Capital Health Network (ACT PHN) 2021 – 2024 Needs Assessment

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The pandemic and subsequent lockdown that occurred in the ACT from the 12th of August 2021 presented numerous challenges to the processes and data collection of the project. This resulted in several priority areas not receiving the required level of detail that was warranted due to inability to consult with required parties and conduct focus groups with consumers from those demographics. These areas will be covered in greater detail in the 2022 CHN Needs Assessment.

Process summary

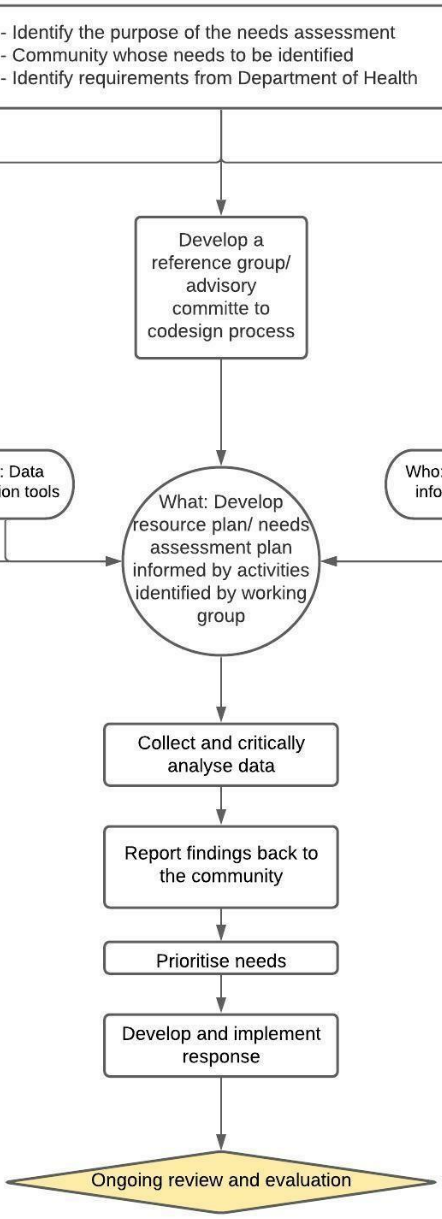
Priority Areas

The Australian Capital Territory Primary Health Network (ACT PHN) has undertaken a comprehensive Needs Assessments and has updated all priority areas with relevant data and feedback from our surveys and stakeholder consultations, health consumers and service providers included. 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:

- Care across the continuum
- Aboriginal and Torres Strait Islander health
- Digital health
- Alcohol and other drugs
- Mental health
- Chronic conditions
- Aged care
- People at risk of poor health outcomes
- Workforce

The process for this Needs Assessment update has involved a review of the quantitative and qualitative data from our CHN 2021 Health Needs Assessment surveys, stakeholder consultations and secondary data sources. 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 Council, 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 conducting the 2021 Needs Assessment is mapped below:



The 2021 Needs Assessment provides a summary of findings against all priority areas. In addition to the updated data and community consultation findings, we have also included a section regarding COVID-19 within each priority area summary. New themes have been identified, with the potential strategies and opportunities to take action. These strategies are categorised into main groups as below:

Strategy group	**Action in details**
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 of the role of ACT PHN in the local health system 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

Aboriginal and Torres Strait Islander health

This priority area focuses on:

- Ensuring access to culturally safe and responsive 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 / Priority	Subcategory	Focus areas	Strategies & opportunities to address	Partnerships and stakeholders
Supporting the primary care workforce to provide culturally appropriate care	Workforce	- Improving identification of Aboriginal and Torres Strait Islander people and supporting them to access culturally appropriate care pathways - Reducing barriers to access by providing training to staff to deliver culturally safe and responsive care	Capacity building System improvement projects	Coolamon Advisors
Access to culturally safe and responsive services	Access	- Supporting mainstream workforce to provide culturally safe and responsive care - Enabling and supporting the Aboriginal and Torres Strait Islander workforce - Improving identification of Aboriginal and Torres Strait Islander status - Improving access to culturally safe services after-hours	Capacity building Commission services	Coolamon Advisors General Practice Commissioned Service Providers
		- Providing trauma informed services		

Improving health outcomes for Aboriginal and Torres Strait Islander people	Aboriginal and Torres Strait Islander Health	- Providing high quality assessment, diagnosis, health promotion and chronic disease management supports - Providing care coordination for chronic conditions, mental health, social and emotional wellbeing services, and AOD services - Providing outreach services to improve service accessibility	Capacity building Commission services Planning	ACCHO General Practice Commissioned Service Providers
Impact of COVID-19	Other – COVID-19 identified	- More responsive and appropriate methods to provide better health management support with lockdown and travel restriction beside telehealth - Support for Aboriginal and Torres Strait Islander who live off the country	Capacity building Planning Strategic partnerships	ACT Health ACCHO Stakeholders: Primary Care Emergency Response Working Group

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 outcomes.
- The health care workforce can deliver culturally safe and responsive care.

Population data

According to ABS statistics, in 2019 there were 8,297 Aboriginal and Torres Strait Islander people in the ACT, accounting for approximately 1.8% of the total population (1). Within Aboriginal and Torres Strait Islander population in the ACT, about 30% are children aged 0-14 years old, 59% are adults from 15-54 years old and about 11% are older people aged 55 and above (1). It is estimated the number of Aboriginal and Torres Strait Islander peoples living in the ACT will increase to more than 11,000 by 2031 (2).

Aboriginal and Torres Strait Islander health and wellbeing

The gap in life expectancy between Indigenous and non-Indigenous Australians is around 10 years (2). Aboriginal and Torres Strait Islander peoples are 1.7 times more likely to have a disability or restrictive long-term health condition and 2.7 times as likely to experience high levels of psychological distress (2).

A significant part of the disparity in health outcomes between Indigenous and non-Indigenous Australians can be largely attributed to the disparities in social determinants such as education, employment and income (3). It is well documented in the literature that rapid cultural destruction, slow violence in the form of government policies and marginalisation from mainstream society are also major causes to the gap in health and wellbeing (4). The systemic racism present in many health services has led to a strong distrust to access mainstream services, resulting in lower access and the gap in health and wellbeing (5). Other main barriers for access include cost, transport and lack of culturally safe health services (4). These themes are echoed in the CHN 2021 Health Needs Assessment surveys and consultations. To achieve better health outcomes for Aboriginal and Torres Strait Islander community, the inequity in the broader health system and social and cultural determinants of health should be addressed (3).

Chronic conditions

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%) (6). Recent data from the 2018-19 National Aboriginal and Torres Strait Islander Health Survey states the most common self-reported chronic health problems among Indigenous populations were eye or sight complications, mental health and behavioural conditions, asthma, ear or hearing, and back problems (6). 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 prevalent as those in non-Indigenous populations (6).

Stakeholders informed us that sleep apnoea is a health issue that is becoming increasingly prevalent in Aboriginal and Torres Strait Islander populations, yet purchasing assistive technology is often too expensive and/or not accessible (5). The prevalence of overweight/obesity and type II diabetes are also increasing in this population (5). Weight gain can exacerbate sleep apnoea which contributes to increasing complications (5). It is often reported that once patients receive equipment needed for sleep apnoea, their general wellbeing and health improves (7). The Integrated Team Care program can support the purchase of breathing equipment. However, these funds are very much limited and have not increased over the past five years (7). ACT Health do have a funding support program, however funding is limited.

One stakeholder reported that they have seen chronic illness increasing in the Indigenous community, particularly diabetes, heart disease and kidney disease (5). It was also reported that a high proportion of the Indigenous community are also highly stressed, which can exacerbate the complexity and severity of chronic illnesses (5). The most common preventable presentations seen by stakeholders was undiagnosed health issues, such as diabetes, sexually transmitted diseases, mental health issues, hearing, sight, autism and other intellectual disabilities (5).

Nationally, cardiac conditions are more common among Aboriginal and Torres Strait Islander people than the general public. The mortality rate remained much higher (1.6 times in 2018) than among non-Indigenous Australians (8). The incidence and recurrence rates of acute rheumatic fever among Aboriginal and Torres Strait Islander community are much higher than among non-Indigenous Australians, 100 per 100,000 in Indigenous versus 0.2 per 100,000 for non-Indigenous people in 2018 (8).

Mental health

According to the 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 the national average of 24% (6). 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 (6). The proportion of people with high or very high psychological distress was double that of non-Indigenous population (6).This can be attributed to the impacts of intergenerational trauma, ongoing impacts of colonisation and factors of social and economic disadvantage, increased morbidity, mortality and disability, reduced social supports and racism and discrimination (5).

Disability

Nationally, Aboriginal and Torres Strait Islander peoples were 1.8 times more likely than non-Indigenous people to be living with a disability (9).

	Aboriginal and Torres Strait Islander (percentage of population)	**Non-Indigenous (percentage of population)**
Physical disability	14.8	11.4
Psychosocial disability	6.6	3.8
Intellectual disability	5.9	2.5
Head injury/stroke/ acquired brain injury	2.1	1.1
Sensory and speech disabilities	6.1	5.8

There is a low uptake of disability support services compared to the actual needs among Aboriginal and Torres Strait Islander peoples in Australia (10). Some of the reasons for low uptake can include:

- unavailability of services in some areas
- mistrust of government agencies
- experiences of discrimination
- Western concepts of disability not reflecting Aboriginal and Torres Strait Islander values, beliefs and social practices regarding health and bodily function
- decisions usually made by non-Indigenous medical experts, which can lead to feelings of inadequacy, helplessness, and anger

Social determinants of health

According to our stakeholders, anecdotally, there is a sense that outcomes are worsening for Aboriginal and/or Torres Strait Islander people in Canberra across all areas (e.g. health, education, employment, incarceration, housing) (5). The stakeholders we engaged indicated that they have seen an increase in substance abuse, antisocial behaviours, and a drop in education attendance (5).

Stressors such as substance, emotional and physical abuse, poor school attendance, low levels of education, high unemployment with poor job prospects, difficulties finding accommodation, lack of parental involvement or control, poverty, and being young single parents with poor parenting skills, are some of the challenges facing young Aboriginal people (11) . According to Winnunga Nimmityjah Aboriginal Health Service, these stressors exist:

- where mainstream culture is dominant;
- when establishing their identity as Aboriginal people, whilst balancing their involvement in the Aboriginal and mainstream community; and
- in facing the challenges for young people coming to terms with who they are.

Housing

ACT remains the only state in Australia to have an Aboriginal housing plan or strategy (12). In 2017-18, 817.7 per 10,000 people who identified as either Aboriginal and/or Torres Strait Islander peoples in the ACT were clients of specialist homelessness services, compared to 78.7 per 10,000 non-Aboriginal and/or Torres Strait Islander people

(13).

The National Aboriginal Community Controlled Health Organisation (NACCHO) observed that Indigenous women are particularly affected by the cycle of homelessness and imprisonment (14). They are the least likely of any group within the corrections system to be able to find appropriate accommodation on release—particularly if they have dependent children (14). Additionally, Aboriginal and Torres Strait Islander women released from prison often remain homeless or return to prison after a short time (14).

Food insecurity

According to the ABS, in 2012-13, over 20% of Aboriginal and Torres Strait Islander people, compared to less than 4% in non-Indigenous populations, were living in a household where someone went without food when the household ran out of food (15). Although this data is quite old, stakeholders reported that lack of access to healthy and nutritional foods remains a significant issue for Aboriginal and/or Torres Strait Islander in the ACT today (5).

Child removal

The ACT has the second highest rate of removal of Aboriginal children from their family and into out-of-home care (12). As of the 30th of June 2020, 213 (30%) of 699 children aged 0-17 in out-of-home care (OOHC) in the ACT were Aboriginal and/or Torres Strait Islander children (13). The rate for Indigenous children in OOHC in the ACT was 72.3 per 1,000 children aged 0-17, which was 14 times the rate for non-Indigenous children (5.2 per 1,000 children) (13). This was also higher than the national rate for Aboriginal and/or Torres Strait Islander children which is 56.3 per 1,000 children (13).

Australia's tragic history of the separation of Aboriginal children from their families and communities has caused epigenetic trauma and severely impacted emotional well-being of Aboriginal and Torres Strait Islander people, particularly deep problems with their personal and cultural identity (5, 16).

Justice

The ACT has the highest rate of age standardised Indigenous incarceration in Australia (12). According to the Productivity Commission, there has been a 279% increase in the number of Aboriginal and/or Torres Strait Islander people in prison in the ACT in the last 9 years, while the average increase across Australia is about 50%. Despite making up less than 2% of the ACT population, Aboriginal and/or Torres Strait Islander people make up 25.8% of the Alexander Maconochie Centre (AMC) prison population (13). Between 2019 and 2020, Aboriginal and/or Torres Strait Islander detainees in the AMC increased by 12% (13). Aboriginal and/or Torres Strait Islander young people are incarcerated at 18 times the rate of non-Indigenous cohort in the ACT (13). There is ample evidence showing that those in prison – particularly Indigenous people – have higher rates of disability (17). Indigenous people with cognitive disability are significantly more likely to be charged with their first offence at a younger age, too, than those without cognitive disability (17).

A stakeholder reported that justice and health issues are inherently linked for Aboriginal and/or Torres Strait Islander people. For example, if hearing issues are not resolved with adequate health care during childhood, many children will be more likely to drop out of school due to reduced capability to listen and engage with school, which can increase the likelihood of them having contact with the judicial system (5). It is also difficult to ensure adequate, culturally appropriate healthcare is provided when they are in the justice system, as appropriate services may not be available for their disability or medical needs (5).

Employment

Nationally, the 2016 Census indicated that the employment rate for Aboriginal and Torres Strait Islanders is 46%, compared to around 72% among non-indigenous groups (18). Aboriginal and/or Torres Strait Islander were only entitled to award wages in the 1968, equating to access to jobs and income only in the last 50 years which highlights the need for systematic frameworks to support education and employment for Aboriginal and/or Torres Strait Islander to ensure equal opportunity (19). Aboriginal and/or Torres Strait Islander people across Australia with severe and profound conditions are almost twice as likely as other Aboriginal and/or Torres Strait Islander people to be unemployed (20).

Culture

Many of the local Indigenous community members within the ACT have come from other areas of Australia (5). Living off Country can be challenging, leaving them without the strong protective benefits for their health and wellbeing (5). Cultural identity in people living off Country can be very strong, but living off Country can bring its own challenges (5). As mentioned earlier, connection to culture is has a strong link to positive health outcomes for Aboriginal and Torres Strait Islander people. Investment in initiatives that strengthen connection to culture and build capacity for communities to practice cultural activities, free from discrimination, is recommended (5). It was noted that COVID-19 and travel restrictions has negatively impacted on First Nations people who were Living Off Country, as they cannot travel to their own Country and/or have the usual community support as they used to pre lockdown (5).

Service access patterns

Aboriginal and Torres Strait islander health is a priority area given its significant service gaps and well documented poorer health outcomes across most areas of well-being (5). Stakeholder feedback reported that Aboriginal and/or Torres Strait Islander people engaged with mainstream primary care and chronic condition management are most likely to be 45 and above. The older indigenous cohorts are more likely to engage with local, community, and government services, although can be overwhelmed with the complexities involved in navigating supports (5). This is further compounded due to their complex health needs and limited means to access services (5). For younger cohorts, there is a perception that it is shameful to access available services and so many do not. When they do, it is more likely for mental health support (5).

Primary care

Data from the ABS shows that the percentage of Aboriginal and/or Torres Strait Islander people in the ACT receiving health check or assessment has reduced from 2017-18 to now across age groups (1). The table below compares the rates of indigenous Canberrans across age groups accessing services (1):

Age group	2017-18	2019-20
Children (0-14)	21.6%	16.1%
Adults (15-54)	21.9%	19.4%
Older people (55+)	24.9%	22.3%
Total population in that year	7,839	8,297

The participation rates of Aboriginal and/or Torres Strait Islander women in BreastScreen Australia in 2018-19 were among the lowest or second lowest in Australia across different age groups (1). According to Patient Experience Survey, 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 (6). 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%) (6).

According to our stakeholder consultation, many Aboriginal and Torres Strait Islander families do not present for full health checks, mostly due to transport barriers and other aforementioned barriers to mainstream health services (5).

Given their lack of presentation for services, some primary care programs are undertaking outreach to communities to support improved health outcomes (5).

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 (9%) in the rates of uptake for MBS General Practitioner Management Plans (MBS item 721), and 9% in Team Care Arrangements among Aboriginal and Torres Strait Islander people aged 35-44 years in the ACT (21). Stakeholders suggested that this could be as a result of the impacts of COVID-19, social distancing, restrictions, and/or that telehealth is not an effective means to interact with Aboriginal and/ or Torres Strait Islander people as their access to mobile phones can sometimes be limited (5).

Mental health

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 the Indigenous population kept rising overtime and was significantly higher than that of non-Indigenous population (6.9% compared to 0.7%) (22). 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) (23). The rate of Indigenous Australians accessing community health services per 1000 population was more than double of the national average (2,816.3 compared to 1,197.4) (22).

Child immunisation

In 2020, immunisation rates of ACT Aboriginal and Torres Strait Islander children in the 1-year category had a coverage of 93.64%, which was less than the rate for all ACT immunisations in the same age group of 96.09% (24). However, the immunisations rates of Aboriginal and/or Torres Strait Islander children in other age groups were higher than those of non-Indigenous community. For the 2-year-old category, 94.18% was the rate of ACT Aboriginal Torres Strait Islander immunisations, compared to 93.29% of all ACT immunisations (24). For 5-yearolds, there was a coverage rate of >97.00% for Aboriginal and Torres Strait Islander immunisations, compared to 95.45% for all ACT immunisations (24).

Hospitalisation

The age-standardised hospitalisation rate (excluding dialysis) for Indigenous Australians in the ACT in 2013-15 was 326 per 1,000 population (23). This was 1.3 times the rate for non-Indigenous Australians, and the rates were higher for females than for males (23). In the same period, some numbers that warrant attention were (23):

- The age-standardised rate of hospitalisation for injury and poisoning were higher than that of nonIndigenous Australians (29 compared with 22 per 1,000). 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 nonIndigenous 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%). Stakeholders informed us that this is likely to be Aboriginal and/or Torres Strait Islander females, when they have care responsibilities for many family members (7).

Service gaps and barriers

Overall, approaches to improving Aboriginal and Torres Strait Islander health need to be holistic, strengthened by a strong First Nations workforce and leadership (5). It is vital that health initiatives are designed and implemented in collaboration with community or delivered by community-controlled organisations (5)

Culturally safe and responsive services

According to AIHW's data on culturally safe health care framework, commissioned in 2017-18, indicates the ACT had some of the lowest rates for several indicators of culturally safe services (25). 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 (25). 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% (25).

For Aboriginal and Torres Strait Islander people, cultural safety and trust are major barriers to accessing 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 (25). 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) (25). Multiple stakeholders commented strongly that in general, there is a lack of cultural safe and responsive services in Canberra. In CHN 2021 Needs Assessment for health consumers, 35% respondents identified as Aboriginal and/or Torres Strait Islander said that the lack of non-judgemental and culturally safe care have negative impacts on their health (5). Practice Incentives Program – Indigenous Health Incentive, requires that only two people in a general practice require cultural awareness training. This can be done once off and does not guarantee ongoing culturally safe and responsive care (7). Many mainstream services lack cultural safety from receptionist through to health staff, and lack understanding and consideration of the cultural nuances of different indigenous families and patients (5). Until recently, aged care facility intake processes would not ask for a client's indigenous status (5). For indigenous families living in large households with extended family and friends, there can be a multitude of issues and complexities that require support (5). Services need sufficient capacity and appropriate delivery models that can work within these dynamics (5).

Mainstream services need more cultural content in their practices to communicate with Aboriginal and/or Torres Strait Islander clients that the service is culturally safe, such as displaying indigenous art and Aboriginal flags in the waiting and clinic rooms (5). Health workers need more training to know how to engage appropriately (5). For example, when undertaking outreach with an Aboriginal and Torres Strait Islander family, health professionals should know that they need to wait to be invited into the home, and always maintain a respectful and nonjudgemental approach. Greater cultural awareness in mainstream services will support intake processes and increase engagement with services.

Stakeholders reported that many inappropriate health referrals were sent to Aboriginal and Torres Strait Islander support services simply because the patient identified themselves as Aboriginal and/or Torres Strait Islander (5). Some health consumers informed us that current services do not have enough capacity and capability to support people with intersecting needs. For example, if an individual identifies as an Aboriginal and/or Torres Strait Islander and a member of LGBTIQA+ community, they can only receive either cultural safe but not genderaffirming care at Aboriginal Controlled Health Organisations, or gender-affirming but not culturally responsive at LGBTIQA+ support services (5). It was highlighted that mainstream services need to build capacity to work with Indigenous clients and those with intersecting needs (5). Paid positions of Elder consultants embedded in mainstream services would be beneficial to advocate for indigenous clients and contribute to service cultural safety (5).

Prevention services

Local report and stakeholders pointed to severe unmet needs in the areas of prevention and early intervention, including the upstream social determinants of health and illness (5, 16). Improvements should be made in areas such as living environment, more facilities for pastimes like sports or art, better transport, and lifestyle changes to reduce or stop problematic drug use (5, 16).

There is a severe need for more effective services to better support clients and their families manage health conditions in the homes (5). For example, Hospital Admission Risk Program (HARP) facilitated in Victoria is designed to reduce indigenous presentations at ED for preventable conditions with better management of chronic conditions, wound and medication in the home. There is a need for culturally safe and responsive community diabetes program that promote beneficial lifestyle strategies, dietetic advice, and podiatry support (5). With better health literacy, healthy cooking skills and clinical support, health outcomes will improve. It is noted by stakeholders that health promotion programs need to consider client's lived experience and realities, e.g. housing status and accessibility to healthy foods, so that it is practical for communities to employ those strategies (5).

Bulk-billed nutrition and dietitian services are needed to address diet as a significant life-style risk factor for prevalent chronic conditions among Aboriginal and Torres Strait Islander population such as diabetes and heart diseases (5). A 2019 systematic review assessing the impacts of nutritional interventions in Australian based Aboriginal and Torres Strait Islander people shows that nutritional interventions improve dietary quality and bring positive health outcomes across a range of factors (26). This review also highlights that for programs to be successful community involvement is critical (26).

There is limited collaboration between mainstream services and Winnunga Nimmityjah Aboriginal Health & Community Services (5). This is a significant barrier to help manage chronic conditions of Aboriginal and Torres Strait Islander peoples in the community, especially when there is high prevalence of comorbidities (5).

Funding a mobile health van and additional outreach services can improve access to indigenous health checks in the ACT (5). An effective engagement strategy used by a previous program was to incorporate sporting events and merchandise with dental and health checks (5).

Other programs and additional supports for prevention and early intervention could include (5):

- self-management workshops such as healthy lung workshops, mental health issue and self-care for carers • workshops to understand lung cancer and the importance of cancer screening
- workshops to understand chronic illness red flags and how to manage stress.
- outpatient case management to reduce service access barriers and admittance rates into hospital
- pharmacist and occupational therapist at Winnunga to better assist medication management and engagement with broader community
- education on what allied health services can do and what services are available to support the person's health and wellbeing

After-hour services

Stakeholders reported that some of the Indigenous community in the ACT engage with ED on a regular basis particularly for weekend and after hours use (5). This is partly because parts of the community are residing in small towns around Canberra and in NSW catchment area, where there is no late-night care, so ED is the only option (5).

Service affordability and transport as barriers to access services

Service affordability is a major barrier to care. About 40% of respondents identified as Aboriginal and/or Torres Strait Islander in CHN 2021 Health Needs Assessment reported the cost to access services to be the major factor that impacts their ability to care for their health and wellbeing (5). Inability to afford specialist treatments and medications is a barrier to good health outcomes (5). Lack of bulk billing GP's is a major barrier, as confirmed throughout our consultations (5).

Transport to access health services is an issue reported by most stakeholders. Although community transport for Aboriginal and Torres Strait Islander communities is available to some, there is not sufficient capacity (5). The poor public transport in Canberra can impact Aboriginal and/or Torres Strait Islander people disproportionately, as there are larger populations of indigenous families in Belconnen and Tuggeranong in comparison to other suburbs (5).

Other service gaps

Consultations and reports 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 (5)
- Mental health programs with Aboriginal workers – especially for adolescents (5)
- Services for incarcerated Aboriginal and Torres Strait Islander women and alcohol and other drug services for women (5)
- Trauma healing/informed programs (5)
- An Aboriginal Community Controlled Legal Service (5)
- Indigenous Children's Commissioner (5)
- A service directory listing all culturally appropriate and Community Controlled services in the ACT (and cross border) (5)
- Aboriginal and Torres Strait Islander Child and Family Service in the ACT based in Canberra's northside (2)
- Ear, Nose and Throat surgery for at risk Aboriginal and Torres Strait Islander infants, children and young people. (14)

- More support and services for Aboriginal and Torres Strait Islander people in the northside of Canberra (5)

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 / Priority	Subcategories	Focus areas	Strategies & opportunities to address	Partnerships and stakeholders
Affordability of services	Access	- High out-of-pocket costs limit access to health services, including primary care, specialists, and allied health - Additional costs of accessing care such as transportation and time off from work should be considered when planning for services - High living cost in the ACT has a major impact on the ability to care for one's health and wellbeing, especially for the missing middles	Commission services Planning	ACT Health Advisory Councils
Accessibility of services	Access	- Cost, long wait times and transport are major barrier to access services - Lack of culturally safe, gender-affirming and nonjudgemental care to make people feel safe to access services - Lack of consideration for social determinants that impact a person's ability to access services	System improvement Capacity building	ACT Health Advisory Councils General practice Commissioned Services Providers
Health literacy including awareness, navigation of	Access	- Lack of awareness and understanding of service options among consumers	Commission services System	ACT Health Health Care Consumers ACT's

services, and confidence in seeking and participating in health		- Lack of support in navigating services, particularly for vulnerable groups.	improvement Awareness raising	Health Literacy Network Advisory Councils Commissioned Services Providers NGO Partners
Lack of supports for prevention and early intervention	Early intervention and prevention	- Lack of health promotion activity to help people manage their conditions at home and in community - Low uptake of regular health check - Lack of holistic and patient-centred care to better manage conditions in community - Long wait-times and high costs to access services prevent people from accessing care early	Capacity building Commission services System improvement	ACT Health Advisory Councils
Lack of collaboration and integration of services, disrupting continuity of care	Care coordination	- Lack of understanding of what other services and health professionals can do in the care of people with complex needs or comorbidities - Lack of a centralised system that can enable information sharing and incompatible digital systems. Although My Health Record exists, the uptake is limited. - Poor renumeration and short-term contracts leading to low staff retention in NGO sector, which then lead to disrupted flow of information	System improvement Strategic partnerships Capacity building	ACT Health Health Care Consumers ACT's Health Literacy Network Advisory Councils Canberra Health Services Calvary Hospital Commissioned Services Providers Professional bodies

		- Lack of resources to enable collaboration and communication - Lack of focus on holistic approach to care		
Patient experience	Access	- Lack of culturally safe, gender-affirming and nonjudgemental care - Lack of patient-centred care	Capacity building Awareness raising	General practice Commission Services Providers
Preventable use of ED and Hospitalisation	Access	Continued use of the ED for low-urgency or preventable conditions.	Commission services	General Practice ACT Health Canberra Health Services Calvary Hospital
Impact of COVID-19	Other – COVID19 identified	- The use of telehealth in providing care should be reviewed to maximise its potential - Upskill health professionals to deliver high quality care via telehealth - Improve procedures, systems and infrastructure to provide continuing and quality support from distance	Capacity building System improvement Planning	General Practice Canberra Health Services ACT Health

Intended outcomes

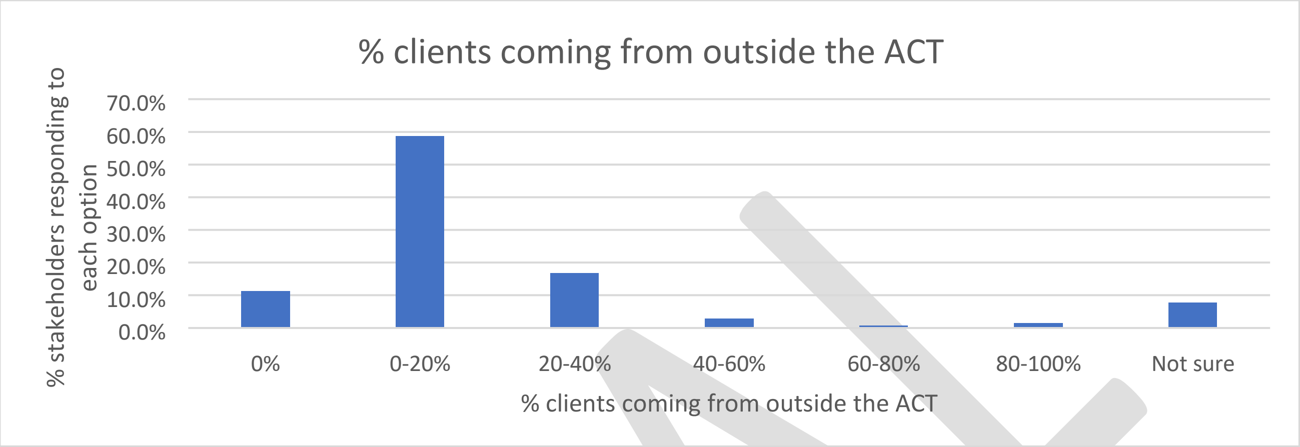
- People can find and access services they need
- People receive care at the right time and the right place • People feel safe and supported when accessing services

General population description

The Capital Region, as defined in the Australian Bureau of Statistics (ABS) Statistical Area 4 ‘Capital Region’ of NSW, includes Queanbeyan, the Snowy Mountains, the NSW South Coast, Goulburn, Young, Yass, and surrounding towns. The ACT health system provides services to the populations of this whole region (14). The ACT also provides services to residents of surrounding NSW communities that are outside of this catchment (14).

The combined population of the ACT and the Capital Region are estimated to be 648,290 on 30 June 2018. Of these, 159,642 (24.6%) people were aged under 20, 121,725 (18.7%) were children aged 0–14, and 100,621 (15.5%) were aged 65 or older. The total population of the ACT is projected to increase from an estimate of 428,509 in 2019 to 526,525 by 2032.

According to respondents of CHN Needs Assessment Service Provider Survey, service loads from outside the ACT is as follows:



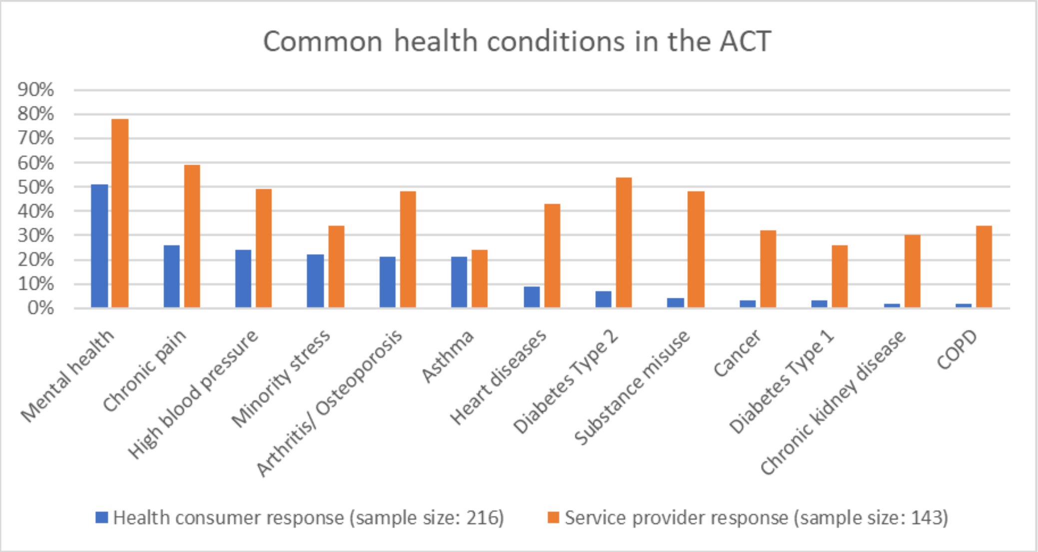
Graph 1: Service loads from residents coming from outside the ACT (source: CHN)

General health and wellbeing

On average, adults living in the ACT have higher levels of personal wellbeing, financial position, better access to transport than the Australian average. They also have a higher cost of living and lower levels of social connection (27). According to AIHW, 88% of ACT residents rated their health as excellent or very good in 2020, which has stayed approximately the same since 2017-2018 (28). However, according to the University of Canberra, in 2019, 48.1% of ACT adults reported very good or excellent health, while 20.5% reported being in fair or poor health (27). The proportion of ACT adults reporting very good or excellent health declined from 48.1% in 2019 to 40.2% in April/May 2020, while the proportion reporting fair or poor health rose from 20.5% to 27.8% (27).

Several aspects of wellbeing worsened in 2019-20, particularly personal wellbeing, self-assessed overall health, psychological distress and loneliness (27). There was also a slight increase in overcrowding, cost of living challenges, and worsening financial position in some households (27).

Approximately 52.3% of ACT adults reported to have a long-term condition in 2019-20 (28). In the Needs Assessment surveys conducted by CHN in 2021, in response to the question, ‘which health condition(s) was the respondent (or client cohort for the Service Provider Survey) experiencing?’, mental health was the most prevalent health concerns among respondents, followed by chronic pain, high blood pressure, arthritis/osteoporosis and asthma (5).



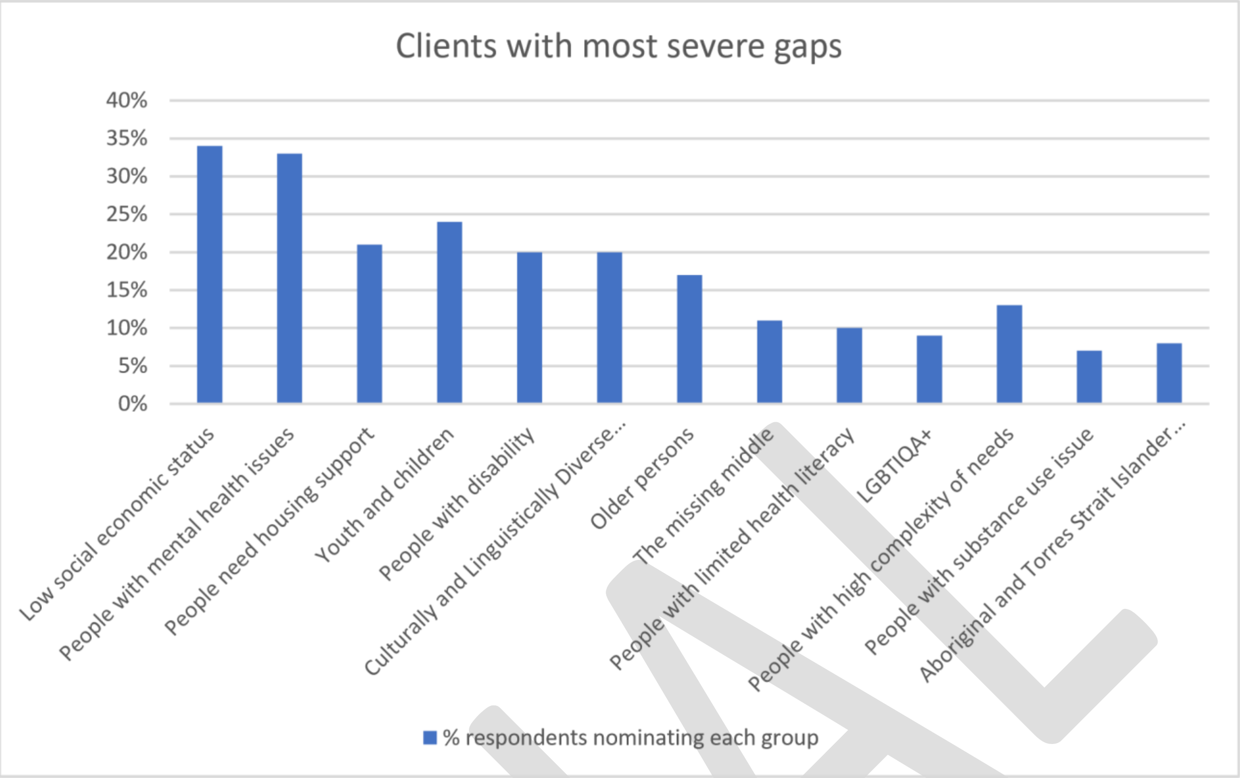
Graph 2: Common health conditions in the ACT (Source: CHN)

A survey conducted by Women's Health Matters in 2018 that the top mental health concerns were anxiety, depression, and stress (29). Top chronic conditions reported were endocrine disorders, bone disorders and chronic pain/ pain conditions (29).

Populations that have lower wellbeing than the average and experience severe service gaps

According to University of Canberra's survey, the groups more likely to report having fair or poor health in 2019-20 compared to the general population were single parents, those with moderate or severe disability, those identifying as LGBTIQA+, carers (particularly those with higher caring obligations), renters, and those living in Tuggeranong South (27). Graph 3 depicts those clients with the most severe needs as per CHN's Needs Assessment Survey for Service Providers. (5).

Graph 3: Clients with most severe gaps (Source: CHN)



Social determinants of health

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 housing affordability and transport. Rent and the living costs in the ACT are high, which impacts people's ability to care for themselves as a significant amount of disposable income goes toward living costs, and less resources available for health promoting activities (5). Social isolation also emerges as a major theme that impact people's health and wellbeing (5). Other determinants that can impact one's ability to access quality care including gender, age and socio-economic status will be explored in later parts of this report.

Transport

In 2019, 81% ACT residents found it easy to get to places they need to, while 16.3% sometimes experienced difficulty, and 2.7% often or always experienced difficulty (27). Those significantly more likely to report to experience difficulty with transport were those with moderate or severe disabilities (both physical and mental disabilities), a sole person household, carers (particularly those with 15 or more hours a week of caring obligations), those who were unemployed and looking for work, those living in the inner North (Downer, Dickson and Watson) and renters (27).

Employment

Self-reported work-life balance changed significantly between 2019 and 2020, with younger people, renters, those from non-English speaking backgrounds and those with moderate or severe disability experiencing high rates of growth in underemployment during this time (27). Students, young people and women were disproportionately affected by COVID-19 restrictions, as these groups are more likely to work in industries that were totally disrupted by lockdown like hospitality and retail (5)

Housing

Lack of access to affordable housing or substandard temporary housing was mentioned as a major source of stress and a barrier for people to care for themselves (5). In 2020, 25% of ACT residents reported that their house was overcrowded, an increase from 16% in 2019 (27). The groups most likely to report over-crowding in 2019 were those aged 30-49, single parents, couples with children of any age under 25 living in the home, and those living in units/apartments (27). Stakeholders also reported a gap in Disability Social Housing within the ACT which impacts on those with a disability accessing disability appropriate social housing services (5).

Living affordability

Overall, 42% of ACT residents thought living costs were not affordable in 2019. This figure rose to 47.0% in 2020, while the proportion of respondents who thought otherwise fell from 34.9% to 25.4% (27). In 2019, the groups who were significantly more likely to find living costs unaffordable were those aged 50-64; those who had lived in the ACT for 3 years or less; couples with children aged under 18 living in the home, particularly those with children aged 5-17; renters; and those living in Weston Creek and Molonglo (27). According to Women's Health Matters, the high cost of housing, low numbers of bulk billing GPs, and high costs in other areas such as food and transport, has contributed to growing numbers of women who have some income from paid employment, but are unable to cover the out-of-pocket costs of private healthcare (29).

Safety

Overall, 87.1% of ACT adults find their local area a safe place to live, while only 15.7% feel that it is unsafe to walk outside in their local area at night and 6.2% feel it is unsafe to walk outside in their local area during the day (27). The groups less likely to report finding their local area a safe place to live were females, those with moderate or severe disability, carers, those living in Tuggeranong South, Weston Creek and Molonglo (27).

Other social determinants of health

Stakeholders also mentioned that the lack of access to good nutrition and food sources, sporting facilities, and exposure to domestic violence/ abuse are also important determinants of health that impact the ability to care for their health and wellbeing in the ACT (5).

Service access pattern

The majority of Living Well in the ACT Survey respondents who accessed walk-in clinics, GPs, dentists or allied health services reported finding it easy to access these services, although around 25%-30% did not find it easy to access each of these (27). Fewer found it easy to access mental health services (38%) or specialist health services other than mental health services (44%) (27). Differences in ability to access health services can be attributed to several factors, including but not limited to poor service availability, high wait-times, affordability, or transport issues (27).

Four groups were less likely to rate access to services as 'easy' than the ACT average are (27):

- Those with moderate or severe disability were less likely to find it easy to access walk-in clinics (62% compared to 72% of ACT average), GPs (66% compared to 75%), dentists (70% compared to 78%), but similarly likely to find it easy to access mental health services, other specialist services, and allied health services.
- Carers were significantly less likely to find it easy to access walk-in clinics (60% compared to 72% of ACT average), GPs (62% compared to 75%), mental health services (17% compared to 38%), other specialist health services (32% compared to 44%) or allied health services (52% compared to 70%).
- Those who identified as LGBTIQA+ were less likely to find it easy to access mental health services, with only 20% reporting this was easy, compared to 38% of ACT average.
- Those who had lived in the ACT for 5 years or less were less likely to find it easy to access a GP (63% compared to the ACT average of 75%), as were those who were unemployed (47%).

According to CHN Needs Assessment Survey for health consumers, 60% respondents said that bulk-billed services are hard to access, 51% indicated specialists and 50% indicated mental health services. Other services which are reported to be hard to access include GPs, care coordination support and dental services (5).

GPs & primary care services

Approximately 83% of ACT respondents of the National Health Survey saw a GP in 2019-20, an increase from 79.1% in the previous survey (28). Apart from the increase in GP attendance, the rates that ACT respondents accessing GPs for other purposes reduced. In particular:

- 9.4% of ACT respondents saw GPs for urgent medical care, reduced from 12.4% in 2017-18 (28)
- 7% had after-hours GP visits in 2018-19, reduced from 9% in 2017-18 (28)

The proportion of GP management plans and team assessment plans reviewed in 2018-19 were the second lowest in Australia, 70.8% plans were reviewed compared to 74.1% nationally (1). Approximately 80% of Canberra respondents have a preferred GP in 2019-20 (national: 76.6%); however, 29.7% could not access their preferred GPs (28).

Regarding patient experience and access, high wait times and serious cost barrier are the major themes:

- 18.5% felt they had to wait longer than acceptable to get an appointment with a GP in 2019-20 (28)
- 6% of ACT respondents delayed seeing a GP due to cost in 2018-19 (national: 3.5%) – the second highest in all PHNs (30)
- 13.2% of ACT respondents needed to see a GP but did not in 2018-19 (national: 12.3%), reduced from 17.1% in 2017-18 (30)
- Annual Medicare Statistics noted that the ACT remained the state/territory with the lowest bulk-billing rates in key primary care areas (31)
- The lack of bulk-billing GPs is among the top 3 most common barriers for a person to care for their health (5).

Medical specialist and allied health

Access to medical specialists is a significant challenge in the ACT due to high cost and significant wait times. In 2018-19, 27% adults referred to a medical specialist reported to wait longer than they felt acceptable to get an appointment (national: 23.8%) (30). According to the Needs Assessment Survey respondents, specialists in high demand are mental health professional (mostly psychologist, psychiatrist and other alternatives for psychologists such as coach and counsellor), dietitian, podiatrist, speech therapist, physiotherapist (especially for pelvic floor management), and occupational therapist (5). Shortages of occupational therapists was a major theme across our consultations, which is likely due to the wide range of areas they can provide support to and high migration of the workforce from public sector into NDIS in recent years (5). Some areas that occupational therapists are needed include but not limited to are disability, palliative care, transitional roles in the community sector, outpatients, public system, and mental health, in particular for the LGBTIQA+ cohort, school-aged children and their parents (5). Private paediatric occupational therapists have long waitlists in excess of 12-18 months or have ceased taking new referrals. This has been further exacerbated with lockdowns as previously some families were travelling to Sydney to access services if unable to access in a timely manner in the ACT (5).

A lack of specialist services for children were a key theme from the service provider survey (5). Most mentioned services that were lacking include paediatric physiotherapist, orthopaedic specialists, early intervention allied health for children with developmental delays who are not eligible for NDIS, and psychiatrists who can facilitate ADHD assessments (5).

Other specialist services mentioned to be lacking include chronic pain management, support for personality disorder, obesity and weight management support, eating disorder, continence support, women’s health, and trans-specific services (5). It is difficult for trans people to access the clinics that provide informed consent to hormone replacement therapy and affirming treatment (5).

ED presentation

In 2019-20, approximately 15% of ACT respondents presented at the Emergency Department (ED) (National: 14.3%), an increase from 13% in 2018-19 (32). In 2019-20, the number of ED presentations in the ACT was highest for people aged 65+ (520.8 per 1,000 population) and children from 0-4 years old (496.1 per 1000 population) compared to figures around 200-300 in other age groups (32). ED presentations per 1000 populations were higher than the national average in all age groups, except for children aged 0-4 (32). The most significant differences were in people aged 65+ (520.8 compared to 461.5), children and young adults aged 15-19 (327 compared to 293.7) and aged 10-14 (262 compared to 236.5) (32). ED presentations for people aged 65+ were most likely to be urgent while it tended to be semi-urgent for people under 65, especially among young children (0-4), children (5-14) and young adults (15-24) (32).

Nationally, “Signs and abnormal clinical and laboratory findings, not elsewhere” and “Injury, poisoning and certain other consequences of external causes” were the top reasons for ED presentations across all age groups (32). The common principal diagnosis among children aged 0-14 were diseases of respiratory system and certain infectious and parasitic diseases (32). The most common diagnosis for people aged 15-44 was mental health, a mix of digestive and musculoskeletal system for people aged 45-54, and diseases for circulatory system from age 55 onwards (32).

For people who had 10 or more presentations to Canberra or Calvary hospital EDs in 2017–18, around 70% presented on weekends or outside business hours and the most frequent reasons for presentation at both sites were unspecified abdominal pain, chest pain, anxiety, suicidal ideation, headaches or unknown causes (14). Of the 100 people most frequently presenting to both EDs in 2017–18, 65% had had a recent contact with mental health services (14).

In 2017-18, 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) (33). Children below 15 years old were most likely to use low urgency care in ED, followed by young adults (15-24 years old) (33). People from Canberra East, the most social-economically disadvantaged area in the ACT, had the highest rate of use of low urgency care (183.9 per 1000 populations) (33).

Stakeholders informed us that lower urgency presentations include a large number of presentations for lessserious ailments, such as pain management, musculoskeletal issues and cold and flu symptoms (5). However, there have been reported cases where clients found their pain issue was treated as a low-urgency presentation by hospital staff, when it should have been treated with greater urgency (5). According to our stakeholders, most lower urgency ED presentations for chronic pain can be reduced in severity and/or avoided with the support from a dedicated primary care physiotherapist (5).

Hospitalisations

In Australia, between 2018–19 and 2019–20 there was decrease in admitted patient activity which has been attributed to be due to the impacts of COVID-19 (34).

- the number of hospitalisations decreased by 2.8%, compared to a 2.6% increase between 2017–18 and 2018–19
- the decrease in hospitalisations was greatest for private hospitals (4.5%) compared to public hospitals (1.7%)

Nationally, almost half of admitted patient days were for older Australians (35). In 2018–19:

- 43% of hospitalisations and 50% of patient days were for people aged 65 and over (35)
- Aboriginal and Torres Strait Islander people made up 5% of hospitalisations (559,000), and they were hospitalised at 2.3 times the rate of other Australians (35)

- diseases of the digestive system accounted for 9.5% of hospitalisations (over 1.0 million) and diseases of the musculoskeletal system and connective tissue accounted for a further 7% of hospitalisations (35)

The number of potentially preventable hospitalisations in 2018-19 were 150 per 100,000 population for vaccine preventable conditions (second lowest in all states and territories, national average: 240) and 1020 per 100,000 population for acute conditions (lowest in Australia, national: 1290) and 770 for chronic conditions (lowest in Australia, national average 1220) (35).

The most common conditions for preventable hospitalisations in the ACT was urinary tract infections including pyelonephritis, followed by dental conditions and cellulitis (35). The most common conditions for chronic condition preventable hospitalisations were COPD, congestive cardiac failure, diabetes complications, asthma and iron deficiency anaemia (35).

For Aboriginal and Torres Strait Islander populations, the two most common conditions for acute preventable hospitalisations in 2018-19 was dental conditions (4.8 per 1000 populations, national average: 3.9), urinary tract infections including pyelonephritis and convulsion and epilepsy (3.4 per 1000 population, lower than the national average), cellulitis (3.2 per 1000 populations) and ear, nose and throat infection (3.1 per 1000 populations) (35). For chronic conditions preventable hospitalization, most common conditions among Aboriginal and Torres Strait Islander populations were COPD, congestive cardiac failure and iron deficiency anaemia) (35).

Palliative Care

Palliative care is another priority area that requires significant investment of resources to meet community need (5). During the period 2014-15 to 2018-19, there was an 8.4% average annual increase in the hospitalisations for palliative care in the ACT (36). In 2018-19, the ACT had the highest rate of palliative clients in the country (22.5 per 10,000 population – national 16.3) (36). The average length of stay for palliative care decreased by about 4% annually on average, reaching 9.2 days in 2018-19 (national 8.9 days) (36). Most palliative care discharges from hospital were due to death (67.9%), which was similar to the rest of Australia (36). Nationally, approximately 74% of episodes were characterised by a cancer diagnosis (36).

Prevention (immunisation & cancer screening)

In 2018-19, the number of children in the ACT who were fully immunised 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) (1).

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) (1). National data show that due to COVID-19, participation in preventative screening has reduced significantly (37).

Use of telehealth

HealthMap data during the first quarter of 2020 notes 7071 Healthdirect Helpline calls in the ACT (38). Despite having smaller population, the ACT has a higher number of episodes than Queensland and Victoria (38). 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 (38). The same goes for After-hour GP Helpline (38). Although the estimated population of Aboriginal and Torres Strait Islander was just approximately 1.8% of the total population, they represented 3.8% of the total number of calls (38).

As seen in the table below, In the first quarter of 2020 when telehealth items were extended to a large variety of health and medical practitioners due to COVID-19, uptake of telephone consultation was much higher than videoconferences for GP's, Other Medical Practitioners and Specialists (39).

COVID-19 related items by mode of delivery - number of services, Q4 quarter, 2019 – Q1, quarter, 2021

		General practitioner attendances			
Year	**Quarter**	**Face-to-face**	**Telephone**	**Video-conference**	**Total**
2021	Q1	27,692,122	7,944,802	127,486	35,764,410
	Total	**27,692,122**	**7,944,802**	**127,486**	**35,764,410**
2020	Q4	26,422,275	9,002,950	164,325	35,589,550
	Q3	25,239,608	12,294,062	288,773	37,822,443
	Q2	25,528,355	12,572,059	412,343	38,512,757
	Q1	32,751,851	978,605	61,695	33,792,151
	Total	**109,942,089**	**34,847,676**	**927,136**	**145,716,901**
2019	Q4	32,615,743	. .	. .	32,615,743

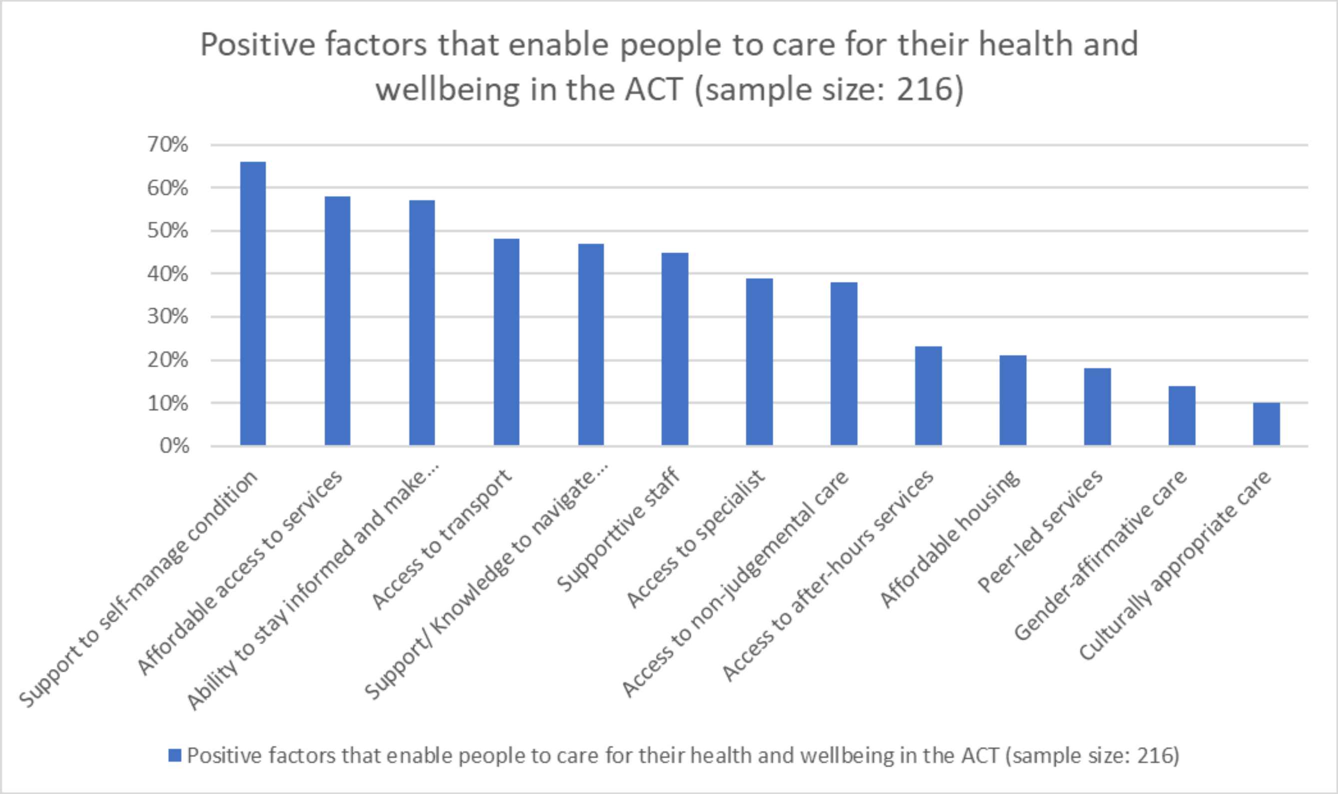
		Other Medical Practitioner attendances			
Year	**Quarter**	**Face-to-face**	**Telephone**	**Video-conference**	**Total**
2021	Q1	919,568	235,182	13,681	1,168,431
	Total	**919,568**	**235,182**	**13,681**	**1,168,431**
2020	Q4	948,329	284,586	15,372	1,248,287
	Q3	959,671	400,811	20,989	1,381,471
	Q2	948,986	365,963	25,969	1,340,918
	Q1	1,208,022	20,867	4,301	1,233,190
	Total	**4,065,008**	**1,072,227**	**66,631**	**5,203,866**
2019	Q4	1,224,570	. .	. .	1,224,570

		Specialist attendances			
Year	**Quarter**	**Face-to-face**	**Telephone**	**Video-conference**	**Total**
2021	Q1	6,425,127	772,902	170,978	7,369,007
-	**Total**	**6,425,127**	**772,902**	**170,978**	**7,369,007**
2020	Q4	6,311,616	998,110	249,286	7,559,012
	Q3	6,095,641	1,235,116	325,281	7,656,038
	Q2	4,833,527	1,538,504	366,708	6,738,739
-	Q1	6,652,687	121,356	28,215	6,802,258
-	**Total**	**23,893,471**	**3,893,086**	**969,490**	**28,756,047**
2019	Q4	7,169,396	. .	. .	7,169,396

According to CHN Needs Assessment Survey respondents, bulk-billed telehealth was a helpful initiative during the pandemic and should be maintained on an ongoing basis (5).

Positive factors that assist people to care for their health and wellbeing

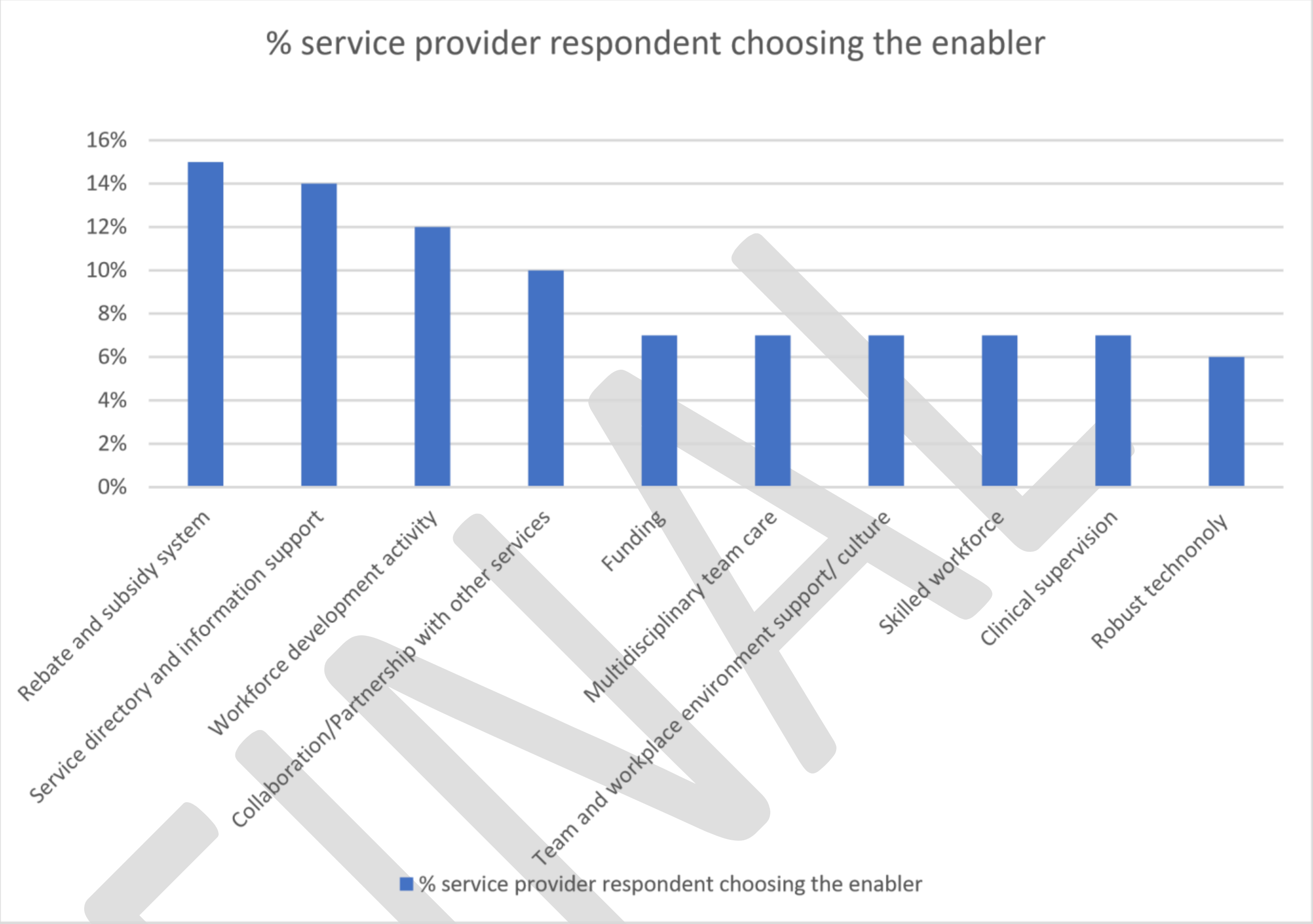
The CHN 2021 Needs Assessment Survey asked for the positive factors that the person has access to in the ACT to care for their health and wellbeing (5). Although the responses were a mix between factors that people have access to and what they think they would like to have access to, they provide a general idea of what consumers believe is important to help them care for their health and wellbeing.



Graph 4: Positive factors that enable people to care for their health and wellbeing (Source: CHN) (5)

Positive factors that enable health professionals to provide quality care

Similarly, to the graph above, CHN conducted surveys to understand the enablers supporting health professionals to deliver quality care.



Graph 5: Enabling factors to provide quality care (Source: CHN) Each

factor includes qualitative themes as below:

Rebate and subsidy systems
Medicare, PBS, Better Access, NDIS and My Aged Care were found to be the most prominent themes in the qualitative survey for this factor. ACT Equipment Loan Scheme and rebated access to allied health such as the Chronic Disease Management (formerly Extended Primary Care) items are also mentioned.

Collaboration/Partnership and working relationships with other services and sectors
Main themes include professional connections with other organisations, teamwork and networks, partnerships and support from other providers, professional structures that support communication and continuum of care. Care coordination supports and established referral pathways are also recommended.

Multidisciplinary team care
Main themes include team care arrangement with allied health professionals, co-location, and access to specialist advice.

Service directory and other information supports
These factors are considered important to inform health professionals of appropriate referral pathways and available services to support clients. They include HealthPathways, Clinical pathways, referral network for advice, Healthlink, Better Health and End of Life Directions for Aged Care (ELDAC).

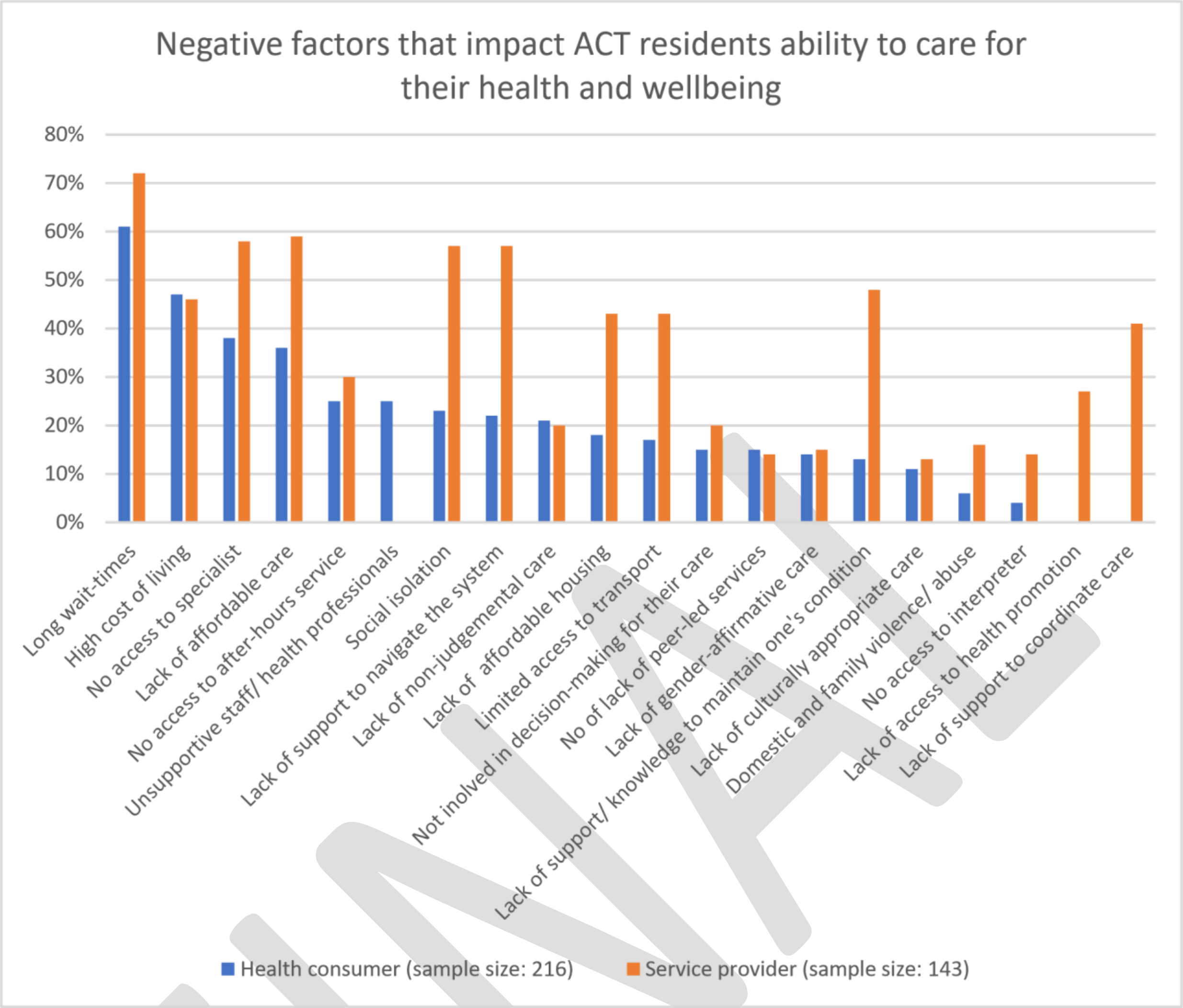
Team environment and workplace condition
These include team support, peer support, infrastructure, and equipment to support delivering care. Robust technology is needed to streamline communication and administrative burden, which helps staff save time to invest in real care. Quality leadership and administrative support are also mentioned. Health professionals value clear communication about their roles, expectations and have their opinions valued. Adequate staffing and funding to reduce the risk of burn-out and ensure better quality of care are also dominant themes.

Strong skilled workforce and workforce development/training activities
This factor includes qualification frameworks, staff training, and continuing professional development. It is important to develop peer workforce and structure to support peer workforce, especially in mental health, alcohol, and other drugs, LGBTIQA+ and youth space. Clinical supervision was a relatively prominent theme as being instrumental in supporting junior staff and growing workforce. There needs to be evidence-based workforce strategy to cover current service gaps and future workforce shortage when baby-boomer generation health professionals retire. Stakeholders also suggest the need to include counsellors and coaches in workforce development strategies and the funded workforce characteristics, particularly in the trauma-informed space. These professionals have been active in supporting clients at different services in the ACT, and many with positive outcomes.

Policy and funding environment
External factors such as a consistent policy-making environment and issues with continuity of funding were also mentioned by many participants. Funding is allocated for such short timeframe that it creates uncertainties for health professionals to stay with the service, hampers service's ability to retain staff and maintain continuity of care for health consumers. At a more strategic level, the roles of primary health networks in supporting workforce development, and peak bodies in advocating for the sector are highly regarded.

Negative factors that impact consumer's ability to care for their health and wellbeing

The negative factors that impact consumer's ability to care for their health and wellbeing include barriers to access care and service gaps. These negative factors usually prevent people from accessing the care that they need, or delay accessing care until when they really need to do so, usually when tertiary intervention is needed. Service gaps can be defined as services that are currently existing but do not have enough capacity to meet demand, or very hard to access, or are non-existent in the ACT. Below is a graph illustrating the prevalence of different negative factors in the ACT from health consumers and service providers perspective.



Graph 6: Negative factors that impact ACT residents the ability to care for their health (Source: CHN)

High wait-times

According to CHN Needs Assessment Survey respondents, high wait times is the most common barrier to access services. Extremely high wait times occur when a consumer needs to access:

- specialist in general, including psychologist, psychiatrist, cardiologist, trans specialist services, maternal health, paediatric endocrinologists, gynaecologist, eating disorder specialist, ENT, Gastroenterologist, AOD specialists, mental health programs and supports
- emergency department
- aged care services and aged care support for those who are currently in hospital • pain management unit
- diagnostic tests.

Cost barrier

Cost is equally common as a barrier that prevented surveyed respondents to care for their health. Approximately 7% of adult respondents of the National Health Survey avoid filling the prescription due to cost (30). In 2018-19, 17.6% of ACT respondents delayed seeing a dentists, hygienist or dental specialist due to cost (30).

According to our survey respondents, services that have significant cost barriers include imaging and diagnostic test services, gender-affirming surgery, mental health care, specialists, and dental care (5). This cost barrier is significant in preventing people seeing GPs early on and accessing other treatments to achieve better health outcomes and often results in clients waiting until the conditions worsens (5). Stakeholders informed us that mental health care is under-subsidised in the ACT, especially sub-acute mental health care, as Medicare and private health rebates for physical care cover a higher proportion of actual cost than for mental health (5). There is little practical and/or financial support available for the ‘missing middle’, e.g. low-to-middle income earners but with intersectoral vulnerabilities, or those with disabilities and/or other health concerns but still have their employment and not eligible for any kind of support (6).

Patient experience

Despite the issues with wait times and accessibility, Canberrans’ satisfaction with the way their GP interacted with them was approximate with the national average:

- In 2017-18, 93% of Canberran respondents reported that their GP always or often listened carefully (national: 92%) (40).
- In 2017-18, 95% reported that their GP always or often showed respect (national: 94%) (40).

Stakeholders have informed us that generally, GPs are helpful in supporting older persons and people with chronic conditions to manage their conditions, while younger people find it quite challenging to engage with GPs, especially those who need mental health care (5). This aligns with AIHW’s findings on patient experience nationally (28). Possible reasons provided from the young consumers we consulted with are:

- Young people are more likely to be able to afford bulk-billed attendance only, and the retention rate of GPs at bulk-billed practice is generally low. Young people need to change their GPs and repeat their story several times, which can lead to no continuity of care and low patient satisfaction.
- Young people feel they are not “talked to” when attending GP appointments if they are underage and attending with their parents.
- Young people feel there is a particular generation gap between them and their GPs, who usually are much older. They have concerns that their needs would not be understood, and they will be discriminated or stigmatised, especially those from sexuality and gender diverse backgrounds, and those with mental health issues.

Lack of respectful and non-judgemental staff is a significant negative experience that inhibit a consumer’s ability to care for themselves (5). Some significant issues are:

- Trans or gender diverse identity is not respected.
- Staff have low regard and expectation for the health quality and wellbeing of people with disability, which can lead to misdiagnosis. Most health issues are regarded as due to the disability rather than an actual medical condition.
- Some health professionals can be patronising and/or dismissive.
- Some health professionals do not recognise chronic pain and chronic fatigue.
- Some respondents reported feeling discriminated and mistreated when they appear overweight, tattooed, pierced, and coming from low SES backgrounds.

There was also some variation in the results according to main language spoken in the home (41). Overall, the proportion of people who disagreed or strongly disagreed that they feel understood and supported by health care providers was similar for people who spoke English in the home (4.2%) and those who did not (5.2%) (41). However, a higher proportion of people who spoke English in the home strongly agreed they feel understood and supported by health care providers (33%) than those who did not speak English in the home (20%) (41). Additionally, those who spoke English in the home were more likely to always find it easy to actively engage with health care providers (34%) than those who spoke a language other than English in the home (26%) (41).

Stakeholders informed us that high-workload and reduced staffing makes person-centred care very difficult (5). Significant administrative burden equates to lack of person-centred care and actual time for patients (5). There is a lack of multidisciplinary teams in community-based settings to provide person-centred care for trans and gender diverse patients (5).

Other factors relating to patient experience that can impact consumer's ability to care for themselves are (5):

- Services at times may not be LGBTIQA+ inclusive. It can be very challenging for a same-sex relationship couples to navigate the system, especially during times of an emergency where their partner may not be included in care arrangement and/or decision-making. Some respondents indicated they have negative experience when presenting at some specialist services.
- Staff are often not aware of covert stigma and discrimination such as intake documentation that are not inclusive of gender diversity and non-inclusive language in written and spoken dialogue.
- Services are not trauma-informed or able to be responsive to clients who have experienced trauma.
- Services that use artificial fragrances can act as barrier for people with chemical sensitivities.
- Bulk-billed GPs usually are less likely to spend enough time with clients and can be dismissive of mental health issues, e.g. refusing to write mental health plans. Stakeholders stated that the following two factors are some of most challenging to overcome:

  Information not being shared with client and/or not including client in the care of their own health and/or their family members; and

  Some complex cases were refused for services due to being deemed as "too complex to treat", yet there were often minimal alternative services to refer clients towards so they are left without support entirely.

Care coordination and continuity of care

Communication and information exchange among health professionals are reported to be problematic. For example, according to our Needs Assessment Survey and consultation, stakeholders and respondents advised:

- There are usually delayed, insufficient and even no communication between services and different health professionals, which leads to inefficient and negative health impacts for patients. Sometimes, the high wait-times in the ACT can render the communication ineffective, as the condition of the patient would have changed after a long wait, making the information invalid. There is no clear communication mechanism or referral pathways between different specialists. There are persistent issues with discharge summaries. They are frequently reported not being sent to GP, or patient is discharged before the summary is available. Information about after-hours treatment is not communicated back to the GP in many cases examined.
- Due to time pressures and reduced resources, there can be reduced investment in writing referrals, leading to low quality referrals with inaccurate, missing and/or misleading information.

- There is no or very poor coordination and integration between services. Service users have to take up coordination of their care, and often do not have enough capacity to take on this role. Possible reasons for the lack of communication and integration are a lack of a centralised system that can enable information sharing, incompatible digital systems, lack of focus on holistic approach to care and tribal/ siloing culture between different types of health professionals.

One major challenge for integrated and holistic care is that the breadth of skill of allied health professionals are not well-known and there is a need for improved education for GPs to understand the roles of other health professionals e.g. when to refer on, what assistance they can provide etc (5). Community care allied health stakeholders have informed us that there are not many chronic disease management plans coming from GPs (5). Education for GPs and medical colleagues is needed to promote uptake (5). Stakeholders also suggested that there should be better integration with private sector to understand what services are available (5). Health Pathways should be utilised more by allied health professionals and other practices to reduce the burden on going to GP for information (5). Other challenges for collaboration across different services and are (5):

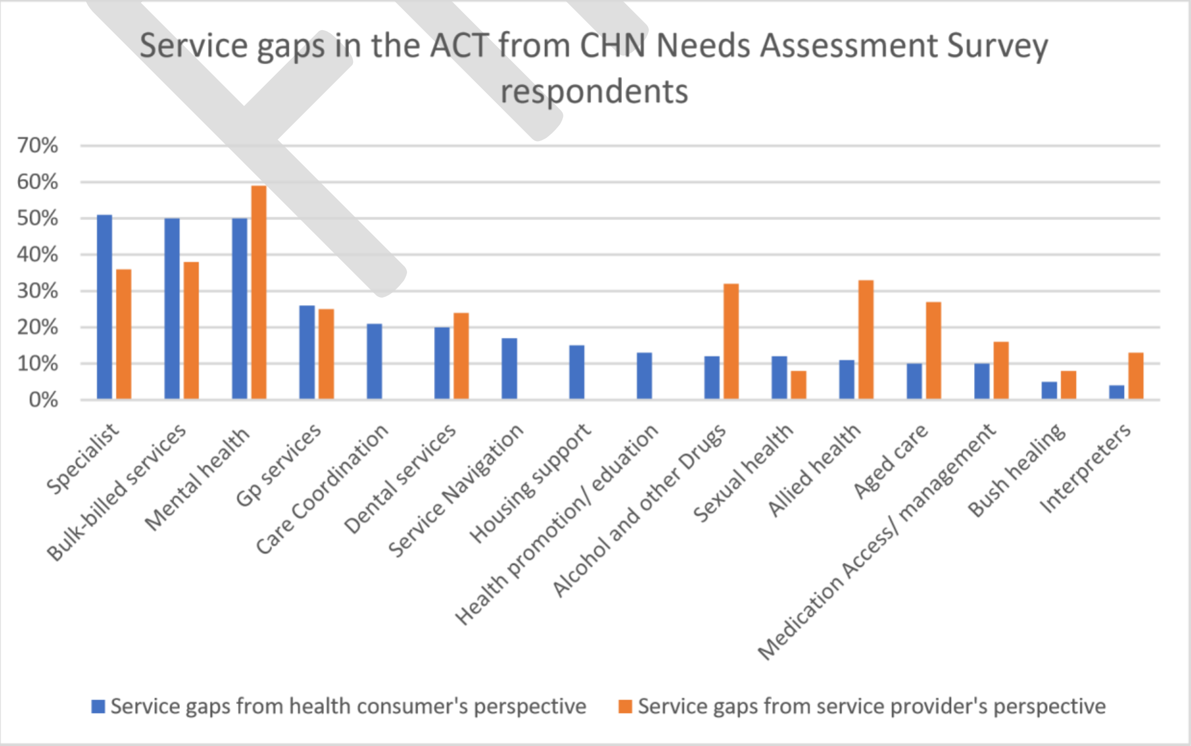
- other services do not have capacity to take on new clients
- resource constraint for collaborative work that are not counted as direct patient time
- no structure of partnership for collaboration

According to our stakeholders, there is an increasing need to build stronger partnerships within the health system 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 (5, 42). 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 (5). Making transition points as seamless as possible minimises handover risk, avoids duplication and treatment delays, and ensures the provision of high-quality, consistent care (5). Some specific suggestions for improved collaboration by the Needs Assessment respondents are:

- increase the use of My Health Record
- streamline process and communication protocols among different partners in care
- create a centralised platform for specialist referrals
- increase awareness of Health Pathways
- shared funding agreements and data among major funders to streamline approach, implement formalised collaborative frameworks and reduce administrative burden
- increase funding for staffing of health professionals and case manager/ care coordinator roles
- fund care models that have a holistic approach that involve multi-disciplinary community-based teams, especially for comorbid conditions

Other service gaps

Survey respondents mentioned several services that are needed, but currently non-existent or do not have sufficient capacity. The chart below provides a general idea about the services CHN Needs Assessment respondents believe are hard for them to access.



Graph 7: Service gaps in the ACT (Source: CHN)

There were frequent mentions of the need for improved provision of prevention and early intervention support (5). This is an important theme shared between both health consumers and service providers. Support should be lasting, accessible and create a sense of social connection (5). Expressed needs for health professional supports in this area include:

- exercise physiologists or physiotherapists to help with management of chronic and musculoskeletal pain
- exercise physiologists to provide health promotion, weight and chronic disease management, especially for low socio-economic groups
- podiatrists for diabetic foot care
- dietitians to provide nutritional support and work with older persons who need to adapt or learn new skills to manage their condition
- asthma education
- community and peer-based support, especially for vulnerable groups in the space of AOD, LGBTIQA+, mental health and Aboriginal and Torres Strait Islander health
- a dental bus to provide dental care outreach
- outpatient clinics with reduced wait times to enhance continuity of care
- holistic medicine and more alternative therapy available, such as music and art therapy

Other service gaps highlighted from the survey include:

- Immediate access to debrief following a traumatic incidence and ongoing support for carers to check in with and debrief
- Trauma-sensitive care that is embedded throughout clinical practice
- Interdisciplinary care for survivors of violence and trauma
- More support for access to telehealth for people who prefer to seek help anonymously or need more flexibility
- Active holding services for mental health
- Enhanced pregnancy support

Health literacy

According to our stakeholders, health literacy is generally slightly higher in the ACT than other parts of Australia (5). Selected estimates from the ABS Health Literacy Survey are (41):

- majority of respondents (97%) agreed or strongly agreed that they have sufficient information to manage their health
- majority of respondents (96%) felt that they are understood and supported by health care providers
- majority of respondents (92%) agreed or strongly agreed that they are actively managing their health
- while the majority of people (83%) felt they are able to appraise health information, as many as 1 in 6 (17%) people disagreed or strongly disagreed that they are able to do so
- almost 2 in 5 people (39%) find it always easy to understand health information well enough to know what to do, with a further 54% stating that they usually find this easy.

The findings from the ABS Health Literacy Survey also showed that for some domains, there was variation in findings of health literacy across different age groups (41). Younger people aged 18–24 were almost twice as likely to strongly agree that they have access to social support compared with older people aged 65 and over (39% compared with 20%) (41). In contrast, navigating the health care system appears to be more difficult for younger age groups (41). Nearly 20% people aged 18–24 stated that they found navigating the health care system difficult, and this decreased to 8% for those aged 65 and over (41). Stakeholders reported that many ACT Health services are not well advertised so more promotion is needed to ensure clients and other service providers are aware of available supports within the community (5).

Impacts of COVID-19

Our consultations with stakeholders inform us that COVID-19 has brought many challenges to continuity of care (5). Reduced face-to-face access to GPs can be challenging for diagnosis/monitoring of conditions, e.g. cervical cancer screening and chronic disease management (5). There have been signs of negative impacts on people who use recreational facilities to manage chronic conditions, such as gymnasiums and swimming pools (5). There is a fear of accessing in-person health services, which in turn can exacerbate existing conditions (5).

With the rapid implementation of telehealth services, GPs reported a lack of clarity around referral pathways and remained concerned that clients would not have access to the appropriate device or space to receive care (5). Opportunities to leverage telehealth to improve continuity of care were acknowledged but more work is required to ensure that quality meet the need of consumers and service providers (5).

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 / Priority	Subcategory	Issues/Needs identified	Strategies & opportunities to address	Partnerships and stakeholders
Prevention and management of chronic conditions	Chronic Conditions	- Focus on limiting risk factors and improving prevention - Building health literacy to support self-management - Need for integrated and multidisciplinary care - Coordination of care and navigation of services including discharge planning, team care arrangements - Understanding the impact that social determinants have on chronic conditions.	Capacity building Commission services Raise awareness	NGO Partners General Practice Canberra Health Services Calvary Hospital
Access to multidisciplinary and team-based care	Access	- The management and care of chronic conditions requires coordination, flexible service delivery, and team-based care - Innovative models of care that improve access to integrated services for chronic conditions.	Capacity building Commission services	General practice ACT Health Canberra Health Service Calvary Hospital Chief Allied Health Officer Professional bodies Universities

Support for workforce	Workforce	- Primary health care professionals should be adequately equipped to identify and address risk factors for chronic conditions - Primary health care professionals need to be supported by effective specialist and allied health referral pathways - Primary health care professionals should be supported to participate in team-based and shared care.	System improvement Capacity building	General practice ACT Health Canberra Health Service Calvary Hospital Chief Allied Health Officer Advisory Councils Professional bodies Universities
Impact of COVID-19	Other – COVID-19 identified	- The use of telehealth in providing care should be reviewed to maximise its potentials - Upskill health professionals to deliver more quality care via telehealth - Improve procedure, system and infrastructure to provide continuing and quality support from distance	Capacity building Planning Raise awareness	General Practice Canberra Health Services ACT Health

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.

Prevalence of chronic conditions in the ACT

According to the ABS National Health Survey in 2017-18, approximately 49% people in the ACT had at least one chronic condition (43). 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 (43). According to our consultation with stakeholders, clients do not usually present with one condition (5). An example being in cases of cardiovascular disease, clients often have diabetes and lifestyle risk factors of poor nutrition, and a low level of physical activity (5).

While there are many health issues that need addressing, the ABS National Health Survey showed that Canberrans are below the national average for a range of health risk factors for chronic conditions. A similar trend was observed with lower rates of adults who were obese in the ACT compared to the rest of the Australia (26.4% compared with 31.3%) and higher rates of adults in the healthy weight range (35.1% compared with 31.7%) (43). The main areas of risk were dietary, accompanied by higher rates in inactivity and exceeding alcohol consumption guidelines on a single occasion (43).

The most common conditions according to CHN's Needs Assessment survey findings, were hay fever and allergic rhinitis, mental health and behavioural conditions, back problems, and arthritis (5). 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%) (5).

According to CHN stakeholder consultation, obesity is a significant and growing health concern in the ACT (5). Back pain is one of the biggest presentations seen by community and hospital allied health teams and was also labelled as one of the highest priority health conditions (5). Chronic pain in the lower back results in the greatest loss in productivity and work hours, and one of the least understood in terms of how to self-manage (5). Because of the lack of ongoing management of chronic pain, patients with back pain can often get to an acute stage, which leads to frequent admissions and preventable ED presentations (5).

Recent analysis by Deloitte Access Economics in 'The Economic Burden of Epilepsy in Australia 2019-20', suggests that there are currently 2,344 families in the ACT with an active case of epilepsy (44). There is reported to be 240 new epilepsy diagnosis each year (44). Epilepsy affects people of all ages, with the two largest groups being those aged over 60, and children and young adults (44). At present, less than 50% of children with epilepsy in the ACT have a plan, and the number is significantly less for adults (44).

Impacts of COVID-19 and the 2019-20 Bushfires

2019-20 Bushfires

The air quality in the ACT was greatly affected by the widespread bushfires burning in NSW and the ACT in 2019– 20 (41). 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 (41). Modelling has estimated that in the ACT, bushfire smoke exposure resulted in 31 excess deaths, 82 hospitalisations for cardiovascular problems, 147 hospitalisations for respiratory problems, and 89 emergency department presentations for asthma (41).

A survey of 12,000 people showed that NSW and the ACT appeared to be more affected than other states in most categories of impact on quality of life (45). One quarter of respondents in the ACT experienced financial stress as a result of the bushfires (45). Of the 1528 survey respondents from the ACT, 866 had asthma, 6% of whom attended the ED, 38% of whom were sick for more than a week, and 14% of whom lost their salary (45).

COVID-19

COVID-19 has led to an increase in use of telehealth to support some patients to better manage their conditions. Stakeholders indicated that webinars, which provided health education and management strategies, were welcomed (5). As noted earlier, COVID-19 has negatively impacted people with chronic conditions to maintain and self-manage their condition while also keeping regular medical appointments (5).

Challenges and opportunities for better care in community

Integration, coordination and continuity of care

Our consultation highlighted several issues within the ACT in delivering quality care for chronic conditions, which included integration and continuity of care (5). This includes the need for systematic approaches to the diagnosis, care planning, and service coordination of chronic disease across the ACT (5).

There is currently limited capability of the service system and the health workforce to respond to the demand for chronic disease integrated care (5). 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 (5). On the contrary, primary care should include close coordination with, and referral to, specialty or tertiary care services as needed (5). Management and care for people with chronic conditions requires coordination, flexible service delivery and team-based care (5). 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 (5). Innovative models could also be implemented to support the delivery of services to people with chronic conditions and complex needs (5). Co-location is emphasised as an essential way to maintain continuity of care for patients (5).

Furthermore, the improvements in GP’s awareness of what allied health professionals can do, and what are the available supports they can refer a patient to can facilitate better integration and continuity of care (5). Health Pathways and knowledge exchange activities, e.g. presentations from different providers about their service suites, are good opportunities to achieve this, as suggested by several stakeholders (5). Workforce development focusing on multidisciplinary care is another opportunity. According to our consultations, focus on training and placement for student-led multidisciplinary work can be the optimum partnership to invest in as it is lower cost, builds workforce capacity and provides students with greater learning opportunities (5). The collaboration between local education providers and health services is needed in this process, as several stakeholders have informed us that the current lack of clinical placement is a major barrier to workforce development.

Better focus on prevention and self-management

Consultations highlighted the need for a strong focus on the proactive prevention and management of chronic diseases, health literacy, and self-management. Health promotion should span across the life span of prevention, early intervention, self–management, and extend to palliative care (5). 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 (5).

Early intervention of pain management strategies that incorporate diet, exercise and psychological support could also help slow down debilitation caused by chronic disease (5). Health promotion activities organised in group settings can help achieve better economic outcomes for each health dollar spent (5). Shorter duration of sessions and using mixed delivery methods can encourage better engagement from clients (5). Health promotion programs should be marketed better to help consumers and health professionals be aware of the range of services available and the health benefits of the programs (5). However, multiple stakeholders reported that it is challenging for health promotion activities to compete with acute care in terms of the allocation of funding (5).

Improving health literacy will empower people to take greater control in managing their health and will improve their overall healthcare experience (5). 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 (5). Embedding social workers or welfare officers at general practices and public places for client’s easy access would be another opportunity for health promotion (5).

Lastly, there is an increased need for nutrition support to assist individuals in self-managing lifestyle-related chronic diseases (5). A 2017 systematic review of dietetic interventions in primary care found that there is fair evidence to support that dietetic interventions improve dietary intake, weight loss outcomes and diabetes clinical measures (46). Accredited practising dietitians can provide dietary interventions that are low-cost and safe to manage chronic conditions such as diabetes, heart disease and arthritis (5).

Better data practices

Stakeholders reported the current utilisation of health data is poor and that there is no consensus on what data to collect to measure patient improvements in a more holistic manner to improve overall functionality. This leads to difficulty in evaluating programs and the ability to generalise effective interventions. A stakeholder reported that there is potential in analysing ED data to determine seasonal issues and inform health promotion activities. For example, seasonal changes resulting in higher need to clean gutters, which can result in increased falls. This could lead to fall-prevention campaigns that are timed within the appropriate season/s (5).

Other service demands that have not been met

Stakeholders informed us that continence physiotherapy and women's health physiotherapy is lacking within the ACT. Topics like pelvic pain and continence are 'taboo' subjects, and that additional awareness would be beneficial to support eliminate the stigma involved (5). There is a lack of services that can support clients who have received trans-vaginal mesh during pelvic reconstructive surgery (5).

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 / Priority	Subcategory	Focus areas	Strategies & opportunities to address	Partnerships and stakeholders
Integration of digital health systems	System integration	- My Health Record (MHR) is not being fully utilised across the continuum of care. - Digital health systems within the health sector and community are not compatible and are therefore burdensome to use.	Capacity building System improvement Strategic partnerships	General Practice ACT Health Canberra Health Services Calvary Hospital
Digital health use among consumers	Other – Digital Health	- Lack of health literacy around the use of digital health tools and systems by consumers. - Lack of understanding of how consumers and carers use digital health or what they want from it.	Planning Awareness raising	Health Literacy Network NGO Partners
Digital health use among health care professionals	Other – Digital Health	- Opportunities to use of digital health systems including e-referrals and secure messaging to improve coordination and communication. - E-prescribing in the ACT is an opportunity to improve medication safety and management. - Support for health professionals to engage consumers in using digital health tools.	Capacity building Strategic partnerships System improvement	General Practice ACT Health Canberra Health Services Calvary Hospital

Impact of COVID-19	Other – COVID-19 identified	- The use of telehealth in providing care should be reviewed to maximise its potentials - Upskill health professionals to deliver more quality care via telehealth - Improve procedure, system and infrastructure to provide continuing and quality support from distance	System improvement Planning Capacity building	General Practice Canberra Health Services ACT Health

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

My Health Record

As of 15 February 2021, in the ACT, there are 95 GPs, 82 Pharmacies and 21 Specialist registered with My Health Record (MHR) (7). For GPs and specialist, although registered, not all providers are actively and regularly uploading shared health summaries, event summaries, or prescriber records (7). They do not actively use it to view patient's medical records either. All pharmacies registered for My Health Record (MHR) are uploading dispense records (7). Regarding MHR uploads from general practices, only 207 event summaries and 10,503 shared health summaries were uploaded compared to 180,266 prescription record uploads as of July 2021 (7). Dietitians can upload information only if they have conformant software which is expensive and typically not designed for allied health practice (5). This has been flagged as an inconsistency and difficulty in access for different members of the primary care multidisciplinary team (5). The use of MHR by specialists and GPs in ACT may also be impacted because of the introduction of the Digital Health Record which will be launched in September 2022.

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 (5). Therefore, the information contained is not comprehensive and the system itself is deemed less useful (5). 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 (5). My Aged Care and My Health Record do not facilitate interoperability, another example of disconnected digital systems.

Consultation informed us that consumers experience challenges and barriers in using MHR, some of which include reduced familiarity and access to digital platforms, lack of necessary health literacy to understand the record and concerns around privacy, confidentiality, and accuracy (5). It was also commented that MHR does not look holistically at individuals, which people feel is a concern when receiving health care (5). When the Commonwealth sought to roll out My Health Record, there was insufficient attention paid to ensuring that MHR would meet the needs of people with disability, people with mental ill health, people in other complex circumstances (6). Information was also not provided in accessible ways and there was no support for decision-making made available to people to help with decisions and implications of using or not using MHR.

Electronic Prescriptions

GPs and medical practices mostly use “Electronic Transfer Prescriptions” where barcodes can be seen on printed scripts (7). Uptake of Electronic Prescription using the token system has been slow as focus was on the COVID-19 vaccine roll out (7). This goes the same with specialists. CHN is currently supporting and educating general practices and specialists on the benefits of the token system. According to Pharmacy Guild of Australia, around 90% of pharmacies are enabled and are offering electronic prescriptions to patients. Active Script List, where a list of current medications can be viewed and dispensed, is in its testing phase in Tasmania and will be rolled out to the nation soon.

Secure Messaging

Many healthcare providers in the ACT are using HealthLink as their secure messaging provider. HealthLink is used mostly for receiving incoming reports or results such as discharge summaries, specialists’ letters, pathology/diagnostic imaging results/reports but GPs are not using it to send electronic referrals. For the most part of the year, only Capital Pathology and Australian Clinical Labs are offering Pathology E-Requesting. Only 24 practices from Capital Pathology and 3 from Australian Clinical Labs are registered but not all of them are actively using it. Stakeholders reported that not all allied health professionals have the same access as GPs to secure messaging, which presents challenges when sharing information with the primary care team to provide best practice care for people in the community (5).

The experience and opportunities to use digital health to improve care

Areas for improvement are required in the digital health space due to an increase in system volume, decentralised system management, multiple sources of patient data/information, reliance on paper-based records, and an ageing infrastructure requiring investment (47). 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 leading 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.

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. Providers were utilising mediums such as email, texts, phone and video calls, social media, and apps to maintain communication with clients and staff during periods of social isolation. While nearly all providers were able to adjust, it brought many challenges 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, internet to facilitate sessions and the reduced ability to build rapport with nonface-to-face mediums, particularly during group work. Benefits to the increased uptake of digital platforms as a medium to deliver services include decreased Do-Not-Attend (DNA) rate for some programs and higher accessibility for clients where transport and time were an obstructing barrier.

Reports from CHN commissioned services showed that in 2020, the number of contacts increased significantly from 1170 contacts in January 2020 to 2008 contacts in July (7). Most contacts were through telephone (55%), followed by face-to-face (30%), Internet-based (8%) and video (6%) (7). The most common contact duration was 46-60 mins, followed by 1-15 mins contacts (7).

During COVID-19, the uptake of telehealth was high across all 97 general practices in the ACT based on engagement and feedback from the sector (48). A survey was conducted by CHN in 2020 across general practices to assess uptake of telehealth, and 36/39 respondents used telehealth to deliver services (48). 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 (48). 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, and created more burden for clients as it required access to a camera (48). This is, again, evidenced in the table, *COVID-19 related items by mode of delivery - number of services, Q4 quarter, 2019 – Q1, quarter, 2021* (pg 29) where telephone consultation had much higher uptake than videoconferencing. Overall, stakeholders have endorsed telehealth as a valued addition to their services but agree it should be delivered in conjunction with in-person care
(3).

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. Based on feedback from key peak organisations, we can report a large majority of community pharmacies have appropriate systems in place and can accept electronic prescriptions. Ongoing cross sector engagement and uptake of digital health tools such as e-prescribing are required to support effective implementation.

Challenges with digitisation

The "digital divide" is a significant issue in modern Australia, particularly with the rapid pace of digitisation brought forward by the COVID-19 pandemic (49) . Some groups are at risk of being left behind and face increasing barriers when interacting with a digitised society. The most at-risk groups for digital exclusion in Australia include Aboriginal and Torres Strait Islander people, low-income households, people experiencing homelessness, people with disability, new cultural and linguistically diverse migrants, refugees, and older people (49). Cultural safety is important to consider when designing and implementing digital health strategies for CALD and indigenous communities. Consumer preferences and realities (e.g. privacy, IT infrastructure, accessibility to technology) need to be identified, and services need to be supported to recognise and respond to these issues (5). Otherwise, there is a risk of exacerbating inequity in service access and health outcomes (5).

Stakeholders told us that while there is great value in video services for telehealth, there is still a strong reliance on audio-only telehealth, likely due to reduced access and familiarity with video-based technology. Telehealth can be less accessible to indigenous communities due to reduced privacy, reduced access to technology and internet as well as living situations that are not conducive to having health appointments done at home. There was also stakeholder feedback that living situations where coercive control and violence in the home can inhibit the viability of telehealth (5). Some services are supporting members to utilise internet through dongles to address these resource barriers. There are also cultural needs that need to be considered when determining whether telehealth is appropriate for some First Nations clients.

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 / Priority	Subcategory	Focus areas	Strategies & opportunities to address	Partnerships and stakeholders
Early intervention and prevention support and harm reduction	Early Intervention and Prevention Appropriate Care After Hours Allied Health Aboriginal and Terres Strait Islander Health	- Intensive community-based outreach models targeted to where populations are located - More capacity for intensive early intervention support & trauma-informed counselling to families and children - More robust pre- and post- program supports, including flexible options when wait lists are long - Expanding access to a Needle and Syringe Program - Trialling of evidence-based stimulant treatment pharmacotherapy programs - Boost number of medical practitioners routinely prescribing naloxone and registered as OST prescribers - Further opportunities to provide in-reach across specialist AOD services	Capacity building System improvement Strategic partnerships Commission services	ATODA AOD community sector providers
		- Develop a resource for consumers to understand services available, based on ATODA Directory		

Invest in infrastructure to deliver quality care	Other – Infrastructure	- Increase funding for residential rehabilitation service places - Conduct infrastructure audit and fund upgrade of facilities delivering AOD services to meet current and projected demand - Increased capacity to provide ongoing crisis supports/accommodation for clients who are intoxicated or in crisis	Commission services System improvement Strategic partnerships	ATODA AOD community sector providers ACT Health
Support for people with intersectoral vulnerabilities	Care coordination Allied Health Safety and quality of Care Social determinants Health literacy System integration Multidisciplinary care Continuity of Care Vulnerable population Emergency Response	- Provision of intensive community-based care as alternative for people with complex needs - Building capacity & capability of specialist AOD services to respond to ancillary health and social needs within scope of practice—e.g., building on existing sector work to respond to DFV - Increasing mechanisms to improve cooperation, coordination and collaboration between AOD and MH sectors, with particular regard for people with concurrent complex AOD and MH issues - Strengthen cross-service coordination and develop an integrated model of care across AOD & allied sectors - Increase community-based withdrawal options, particularly for specific population groups - Specialised support & intensive treatment for families at risk of interaction with child protection system due to AOD issues	Capacity building System improvement Strategic partnerships	ATODA AOD community sector providers Regional Mental Health Plan working group

Safe and responsive services	Aboriginal and Torres Strait Islander Health Access Workforce Practice Support Appropriate Care	- Improving cultural security within specialist AOD services, including through funding and supporting Aboriginal AOD & liaison workers - Fund an Aboriginal Community Controlled residential rehabilitation facility - Increase capability of AOD service users to provide treatment that integrates dependent children - Increase services to support family members of people who use drugs, including improved online/phone advice, support groups and individual counselling.	Capacity building System improvement Strategic partnerships	ACT Health ATODA ACCHO

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.

For more information, please refer to ATODA's AOD Needs Assessment commissioned by CHN at: https://www.chnact.org.au/wp-content/uploads/2021/12/CHN_AOD-2021-ATODA-Needs.pdf

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 / Priority	Subcategory	Issues/Needs identified	Strategies & opportunities to address	Lead Agency &/or Stakeholders
Improving access and outcomes for people with mental illness	Access Safety and quality of care Allied Health Care coordination Chronic Conditions Appropriate care Early intervention and prevention Health literacy Workforce Vulnerable population	- Awareness of services and communication about how to access services - Addressing barriers to accessing care such as wait times and affordability - Culturally appropriate, safe, and responsive services - Gender-affirmative mental health care - Tailored services for people with intersectoral vulnerabilities and with comorbidities of disability and/or substance use issue - Clinical services for people with mild-to-moderate and severe mental illness - Trauma-informed mental health services for vulnerable groups - Workforce strategy for mental health and alternative professionals to fill service gaps - Better access to diagnostic services that can distinguish between mental health concerns and cognitive disability	Commission services System improvement Capacity building	Regional Mental Health Plan working group NGO partners Communitybased mental health service providers Professional bodies Universities

Integrated mental health services	System integration HealthPathways	- Availability of services across the stepped care continuum and effective referral pathways between steps - Availability of information for consumers and health professionals to support service navigation.	Commission services System improvement	Regional Mental Health Plan working group NGO partners Communitybased mental health service providers General Practice
Whole-of-person care	Care coordination System integration Multi-disciplinary care	- Holistic, wrap-around services including mental, physical, and social health - Consideration for social needs during assessment and care planning - Ongoing, consistent, and comprehensive psychosocial services for people with severe mental illness - Long-term services that focus on client's recovery, independence, and capacity building	Commission services Capacity building	Regional Mental Health Plan working group NGO partners Communitybased mental health service providers General Practice

Supporting the mental health workforce	Other – Mental Health Vulnerable population	- Workforce has good skill mix but limited in volume, especially in children and older person mental health space - More support and structure needed to develop peer workforce - Support workforce to provide culturally appropriate, safe, and responsive care - Support workforce to deliver gender-affirming mental health care - Expand non-clinical workforce	Capacity building	Regional Mental Health Plan working group NGO partners Communitybased mental health service providers General Practice Professional bodies Universities
Suicide prevention	Vulnerable population	- Providing integrated suicide prevention services and initiatives - Suicide prevention services - More on-going and long-term support after suicide attempt	Commission services Capacity building	Regional Mental Health Plan working group NGO partners Communitybased mental health service providers General Practice

Early intervention in life, illness, and episode	Vulnerable population	- Early identification and assessment of mental ill health - Provision of preventative support during stressful life transition periods - Provision of low intensity services earlier in illness or episode - High rates of mental illness and psychological distress among children and young people - Supports for children and young people with emerging emotional regulation and behavioural issues	Commission services System improvement	Regional Mental Health Plan working group NGO partners Communitybased mental health service providers General Practice
Impact of COVID-19	Other – COVID-19 identified Vulnerable population	- More mental health support for people whose conditions got worse during lockdown - Telehealth needs to consider factors such as privacy and quiet space for people to access services - Services to support mental health vulnerable groups beside telehealth, as many do not have access to the suitable device	Capacity building System improvement Planning Commission services	Regional Mental Health Plan working group NGO partners Communitybased mental health service providers General Practice

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

Prevalence and severity

Mental illness is a leading cause of chronic disease in the ACT and is increasing in the community both in severity and prevalence. According to National Health Survey 2017-18, around 20.8% of people aged 15 and over in the ACT had mental health and behavioural issues (43). 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 (7).

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) (50). There were 4,963 mental health-related ED presentations in the ACT in 2019-20. The ACT had the fastest increase in mental health-related ED presentations in Australia, 4.6% compared to the national average of 0.8% from 2015-16 to 2019-20 (51). In 2018-19, ACT had the second highest rate of patients accessing community mental health services per 1000 population (25.7 compared to 18 of national average) and the highest rate of contacts per 1000 population (749.5 compared to national average 385.5) (52).

Severity of mental health issues in the ACT is also among the highest in the country. In 2018-19 (22):

- the average service contacts per person was the second highest in Australia (29.1 compared to national average of 21.4)
- admission preceded by community mental health care was the highest (64.4%, national: 42.2%)
- seclusion rate was the highest in Australia (12.2 events per 1000 patients, national: 8.1%)
- contacts to specialised mental health services was the second highest (2.7%, national: 1.9%)
- restraint rate per 1000 patient days was the third highest (17.4, national: 11)

Evidence from the Primary Mental Health Care Minimum Data Set highlights 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 (53). The prevalence is similar to data from CHN's commissioned services.

The most common conditions for ACT Government-funded community mental health care service access in 2018-19 were schizophrenia (53,905 contacts), schizoaffective disorders (18,244 contacts), specific personality disorder (12,553 contacts), bipolar affective disorder (11,365 contacts), depressive episode (8,572 contacts) and mental and behavioural disorders due to other psychoactive substance use (7,939 contacts) (52). Besides 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 (52).

There has been an average increase in psychiatry separations of 11.5% per annum across the ACT, which is an overall increase of 50% from 2013–14 to 2017–18 (14). The increase in demand for acute services is driven by population growth, limitations in service capacity, and gaps in the availability of sub-acute and community-based services and supports (14). An increasing number of highly complex patients are requiring extended secure care (14). Psychiatry multi-day inpatient separations are projected to increase substantially in 2026–27 (14). Without significant interventions to manage growth in inpatient demand, there will be an increase in separations of 4.6% per annum at Canberra Health Service and 5.3% at Calvary Public Hospital Bruce (14).

Consumer demographic of mental health services

In 2018-19, the greatest number of community mental health service contacts was among people aged 25-34 (62,980 contacts), followed by people aged 35-44 (59,793 contacts), children and young people from 12-17 (56,000) and young adults aged 18-24 (52,318) (52). However, the rate of community mental health care service contacts per 1000 population was significant among children and young people aged 12-17 (2,016.2 contacts per 1000 population), and young adults aged 18-24 (1,143.8 contacts per 1000 population) (52). This can be that there is higher prevalence of mental health issues or higher severity of mental health issues among young people and young adults in the mentioned age groups. These figures are 3 times higher than the national average. The rate service contacts per 1000 of Aboriginal and Torres Strait Islander people in the ACT accessing community mental health services per 1000 population was more than double the national average (2,816.3 compared to 1,197.4) (52). People with comorbid ADHD and Autism Spectrum Disorder are underserviced by the mental health sector (5). Accessing mainstream services can be difficult for these groups, as many services will not work with people if they have comorbid conditions (5).

All areas in the ACT had increases in mental health service contacts from 2016-17 to 2017-18, except for Canberra

East (52). 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 (52). The greatest increases were in Weston Creek (311%), South Canberra (257%), Tuggeranong (241%), Woden Valley (238%), and Gungahlin (166%) from 2016-17 to 201819 (52). The highest number of contacts per Aboriginal and Torres Strait Islander person was in South Canberra, followed by North Canberra, Canberra East, Weston Creek and Tuggeranong (52). There were 111.2 per 10000 population (4,626 people) mental health ED presentations in 2017-18, double the rate in 2004 (51).

Health and wellbeing of people with mental health concerns

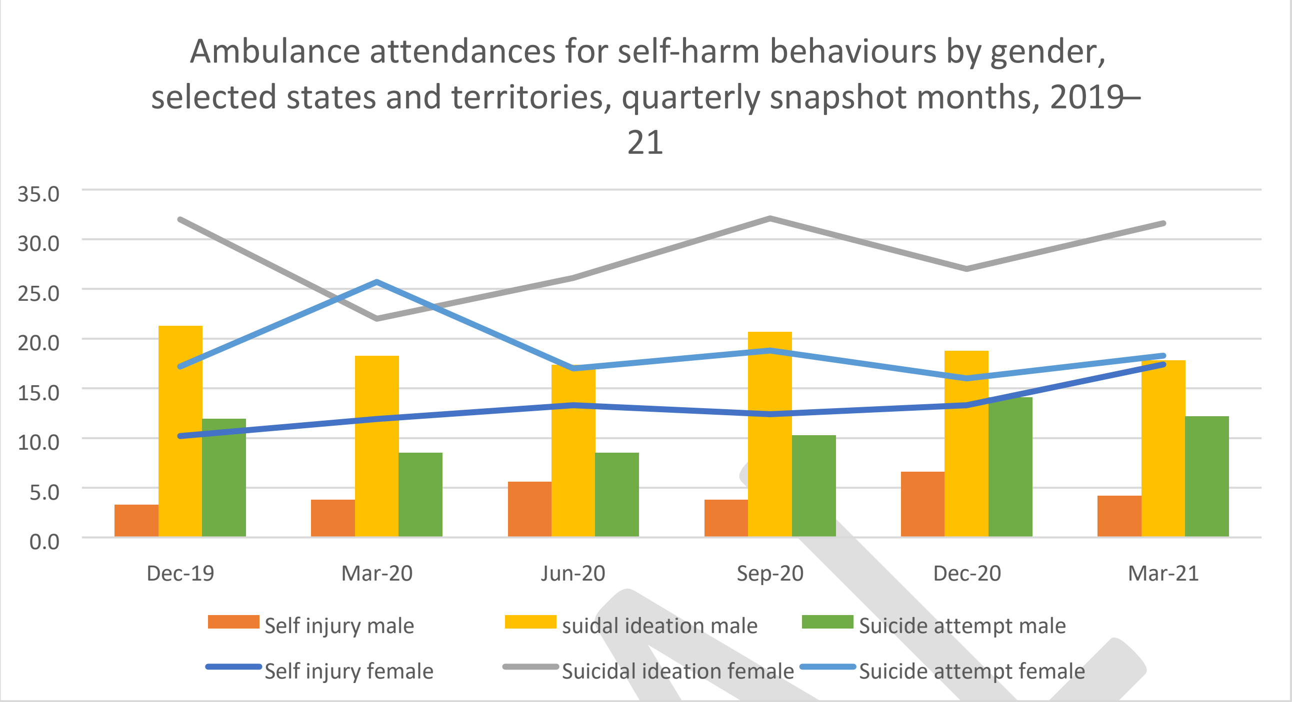
A significant number of people experiencing severe mental health issues are also living with chronic physical health conditions (5). A significant physical health disparity exists between people with severe mental illness and the rest of the population (54). The life expectancy of someone with severe mental illness is approximately 14 – 23 years less than the general population (54). According to the National Mental Health Commission (56), compared to the general population, those living with severe mental illness are:

- Two times more likely to have cardiovascular disease, respiratory disease, metabolic syndrome, diabetes, or osteoporosis
- Six times more likely to have dental problems
- Five times more likely to smoke.

The prevalence of co-occurring mental health and substance use is well documented – 60% people who have issues with alcohol and other drugs also experience a mental health disorder (55).

Suicide and self-harm

In 2019-20, there were 151.6 intentional self-harm hospitalisations per 100,000 population in the ACT, ranked third nationally (national average: 112.9 per 100,000 population) (56). The rates of ambulance attendance for selfharm behaviours have increased over time from 2018 to 2021 across age groups under 45 years of age, with the most significant increase (almost double from 7.4 to 14.7) in children and young adult group aged 0-24 (56). The rates of ambulance attendances for self-harm behaviours in the ACT were higher among females than males across behaviours (56) (See Graph 9).



Graph 9: Ambulance attendances for self-harm behaviours by gender, selected states and territories, quarterly snapshot months, 2019–21 (Source: AIHW)

AIHW's Geography of Injury report showed that from 2017-18 data, women were much more likely to be hospitalised than men for intentional self-harm (females at a rate of 211.9 compared to the male rate of 75.8), but the male death rate for intentional self-harm was much higher than women at a rate of 24.8 compared to 5.2, which is in line with national trends (57).

Service landscape

In general

According to Mental Health Community Coalition ACT in 2018, there were 110 services with 122 main types of care. 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 (5%) (58). Although the number of new clients tends to reduce overtime, the demand of services is increasing in duration, complexity, severity, and quality (58). 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 alcohol and other drug (AOD) and other health services (5). The gaps in primary and community services have led to high demands in mental health presentations, and an increased burden on hospital mental health care (5).

Impacts of NDIS on mental health service landscape

The extent of disruption in the ACT mental health sector in recent years has been significant. There is now a real need to consolidate and ensure that the ACT has a robust mental health sector that is well integrated, accessible and caters to all types of needs (54). The ACT mental health sector can be characterised by a lack of integration, which can be attributed to specifications of government funding, distinctions between different levels of government, between different parts of government such as health, disability and social security, and hard boundaries based on symptoms and severity (54).

The National Disability Insurance Scheme (NDIS) in the ACT has had a particularly significant impact on NFP community-managed mental health service offerings and viability (5). The scheme has required fundamental business model restructuring, reduced wages and therefore qualifications of the workforce, and resulted in an unprecedented level of debt and financial instability (5). Many people needing mental health services have found themselves left worse off due either to their experience with the NDIS or because service gaps have opened leaving them with nowhere to go (5).

Mental health expenditure

The total expenditure for mental health services in the ACT has increased by 3.7% from 2014-15 to 2018-19, the second most rapidly in Australia (59). However, investment focuses more on acute care. The significant increase went to specialised psychiatric units or wards in public acute hospitals (21.1%), while expenditures for residential mental health services reduced by 27.6% and 14.9% for non-government organisations (59). Although the expenditure for services increased, the expenditure per capita did not increase significantly (1.7% from 2014-15 to 2018-19) (59). Given the ACT had the highest community mental health service contact, this presents a risk of insufficient funding for prevention and early intervention in mental health care.

The average cost for specialised mental health public hospital services increased significantly overtime, by 7.1% from 2014-15 to 2018-19 (national average: 2.7%) (59). The cost per bed in the ACT was the highest in Australia in 2018-19 ($184,901 compared to $104,713 of national average) (59). However, average cost per acute mental health admission day and per community treatment day were the lowest in Australia, $854 compared to $1,135 nationally and $277 compared to $353 respectively (59).

The greatest increase in Medicare expenditure from 2014-15 to 2018-19 was for other psychologist (9.5%), followed by psychiatrist (7.5%) and general practitioner (7.3%) (59). Medicare expenditure for mental health specific per capita in 2018-19 was in the lower group compared to other states and territory ($44.43 compared to the national average of $51.45) (59).

Service needs and gaps

In general

Overall, mental health is identified as one of the highest priority health needs across nearly all of the priority populations (5). There is a lack of sufficient and quality service access across all levels of support and intervention, from prevention through to acute (5).

Issues regarding access to appropriate services is a prominent theme from our previous consultations. Concerns were raised regarding wait times, transportation to and from appointments, affordability, challenges regarding service navigation for clients and their families/carers, and appropriate housing options for both crisis and noncrisis situations (5). There needs to be a focus on improving mental health wellness through community engagement, prevention, early intervention, service navigation and improvement of health literacy in the community (5). A lack of integrated and holistic support between mental and physical health care has been repeatedly flagged by CHN's stakeholders over the years. Lifestyle and diet interventions to better support the recovery of people with mental health issues and address the early needs of those having concerns are needed (5). The role of dietitians to support people at these stages, beside eating disorders, should be recognised (5).

Regarding service navigation, simple language is needed to educate the community regarding mental health, available services and resources, and how to access a GP for a mental health plan (5). According to our stakeholders, many consumers were turned away as they did not know they have to book a 20-minute appointment, then have to wait again for 2-3 weeks to get their designated mental health appointment (5). Many indicated they found the experience dismissive (5).

Eligibility criteria for services need to be more flexible to be more inclusive to clients (5). Mental health clients usually have many comorbidities (5). However, many services will not work with clients if they have a mental health disorder, ASD diagnosis or substance use issue (5). There were also lots of reports that patients with a personality disorder are refused mental health support because it is not a mental illness, or that it was too severe for their service (5). Other stakeholders also informed us that free mental health programs have limited eligibility criteria, are limited in what they can provide, and often have large wait times (5).

Many stakeholders reported a lack of services that can work to address trauma despite trauma therapy being incredibly effective when accessible (5). Mainstream services need to be trauma-informed and specialist trauma services that can meet needs of vulnerable groups should be more readily available (5).

The lack of continuity of care between and among services within the broader ACT health system remains a large barrier to positive health outcomes (5). Service integration with a key worker can help better coordinate and provide more holistic care for patients (5). However, there needs to be an improved framework regarding data and information sharing, this will support collaboration across services (5).

For Aboriginal and Torres Strait Islander Community

Stakeholders reported that there is a significant need for Aboriginal and Torres Strait Islander-led mental health services that are culturally appropriate, can work collaboratively with family and community, and have the capacity and training to work with intergenerational trauma (5).

For mainstream services there needs to be greater training and capability to work with and respect cultural needs of Indigenous communities, as well as Aboriginal workers within those organisations to help support Indigenous clients (5).

Educating communities through outreach promotional self-management activities such as how to identify and manage mental health and stress were identified as potential opportunities to help address the rates of poor psychological wellbeing and stress amongst Indigenous Canberrans (5).

For people with moderate to severe mental health illness

Clinical acute supports

Stakeholders reported that clinical mental health teams were able to work under extreme pressure and provide acute care to clients experiencing severe psychological distress (5). However, there were also reports that the teams can take hours to get contact, and some consumers reported to have received invalidating responses for extreme distress, or instances where their case was not picked up or not fully assessed (5). This results in clients going through high levels of distress and reaching out for help, but often, many are left without support (5). There were also cases where services referred clients through to Access Mental Health without informing the client, which is considered by some clients to be a breach of confidentiality (5). There is a recognition that the acute system in the ACT is hardworking and highly skilled but under-resourced. Some clients are not receiving the care that their condition warranted (5).

Borderline Personality Disorder (BPD) supports

There was strong stakeholder feedback that there is a large increase in personality disorders reported across all ages, especially diagnosis in BPD, and services to support these cohorts are severely lacking in the ACT (5). People living with BPD experience many challenges across many areas of wellbeing and there is often co-occurring impulsivity, self-harm, emotional regulation issues, and substance use (5). As complications associated with the disorder can make it difficult to have consistent contact with health professionals, engagement with services can break down (5). As many clients with BPD have experienced a history of trauma and poor experiences engaging with services, having a key support worker to help them engaging with supports can help rebuild their trust in services (5). Stakeholders reported that clients with BPD could often not access public Dialectical Behaviour Therapy (DBT) programs due to eligibility criteria that exclude anyone not in crisis, experiencing psychosis, or within a certain age bracket (5). Private psychologists that specialise in DBT were often not viable due to financial hardship (5). Subsequently, it is evident there is a significant gap in early intervention support for people living with BPD.

There is a service in the ACT helping young people with emerging signs of BPD to address their mental health and build effective coping strategies, but it needs expanded and/or flexible eligibility requirements to be accessible to more clients in older age groups and those with more severe presentations(5). The program also requires clients to be ready to engage in group work, which can be challenging to many (5). A stakeholder reported that it would also be helpful if there were supports to provide Early Motivation to Change interventions with people with BPD to help prepare them for more intensive supports (5). It was also reported that it would be beneficial if there was flexibility in the DBT approach, particularly the components that require family intervention work, which can exclude clients who have had a breakdown or loss in their family relationships (5).

If trauma and/or BPD are left untreated it could impede progress across other areas of wellbeing and make recovery very difficult (5). Therapeutic support services are needed for adults who have undergone trauma to promote sustained recovery and reduce the likelihood of the patient ending up in acute services (5). Many stakeholders reported a significant gap in the ACT for therapeutic interventions with sufficient resources to provide the required level intensity needed for beneficial outcomes (5). This type of therapeutic intervention for the moderate to severe mental health presentations is often not supported adequately by the Better Access scheme which usually only allows 20 sessions for a patient (5).

Non-clinical supports

Stakeholders reported that whilst there is need for a robust acute and clinical mental support system, there is a need to provide additional resourcing to the lower intensity programs that are working well (5). Additionally, Canberra requires additional psychosocial supports that can maintain contact with vulnerable cohorts and effectively step clients up or down to the next tier of support (5). There is also a need for more upstream and moderate intensity programs that have the flexibility and resources to invest in their clients' lives longer-term, that work to consolidate recovery into independence, thereby reducing pressure on the acute system (5). After the NDIS was implemented, a lot of community-based services were defunded, and the sector lost a lot of broader long-term supports (5). This puts greater pressure on clinical system and acute system and increases focus of funding to meet the demand of acuity, but does not work to provide the necessary supports that can prevent clients ending up in crisis (5).

For suicide prevention

Addressing risk factors of suicide such as single or compounding vulnerabilities of disability, isolation, mental health, housing stress, and chronic conditions is required to reduce a person's risk of suicide (5). Relationship breakdown was identified by multiple stakeholders as a major cause of distress for people and potentially trigger a suicide attempt (5). Access to free programs that can provide counselling and relationship skill-building that can work to a client's individual needs, such as their cultural or LGBTIQA+ considerations, are needed within the community (5).

There is excess demand for a service designed to support people in the first few months after a suicide attempt – a time when people are at high risk of a re-attempt (54). There are also only sufficient staffing resources to cater for people who have already attempted suicide, with no available resources to work with people at risk of attempting suicide (5). Extra funding is needed to widen support for people who need suicide prevention support. Staff burnout is also a considerable risk (5).

Older Persons

Although a majority of community mental health services are targeted at adults, most do not include people over 65 years old (5). Next Step in RACF and Older Persons Mental Health Community team are mentioned as the limited mental health supports available for older people in the ACT (5). Stakeholders informed us that there is a gap for older people in relation to non-clinical supports for mental health care.

For older people in RACFs

There is a need to have mental health services available in Aged Care Services that can cater to a range of needs such as grief counselling, psychosocial supports and complex life circumstances (5). There is a severe lack of mental health support for older persons in general, which is exacerbated once a person goes into an Aged Care facility (5). The recent COVID-19 lockdowns and subsequent isolation intensified the poor mental health outcomes experienced by RACF residents and highlighted that the mental health services and the support to access these services were lacking considerably (5).

Due to COVID-19 impacts (lockdowns etc) the Next Step RACF program, which intended to support older people with mental health in RACFs, was unable to fully launch and provide intended support services (7). RACFs are often too under-resourced to have staff available to facilitate the resident's access to the program. Stakeholders also informed us that as Next Step is based on a CBT-driven approach, it would not be suitable for residents who experience cognitive difficulties such as dementia. This means that there remain gaps for mental health support for residents having cognitive difficulties in RACFs (5).

A stakeholder reported that there is a need for staff to be able to identify, understand and work with dementia presentations separate to mental health issues (5). Staff who can understand the difference and are educated on how to support and manage behaviour manifestations of dementia are key (5). Residents with long-term personality disorders going into RACFs also need this better support from staff (5).

Older persons living in the community

Issues with mental health and social isolation are increasing in prevalence in the older person population in the ACT, as is suicide and cases of hoarding and squalor, which require intervention from specialist services (5). There is a need to develop strategies to get education and service information out to the older persons cohort that are isolated and not involved in online networks (5). Stigma in older persons cohort around mental health is still very prevalent; therefore, there needs to be supports and strategies that seek to change this dialogue (5). A stakeholder reported there is a need to think about language use for older persons due to stigma around mental health, using 'wellbeing' as a term instead of 'mental health' would be a good beginning approach (5).

For vulnerable groups

People who have been identified as being part of the following 'at risk' population groups also experience service gaps and/or underservicing (5). This includes groups such as Aboriginal and Torres Strait Islanders; people with sex, sexuality and gender diverse identities; Culturally and Linguistically Diverse (CALD) people; and prisoners, exprisoners and others who interact with the justice system (5). It is well documented that people in these population groups have a higher prevalence and severity of mental illness than the wider population. They can be characterised as being subject to higher levels of stigma, discrimination, and marginalisation, and as such are often economically and socially disadvantaged.

People with a disability

There is a severe shortage of appropriately skilled professionals and programs to support people with complex needs such as those with comorbid disability and mental health challenges, especially longer term supports (60, 54). Some mainstream supports will seek to cease supporting clients if they are on NDIS, or receiving My Aged Care supports due to misconceptions regarding what the NDIS/My Aged Care funds. This can leave clients without support if their NDIS plan or Aged Care services do not provide services for all of their needs (5). There are service gaps in the non-government space working with autism and ADHD, while these groups of disabilities are usually found to have co-morbid mental health concerns (5).

For children and youth

It was reported via CHN consultation that youth mental health prevalence and severity are increasing at an alarming rate (5). COVID-19 has further impacted areas such as schooling, isolation and family stress (5). In young people aged 10-14 who are involved with the criminal justice system, there is a high prevalence of health concerns, mental health and neurological issues as well as foetal alcohol syndrome (5). Autism diagnoses can be hard to access and even when available, support services are often not accessible (5). In children aged 8-12 years, there is a cohort that do not necessarily need to access clinical mental health support but have behavioural issues emerging, which means there is a need for behavioural support services for children (5). They often do not meet a disability or mental health diagnosis, but emotional regulation is still an issue (5).

Barriers to services for young people include limited finances, high wait times, having to make the call themselves, work/school balance, being previously denied services before, and previous breaches in confidentiality (5). Young people also found the legal requirement for parental involvement and in their care to be a barrier to accessing services and felt that they had no autonomy over their own health and wellbeing (5). Building relationships with clients to build trust takes time and often staff movement can mean that young person is sharing their story many times (5). Some stakeholders felt that they had been pushed to share their story, and then no follow up support was provided (5).

Needed services for young people include (5):

- education on mental health literacy to understand preventative measures and early support
- more specialist trauma-informed programs especially for those over 12
- support for family to work with behaviour presentations
- family counselling to help parents overcome their own challenges in supporting their children, improving the awareness, and acknowledging mental health issues and diversity and improving family relationships
- extra resourcing, secured long-term funding and wider eligibility (to allow for younger cohort) for the WOKE program as it is filling a much-needed service gap for those with emerging BPD traits
- multi-disciplinary support teams for youth experiencing severe and complex mental health, including provision of psychologists, counsellors, and social workers.

LGBTIQA+

LGBTIQA+ young people are experiencing significant mental health service gaps in the ACT, but people aged 16 and under are in extreme need of accessible and appropriate mental health support as they are not eligible for Inclusive Pathways, and current Commonwealth government does not fund LGBTIQA+ specific services for people under 16 (5). Long wait times to access LGBTIQA+ mental health professionals are an issue for the whole community (5). This is especially distressing for young trans and gender diverse people where access to hormone therapy is time critical due to the onset of puberty occurring during adolescence (5). The requirement for LGBTIQA+ clients to obtain a mental health treatment plan prior to accessing mental health services is a barrier to many people as many have experienced trauma, stigma, and dismissal from medical professionals and to retell their story in that same setting is potentially re-traumatising (5).

Needed services for this cohort include (5):

- Psychoeducation and counselling are needed for parents or carers for young LGBTIQA+ people. Providing this education service to support family members or carers ensures that the burden of responsibility is not on the trans/gender diverse person to provide this education to their family/allies whilst they are managing their transition.

- LGBTIQA+ people are at very high risk of re-harming after hospital discharge post-suicide attempt. Services such as The Way Back Support Service provide suicide postvention support for these clients but there needs to be more of an integrated discharge planning to ensure that LGBTIQA+ clients are directed into peer services so that they can be supported by their community.
- Gender-affirming services for community members presenting with psychosis and mental health crisis. Many LGBTIQA+ clients reported active and sustained suicidality but refrain from accessing services as their identity and gender expression are not respected.
- There is a complete lack of medical services to support people with an intersex variation in Canberra.
- There is a lack of specialist eating disorder supports that can work safely with the trans and gender diverse cohort, where eating disorders are a prevalent concern due to issues linked with body dysphoria and gender expressions.

For the Culturally and Linguistically Diverse Community

There needs to be more culturally appropriate mental health supports for the CALD community, and adequate training to bolster cultural awareness in mainstream health support staff (5). There is a need to determine the appropriate place and time to target CALD audiences to conduct health promotion around mental health wellness (5). Opportunities could include stigma reduction and dispelling of myths about mental illness, upskilling the population about how to engage with someone with mental illness to support them, and upskilling the population about how to ask for help if you have mental illness (5). Political situations in a person's home country can impact help-seeking behaviour due to concerns about deportation and impacts on visa if seen to be 'causing trouble' by asking for support (5).

For people exiting prison

Stakeholders reported that cognitive disability can contribute to the reasons why people end up in prison (5). It was reported that a large portion of people in prison have a disability of some kind and disability-informed supports are needed to reduce their contact with criminal justice system and to also reduce recidivism in those who are currently involved in the system (5). It was reported that services need to focus on building trust to support this cohort and to facilitate consistent engagement. People can be receiving forensic mental health and crisis support while in prison but handover to external services upon release is poor and many highly vulnerable people are left without support (5). This cohort are also likely to experience stigma and discrimination from services, which contributes to barriers to accessing supports.

For people experiencing domestic and family violence/abuse

There are many mental health challenges with this cohort who often experience compounding vulnerabilities (5). CHN consultation and survey findings noted that there has been an increase in clients from this cohort presenting with more complex issues in recent years (5). Many have multiple physical and mental health issues, as well as legal issues and involvement with other services (5). Stakeholders reported that there are not many safe places for women who are experiencing domestic and family violence (DFV) and there is often nowhere to take them in moment of crisis, especially if deemed not eligible for crisis support (5). There are also challenges for this cohort in help-seeking when experiencing DFV or emotional abuse when elements of coercive control and/or surveillance are present, so there needs to be strategies that can support discrete engagement with support services. Domestic and family violence services have been experiencing a rise in demand under the impacts of COVID-19 and the lockdowns (5). It is also reported that a younger age cohort of women are coming through services (5).

Overall, the sector has a good understanding of what women experiencing violence need, but the capacity is lacking (5). The few mental health workers that are working across AOD, homelessness and mental health have a lot of expectations to carry as there is limited services to support them (5).

Needed mental health services for this cohort include (5):

- Specialist trauma-informed mental health programs for people with complex situations involving sexual violence, abuse, involvements with justice system and CYPS. One service has been lobbying for child trauma counsellors for years as on any given day they have 80 children that have experienced significant trauma. Intergenerational trauma also impacts this cohort.
- Free DBT support programs with wide eligibility criteria to not exclude people in need

For people experiencing homelessness

In the ACT, there were 415 per 100,000 population of Specialist Homelessness Service (SHS) clients who had a current mental health issue in 2018-19 (national average: 393.4 per 100,000 population) (61). Nationally, in 2018– 19, the rate of SHS clients with a current mental health issue was highest for 15–17 year olds, followed by 18–24 year olds (61). The rate of SHS clients with a current mental health issue was almost 7 times higher for Indigenous Australian clients than non-Indigenous clients in 2018–19 (1,936.3 and 278.0 per 100,000 population respectively) (61). Clients with a current mental health issue reported housing crises as the main reason for seeking assistance, followed by domestic and family violence, inadequate or inappropriate dwelling conditions and financial difficulties (61).

Housing stress and homelessness disproportionately impact people with mental illness across Canberra (62). From the beginning of 2020, the increase in anxiety and depression among Havelock Housing Association's 400+ residents became an increasing concern (62). Isolation due to COVID-19 lockdowns and social restrictions have seriously impacted residents' mental health and well-being. Residents face significant challenges in accessing suitable, affordable mental health counselling and other support within the ACT community (62).

Stakeholders report that mental health outreach for homeless cohorts, particularly for those not already engaged with mental health services, is needed (7). Many people experiencing chronic homelessness have a background of complex mental health issues or trauma that will continue to inhibit sustainable, beneficial outcomes until they are addressed (5). A 'housing first' approach to homelessness would promote the safety and stability required to engage in meaningful mental health support/treatment (5).

For people in socially and economically disadvantaged situations

Nationally, between 20-25% of those in the lowest five income and SEIFA groups report mental health conditions related to mood (affective) disorders and anxiety disorders (63). The prevalence of mental health conditions is more than two times higher among those under 65 years not in the labour force and those unemployed compared with those employed full time (63). Similarly, close to 50% of people on a government pension or allowance under the age of 65 years report a mental health condition, that may create significant barriers to participation in the labour market (63).

Other service gaps

Lack of services for the missing-middle – people who are often too unwell for primary care, but not unwell enough for state-based, acute services, as defined by Orygen (64).

- Another missing middle comes from transitional ages such as 8, 12, 18, 25, 65, where clients usually fall through the gaps when they cease being eligible for one service, and replacement services are not available (5).
- Lack of acute and non-acute alternatives to hospitalisation, acute and non-acute health-related day programs and employment-related services to support those with pre-existing mental health conditions (5)
- There is a greater demand and preference for female mental health practitioners, although they are usually booked out (5)
- There is a need to fill the gaps during the long waiting periods between referrals and appointments (5)

- Mental health services for specific vulnerable populations, including older people with an intellectual disability, refugee population, carers, children, and people with complex comorbid disabilities (5)
- More mental health services are needed in the northside of Canberra (60)

Impacts of COVID-19

Generally, people's mental health is negatively impacted by COVID-19 to a significant extent. In July 2020, Lifeline answered 4,400 calls from Canberra — almost 900 more than any single month previously (65). This is a 35% increase in calls compared to July 2019. Of those callers, 43 had immediate safety risks and emergency services were required. 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.

Reports from CHN commissioned services showed that in 2020, the number of contacts increased significantly from 1170 contacts in January 2020 to 2008 contacts in July 2020 (7). Most clients were female (62.27%), 34.67% were male, and around 3% were other genders or inadequately identified (7). Approximately 41% of episodes were for low intensity psychological intervention and 24% was for psychological therapies (7). The number of contacts per episode were most intensive for psychosocial supports (10143 contacts over 429 episodes) and psychological therapy (4514 contacts over 566 episodes) (7).

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 (66) . 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 (66). Services were reporting higher demand from existing clients seeking emotional support. Online and phone-based mental health providers reported an increasing demand for counselling also (67).

It was also advised, through CHN consultation, that the mental health of older people (especially those living in residential aged care) is likely to have been very significantly affected by COVID-19 and COVID-19 restrictions, however that inclusive research efforts are needed to determine the extent and scope of the full impact (6).

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 (5). Services have witnessed a surge in presentations for mental health care with increased complexity (5). Stakeholders informed us that the reasons for increased mental health presentations was due to greater economic and occupational uncertainty, increased social isolation and worsening chronic illness burden (5).

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 (5). 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 (5). GPs have reported increased mental health presentations and long waitlists for services also (5).

Integration between agencies, programs, and sectors

Stakeholders reported that there is a lower than ideal quality of integration between mental health services and related sectors (5). Despite the well-known benefit of integration, it is not as efficient and accessible as it should be (5). A stakeholder raised that by being a small jurisdiction, it should be possible to provide integrated care in the ACT and was reported to have been more effective in the past (5). Impacts of the NDIS and changes within ACT Health and Canberra Health Services have contributed to a more isolated working style within and between sectors (5). It was also noted that competitive tendering processes do not support true collaboration and resource/information sharing between services (5). A stakeholder reported that there a large amount of crosssectoral work that could be happening in the AOD and homelessness sectors (5). There is a lot of potential for programs that include dual-diagnosis teams, and staff that can work with mental health and AOD (5). There is the major issue that clients can't go into rehabilitation services because of pre-existing mental health issues (5).

There were also comments from stakeholders that the mental health sector in Canberra has a strong focus on adult mental health, but youth mental health does not have as much attention (5). Other agencies, such as the Office of Mental Health and Wellbeing, are working to address the mental health needs of young people (5). This agency was also reported to have the ability to bring together the AOD and mental health sectors to work more collaboratively (5).

Solutions and opportunities to improve care

Strengths of the service sector

The community mental health service providers have a strong belief in the power of recovery and wellbeing. It was reported that if services can work in an integrated manner with access to sufficient therapeutic supports, this could be of a tremendous benefit to the client and their journey toward wellness (5). A stakeholder from a community organisation stated that staff do put in a great amount of effort to support integration, to support clients to access other services and, as such, can be important advocates for these vulnerable cohorts (5).

It was reported during consultation that there needs to be a readjustment of the tiers of care of mental health services in the ACT, and that there may need to be a different scope for psychiatry to provide the care required as the severe shortage of psychiatrists have left a significant gap in specialised mental health care (5). It was noted that GPs with specialised interest in mental health could provide broader scope to fill this gap, as well as utilisation of allied health such as occupational therapists who can work effectively across all areas of mental health from prevention, early intervention, community through to acute services. (5). It was also reported that utilisation of peer workers would be beneficial to engage people locally before they become isolated, such as community members who are able to knock on people's door to provide a warm 'check-in' on consumer well-being (5).

Improve general health and wellbeing in people with mental health issues

Findings from consultations and surveys demonstrated that the health and support system need to be able to respond to a person's individual needs in a holistic, person-centred way (5). There is growing recognition that a high proportion of physical illness amongst people with mental illness can be prevented and treated with improvements in (5):

- screening and assessment of physical health conditions and risk factors
- physical health promotion, prevention, and early intervention strategies. There is also increasing interest and recommendation for the prescription of exercise to help manage mental health but financial support to reduce the cost of exercise facilities such as gym memberships is needed for vulnerable cohorts.
- better coordination and equitable physical health care
- having services that can address mental health and AOD issues in conjunction with one another are needed. It would be highly beneficial if existing AOD services had greater capacity to host in-house mental health staff to support clients' mental health while undergoing AOD support.
- extra funding for psychosocial programs to allow more participants to be a part of support group. Stakeholders reported these supports needed to be doubled or tripled in capacity to meet demand.
- lack of understanding of the complexities of the system is a significant barrier to many people. Having social workers that are accessible (e.g. via hotline or at walk-in centres) could be highly beneficial to help navigate clients through to available services

- embedding early intervention initiatives/referral pathways to available supports within existing areas that clients engage with in the healthcare system such as ED, the upcoming Safe Haven services and existing programs such as Next Step would be advantageous to help link clients with established supports.

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 / Priority	Subcategories	Issues/Needs identified	Strategies & opportunities to address	Lead Agency &/or stakeholder
Inadequate access to primary health services and multidisciplinary care	Multidisciplinary Care Access Potentially preventable hospitalisations Aged Care	- Access to primary care, including GP, allied health (including mental health) and dental - High rates of preventable hospitalisation among older Australians - Limited access to supports for self-management and remaining independent in community - Limited access to early diagnosis of dementia and available support for early onset - Limited multi-disciplinary care for people with comorbidities - Limited care coordination and service navigation support - Limited mental health support - Services for older people with dual diagnosis of mental health and dementia	Commission services System improvement	RACF network General Practice Advisory Councils Allied Health providers

Integration of aged care and health services	Aged Care System integration	- The aged care system and health system are siloed and do not work together - Improved communication between hospitals and aged care facilities on discharge	System improvement	ACT Health Commonwealth Department of Health
Medication management	System integration Vulnerable population Aged Care	- Improved health literacy around medications for older Canberrans. - Improved medication management and medication safety in residential aged care facilities	Commission services	RACF network General Practice Advisory Councils
Supporting the aged care and health workforce	Aged Care Workforce Vulnerable	- Health sector and aged care workforce require support to better work together - Ongoing training and support for aged care and health workforce in Advanced Care Planning, medication management and behavioural support - Ongoing support to delivering safe care to a diverse group of older people including LGBTQI+, CALD, and Aboriginal and Torres Strait Islander people	Capacity building System improvement	ACT Health Commonwealth Department of Health General Practice Allied Health NGO partners Professional bodies Universities
Impact of COVID-19	Other – COVID-19 identified	More service to support older person's mental health due to increased social isolation and limited access to telehealth	Capacity building System improvement Planning Strategic partnerships	ACT Health Commissioned Service providers

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.

General health and wellbeing

According to the ABS in 2018, there were nearly 53,639 older (65+ years) people in the ACT (12.75% of the total population) (68). 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) (69).

The life expectancy of ACT residents has increased over the last ten years and is the highest in Australia (69). 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 (68). Suburbs with the highest proportions of people aged 65 and over were Yarralumla and Page (25% in each suburb) (68). 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 suburbs (70).

Approximately 80.8% of older people in the ACT in 2018 had at least one or more long term physical health condition (71). According to ABS Disability, Aging and Carers Survey in 2018, about 24,500 older people in the ACT reported to have a disability and around 11,400 had profound or severe core activity limitation (71). Around 22.2% older people in ACT need assistance with at least one activity (71). 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%) (71).

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 8,300 (16.9%) people aged 65+ had mental and behavioural problems (52). Males over 65 have high or very high levels of psychological distress compared to women (52). Older people in the ACT are over-represented in community mental health and hospital out-patient services with depression and anxiety being most common (52). A snapshot of people living in residential aged care in 2019, a majority (87%) were diagnosed with at least one mental health or behavioural condition, and almost half of people in RACF had a diagnosis of depression (72). There were 21,420 mental health services contacts of people aged 65+ in the ACT in 2017-18 (52). 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) (73). Mental health for older people remains a strong theme in our consultation. It is noted that people with a dual diagnosis of dementia and mental health issues were likely to be excluded from services, or not receiving the right level of care and support for their conditions.

Dementia is one of the largest health and social challenges facing Australia and the world (74). It is the leading cause of death of women in Australia, the second leading cause of death overall in this country and it is predicted to become the leading cause of death within the next five years (74). It is estimated that in 2021 there will be 6,360 people living with dementia in the ACT and by 2058 there will be approximately 18,900 people living with dementia (75).

Potentially preventable hospitalisations (PPHs) of older people in the ACT in 2017-18 was 3,795, equivalent to 7,351 PPHs per 100,000 people (76). 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) (76). The areas with the highest PPHs in 2017-18 were Belconnen (1,005 PPHs) and Tuggeranong 795 (PPHs) (76). However, older people in North Canberra had the highest PPHs per 100,000 people (8,200 hospitalisations), followed by older people in Weston Creek (7694 hospitalisations), Belconnen (7,403 hospitalisations) and Tuggeranong (7,362 hospitalisations) (76).

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 (77). 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) (77). This figure was highest in Belconnen (91.8 presentations per 1,000 population), followed by Gungahlin (86.7 presentations per 1,000 population) (77). According to Women's Centre for Health Matters, women aged 75+ advised that they went to the 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 (78).

Older people and people with chronic conditions are a particular priority for service reform as they represent a growing cohort of our population with longer lengths of stay in hospital and higher readmission rates (14). The average length of stay under the clinical unit of Geriatric Medicine for the 2019–20 period at University of Canberra Hospital was 28.4 bed-days compared to 8.9 bed-days for Canberra Health Service and 7.0 bed-days for Canberra Public Hospital Bruce (14). The ageing population is placing increasing pressure on hospital services, requiring strategies and supports that can work to reduce admission rates, preventable hospitalisations and the length of stay through provision of adequate preventative and management supports (e.g. utilising increased allied health access) (14, 5). This is of particular importance, given the increased likelihood of loss of mobility, physical function, heightened frailty and other related complications that can result from hospitalisations among this cohort (5). Such strategies could include bolstering capacity for access to primary care and allied health supports for residents in Aged Care facilities to provide early intervention and sufficient management of illnesses to prevent hospitalisation.

Social determinants of health of older people

Housing

In March 2021, only 32 out of 1,058 private rental properties in the ACT were affordable for a couple on the age pension, while only 20 were affordable for a single person on the age pension (13). Older women – those aged 55 and over – was the fastest growing cohort of homeless Australians between 2011 and 2016, increasing by over 30% (13). Housing is difficult for single, older women due to financial losses from marriage separation or loss of spouse and lower superannuation. This vulnerability is exacerbated for women who are leaving violent and financially abusive relationships after many years, with no assets and no savings (5). This group can also experience reduced financial literacy and practical skills(5). This was due to historical gender roles that often occurred in the relationships of this generation (5). There is an absence of timely support available for older residents at risk of or experiencing homelessness, and little to no available crisis accommodation for this cohort (79). The eligibility criteria for public and community housing prevent many older people from registering on financial grounds – the assets test rules out people with modest lifetime savings (13). This is creating a growing cohort of older people who have too much money to apply for social housing but not enough to rent or buy on the private market (13). It is likely this trend will continue to grow given the ongoing shortage of affordable housing, the ageing population, and the significant gap in wealth accumulation between men and women across their lifetimes (13).

Transport

Older people are among those demographic groups most likely to experience transport disadvantage (13). This was further evidenced for women due to a lack of transport options for those separated given their dependence on their partner for transport (13).

Abuse of Older People

According to our stakeholder consultation, abuse of older people and enduring power of attorney issues are increasing. It is estimated that between 2% and 14% of older Australians experience abuse in any given year, with the prevalence of neglect likely higher (13).

Older Canberrans living in Residential Aged Care Facilities (RACF)

In 2017-18, there were 3,176 older people residing in RACF within the ACT (80). There were only 2,252 people in RACF as of 30 June 2020 (81). Approximately 80% of aged care residents were aged 80 years or over, with more women living in permanent residential care than men (80). The ACT has lower than the national average proportion of target population using permanent residential care (38.7 per 1,000 target population compared to 42.9 per 1,000 population (81).

Almost one-third (31%) of people living in permanent care had a claim for a medication management review—this compared with 4% for people living in the community and using aged care, and 1% for people living in the community and not using aged care. The most dispensed medicine was those which acted on the nervous system; people living in permanent care were more likely to have at least 1 antipsychotic prescription. The ACT had the highest rate of falls in facilities (4.3%) compared to the national average of 3.3% (35). Many people are waiting in hospital for beds and high-level dementia care specific facilities are not available. A lack of appropriate nursing home beds and quality of care in the ACT further compounds waiting times.

ACT had the lowest proportion of all re-accredited residential aged care facilities that have been granted a reaccreditation approval for a period of three years (80). As of the 30th of June 2020, this was 64%; the National proportion was 89.4% (80).

Stakeholders informed us that the quality and continuity of care for RACF residents are affected by the continuous change in visiting health practitioners. There was 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 by visiting practitioners has made it difficult to keep a clear track record of residential care. This significantly hampered the ability for providers to understand care needs and resulted in similar or identical questions being asked of the patient. Lastly, and most importantly, it impacted on a provider's ability to provide quality patient-centred care.

According to our previous consultations and findings, most residents in RACFs have higher care needs, but experience issues related to workforce shortage. The increasing acuity of people entering aged care facilities needs more responsive GP services. 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. Staff coming from different cultural background can experience challenges in creating therapeutic relationships due to differences in perceptions of aging, health, and wellbeing. 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.

There is a need to ensure activities in RACFs are engaging to the residents and designed to keep them able. Activities that work to create, allow, and encourage more independence is needed. Resourcing for RACFs is needed to be able to facilitate support for external services. Extra funding for services to provide viable in-reach is also needed.

RACFs need to be catered to needs of CALD older persons. CALD clients don't get referred as much to services, this was believed to be due to cultural approaches to caring for family at home, as well as cultural inappropriateness of RACFs.

Older Canberrans living in the community

In 2017-18, around 96% of older persons in the ACT lived at home and 63% of ACATs clients are suggested to continue living in community (80). There were 1,464 people using home care and 11,524 using home support (80). People using community-based aged care (either entry-level home support, or the higher levels of assistance available through home care) were younger than those who were living in permanent care for the full year— of those using home support and home care, 25% and 37% were aged 85 and over, compared with 57% among people in permanent care (79). Medicines for the cardiovascular system were the most common type dispensed for people in community based aged care and those with no use of aged care (79).

The five most common services in Commonwealth Home Support Program in the ACT in 2018-19 were allied health and therapy services, domestic assistance, transport, social support individual and nursing (81). Total government spending on aged care in 2019-20 in the ACT was the highest in Australia, yet the composition was quite different (81). While spending the second lowest for residential care ($2,517 per person compared to $3,209 per person of national average), the ACT spent significantly more on home care support ($2,464 per person compared to $1,584 of national average) and spent the greatest in Australia in workforce and service improvement ($740 per person compared to $35 of national average) and assessment and information services ($300 per person compared to $55 of national average) (81). ACT had the highest expenditure on aged care assessments per completed assessment 2019-2020 at $849.07, the National was $689.65.

ACT had the second lowest proportion of people aged 65 years or over and living in households and their carers, who are satisfied with the quality of assistance received from organised and formal services in the last six months (80). In 2018, 78.9% of older people in the ACT said that they were satisfied with the quality of care they received, compared to 84.4% of the national average.

Our consultations have identified issues for older person care around early assessment, diagnosis, and care planning especially for chronic diseases, dementia, and chronic pain. Stakeholders all acknowledged that these conditions are often not managed until they are quite severe and taking a significant toll on the quality of life, or people are ending up in hospital due to exacerbation of their condition. This implies there are significant gaps in community services for older people, especially low intensity supports and early interventions to reduce the number of people in need of more advanced care. Even when a condition has been identified, problematic wait times to access specialist care also contribute to increased deterioration and high hospitalisation rates. 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 and the confusion usually led to delayed diagnosis. Clients and/or their carers often 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 government system.

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 of residents.

Finally, poor quality and low uptake of advance care planning was also a major theme identified through our consultation. Advanced care plans were often not completed prior to when the support is needed and were mostly done in response to crisis. This often resulted in negative experience to patients as they encountered large wait times to access services and an excessive administrative burden that was extra stressful due to the immediate need for service support. It was recommended that staff should be supported to upskill in this area to facilitate initiation of the conversation with clients and their families to begin the process early, improve the administrative process around advance care planning, and improve the awareness of patients about advance care planning options, prior to crisis.

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. Coordination and continuity of care was disrupted due to low uptake of e-prescribing from GPs and fractured referral pathways.

Stakeholders have highlighted concerns around mental health for older people due to increased levels of isolation both in RACFs and the community. Older people have struggled with fear, depression and isolation during the current pandemic. COTA's recent research partnership with the University of Canberra News and Media Research Centre highlighted that some older Canberrans respondents are not confident with using video apps (Zoom, Skype) or social networking applications (Facebook, Twitter) (79). COTA suggest a senior- specific information strategy to include community radio and news, as well as enhancing digital literacy around trusted information and sources for those aged over 50.

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 inhibited
- *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.

Culturally and Linguistically Diverse older people are further disadvantaged due the lack of in-person support, especially with interpreters and navigating an unknown system they would have otherwise not needed to use due to social distancing restriction.

Service gaps and opportunities to improve care

Dementia

The Royal Commission into Aged Care Quality and Safety identified multiple systemic failings for people living with dementia, their families, and carers (80). Key concerns include: a lack of a clear and accessible pathway from diagnosis and supports; health, disability and aged care staff lack the skills; knowledge and capability to provide appropriate care and support for people living with dementia (80).

Mental health

Many stakeholders reported that there are significant service gaps for people living in RACFs to access mental health. Whilst cognitive behaviour therapy (CBT) has a strong evidence base for many mental health issues and is currently being provided by the Next Step program to a small number of RACFs in Canberra, CBT-based programs do not meet the needs of all residents. A wider range of supports need to be provided including grief-counselling and programs to address psychosocial needs and support for complex life circumstances. Stakeholders also informed us that while most community mental health services target at adults, they usually exclude people over 65 (5).

Improve medication access and practice

In Australia, only the ACT and NSW are not currently signatories to agreements with the Commonwealth to enable access to PBS medicines under Public Hospital Pharmaceutical Reforms (PHPR) (82). Currently ACT patients receive between 3 to 7 days of medicines at discharge (82). Anecdotal information from within the Territory suggests that patients discharged to RACFs often return without discharge medicines. This can lead to poor transition of care and for those conditions that require ongoing compliance with medication, such as heart failure, result in hospital re-admission or re-presentation to the emergency department. Medication management was also mentioned as an area that needs to be addressed.

Hospital care and discharge

Medical procedures at hospitals need to be improved for seniors. There is a lot of criticism from older people in hospitals not being looked after properly while in hospital, as reported from both consumers and providers. Health support post-discharge is an important for older persons as it contributes to poor health outcomes if inadequate. Transitioning from hospital is a time of heightened vulnerability yet there are frequent reports that older persons are discharged without support or information on how to access supports. Enhanced communication regarding available services and how to access them is needed.

Improve patient activation, health literacy and better self-management practice

There is growing evidence regarding the negative impact on physical and emotional health of social isolation and a lack of supportive social networks, and of the importance of health promoting physical activity programs building in socialisation opportunities for participants (79).

Several Australian studies have identified a prevalence of malnutrition from 22% up to 50% in RACFs (5). A stakeholder informed us that often, unintentional weight loss or underweight patients have been identified in an Aged Care assessment but no referral is made to a dietitian (5). The dietitian only becomes aware of the client when they are in a debilitated state and referred through other avenues (eg community nursing, hospital referrals) (5). Lack of timely referral to a dietitian is a problem when an older person requiring enteral nutrition through a feeding tube returns home from a hospital (5). Without dietetic review, the initiation of enteral feeding products is delayed, which presents an immediate risk of dehydration and malnutrition when that is the sole source of nutrition for the person (5). Routine malnutrition screening needed to happen at the beginning of care and on a regular basis, for both older people in RACF and community (5). However, access to a dietitian can be challenging, as home care and local community health services may not employ dietitian, older people may not have private insurance and Medicare Allied Health Chronic Disease Management items is limited to five services per year across all eligible professions (5). GPs should focus on supporting older men to enhance their nutrition, particularly those that are widowed or recently divorced as gendered roles in this generation has often led to older men lacking knowledge in cooking and health literacy around eating habits.

Occupational therapists, with their unique skillset and focus on ‘occupations’, have a key role in supporting older people to remain at home safely and as independently as possible. Occupational therapists can play a key role in supporting older persons to access services such as falls prevention, follow-up therapy in a timely manner and assist with coordination and integration (83). Optimising the role of community pharmacists at local pharmacy to check in on older people and provide basic information and self-management support is a potential avenue for this engagement, as they have established relationship with clients through repeated prescription (5).

Advocacy

Older persons can be highly vulnerable due to issues around lack of financial resources, social isolation, chronic health conditions, greater physical and support needs, cognitive impairments as well as reduced familiarity with using digital avenues to seek support. Advocacy has shown to be a strong protective factor when people’s needs are not being met, more resources are needed to provide timely and responsive advocacy and assistance to the growing older persons population in the ACT.

More health promotion initiatives and services to keep people stay healthy from home.

The number of older people requiring support from the health and aged care and public health system is increasing, and services are struggling to meet demand with the number of admissions and complexity of presentations (5). Services that focus on supporting clients to maintain functional capability to manage at home is needed (5). The Geriatric Rapid Acute Care Evaluation (GRACE) program has done well from that perspective and could be extended to included allied health (5).

Other service gaps

- There is a shortage of supports and services for neuro-degenerative diseases in the north side of Canberra (5).
- A service gap also exists in that there is little training or ongoing support for people who might be appointed as substitute-decision-makers (whether power of attorney, guardian, health attorney etc), to seek to ensure that they are aware of the responsibilities and limitations of their role, and such that they understand and can apply human rights and supported decision-making principles. At present there is are also very limited formal supported decision-making services available for those who do not have informal networks able to provide support for decision-making assistance.(5).
- More administrative, non-clinical and clinical personnel working for the My Aged Care gateway to lessen the excessive waiting period between eligibility assessment and funding allocation (5).
- A transparent and streamlined process for all health and allied health professions wishing to qualify for approval in specific service support streams of the NDIS, Commonwealth residential care and home care services. This will help facilitate better engagement from different health professionals to provide holistic care for older people(5).

People at risk of poor health outcomes

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 social and economic disadvantage, discrimination, social exclusion, limited access to education and employment, and other factors can place individuals and communities at higher risk of poor health outcomes. In the 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 (Please access Carers Needs Assessment here: https://www.chnact.org.au/wpcontent/uploads/2021/12/CHN_Carers-Needs-Assessment_April-2021.pdf)
- Families experiencing complex social and health needs
- People in detention and people exiting prison
- People living with blood-borne viruses.

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

Theme / Priority	Subcategory	Issues/Needs identified	Strategies & opportunities to address	Lead Agency &/or Stakeholders
Health literacy including awareness, navigation of services, and confidence in seeking and participating in health	System integration Health literacy Access	- Having information and services available in a variety of formats that are easy to read, in your own language, and relevant. - Need for increased support around navigating services	Commission services System improvement	NGO partners ACT Health Advisory Councils
Access to and quality of care for at-risk-populations	Access Safety and quality of care	- High out-of-pocket costs limit access to health services including primary care, specialists, and allied health - Social determinants of	System improvement Commission Services Capacity building	NGO partners ACT Health Advisory Councils

		health (e.g. housing, transport, social economic status) need to be considered when planning for health services - Services should be delivered flexibly and through alternative settings such as in-reach and outreach to increase access - Access to integrated and multidisciplinary care including physical and mental health - Services for people with inter-sectoral vulnerabilities, complexity and comorbidities - Services that are safe, responsive and affirming - More opportunistic screening to identify support needs, especially for people experiencing violence and/or abuse - More strength-based and capacity-building supports to help people build their independence and resilience - Services across health, social, disability and justice need to have better collaboration to provide effective wrap-around supports - More prevention and early intervention support to assist vulnerable groups address risk factors and avoid the need for tertiary care		
Stigma and minority stress	Vulnerable population	- Many at-risk populations experience high levels of stress - Experiencing stigma and discrimination in health care settings	Capacity building System improvement Raising awareness	General practice NGO partners

		- Health professionals must be aware of covert bias and discrimination		
Inclusive and responsive care	Satefy and quality of care Care coordination	- Services need to be trauma-informed - Upskilling the primary health care workforce to provide inclusive, responsive, and affirming health care - Ensuring there is shared decision making between consumers and health care providers - Holistic, wrap-around services to support complex health and social experiences	Capacity building System improvement	General practice Commissioned Services providers
Impact of COVID19	Other – COVID-19 identified Access Safety and quality of care Allied Health Care coordination Appropriate care Early intervention and prevention Social determinants	- Telehealth support need to consider for the living circumstances and other social determinants of health when deliver services to people (e.g. access to internet, suitable device, quite space) - Provide mental health support for people experiencing stress during lockdown and have their life affected (e.g. people who are socially and economically disadvantaged, women, children and international students who work part time or casual)	System improvement Capacity building Planning	ACT Health General Practice Commissioned services providers

People from culturally and linguistically diverse backgrounds (CALD)

Demographic

According to ABS 2016, 26.5% ACT residents were born overseas. Top 5 non-English speaking communities are India, China, Malaysia, Germany, and Korea. Geographical distribution in the ACT is as the table below:

Area	**% of population in that area**	**Est. head counts**
Woden Valley	30%	10,616

Molonglo Valley	31.5%	1,447
Weston Creek	20.7%	4,819
Tuggeranong	19.6%	16,842
Urriarra Namadgi	11%	66
Gungahlin	37.8%	26,891
Belconnen	31.1%	28,005

General health and wellbeing

CALD communities have different health needs to Australian-born populations. This can be seen in differing approaches to communication with health professionals, the involvement of family in their care, description of symptoms, treatment preferences, exposure to risk factors prior to arriving in Australia, and the prevalence of conditions such as diabetes, Hepatitis B and tuberculosis (14). According to our stakeholders, some common health concerns among CALD communities are (5):

- Mental health: many community members have a background of trauma due to experiences in their home country
- Diabetes: particularly concerning among Indian, Chinese, and African communities
- Alcohol use: men appear to present with more alcohol issues more often than women, with the under 40s age group being the most prevalent.
- Dental health: particularly of concern for those on temporary visas as they are not eligible for public dental and can struggle to pay for private dental services. Community organisations that support CALD communities receive many support requests for dental care.

Stakeholders informed us that most people in the multicultural community do not know how to access primary care in Australia (5). Navigating the health system here is challenging, especially with the language barrier and a different health system from their home country (5). Most will talk to family or friend who have lived in Australia longer, or they will reach out to trusted services to find out what support is available (5). If people access services, it is common for them to engage their local community doctor to seek medical advice (5).

Factors impacting individual ability to care for health and wellbeing

Stakeholders have informed us that transport and language barriers are large determinants of health for the multicultural community, as was visa type which impacts on eligibility for work, Medicare and income support (5). Factors associated with transport impacting on an individual's ability to access healthcare include location of services, areas of residence within multicultural communities, parking, access to own motor vehicle and their ability to drive (5). This may be due to clients not feeling comfortable to take public transport or may face financial or language barriers that inhibit usage of public transport, as well as the well-known limitations on the availability of public transport in Canberra (5). Community support organisations will often assist with transport to help clients attend their appointments (5). Areas of greater CALD population density such as Gungahlin and Molonglo Valley often have poor public transport options (5). The language barrier impacts on health outcomes through many avenues, but especially when CALD patients are not given the opportunity to have a translator in medical appointment (5).

Vulnerable subgroups and specific challenges

Older persons

Stakeholders informed us that older CALD people require additional support to access services, and often rely on family, friends, children, and other community services to make bookings, assist with transport and attend appointments (5).

There is also a need for Aged Care facilities able to meet the needs of specific multicultural communities in the ACT (5). Older CALD adults are less likely to use services and supports than other Australians (84). Residential aged care options may be viewed negatively by this population, with home care options preferred (84). The common dynamic is that children will most likely have in-home caring facilities, which can lead to an increased risk of elder abuse (5). Stakeholders informed us that there is usually reluctance from the individual to involve police services, even in extreme cases of elder abuse (5).

Women

Women who are on temporary visas can be highly vulnerable, often waiting 6 months to 2 years to access housing (5). Some could be overseas migrants who receive no supplementary funding and have no income due to their visa conditions prohibiting them from working (5).

CALD women experiencing domestic violence and abuse are highly vulnerable due to large cultural and financial reliance on their male partners (5) A stakeholder reported that a woman's VISA status can be used as a means of control from a perpetrator who uses threats to cancel support for their VISA/residency application as a form of manipulation. Many CALD women experiencing domestic violence will only go through trusted services due to lack of support from community and culturally systemic shame from disclosure (5). There are many other factors preventing them to leave a violent and/or abusive relationship, including family, community, culture dynamics, dynamics with children, family, and their community in their home country (5).

Children with disability

Stakeholders informed us that demand for NDIS supports in children are increasing in the multicultural community (5). Western definitions of disability and how the local support systems work with disability are different to nonwestern countries (5). It can be a common occurrence that mothers will reach out to their trusted cultural community organisations to discuss their child's behaviour and challenges, as schools have asked parents to complete assessments on autism or ADHD (5). Community services need to explain what NDIS is and work with the family to help them understand the child's disability, as a formal medical diagnosis may be a foreign concept (5). Community services also need to work with the family to help them gather information and evidence, and to understand what they may or may not be able to access (5). Yet this type of information can be highly variable and hard to predict until NDIS applications are approved. In some circumstances, individuals can struggle to apply for and receive disability support without community intervention from CALD appropriate services (5).

Service gaps and needs

Health literacy, health promotion and communication

The most significant vulnerability when working with the multicultural community is their visa status as it determines what services and supports they are eligible for (5). Although there are materials and guidelines on this matter, navigating the system to access to the information is challenging due to language barrier and low health literacy (5). It was reported that the need to enhance health literacy and education for CALD women that is culturally appropriate, age appropriate, and in their language is needed (5). Understanding different cultural approaches to health and illness is important when seeking to provide health advice and support to CALD groups (5).

Good avenues for health promotion and education can be through cultural gatherings, community leaders, community association meetings, festivals, and spiritual groups (5). Some CALD cohorts are not literate in their own language so communication through pictures should also be considered (5). Social media channels such as multicultural Facebook and Whatsapp groups are often active and can be a viable avenue to share information and promote health services (5). Use of apps such as Burst SMS software through existing multicultural organisations can be a good way to share information to community (5). Word of mouth is another effective channel of communication (5). Community leaders are underutilised but are also one of the most effective ways to distribute information to the community (5).

Mental health

There is need for effective education strategies for CALD communities to raise awareness for mental health as well as the early and established signs of mental illness (5). Access to mental health services by CALD populations may be limited by stigma, especially in Chinese and Indian-born populations. These services may be underutilised, and mental illness may be presented to doctors as somatic complaints to avoid the shame associated with seeking mental health assistance (14). Services offering trauma-informed mental health that is accessible and culturally appropriate are also needed (5).

Other service needs

- Affordable and cultural-appropriate dental and primary health care (5)
- Sexual health services for young women due to more opportunities and awareness for family planning (5)
- More culturally sensitive domestic violence specific services available (5)
- Options for older CALD people to care for themselves in the community (5)

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 (85). 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 (85). 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 (5). This has resulted in severe impacts on this population’s mental health and wellbeing (5).

Stakeholders suggested that refugees would benefit from early intervention and prevention initiatives through existing settlement programs such as the Humanitarian Settlement Program of Red Cross (5). Necessary information about health literacy, available services and how to access them can be included in an information pack provided through these programs (5). Young people can be reached through initiatives that are run through schools, clubs, and associations in school (5).

People experiencing homelessness

Demographic

At the last Census, there were almost 1,600 people experiencing homelessness in the ACT (86). However, homelessness prevalence in ABS data is underrepresented as people experiencing domestic violence will not report their situation due to fear of disclosure (5). According to AIHW, in 2019, the majority of the people who received Commonwealth Rent Assistance in the ACT were families who received tax benefit (21%), Youth Allowance receivers (19%), disability support pension receiver (17%), new start allowance receiver (15%) and age pension receiver (14%) (87). Approximately 74% young people below 24 in the ACT received Commonwealth Rent Assistance and 88% of those without are paying more than 30% of their income on housing, which is the highest rate in Australia (national average: 57.7% and 78.8% respectively) (87). Of the 60,000 households in the ACT that sit within the lowest 40% of incomes, almost 8000 households in the private rental market pay more than 30% of their income on rent and are at an increased risk of homelessness (88).

Stakeholders informed us that the demographic of their homeless clients are mostly men aged 25 – 40 years (5). About 80% of clients are male and about 20% are women (5). Women are frequently reported to sleep at their friends, couch-surf, or sleep in their cars and are not as commonly seen as rough sleepers (5). Anecdotally, there has been a drop in young people seeking services and an increase in older people (women and men) and working aged men (5). Female populations at increased risk of homelessness include older women, women with pets and children, and those released from prison (5).

In 2019-20, ACT had the third lowest percentage of Indigenous clients with met demand for accommodation services at 18.5%, which was below the National of 31.4%, a slight improvement from 2017-18 when ACT's percentage was 20.6% (89). In 2019-20, 15.7% of Specialist homelessness clients presented as Indigenous, below the national percentage of 26.7% (89). While only accounting for 1.3% of the ACT population, they make up around 17% of those seeking support from homeless services (88).

The ACT had the highest representation from CALD cohort for Specialist Homelessness Services clients at 21.9%, nearly double the national percentage of 11.0% (89). This statistic has increased slightly since 2017-18 from 19.8%.

The inner north suburbs such as Dickson and Ainslie have high populations of people experiencing homelessness according to stakeholders, yet young people who are sleeping rough tend to avoid these areas, out of safety concerns, as most spaces are monopolised by adults experiencing homelessness (5). Tuggeranong and Gungahlin also identified as having high needs (5). Stakeholders reported that most cohorts fear health services so will not engage with most general practices and Walk-in Centres (5).

Stakeholders in the ACT informed us that people seeking homelessness services can fall into a few general categories (5). One group are those who can't afford private rentals but are new to needing support and can generally find housing stability relatively quickly with the right support (5). The other group often have entrenched disadvantage and longer histories of homelessness, often co-occurring significant mental health issues, trauma, HIV, autism spectrum disorder, Hep C, acquired brain injury and chronic health issues (5). There is another group of people who have been experiencing homelessness for a long time but have found ways to make it work. This may have been through having several 'couch surf' locations that they cycle between, so as not to burden any one household. Some people can do this work for incredibly long periods. COVID-19 caused this living situation to be

no longer viable for this group due to fears around transmission and breach of household number rules, pushing them further into increased vulnerability (5).

Factors that impact homelessness

Total clients receiving Specialist Homelessness Services (SHS) in the ACT in March 2020 had risen to 1886, peaking at 1946 in June 2020 before gradually decreasing to 1780 in December 2020 (90). This peak in June 2020 could be attributed to the economic fall-out of COVID-19 (90).

In the ACT, females make up a larger proportion of the total clients seeking SHS assistance (90). In June 2021, 667 (63%) female clients reported interpersonal relationships as the main reason they were seeking SHS services (90). Domestic and family violence was reported by 480 (45%) females to be the main reason for seeking assistance (90). Financial reasons were the second most reported reason with 653 (61%) female clients (90). Approximately 9% of female clients reported problematic substance use and 3% reported problematic alcohol use as the reasons for seeking assistance (90). For Males in June 2021, the most reported reason for seeking assistance was 'accommodation' at 445 (59%), with housing crisis and being evicted as the most common reason at 280 (37%), 247 (33%) reported inadequate or inappropriate dwelling conditions (90). Financial reasons were the second most common reason at 426 (58%) (90).

High wages, low unemployment, and many dual-income families in the ACT has meant that the housing market is within reach of most but is well beyond many families on lower or single incomes (88). For low-income households, high rents are impacting on their ability to pay for other essentials, including utility bills (88). In 2011, the typical Canberra household needed 4.8 times its annual income to purchase a median priced house but in 2016 this increased to 5.7 times (88). While many Canberra households have been able to absorb these increases, a growing number of low-income households have not (90).

Vulnerable subgroups

According to our stakeholders, a consultation completed by ACT government on affordable housing in 2018 and the Inquiry into Homelessness in Australia, key vulnerable groups are those who have the following (18, 91, 5):

- Gender and age: men, people over 45, older people forced out of multigenerational homes in CALD communities, older women with limited financial resources due to their lower levels of savings and disadvantaged position in the labour market and young people aged 15-24.
- Cultural risk factors: Aboriginal and Torres Strait Islander, people from culturally and linguistically diverse (CALD) backgrounds and migrants with uncertain immigration status. Aboriginal and Torres Strait Islander people continue to be over-represented.
- Human capital risk factors: unemployment and not being in the labour force, people forced out of workforce due to ageism (growing mid to late 50s and 60s cohorts), casual and fixed-term contract employment and low educational attainment
- Relationship risk factors: family and domestic violence, sexual, physical and emotional abuse, losing a partner through relationship breakdown or death. Domestic and family violence is a key driver of homelessness affecting children and young people.
- Health related risk factors: mental health, disability, traumatic stress, traumatic brain injury and problematic drug and/or alcohol use.
- Exiting institutions risk factors: transitioning between or to and from institutions, particularly exprisoners, people leaving care (hospital, rehabilitation, foster care, etc.) and veterans from the military.
- Previous or intergenerational homelessness risk factors: some groups may have high levels of persistent homelessness. These include people with previous experience of homelessness, people with experience of child homelessness and those in families with intergenerational homelessness.

General health and wellbeing

Mental health and disability can impact on homelessness of people in the ACT. In 2018-19, 47.3% of the 3223 people who sought assistance from the specialist homelessness services in the ACT experienced mental health issues (92). 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%) (93). Mental health issues and lack of support can keep people on the street for long time (5). If they are not doing any harm to others and themselves, they do not get any intervention – which contributes to the long-term nature of sleeping rough (5). Some people may also choose to sleep rough after being offered many interventions, but none may be suitable for the individual as there are very few options for truly tailored support. There are also minimal housing options where people aren't required to stabilise and get well before being housed, which is very difficult to do without safe accommodation first (5). The longer people stay sleeping rough, the harder it is to break the cycle and their mental health can deteriorate as a result (5). Some cohorts are sleeping rough due to mental health issues and other develop mental health issues whilst sleeping rough (5). People experiencing challenging circumstances can often get banned from crisis accommodation due to behavioural issues caused by mental health and other associated issues (5).

There are some agencies that currently provide skills building and employment work, while some have vacancies for homeless people, but many are not job ready, and couldn't make it to the job training (5). Mental health and other obstacles mean they are not ready to work (5). Some training would enhance participation if it was less intensive e.g. part-time employment programs (5). Often people report that are often too busy to make an appointment as they must search for a place to sleep for the night (5).

Other health needs include high blood pressure, cholesterol problems, diabetes or borderline diabetes, and substance use issues (5). Clients come in with a mix of injuries and infections as violence occurs in community, and people in poor health may be unable to manage their infections in an appropriate way (5).

Service gaps and needs

Mental health

In-house counselling and psychotherapy within homelessness and community housing services will provide better access to needed mental health services, enhance the mental and overall wellbeing of residents and clients, thereby enabling them to sustain their tenancies, remain socially connected, and receive referral to other essential services (62). There is a need for an outreach mental health team to work with those that are not engaged or do not have a fixed address, as accessing mental health supports through ACT Health case management requires that the person has proof that they reside in the ACT region (5). Trauma was both a cause and consequence of homelessness and there is a need to provide adequate responses to people who have experienced trauma (5).

Physical health care

Stakeholder feedback has advised there once was a wound clinic in the Canberra city centre (5). The closure of this site has seen a significant impact on wound care, management, and prevention among the homeless population (5). There is a lack of bulk-billed medical services in the city to help this cohort have better management of their comorbidities and take care of other health issues early on. To address this, stakeholders suggested more outreach services that combine food and health care like Chat to Pat (5). There should be more choices available in different locations and more discretion to help people to overcome stigma when accessing services (5)

Better integration for holistic support

Stakeholders reported several challenges to integrated care that have people fall through the gaps between services as follow (5):

- Homeless population usually have intersectoral vulnerabilities (e.g. substance use issues, domestic and family violence, mental health), and some services have condition of entry that limit the access of complex clients
- Collaboration in the sector relies on the informal relationships between staff at different organisations, rather than established formalised relationships

To address this, it would be helpful to have a multi-disciplinary team who can work across Canberra and sectors to coordinate client's movement through services as an integrated response (5). They would be working at case management level providing end to end support in their service journey (5). Place-based interventions are effective and needed, such as combining mental health and physical health supports at homelessness services (5).

Other needs and gaps

- holistic, gender-inclusive and culturally appropriate homeless support (91)
- access to services outside business hours (5)
- more crisis accommodation and pathways out for those who are no longer in crisis (5)
- non-judgemental services (5)
- more fall prevention intervention for older cohorts (e.g. installing ramps, home modifications) to reduce older people having accident then being in hospital and then losing rental (5).
- There is a need to provide early intervention services to support tenancies at risk, rather than waiting until the person becomes homeless to provide a homelessness support

People experiencing family and domestic violence/ abuse

In 2019, data from the Australian Bureau of Statistics showed that 67.1% of the family violence cases were perpetuated by an intimate partner on a female victim in the ACT (60). Domestic and family violence occurs at higher rates amongst young women, Indigenous women, women with disabilities, and women from CALD backgrounds (94). According to Personal Safety Survey in 2016, the most common type of abuse was emotional abuse, followed by any violence, physical violence, and sexual violence (95). While the number of other forms of violence and abuse reduced overtime, the prevalence of emotional abuse increased. Lifeline data has witnessed a great increase in support for domestic violence supports. Young girls and women are at greater risk of abuse in their family (96). Detecting and responding to domestic and family violence is complicated by diagnostic overshadowing and the lack of access to frontline services (96).

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 (97). In the ACT, the most common type of abuse was emotional abuse, followed by neglect, physical abuse, and sexual abuse (97). Boys were more likely to experience physical and emotional abuse whereas girls were more likely to experience sexual abuse and neglect (97). The rates of physical abuse and emotional abuse are much higher than the national average (97). 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%) (97).

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 (97). 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) (97). 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%) (97). Culturally appropriate services that can work to address this critical issue is paramount to reducing the prevalence of CYPS involvement and the increased likelihood of involvement with justice and incarceration systems later in life if these early traumas are left unaddressed.

Financial abuse is also a common type of abuse. According to Care Inc., people who are particularly vulnerable to financial violence include: Aboriginal and Torres Strait Islander people, the elderly and people living with a disability; refugee and migrant populations and people on temporary visas, people detained in prison – in particular, women in the Alexander Maconochie Centre – and the LGBTQIA+ community (98). In the 2020-21 financial year, the Care financial counsellors assisted over 400 clients who identified they had been impacted by domestic violence (98). According to Australian Research Organisation for Women's Safety Limited (ANROWS), around one in five women returned to violent partners because they had no financial support, or nowhere else to go. Financial stress is a significant but under addressed barrier to safety for women experiencing domestic and family violence (5).

The COVID-19 pandemic has increased the rates of physical and sexual violence against women, most likely from a combination of economic stress and social isolation (5). Factors contributing to the increase and prevalence of domestic violence include victims and offenders spending more time together, increased wait times and reduced capacity for support services, increased social isolation and increased stressors such as financial stress and job insecurity (5). An increase in alcohol consumption among perpetrators has also been documented, which was likely exacerbated by the increase of 'delivery on demand' alcohol sales over the past 2 years in the ACT (5). Toora Women Inc said that they supported over 150 children, with approximately 80 residing in their accommodation on any given day last year (5).

General health and wellbeing of people experiencing family and domestic violence/ abuse

It has been noted through consultation and survey findings that clients seem to be presenting with more complex issues (5). Many clients in recent years have multiple physical and mental health issues (5). There seems to be more legal issues and involvement with other services (5). Common comorbidities include co-occurring mental health (anxiety, depression, schizophrenia, bipolar, PTSD), trauma, poly drug use, dental issues, pain management, pregnancy, acquired brain injury and hepatitis (5).

Evidence shows that domestic and family violence has a serious impact on children's current and future physical, psychological, and emotional wellbeing (94). Victims are more likely to experience higher rates of depression and anxiety, trauma symptoms and behavioural and cognitive problems (94). According to a consultation conducted by Family Safety Hub and the ACT Children and Young People Commissioner, the key impacts of domestic and family violence on young people include feeling of abandonment, lack of confidence in the social/protection system, fear of losing immediate family/siblings; not being seen as a person; underlying love for parents; feeling there is no safe place to go and some turn to violence themselves (99).

Service needs and gaps

Mental health

Stakeholder feedback reported that overall, the sectors work well in understanding what women require, but capacity is lacking (5). Mental health workers that are working across AOD, homelessness and mental health have to carry many expectations of supporting their client's different needs (5). There is a significant gap of mental health supports, particularly timely access to psychiatrists/psychologists, dialectical behaviour therapy, and a step up/step down crisis service (5). Services need to be trauma-informed as intergenerational trauma impacts many clients experiencing domestic violence (5).

Service accessibility

Canberra Rape Crisis Centre and Domestic Violence Crisis Service are not accessible by public transport and are in the southern suburbs (5). Victim-survivors who self-admit in other health services in the northern suburbs and who rely on public transportation struggle to access the services they need (5). There is not many safe places for these women and nowhere to take them in moment of crisis (5).

Better access to housing and supports can help reducing the number of women and children seeking assistance from homelessness agencies (60). Supports should have a greater focus on providing space from the perpetrator and enabling women and children to remain in their homes and connected to their schools and communities (5). The Smart Accommodation Report released by DVCS ACT in 2020 highlighted cases where victim-survivors were forced into homelessness to become eligible to access support for housing while others moved back in with perpetrators of violence as safe alternatives were not available (100).

Better screening for domestic and family violence

According to 2016 ABS National data from the Personal Safety Survey regarding women who experienced partner violence (either previous or current partner) and sought advice or support, 'Friend or family member' was the main area of type of advice or support that was sought (approximately 67% for current partner violence and 65% for previous partner violence) (95). Advice or support from 'General Practitioner' was sought for approximately 33% and 26% of survey respondents experiencing current partner violence and previous partner violence, respectively (95). Advice or support from 'Other Health Professional' was sought for approximately 20% of respondents for current partner violence and for approximately 18% of previous partner violence (95). Advice or support from 'Counsellor or Support Worker' was sought for approximately 25% of respondents for current and previous partner violence (95).

Better training is required for clinicians and staff at assessment to primary care, mental health, homelessness, and other support services to detect domestic violence and navigate difficult conversations (5). Many health professionals and support staff cannot detect the situation early and do not know how to ask the right questions (5). For that reason, domestic violence usually goes undetected and positive experiences with staff do happen but are rare, according to a stakeholder (5). From a CHN's professional development survey, health professionals expressed the needs to be equipped with legal knowledge regarding the impacts of reporting a domestic violence situation and supporting a client in that situation (7).

Support for complex clients

Barriers to access services can include lack of stable housing, childcare, legal supports, services to support families or parents with children and caring responsibilities. Others include financial dependency, stigma, and other cultural and social factors (5). Ancillary services to meet intersectional needs of victim of violence and abuse are required (5).

There is the significant constraint in resources to support highly complex clients (5). Client often present with low literacy skills, multiple physical health issues, complex trauma – or a combination of vulnerable factors – which takes extra time and resources from staff (5). However, there is no extra time or funding to accommodate this, which is partly a reason why some services may deny highly complex clients despite this cohort needing significantly more support (5). Clients are often refused services if their behaviour is deemed 'unacceptable' even if driven by crisis or distress (5).

Homeless services report that they work well with other services (e.g. AOD and mental health), but limited capacity is the barrier (5). The services and sectors would collaborate more effectively if funding structures included resources for collaboration (5).

Other needed services

According to a stakeholder many vulnerable clients struggle to separate from detrimental relationships, and codependency is common (5). Supporting couples to learn healthy coping mechanisms, support strengths, stay together and work through issues can be a more effective and realistic approach than encouraging separation (5). Domestic violence needs a more nuanced approach to the underlying problems (5). There are currently very few services that can work with the perpetrators of family violence. Everyman support men through behaviour change programs which are effective but unable to meet demand. Additional resourcing is needed to make broader community impact and reduce prevalence and harms associated with domestic/family/community violence.

Many women do not reach out to health support if they have AOD issues due to stigma (5). Women need a lot of support when there are AOD issues present, as often women have dependent children and family members that are also negatively impacted (5). Services need to work on stigma reduction to encourage more women to engage with services (5). As many women have had their children removed, parenting supports are needed as stakeholders reported that stabilising family units can have a positive impact on recovery outcomes (5).

Young people experiencing domestic violence need a diverse range of support. There needs to be supports for siblings to stay together; support for the whole family and supports to mitigate violence among siblings (99). There were cases where transgender young people found the current system did not meet their needs and perpetuated abuse (5). A stakeholder reported that every domestic violence and AOD service needs to have trauma counsellor for the children (5).

LGBTIQA+

There has been approximately 30% increase in demand for health services among people identifying as trans and gender diverse for the last two years (5). Members of LGBTIQA+ in the ACT are diverse. According to Writing Themselves In 4 Survey (101), in the ACT, there are:

- 2% of participants identifying as Aboriginal and/or Torres Strait Islander

- 12% are born overseas
- 46% identify as having a disability or long-term health condition
- 54% of participants identify as cisgender women, 19% as non-binary, 16% as cisgender men, 7% as trans men, and 3% as trans women. It should be noted that often people who identify as being trans will identify as a binary gender e.g. men or women, whilst also having a trans experience (5).
- 33% of participants identify as bisexual, 13% as pansexual, 12% as gay, 12% as lesbian, 8% as queer, 7% as asexual, and 15% reported ‘something else’ regarding their sexual orientation.

General health and wellbeing

In the ACT, according to Writing Themselves in 4 (101):

- 80% of all participants had experienced high or very high levels of psychological distress during the past four weeks
- 90% of participants aged 16–17 reported high or very high levels of psychological distress, more than three times the level reported in16–17-year-olds in the general population
- 60% of participants reported having been diagnosed with depression and 54% with generalised anxiety disorder.
- 55% of participants and almost 57% of participants aged 16-17 had seriously considered attempting suicide in the past 12 months, five times the rate of the general population aged 16–17
- 10% of all participants and 13% of those aged 16-17 had attempted suicide in the past 12 months, more than three times the rate of the general population aged 16–17.
- 15% of participants had run away from home or the place they lived, and 9% had ever left home or the place they live because they were asked or made to leave.

Service needs and gaps

Gender affirming health care

Gender affirming healthcare can include hormone treatments, vocal and communication therapy, genital surgical interventions, non-genital surgical interventions and/or psychological support (102). Gender affirming care must be patient-centred, personalised, accessible, rights-based and working from a model of informed consent (102, 5). There is limited access to such services in the ACT and coordinated action is needed to improve and expand service provision across all tiers of healthcare with increase in volume, and that the care is always safe and well-informed of the needs of this diverse cohort (102). Clients are saying that the main points of limited access to gender affirming care are psychiatric support, access to surgical and non-surgical interventions, and the psychological assessments needed for this process (5). LGBTIQA+ young people have reported there is a severe lack of postoperative support for gender affirming surgery as well as financial assistance to support surgery or transportation interstate to receive surgery (5). Canberra Sexual Health Centre currently operates as a specialist referral point for GPs who need assistance with gender-affirming healthcare, including the initiation of hormones, but is not funded to operate in this way and cannot meet the demand for this service with the current resources available (5).

There is also a growing service gap in writing reports for gender-affirming surgery and Hormone Replacement Therapy (HRT) that requires specific and ongoing training and support (5). Clinicians from LGBTIQA+ specific services tell us that writing support letters for HRT can be done by GP’s, but in their experience, GP’s lack the confidence or the skills in this space (5).

There is a lack of case coordination for trans, gender-diverse, non-binary and gender non-conforming people of all ages (5). Medical care for this cohort can be complicated and many clients require support and advocacy in this space (5). This needs to include providing client with options for navigation, social work or case co-ordination services that can co-ordinate care across health professionals including psychologists/GP's for HRT letters, counsellors for gender-

affirming therapy, psychologists for gender-affirming surgery reporting, access to an endocrinologist's, gender-affirming surgeon/s and navigation of services related to name/gender marker changes
(5).

Housing and family violence supports

There needs to be a LGBTIQA+ specific housing and family violence service. All refuges are currently gendered, with the exception of Haven House with YWCA, although this a transitional support, not emergency accommodation (5). Homeless shelters, shared accommodation, and services offering support for those experiencing housing insecurity need to be assessed for inclusivity in the way they offer services (103). Services working with families should be made aware of risk factors for young LGBTIQA+ people that can lead to homelessness (5). Services should be without faith bias, as LGBTIQA+ of all ages fear discrimination, judgement and prejudice that may arise from a faith based allied professional (5).

Mental health services

There is a large service gap for mental health support for under 15/16-year-olds from the LGBTIQA+ community as Meridian's Inclusive Pathways can only work with clients over 16 years of age (5). Additional barriers for this age group are that it can be difficult for a young person without parental or carer's consent to engage with a service, while many in this age group want to keep their situation private from their family (5).

Stakeholders informed us that there is a very limited community service providing psychological support for clients presenting with severe, chronic, and complex mental health (5). Service providers reported that their clinicians are not confident in referring LGBTIQA+ clients with severe and/or complex mental health needs to acute or tertiary services as they are concerned the client will "fall through the cracks", either by delay in response or not receiving affirmative care (5).

Psychoeducation and counselling for parents or carers is a vital support for young LGBTIQA+ people and should be officially recognised within the workforce characteristics of funding agreements (5). Providing this service to support people ensures that the burden of responsibility is not on the trans/gender diverse person to provide this education to their family/allies whilst they are managing with their own transition (5). (5). Schools could be a good avenue as this is often where parent and children are interacting with outside services and support (5). Some helpful information can be found in the Guidance to support gender affirming care for mental health of the Office of Mental Health and Wellbeing.

Other needs and gaps include better access to affordable mental health services, AOD and harm reduction services, targeted evidence-based programs such as the Dialectical Behaviour Therapy (DBT) programs, sexual assault and trauma counselling, counselling for transition, counselling with LGBTIQA+ relationship awareness, sex addiction counselling, eating disorder, and grief and loss (5). An increase in local doctors or mental health practitioners who understand complexities of intersex variations are needed to improve the outcomes for this cohort (5).

Peer support

Peer support services play an important role in connecting trans and gender diverse people to clinicians and supporting them to feel safe when accessing services (5). Peer support services also play a crucial role in building community, creating social connections, and providing mentorship and general guidance to trans and gender diverse people (5). Peer-based services provide an even greater level of support for LGBTIQA+ communities due to the high levels of isolation, stigma, and discrimination as well as complicated and invalidated health system journeys that these cohorts face (5). Peer led services offer service information, social connectedness, and reduced isolation, which can contribute to improved ability to cope with mental health concerns (5). Peer-based services strengthen community whilst improving health outcomes (5).

Information, education, and advocacy support

Stakeholders informed us that there need to be assistance in:

- workshops to support participants to build communication and relationship skills
- sex education and sexual health options for queer people wanting to start a family, IVF and adoption • financial support for surrogacy

Services improvements

Stakeholders informed us that services need to:

- advocate for and educate aged care workforce to increase LGBTIQA+ sensitivity of aged services
- respect and include chosen families in decision making
- have more outreach services
- offer cultural appropriate services for LGBTIQA+ Indigenous and CALD communities
- time and resourcing to build relationships and sustain appropriate referral pathways and capacity for collaborative client care between services
- Clinical case-coordinators and peer workers need to be recognised and resourced as part of the workforce.
- upgrade staff capacity to work safely and with a human-rights based approach with LGBTIQA+ cohorts, instead of just referring everyone identified for any reason or issue, even out of scope, to services like Meridian. Training for Mental health professionals needs to around inclusive practice, informed consent and what it means to provide trauma-informed and gender affirming care.

Other services

Other services needed include:

- more paediatric endocrinologists, as current wait times can be up to 6-7 months
- a child, youth, and family support service
- speech therapy
- an exercise physiology service for people going through gender-affirming surgery

Barriers to access services

The requirement for LGBTIQA+ clients to obtain a Mental Health Treatment Plan prior to accessing mental health services is a barrier as many have had experienced trauma, stigma, and dismissal from medical professionals (5). Retelling their story in that same GP space is potentially retraumatising and the experience of having their trans identity pathologized was also a barrier to accessing services (5). The lack of affordable mental health care and transport to access services are also prominent barriers for our stakeholders (5). The lack of knowledge of available services to support the community from both clients and health professionals is another common barrier (5).

There is positive feedback about the Adult Step-Up, Step-Down programs but eligibility for most of these services requires that the client must be receiving clinical management through ACT Mental Health, Justice Health and Alcohol and Drug Services which can mean that many people in need of acute care are not eligible (5).

Children and young people

General health and wellbeing

Mental health

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 (43). 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 (73). In the ACT, the top three identified mental health issues for those under 25 years were anxiety/stress (coping), school or study problems, and those experiencing bullying (67). The top three barriers were affordability, wait times for access, and the stigma associated with mental health (67).

A stakeholder from the support sector reported that the demographic is changing in their youth client cohort, and that they are seeing many more early manifestations of mental health concerns, especially in the age groups that are in transition periods of year 6-7 and year 10-11 (5). Increases in the level of younger people struggling and the number of areas they are struggling with is reported to be on the rise (5). Stressors to young people include societal pressures and expectations (often those with trauma backgrounds and disadvantaged youth), mental health concerns, climate change, violence, social media and AOD issues (5). There is an unprecedented number in 8–12-year-olds (sometimes as young as 5) – presenting with extreme anxiety and violent behaviours. This is reported to be happening across all levels of socioeconomic status (5). Trauma awareness and autism awareness has led to increase in prevalence and severity of both conditions (5).

Complex clients experience significant gaps in the ACT. A large increase in personality disorder across all ages has been reported by multiple stakeholders (6). BPD diagnoses have increased across a spectrum of presentations and there are also needs to increase supports for those with emerging traits but are not yet diagnosed (6).

Physical health

Physical health concerns from young people include food security and access to good quality and regular food (5). There are many young people consuming high amounts of energy drinks and caffeine supplements, which highlights the need for nutrition education and health promotion (5). There is an ongoing issue around affordability of whole foods in comparison to junk foods which continues to drive consumption of poor diets (5). Chronic fatigue is a physical health concern theme that a stakeholder reported to be hearing frequently amongst youth cohort (5). Other physical concerns include issues with sleep hygiene and increased screen times (5). There is a need to educate on the ramifications of poor sleep management and the impact this may have on their overall wellbeing (5). Other needs for young people include education and support around essential life skill-building relating to financial management, community engagement, setting budget, and how to apply for housing and employment (5).

Impacts of lockdown on youth

There is a cohort of young people who have never had significant mental health concerns (anxiety or depression) and experienced their first episodes due to lockdowns (5). Presentations include feeling tense, 'off' and unable to concentrate. This presentation can be identified as an adjustment issue with challenges adjusting to all of the increased uncertainty, what it will mean for their future in terms of employment, travel, and study (5). Early intervention is recommended for this cohort to reduce the likelihood of long-term impacts relating to the significant periods of isolation within the ACT (5). Coaches are a great workforce to utilise for this type of low intensity intervention, according to a stakeholder (5).

Some young people with pre-existing anxiety have seen improved outcomes during lockdown (5). It was evident this was due to the removal of situations that usually trigger symptoms of anxiety (5). There is a need to be mindful of how this group will navigate the changes when restrictions ease, and what additional supports may be needed to support them with the adjustment post-lockdown (5).

A cohort of young people whose family environment is a big contributor to mental illness have reported to be struggling in lockdown due to removal of their social support structures and excess time with family (5). A large portion of young people were spending increased amounts of time in their rooms because it feels private and safe (5). This led to reduced level of physical activity and time outside, which contributed to reduced levels of wellbeing (5). Accessing telehealth services during lockdown has been challenging, as many do not have a private and quiet space discuss their conditions with health professionals, or under constant surveillance of their parents when they do not want to keep their condition confidential (5). The Lockdown also had impacts on safety planning for young people experiencing violence at home, as there was reduced viability of staying with other friends/family/informal supports due to social distancing requirements.

Some young people may not feel comfortable with telehealth sessions for mental health, so accessing supports during lockdown has been difficult (5). Stakeholders informed us that clients with pre-existing moderate to severe mental health condition, high levels of complexity through AOD use, chronic health, have reported serious deterioration due to the lockdown (5). Lockdown has been difficult for this cohort and caused a worsening of mental health symptoms, with prior progression towards wellness that may have regressed during the isolation
(5).

Vulnerable subgroups and their specific needs

Children and young people with disability and developmental delay

Children and young people with disability are a distinct category of healthcare consumers (96). The ACT has 2,616 participants aged 0-24 years who are NDIS participants (96). Public data on children and young people with disabilities who are not NDIS participants are less readily available (96). Evidence also shows that Aboriginal and Torres Strait Island children experience a higher prevalence of disability than other Australian children (96).

Currently in the ACT, more than 20% of children start school with a developmental vulnerability (104). This is concerning because some children who enter school developmentally vulnerable can fail to catch up, with 10% remaining behind through middle school years (104).

Children and young people with disability often have co-existing mental conditions (96). However, they are less likely to receive treatment and support for their mental health condition (96). Areas of concern include:

- Accessibility: the services for children and young people in ACT (Headspace, CAMHS) often have long waiting times. The location or mode of delivery of services can also reduce accessibility (for example, the limited availability of outreach-based support), reduced transport to and from services, and the limited use of youth-friendly strategies to actively engage with young people.
- Recognition and identification of mental illness: children and young people with disability are more likely to have atypical presentation of mental illness; professionals often have difficulty distinguishing between mental illness and challenging behaviour
- Responses from services and support: lack of services and disability-specific services; many services can refuse service to someone with challenging behaviour; a siloed approach to care. It was also noted that some young people may need a combination of support, including clinical and non-clinical, in order to provide the best outcomes.

Child protection services and out-of-home care

The Family Matters report 2020 suggests that Aboriginal and/or Torres Strait Islander children 12.7 times more likely to be in out-of-home care in the ACT. In the ACT, the number of notifications for the period Mar-Aug 2020 fell by 5.8% compared to 2019, and the number of substantiations by 31.1% (105). In both periods, the most reported abuse was emotional abuse. The COVID-19 pandemic has affected daily life through restrictions on people's movements and interactions, which can potentially limit the opportunities for child abuse and neglect to be detected and reported (105).

For those children who are already in care, carer support can be insufficient to ensure the best care for vulnerable children (60). While there has been financial support for foster carers, it is not the case for kinship carers (60). Although the ACT government has made a significant step to address the needs of carers through the introduction of the ACT Carer strategy 2018-2028, there has been no additional injection of funding to this strategy in the 202021 budget (60).

Youth transitioning from out-of-home care are also at high risk of poor health outcomes due to historic trauma, reduced life skills, housing and employment opportunities and are left without social support of safe, organic relationships with adults who are not paid to care for them (60).

Homeless youth

Homelessness for children and young people under the age of 16 has been identified as a significant concern in the ACT for over twenty years, by both community and government (106). Homeless youth are among the most vulnerable cohorts of young people and young people under 16 are ineligible for refuge accommodation. If the young person is forced out of home or if their home is no longer safe, they have nowhere to go and CYPS are unlikely to get involved, at that age (5). A young person who is experiencing homelessness is likely to experience a lack of education, employment, rental stress, domestic violence, debt, substance use, and mental health (106). Stakeholders informed us that homelessness services often operate without acknowledgement of what drives initially young people to homelessness (5). Often without an address, client cannot access services. Lying and deceitful behaviour is then needed to access services when a person has comorbidities such as: mental health, or substance use issue (5). Stakeholder's report there are many young people being declined access to emergency accommodation despite meeting the eligibility criteria (5). It is understood this is due to an assessment which determines they're "too complex" to support (5). There is also a lack of consequences for services when turning away clients, and 'met quota' does not show the high needs clients that were turned away as contractual needs were met (5).

There is currently no coordinated service response for children and young people experiencing family conflict who are at risk of homelessness (5). An ongoing, coordinated service response for this cohort that addresses family conflict and provides therapeutic residential accommodation, would support young people to reunite with their families and reduce the risk of homelessness (5). There are currently no residential services for these children and young people, which often leads to them staying in harmful or unsafe circumstances (5).

Other vulnerable groups

Stakeholders informed us that the cohort entering Justice system in the age group of 10-14 have significant mental health and neurological issues (5). Stakeholders also reported high rates of unaddressed Foetal Alcohol Syndrome within this cohort (5). Autism diagnosis can be hard to access and even when available, can be a come with additional complications as services are not accessible to clients, yet stigma can come with diagnosis (5).

Young sex workers are another vulnerable population within the youth cohort that experience a lot of stigma and reduced access to services due to discrimination from health workers (5).

Young carers are a group that are really struggling with issues such as minimal resources to care for their own health and the person in their care, mental health and disability support and decreased ability to navigate the health system (5). There are minimal supports that are tailored to meet their needs (5).

Stakeholders have reported that there are young people who are deliberately getting arrested because they gain access to a counsellor, healthcare services, and reliable food (5). More affordable, appropriate and meaningful housing is needed to give this cohort a stable base to work toward wellbeing and life attainment goals (5).

Among children aged between 8-12 years, there is a cohort of clients have emerging behavioural issues. Changing family dynamics, including changes in work styles, higher engagement with technology and virtual interactions via social media, video games and changes in social norms of both parents working is said to be contributing factors to this increasing prevalence of behavioural issues (5). Families need support in understanding and working with behaviour presentations (5). Occupational Therapists can be difficult to recruit but can work well with this cohort (5).

Service needs and gaps

Mental health and wellbeing

There was a consensus that more counsellors, psychologists, and youth workers were needed in the south of Canberra, with many concerns regarding transport and wait times (107). There was also a recognition that health promotion could be targeted at supporting specific groups to access mental health support, LGBTQIA+ communities (5). Many commented that they had concerns regarding accessing Mental Health Services and were uncertain of how their parents may be informed (5). Services need to be more transparent over disclosure, confidentiality, cost and logistical requirements of transportation in and around Canberra (5).

Stakeholders reported that there are many young people having behavioural and emotional regulation issues that have been pathologised (5). This is exacerbated by the lack of service provision and the inability to access services unless you have complex mental health needs (5). A stakeholder reported that there are some young people who are also looking for a diagnosis to explain their challenges, find relief in a label or to be eligible for services (5). It was reported that this highlighted the need for thorough explanation of repercussions of diagnosis as well as use of prescribed psychiatric medicines (5). Education on mental health literacy is needed to understand preventative measures and accessing early support (5).

Services are finding a lot of their younger mental health clients often have a primary diagnosis of mental illness and secondary diagnosis being ASD or ADHD (5). Stakeholder feedback reported that there had been an increase in awareness of cognitive impairment and anxiety in schools (5). Many services will not work with young people if they have comorbidity, and many supports finish at school and are not continued into college or continued if the young person withdraws from mainstream education (5). Flexible and extended models of care is needed (5).

Stakeholders informed us that eating disorders are an increasing mental health concern in young people and support services in the ACT are inadequate and have high wait times (5).

Physical health needs

Many young people do not have a regular GP. While this may severely impact a person's continuity of care, this would improve the ability to obtain a mental health treatment plan, as young people can avoid the bias about their mental health condition from the previous GP that had caused them to be unable to obtain a mental health treatment plan (5). Young people need to be able to access services without parental involvement, when needed, to promote autonomy over health and wellbeing. This is especially important when the young person may be experiencing violence and abuse at home (5). Stakeholders informed us that there needs to be locally accessible health networks that are set up for young people to recommend free and accessible GP's who can provide inclusive and non-judgemental care, without a waitlist (5). Stakeholders also told us that educating youth on the skills required to make affordable and healthy meals is needed (5). A good project would be for community centres to host a shared meal with youth in the area, to promote the ideology that food is a meaningful part of connection and a significant contributor to positive mental health (5). It is also an opportunity to provide skill-building support (5).

Maternal and sexual health needs

Stakeholders informed us that pregnancy support is lacking for young people who either choose termination, or to go through pregnancy (5). There is a severe lack of financial support to access termination for vulnerable younger women as well as post-natal support for this age group (5). There is also a need to educate on sexual health as there is an increasing trend toward natural contraceptive measures, with the pill being less popular. There is need for services to be able to meet that need (5).

Other needed services and improvements

Stakeholders informed us of the following service gaps (5):

- Domestic and family violence initiatives are needed in schools to identify and intervene early. There are also supports needed to provide behaviours changes interventions with young people who are using violence against others.
- More head injury assessment, neuro-injury assessments and neurodevelopmental problems assessment
- More flexibility around DBT application, and additional capacity to support early motivation
- More support to navigate and engage with services, especially for those with histories of trauma.
- Greater promotion and availability of post-separation support services to assist young people who are experiencing challenging family circumstances
- Improvement in accessibility for clients with physical and sensory challenges.
- Respect for the choice of the young person when accessing services.
- Education regarding consent when accessing services for young people

Specialist and dental services for children

As of 30 June 2020, there were about 3,700 children under 16 waiting for an initial appointment with a specialist (13). Median wait times for a child to get a dermatology appointment were as long as four years, while for some urology patients it was more than three years (13).

People with disability

The number of people with a 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 (71). According to the National Aboriginal and Torres Strait Islander Health Survey in 2017-18, approximately 32.5% of Aboriginal and Torres Strait Islander people in the ACT have a disability or restrictive long-term condition, which was much higher than the national average at 27.1% (6). The rate of disability generally increases with age for both males and females (13). As at 30/09/2019, 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 (108).

According to 2017-18 data, people with disability of restrictive long-term conditions had a much higher rates of high or very high psychological distress compared to population without (28.4% compared to 6%) (50). Roughly one-third of LGBTIQA+ people who have a disability describe it as being primarily psychiatric (109). 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 (110). More than one-quarter of service users who identified with a disability (28.8%) indicated that they identified as someone with a mental health disorder (110).

Stakeholders informed us that there is a significant service gap for those aged over 65 with disability, as funding levels and thus quality of life is not the same in My Aged Care as that available under NDIS. Once a participant of the NDIS scheme who is aged over 65 moves into an RACF, they are then no longer eligible for NDIS – this causes a significant gap in service offerings as Aged Care facilities are not funded to provide the level of disability support offered by the NDIS (5).

There are now 41,900 women with disabilities in the ACT - an increase of about 6,000 women since 2015 (71). Young women with disabilities experience greater disadvantage in relation to education (111). This decreased access to education leads to poor employment outcomes and increased poverty for women with disabilities (111).
Currently, there are limited programs and mentorships available to young women with disability in the ACT (111).
WWDACT's Parenting Peer Support Group has found that parents and mothers with disability face increased stigma

from health care professionals as well as disability specific support in maternal health services and other parenting services (111). This leads to increase social isolation and decreased mental wellbeing among this cohort (111).

Canberrans who are ineligible for the National Disability Insurance Scheme are ‘falling through the gaps,’ with access to services that support their needs proving difficult (13). For example, an individual who is not clinically blind but is losing their sight does not qualify for NDIS. However, they still need supports to maximise their independence, safety, and participation in meaningful activities (13). The closure of Therapy ACT with the rollout of the NDIS has meant Canberrans deemed ineligible for the NDIS are left with limited access to public services (13).

One stakeholder reported that clients with disability can often have compounding vulnerabilities of complex health needs, poverty, disability, mental health, domestic violence and childhood abuse, but face significant barriers to accessing care (5). Approximately 47% of adults with disability have experienced violence after the age of 15, compared with 36% without disability (13). Only 24% of adults with disability experience very good or excellent health, compared with 65% of without disability (14). People with disability continue to experience disproportionately low levels of employment at only 52% compared to over 82% for the rest of the community (14). This disparity increases for people with more significant disability (14).

Barriers to quality of care

The NDS 2020 State of the Sector report found there are several issues preventing the sector from operating at full strength (14). These include pricing, processes, and workforce challenges (14). Worker shortages are now reaching crisis levels, as the demand for services continues to grow (14). This is particularly critical in relation to therapists, behaviour support practitioners, and skilled disability support workers (14). Stakeholders also informed us that the current prevalence of medical model of disability impacts the access to quality care with its deficit focus, that disability is all about what a person cannot do and cannot be (112, 5). There is insufficient focus on the social model of disability, which will help to address the physical, attitudinal, communication and social barriers that prevent people with disability to access the care they need and deserve (112, 5).

Service needs and gaps

Mental health needs

Mental health support is hard to access, as most government supports will stop once someone is on NDIS (5). Clients have to be in crisis to go through ACT mental health and must be under psychiatric management to get ongoing support (5). There is no early support or support for people who have ongoing mental health issues but not in crisis (5).

Housing

There are ongoing challenges for people with disability seeking access to the housing market (5). In conjunction with the adoption of accessible housing regulation standards, there is a continuing need to provide more options for people with disability, including through subdivision design and affordability measures (5).

System navigation and information support

CALD communities need additional support as they struggle with applications, service navigation and service availability (5).

Specialist services

There are no free services for speech therapy or occupational therapy. Speech pathology, occupational therapy and psychology have significant waiting periods in Canberra (5).

Physiotherapy for children is limited, those who have joint troubles but are still walking can't receive services as this is prioritised for children who are not walking at all (5).

There needs to be diagnostic, and management supports for children displaying signs of neurodiversity such as autism but are not severe enough to qualify for NDIS supports (5).

Accredited Practising Dietitian (APD) services are essential components of comprehensive health care for people with disability and should be provided throughout life in a manner that is interdisciplinary, person-centred, and culturally appropriate (113-115). However, access to APD services for people with disability is inadequate, across the spectrum of health care and in both mainstream and NDIS service settings (116).

Other needed services

- School supports are needed that can assist with helping children articulate their need for space, and fellow student awareness, before child has an episode of intensity (5).
- Schools should embrace and celebrate and normalise differences in children (5).
- Every piece of health information should have an easy English version and conversational language version (5). Having communication that was segmented and had visual representation and spacing to communicate health messaging from ACT Health was helpful. Consistent patterns of text that are easy to understand is needed to ensure health messaging can reach populations with disability (5).
- Practical support for parents with disability and/or mental ill health to take care of themselves and their children (5).

Families experiencing complex social and health needs

General health and wellbeing

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 (52). In 2017-18, people in the most disadvantaged group had the worst community follow-up within the first 7 days of discharge from psychiatric admission nationally (35.7% compared to 76.6% of national average) (50). People in more disadvantaged quintiles tend to have more complicated mental health conditions (73). 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 (73). According to ATODA's to Service User's Satisfaction and Outcomes Survey in 2018, socioeconomic disadvantage is clearly a characteristic of the AOD service user population and has implications for AOD service delivery (110).

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 (5). 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 (5).

Social determinants of health

On a macro scale, the ACT shows higher enabling socioeconomic characteristics (117). However, there are significant disadvantages (13). In the ACT:

- Approximately 9% Canberrans (c.38,000) are living below the poverty line.
- Over 25,000 people who live in low-income households are experiencing food stress.
- As of March 2021, the number of Canberrans in search of work and relying on Jobseeker and Youth Allowance was 11,311, an increase of almost 60% compared to pre-COVID-19 levels.
- ACT has a shortfall of around 3,100 social housing dwellings. Canberrans face a 3.8 year wait for a standard public housing property.

- The ACT has the highest rate of rental stress among lower income private rental households at 73%. In the ACT one in 10 young people had couch surfed and 2.6% had lived without a fixed address. There were 23 small areas in the ACT (2.3%) that were paying more than 30% of their gross income on rent (118).

There are pockets of disadvantage in the ACT that are usually hidden by statistics produced at larger area levels (118). In 10% of smaller areas in the ACT, the proportion of persons living in low-income households is higher than the average for Australian capital cities (118). For 16% of ACT small areas, the proportion of children living in lowincome households is higher than the capital city average (118). Approximately 23% of small areas in the ACT had a higher proportion of persons living in a sole parent family in low-income households than the national average (118). Stakeholders also informed us that varying socioeconomic status can impact on service access (5). Community-based services can sometimes prioritise families who can't afford to pay which leaves middle income earners without adequate support or any support at all (5).

Impacts of COVID-19

Over the previous 18 months, the COVID-19 health and economic crisis has had a significant impact on low-income households in the ACT (86). During the first six months of the COVID-19 pandemic, the number of people in the ACT receiving income support while looking for work more than doubled over just two months from 7,135 in March 2020 to 14,858 in May 2020; remaining above 14,000 through to September 2020 (86). By June 2021, this figure had fallen to 9,341 – 30% higher than the pre-COVID level (86).

COVID-19 social and economic impacts influence women disproportionately compared to men due to greater levels of caring responsibilities, working in industries negatively impacted by lockdowns, and exacerbation of existing vulnerabilities such as social isolation and exposure to domestic violence (86).

Living costs

Low-income households spend a greater proportion of their income on essential goods and services compared to middle- and high-income households (86). According to the ABS, between 2005 and 2020, the prices of essential goods and services increased at a significantly higher rate than those of nonessential ones – 43.8% compared to 31.8%.

Parenting skills

Stakeholders reported that they believed many adult presentations that were being seen through their mental health support program were due to outcomes of adverse childhood experiences (5). These clients present with ongoing, persistent issues around how to engage with fellow adults and relationships (5). This is often due to histories of childhood neglect, DFV and emotional abuse which can often leads to ongoing physical health concerns as well as mental and social challenges (5).

Service needs and gaps

Parenting, family and relationship support

Funding bodies should consider stronger contributions to early years child-rearing supports and supporting parents with attachment styles and behavioural management, intervening early while young could make a huge benefit to outcomes later in life (5). Programs like Circle of Security, tuning into teens are making a positive difference in this space but needs to upscaled to meet demand, and work across spectrum of ages and demographics (5). There needs to be a collaborative and innovative approach to how these programs can be established and communicated to the community; in-reach programs to other social/health supports could be a beneficial avenue (5).

It was reported from one agency that relationship and family counselling services in the ACT do not have an extensive wait time but that gap fees are charged on a scale of income, with fees being waived for clients who cannot afford the gap (5). Whilst there is a lot of access to family and relationship counselling in the ACT, there is less access to family therapy (5).

Stakeholders reported that more focus on building capacity of family services would be helpful (5). To train staff to work in this space, Family Systems Therapy courses have a good evidence base but are expensive to put staff through (approx. $10,000 per clinician) (5). Funders could seek to boost upskilling of service staff by providing opportunities to train staff in evidence-based therapies that seek to provide family therapy to meet this service gap (5).

Other needed services and improvements

Stakeholders reported that there are lots of different projects that are working well, but there is room for improvement everywhere (5). Stakeholders reported the following feedback (5):

- ACT's Community Assistance Support Program is working well but does not cover enough of what is needed.
- There has been good work coming out health justice partnerships that Legal Aid and Canberra Community Law are doing in hospitals.
- A program was having a positive impact in supporting families with complex needs was Newpin, but has unfortunately stopped operation
- There were limited capacity of family support services to support other kin relationships, beside parents, such as grandparents or siblings. There was also limited capacity for support services to facilitate access to child whilst carer was in residential services.

People in detention and exiting prison

From 30 June 2019 to 30 June 2020, total prisoners decreased by 5% (25) to 449 (119). The imprisonment rate decreased by 7% from 143 to 133 prisoners per 100,000 adult population (119). Male prisoners decreased by 7% (31) to 413 and female prisoners increased by 18% from 33 to 39 (119). Aboriginal and Torres Strait Islander prisoners increased by 12% (12) to 116 (119). A stakeholder reported that up to 80% of women were kept in remand because they had no home (5).

General health and wellbeing

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 (120). 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 (121). There is a large proportion of women in the AMC who show strong signs of experiencing BPD symptoms, and a majority of people in prison have a disability of some kind (5). Cognitive disability can contribute to the reasons why people end up prison (5). It was estimated that 77% of ACT prison entrants were current smokers, 17% were ex-smokers and 6% had never smoked (122). 31% of ACT prison entrants in 2018 were drinking at high risk of alcohol related harm, 51% were drinking at low risk and 17% did not drink (122). 89% of ACT prison entrants in 2018 reported illicit drug use in the past 12 months, 11% had not reported illicit drug use in the last 12 months (122).

The interplay between mental health and alcohol and drug usage affects a person with a mental illness's engagement in the justice system (5). These people often require specialist support that needs to transition with the person through their entry to and exit from custody (5). They may also be vulnerable in prison environments and may engage in crime to support alcohol and drug dependence(5). The breaking of this cycle can be challenging and require ongoing, professional supports of significant duration (5).

It is important to note that the social stigma against seeking support is likely to be amplified in the custodial environment (5). There is a need to continue activities that aim to reduce stigma and encourage help-seeking behaviours (5).

Service needs and gaps

Stakeholders highlighted significant service gaps in transition from post prison and high risk of homelessness as there is minimal availability in the sector to support them. Issues include women released earlier than planned when supports are not ready, being released into addresses where there is known family violence, women released on a Friday with no supports over the weekend, and no rehabilitation facilities for women to exit into. Women who cannot access support in timely manner are likely to end up in homelessness service, which is not ideal for those struggling with addiction.

More work is needed to reduce recidivism among people who interact with the justice system (recidivism rate of prisoners in the ACT is almost 40%) (54). This needs to focus on prevention when individuals and families are at risk of criminal activity; intervention while people are engaged with the justice system; and post-contact support to build people's capacity to engage with the community when they leave the justice system (5).

Funding for educational workshops of psychotherapy and emotional regulation for AMC residents and staff is needed, as BPD is common in the AMC (5). This would seek to support residents of the AMC to understand and manage their reactions better as well as supporting the AMC staff would then be able to respond better to residents (5).

Support for early identification of disability needs to be improved, as does the supports for people where disability has already been identified. Via the Disability Justice Strategy, there is much work occurring to seek to address some of the barriers that people in detention with disability face (5). This population had huge barriers to access diagnostic processes before people get into prison (5). Issues also exist that many people in prison don't want to identify with disability as it makes them vulnerable. Services need to build trust to build supports to helping them meet their parole (5).

Stakeholders informed us that there is a growing need to be able to provide therapeutic services to men who are adult survivors of child sexual assault (5). On average it is currently 30 years between when the abuse stopped and when men seek help for impacts of childhood trauma. Survivors of child sexual assault are overrepresented in Australian prisons at rates of 90% for women and 70% for men. This statistic has not changed for 3 decades.

People living with blood-borne viruses and sexually transmitted infections

Hepatitis B (CHB)

In 2018, the prevalence of CHB was 0.80% (3,386 people) in the ACT (123) with treatment uptake estimated at 10.1%, with the National target set at 20%. Care uptake estimated at 22.1%, also well below the National of 50% (123). The ACT PHN is ranked 6th out of all PHNs for CHB treatment uptake, and 10th in care uptake (123).

In 2017, vaccination uptake in the ACT reached the highest of any PHN in Australia, with an increase from 96.0% to 96.7% in the ACT (123).

Hepatitis C (HCV)

There are an estimated 2,533 people living with Hepatitis C in the ACT (124). Despite the availability of effective direct acting antiviral treatment for HCV, 60.2% per cent of people living with HCV in the ACT are not on treatment (124). Additionally, in 2018-2019, the ACT experienced the largest decline in treatment uptake of all the national Primary Health Networks (124). Prevalence of people with viral hepatitis is well above other areas and is not given attention it needs. Testing needs to be more comprehensive (124). There is a need for more accessible testing for viral loads and medications and tests that are not eligible for Medicare need to be made more accessible (124).

HIV

Over the past decade in the ACT, new HIV diagnosis rates were increasing to a level similar to NSW in 2014 (4.5 per 100,000 in 2014), but have since declined, with 1.3 per 100,000 reported in 2018 (123). It was noted that 17 (30.9%) of HIV notifications from 2013 to 2017 in the ACT were classified as late diagnoses, as determined by immune function testing, indicating further awareness and promotion of HIV testing is needed.

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 (5). For individuals living with HIV, the chances of developing long-term, life-threatening health conditions are significantly higher. These conditions include higher risk of cardiovascular disease, higher risk of diabetes, bone and joint disorders, hypertension, kidney disease, dementia and other neuro-cognitive impairment (5). People with HIV represent diversity in the ageing population, with groups most affected including gay, bisexual, or other men who have sex with men, people who inject drugs, sex workers, people from culturally and linguistically diverse backgrounds, and Aboriginal and Torres Strait Islander people (5). Multi-layered stigma, which is further compounded by pre-existing or emerging social and economic disadvantages, a lack of adequate social support, and a disproportionate burden of mental health conditions, creates substantial structural barriers for these people, especially when they access various health and community service systems and transit between them (5).

There is need to advocate for and implement more comprehensive approaches to HIV prevention, care and support, including systematic community-led peer navigation that provides for regular review of people with HIV concerns relating to treatment, comorbidities, and medication contraindications to help alleviate anxieties and worry (5). Prevention efforts continue to be important as well as testing, treatment, and broad prevention frameworks (5).

In the ACT, there is a lack of choice for community S100 prescribers and there is a need for more doctors need to be trained and incentivised to take on clients living with HIV (5).

Gonorrhoea, Chlamydia, and Syphilis

Gonorrhoea notifications have been increasing in the ACT in recent years, with 120 notifications reported in 2014 to 330 notifications in 2018 (50). The rate of Gonorrhoea is much higher in men who have sex with men than in heterosexual cohorts, which is believed to be due to unique behavioural characteristics as well as asymptomatic principal drivers (5).

The rate of syphilis diagnosis is higher among young people and men who have sex with men, indicating that these demographics are priority groups for targeted prevention, care and treatment campaigns to support improved sexual health (5).

Data from ACT Health reveals the number of recorded cases of Chlamydia increased from 1197 five years ago to 1649 recorded cases in 2020. Instances of Syphilis has doubled from 40 to 85 in the same period. The rate of syphilis diagnosis is higher among young people and men who have sex with men, indicating that these demographics are priority groups for targeted prevention, care and treatment campaigns to support improved sexual health (5).

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.

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 / Priority	Subcategory	Issues/Needs identified	Strategies & opportunities to address	Lead Agency &/or stakeholders
Culturally safe and responsive care for Aboriginal and Torres Strait Islander people and people from CALD backgrounds	Appropriate care Workforce	- Supporting mainstream workforce to provide culturally safe and responsive care - Enable and support the Aboriginal and Torres Strait Islander workforce - Enable and support CALD workforce - Raise awareness among workforce about covert bias	Capacity building	General practice ACCHO Coolamon Advisors Commissioned services providers
Digital health	System literacy Practice Support	- Support for health professionals to engage consumers in using digital health tools.	Capacity building System improvement	General practice Pharmacies Specialists Allied health
Develop workforce in terms of skill base and volume	Workforce Practice support Health literacy	- Provide training to conduct opportunistic screening for substance use, domestic and family violence/ abuse - Raise awareness among workforce regarding covert bias for vulnerable people with complex social determinants of health - Develop non-clinical and peer-based workforce to fill the gap of ongoing and	Capacity building System improvement Strategic partnerships	NGO partners Primary care professionals Universities

		low intensity care - Develop specialist workforce, especially in child, youth, and mental health space		
Create supportive environment to sustain and retain workforce	Workforce Practice Support	- More viable renumeration for GPs and other health professionals other than via Medicare - Longer-term funding agreements to create stability for staff - Quality administrative support to reduce reporting burden for staff to focus more on actual care - More support for professional development, staff mental health care and burnout - Increase level of staffing at several services - Create a respectful and safe environment for staff to work in - Streamline process to reduce administrative burden	Capacity building System improvement	Professional bodies Advisory councils
Impact of COVID-19	Other – COVID-19 identified Other - telehealth	- Upskill health professionals to deliver more quality care via telehealth - Improve procedure, system and infrastructure to provide continuing and quality support from distance	Planning System improvement Strategic partnerships Capacity building	ACT Health General practice

Workforce overview

Generally, 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 (1)	88.5 (the lowest in Australia)	113.4
Female GPs per 100,000 females (1)	81.9	87

Dentists per 100,000 population (1)	5	5.7
Occupational therapists per 100,000 population (1)	23.3	26.3
Psychologists per 100,000 population (1)	52.3 (the highest in Australia)	26.5
Nurses and Midwives full-time equivalent per 100,000 population (125)	1,274.2	1,197.4
Pharmacists full-time equivalent per 100,000 population (126)	107.9 (the highest in Australia)	94.1
Aboriginal and Torres Strait Islander Health Practitioner average hours worked (25)	36	40.5
Indigenous health professionals employed per 100,000 population (25)	38.8 (significantly below the national average)	59.8

Stakeholders informed us that the ACT has a good mix of services but lacks in volume. The priority should increase in areas of alcohol and other drugs, allied health, mental health and Aboriginal and Torres Strait Islander health. More specialists are needed to reduce wait times, especially in area of children's 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 and dementia), services for people with complex and intersecting needs, trauma-informed care, culturally appropriate care, and appropriate referral pathways. With the emergence of COVID-19, stakeholders have also identified the needs to improve health professional's capacity to deliver quality care via digital tools.

Workforce shortage

In general, nearly all stakeholders reported that workforce shortages were a major impediment to client outcomes as issues with staff recruitment, retention and subsequent burnout on remaining staff have a large impact on program capacity. Many stakeholders reported the severe impact that the NDIS roll-out had on the workforce in ACT as many health professionals moved into private practice due to higher remuneration. It is also reported to be quite difficult to recruit staff from out-of-state (from Sydney and Melbourne). Other factors such as the COVID-19 pandemic has impacted on workforce, anecdotally, by increasing strain and responsibilities on staff, who worked to cover the gaps caused by required program adaptations such as additional social distancing/hygiene measures, migration to digital platform delivery, or working additional hours to meet increased client demand.

Mental health workforce

In general, there is a severe lack of mental health professionals in the ACT, which include:

- psychiatrists, especially those who can do disability assessment

- psychologists
- mental health nurses
- workforce experienced in trauma
- more non-clinical staff to work with vulnerable populations at support worker level

- allied health in acute mental health services
- practitioners for more senior roles with AHPRA accreditation

Although the ACT has the highest number of psychologists per 100,000 populations, the much higher demand for mental health services compared to other states and territory in Australia as mentioned in the Mental Health section of this Needs Assessment report, and the limited mix of mental health accredited health professionals have actually offset the surplus supply of psychologists reported in the ABS data (1, 7, 5). One community mental health stakeholder reported that they do not have any new psychologist graduates, and received minimal applications from this cohort (5). Next step is a great option for building workforce, but the training and supervision of the nonclinical workforce does have an increased cost (5). It was also recommended that professional development for non-clinical staff to complete counselling training would bolster the capacity of the mental health workforce (5).

Feedback via CHN consultation suggests there are opportunities in the mental health sector for workforce development around building mental health nursing workforce. If there was flexibility in mental health programs to recruit social work interns, occupational therapists and mental health nurses to support them toward accreditation, like how the process is currently done with psychologists, this would be highly beneficial to broadening the training and use of multidisciplinary teams (5). Currently there are minimal incentives for nurses to work toward mental health training as it requires an extensive amount of time to achieve accreditation (5).

Stakeholder feedback reported that recruitment has been the biggest challenge for the more senior roles where services are hiring someone with AHPRA accreditation, as these staff often only want the role a few days a week as they work in private practice for their remaining days. One community mental health stakeholder reported that they do not have any new psychologist graduates, and not many applications from that cohort of the workforce.

Stakeholders reported that the child trauma support area is severely lacking in adequately trained and experienced staff, placing a large barrier to expanding services and programs to support this area despite funding being available.

Provision of professional development to facilitate more non-clinical mental health workers to do counselling would help to build capacity in the workforce (5). A stakeholder reported that for non-clinical staff working with vulnerable groups at the support worker level, there needs to be more training in trauma awareness. The NDIS roll-out and removal of block funding for organisations has had a drastic impact in terms of de-skilling of the support workforce. There is a need to increase the training requirements of the non-clinical support staff in a way that will not reduce the capacity of the workforce.

Aboriginal and Torres Strait Islander Workforce

Workforce shortage in Aboriginal and Torres Strait Islander space are (5):

- Limited representation of indigenous people across all health professions, roles, sectors, and settings, including allied health, nursing, midwifery, and medicine
- Aboriginal Liaison Officer at mainstream services, as indigenous clients lean more on non-indigenous services due to shame around confidentiality. They need to understand the dynamics of Aboriginal families and those who have gone through Stolen generations.
- Indigenous care coordinators to support Indigenous patients to navigate the complex mainstream health system

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 build trust and relationship with clients; therefore, to better engage patients in care. Stakeholders have informed us that the number of Aboriginal-specific health professionals are also declining in the ACT and nationally (5). A stakeholder has informed us that this may be due to the change in qualification requirements for this role, which now requires a certificate IV in training. It was also suggested that Aboriginal health career progression can stagnate, which drives these professionals to seek opportunities in allied health or public policy.

Stakeholders informed us that cultural knowledge often does not get valued in workplaces and in education settings, and tertiary education often do not support Indigenous approaches to clinical roles. It was suggested there was a need within the community for indigenous leadership to support cultural safety and encourage the participation of indigenous workforce, with the support of mainstream stakeholders.

From a workforce perspective, the additional cultural load, the burnout, and the trauma are high for Indigenous health staff working to meet the needs of Indigenous communities, despite the strong desire from staff to support these communities. Often the roles of working in community require an input over and above the standard 9-5, with a high risk of vicarious trauma which requires a strong self-care approach to mitigate.

IAHA are working to establish an ACT Aboriginal and Torres Strait Islander Health Academy to support access to culturally safe education and training pathways for young indigenous people in the ACT, which has the support of the Elected Body and ACT Government (5). The Academy can improve social determinants of health and provide wrap-around support for indigenous students to engage in training and education towards an allied health certificate (5). A stakeholder reported that this is a potential model to build workforce capacity and enhance the provision of culturally safe and responsive healthcare (5).

Homeless workforce

Stakeholders reported that recruitment and retention in homelessness sector is relatively stable compared to other sectors although there are few opportunities for career progression. Informal relationships between staff from other services can help facilitate referrals, as do sector meetings and forums which are great networking areas. It was mentioned that there is relatively good communication between services, as people in the sector have similar goals and are passionate about wanting to help their clients. However, it is reported that the intersectionality of vulnerabilities (e.g. cultural background, disability, trauma, mental health) and how they impact clients are poorly understood so additional training would beneficial.

It was suggested that services could deliver housing and health supports together including primary health, dental and mental health care. There are good partnerships between mental health and homelessness services that exist already which could be scaled up, but additional resourcing and planning is needed.

Peer workforce

The value of peer workers and peer-run programs was well-evidenced in the consultation and surveys conducted for the needs assessment, as many participants stated that programs that were peer-led or had peer support staff were a strong enabler to recovery and wellness goals of many clients. Areas such as First Nations health, mental health, LGBTIQA+ and clients with AOD issues that face high levels of stigma were reported to benefit significantly from peer support workers.

There is no peer worker training that is fit for purpose to support specific cohorts and a severe lack of support structures to develop this workforce. It was reported that recruitment for peer workers is difficult, often staff move from other areas with previous training history but often find it hard to come to terms with the ethics of being a peer worker. Alternatively, organisations train their own peer workers from volunteers which can have great outcomes but is incredibly resource intensive and the resources often need to come from in-house, as there is no additional funding to cover the training and supervision.

Stakeholders reported that the lived experience required for peer support work, and complexities around peer support, are not valued or understood well. Often peer workers are working with more than one set of complexities and are working within with family dynamics or with multiple issues. However, they are not trained as social workers, although would do well with this kind of training. There needs to be self-care training for these staff as well as support for vicarious trauma. As people with lived experience, they have many triggers which can be difficult when working with vulnerable groups from challenging circumstances.

Allied health workforce

Stakeholders informed us that there are significant gaps in utilising allied health workforce to form multidisciplinary care that can better support patients in a more holistic way, especially in primary care and chronic condition management. There needs to be better understanding from GPs about what allied health professionals can contribute to care and increasing uptake of Team Care Arrangement and GP Management Plan can help facilitate this. In some professions such as dietetics and physiotherapy, stakeholders informed us that there is not a shortage of workforce, but there is a shortage of service delivery due to lack of publicly funded services. Our findings suggest allied health practitioners that are currently lacking in the ACT are:

- Sonography
- Occupational therapist working in the public sector due to movement into the NDIS. There was reported shortages of OTs across all areas, public and private as well as all age groups and practice areas.
- Speech pathologists in disability sector
- Physiotherapists/occupational therapists with experience working with people with disabilities
- Allied health in public settings and prevention space
- Palliative workforce
- Social workers in Pain Management Unit and oncology
- Workforce to diagnose Foetal Alcohol Spectrum Disorder (FASD)

Some areas of underutilisation of allied health workforce reported by our stakeholders are:

- allied health assistant to better support clients with ongoing management
- podiatrists to prescribe medicines yet additional training would be needed
- physios have extended scope in physio model to order x-rays in ED
- speech pathologists with advancing scope such as use of videoscope to assess swallow function
- dental therapists to prescribe antibiotics
- dietitians to order blood tests

Needed workforce support

Viable renumeration

Stakeholders informed us that MBS rebates are not viable for clinicians, so they often need to move in and out of private practice despite wanting to stay in the community sector. The aged care sector suffers severe workforce shortage due to demanding workload yet unmatched renumeration. Large movement in staff is reported to affect the experience of clients when accessing mental health services, as they then need to tell their story repeatedly due to the frequent turnover of clinicians. The ability for programs to provide salaried positions was reported to be crucial to retaining high quality staff.

Support to foster collaboration and coordinated care

There needs to be supports to foster collaboration on the ground level, to enable more shared care with other services as a big gap exists for services that work across sectors to support integration across the community, primary care, and tertiary sectors. There are some systemic barriers to collaboration such as competitive tendering and lack of system supports to enable shared care, but training and permission to start those collaborations would be beneficial. There also needs to be quality leadership to support interagency coordination. A more streamlined and collaborative policy approach with reduced red tape is another common mention among our stakeholders.

Having a key worker to support people to access support across sectors would be beneficial, for vulnerable clients engaging with mental health services and other support services. These support roles could be peer workers, youth and wellbeing workers, counsellors, and social workers. However, in severe and complex space, peer workers may not be appropriate for youth, due to the level of experience, stability and training needed.

Workplace environment and cultural safety

Support structures to enable staff to deliver quality care and maintain wellbeing receives many suggestions from our stakeholders. In terms of practical support to deliver quality care, expressed needs for support include:

- support to avoid burnout and vicarious trauma. This need is prevalent among professionals working in Indigenous health, mental health, domestic and family violence and LGBTIQA+ areas
- increase level of staffing when workloads increase and provision of quality administrative support so that staff can use time to focus on patient care
- better defined administrative structure to better plan for workload and staffing. This particularly impacts the capacity of smaller organisations and aged care facilities, where regulatory practices and accreditation severely impacts capacity to provide care due to small staff base
- greater transparency and accountability from employers

Training and workforce development opportunities

Youth workforce

In the youth worker space, a stakeholder reported there was a lack of professionalism within some areas of youth practice. Youth practitioners working in the youth space need upskilling and training to underpin understanding of mental health and trauma literacy, also able to take on responsibility to refer correctly to other services. There is also a need for training staff to appropriately talk with young people who use violence and understanding the underlying needs that drive the behaviour.

Telehealth

Telehealth is not new for allied health professionals, but considerations for maintaining quality and safety are needed (5). Stakeholders reported that there may be temptation to overservice and that general IT skills are needed for both staff and clients.

Potential Industry changes in future

- Pharmacy is looking at potentially have assistants that could provide checking of medications to allow pharmacists to focus on patient interaction. New Zealand uses this model and has a training model that may be able to be emulated in Australia.
- Genetic testing for DNA testing is expected to increase.
- Radiation type devices will get easier to use.
- Biomedical engineering will increase as will maintenance of associated equipment.

Better workforce development practices

- Clearer expectation around minimum working and training required of staff in suicide prevention, AOD, basics around sexual health and wellbeing
- A state-wide workforce and recruitment strategy that include all parts of the care system, NGOs and nonclinical included. This will enable sharing positions across system or combining part-time positions to make a full-time role to maximise the capacity of current limited workforce. There also needs to be specific strategies for the Aboriginal and Torres Strait Islander health workforce that address social determinants of health
- Strategic workforce partnerships with universities and training organisations to build pipeline of primary care workforce including general practice, mental health, Aboriginal and Torres Strait Islander Health Workers
- Care system needs to collaborate with other sectors in developing workforce (e.g. disability, education, aged care and childcare) and bring education and training providers into planning

- Better career progression for allied health, as there is a tendency to see a loss of allied health into policy areas and the public service where there is more progression or better opportunities.
- More culturally appropriate work and education settings for Aboriginal health students/ staff.
- Growth in clinical supervision and placement. This can be achieved by better renumerating senior clinician’s time to support more junior staff.
- More university post-grad training places are needed, particularly in areas such as chronic healthcare and nurse practitioner studies
- An experiential tertiary program using paid learning to reduce the burden of student and promote on-job training. Funding for community development would mean that programs could train their own peerbased workers
- Strategies to plan for workforce to fill in the gap when the baby boomers’ generation of health professionals retire
- Interdisciplinary training opportunities to support collaboration and multidisciplinary care

Funding

Funding is one of the largest impacts of service’s structure and staffing capacity. A stakeholder reported that contract budget allocations were often inflexible, yet there was often a push for innovation from funding bodies, but no spare funding was provided for research and development of innovative programs.

Uncertain funding agreements are a challenge for services to retain staff. There was also frequent mention during consultation that the short-term funding allocation to the community made it difficult to sustain workforce and enhance capacity plan for services beyond more than 1-2 years at a time.

Appendix

CHN Service Provider survey respondent characteristics

The Service provider survey was sent out to general practices, aged care facilities, Canberra Health Services staff, community allied health professionals, university staff, community health organisations, advocacy and service providers, peak bodies and health consumer representatives, private health providers and ACT health services. 143 complete responses were received. 29 respondents were GP's (20.3%), 15 were physiotherapist (10.5%), 16 were nurses (11.2%), 13 were OT's (9%), 12 were psychologists (8.4%), 9 were dietitians (6.3%).

36% of respondents worked in the community sector, 23% in the public sector, 21% in the NGO sector, 27% in the hospital sector, 24% in general practice, 14% in the private sector, 5% were sole providers.

23.8% had worked in their sector 5-10 years, 53.1% had worked in it for more than 10 years, 19.6% had worked in it 1-4 years and 3.5% had worked in it less than 1 year.

CHN health consumer survey respondent characteristics

The health consumer survey was distributed amongst the same networks as the service provider survey, to be promoted through their client cohorts and digital networks of email lists, social media, posters and intake webpages. 216 complete responses were received. There was good uptake and reception within certain groups such as older persons, people who identify as female and the LGBTIQA+ community which resulted in a high representation in the survey results with over 34% identifying as being a part of the sexuality diverse community and 7.5% identifying as gender diverse community, 74.5% identified as female gender, 13.9% are retired and 25.5% working part time. Over 2/3 of respondents were over the age of 40.

2.3% of respondents identified as Aboriginal and 12% identified as culturally and linguistically diverse. 23.1% reported their household income to be below $69,390 before tax, 48.1% reported their household income to be between $69,390 and %174,390. 18% reported to be over $174,390. 34.3% of respondents were carers.

GLOSSSARY

ACT	Australian Capital Territory
AHPRA	Australian Health Practitioner Regulation Agency
AOD	Alcohol and Other Drug
BPD	Borderline Personality Disorder
CALD	Culturally and Linguistically Diverse
CHN	Capital Health Network, the ACT's Primary Health Network
DBT	Dialectical Behaviour Therapy
ED	Emergency Department
COPD	Chronic Obstructive Pulmonary Disease
ENT	Ear, Nose and Throat
GP	General Practitioner

HIV	Human Immunodeficiency Virus
LGBTIQA+	CHN uses the initialism LGBTIQA+ to refer to people of diverse genders, sexualities and sex characteristics, including but not limited to people who identify as lesbian, gay, bisexual, trans, queer, asexual, agender, non-binary, gender fluid, pansexual, and people who have an intersex variation. We recognise that the initialism does not capture the full diversity of sexualities, bodies, identities, and experiences that exist within this community, however we also recognise the value of the term when exploring collective experiences of stigma, discrimination, and marginalisation, and experiences of minority stress.
IAHA	Indigenous Allied Health Australia
NDIS	National Disability Insurance Scheme
NFP	Not-For-Profit
NGO	Non-Government Organisation
MBS	Medicare Benefits Schedule
MHR	My Health Record
RACF	Residential Aged Care Facility
SES	Socioeconomic Status
SHS	Specialist Homelessness Services

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