking: a qualitative analysis of reported middle-class alcohol use. Sociology of Health & Illness. 2014.
31. PhD Anders Hammarberg , Caisa Öster , PhD &Christina Nehlin , PhD. Drinking motives of adult patients seeking treatment for problematic alcohol use. Journal of Addictive Diseases. 2017;36(2).
32. Foundation for Alcohol Research and Education. Alcohol home delivery services: an investigation of use and risk. 2019.
33. Capital Health Network. Internal data (unpublished). 2019.
34. Department of Health. Primary Mental Health Care Minimum Data Set. 2019-20.
35. ACT Health. Healthy Canberra: Australian Capital Territory Chief Health Officer's Report 2018. 2018.
36. Mental Health Community Coalition ACT. When the NDIS came to the ACT: A story of Hope and Disruption in the Mental Health Sector. 2018.
37. AIHW. State and territory community mental health care 2018-19. 2017-18.
38. AIHW. Key Performance Indicators for Australian Public Mental Health Services. 2020.
39. Productivity Commission. Report on Government Services - Mental Health. 2020.
40. AIHW. Mental health services in Australia: Services provided in public hospital emergency department. 2020.
41. Orygen. Defining the missing middle. 2019.
42. National Disability Insurance Agency. People with a psychosocial disability in the NDIS. 2019.
43. National Mental Health Commission. Monitoring mental health and suicide prevention reform - National Report 2019. 2019.
44. Disability, Ageing and Carers, Australia: Summary of findings 2018. 2019.
45. Isaac Nowroozi. Calls to Lifeline from Canberrans reach record levels during coronavirus as many report loneliness. 2020.
46. Youth Coalition. Submission to the inquiry into youth mental health in the ACT. 2020.
47. Employment and Youth Affairs Standing Committee on Education. Youth Mental Health in the ACT. 2020.
48. Ian Hickie. As 'lockdown fatigue' sets in, the toll on mental health will require an urgent response. 2020.
49. AIHW. Australia's health 2020. 2020.
50. ABS. Australian Demographic Statistics, Dec 2018. 2019.
51. ACT Health. Focus on healthy aging in the ACT. 2018.
52. ABS. Census Table Builder. 2016.
53. ABS. Disability, Aging and Carers 2018. 2018.
54. AIHW. Potentially preventable hospitalisations in Australia by age groups and small geographic areas 2017-18. 2019.
55. AIHW. Use of emergency departments for lower urgency care: 2015–16 to 2018-19. 2020.
56. Women's Centre for Health Matters. Top-Level Results on WCHM research on the health and well-being of older ACT women. 2020.
57. Productivity Commission. Reports on Government Services -Aged care. 2019.
58. End of life Directions for Aged Care (ELDAC). Australia's ageing Culturally and Linguistically Diverse population. 2020.
59. Ida Kaplan. Experiences of torture and trauma: psychological and physical effects, management and psychological approaches. 2018.
60. AIHW. Specialist Homelessness Services annual report 2018–19. 2019.
61. AIHW. Sleeping rough: a profile of Specialist Homelessness Services clients. 2018.
62. ABS. Personal Safety Australia. 2016.
63. AIHW. AIHW child protection Australia 2018-19. 2020.
64. AIDS Action Council. Blueprint for a coordinated response to the health needs of LGBTIQ people, their families, and communities in the ACT. 2019.
65. National LGBTI Health Alliance. Snapshot of mental health and suicide prevention statistics for LGBTI people. 2020.
66. Canberra LGBTIQ Community Consortium. Consultation findings. 2016.
67. Kirby Institute (UNSW). 2018 Australian Trans and Gender Diverse Sexual Health Survey: Report of Findings. 2019.
68. Niki Burnside. Thousands of Canberra's young people on specialist waiting lists, travelling interstate as Opposition calls for better healthcare. 2020.
69. Carers ACT. Carers ACT 2020 Budget Submission. 2020.
70. Women's Centre for Health Matters. Strong Women Great City. 2012.
71. Carers ACT. Position Statement 2019. 2019.
72. Jacki Schirmer. Carers in regional Australia - 2016 Regional Wellbeing Survey report. 2017.
73. ACT Government. ACT government response - Productivity Commission's inquiry into the social and economic benefits of improving mental health. 2019.
74. AIHW. Prisoner's Health 2018. 2018.
75. S. Cahill, and Valadéz, R. . Growing older with HIV/AIDS: new public health challenges. American journal of public health, 103(3), e7–e15. 2013.
76. Health Workforce Data. Nurses and midwives. 2019.
77. Health Workforce Data. Pharmacists. 2017.