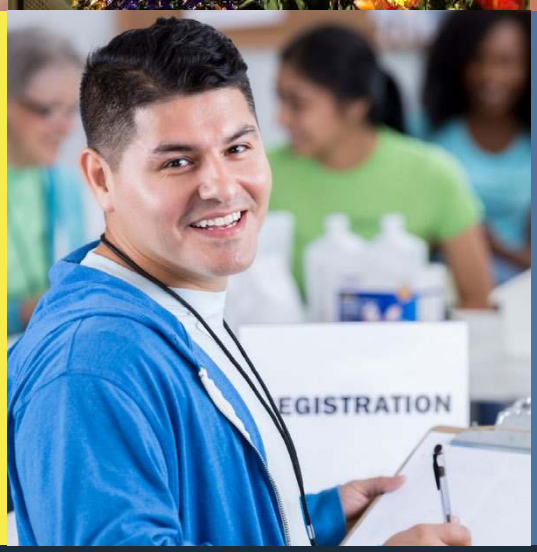










CAPITAL HEALTH NETWORK

ANNUAL REPORT 2023/24

phn ACT

An Australian Government Initiative

Capital Health Network

Partnering for better health

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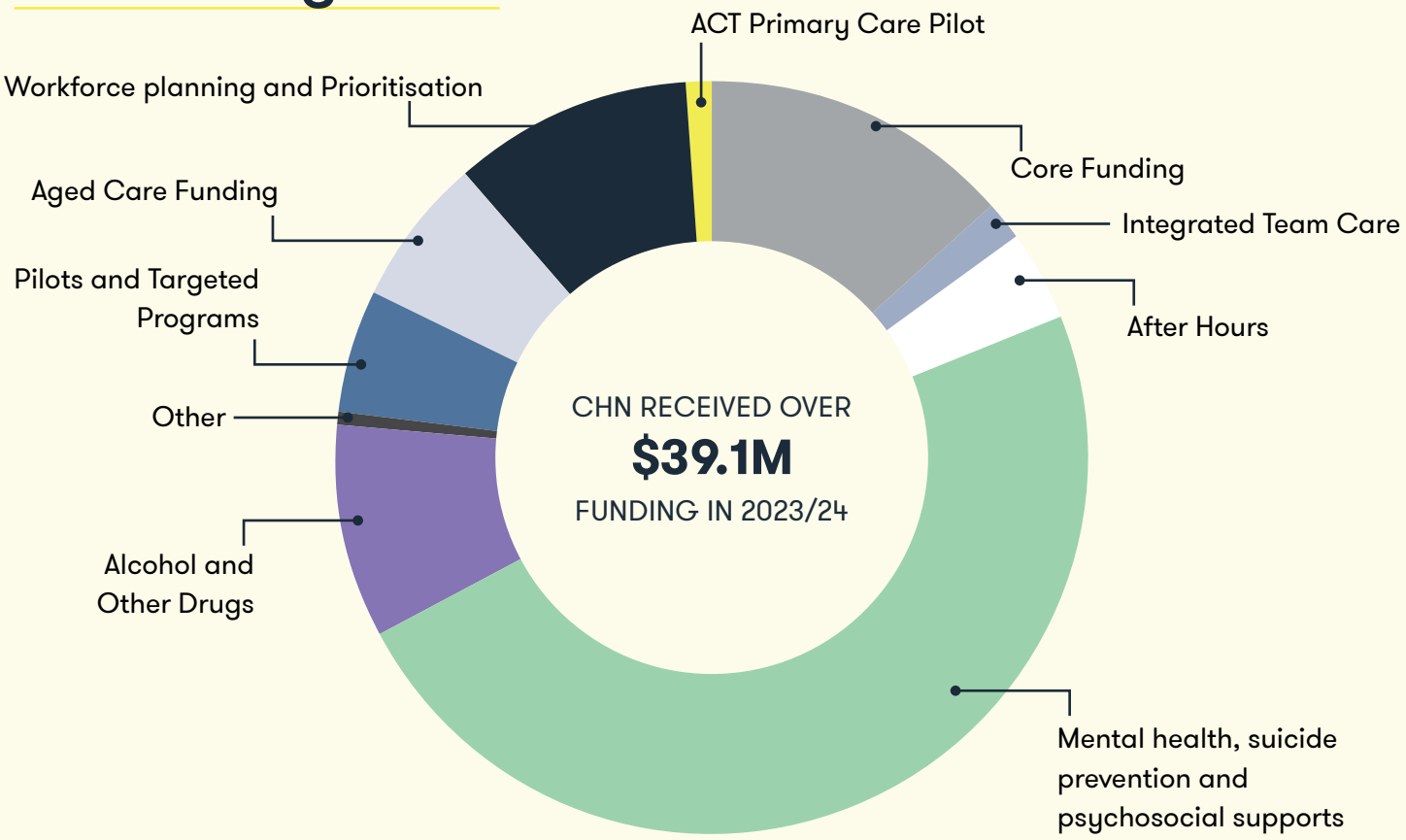
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Capital Health Network acknowledges the Traditional Custodians of the country on which we work and live, and recognises their continuing connect to land, waters and community. We pay our respects to them and their cultures, and to Elders both past and present.

CHN at a glance



ALLOCATED OVER **$31 MILLION** TO LOCAL COMMISSIONED SERVICE PROVIDERS

62 COMMISSIONED SERVICE PROVIDERS

91 CONTRACTS

16 NEW PROCUREMENTS

110 GRANTS

12 FORMAL PARTNERSHIPS

5 INNOVATIVE TRIALS

1264 PRIMARY HEALTH CARE PRACTICE ENGAGEMENTS

9 ADVISORY COUNCIL MEETINGS

58 STAFF



From the Chair

Julie Blackburn

This year has been one of significant change, progress and achievement for Capital Health Network (CHN).

As the ACT's Primary Health Network, we continued to work proactively with government departments and agencies, health professionals and community organisations to enhance access to primary health care services in Canberra. Our Needs Assessment, General Practice Advisory Council, Community Advisory Council and ACT Clinical Council continued to inform our work focussed on improving the reach and impact of much-needed local services within our priority areas.

This year we allocated over $31 million to 62 commissioned service providers (for 91 contracts) in 2023/24 to meet our community needs. Compared to the previous year, this is an increase of over $7.5 million with an additional 17 commissioned services providers.

Our commitment to strong corporate governance was unwavering. End of 2023, we farewelled Dr Mel Deery, who after 6 years of Board guidance, from the general practice perspective, ended her elected term on the Board. We welcomed 3 new Directors to our Board: Dr Jessica Tidemann (General Practice Director), Dr Vik Fraser (Consumer Director) and Rachel Fishlock (Board Director). You can read about their experience and interests on our CHN Board webpage.

We were delighted to celebrate a baby for our CEO Stacy Leavens in January. To support the maternity leave, we made some temporary amendments to the Governance structure at CHN, seeing me become inactive on the Board as Chair to take on Acting CEO role, and Peter Quiggin PSM KC leading the Board as Acting Chair. These changes ensured the Board remained engaged in overseeing the execution of our strategy, ensuring compliance with regulatory requirements and providing corporate oversight.

I would like to extend my heartfelt thanks to all Board members, management team, employees, and advisory council members for their unwavering support and dedication to the work of CHN. All of these contributions have been instrumental in our successes this financial year.

I am optimistic about our future and look forward to another year of improvements to primary health in the ACT. It is my pleasure to present to you the Annual Report for 2023/24.

Sincerely
Julie Blackburn, CHN Chair



l-r: Dr Liz Develin, Deputy Secretary, Primary and Community Care Group, Department of Health and Aged Care with Acting CHN CEO, Julie Blackburn.



From the CEO

Stacy Leavens

One of CHN's goals, as ACT's Primary Health Network, is to improve health outcomes for Canberrans. This year, with this goal in mind, we delivered four innovative trials to determine new models to improve health outcomes:

- **ACT Primary Care Pilot** – To support general practices to help patients with complex health care needs, CHN has collaborated with ACT Health and Canberra Health Services to roll out the federally-funded ACT Primary Care Pilot. The pilot is testing an innovative model to reduce demand on public Emergency Departments, by strengthening integration between ACT general practices and the public health system for people who either attend hospital frequently or are at risk of attending in the near future. GPs and Nurse Practitioners from the 15 participating general practices have worked closely with Canberra Health Services' Liaison and Navigation Service to develop a comprehensive care plan to assist 149 patients in the pilot to stay well in the community. Nous will evaluate the trial.
- **Family Safey Pilot** - We know that a GP is likely to see up to 5 women per week who have experienced some form of intimate partner abuse in the last 12 months. So CHN is running a new Family Safey Pilot Program in the ACT where primary health care professionals will receive free, tailored, ACT-specific training to recognise and respond to early signs of family, domestic, sexual violence and child sexual abuse. We have commissioned the Domestic Violence Crisis Service (DVCS) and the Canberra Rape Crisis Centre (CRCC) to deliver the pilot over the next 2 years. Link Workers, embedded within DVCS and CRCC, will facilitate coordination of referrals from general practices to relevant support services and enhance service navigation for victim-survivors.
- **Social Workers in General Practice** - CHN's Needs Assessment highlighted social determinants of health as a major barrier to accessing health care in the ACT, particularly for those with complex social and health needs. As a first in Australia, CHN funded 4 general practices in the ACT to participate in the Social Workers in General Practice Pilot, with Social Workers as an integrated part of their general practice team. Over 650 patients were seen by a Social Worker who addressed barriers to health care access by coordinating additional help from social, welfare or community support. Early results from the trial reveal that the inclusion of Social Workers in general practice has had a positive impact in patient support, practice team capacity and education. University of Canberra is conducting an evaluation of the trial.
- **ACT Breathlessness Intervention Service** - Many people with lung and heart conditions live with breathlessness every day, which can stop them from doing simple day-to-day activities. Chronic breathlessness is also a frequent reason for Emergency Department visits and hospital admissions. To address this, CHN's ACT Breathlessness Intervention Service (ABIS) trial has involved the Southside Physio Mobile team visiting clients in their home to provide non-pharmacological interventions. All patients completing ABIS achieved improvement on at least one outcome measure e.g. severity of breathlessness, performance of nominated activity of daily living. Also, 21% of patients who have received at least one visit so far said they avoided calling an ambulance on 33 occasions, when they normally would, by using ABIS techniques themselves. The ABIS trial will be evaluated by the University of Technology Sydney.

None of these achievements would be possible without the innovation and dedication of our Board, partners, primary health care professionals and CHN staff. Thank you to Julie Blackburn who took on the Acting CEO role and Peter Quiggin PSM KC who led the Board as Acting Chair, while I was on maternity leave. I also thank the Executive Team and Senior Managers for their ongoing leadership.

I look forward to the year ahead where we will continue to work with partners to improve the health outcomes of Canberrans.

Kind regards
Stacy Leavens, CHN CEO



CHN's CEO, Stacy Leavens, attended the ANU School of Medicine and Psychology MChD (Doctor of Medicine and Surgery degree) prizes evening and presented the CHN GP Scholarship to: Emma Young, Clair Bannerman, Christine Ishak and Emily Rickard.



Staff Planning Day 2024

CHN HAD **617 MEMBERS** AS AT 30 JUNE 2024 CONSISTING OF:

239 GPs

269 PRIMARY HEALTH CARE PRACTITIONERS

70 SERVICE PROVIDER ORGANISATIONS

17 CONSUMER ORGANISATIONS

22 PEAK BODIES

CHN Board

Capital Health Network Board members (as at 30 June 2024)



Mr Peter Quiggin PSM KC

LLB, BSC, Grad Dip Prof Accounting, FAICD

Acting CHN Chair (January - June 2024).
Appointed Board Director, March 2022.
Peter is a highly experienced former Australian Government agency head and is a Commonwealth King's Counsel. He led the highly respected Australian Office of Parliamentary Counsel for 17 years. As a former First Parliamentary Counsel, Peter has an outstanding understanding of legislation and legislative schemes and the operations of government.

Peter has been on a number of Boards including the Board of Taxation and not-for-profit Boards. He was President of an international association – the Commonwealth Association of Legislative Counsel – for a record three terms. He has also been on a range of Finance and Audit Committees in both the public and not-for-profit sectors. He is a Fellow of the Australian Institute of Company Directors, was awarded a Public Service Medal for services to legislative drafting and recently awarded a Chief Minister's Canberra Gold Award.



Ms Julie Blackburn – Chair

RM, RN, GAICD

Chair, as elected by the Board November 2020 (inactive from January – June 2024 while in Acting CHN CEO position).
Primary Health Care Clinician Director, re-elected 2022 AGM.
Julie Blackburn is a Registered Nurse, Midwife and Educator, with over 25 years expertise in primary care, maternal and family health. She works as a lecturer of nursing at the University of Canberra and contributes to the Parent Education Program at North Canberra Hospital. Julie is also an experienced non-executive director of more than 10 years. Julie has direct experience in reporting to Ministers at both local and federal levels, including as a member of the ACT Ministerial Advisory Council for Women 2014-2018. Julie was Deputy Chair and Public Officer for Karralika Programmes until November 2023, and has previous board experience in Private Health Insurance.



Ms Darlene Cox

BA Dip Ed, Grad Dip AppEc, B Ed

Appointed Board Director 2023 AGM.
Darlene is an experienced executive, director and advocate. She has been active in the health consumer movement and community sector since the late 1990s. Darlene has been the Executive Director of Health Care Consumers' Association since 2008. She contributes to local and national health committees including the Australian Commission on Safety and Quality in Healthcare, Australian Digital Health Agency and ACT Government.



Dr Niral Shah

MBBS, MS(Orthopaedic), MHSM, DCH, FRACGP

Elected Director, re-elected 2022 AGM.
Dr Niral Shah is an overseas-trained doctor, obtaining his primary medical degree and specialist qualifications in Orthopedic Surgery from India. After 6 years of hospital experience in Australia, he joined general practice training in 2012. He completed his GP training in 2016 by working in rural as well urban general practice and an extended skills academic position at the ANU.

Niral is working part-time as a GP in a group practice in Gungahlin. He also is a senior medical educator with GP Synergy and has been actively involved in GP registrar training. He is also an ACT representative on the RACGP Faculty Board representing the ACT's voice, advocating for local issues at the Federal and State level and developing various quality improvement and continuing professional development programs.



Mr Steven Baker

BComm (Acctg), ICAA, MIIA, GAICD

Appointed Board Director, March 2021.
Steven has served on numerous Boards, Committees, Audit and Finance Committees as a member and/or Chairperson, in addition to participating in many as an observer as either the internal or external audit provider.
Steven has over 25 years in professional services delivery in Australia and has worked for Ernst & Young, WalterTurnbull Pty Ltd, PricewaterhouseCoopers and currently for global consulting business Protiviti Pty Ltd. Steven has many years' experience providing professional consulting services, as well as board and committee experience within the health and education sectors.



Dr Vik Fraser

Consumer Director, elected November 2023.

Dr Vik Fraser has been an advocate for LGBTIQ+ rights since they were 17 years old. They are passionate about the social determinants of health, and the role that human rights has in building good health care. The intersections they experience in their own life, including as a queer person with a hidden disability, drive Vik's understanding of some of the complexities of health access and health needs across the community. Vik is also the Executive Director of A Gender Agenda, and has had a working life that has spanned education, research and government sectors.



Dr Jessica Tidemann

General Practice Director, elected November 2023.

Dr Jessica Tidemann is a specialist GP working in roles across clinical practice, medical education and government. She has worked in several roles for the Australian Government Department of Health and Aged Care over a period spanning 20 years. Jess was an invited member of the CHN GP Advisory Council prior to becoming a member of the board and has held several other professional positions, including Board Director, GP Registrars Australia and multiple roles with the RACGP."



Ms Rachel Fishlock

Appointed Board Director, December 2023.

Rachel is a proud descendant of the Yuin Nation and is the CEO of Gayaa Dhuwi (Proud Spirit) Australia. Rachel has over a decade of experience in the health sector including the optometry industry and community-controlled sector at the National Aboriginal Community Controlled Health Organisation (NACCHO). Rachel was recognised by Lifeline Canberra as the 2022 Rising Woman of Spirit for her outstanding community spirit and resilience in the face of adversity, through continuing to advocate for reforms to ensure other children do not experience systemic neglect.

Resigned Capital Health Network Board members



Dr Mel Deery

MBBS (UNSW)

General Practice Director, elected 2017 AGM, reappointed at 2020 AGM, resigned in November 2023.

Along with her husband John, Mel is a GP and practice owner at YourGP. She is passionate about developing YourGP to better fulfil the vision of 'genuine care, clinical excellence'. She enjoys all areas of general practice with special interests in paediatrics, women's health, pregnancy care and mental health.

CHN Advisory Councils

a) ACT Clinical Council

The ACT Clinical Council provides a forum for a multidisciplinary group of clinicians to share their collective knowledge and expertise. The Council also provides advice on strategic clinical and wider health system issues and local strategies to improve the operation of the ACT primary health care system for consumers, facilitating effective primary health care provision to improve health outcomes.

Members as at 30 June 2024

- Jason McCrae (Chair), Psychologist Think Psychology Solutions
- Melanie Dorrington, Chief GP and Primary Care Advisor, ACT Health
- Kamla Brisbane, Carers ACT Representative
- Jackie Lockley, Pharmacist, Capital Chemist O'Connor
- Mary Ann Ryall, Senior Staff Specialist in General and Geriatric medicine, Calvary Public Hospital
- Chelsea Hillenaar, Community Care Health Promotion Project Officer, Canberra Health Services
- Adnan Asger Ali, Director & Principal Physiotherapist, Accelerate Physiotherapy
- Nike Aina, Senior Registered Nurse, LDK Greenway
- Adnan Alam, General Practitioner, Hobart Place General Practice

Resigned

- Michael Culhane, Executive Group Manager, Policy Partnerships and Programs, ACT Health
- Elizabeth Moore, Coordinator General, ACT Office for Mental Health and Wellbeing
- Shelley McInnis, Health Care Consumers' Association (HCCA) member
- Prof. Kirsty Douglas (Co-Chair), Director Academic Unit of General Practice, ACT Health

b) Community Advisory Council

The Community Advisory Council provides advice and recommendations to the Board to ensure that strategies and initiatives are consumer focused, cost effective, locally relevant and aligned to improving local health care experiences and expectations.

Members as at 30 June 2024

- Lisa Kelly (Chair), CEO, Carers ACT
- Wendy Prowse, CEO, ACT Disability, Aged & Carer Advocacy Services (ADACAS)
- Chris Gough, Executive Director, Canberra Alliance for Harm Minimisation & Advocacy
- Madhumita Iyengar (membership transfer from Chin Wong in February 2024), CMCF Representative
- Paul Thompson, Mental Health Consumer Representative
- Kirsten Cross, Council of the Ageing (COTA) Representative
- Erin Barry, Director Policy & Evaluation, Youth Coalition of the ACT
- Lauren Anthes, CEO, Women's Centre for Health Matters
- Karin Calford, Health Care Consumers' ACT Consumer Representative

C) General Practice Advisory Council

The General Practice Advisory Council provides advice and recommendations to the Board on its communications with GPs, strategies to strengthen and promote GP engagement and participation, and on priority areas and issues requiring GP participation.

General Practice Advisory Council as at 30 June 2024

- Dr Niral Shah (Chair), Board Member, Capital Health Network; My GP Gungahlin
- Dr Anne-Marie Svoboda, GP, Fisher Family Practice; ACT Health GP Liaison Officer
- Dr Mel Deery, Board Member, Capital Health Network; Practice Principal, Your GP@Crace, Your GP@Lyneham and Your GP@Denman
- Dr Felicity Donaghy, Practice Principal, Garema Place Surgery
- Dr Emma Cunningham, Practice Owner, Wakefield Gardens Surgery
- Dr Penny Gosling (replaced Mel Choy while on maternity leave)
- Dr Julie Carr, GP Liaison Officer, Canberra North Hospital
- Dr James Manley, GP registrar, Interchange General Practice; Your GP@Denman
- Dr Dorothy Monk, GP, Hawker Medical Practice
- Dr Emily Jehne, GP, Interchange Health Co-op

Resigned

- Dr Jessica Tidemann

Priority Area 1:
Workforce



CHN's Education Program



HOSTED **68** EDUCATIONAL EVENTS FOR PRIMARY HEALTH CARE PROFESSIONALS



ATTENDED BY OVER **6,500** PARTICIPANTS

1. Delivering education to primary health care professionals

Over the last year, the CHN Education Program significantly advanced the knowledge and skills of primary health care professionals by hosting 68 educational events, attended by over 6,551 participants. This included 20 face-to-face training sessions and 48 online events, ensuring comprehensive coverage of all 9 key priority areas.

In addition to internally driven educational events, CHN assisted 25 external organisations in delivering educational activities within the region. This collaborative approach has enriched the learning landscape for primary health care professionals.

The CHN YouTube page now hosts 14 playlist options, featuring 89 educational event recordings, covering a wide range of topics such as the sleep webinar series, obesity management, men's and women's health, and physiotherapy. In total, these videos have received a significant response, with thousands of views, demonstrating the value and reach of our educational content.

The CHN Education Program continues to play a pivotal role in fostering professional development and integrated care, benefiting the broader health care community.

Testimonials

Participant testimonials from post-event surveys highlight the program's impact:

- *"The CPD hours earned through these events have been essential for my professional development and keeping my practice up-to-date."* - GP
- *"The quality of speakers and the depth of knowledge shared in these sessions were exceptional. I always leave these events feeling more competent and confident."* - Practice Manager
- *"The hybrid format was incredibly convenient, allowing me to participate from my clinic without missing out on any valuable information."* - GP





Family Health Nurses attended CHN's Practice Connect event.

2. Workforce planning and prioritisation

The NSW and ACT GP Workforce Planning and Prioritisation (WPP) Consortium continues to provide independent, evidence-based recommendations to inform the geographic distribution and placement of GP registrars in NSW and ACT regions. The NSW & ACT WPP Consortium, consisting of 11 PHNs led by CHN, makes suggestions to guide the 2 GP training colleges, RACGP and ACRRM, in their placement allocation processes to meet the community's current and future GP workforce needs. Over the last year, the NSW & ACT WPP Consortium submitted Reports 2 and 3 to the Department of Health and Aged Care.

CHN is building its knowledge and understanding of GP training and workforce planning, and ways to encourage general practice as a career choice through collaboration and consultation with local key stakeholders.

In collaboration with the ACT Medical Officer Support, Credentialing, Employment and Training Unit (MOSCETU), CHN met with ACT junior medical officers (JMOs) to gather insights from the future medical workforce about their interest in general practice training. Of the JMOs and IMGs attending the event, some had decided to choose general practice as their specialty, some were undecided, and others had decided on non-GP specialties. Some aspects of general practice that interest JMOs is the provision of continuity of care, interesting case mix and good work life balance. Barriers to choosing general practice as a career included reduction in income when moving from the hospital system to the community, loss of employment entitlements, and the 10-year moratorium requirement for IMGs which requires working in a rural location.

Additional local engagement held with GP registrars, medical educators and RACGP provided insights from trainees about the contributing factors to choosing general practice as a career which include lifestyle, flexibility of hours, diversity of clinical work, provision of continuity of care and opportunities to subspecialise. The event will be an ongoing collaboration between CHN and RACGP as both organisations look for ways to provide support the future ACT GP workforce.

Testimonial

- *"The Workforce Planning and Prioritisation Program is working to advance the provision of primary care in the ACT region, through its extensive work in identifying areas of need for GPs. The program has focused strongly on collaboration from a wide variety of stakeholders and has an excellent track record of incorporating stakeholder feedback into its methods and considerations. The program has made extensive progress on identifying improvements for general practice training and community access to primary care for the ACT region."* - Professor Emily Haesler, Director of Canberra Region Medical Education Council – NSW and ACT WPP Steering Group member



CHN's First Nations Community Yarning Session.

3. Continuous quality improvement

CHN supports primary health care by facilitating the development and implementation of structured Continuous Quality Improvement (CQI) activities using our Quality Improvement Kit (QuIK) resources as well as delivering educational events focused on integration, skill development and knowledge sharing.

CHN conducted 64 QuIK Skills and QuIK visits to general practices, over the last year. Over 1,200 information request engagements with general practices and other primary health care providers were delivered through email and phone.

CHN supports all CQI activities for primary care through our QuIK resources, which have several features to support primary care:

- QuIK Visits focus on identifying the needs of general practices and co-designing QuIK Cycles in collaboration with CHN.
- QuIK Cycles focus on structured CQI activities, with primary care professionals able to earn Continuing Professional Development (CPD) hours for their involvement.
- QuIK Skills focuses on enhancing the quality improvement skillset of primary care staff (Clinical Audit Tool 4).
- QuIK Reviews provide individualised practice data with a quality improvement focus and practical format for use by general practices.
- QuIK Library is a repository of resources developed to inform and support primary care in CQI.
- QuIK Tips are concise one-page documents covering a range of important topics.
- QuIK Steps are a compilation of resources and topics relevant for starters to general practice.

CHN has been participating in the Improvement Science in Action for Primary Care course (led by the PHN National Improvement Network Collaborative (NINCo), the Institute for Healthcare Improvement and Prestantia Health), learning new methods to further support CQI in primary care.

QuIK engagement has assisted general practice staff to examine their own practice data to initiate and continue quality improvement activities to enhance patient and practice outcomes. CHN supported practices through a range of programs and incentives including MyMedicare, the ACT Primary Care Pilot, COVID-19 related activities, Strengthening Medicare in General Practice grants, Practice Incentive Program – Quality Improvement (PIPQI), clinical audit tool training, data sharing and Practice Nurse support.

Testimonials

- *"CHN's trainers were very helpful and were able to run us through on the training data"*
  - Practice Nurse, March 2024
- *"Thank you [for] coming out last week - your visit was very informational and useful"*
  - Practice Manager, March 2024



Interchange Health Co-op

4. Practice Nurse support

One of the 9 key priority areas of CHN is workforce, which includes supporting Practice Nurses to continue to play a key role in primary health care. To provide ongoing support and opportunities for Practice Nurses, CHN has implemented initiatives aimed to ensure that the ACT has a skilled, capable and productive workforce to ensure delivery of safe and quality health care.

CHN supported workforce recruitment with 9 Practice Nurse positions advertised on our website over the last year. CHN delivered educational events for Practice Nurses, covering topics such as chronic disease management, immunisation and baby checks. To address information requests and clinical audit tool training to support their quality improvement activities, CHN actively engaged with Practice Nurses.

Since 2022, CHN has supported 32 Practice Nurses to secure a scholarship to complete SA Health's Understanding Vaccines and the National Immunisation Program, with the final 2 Nurses being certified in the last year.



l-r: CHN's General Manager – Health System Improvement, Anais le Gall with APNA's General Manager Health Care Solutions, Mia Dhillon and Acting CHN CEO, Julie Blackburn.

Our ongoing collaboration with the Australian Primary Health Care Nurses Association (APNA) has also allowed promotion of programs and opportunities, such as their student Nurse placements in primary care through our newsletters. The partnership with APNA has enabled CHN to support Practice Nurses through the Transition to Practice Program (TPP), with 11 Nurses completing the program in October 2023 and a further 7 Nurses still undertaking the course. A popular component of TPP is the mentorship provided to participants by experienced primary care nurses.

- *"Thank you for the links you provided, that's very helpful and insightful. This gives me heaps of options to check. Appreciate it, thanks again."* - Practice Nurse

Testimonials

- *"The TPP team has always been a wonderful resource, I have never been left on my own and have appreciated their advice or guidance when I have needed this. The resources provided on mentorloop, and the education on APNA have been very valuable."* - TPP Nurse

- *"I have found the one-on-one mentoring extremely valuable, not only in my skills development, but also in knowing that there is someone outside of work who can help support me, someone who is actively rooting for me to continue my development."* - TPP Nurse

- *"My mentor has encouraged me to think outside the box, and this has positively my abilities to gather and analyse data and lead a team. The quality improvement mechanisms taught in the program have allowed me to contribute to the implementation of services that use an innovative, collaborative and holistic approach with their patients."* - TPP Nurse

- *"Before commencing the program, I had minimal confidence with mentoring and providing feedback (particularly when focused on a need for improvement). Completing the program has allowed me to develop my mentoring and leadership skills, which has increased my confidence in mentoring either in the program, colleagues or student nurses I work with in the future. I feel this skill development will also support my role as lead nurse."* - TPP Mentor



5. GP Scholarship Program

Over the past year, CHN, in partnership with the Academic Unit of General Practice at the Australian National University Medical School, administered a GP Scholarship Program for medical students. The program aims to help students stay connected to GP mentors during their final year of medical school and throughout their early years of junior doctor training. By fostering these connections, the program provided essential support, networking opportunities and mentorship to aid in the transition from medical school to hospital settings and general practice environments.

Students who showed an interest in general practice during their third-year placements were invited to apply for the three-year scholarship, with 4 awarded each year. Under the scholarship, the students were connected with their respective GP mentors over 2 formal dinners during their fourth year of study, as well as having the opportunity to attend a GP conference in their first 2 years as a junior Doctor.



CHN's CEO, Stacy Leavens, attended the ANU School of Medicine and Psychology MChD (Doctor of Medicine and Surgery degree) prizes evening and presented the CHN GP Scholarship to: Emma Young, Clair Bannerman, Christine Ishak, and Emily Rickard.

6. Primary Care COVID-19 Grants

CHN, ACT's PHN recognises the role of primary care in supporting the prevention, treatment and recovery from COVID-19 and prolonged COVID-19 symptoms. In April 2024, CHN opened a grant opportunity, with funding from the Department of Health and Aged Care, to primary health care providers that aimed to address the gaps in the health system relating to COVID-19. One of the key proposed activities of this grant was enhancing telehealth services to support better access to care of patients in the ACT. Out of the 38 primary care organisations who applied, and were successful for the grant, 14 general practices proposed an activity to improve their telehealth services. Other COVID-19 related activities included infrastructure upgrade, education and exercise programs for patients and carers, upskilling of staff, and mobile service provision for the vulnerable population.



Accelerate Physiotherapy is one of 38 organisations to receive a COVID-19 grant.

7. Allied health engagement

In the CHN Needs Assessment 2021-24, stakeholders identified significant gaps in the utilisation of the allied health workforce. These gaps are particularly evident in the creation of multidisciplinary team (MDT) care to enhance patient support, especially in primary care and chronic condition management. While there is an ample supply of workers in some fields such as dietetics and physiotherapy, the lack of publicly funded services has resulted in a shortage of service delivery.

An Allied Health Engagement Officer joined CHN in late 2023 to lead CHN's engagement with the sector, following the National PHN Allied Health in Primary Care Engagement Framework. By working closely with Allied Health professionals (AHPs), CHN can significantly contribute to supporting AHPs as an essential part of an integrated health system, resulting in a collaboration that contributes to focus on improving health outcomes. This involves regular stakeholder engagement with AHPs in primary care, community, public health, academia, as well as PHNs, national groups, peak bodies, and other relevant stakeholders, such as the ACT Office of the Chief Allied Health Officer and the Department of Health and Aged Care (DoHAC).

The primary health care sector has been the focus of our team's efforts to better understand opportunities and to identify gaps in community needs for allied health services and multidisciplinary models of care. This involves active stakeholder engagement with the AHPs in primary care sector and the community. Through these collaborative efforts, CHN has gained valuable insights into areas that require improvement or further attention. By liaising with peak bodies, CHN has developed free clinical education webinars for AHPs and MDTs, covering topics where gaps may have been identified. CHN has also shared the positive impacts of integrating a Social Worker in General Practice with health leaders at the 2024 ACT Allied Health Professional Associations Forum, and other opportunities. including conferences and the Department of Health and Aged Care – Allied Health and Service Integration Branch meeting.



ACT Chief Allied Health Officer, Dr Sue Fitzpatrick (second from right) with CHN's Senior Manager for Primary Care Integration, Russelle Trinidad, and CHN's Allied Health Engagement Officer, Sheila Brito, together with the Office of the Chief Allied Health Officer team at the ACT Allied Health Professionals Association Forum.



Alecia Filmer, Senior Physiotherapist, ACT Paediatric Physiotherapy Outpatient Clinic, Canberra Health Services.

Priority Area 2:
Care across the continuum

CHN commissioned services to provide:

SUPPORT FROM SOCIAL WORKERS IN GENERAL PRACTICE

IN-HOME PHYSIO FOR PEOPLE LIVING WITH BREATHLESSNESS

CHN provided:

AN ONLINE TOOL PROVIDING CONDITION-BASED ASSESSMENT, MANAGEMENT AND REFERRAL INFORMATION

PALLIATIVE CARE EDUCATION AND ADVOCACY

1. Social Workers in General Practice

CHN's Needs Assessment 2021-2024 highlighted social determinants of health as a major barrier to accessing health care in the ACT. The absence of adequate support for individuals with complex social and health needs becomes particularly apparent when they are trying to access and move between health services.

As a first in Australia, CHN, ACT's PHN funded 4 general practices in the ACT to participate in the Social Workers in General Practice Pilot, with Social Workers as an integrated part of their general practice team. A total of 4 Social Workers were employed and embedded in Interchange Health Co-op, Next Practice Deakin, Fisher Family Practice and Wakefield Gardens.
The Social Workers received support from funded professional clinical supervision and initially, a community of practice. The pilot program also provided funding for a nominated GP champion in each practice. The Social Workers were involved in various activities that directly supported patients, such as counselling, assisting with health care systems, and educating practice staff and patients on the role of Social Workers in general practice.
This has resulted in improved referral.

Over the last year:

651
PATIENTS WERE SEEN BY A SOCIAL WORKER

500
REFERRALS WERE RECEIVED

229
CARE PLANS WERE CONTRIBUTED TO BY A SOCIAL WORKER

Social Workers are addressing barriers to health care access by coordinating additional help from social, welfare or community support. Their work focuses on ensuring people who are at risk of poor health outcomes receive the right care, in the right place, and at the right time.

Early results from the trial reveal that the inclusion of Social Workers in general practice has had a positive impact in:

- patient support, including psychological support, counselling, advocacy
- navigation of health care system and government services e.g. My Aged Care, Centrelink, NDIS
- continuity of care
- integration of social work in general practice teams
- additional capacity of practice teams to offer specialty services
- improved capacity of GPs to focus on the clinical side of health care
- education of practice teams in changes to Government programs and/or limitations of services.



Social Workers in General Practice Postcard

Client story



Social Worker Barbara Shone, Next Practice Deakin is involved in the Social Workers in General Practice Pilot.

A Social Worker supported a client who had experienced domestic violence and trauma and her 3 children to move into a new 4-bedroom rental home. The home is subsidised by the Rent Start Safely Program, where 75% of the rent for the home is paid for by the NSW Department of Communities and Justice. Previously, the client's eldest teenager had to live with her maternal grandmother, as she could not fit in the family's previous rental accommodation.

Under the Escaping Violence Program, the Social Worker was able to connect this patient with $5,000 worth of funding to assist her. The home has recently been furnished with $3,500 of new furniture and $500 worth of Woolworths' goods to cover the family through the Christmas period. The client reported being "excited and happy" and her children all now settled back under the one roof, representing 12 months' worth of social work provision.

2. ACT Breathlessness Intervention Service

Many people with lung and heart conditions live with breathlessness every day. Even when they receive good medical care, managing this distressing symptom stops people doing simple day-to-day activities. Many people with chronic breathlessness and their family/carers experience anxiety, depression and social isolation. Chronic breathlessness is a frequent reason for Emergency Department visits and hospital admissions, resulting in high health care costs for services, out-of-pocket expenses and increased care and support needs provided by carers.

Internationally, growing research evidence supports the use of symptom-based care to lessen the effects of breathlessness on the of quality of life and distress to families. There is compelling evidence that in the year after receiving brief symptom-based interventions through a Breathlessness Intervention Service (BIS), unplanned hospital admissions reduce by as much as 50-60%. Despite this, few services are available in Australia that focus on the management of this troubling symptom.

CHN engaged University of Technology Sydney, Southside Physio and consumers and clinicians to co-design and develop a pilot of a Breathlessness Intervention Service in the ACT. The ACT Breathlessness Intervention Service (ABIS) is addressing the local primary and community care needs. This pilot is contributing towards growing evidence about how a BIS could work best for our local community. It is also highlighting to clinicians the role of non-pharmacological interventions, including engagement of Allied Health practitioners, in managing breathlessness to reduce distress and improve quality of life of patients and their carers.

The ABIS Pilot program was delivered by the Southside Physio Mobile team. Requiring a medical referral, the client received an initial home visit by Physiotherapist, with 2 to 4 follow-ups at home or by phone. Interventions are non-pharmacological and address the 'Breathing, Thinking and Functioning' components of breathlessness. Interventions are aimed at both patient and/or their carer.

Key outcomes

- Ethics approval was granted for collection of quantitative data of patient and carer outcome measures and qualitative data from patient, care and referring health professional interviews feeding into a rolling analysis to inform improvement strategies via a co-design process.
- ABIS opened referrals from general practice in March 2023 and referrals from other health professionals opened in March 2024. 124 eligible patients have been referred to ABIS with 85 patients receiving at least one home consultation. 70 patients have completed the ABIS program. Most patients require 4-5 visits to gain maximum benefit from the ABIS intervention.
- All patients completing ABIS achieved improvement on at least one outcome measure e.g. severity of breathlessness, performance of nominated activity of daily living.
- 21% of patients who have received at least one visit so far reported thinking about calling an ambulance on 33 occasions, but self-managed instead using ABIS techniques.
- 77% of carers, of those patients who completed the program, reported at least a one-point improvement from "not confident" to "somewhat" or "very confident" in managing symptoms of breathlessness from their first session in comparison to their last session.
- 14 patients and one carer agreed to interview appreciating the benefits of a flexible program that was person-centred and the home-based features of the service.
- One Breathlessness Webinar for health practitioners in the community and general practice settings.
- 'Evaluation of a Co-Designed Breathlessness Intervention Service for the ACT' delivered at Canberra Health Annual Research Meeting (CHARM).

Testimonial

- *A patient was referred to the ABIS program with a history of chronic obstructive pulmonary disease, severe osteoarthritis and hypertension. This patient loved his garden and produced almost all of his food himself. They have a few olive trees, and it always was a great love and passion for this patient to produce several products with them. Due to being anxious of feeling breathless, they reduced their activity level severely. This led to an increase in pain due to their osteoarthritis, which then further reduced their activity level. Through the program we increased their activity level using a slow introduction to some functional activities around and inside his house. Due to the education given, the patient was not scared or anxious to go into a state of being breathless and could manage it with breathing techniques. Slowly their osteoarthritis pain improved, and they managed a higher level of activity. Initially they highly considered knee replacements, but after completing the program their pain reduced enough to go without surgery. In our last session they managed to have a full olive production going. The patient was loving every moment of it and was so appreciative of what the program meant to them.*



3. ACT & SNSW HealthPathways

The ACT and SNSW HealthPathways Program is a free online tool for primary health care professionals that provides condition-based assessment, management and referral information. The program is a unique cross-border partnership involving CHN, ACT Health, COORDINARE (South-Eastern NSW PHN) and Southern NSW Local Health District.

Key program statistics (2023/24)

672 LOCALISED PATHWAYS AS AT 30 JUNE 2024

6,601 USERS

206,251 PAGE VIEWS

23 PATHWAYS WERE LOCALISED AND

195 PATHWAYS WERE REVIEWED

a) Evaluating HealthPathways

As part of the program's evaluation framework, HealthPathways explored the extent to which HealthPathways can support health professionals in providing the best possible care for patients living with dementia and their carers/family: HealthPathways Program Evaluation Report.

Focus groups with GPs, Nurses and Allied Health Professionals informed the team about the challenges both they and their patients can face in the diagnosis and management of dementia. The team also heard about what information health professionals need when they are supporting a patient living with dementia and/or their carer.

A consistent theme from all participants was the need for more information to help facilitate wrap-around psychosocial supports. This included access to information to provide to patients and carers/families:

- *"Dementia care isn't just about managing medical symptoms; it's about helping patients maintain their daily activities and quality of life. This requires continuous adjustments and a lot of coordination with other health care providers."*

Due to the need for integrated and coordinated care in the management of dementia, participants highlighted that it was useful to have HealthPathways as a source of information that could be utilised by all health professionals within the scope of their care.

b) When networks unite – management of chronic conditions

The ACT & SNSW HealthPathways team partnered with the Health Care Consumers' Association (HCCA) Chronic Conditions Network to update information on the HealthPathways site. Members of the network are local advocacy organisations, representing over 30 different chronic conditions.

Through our network partnership, over 20 pathways have been updated with correct service details, new services, expanded psychosocial supports, accessible patient information and useful information and educational opportunities for health professionals.

c) Promoting better care outcomes in the ACT

The ACT & SNSW HealthPathways team continued to support health professionals and promote better care outcomes within the ACT community this year.

The 3 focus areas included:

- inclusive information
- responsiveness to local needs
- dementia care education for health professionals.

d) Inclusive information

The team launched a new flag icon on the site this year to identify information on pathways that support better provision of care specific to the LGBTIQA+ community. There are now three flag icons on the site that identify information specific to First Nations, Culturally and Linguistically Diverse CALD and LGBTIQA+ communities.



The information highlighted by the icons on the site include:

- clinical points of care
- identified clinical care guidance
- guidance for culturally appropriate care and cultural safety
- identified patient information
- translated resources
- interpreter services
- and local service providers and support services in the ACT.

e) Responsive to local needs

Over the last year, the team localised 11 clinical pathways that provide best practice information on the assessment, management and referral options for the following conditions.

f) Rapid localisation

Rheumatic Heart Disease and heat-related Illness pathways were rapidly localised, in response to concerns of rising case numbers and summer temperatures.

The HealthPathways team also worked with the ACT Health's Public Health Response and Capability Unit, on the Post Natural Disaster HealthPathway as part of the Summer Preparedness Campaign.

g) Localisations for conditions typically managed within primary health care

Vaping in Youth, Safe Prescribing of Non-Steroidal Anti-Inflammatory Medications, Inflammatory Arthritis, B12 Deficiency, Travel Medicine and Transgender Health – Gender-affirming Hormone Therapy pathways were localised in recognition of the role primary care providers have in the continued management of these conditions.

h) Older adults' health

Comprehensive Medical Assessment for Residential Aged Care Homes and Older Adults' Weight and Nutrition pathways were localised in reflection of the national priority to support better care provision for older adults.

i) Dementia care education for primary care professionals

As part of the Department of Health and Aged Care (DoHAC) funded Dementia Pathway Project, the ACT & SNSW HealthPathways team helped facilitate 4 educational webinars with Dementia Training Australia to support GPs in the early diagnosis and management of dementia. Webinar sessions covered the foundations of dementia diagnosis, mild cognitive impairment and changed behaviours in dementia.



l-r: HealthPathways ACT & NSW Project Coordinator, Bianca Coffey with Support Officer, Melissa Morthorpe and Manager, Gill O'Donnell at the HealthPathways Conference.

4. Greater Choice for At Home Palliative Care Measure

The experience of death and dying has changed considerably in Australia over the last century. Social, economic, and carer circumstances have evolved, and life expectancy has increased alongside a greater prevalence of chronic conditions with complex symptoms and multi-morbidity. This has influenced a shift to larger proportion of deaths into hospitals and residential aged care facilities.

However, being cared for and dying at home is most people's preference. The Greater Choice for At Home Palliative Care (GCfAHPC) measure aims to help make that possible. The GCfAHPC measure provides funding for coordinating palliative care through PHNs. Goals include to:

- improve your access to the best palliative care at home
- support palliative care services in primary health and community care
- make sure you get the right care, at the right time and in the right place to reduce unnecessary hospital visits
- generate and use data to improve services
- use technology to provide flexible and responsive care, including after-hours care.

During Advance Care Planning Week 2024, CHN conducted a face-to-face workshop for Practice Nurses, promoting advance care planning programs and resources. CHN is represented at the ACT Advance Care Planning Networking Meeting, which identifies gaps and enablers in advance care planning and solution brokering across the ACT.

Two workshops were held including a 'Breathlessness' webinar and an evening workshop titled 'Palliative Care in RACF for GPs'. They were well attended by GPs and Practice Nurses. The aim of the second workshop was to increase GP awareness of resources available to them when supporting their patients in residential aged care for end of life. GPs met with services providers such as CALMS, PEACE and GRACE to learn about their service models of care. In collaboration with GPs and RACF palliative care services providers, a 'Residential Aged End of Life Primary Care Resource' was created and sent out to all GPs, CALMS and RACF facilities across ACT. CHN participated in the RACGP palliative care GP training session and promoted CHN palliative care activities.

CHN began chairing the ACT Health Palliative Care Operations Committee and is represented at the Governance Committee. CHN is represented at the palliative care Single Point of Referral and Triage Working Group which aims to create a model of care for consideration of a single point of referral and triage. CHN has collaborated with local palliative care networks and working groups including Palliative Care ACT, Health Care Consumers Association, Carers ACT and other key stakeholders.

CHN supported the Community Health Nursing Team to assess, monitor and respond to physical and psychosocial needs of patients as they approach end of life. CHN has promoted palliative care resources, learning opportunities and programs available to service providers and general practices through GP Liaison Units, CHN newsletters, HealthPathways and social media.

CHN engaged with the sector to design a quality improvement activity, 'Palliative Care in General Practice', to develop strategies to improve linkages, coordinate services and improve access to palliative care in primary care and the community.

Testimonial

GPs attending the Palliative Care in RACF GP Workshop found most valuable the learning on syringe drivers, symptom management, different available services, networking and discussions with colleagues, in developing their knowledge, capability and understanding of palliative and end-of-life care.



CHN's Palliative Care Planning Manager, Ros Kirk with Project Officer, Mirei Churton

Priority Area 3:

People at-risk of poor health outcomes



CHN commissioned services to provide:

COORDINATED CARE FOR PATIENTS WITH COMPLEX HEALTH CARE NEEDS

AOD PRIMARY CARE, COUNSELLING OR CASE MANAGEMENT TO OVER **1000** PEOPLE

A FAMILY, DOMESTIC, SEXUAL VIOLENCE AND CHILD SEXUAL ABUSE TRIAL

3,400 COVID-19 VACCINES TO VULNERABLE PEOPLE

1. ACT Primary Care Pilot

The ACT Primary Care Pilot is a federally-funded collaboration between ACT Health, Canberra Health Services and CHN. It is testing an innovative model to reduce demand on public Emergency Departments, by strengthening integration between ACT general practices and the public health system for people who either attend hospital frequently or are at risk of attending in the near future.

The pilot is supporting general practices to help patients with complex health care needs, and at risk of going to the Emergency Department or hospital, to stay well in the community. By providing a coordinated care program for these patients, the pilot is aiming to improve their health outcomes through early recognition of potential deterioration and the provision of a collaborative intervention.

The pilot which began in 2023 with an initial group of 5 participating general practices, has since expanded to include 15 general practices. GP and Nurse Practitioners (NP) from these practices work closely with Canberra Health Services' Liaison and Navigation Service (LaNS), and their pilot patients to develop a comprehensive care plan and achieve the goals of that plan, to assist the person to stay well in the community. As part of the pilot, GPs and NPs accessed advice from select non-GP medical specialists within Canberra Health Services about how to best manage their patient within the primary care setting. Patients were also able to get timely access to allied health, in particular physiotherapy. As of 30 June 2024, 149 patients had been accepted into the Pilot.

Testimonials

- *"Often in primary health care, the definition of 'consultation' is very restrictive. Thanks to this pilot's funding, the concept of consultation can be broadened beyond the time spent face-to face with the patient, as it supports administrative processes, phone calls with specialists, writing referrals and other processes that are necessary to provide the care that patients require"* - Dr Chris Harrison, Ochre Medical Centre Bruce.

- *"I remember how beneficial the program was to the very first participating patient who had been frequently visiting the hospital for treatment. We were able to provide him with the right treatment and support here, with guidance from a specialist, and he became more independent and significantly reduced his hospital visits"* - Maria Haider, Practice Manager at Oche Medical Centre Bruce.



Dr Chris Harrison, Ochre Medical Centre Bruce.

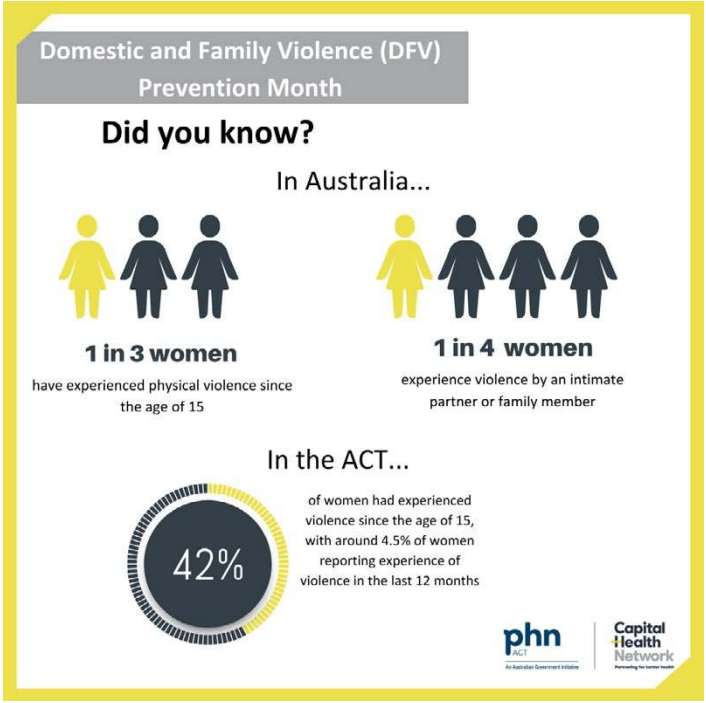
2. Strengthening primary care sector response to family, domestic, sexual violence and child sexual abuse

Family, domestic and sexual violence, including child sexual abuse (FDSV) is a serious public health issue. It can cause significant physical, emotional, psychological and financial harm to those impacted by it. Nationally, about one in 3 women had experienced physical violence since the age of 15, and one in 5 had experienced sexual violence. Approximately one in 4 women and one in 14 men had experienced violence by an intimate partner. On average, one woman is killed by an intimate partner every 10 days.

In the ACT, 42% of women had experienced violence since the age of 15, with around 4.5% of women reporting experience of violence in the last 12 months. Among women aged 18 to 44 years, violence is the single biggest risk factor contributing to disease burden; surpassing smoking, drinking or obesity.

It is estimated that a full-time GP is likely to see up to 5 women per week who had experienced some form of intimate partner abuse in the last 12 months. Primary health care professionals such as GPs are often the first point of health professional contact for victim-survivors of FDSV due to the physical injuries and mental health issues resulting from abuse and violence. As such, primary health care professionals have an important role in prevention, early identification, and responding to disclosures of FDSV.

In 2023, CHN received funding from the Australian Government to establish a Family, Domestic, Sexual Violence and Child Sexual Abuse (FDSV) Pilot in the ACT. The funding forms part of a suite of Australian Government initiatives to reduce all forms of family, domestic and sexual violence against women and children, and supports the implementation of the National Plan to End Violence against Women and Children 2022-23.



FDSV infographics

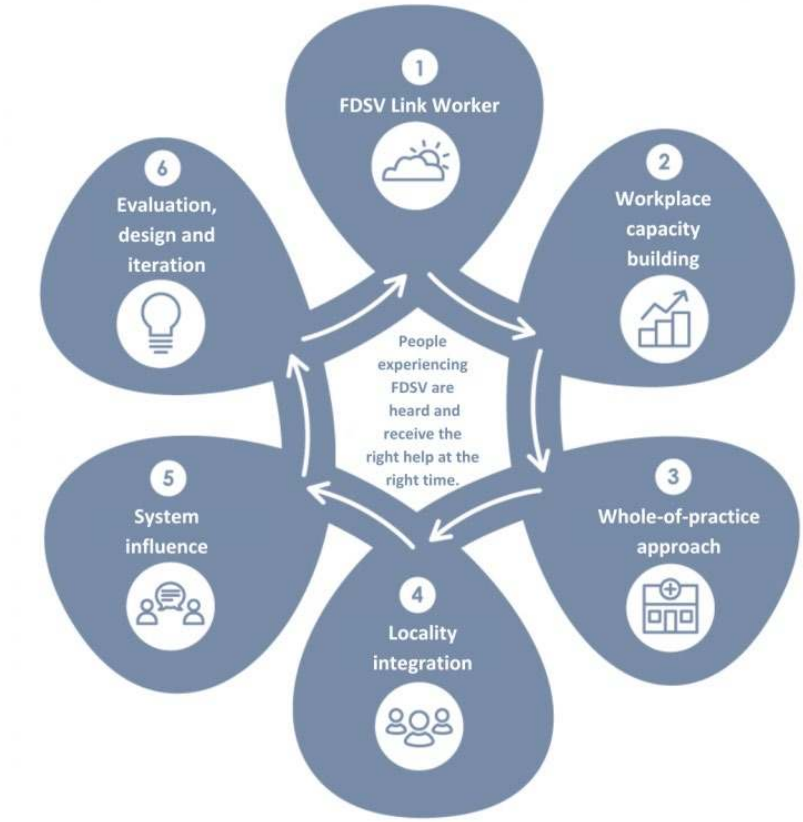
The Pilot aims to support primary health care professionals (general practice staff and broader allied health professionals) in recognising the early signs of FDSV, responding to FDSV using a trauma-informed approach, and facilitating the coordination of referrals to appropriate support services through establishment of FDSV Link Workers embedded within community organisations. The Link Workers will enhance primary health care workforce capacity and capability via whole-of-practice education and training opportunities, and act as a conduit between the primary care and FDSV sector to strengthen and support the provision of care and service navigation for victim-survivors of FDSV within ACT.

CHN's FDSV Pilot builds upon existing domestic and family violence (DFV) pilots which have been underway since 2019-20 in 6 other Primary Health Network (PHN) regions across Australia. CHN is one of the 5 new PHN FDSV pilot sites funded until 30 June 2026. Evaluation data from the existing Pilot sites indicate that the training and support provided by the Link Workers has had a significant impact on enhancing the primary care sector's DFV

capacity and has improved outcomes for DFV victim-survivors. Participating general practices from existing Pilot sites perceived Pilot activities as useful, important, timely, of high quality and much needed, and appreciated the practical resources and tools delivered by Link Workers.

Over the last year, CHN has engaged in a number of planning and development activities, including recruitment of the internal CHN Family Safety team, needs analysis, review of existing resources and training materials, mapping of existing FDSV services, rapid review of FDSV legislations, relationship building with key stakeholders, monthly meetings with the ACT Government's Domestic Family and Sexual Violence Office, and co-design workshops to inform the service delivery model and explore opportunities for collaboration.

In June 2024, following an open tender process, CHN commissioned Domestic Violence Crisis Centre and Canberra Rape Crisis Centre to deliver the Supporting Primary Care Sector Response to Domestic and Family Violence (DFV), Sexual Violence and Child Sexual Abuse Pilot program. The Pilot will support primary health care professionals become part of a multidisciplinary and integrated response to addressing family, domestic and sexual violence, and child sexual abuse.



Recognise Respond Refer FDSV Model
(adapted from Brisbane South PHN DFV Model)



GP Advisor Family Safety, Dr Anita Hutchison

3. Integrated AOD and Primary Care Outreach Services

People who experience drug dependence in the ACT experience stigma, discrimination and ongoing impacts of criminalisation. This leads to a wide range of social and health inequities and requires an integrated approach in providing appropriate health care. Many people experiencing alcohol and other drugs (AOD) dependence need multidisciplinary approaches to primary health care. Many people experiencing AOD dependence have challenges navigating the primary health care system due to a lack of tailored support services and complex needs. Outreach services can reduce barriers and increase access to health services and treatment for vulnerable populations.

Directions Health Services' integrated AOD primary care and counselling/case management outreach and in-reach services provide wrap around, responsive health care to people at-risk of poor health outcomes. The services utilise a drop-in arrangement, optimising practitioner time and the clinics' accessibility to clients. Clients may not have previously accessed health care for lengthy periods, despite having complex needs for many years prior to engaging with the service, due to stigma, previous negative help-seeking experiences and challenges navigating the health care system. The service also includes Pathways to Assistance and Treatment (PAT), Directions' mobile clinic. This custom-built clinic enables Directions' staff to offer the full range of minor procedures and services usually on offer in a standard GP clinic, enhancing clients' access to health care. Mobile in-reach primary care services provided a minimum of 2 days per week, led by a team of nurses and GPs with additional services and supports from AOD counsellors.

Directions continues to provide comprehensive, respectful, non-judgemental support to people who are impacted by AOD, and their families in the ACT and surrounding regions of NSW. Over the last year, the service delivered 208 clinics and supported 1,082 individuals through 3,550 client presentations.

Over the last 6 months, there has been a 12.5% increase in client presentations per clinic. A survey of PAT respondents showed 73% had accessed Directions' services more than 10 times, and more than 89% had accessed more than 5 times. When asked if Directions helped with difficulties in other areas of their lives, demonstrating the holistic impact of the service PAT respondents indicated the following:

- **96.5%** rated the quality of the services they received from Directions as either 'Excellent' or 'Good'.
- **99%** indicated that Directions provides the kind of assistance they want
- **85%** indicated that the services they received from Directions were better than other AOD services they had previously attended
- **99%** were satisfied with the services they received.

Directions' reflection

Since February 2024, the PAT GP and Nurse operating at outreach sites attended 3 emergency calls for help nearby the PAT bus. All 3 emergencies required resuscitations for people experiencing opioid overdose. None of the people assisted were active Directions clients. In all 3 cases, the clients were unresponsive and not breathing when PAT team arrived. The PAT team were able to revive the 3 clients with CPR, including airway management, and administered further doses of Nyxoid. Emergency services attended each resuscitation with Police aiding with chest compressions in one case, and the client's regaining consciousness in the other 2 cases. In each case, it was residents that alerted the PAT team to the overdoses and were actively seeking assistance. In 2/3 cases, residents had already administered Nyxoid (Naloxone) to treat a possible overdose and commenced CPR before the

PAT team arrived. This reflects that the community is responding to the training and awareness of overdose management offered through PAT services and Directions' Needle Syringe Program.

Directions has successfully navigated the Pharmaceutical Benefits Scheme changes regarding Opioid Maintenance Treatment, in particular access to Buvidal depot medication, a replacement in the treatment of heroin and methadone dependence. Prior to Buvidal being listed on the PBS, it was supplied by the wholesaler free of charge to Directions. Once Buvidal was listed on the PBS, Directions were unable to continue sourcing free supplies from the wholesaler – it could only be dispensed by a pharmacy on production of a PBS prescription. This would have resulted in clients being responsible for the co-payment, which ranges from $7.70 for concession card holders per prescription through to around $400 for clients who are ineligible for Medicare.

A workable system has been implemented with an ACT pharmacy that maintains our capacity to provide Buvidal for clients who present on outreach, including opportunistic treatment for clients in withdrawal. Funding from ACT Health to cover the client co-payment has meant clients can continue to access Buvidal free of charge.

4. Vulnerable Populations COVID-19 Vaccination Program

In response to the low vaccination numbers in vulnerable populations, the Department of Health and Aged Care (DoHAC) funded the Vulnerable Populations COVID-19 Vaccination Program to support activities at a local level to remove barriers to vaccination.

The Vulnerable Populations COVID-19 Vaccination Program funded general practice, pharmacies, and other health and community care providers to undertake activities to promote and support COVID-19 vaccinations to vulnerable groups. The funding also covered the cost of vaccination for non-Medicare patients.

Activities included:

- In-reach clinics e.g. Residential Aged Care Homes (RACH), Supported Disability Accommodation or Supported Independent Living residents, embassies, sex on premises locations
- Pop-up clinics e.g. held in community facilities or events
- Mobile clinics e.g. vaccinations offered from a purpose-built van at locations responsive to need
- Clinics at the general practice or pharmacy
- Support to access vaccination e.g. transport
- Vaccinations in home to those who are homebound
- Resource development to support people with language barriers.

Over the last year, CHN commissioned the following providers to deliver these services:

- Women's Centre for Health Matters
- Meridian Incorporated
- Gungahlin Square Priceline Pharmacy
- Amcal+ Pharmacy Belconnen
- Next Practice Deakin
- Directions Health Services
- Erindale Pharmacy
- Company Medical Services
- Erindale Healthcare
- Gungahlin Family Healthcare
- Guardian Pharmacy Belconnen
- Interchange Health Co-Operative.



These providers delivered 3,450 COVID-19 vaccines over the last year, including:

- 263 vaccines to individuals who are non-Medicare eligible
- 88 vaccines to individuals homebound
- 111 vaccines to individuals in isolated communities
- 23 vaccines to Aboriginal and Torres Strait Islander people
- 146 vaccines to aged care and disability workers
- 39 vaccines to children 5 - 11 years
- 346 vaccines delivered to people from Culturally and Linguistically Diverse communities
- 2207 vaccines delivered to people who are frail and have a disability
- 22 vaccines delivered to people who are homeless.



Gungahlin Square Priceline Pharmacy mobile COVID vaccination clinic.

Testimonials

- *"We held an off-site vaccination clinic at Ngunnawal Pantry, where we vaccinated a neurodivergent child. The mother had told us that she had taken him to the doctors twice to be vaccinated but as he panicked it put him at risk of a needle stick injury. She asked if we could vaccinate him while he was comfortable sitting in their car and playing a game on his device. I went in the car and asked him if I could give him a vaccine. He said OK. His father was sitting next to him, I was able to vaccinate him smoothly without any problems."* - Amcal+ Pharmacy

- *"A client reported that the full suite of services they receive at 'Chat to PAT' mobile health clinic has made a positive impact for them and they would not otherwise have access to health professionals to help them or to stay up-to-date with their COVID-19 vaccine."* - Directions Health Services

- *"Several RACH had a substantial number of residents ready for their 6-month booster, so our team were able to attend and vaccinate quite a lot residents at the same time, which was logistically more efficient than repeated visits. This ensured residents were up to date with their COVID-19 vaccine over the Christmas period."* - Next Practice Deakin

Priority Area 4:
Mental Health



CHN's commissioned mental health services provided support for:

OVER **1,500** PEOPLE THROUGH PSYCHOLOGICAL SUPPORT SERVICES	**1,280** YOUNG PEOPLE	**282** FIRST NATIONS PEOPLE	**473** PEOPLE LIVING WITH A SEVERE MENTAL ILLNESS
255 PEOPLE FOLLOWING A SUICIDE ATTEMPT	**121** PEOPLE THROUGH PEER WORKERS		**68** PEOPLE FROM THE LGBTIQA+ COMMUNITY.

1. ACT Mental Health and Suicide Prevention Strategy

The ACT Joint Regional Mental Health and Suicide Prevention Plan 2019-2024 (the ACT Plan) was first developed and released in 2019 by CHN, in partnership with ACT Health, Canberra Health Services, the Office for Mental Health and Wellbeing, the ACT Mental Health Consumer Network, Carers ACT and the Mental Health Community Coalition. The ACT Plan aimed to guide parties in working together to identify and address the mental health and suicide prevention priorities of the ACT region. As the life of this Plan reaches an end this year, CHN and ACT Health identified a need to build on the learnings and achievements of this plan to inform future collaboration on mental health and suicide prevention policy, planning and activities, and to work in partnership to address community needs and improve outcomes for people in the ACT.

To address this need, CHN commenced a partnership with ACT Health to develop a joint ACT Mental Health and Suicide Prevention Strategy (the Strategy), which will establish key principles and directions for mental health and suicide prevention activities within the region over a 10-year period. This Strategy will fulfill the role of the next iteration of the ACT Plan, and inform whole-of-system planning, development, and delivery of health systems through a value-based lens. CHN and ACT Health worked together to define this role, review the previous ACT Plan, determine the scope of the Strategy, commence early stakeholder engagement, and develop a plan for consultation, governance and shared project management.

CHN and ACT Health jointly initiated a Development and Implementation Committee to leverage the breadth of knowledge and expertise across government and community for the Strategy. This marked the start of a new stage of joint regional planning and collaborative commissioning for mental health and suicide prevention in the ACT, supporting integrated mental health care, better use of limited resources, a connected health system, and positive health outcomes for our community.



ACT Mental Health Minister, Emma Davidson (right) with Acting CHN CEO, Julie Blackburn.



Acting CHN CEO, Julie Blackburn with Mental Health Consumer Network Chair, Paul Thompson

2. Child and Youth Mental Health Sector Alliance

CHN, ACT's PHN worked in partnership with the Office for Mental Health and Wellbeing (the Office) and the Youth Coalition of the ACT to understand the challenges experienced by children and young people with moderate to severe mental health concerns. Together, we learned the complexity of these issues and found that a range of barriers to support exist at both the service level and the system level, including outside the mental health sector. To address these barriers, a different way of working across sectors was required to support better coordination and collaboration.

In 2023, CHN, the Office and the Youth Coalition established the Child and Youth Mental Health Services Alliance (the Alliance), after a co-development process with a range of stakeholders. The Alliance enables a structured, formal mechanism for multiple stakeholder groups to connect and work collaboratively across a fragmented system, towards a common goal of improving service system responses for children and young people. The Alliance aims to be responsive at a range of levels – from high-level strategic planning, through to supporting frontline workers to connect and improve practice. This has led to the Alliance being supported by a range of components which have all been built over the last year, including:

- backbone support and governance, enabled by the 3 lead agencies and a Coordinating Committee that includes government, community and lived experience representation
- strategic coordination and collaboration, through bi-annual Alliance forums, a youth reference group, and Alliance working groups that progress specific issues
- practice, information sharing, and connection, through a community of practice, an Alliance website, and monthly e-bulletins.

Enabled by these components, the Alliance has identified 2 key priorities to be initially progressed by the working group: improving young people's experiences of mental health services and improving service and system responses for people with complex or co-occurring concerns. The working group has developed projects to address these priorities.

The goal of the Alliance is to make the invisible visible – through naming the challenges and barriers occurring in the system and having clear and transparent processes. In its first full year of operation, the Alliance has taken substantial actions towards this and seen some positive early outcomes. The Alliance enables different parts of the system to work together to begin solving systemic problems, and breaking



Erin Barry (left), Director - Policy and Evaluation, the Youth Coalition of the ACT and Stephanie Lentern, Mental Health and Suicide Prevention Manager, Capital Health Network leading a planning activity with the Child and Youth Mental Health Sector Alliance Working Group

down silos between services, sectors, and with young people and families. It is building shared understandings of issues and priorities, and pooling knowledge and scarce resources for genuine system outcomes that cannot be achieved by one individual or organisations on their own.

In addition to the direct work of the Alliance, the connections and conversations occurring through those activities act as a common shared platform enabling organisations to come together. for additional work to occur. Key enablers that support these early outcomes include a collaborative and trust-based relationship between the 3 lead agencies that allows the Alliance to be co-owned across our PHN, government and community; inclusion of youth lived experience; and strong engagement and commitment across the membership. The recognition that child and youth mental health is a whole of community issue allows a range of system players to work together to improve mental health outcomes. The collaboration and integration created by the Alliance exemplifies the power of a unified voice in creating change.

3. Adult mental health centre

a) Canberra Medicare Mental Health Centre

Free Medicare Mental Health Centre sites (previously known as Head to Health) operate around Australia and offer an entry point for adults to access a range of mental health services, without needing an appointment or referral. These services address fragmentation in the mental health service system and enhance local service integration to offer a seamless care pathway for consumers to receive the right level of care, at the right time, to meet their mental health needs.

Canberra Medicare Mental Health Centre provides accessible, person-centred, high-quality care to support adults. This includes immediate support or de-escalation for people in distress, including those at heightened risk of suicide, to reduce the need for Emergency Department attendance. Appropriate warm hand-over to acute services for crisis management is provided, when necessary.

The program aims to reduce risk and demand for these acute services by providing timely person-centred support for people experiencing situational or emotional distress. This includes providing a safe place to present in distress and offering continued contact and follow-up support through an episode of care model, until individuals are either in recovery or connected to services to meet their ongoing needs. Digital assistance is also available through a phone service and online enquiries. In addition, Canberra Medicare Mental Health Centre (MMHC) maintained close referral relationships with local emergency, acute and front-line services to allow ease of access when needed and ensure safety for clients and staff.

In recognition of ongoing demand and, often, complexity of those accessing intake services, additional resources were allocated to the phone service during recent months. Additional projects and expansion of high demand services were also undertaken, such as additional Dialectical Behaviour Therapy (DBT) training and support, including specialised supervision, and a ‘summer school’ DBT program to support consumers during a period with typically less available services.
The MMHC has continued to provide much sought after assessment and referral services to a broad range of ACT individuals, along with a range of intervention services provided to those with moderate to high needs. While digital options are offered, 80% of initial assessments were performed in person at the MMHC. The numbers of consumers coming through the service indicates its profile is growing and the service is addressing an unmet community need, with 2,171 contacts, 4,913 sessions and 334 psychiatry appointments being provided over the last year.

Client story

Aditi* (not her real name) presented at Canberra Medicare Mental Health Centre and engaged with the intake team who completed an Initial Assessment and Referral using the Initial Assessment and Referral Decision Support Tool. Aditi presented with symptoms of acute stress, distress and low mood, following a violent incident. They received a comprehensive mental health assessment with a Mental Health Clinician, with a diagnosis of acute Adjustment Disorder.

Aditi completed 16 sessions of standard psychological therapy, with a trauma-informed cognitive behaviour therapy approach, incorporating mindfulness exercises. The Clinician liaised with Victims Support ACT to ensure that Aditi would have ongoing therapeutic supports at the end of her episode of care. Aditi expressed a desire to engage with more social supports in the community. The Clinician facilitated a warm referral to the ACT Walking for pleasure group, which Aditi found to be a good fit for their needs.

At the completion of the episode of care, Aditi reported marked improvement in their distress and range of symptoms. This improvement was reflected in their responses on the standard outcome measures and daily functioning and hopefulness for the future. Aditi was appreciative of the service she received at Head to Health reporting it to be “fabulous.” The discharge plan for Aditi was that she would continue engaging with ongoing support through Victims Support and the ACT Walking for Pleasure group, and to re-engage with Head to Health if required in the future.



b) Tuggeranong Medicare Mental Health Centre

Mental health and wellbeing continue to pose major challenges for the ACT, affecting individuals, communities, services and systems. In the 2020-2022 National Study of Mental Health and Wellbeing, 45.7% of ACT residents had been diagnosed with a mental health condition at some point in their lifetime, while 25.5% had experienced a mental health disorder in the last 12 months. Some of these ACT residents remain unable to receive the right care to meet their individual needs, due to accessibility challenges and difficulty navigating the complex mental health system.

In 2023, the Commonwealth Government announced funding for the establishment of a second Medicare Mental Health Centre (MMHC) (formerly Head to Health) in the ACT. MMHCs are designed to address fragmentation in the mental health service system and enhance local service integration to offer a seamless care pathway for consumers to receive the right level of care, at the right time, to meet their mental health needs. Following a needs assessment process, Tuggeranong was selected as the location for the new MMHC, with the aim of improving access to mental health services in the Tuggeranong region. Building off the success of the Canberra MMHC (formerly Canberra Head to Health), which was established in 2021, the Tuggeranong MMHC will ensure that more Canberrans can access mental health support and have their needs met.

Over the last year, CHN initiated planning and development activities to support the establishment of the new Tuggeranong MMHC, including early consultation, connecting with a working group to explore local community needs, exploring opportunities for co-location, site search processes, and commencement of procurement processes for a lead agency for the service. Tuggeranong MMHC will provide an accessible and highly visible entry point to services for people experiencing psychological distress, including person-centred, high-quality, and culturally safe assessment, navigation support and mental health interventions. The Tuggeranong MMHC is expected to commence service delivery by the end of 2024.

4. Mental health services for young people: headspace

The ACT has 2 headspace centres, one in Tuggeranong and the other in Braddon. CHN, ACT's PHN, commissioned Grand Pacific Health to operate both centres, as the lead agency. ACT headspace centres work to build the resilience of young people (12-25 years) by delivering effective youth mental health services in partnership with young people, their families and their local communities. Over the last year, headspace Canberra and headspace Tuggeranong delivered services to 1,280 young people, of which 799 young people came to a headspace centre for the first time. Service demand is reflected through the 5,187 occasions of service. headspace Tuggeranong exceeded national averages in service delivery.

The following headspace services were delivered:

- **Mental Health Counselling** - delivered by qualified mental health practitioners offering time limited, evidence-based counselling services.
- **Online and phone support** - headspace has a range of ways to support young people both online or by phone. Young people can get support for their mental health by simply creating a headspace account.
- **GP support** - support to address physical and sexual health issues, as well as mental health consultations by a GP skilled in working with young people.
- **AOD support** - support to address issues with Alcohol and other drugs delivered on site by Directions Health.
- **Individual Placement and Support Program** - provides in person, one-on-one support for your work and study goals. IPS Vocational Specialists will collaborate with a young person's mental health worker to ensure the support they receive helps them achieve their goals.
- **Peer support** – access to a trained peer worker, who uses their own experiences of a mental health issue to provide support and role modelling as well as linking with services and supports both within headspace and the community.
- **Care coordination** - support to link with the services and supports in the community that can support recovery.
- **Family Supports** - individual and group interventions that can support families and friends to more effectively support their young person's recovery.
- **Volunteering** - opportunity for young people to join the Youth Reference Groups and work with other young people to inform service delivery in the centres and deliver community activities.
- **Community Engagement** - a range of community development and education programs delivered in partnership with other agencies across the Canberra region.

Client story

Good news story – headspace Canberra

A young person attended headspace Canberra and was seeing a Youth Counsellor under the 6-session model. The young person presented with severe anxiety, poor school attendance and performance, as well as constant arguments with her parents at home. During the sessions, the young person reported that constant bullying and peer pressure from her peers led to the deterioration of her mental health, which also led to deliberate self-harm and hospitalisation.



headspace Canberra staff with CHN staff.

The Clinician worked on coping strategies such as breathing techniques for when the young person felt overwhelmed, as well as assertive communication strategies when the young person felt she was being peer pressured, to prioritise her boundaries.

During one of the sessions, the young person's mother was present where it was discussed that the young person would like to move schools to be with her other friends. The young person stated that her parents didn't listen to her. Her mother began to cry as she conveyed that she had become frustrated and numb over the same stories of bullying and that she didn't know what to do anymore. The clinician discussed with the mother that the young person may just need someone to listen and validate her feelings so she could express her difficulties at school, to which the young person's mother agreed. With the help of a Youth Care Coordinator at headspace Canberra, a support letter was developed.

A few weeks later the Clinician received an email from the young person's mother, stating that the young person wasn't needing to attend headspace anymore as she had successfully transferred into the new school. The young person was settling in well, had been attending all her classes, that there had been no conflict at home, and most importantly was very happy. The young person had also discussed strategies in session to avoid self-harming behaviour and utilised the sessions to talk about her own beliefs and motivations for not engaging in self-harm.

5. headspace Early Psychosis Canberra

In 2022, CHN received funding from the Australian Government for the establishment of a headspace Early Psychosis (hEP) site in the ACT under the Early Psychosis Youth Services (EPYS) Program. This program aims to reduce the incidence and severity of psychosis within the community through prevention, early detection and coordinated care delivery for young people aged 12-25.

In 2023, CHN underwent procurement for a lead agency to deliver the hEP service, and following a competitive open tender process selected Uniting NSW/ACT as the provider. Uniting were able to initiate their comprehensive service planning activities and have been working closely with local providers to enable connected and high-quality supports, including Grand Pacific Health's headspace Canberra team, where the hEP service will be integrated.

CHN commissioned JLL to provide comprehensive support to CHN, Uniting and Grand Pacific Health to understand and navigate the local real estate environment and aided the lead agency in securing a new site for hEP Canberra. The existing headspace Canberra service will also relocate to the new location in 2025.

CHN continued to support establishment activities for the service throughout the year, including leading community consultations, assisting with key governance and service delivery documentation, and facilitating relationship-building between hEP and key local stakeholders. hEP Canberra is anticipated to commence service delivery in the 2024/25 and will enable young people to access free specialist mental health support in an accessible, youth-friendly environment.

Testimonials

Uniting NSW.ACT Director of Communities, Dr Andrew Montague said that Uniting NSW.ACT is excited to deliver the first headspace Early Psychosis program in the ACT.

> *"headspace Early Psychosis supports 12–25-year-olds that are experiencing a first episode of psychosis or are at ultra-high risk of developing psychosis. headspace Early Psychosis is all about intervening as early as possible to provide young people with the supports they require to live full healthy lives. Uniting is confident this new service will make a significant impact on young people's lives in Canberra,"* said Dr Montague.



l-r: Assistant Minister for Mental Health and Suicide Prevention Emma McBride, Federal Member for Canberra Alicia Payne, Capital Health Network Acting CEO Julie Blackburn and Head of Uniting Recovery Chantal Nagib attending the headspace Early Psychosis announcement at headspace Canberra.

6. Initial Assessment and Referral Program

The Initial Assessment and Referral (IAR) program is a Commonwealth Government initiative embedded within PHNs, which aims to support the primary care and mental health workforce to provide and improve access to tailored mental health care, in line with the stepped care approach to service delivery. Over the last year, CHN focused on developing and localising the IAR program to deliver local and value-based training to ACT's GPs, mental health clinicians and other members of the primary mental health care workforce. This training enables clinicians to use the IAR Decision Support Tool (IAR-DST), an evidence-informed tool that can be used in conjunction with clinical judgement and expertise to support mental health referrals and recommendations. Local IAR training is delivered by CHN's accredited Training and Support Officer (TSO).

Local training was delivered for the first time in the ACT when CHN's training program began in February 2024. Since then:

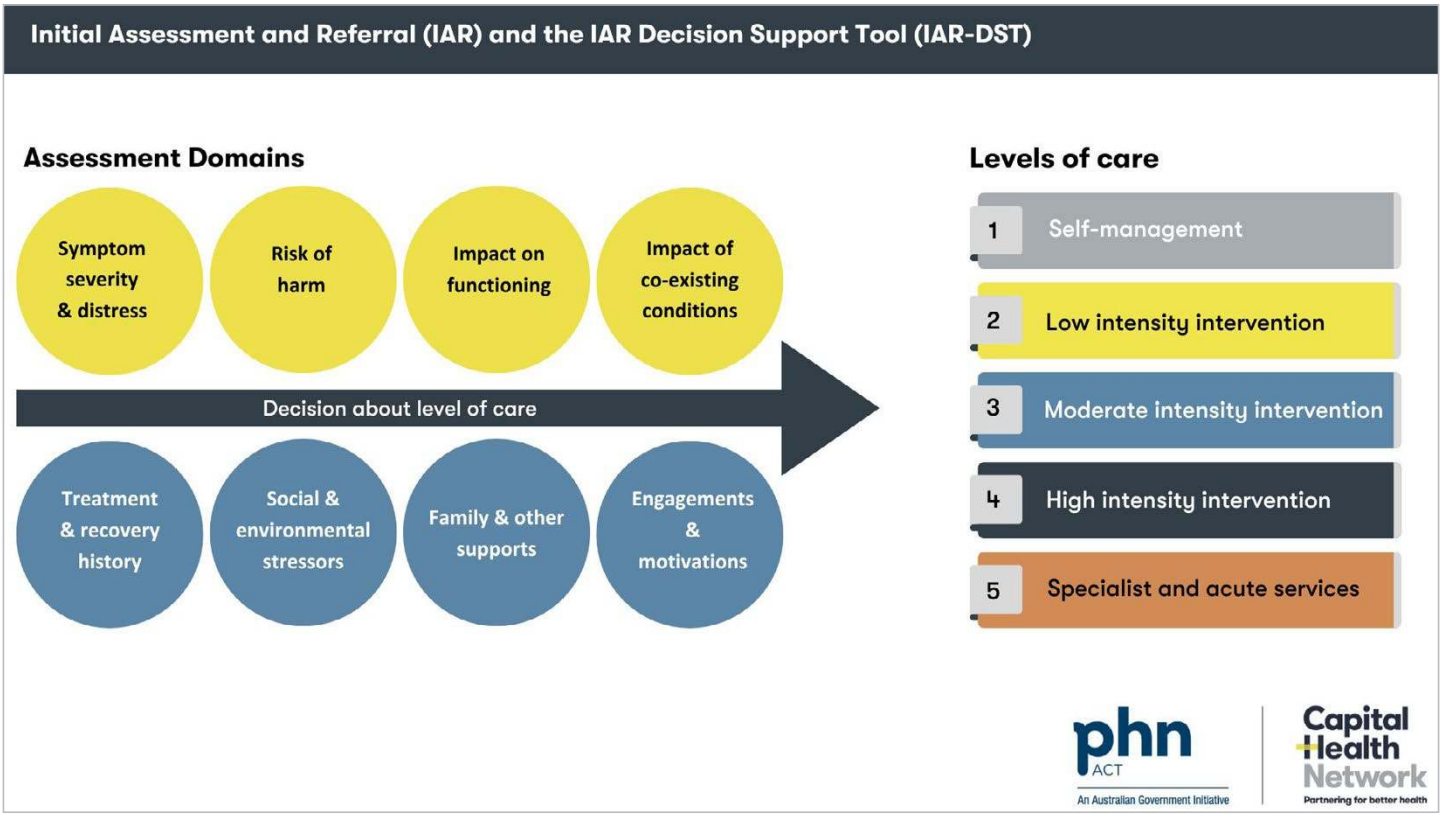
- 6 locally delivered training sessions were conducted
- 18 total participants were trained
- 11 GPs were trained: 8 through CHN's local training program; 3 through national training.
- consistent positive feedback was received from GPs and other clinicians on the local delivery of the training

Alongside the planning, commencement and delivery of the local training, CHN has supported the IAR program through a number of activities. This has included service mapping of CHN's commissioned mental health, psychosocial and AOD services, to develop a resource that can support clinicians to make high quality mental health referrals and also provide a useful snapshot of local services for broader stakeholders. CHN also established an internal IAR Working Group and developed numerous external stakeholder relationships, to promote collaboration, support and understanding of the value of the IAR across the wider community.

Testimonials

Some comments from training participants:

- *"It's a useful tool to establish which patients would possibly benefit from either a community level of care vs GP lead and Psychologist."*
- *"Great presenter, very encouraging and supportive."*
- *"Very good webinar, engaging and interesting."*
- *"I will engage more with the tool (IAR-DST) and Head to Health."*
- *"A useful tool that can be utilised for patients to risk stratify them into appropriate level of care."*



7. Suicide Prevention

The causes of suicide are multifactorial, strongly linked to social determinants of health and wellbeing, and are unique for each region and community. As a result, there is a need for suicide prevention strategies that are adapted to engage local communities and can span across sectors. A systems-based approach to preventing suicide and suicidality enables a pathway for promotion of protective factors, compassionate response to early signs of distress, and social, emotional and cultural wellbeing. This is the rationale for CHN's Suicide Prevention Program, established in July 2023 as part of the national Targeted Regional Initiatives for Suicide Prevention (TRISP) Program.

CHN has adopted a community-led and systems-based approach to building initiatives that respond to the specific needs of the ACT community, including targeting populations identified at risk of suicide or suicidal distress in our region. To enable this, CHN established the ACT & Region Suicide Prevention Community Collaborative (the Collaborative), which was formed in the spirit of collaboration and integration across individuals, government and non-government agencies who are committed to suicide prevention at a community level in the ACT. The Collaborative has over 50 members from multiple sectors and roles.

A key initial activity of the Collaborative was planning and prioritisation for CHN's commissioning of TRISP initiatives in the ACT. This included workshops and consultation where the Collaborative considered and unpacked which population groups in the ACT were at increased risk of suicide or suicidal distress, and planned for how best to target and support these groups. The Collaborative's shared planning and prioritisation facilitated the establishment of 3 sustainable initiatives aimed at supporting men and multicultural communities in the ACT, and has informed broader planning for suicide prevention for CHN and the wider system.

8. Mental health support: Next Step

The ACT experienced increased demand for health care service delivery for people experiencing mild to severe mental illness and complex mental health issues. There was a need for services to improve suicide prevention and address service gaps in the provision of psychological therapies for people in underserviced and hard to reach populations.

Next Step is a mental health stepped care program which provides free and confidential Low and High Intensity psychological support services for people of all age groups. The Next Step program is based on the UK's Improving Access to Psychological Therapies (IAPT) model, where clients presenting with symptoms are assessed and then 'stepped' into a low or high intensity mental health service that best suits their needs. Next Step services are offered by trained clinical and non-clinical workforces who provide Cognitive Behavioural Therapy (CBT) to help participants work through difficult times in their life that impact the way they function day-to-day.

Over the last year, 1,061 new clients were seen through the Next Step Program, with 2,948 Low Intensity occasions of service and 4,719 High Intensity occasions of service delivered. During the later part of this reporting period, there was a large growth in youth services for young people under 18. Compared to the same time the previous year, youth services increased for both High Intensity (29%) and Low Intensity (16%). There was also a 23% increase in referrals for children under 12 and a 12.5% increase in High Intensity adult referrals.



Marymead CatholicCare's Next Step team.

Client testimonials

- *'The coach clearly explained things to me, even in my frazzled state. I appreciated her structured, firm and encouraging approach. She was extremely professional, knowledgeable and was also wise and kind with me when I needed it. I felt patronised by other agencies but not at all with Next Step.'*

- *'I specifically enjoyed the structure of the program and that I was able have the same Therapist who I connected with very well. The Therapist kept the sessions on track which was perfect for my needs. It's a proactive course and regardless of the complexity of my issues, it worked very well for me.'*

- *'My Therapist quickly realised what worked for me and tailored our sessions accordingly.'*

- *'My daughter received treatment, and she learnt to manage situations much better. As a teenager it can take several years working through the growth of life to manage mental health, because each month can bring new experiences. I feel there is still much guidance she can benefit from through Next Step.'*

- *'My clinician was the most incredible Therapist. I have been to multiple sessions with other Psychologists doing the same CBT treatments and none have made such an impact. I have decreased my overall anxiety by miles, all thanks to her.'*

9. Mental health services for the LGBTIQA+ community: Inclusive Pathways

LGBTIQA+ communities in the ACT have diverse health needs. Historically, health services have not had a strong understanding of the mental health needs of LGBTIQA+ communities. Prevailing social stigma and discrimination have led to greater barriers to accessing health services and poorer mental health outcomes. Therefore, there is a need for community-oriented and person-centred mental health services that identify and understand the intersectional needs of the ACT LGBTIQA+ community.

CHN, ACT's PHN, commissioned Meridian to run the Inclusive Pathways program to provide high-quality and trauma informed evidence-based psychological therapies and psychosocial strategies to the LGBTIQA+ community that live/work/study in the ACT. The program fosters mental well-being and resilience within the LGBTIQA+ community, continuing to set benchmarks in inclusive and accessible mental health care. With a strong and unwavering demand for services, Inclusive Pathways operates at full capacity while also effectively managing a waitlist. In addition, over the last year it also ran group activities and hosted a Master of Clinical Psychology student and a Master of Social Work student on placement, both of whom contributed to the delivery of safe, high-quality, evidence-based, and trauma-informed mental health services to the LGBTIQA+ community in the ACT. Resulting in an offer of employment to the Master of Clinical Psychology student at the end of their placement.

Through its comprehensive and individualised approach, Inclusive Pathways provides invaluable support to individuals with diverse lived experiences. By combining evidence-based psychological strategies with specialised care, the program empowers clients to address mental health concerns and explore their identities with an affirming and inclusive approach.

Over the last year, Inclusive Pathways provided support to 68 clients. Of those who participated in the program, 99% felt safe to be themselves and accepted, 96% felt their experiences and needs were understood, 83% showed improved emotional wellbeing and resilience and 81% reported improved health and wellbeing. Meridian also recently launched its GP/Nurse primary health services which included support for Inclusive Pathways clients in accessing a Mental Health Treatment Plan (MHTP) at no cost.

Engaging with peer-informed and lived-experience clinicians in a LGBTIQA+ affirming practice has consistently resulted in significant reductions in psychological distress across a diverse range of client needs. These outcomes not only reflect the effectiveness of tailored support. Each client received personalised care that included thorough assessments of their psychological and emotional needs, leading to the development of structured treatment plans aimed at achieving specific therapeutic goals. By integrating these elements into practice, clients received holistic and effective psychological interventions that promoted long-term well-being and resilience. This approach underscores the importance of inclusive and competent psychological services in supporting individuals as they navigate complex life challenges and diverse identities.

Client story

Samuel* (not his real name) sought psychological support to address gender dysphoria. Samuel was struggling with alcohol use and had broad and complex needs beyond specific mental health needs, including risk of homelessness, financial distress, social isolation, and lack of formal and informal support.



A personalised care plan was created with Samuel to address both alcohol use and gender-related health goals. Access to gender-affirming health care, and other inclusive support services catering psychological and non-psychological needs was facilitated. Samuel sought assistance at a residential Alcohol and Other Drug (AOD) service to manage their substance use.

Samuel expressed the intention to return to our service once their substance use was appropriately managed through the residential AOD program. A plan was put in place to resume support upon Samuel 's return, ensuring a more structured and effective approach to addressing both gender dysphoria and substance use. This case study highlights the importance of integrating substance use management strategies into the treatment plan for clients experiencing gender dysphoria, particularly when their behaviours pose challenges to the therapeutic process. By addressing both aspects simultaneously, a more comprehensive and tailored approach can be taken to support individuals on their journey towards improved mental health and well-being.

10. Support following a suicide attempt: The Way Back Support Service

Suicide and intentional self-harm are tragic and preventable health issues in Australia. In 2023, the national reported suicide rate was approximately 9 deaths per day (AIHW, 2023). A total of 934 suspected or confirmed suicide deaths was recorded for the full year in 2023. People who have attempted suicide or experienced a suicidal crisis often experience severe distress in the days and weeks immediately afterwards, and they are at high risk of attempting again. Providing individuals with support at times when they are most vulnerable is critical to ensuring that support is effective in achieving safety. Presenting at and/or being admitted to hospital following a suicide attempt or suicidal crisis is a time of heightened risk, therefore health interventions must support vulnerable individuals when transitioning out of acute settings and into the community.

CHN, ACT's PHN, commissioned Woden Community Service (WCS) to deliver The Way Back Support Service (TWBSS) to support people in the first few months following a suicide attempt. People who have experienced a suicide attempt are referred to the program by Canberra Health Services (CHS) hospital emergency department and mental health units for follow-up psychosocial support which can last up to 12 weeks. This is seen as a critical suicide prevention aftercare response for a person at a high-risk time and is a key element of the Lifespan integrated framework for suicide prevention. WCS provides integrated and person-centred care to vulnerable individuals to empower them to feel healthier and more confident about their future.

Over the last year, The Way Back Support Service received 255 referrals, 194 were directly following a suicide attempt and 61 presented as high risk of attempting suicide. It continues to receive overwhelming positive feedback from clients, with 100% of those participating positively reporting satisfaction with the service, that the staff was supportive and understanding and that they were encouraged towards recovery. The Way Back Support Service's leadership collaborated with external partners, including ACT Health, CHN and Canberra Health Services to introduce a new role and streamline referral processes, with a focus on improving efficiency for both CHS and WCS staff. WCS successfully embedded this new role within the TWBSS structure. Through regular in-service visits with external stakeholders and extensive networking, this role contributed an increase of referrals between July-Dec. 2023 to Jan-June 2024 of 32%. Over the last year, TWBSS recorded the highest number of referrals and active participants in over 2 years.

Client story

Leopold* (not his real name) was referred to the service following an interrupted suicide attempt and ongoing suicidal crisis. Stressors included difficulties at work from the intense office environment and high expectations, which resulted in temporary leave from work and uncertainty about whether he would continue with the same organisation. Leopold also had concerns with alcohol use and poor help seeking behaviours. Leopold identified a desire to work on his alcohol dependency, with the view to accessing outpatient service. Leopold opted to use TWBSS support to discuss the previous week and plan the upcoming week. He commented that this was very useful and appreciated the time and space provided.

During the support period, Leopold returned to work, having resolved some key areas of concern with his Manager, and attended Alcoholics Anonymous (AA) meetings. Leopold opted not to access an outpatient unit at this time as he felt well supported by AA and had developed good natural support which had become a valuable part of his recovery. Safety planning was reviewed frequently throughout the support period, with attention paid to recognising warning signs and what actions were required to manage these. Leopold noted improvements with recognition of warning signs and noted an overall reduction in distressing signs and consequently reduced alcohol intake and better connection with family.



"You have been amazing and really helped me a lot. I am so grateful you have been there and followed up. It's kept me on track," said Leopold.

11. Psychosocial support for people with severe mental illness

Within the ACT are people who live with severe mental illness and associated psychosocial functional impairment. As some are unable to access the National Disability Insurance Scheme (NDIS), this lack of support led to a need for more intense and acute health services and potentially higher than necessary unplanned or crisis driven uses of the health system.

Through the Commonwealth Psychosocial Support Program, CHN has funded 3 services in the ACT to provide recovery-focused psychosocial supports to people living with severe mental health illness and issues. Over the last year, Woden Community Service (WCS), Flourish and Directions Health Services successfully delivered the Commonwealth Psychosocial Support Program to a total of 473 participants, over 6,518 occasions of service and 282 peer group sessions.

a) Woden Community Service – New Path

CHN, ACT's PHN, commissioned Woden Community Service (WCS) to deliver New Path, an early intervention recovery program for people whose ability to manage daily activities and to live independently in the community has been seriously affected by their mental health issues. Participants receive support through a range of co-designed activities linked to an individual recovery plan.

The New Path program supports people typically aged 18 to 35, and up to 64 years of age. Over the last year, 231 participants through 2288 occasions of service. All participants indicated they had a positive experience with New Path.

The Commonwealth Psychosocial Support Program (CPSP) has experienced high demand for services and meaningful outcomes for participants accessing both group and individual supports. WCS participants have been supported to achieve a wide range of personal recovery goals. Many have used practical support to pursue employment, volunteering or education, and have built strong support systems to help maintain their independence. Participants have also received support to improve their mental wellbeing and develop skills in resilience, problem-solving and emotional regulation through therapeutic interventions.

WCS reported significant achievements among those accessing group-based supports. Many participants have transitioned from relying heavily on staff to achieving greater independence and are now confident forming peer relationships. Others have organically taken on senior peer roles within the groups and are proactive in welcoming new members.

Client testimonials

- *"I really enjoy the groups; they get me out and about interacting with other people in a safe environment. They provide social connection and improve my wellbeing."*
- *"I feel like my life is back on track and that I am now doing the things I am meant to be doing."*
- *"Before the program, I felt lost and now, all-in-all, I feel positive, and I feel happy because I know my path."*
- *"I felt heard every step of the way, I was treated with dignity and kindness and given hope for my recovery."*

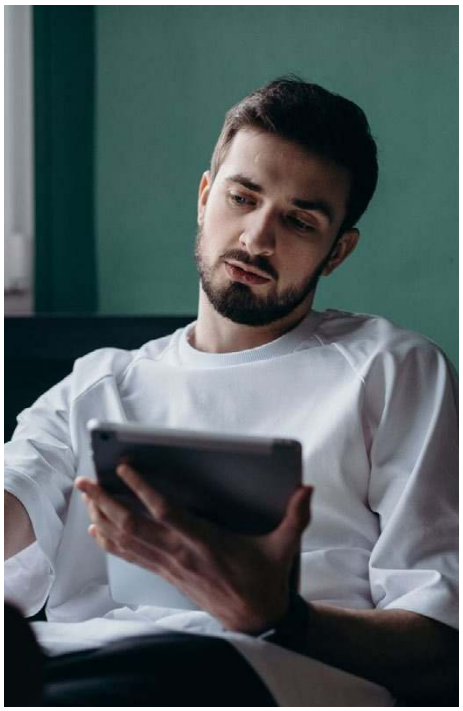
Client story

Amihan* (not her real name) was referred to New Path for support to increase her wellbeing and independence. A Peer Worker supported Amihan to identify a range of recovery goals aimed at improving her confidence and independence, including re-engaging in education and employment. Amihan faced significant challenges, including persistent anxiety and depression, and struggled with associated shame and stigma. To address this, Amihan's Peer Worker provided a safe environment to engaged in supportive discussions to navigate these emotions and improve emotional regulation. Through these dialogues, Amihan learned self-care practices, strategies to reframe negative thoughts, and improve her ability to identify and acknowledge her achievements.

Amihan was supported to address her situational anxiety, which she identified as significant barrier to employment. The Peer Worker provided emotional support through safe storytelling and practical strategies to navigate feelings of significant discomfort in social settings, including mock interviews. Amihan actively participated in resume enhancement and job interview preparation, displaying newfound confidence in pursuing employment opportunities. Amihan's mental health significantly improved over time, with reduced anxiety and depression symptoms, and increased hopefulness. This enabled Amihan to reengage in study and successfully complete her Bachelor's degree, showcasing her commitment to personal and professional growth. Amihan has now gained full-time employment as a gardener and tutor and feels well positioned for future career opportunities. Amihan's journey with New Path, which included 7-months of weekly support, highlights the transformative impact of tailored support in overcoming mental health challenges.



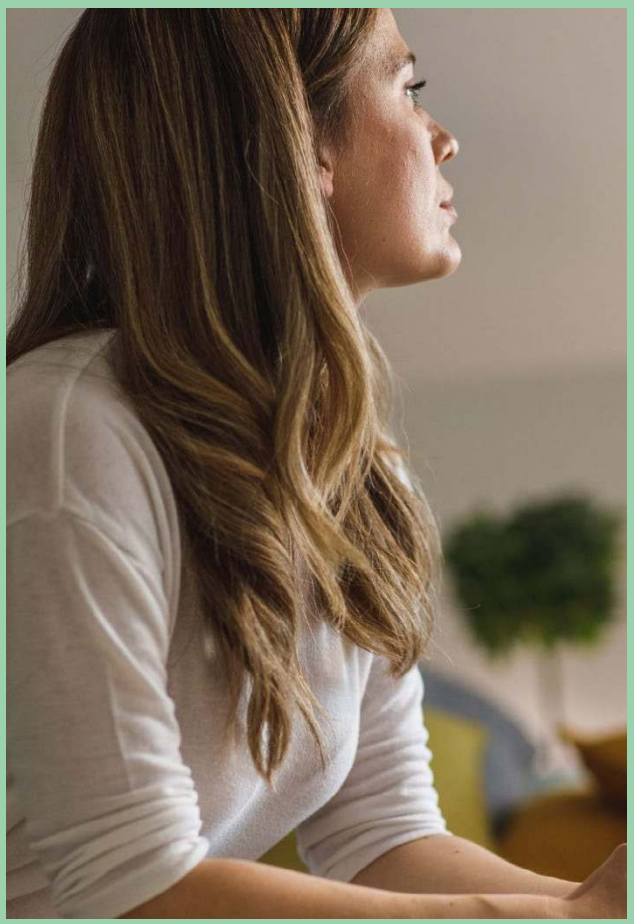
b) Flourish – Bloom Healthy Living



The Bloom Healthy Living Program supports people aged between 18 - 64 years of age, who are experiencing chronic and severe mental health issues that impact on their capacity to participate in activities of daily living and have not been funded through the National Disability Insurance Scheme (NDIS). Over the last year, CHN, ACT's PHN commissioned Flourish to provide support to 179 participants, through 3,186 occasions of service. In January 2023, Flourish introduced the iPad Program that was initiated to provide participants with access to technology to support various aspects of their lives, including education, employment, social engagement and personal development. An evaluation found that the iPad program demonstrated significant benefits in supporting participant goals, and it also facilitated meaningful family connections for those facing physical limitations. The program has shown promise in empowering individuals to take control of their lives and pursue their aspirations. By implementing targeted strategies and addressing identified hurdles, the program can further enhance its impact and ensure continued success in supporting participant well-being and recovery journeys.

Client story

Li* (not her real name) has a lived experience of trauma via technology and a lived experience of domestic violence. Flourish supported Li to access the NDIS and she was approved for support 3 days per week and started the process of accessing support from an assistance animal. Li identified a goal which included making an application for financial support through the Public Trustee. They were assisted to submit forms to ACT Civil & Administrative Tribunal to have this assessed. Li was also supported to build capacity to confidently access the community, which reduced the sense of isolation and supported her on her recovery journey. She was linked with services for longer term support to continue on that journey. Li reported she feels a renewed sense of hope in her recovery journey and recommends Flourish to other people.



c) Directions – Alongside

CHN funded Directions Health Services to deliver the Alongside Program under the Commonwealth Psychosocial Support Program. Program growth has enabled eligibility to be expanded to include young people 16 years and over. The service offered integrated care, working closely with Directions' Psychiatrist, primary health team, and counselling and case management teams to meet clients' complex needs. In the 6 months from January 2024 to June 2024, the number of participants and occasions of service provided represent a 22% and 54% increase, respectively. Over the last year, Directions provided support to 63 participants over 1044 occasions of service.

Client story



Mila* (not her real name) was referred to Alongside by Directions' 'Chat to PAT' mobile health clinic for support to prevent eviction from her public housing property. Mila has a lifetime history of significant trauma and polysubstance use, has Post Traumatic Stress Disorder and anxiety, and multiple physical health conditions. Housing ACT had begun formal eviction proceedings due to severe hoarding at Mila's public housing property. She had made several appearances before the ACT Civil & Administrative Tribunal (ACAT) with little progress and eviction was likely. Canberra Community Law (CCL) was acting for Mila, but were struggling to maintain contact. Mila had not engaged with support or medical services for some years prior to engagement with Directions.

The Alongside Program Worker provided outreach support, working flexibly to build trust to establish and maintain engagement. Mila had filled one skip bin provided by Housing ACT. However, she was overwhelmed and traumatised by the scope of the task and the ACAT process. Balancing the urgency of the situation with an awareness of the complex mental health issues underpinning hoarding, the program worker worked with Mila and CCL on actions needed to prevent eviction. This included obtaining medical and mental health support documentation, arranging a My Aged Care assessment for hoarding support services, and seeking a referral to the Directions' Psychiatrist and CatholicCare's Next Steps counselling program. It also included supporting Mila to prepare a formal Witness Statement for ACAT and a referral to the specialised group program Buried in Treasures, run by Woden Community Service.

The probability of Mila being evicted from a public housing property into homelessness has been substantially reduced, and she is now receiving support services and medical care. Alongside involvement will continue with the aim of preventing eviction, maintaining engagement with appropriate supports, and addressing the longer-term issues underpinning hoarding to ensure the sustainability of her tenancy. If Mila is ultimately evicted, Alongside will remain engaged with her to provide support with the trauma of such an outcome, address immediate and emerging needs, explore housing options, and maintain connection with services.

12. Safe Haven

There can be limited options for people seeking face-to-face support when experiencing emotional distress or suicidal thoughts, in an environment they feel safe and comfortable. The reasons are varied, but often include access or affordability, isolation when living away from home for study, homelessness, not feeling comfortable to talk to family or friends, or they might just not know where to start to seek help.

CHN, ACT's PHN and ACT Health partnered and collaborated on the funding and commissioning of the ACT Safe Haven service which was opened in Belconnen in November 2021 by Stride Mental Health. Safe Haven is a free, walk-in, non-clinical, safe place. It was designed to be a comfortable space for people seeking connection and support, if they are experiencing emotional distress, mental health concerns, isolation and loneliness. Safe Haven assists people in their journey of recovery by offering support and opportunities in a supportive environment to address challenges, and develop skills and resources, to help them navigate their distress and promote successful community living. The team is comprised of peer workers, and people with a lived experience of mental health issues, who are appropriately trained to support guests of Safe Haven.

The Safe Haven team is diverse in experience and background, including their peer experience. The service has male, female and non-binary workers who come from many different walks of life and have a range of lived experience backgrounds, providing various perspectives for all the guests.

Safe Haven received 1,165 visits, averaging at around 22 visits per week, in the last year. On average, people who accessed the service reported a 25% decrease in their level of distress by the time they departed the service. This is a 6% improvement on the previous years reported reduction level.

Client story



A guest began presenting to Safe Haven semi-regularly, explaining they struggled to be understood by most health professionals and were seeking a diagnosis of autism spectrum disorder. They were aiming to decrease the frequency of members of the public calling for welfare checks on them, due to having 'meltdowns' in public. In the past, this had led to escalation and instances of reported police brutality. Safe Haven supported this guest to work on their emotional regulation skills and preventative strategies of self-care. This guest was able to access and build relationships with a Psychiatrist and join a Dialectical Behaviour Therapy group to further their skills. Safe Haven supported this guest through a period of homelessness.

This guest has recently expressed gratitude to Safe Haven staff, explaining they now feel they can manage their distress in ways they had thought were not possible for them. They are now living independently, have reconnected with family, are employed and about to engage in further education. They have expressed optimism about their future.

Priority Area 5:
Aged Care

CHN commissioned aged care services to:

HELP OLDER PEOPLE TO ACCESS SUPPORT TO REMAIN IN THEIR OWN HOME

PROVIDE HEALTHY AGEING ACTIVITIES

PROVIDE CATHETER AND WOUND MANAGEMENT TRAINING TO RESIDENTIAL AGED CARE HOMES (RACH) STAFF.

CHN'S TELEHEALTH GRANTS PROVIDED TELEHEALTH EQUIPMENT AND TRAINING FOR RACH STAFF.

1. Support for older people to access help: care finder

Some older Australians need additional support to access the support they need to remain in their own home. The barriers that contribute to this can include:

- communication and language barriers
- difficulty processing information due to cognitive decline
- reluctance to engage with a need for support
- reluctance to engage with government services.

In response to a recommendation of the Royal Commission into Aged Care Quality and Safety, the Department of Health and Aged Care implemented the care finder program nationally, following the successful Aged Care System Navigators trial program.

Commencing in January 2023, the care finder program has provided tailored intensive support to older people in the target group to:

- help people understand and access aged care and connect with other relevant supports in their community
- target people who have one or more reasons for requiring intensive support to interact with My Aged Care and access aged care services and other relevant community supports.
- resolve homelessness or reduce the risk of homelessness.

CHN commissioned 5 care finder providers within the ACT to deliver these services:

- ADACAS
- Community Services #1
- North Community Services
- Woden Community Services
- Meridian.

Together over the last year, the care finders have provided specialised and intensive face-face assistance with the vulnerable population, who would otherwise fall through the gaps in the aged care system. Between the 5 providers, they had 208 new cases, with a monthly average of 130 active cases. They provided:

- **498** support activities to find required aged care supports and services or to access other relevant supports
- **505** high level check-ins and follow-up support after service commencement
- **854** engagement and rapport building activities.

Client story

Good News Story

Following a scam, Edith* (not her real name) was left facing serious financial hardship in her early 60s. Edith was struggling to gain employment and relied upon Job Seeker payments. Edith reported feelings of humiliation and stress and was becoming increasingly worried about how to afford life's basic needs. Care finder began to support Edith to apply for the disability support pension, recognising Edith's physical and mental health conditions. Care finder began to explore other options, such as the Aged Care Pension, however she was too young.

When speaking with Centrelink regarding the Disability Support Pension, they granted Edith a full exemption from applying for work until next year, which took a huge mental load off Cassandra's shoulders. Care finder then began actioning some Aged Care services, beginning with obtaining a hoarding and squalor code for Cassandra's home. This was a huge step forward in Edith's journey, as it alleviated a barrier to her receiving other services in the future.

Since joining the Care finder program, Edith is now attending a mental health peer support group, is receiving assistance from Care Financial, has had an energy efficiency assessment with Vinnies, received food vouchers and hampers from Salvos and is also connected to a community pantry. Edith is also now attending 2 separate free social groups which has improved her mental health significantly after developing friendships within the group. She has also mended relationships within her family.



Care finder providers at the COTA Expo

2. Support for older people in the community: healthy ageing

Some older Australians are entering aged care earlier than they may otherwise need, due to a lack of support for healthy ageing or ability to manage their chronic conditions in the community.

The Healthy Ageing, Early Intervention Program funds community care providers to undertake activities that support older persons to live at home longer. It aims to promote healthy ageing, slow decline and support the ongoing management of chronic conditions. The program also involves:

- co-design and implementation of targeted interventions to prevent, identify and reduce chronic disease and health issues, avoid inappropriate hospital admissions and improve health outcomes for the elderly
- supporting collaborative approaches between multidisciplinary teams and primary care providers
- expanding existing healthy ageing programs
- educating primary health care providers on how to connect senior Australians with necessary psychosocial, health, social and welfare supports
- educating family members or carers on how to manage an older person's health.

Over the last year, CHN commissioned the following 6 providers to deliver the requested services.

a) CAHMA's Healthy and Creative Ageing Program

The Healthy and Creative Ageing Program brought together around 60 participants, who were over 40 years old and have lived experience of drug use and other types of marginalisation. CAHMA provided participants wrap around support services such as information and education, case management, transport to attend health appointments, counselling and a creative art social program. The creative sessions involved ceramic classes and printmaking sessions, with excursions to exhibitions and galleries. At the end of the art sessions, CAHMA held an art exhibition to showcase all the participant's artwork they have been working on, with over 50 people present at the launch with many more attending throughout the week.



Artwork showcased at the launch of the CAHMA Art Exhibition

b) Annecto's Social and Nutrition Workshops

Annecto completed 3 rounds of their Social and Nutrition Workshops over 7 weeks to empower participants living with chronic health conditions to better manage their health through improved nutrition. Throughout the sessions they covered the importance of nutrition on chronic disease, how to interpret nutritional information on food items and skills to prepare nutritious meals. A survey conducted showed that:

- 83% said the workshops were helpful in their daily lives.
- 83% said their expectations were met
- 100% enjoyed the workshops
- 53% were interested in continuing to meet as a social group, 29% were unsure and 18% were not interested.

Testimonial

- *"We learnt that offering events with a purpose resulted in a better take up, rather than simply offering a social get together. It seemed to lessen people's anxiety about having to 'make new friends' in a new setting. It gave them something to talk about that wasn't the usual small talk. We saw some great friendships develop,"* said a worker involved in the program.



c) Carers ACT's Care Tribes

Carers ACT created an innovative online platform to link carers for individuals with dementia to form informal support groups called Caring Together. They successfully matched 40 carers and their care recipients into 10 care tribes. The care tribes then participated in face-to-face activities that focused on social inclusion and reducing feelings of isolation from the community. As a result:

- 77% of carers reported that they felt the program was helpful and practical
- 88% of carers reported that they will continue to meet with others in their care tribes, after the program ends.

Client story

"Eveleen* (not her real name) came along this time, I can tell she loves the socialisation and enjoys the good company and relaxing atmosphere. [Two other carers] are two lovely ladies, we get along well. It's exciting to find out that we actually share many common interests and consensus. Thank you for arranging such great connection event for us, and I hope I can bring Eveleen along with me for more of our tribe events and make some new friends. When they're with me, I don't have to worry about them home alone when I am away for the tribe event, in case medical emergency happens and I am not around," said a carer from a culturally and linguistically diverse background.



d) Wound Innovations' Education Events

CHN commissioned Wound Innovations to deliver 3 × face-to-face education events attended by 125 Nurses and GPs across the three 8-hour sessions. The face-to-face sessions were focused on the fundamentals of wound management, with many attendees expressing that they feel more confident in managing wounds and have an improved wound knowledge. Wound Innovations delivered 81 face-to-face and telehealth specialist wound consultations, this included bedside coaching to local clinical staff members.

Testimonial

Wound Innovations face-to-face educations sessions, "Fundamentals of Wound Management", were well attended by Nurses and GPs, with 140 participants across the three 8-hour sessions. The sessions were well received by the participants, with a very high level of satisfaction and positive feedback, including that the sessions were relevant to the participants clinical practice and delivered effectively. Importantly, the education was also shown to improve wound knowledge, with a written quiz showing that staff demonstrated an average wound knowledge score of 73% before the education session, compared to an improved average score of 91% following the session. Testimonials were very positive with statements indicating the education was well received and will provide ongoing to benefits to clinicians in the CHN and their patients. Comments included:

- *"Start to end I liked the whole education. Management of wound and phases of healing the wound. Everyone should have this education to have more knowledge about wounds."*
- *"Good overall wound training with plenty of information that we will actually use."*
- *"I would recommend this as it gave a comprehensive overview on how to treat wounds commonly seen in primary practice."*
- *"All Registered Nurses and Enrolled Nurses should do this course."*
- *"Very informative and applicable."*



e) Fisher Family Practice's HAPPIER Program

CHN commissioned Fisher Family Practice to deliver the HAPPIER Program, which aimed to improve participants' function and physical ability through positive interventions and targeted exercise rehabilitation. Fisher Family Practice had 687 service encounters over the last year, including:

- personal training
- physiotherapy
- body composition
- reviews with Practice Nurses.

Client story

A participant disclosed that they had never participated in any exercise regime or attended a Physiotherapist before, due to being extremely self-conscious about their physical limitations and body image. The participant was anxious about joining the program, but with some encouragement from the team became an active member. They were excited to be engaging in health interventions. It was the first time they had attempted to embark on a positive change to their weight and mobility, despite significant encouragement from their long-term GP over many years.



f) Interchange Health Co-operative's Healthy Ageing Exercise Program

Led by a Nurse Co-ordinator, the Healthy Ageing Exercise Program involved a multidisciplinary team aiming to prevent chronic conditions and health issues to reduce hospitalisation. The program involved:

- Exercise Physiologist – exercise programs
- Occupational Therapist – home reviews
- Pharmacist - medication reviews
- Nurse – healthy ageing assessment
- Dietitian – dietary review and health checks, including group sessions
- Social Worker – group and individual sessions.

Interchange Health Co-operative had a total of 60 participants involved in the program over the last year, with a total of 354 service occasions with each component of the program. Participants have reported that they have increased strength, endurance, balance and function after completing the program.

3. Enhanced out of hours support for residential aged care homes

CHN's consultations and engagement with Residential Aged Care Homes (RACH) identified the need to avoid resident deterioration and presentation to Emergency Department after hours. The consultations identified the need for RACH staff training in catheter care and wound management to support them to provide quality care and improved health outcomes to their residents, reduce the need for access to afterhours services and avoid unnecessary hospital admissions.

a) Catheter training

CHN, ACT's PHN commissioned the Australian College of Nursing to provide catheter care training to RACH staff. The training includes face-to-face practical workshops, online learning modules, access to the Communities of Practice hub and resources for RACH nursing staff.

b) Wound management

CHN will continue to work with RACH providers to identify solutions to improving wound management and opportunities for staff to continue increasing their capabilities in this area

Testimonial

- *"This is a wonderful initiative; we will be enrolling our Nurses in this catheter care training."* - RACH Manager

4. Telehealth: Support for older people in Residential Aged Care Homes

Residents of Aged Care Homes (RACHs) experience challenges with timely access to GPs and allied health and afterhours hospital transfers. It is often difficult for residents to be transported to external appointments or identify specialists who will provide consultations on site. RACHs require adequate telehealth facilities to support access to virtual consultations to care for their residents.

CHN received funding from the Australian Government to support the uplifting of telehealth capabilities in RACH. The funding was distributed by CHN as "Telehealth Grants" which enabled the 24 ACT RACHs who applied to purchase telehealth enabled equipment for virtual care, including computers on wheels, laptops, tablets and remote tele-monitoring systems. RACHs were able to choose from a range of recommended equipment that was most suitable as per their need and other IT infrastructure. Additionally, some RACHs have been able to access training through the supplier of their equipment, while others were able to draw on their internal training programs.

Our consultations with RACHs also revealed that successful telehealth consults required to the implementation of telehealth into the RACH policies, procedures and to embed it in their operational workflow. In response, CHN through a successful tender process has been able to work with Enkindle Consulting to implement a comprehensive telehealth training and coaching program.

The training sessions will cover how to use telehealth equipment, how to conduct virtual consultations that will enable the resident and health care professional to achieve high quality consultations. The training will also provide practical information on embedding and integrating telehealth with other existing systems and processes within the residential aged care homes and additional resources or guides to use post training.

- 7/27 Residential Aged Care Homes (RACHs) now registered to use HealthDirect Video Call. There has been an increase in uptake of bookings via Health Practitioners therefore RACHs aren't required to be registered.
- Residents of Aged Care Homes have better access to GPs, specialists and allied health through the option of virtual care using telehealth when clinically appropriate.
- Complex wounds are now able to be assessed without delay, the homes can apply the treatments with virtual support and without the need for a transfer to hospital.
- One residential aged care home reported the telehealth equipment funded by CHN was used to facilitate a family case conference for a resident whose family lived overseas. This was the first time the family member was able to participate in such a consultation as they were not physically able to travel.

Testimonial

Provided by a RACH telehealth grant recipient:

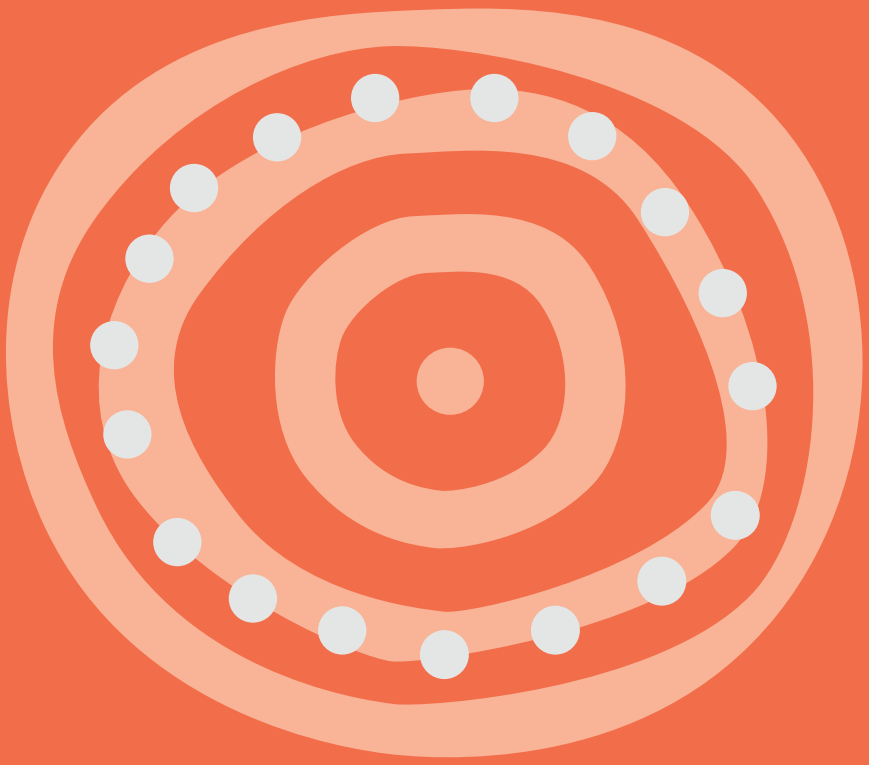
- *"We acquired a computer on wheels, 3 laptops, 3 webcams and an iPad. Our clinical assessments are now conducted directly with residents while using electronic devices during face-to-face interactions. The convenience of these devices is evident during our weekly GP rounds. The introduction of these devices has increased the amount of face-to-face time residents have with our clinical team, including Clinical Nurse Specialists, the palliative care team, GPs and Registered Nurses.*
- *Residents appreciate the increased virtual engagement with medical professionals. Logistically our residents enjoy avoiding a physical trip to a GP and allied health service just for simple prescriptions or follow-up appointments. They also appreciate having issues addressed promptly, rather than having to wait for physical appointments.*
- *Telehealth equipment has enabled wound specialists to manage and support wound care remotely and GPs to provide additional support to their regular on-site rounds."*



Lovielyn Torres, Registered Nurse working at Warrigal Residential Aged Care Home, one of the recipients of the telehealth grants for RACHs

Priority Area 6:

Aboriginal and Torres Strait Islander Health



CHN's commissioned services provided support for:

FIRST NATIONS PEOPLE LIVING WITH CHRONIC DISEASE, THROUGH **9,990** OCCASIONS OF SERVICE

282 FIRST NATIONS PEOPLE LIVING WITH MENTAL HEALTH ISSUES

125 FIRST NATIONS PEOPLE LIVING WITH ALCOHOL AND OTHER DRUG ISSUES

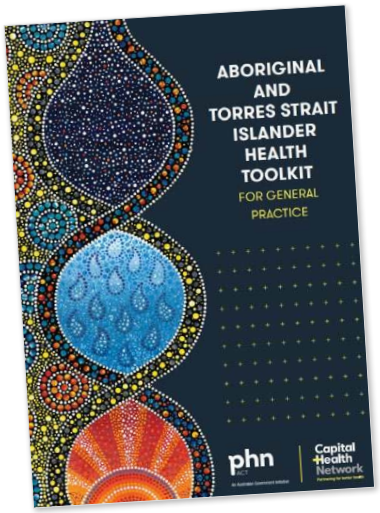
CHN, ACT's PHN is committed to improving access to high quality, culturally safe and responsive health services for the First Nations peoples in the ACT. As one of the key priority areas for our PHN, the betterment of health and wellbeing of Aboriginal and Torres Strait Islander peoples continues to be a major focus. CHN continues to strive to work with local First Nations people and organisations to bridge gaps, decrease barriers to health care, and build support and capacity in the First Nations health workforce.

1. Cultural awareness/safety and practice improvement activities

CHN partnered with Coolamon Advisors to provide Cultural Awareness Training for 3 key cohorts: primary health care providers, staff in services commissioned by CHN and CHN internal staff. Six training sessions were held, with content covering various topics, including the history and impact of colonisation in Australia, ongoing psychosocial and health impacts on First Nations peoples, cultural safety considerations in a health care setting, and understanding differences in the understanding of health, wellness, time, family/kinship and communication between western and First Nations societies. Over the last year, CHN and Coolamon Advisors provided Cultural Awareness Training to 124 local medical professionals and community health workers.

CHN has attended allied health services and general practices to educate medical professionals on cultural safety measures they should employ in order to better service their First Nations patients. Education have been provided at CHN educational events (e.g. Practice Connect) to encourage the uptake of priority MBS Items like the Aboriginal and Torres Strait Islander Health Assessment (MBS Item 715), and referral to local services that may improve health care access for First Nations patients of professionals or practices in attendance.

Tools, service, improvement measures and information has been provided to practices and practitioners through regular CHN newsletters. This includes promoting HealthPathways, educational events, "CHN's Aboriginal and Torres Strait Islander Health Toolkit for General Practice" and providing up-to-date and topical reports and articles to help practitioners better understand the current needs of the First Nations population.



Testimonial

Feedback received from attendees of our Cultural Awareness Training sessions indicated that the content was 100% relevant to the work of the audience. Attendees also highly rated the degree to which learning outcomes were delivered during their sessions, with 80% responding they were entirely met.

Respondents to the post event survey commented that as a result of attending the training they would:

- *"Keep in mind the different worldview of people from Indigenous backgrounds and ask open-ended questions."*
- *"Seek more stories/contact with local communities."*
- *"Hold staff even more accountable for self-education on First Nations' issues."*

One attendee emailed CHN with:

- *"The training was amazing. The only feedback is we would have loved it to be longer. It was by far the best cultural awareness training we have attended and would highly recommend it to anyone."*

Cultural Competency Framework

CHN's ongoing commitment and journey towards implementing our Cultural Competency Framework (CCF) continues. The journey towards cultural competency is both an individual and organisational responsibility. Our CCF is embedded in all areas of the organisation and is used to inform our approach to 'business as usual'. Implementation of the CCF is driven by our internal Cultural Diversity Working Group, comprising representatives from each business unit and endorsed by an Executive sponsor. Over the last year, the group has been working on the ongoing reviews of internal policies, procedures and frameworks with a cultural competency lens. CHN continued to offer training, development and cultural immersion opportunities for our staff. CHN's ongoing work on the implementation of our CCF has not only strengthened our staff's cultural competence, but it has also seen our relationships and partnerships with First Nations people in the ACT grow and develop. In addition, our improved ability to effectively work with stakeholders has enhanced the provision of better health outcomes for First Nations people in the ACT.



CHN staff enjoyed a cultural immersion activity to complete their own artwork.

Cultural Diversity

With a broader commitment to inclusion and embracing diversity, CHN reviewed our Cultural Diversity Policy and adopted the PHN Multicultural Framework. CHN explored and accessed multiple types of diversity and inclusivity training and tools for staff and teams. CHN and our internal Cultural Diversity Working Group sought quality improvement activities to ensure this ongoing journey toward competency and inclusivity for the diverse communities with which we work.

HealthPathways suite

ACT & Southern NSW joint HealthPathways program continues to be the national lead region for the Aboriginal and Torres Strait Islander Health HealthPathways. CHN reviewed these pathways to ensure they are up-to-date and contain the most useful and relevant information for primary care providers working with Aboriginal and Torres Strait Islander people in the region. A new pathway 'Framework for Care Provision for Aboriginal and Torres Strait Islander Peoples' was included and the Aboriginal and Torres Strait Islander Health Services Directory was updated.
Aboriginal and Torres Strait Islander Health - Community HealthPathways ACT and SNSW

Memorandum of Understanding with Yerrabi Yurwang

People and their families, through health, wellbeing and social brokerage in alignment with the National and ACT Agreements on Closing the Gap. A draft work plan commenced development to jointly agree on priorities and actions that will include early intervention, culturally appropriate primary health care delivery, primary prevention and diversionary initiatives, cultural competency and potential infrastructure requirements.



Dea Delaney-Thiele (left), Yerrabi Yurwang Child & Family Aboriginal Corporation CEO with Acting CEO, Julie Blackburn

2. Support for First Nations people with chronic disease: Integrated Team Care Program

To support local First Nations people with chronic disease, CHN partners with local organisations to provide care coordination and supplementary services and funding to First Nations people living with chronic illness.

The Integrated Team Care (ITC) Program assists their clients to navigate the health care system, improving integration of care among the multidisciplinary professionals who provide services to their clients by liaising directly with these practitioners. The program also offers transport assistance, health literacy support, care planning and financial assistance for some of the appointments and medical equipment that these clients require.

CHN, ACT's PHN, commissioned Grand Pacific Health (GPH) to support clients who have been referred to them through mainstream GPs and Winnunga Nimmityjah Aboriginal Health and Community Services to provide the program for their internally referred clients. Over the last year, a total of 9,990 occasions of services were provided through the ITC Program, including:

- 2,422 occasions of care coordination services
- 997 supplementary services
- 4,870 clinical services
- 1,701 services such as telephone encounters with chronic disease, palliative care, mental health, aged care and NDIS support, transport, cultural heritage and art groups.

In addition, due to continued demand, CHN supported the GPH ITC Program to deliver a supplementary mental health project to facilitate increased access to existing appropriate mental health care services for Aboriginal and Torres Strait Islander people in the ACT region. The project supported 71 participants to access 173 services that included Psychologists and Psychiatrists, that they would not normally be able to secure due to waitlist demands and/or the prohibitive out of pocket expenses.

Testimonial

In recognition of the importance of both physical and mental wellbeing and chronic health conditions, the GPH ITC Program provided a Cultural Heritage Program. It included a 10-week program aimed at supporting Elders and community members to engage with their family heritage and genealogy. Partnering with the National Library, the program allowed approximately 12 community members to delve into their ancestry. For many participants, especially those from the Stolen Generations, reconnecting with their family history was not only enlightening but also instrumental in fostering a sense of identity and belonging. This initiative positively impacted their social and emotional well-being, providing them with tools to understand and appreciate their cultural background. Participants expressed significant appreciation for the opportunity to learn about their family histories, which many had previously struggled to uncover. The program was characterised by high levels of participant engagement and satisfaction, leading to the decision to develop a series of ongoing workshops. These workshops aim to strengthen community ties and enhance opportunities for individuals to maintain their independence while living at home, promoting overall well-being and resilience within the community.

The introduction of the Red Dust Healing Program marked a significant milestone in mental health support for First Nations communities in the ACT. The one-day seminar attracted 47 participants, providing them with essential tools and insights to support mental health within their communities. The feedback from the session was overwhelmingly positive, with nearly all participants expressing interest in attending follow-up sessions. This indicates a strong demand for continued education and support, highlighting the effectiveness of the program in addressing the unique mental health needs of First Nations people.





Team members of the Integrated Team Care Program.

3. Mental health support

To support local First Nations people with mental health, CHN partnered with local Aboriginal Community Controlled Health Organisation, Winnunga Nimmityjah Aboriginal Health and Community Services to provide evidence-based, culturally sensitive mental health services to eligible First Nations people aged under 25 years.

Clients continue to be encouraged to express themselves in the most comfortable manner for them. Winnunga provides an open, trusting and culturally appropriate environment for clients to be able to express themselves however they wish. Clients are able use whatever means necessary to tell their story. Individuals and families often approach Winnunga when they are at their 'worst'. Winnunga has a therapeutic response to assist the client to be seen by a GP, Psychologist or Psychiatrist as soon as possible in order to commence the treatment/healing process. Ongoing care and support is provided for as long as required. The team strive to provide the best care for all clients making sure individuals and their family are involved in current and ongoing care. Having support of family or close friends is a vital step in mental wellbeing and is an excellent source of comfort and support while interacting with the supportive services at Winnunga.

Over the last year, **282** clients saw a Psychiatrists, Psychologists or GP. The program also provided:

- **1,033** mental health encounters provided by Winnunga Nimmityjah staff and services
- **870** mental health encounters provided by Psychiatrists or Psychologists
- **123** GP mental health care plans.

4. AOD support for Aboriginal and Torres Strait Islander people

People who experience drug dependence and/or have lived experience of drug dependence in the ACT experience stigma, discrimination and ongoing impacts of criminalisation. This leads to a wide range of social and health inequities and requires an integrated approach in providing appropriate harm reduction services. For Aboriginal and Torres Strait Islander communities, the ongoing impacts of colonisation compound these health inequities. Therefore, the Indigenous community in the ACT need holistic and culturally sensitive harm reduction and health services that empower community members.

CHN, ACT's PHN, commissioned Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) to deliver The Connection, a peer-based drug and alcohol service, run by and for Aboriginal and Torres Strait Islander people. The Connection focuses on the specific needs of members of the Indigenous community in the ACT. The Connection aims to improve the health literacy of our service users and to empower people to take agency of their health and wellbeing through the provision of culturally secure peer treatment support and case management services.

The Connection runs group workshops for Indigenous clients that focus on consultation with local community and helping to address identified needs. The Connection runs across all programs of CAHMA ensuring local Aboriginal and Torres Strait Islander people can access culturally safe and secure services within CAHMA and the health care sector. The Connection workers have accompanied clients to Winnunga Nimmityjah Aboriginal Health Centre, both to support and advocate for them at medical appointments and to assist them to attend the Wellbeing Group.

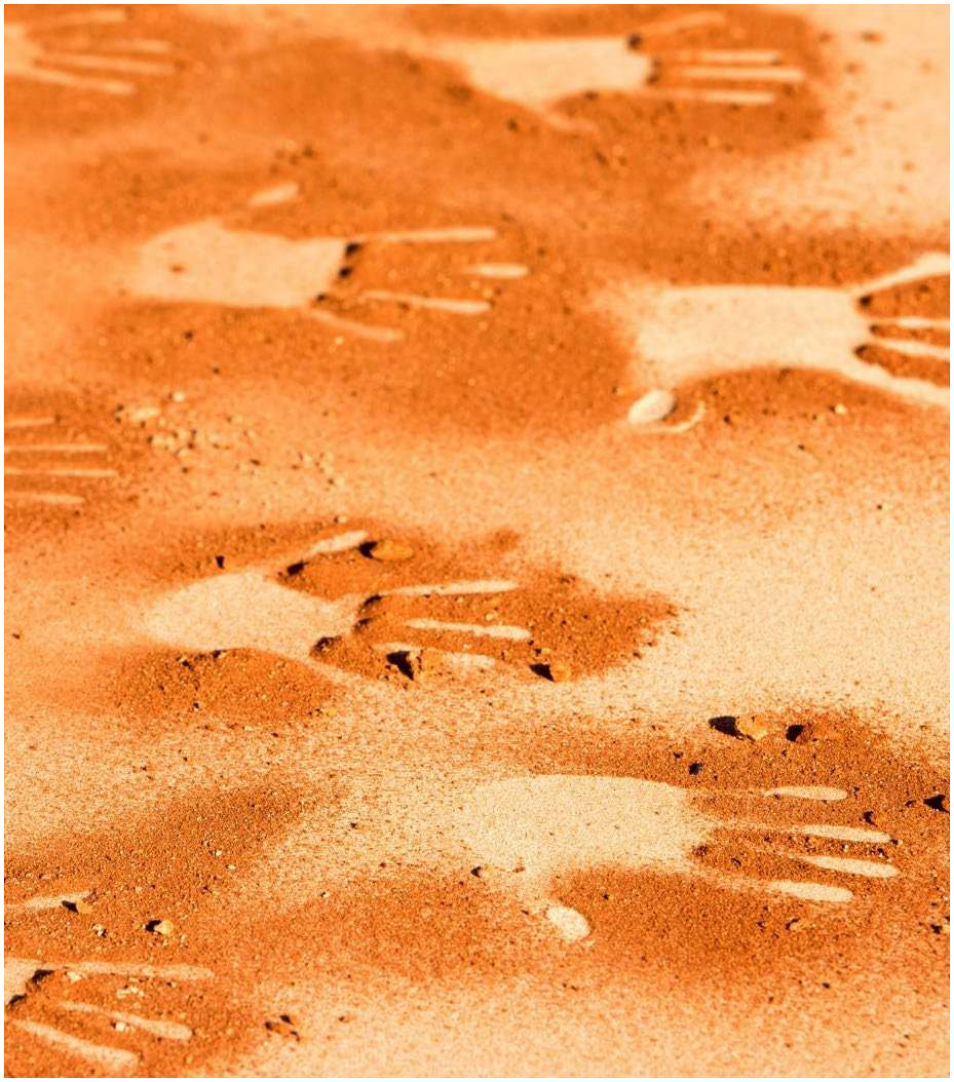
Over the last year, The Connection provided culturally appropriate and sensitive services to Aboriginal or Torres Strait Islander people in the ACT, with 100% of service users providing positive endorsement of the program.
Over the last year, The Connection delivered a total of 147 completed episodes of treatment with 125 Aboriginal and Torres Strait Islander clients. 109 identified as being of Aboriginal heritage, two clients identified as being of Torres Strait Islander heritage; 12 clients identified as both Aboriginal and Torres Strait Islander.

In addition, ACT Corrections continues to provide a weekly in-reach service which allows for Indigenous clients to fulfil their reporting or probational requirements in a safe and welcoming environment.
This service aims to reduce the number of Indigenous Australians in custody in the ACT, and to address the risks of criminal recidivism. The Connection welcomes the opportunity to provide wraparound services for clients of ACT Corrections' in-reach service.

Testimonial

In 2023, Indigenous Case Workers from ACT Corrections performed a weekly in-reach service to reduce incidents of Aboriginal incarceration and recidivism in the ACT. It was held at CAHMA and The Connection all day Friday, to provide a more welcoming environment for Indigenous clients of ACT Corrections, than what was offered at their Civic office.

To combat limited space, CAHMA secured additional office space in the same building, but away from the drop-in centre. This freed up space in the drop-in centre and improved the scope for in-reach services. The Connection service users have been pleased and CAHMA and The Connection workers have made use of 2 new break out rooms where they can have private conversations with clients in a welcoming and comforting environment.



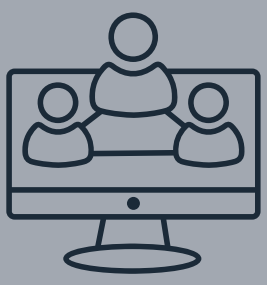
Priority Area 7:
Digital Health



e-referrals increased to:



CANBERRA HEALTH SERVICES CENTRAL HEALTH INTAKE TEAM VIA SMARTFORMS BY **59%**



PRIVATE SPECIALISTS, WITH **94%** OF ALL REFERRALS BEING E-REFERRALS

Digital health is one of the 9 key priority areas for CHN and is integrated into all CHN projects and planning. Twelve staff members completed the Digital Health Foundations training, through Semantic Consulting.

a) Education

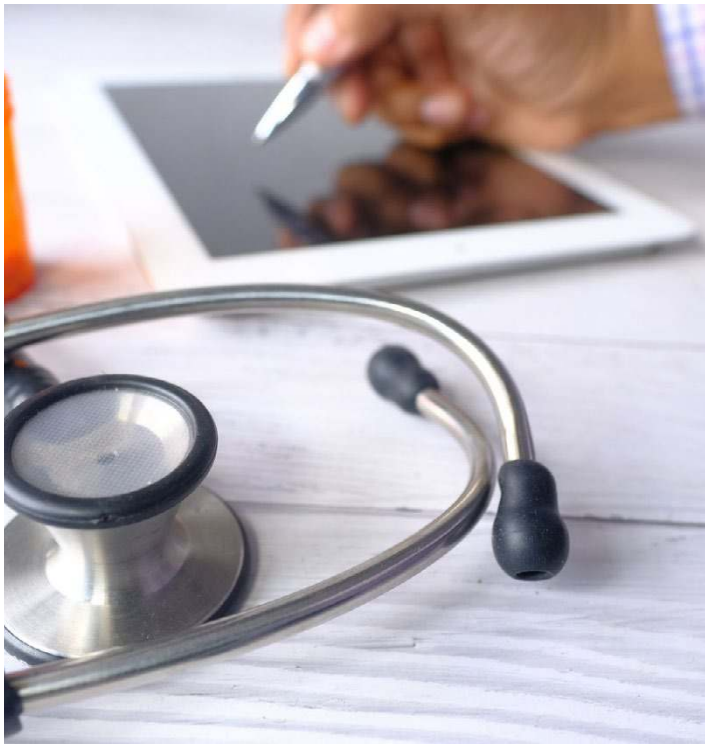
CHN hosted an educational webinar on the Australian Digital Health Agency's Provider Connect Australia platform. Provider Connect Australia also featured as a topic at CHN's quarterly educational Practice Connect event, providing education to Practice Nurses and Practice Managers about its use and benefits.

CHN promoted digital health engagement in primary care with regular communications through newsletters, promoting digital health tools and platforms to CHN's subscribers.

b) Digital health usage in the ACT

In the last year in the ACT:

- the number of e-referrals sent via SmartForms to the Canberra Health Services Central Health Intake Team increased by 59% (46,000 e-referrals)
- 94% of referrals to private specialists were sent by e-referrals (over 35,000)
- 101 practices registered for My Health Record
- over 4.1 million uploads to My Health Record from primary care, over an additional 600,000 compared to last year
- over 3,500 telehealth consultations from general practices on HealthDirect, consistent with the year prior. An additional 896 consultations from allied health occurred with the rollout of free access to this sector
- an increased number of electronic prescriptions were written, with a total of over 799,000
- the first Provider Connect Australia registration occurred.



c) Stakeholder relationships

CHN continued to collaborate with general practices, pharmacies, private specialists, Allied Health professionals, Residential Aged Care Homes and Canberra Health Services. Our ongoing relationships with fellow PHN digital health staff from around Australia has continued to develop. Regular meetings and information sharing have allowed PHN teams to share experiences, solutions to shared problems or obstacles faced, and collaborate on educational events or projects.

Priority Area 8:
Alcohol and other drugs



CHN's commissioned alcohol and other drug services provided support for:

OVER **1000** PEOPLE THROUGH PRIMARY AND SECONDARY HEALTH CARE SERVICES	**202** ADULTS THROUGH COUNSELLING IN THEIR OWN HOME	**179** WOMEN THROUGH A HEALTH PROGRAM
153 PEOPLE LINKED WITH THE CRIMINAL JUSTICE SYSTEM THROUGH COMMUNITY-BASED COUNSELLING	**125** ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE THROUGH A PEER-BASED DRUG AND ALCOHOL SERVICE	**109** PEOPLE WITH MILD TO MODERATE WITHDRAWAL SYMPTOMS TO REDUCE THEIR SUBSTANCE USE IN THEIR OWN HOME
108 CLIENTS THROUGH PEER WORKER CASE MANAGEMENT AND ADVOCACY	**75** PEOPLE OVER THE AGE OF 16 YEARS THROUGH CASE MANAGEMENT	**45** PEOPLE THROUGH A WITHDRAWAL DAY PROGRAM

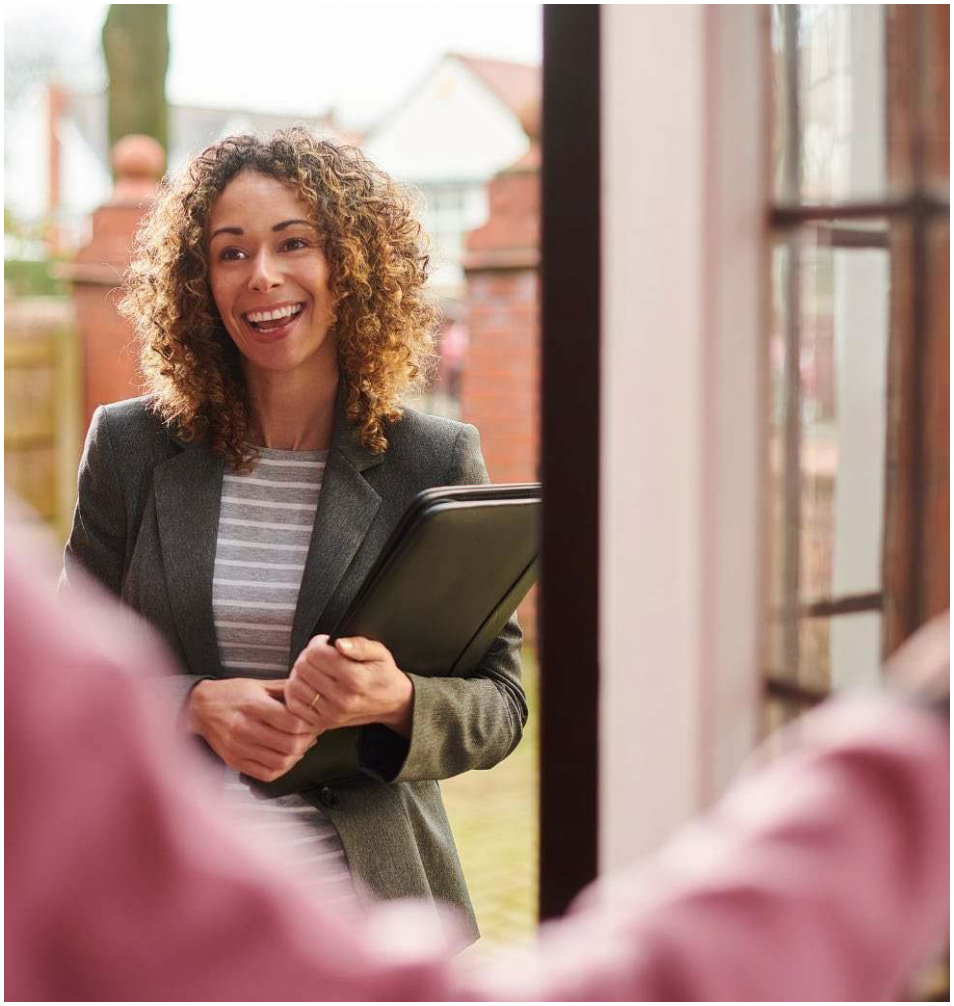
1. Non-Residential Withdrawal Support Service: Karralika

A significant amount of people in the ACT are impacted by Alcohol and Other Drug (AOD) issues, including people with insecure accommodation and experiencing homelessness. Many of these individuals also experience mental health challenges and other health conditions. Residential withdrawal services in the ACT have a high demand and limited supply of services, therefore non-residential services can improve access to health services. The provision of quality primary health, AOD and outreach support services is of key importance to tackling these issues and improving the health inequities experienced by these individuals.

The Karralika Programs Non-Residential Withdrawal Support Service (NRWSS) supports people with anticipated mild to moderate withdrawal symptoms, to safely withdraw or reduce their substance use in the comfort of their own home. CHN commissioned Karralika Programs to pilot the program in 2018. Due to its success, in 2021 CHN was successful in achieving a Community Health and Hospitals Program Grant to expand the program so up to 4 Registered Nurses could be employed.

Over the last year, there were 1,532 direct client contacts. Of those, 57 clients received most of their treatment at home, 36 clients at the non-residential treatment site, 14 clients at a residential AOD service and 2 through outreach. At times, the residential rehabilitation service requested the NRWSS when they admitted someone who was still in a withdrawal state or when the client has briefly lapsed, been discharged and then readmitted and required NRW support or treatment.

Clients utilising the service provided overwhelmingly positive feedback by rating their physical and psychological health and overall quality of life at the beginning and end of the NRWSS. The mean score for the clients self-rated physical health, psychological health and overall quality life all increased significantly throughout the course of the program, illustrating the significance of non-residential withdrawal support services in empowering individuals to self-manage their AOD related health issues, mental health and improve their holistic wellbeing.



Client story

Amelie* (not her real name) lived in a "granny flat" at the back of her supportive father's house. Amelie had a history of drinking alcohol since the age of 13, with periods of sobriety. She worked full-time in the same job for many years, despite her alcohol use issues. Amelie had attended residential rehabilitation and 2 different day programs. She was undergoing counselling and taking antidepressant medication, to avoid using alcohol to self-medicate.

Amelie reported to be consuming 14 – 20 standard drinks per day, which led to a lot of absenteeism at work. Amelie reported that her drinking had caused problems by exacerbating her experiences of depressive episodes and mood swings. She had experiences of self-harm and two suicide attempts. She also said that drinking made her gain weight and suffer from insomnia.

Amelie and the NRW Nurse developed a treatment plan, in collaboration with her GP. The NRW Nurse saw Amelie every day in her own home for that first week of withdrawal and conducted an alcohol withdrawal scale during each visit. The Nurse ensured Amelie was using her Valium as advised. In the second week, the NRW Nurse conducted 3 home visits and phoned Amelie on alternate days.

The NRW program worked with Amelie for 2 weeks, while she re-established AOD counselling and commenced going to two Alcoholics Anonymous (AA) meetings per week. Amelie did not want to do rehabilitation at this time, as she did not want to leave her workplace. After 3 weeks in the program, Amelie was discharged as she was engaged with AA and counselling and had maintained sobriety in that time.



2. Withdrawal, Day and Residential AOD programs: Arcadia House

People who experience drug dependence in the ACT experience stigma, discrimination and the ongoing impacts of criminalisation. This leads to a wide range of social and health inequities and requires an integrated approach in providing appropriate health care. Demand reduction to support people to recover from harmful substance use is a core element of the national approach to harm minimisation. People who are seeking to successfully withdraw, recover and abstain from AOD dependence need holistic therapeutic support to develop and foster a healthy lifestyle that is substance-free.

Directions Health Services runs Arcadia House which is a 14-bed facility providing Withdrawal, Day and Residential rehabilitation programs. Arcadia House is a therapeutic community utilising 'Community as Method' to support clients in the development of life skills and sustainable positive behaviour change as the foundation for their continued recovery. The program incorporates cognitive behavioural therapy (CBT) psychoeducational groups and peer support into the therapeutic community approach to provide comprehensive evidence-based treatment. CHN funds the Day Program, while ACT Health and COORDINARE (Southeastern NSW PHN) fund the Withdrawal and Residential Programs. The Day Program is designed for those unable to access residential treatment due to external responsibilities and for those not requiring the intensity of a residential program but needing more than traditional community-based treatment options. ACT residents have the option of stepping-down to the Day Program for the final 4 weeks of their program. This supports their transition back to community living and an opportunity to implement relapse prevention strategies prior to completion.

Each client works collaboratively with their Case Manager, creating an individual treatment plan based on their goals and strategies to achieve them with discharge-planning incorporated throughout the treatment journey. Case Managers facilitate access to services to address complex needs, including mental and physical health services, legal, employment, housing and child protection. Clients are supported pre and post admission by the Arcadia Continuum of Care Team to ensure clients ongoing support, no matter their circumstances.

Over the last year, 45 participants received AOD treatment services at Arcadia House. Clients report consistently high satisfaction rates, with all respondents indicating that Directions provides the kind of assistance they want, with 89% of respondents rating the quality of the services they received as excellent or good, with all or more of their needs met. In addition, Arcadia House has enhanced its capacity to provide services to those with more complex co-occurring needs. The programs' length and access to a suite of concurrent services allows for the increased flexibility in the treatment approach required by people with complex mental health issues. Arcadia staff work collaboratively with primary and mental health services and other community services to ensure wrap-around support is in place. More recently, as part of their ongoing commitment to quality improvement, they have established additional consultation space to provide Case Managers and clients with a more private and efficient working environment, optimising Arcadia's ability to deliver high-quality, personalised care.

Client story

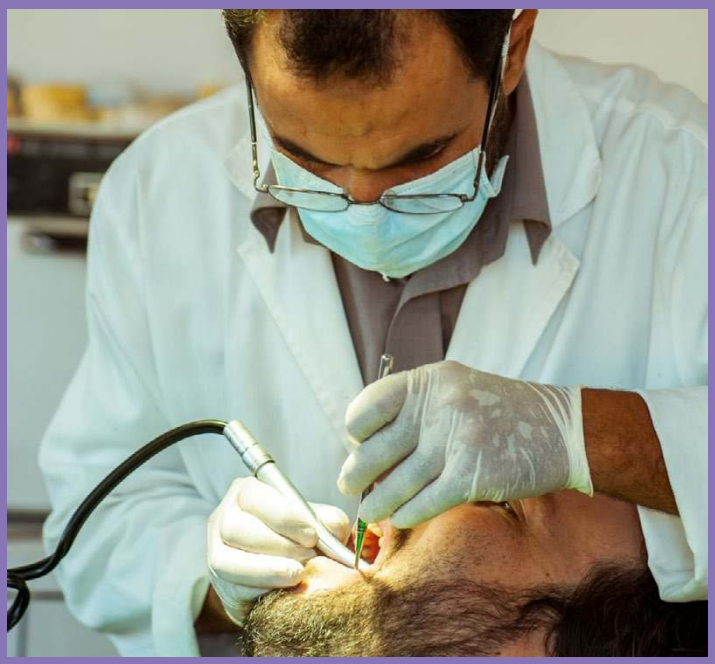
Grayson* (not his real name) was diagnosed with Attention Deficit Hyperactive Disorder (ADHD), obsessive compulsive disorder (OCD) and Oppositional Defiance Disorder (ODD) during childhood and ceased use of medication during adolescence. Grayson commenced methamphetamine usage at age 30, stating he was attempting to alleviate symptoms of ADHD. Grayson began to experience depression, anxiety and intrusive thoughts which persisted, despite trialling a range of anti-anxiety and depression medications and presentations to Emergency Departments. After attending a couple of residential rehabilitation programs in NSW, Grayson reported relapses occurring within 24-hours of self-discharging.

During his attendance in the Arcadia House Day Program, Grayson experienced high levels of anxiety and frequent panic attacks. Grayson also experienced distorted thought patterns, self-esteem issues, intrusive thoughts, loneliness and feelings of hopelessness. It became evident that this often resulted in suicidal ideation.

Grayson received regular one-on-one case management sessions and daily therapeutic and educational group participation. He received ongoing support and treatment from mental health services. Grayson received education and support with sleep hygiene, healthy diet, exercise and ceased smoking with the initial aid of Nicotine Replacement Therapy provided cost-free. As with all Arcadia House clients, Grayson was encouraged to build a support network that could be utilised upon program completion. He attended a minimum of 3 Narcotics Anonymous meetings per week.

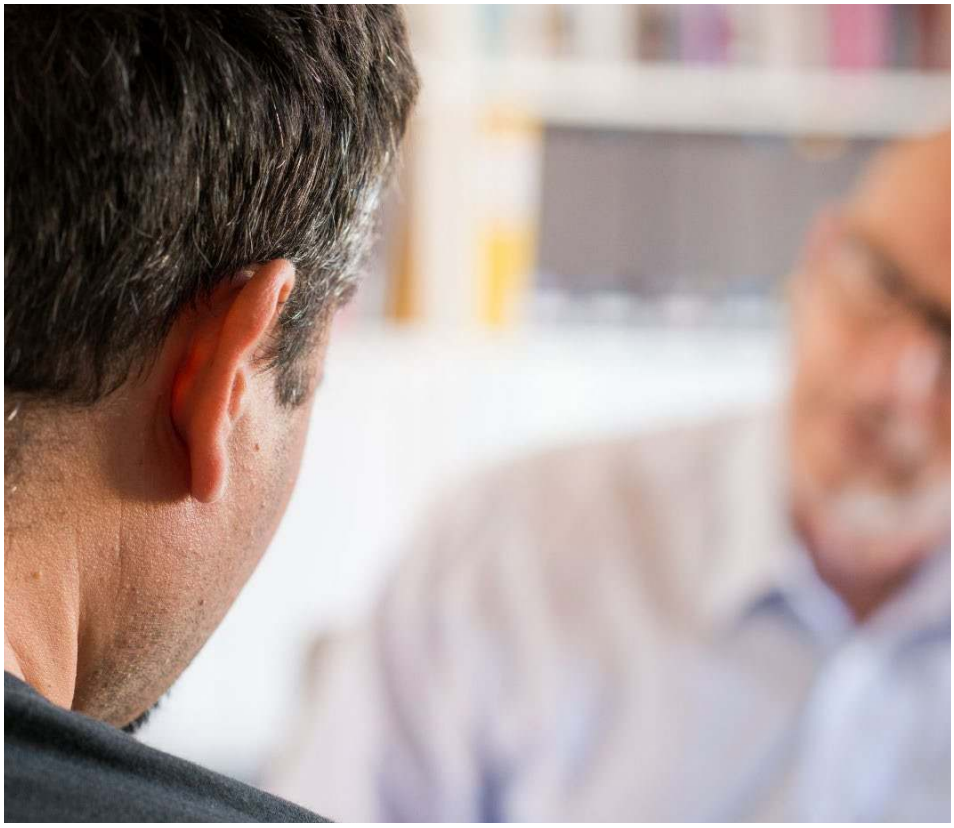
Grayson maintained abstinence throughout treatment and continued to access dental treatment. His self-esteem improved and the frequency of his mental health issues decreased, however his psychological distress did not reduce, and he was referred for ongoing mental health support. Importantly, Grayson was able to develop strategies effective enough to manage his symptoms without feeling the need to use substances.

Grayson's treatment journey highlights the importance and challenges of addressing co-occurring mental health and other health issues alongside alcohol and other drug rehabilitation. The holistic approach and tailored comprehensive support provided by the Arcadia House Day Program proved effective in supporting Grayson to achieve positive changes across multiple life domains.



3. Community-based AOD Counselling: Karralika Justice Services

Individuals linked with the Criminal Justice System in the ACT, particularly people with lived experience of alcohol and other drugs (AOD) dependence, are vulnerable to relapse and recidivism without appropriate, person-centred care. Such populations experience intersectional barriers, challenges and stigma in seeking care, therefore strong collaboration between the AOD sector and ACT Corrections staff is key to ensure that individuals are supported by trauma informed, specialist therapeutic care and AOD counselling.



Karralika AOD Counselling Service provides community-based AOD counselling for individuals associated with the criminal justice system in the ACT. CHN funds Karralika Programs to support the employment of one Counsellor to deliver the service. Karralika is addressing specialist AOD use needs for those in contact with the justice system through flexible models of care. Karralika Programs, supported by CHN, continues to employ a specialised AOD Case Manager who has provided invaluable, holistic support to program participants that extends beyond therapeutic counselling. The service continues to experience high demand, with a notable consistency in referrals in each quarter. Over the last year, 153 clients associated with the criminal justice system were supported by Karralika to access AOD counselling services based on harm minimisation and reducing recidivism.

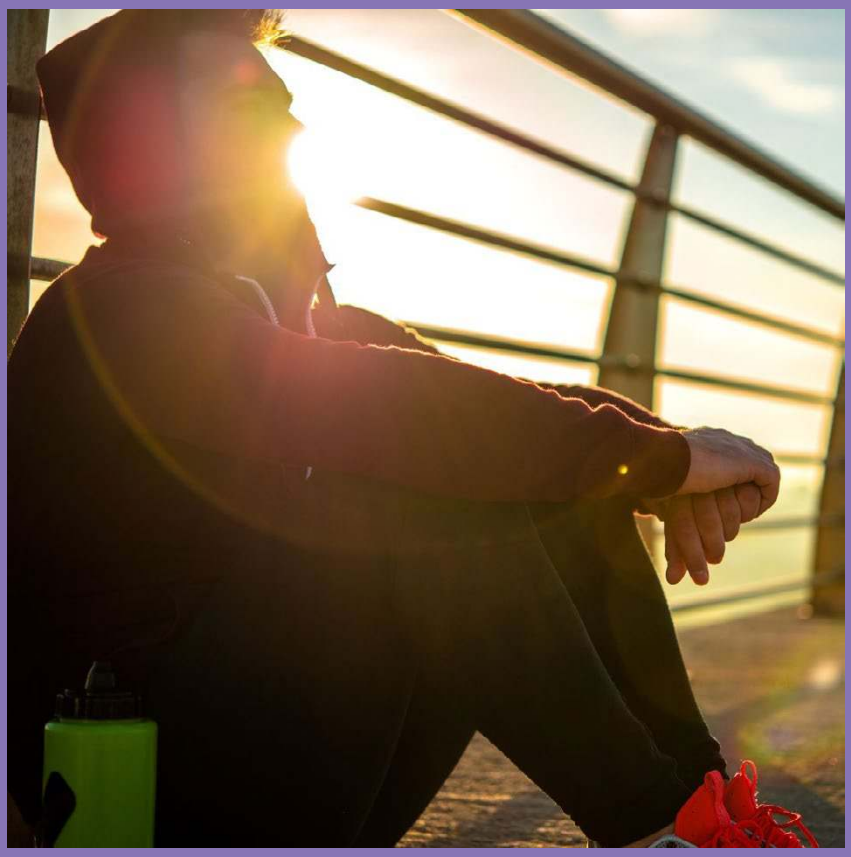
The Karralika AOD Counselling Service has established a strong collaborative relationship with ACT Corrections staff in the community and the Alexander Maconochie Centre and continues to provide programs and support to vulnerable individuals. Both new and existing clients receive ongoing support, through a mix of face-to-face, telehealth and online support to meet their individual needs and circumstances.

Client story

The client is a 39-year-old male, who has had issues with alcohol consumption for over 10 years. This has impacted on his physical and mental health, employment, family relationships and led to the most recent criminal charges. Following a referral by his Community Corrections Officer, he has received treatment from Karralika's Non-Residential Withdrawal (NRW) and Justice Counselling services. Both services worked collaboratively with the client to assist him with his alcohol abstinence goal. Karralika's NRW Registered Nurses provided treatment for his alcohol withdrawal at his residence, and he received phone support from the Justice Services Counsellor. This was the client's first-time receiving treatment, and he stated that he found the service very convenient and felt comfortable.

Following on from his 7-day NRW treatment, the client received ongoing phone support from the Justice Counsellor. The Counsellor worked with the client to enable him to maintain his goal of abstinence. Weekly phone sessions with a focus on relapse prevention enabled him to work through difficult emotions that often arose during this period.

8 months after the initial engagement the client has maintained his goal of abstinence. He continues to have monthly check-ins to maintain motivation and build his resilience. He is working full-time and starting to repair family relationships. He reports his physical and mental health are the best they have been in years. The support provided by Karralika has enabled him to find a way out of his despair and into an empowered and productive life.



4. AOD counselling: Support Connections and Reaching Out

a) Support Connections

People who experience drug dependence and/or have lived experience of drug dependence in the ACT experience stigma, discrimination and ongoing impacts of criminalisation. This leads to a wide range of social and health inequities and requires an integrated approach in providing appropriate health care. Many people experiencing alcohol and other drug (AOD) dependence need multidisciplinary approaches to providing comprehensive, specialist health care through integrated AOD counselling and case management. Furthermore, outreach services can improve access to health services for individuals unable to access services due to personal circumstances and/or risk of being identified in service settings.

CHN commissioned Marymead Catholic Care to provide AOD Support Connections. This outreach case management program works in partnership with anyone over 16 years of age wanting to stop or reduce their alcohol and other drugs use. The AOD Support Connections Case Manager can assist individuals to make meaningful and sustainable changes to their AOD dependence and broader lifestyles. This includes developing therapeutic alliance to provide holistic, person-centred care; developing crisis and relapse prevention plans; exploring harm reduction strategies to help individuals in gaining better control of their dependence; and connecting individuals with other community and health services to improve their health and wellbeing.

The AOD Support Connections Case Manager continues the provision of holistic support to clients who self-identify problematic use of alcohol and other drugs. This involves collaborative case planning that empowers clients to make changes to their alcohol and other drug use, connect with physical and mental health services, address legal; financial or housing problems, safety plan around domestic and family violence, build formal and informal support networks. The Case Manager has continued to work closely with housing and homelessness services, allied health providers and numerous community agencies to provide holistic and coordinated care for a highly complex client group.

Over the last year, 75 clients were assisted through over 400 occasions of service, 100% of which positively endorse the service through Catholic Care AOD Support Connections surveys completed. The Case Manager has maintained a caseload of 15-20 clients at any given time and high rates of service user engagement; and stronger stakeholder relationships with other community services.

Client story



The AOD Support Connections Case Manager has been assisting a 35-year-old male, Angelo* (not his real name) with a history of polysubstance use, recently struggling with alcohol and cannabis dependency. Angelo had previously attempted residential treatment, achieving extended periods of abstinence. Initially connected to AOD Support Connections through another program, Angelo was unemployed and heavily reliant on substances daily. With support from the AODSC team, he made progress, securing part-time work and accommodation with a family member. He also regained access to his children with the help of his ex-partner. During this time, Angelo successfully reduced his alcohol intake and ceased cannabis use.

A few months later, Angelo reached out to AODSC, explaining how his situation deteriorated when he lost his family support, resulting in a relapse, homelessness and disengagement with supports. Based on his positive experience in the past with AODSC and the wider Marymead CatholicCare teams, Angelo reengaged in AODSC through self-referral. The AODSC Case Manager developed a revised case plan with Angelo, where he identified his desire for detox, and securing permanent accommodation as he was couch surfing with friends.

Angelo was successful in his planned detox, seeking medical supports to ensure his safety. Once detoxed from AOD use, the AODSC Case Manager supported Angelo to apply for Priority Needs with Housing ACT. Angelo was excited to be approved within 6 weeks and offered a property in his preferred location. With support from his AODSC Case Manager, Angelo furnished his new home, providing him stability and the foundation to rebuild his life. Angelo reports having reconnected with his partner and children and has continued to maintain his abstinence from substance use. During a recent follow-up, Angelo expressed gratitude and optimism, describing his family life as wonderful and affirming his commitment to ongoing positive progress in his life.

b) Reaching Out

People who experience drug dependence and/or have lived experience of drug dependence in the ACT experience stigma, discrimination, and ongoing impacts of criminalisation. This leads to a wide range of social and health inequities and requires an integrated approach in providing appropriate health care. Many people experiencing AOD dependence need multidisciplinary approaches to providing comprehensive, specialist health care through integrated AOD counselling and case management. Furthermore, outreach services can improve access to health services for individuals unable to access services due to personal circumstances and/or risk of being identified in service settings.

CHN, ACT's PHN, commissioned Marymead Catholic Care Goulburn to run the Reaching Out Program. Reaching Out provides Alcohol and Other Drugs (AOD) counselling through assertive outreach, with Counsellor's meeting individuals where they feel most safe and comfortable, including in the privacy of their home. This person-centred, individualised approach can improve therapeutic alliance between Counsellors and their clients, and lead to more holistic and sustainable health outcomes. Due to the impacts of COVID-19, the counselling team also developed initiatives for providing more flexible delivery of services through telehealth and supporting clients to use digital apps where necessary.

Marymead Catholic Care Goulburn has continued to provide person-centred and comprehensive counselling services for people experiencing AOD dependence in the ACT. AOD Counselling includes a wide range of therapeutic approaches and harm reduction strategies, to empower individuals through strengths-based, person-centred care. The Reaching Out AOD Counsellors provide a high level of individualised support to clients with continuity of care and minimal disruption and it's continued success and need in the community has been especially evident over the last 6 months with significantly increase in referrals (by 28%), with the service providing assistance to 113 clients between January - June 2024, in comparison to 89 clients between July - December 2023, a total of 202.

Additionally, 100% of service users surveyed continued to endorse the service positively. Of those surveyed, 54.2% of clients reported a significant reduction in their alcohol or other drug use, and 9.4% reported sustained abstinence. In October 2023, the Reaching Out Team piloted the Integrated Group Program (IGT). The IGT has been extensively researched and adapted by Marymead CatholicCare to address both substance use and mental health concurrently. It has been shown to improve long-term outcomes over and above sequential or parallel treatment. The program is designed so it can be attended as a one-off session, although it is still most beneficial to complete the program in its entirety. During the pilot, individuals were offered the opportunity to participate in the IGT, while they await to be allocated a Counsellor. The pilot was a success, and another is currently planned for the second half of 2024.



100% OF SERVICE USERS SURVEYED ENDORSED THE SERVICE POSITIVELY

Client story

Layla* (not her real name) initially sought help through the Support Connection Program and was later referred to Reaching Out. Layla presented with challenges including high alcohol consumption, strained family relationships, low self-esteem, social isolation and mental health symptoms, such as psychosis. Layla migrated to Australia from Africa as a child but spent most of her teenage years in Africa.

Initially, Layla was reluctant to engage in face-to-face sessions and was supported through counselling sessions via FaceTime. During this time, Layla attempted rehab but left after one week due to mental health symptoms exacerbating her condition. Achieving abstinence from alcohol was a primary goal for Layla. Gradually, a therapeutic relationship developed, leading her to participate in face-to-face counselling sessions. Layla expressed trust and commitment in the counselling process. Narrative therapy facilitated exploration of childhood trauma, the client's role as a primary caregiver in her family, and the impact of migration and cultural adjustment during her childhood and teenage years.

Grief counselling was conducted to address Layla's feelings of loss, following the death of a family member, a significant trigger for relapse. Support was provided to help her to navigate feelings of guilt and shame, and strategies were explored to establish boundaries and practice assertive communication with family members. As treatment progressed, Layla reported improved self-esteem and healthier relationships with family members. Layla indicated developing the ability to manage triggers through consequential thinking and self-questioning.

Towards the conclusion of treatment, Layla demonstrated a noticeable sense of empowerment. Layla's alcohol use decreased, and she has-maintained abstinence for 6 months up to the last contact. Continued therapeutic support and encouragement to apply counselling skills were crucial for Layla's progress. Building trust gradually played a significant role in achieving a positive treatment outcome.



5. Multidisciplinary AOD support: Althea Wellness Centre

People who experience drug dependence in the ACT experience stigma, discrimination and ongoing impacts of criminalisation. This leads to a wide range of social and health inequities and requires an integrated approach in providing appropriate health care. Many people experiencing AOD dependence need multidisciplinary approaches to primary health care. Accessing specialist public mental health services remains the most challenging issue for individuals with co-occurring AOD dependence, mental health conditions and complex health and social needs.

Althea Wellness Centre is a primary and secondary health care service that provides integrated multidisciplinary care for clients with current or past alcohol and drug dependency, complex health and social needs in collaboration with other programs and services. Althea is comprised of General Practitioner, nursing, psychiatry, psychology, non-dispensing pharmacist and AOD health professionals. Althea is located at Directions Health Services' Woden site. The service is additionally funded by CHN and ACT Health to provide outreach to several other locations within the ACT to reduce barriers to health care and better engage hard to reach at risk population groups.

The Althea Wellness Centre services provide outreach via regular pop-up clinics and 'Chat to PAT', mobile clinic, to several other locations within the ACT. These services help to reduce barriers to health care, and better engage vulnerable and hard to reach population groups. The service also works closely with Directions AOD and Psychosocial Teams, ensuring clients receive holistic person-centred care. This service has been very well endorsed by users who would otherwise find it very difficult to access specialist, multidisciplinary primary health care including access to a GP, psychiatrist, psychologist, non-dispensing pharmacist, AOD practitioners and other referring clinicians who provide additional support to patients.

Over the last year, 1,071 participants were assisted through 9,671 occasions of service. All respondents of a survey said that Directions provides the kind of assistance they want and were satisfied with the services provided by the Althea team. This year saw the introduction of a gynaecology bed, along with the engagement of a GP that can perform Mirena® insertion and removal, giving our female clients increased freedom of choice when it comes to contraception options and increased comfort when attending for Cervical Screening Tests. Althea also participated in the ACT Primary Care Pilot, actively referring clients with complex needs who are eligible and would benefit from access to additional clinical services. Improved system navigation and collaborative coordination of care has increased access to services for participating clients. Althea continues to increase access to Opioid Maintenance and Nicotine Replacement Therapies as part of the suite of primary health care services for disadvantaged populations, as well as referral to specialised smoking reduction/cessation support through Directions' Butt it Out Program.

Client story

Arlo* (not their real name) sought assistance from Althea, as he was using heroin daily and was encountering multiple problems as a result. Arlo was homeless due to a recent relationship breakdown with his partner and was not allowed access to his children. While maintaining employment, he was in significant financial difficulty due to his substance use. Arlo wanted to be able to afford personal transport but had never been able to save the money to purchase a vehicle.

Arlo was commenced on Buvidal weekly, then monthly depot injections, as per the Buvidal protocol. During the initial weekly appointments, Arlo was able to frequently discuss his situation with the Nurses, who supported him with decision making around the key areas of his life that he wanted to progress. Arlo's appointments then tapered to monthly, which maintained regular check-ins and assisted with relapse prevention strategies.

Buvidal treatment was effective for Arlo, and he ceased heroin use. As a result, Arlo was able to see his children and re-establish a positive relationship with his partner. Arlo eventually moved back in with his partner and re-established a functional relationship with his kids. Arlo was also able to buy a vehicle with the money he had saved.



6. Peer Treatment Support Service

People who experience drug dependence and/or have lived experience of drug dependence in the ACT experience stigma, discrimination and ongoing impacts of criminalisation. This leads to a wide range of social and health inequities and requires an integrated approach in providing appropriate harm reduction services. Peer based health promotion and treatment is a community centred public health approach in empowering individuals to make healthier choices by promoting leadership of those who have lived experience in the community.

CHN, ACT's PHN, commissioned Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) Peer Treatment Support Service (PTSS). PTSS workers are peers who are skilled in complex case management. PTS workers work to support individuals' long-term health and wellbeing by meeting them where they are and walking with them through their journey. PTSS workers help individuals with specific issues around drug and alcohol as well as general health, holistic wellbeing and social support. CAHMA works to meet and empower individual's in achieving goals and addressing needs through a person-centred approach.

The CAHMA PTSS continues to provide a high level of support to people who use drugs and drug

treatment services in the ACT. This is done by providing complex case management and patient advocacy across a diverse range of ACT health and social services associated with alcohol, tobacco and other drugs (ATOD) treatment and holistic care.

Over the last year, CAHMA provided case management support services to 108 clients, with 812 occasions of service, demonstrating significant community demand of PTSS. Community need has focused on access to primary health care services, access to detoxification and rehabilitation treatment, pre-hospital planning and post hospital stabilisation, access to mental health services, case management which addresses the social determinants of health (e.g. homelessness, CYPS engagement, food and clothing relief, referral and support to access legal services).

Provision of food continues to be a high priority for service users and the PTSS Coordinator and team have been able to find an amazing community volunteer who cooks approximately 50 meals every week that CAHMA provides to the community. Clients answered the question: "If a friend was in need of similar help, would you recommend this service/program to them?" 90% of CAHMA service users responded "Yes, definitely".

Client story

Marlon* (not their real name) presented to CAHMA with ongoing anxiety, PTSD, depression, low self-esteem and struggles to maintain sobriety for alcohol and heroin use. When Marlon first engaged with CAHMA, he was living with his partner and reported ongoing domestic and family violence and was struggling with his living situation. He also had lack of support due to a tendency to isolate from social and emotional support networks.

CAHMA's PTSS empowered Marlon to utilise a variety of CAHMA harm reduction services and projects, including naloxone training; brief intervention; ongoing grief counselling and peer treatment support. During this time, he consistently maintained weekly case management attendance and discussed strategies for harm reduction and addressing ongoing triggers. Various referrals were also made for Marlon to engage with a variety of community and counselling services in the ACT.

Throughout his engagement with CAHMA, Marlon demonstrated deep insight into his past and present struggles. He is determined and highly motivated to achieve what he sets out to do, despite any challenges he may face along the way. He has engaged well with other organisations, such as Onelink, Everyman and St Vincent de Paul.



Now, more than a year after he first engaged with CAHMA's PTSS, Marlon is doing very well. He has a new property, lives independently and is very engaged with CAHMA on several projects. Marlon has expressed feeling good and more confident in social settings. He feels like he has more control over his life and is looking forward to exploring opportunities for personal and professional development.

7. AOD Day Program: Toora Women

Women who experience alcohol and other drug (AOD) dependence and/or have lived experience of AOD dependence in the ACT experience significant stigma, discrimination and barriers to accessing health care. This leads to a wide range of social and health inequities, therefore supporting women to address AOD dependence issues requires a person-centred approach. Peer based health promotion is a powerful method for empowering women holistically to make healthier choices by feeling more connected to community members who have lived experience

The Toora Women AOD Service (and Day Program) is an evidence-based health program for women to help them learn the skills they need to live a full and meaningful life free from alcohol and other drugs dependence. It is an 8-week group program, and each client is allocated their own case coordinator to develop their individual treatment plan and to make sure they receive a full wrap-around service of supports. Clients are supported in an affirming, women-led community through harm minimisation strategies to better address the determinants behind their AOD dependencies and feel empowered to have improved mental health and holistic wellbeing

The Toora AOD Service (and Day Program) provides a safe and respectful environment for women to build relationships with one another to learn from each other and explore personal issues that led to their AOD dependence. It allows women to challenge harmful behaviours; to trust and build on their strengths; develop new skills; and make positive choices for the future.

Over the last year Toora supported 179 clients through AOD services. Toora clinical services continue to offer Dialectical Behaviour Therapy, Cognitive Behavioural Therapy and motivational interviewing-based counselling and mindfulness groups, targeting past traumas, using a strength-based approach.
The Clinical Team worked closely with all clients either in the Day Program or in the Residential Service to ensure that the underlying drivers to addiction were addressed, allowing clients to comprehensively treat their substance misuse. Toora has continued to experience an increase in co-morbid mental health conditions, such as Complex Post Traumatic Stress Disorder (CPTSD), schizophrenia, bipolar and borderline personality disorder. Toora clients from residential, counselling and Day Program rated Toora incredibly well in 'satisfaction by organisation' against other services within the ACT. When broken into service types, Toora rated highest for satisfaction for residential and 87.5% satisfaction for non-residential programs. During Jan.-June 2024, Toora also experienced an increase in Aboriginal and Torres Strait Islander participation, a 66% increase from the previous 6-month period.

Client story

Jing* (not her real name) came to Lesley Place and the Day Program in early 2024. Jing had come from severe alcohol abuse and had been arrested for drink driving on multiple occasions. Jing struggled initially with flashbacks and difficult emotional regulation, she was often in tears and unable to articulate what was happening for her. Through attending regular Alcoholics Anonymous meetings, case management, Day Program and counselling she was able to stabilise and name her emotions. Jing made the decision to return to her original geographical town after securing a holistic suite of support. Jing is still sober and is working a strong program with two meetings per day, grief counselling, probation and parole and a sponsor on board. Jing continues to utilise Toora's Outreach Aftercare Program, with weekly check-ins over the phone and hasn't used alcohol for 4 months.



Priority Area 9:
Chronic Disease



CHN commissioned a provider to run the Endometriosis and Pelvic Pain GP Clinic.



1. Endometriosis and Pelvic Pain GP Clinic

In 2023, funding was provided by the Australian Government for the establishment of targeted Endometriosis and Pelvic Pain GP Clinics (GP clinics) in primary care settings to provide enhanced services for the treatment and management of endometriosis and pelvic pain. The key program objectives were to support clinics to provide multi-disciplinary care with a focus on improving diagnostic delay and to promote early access to intervention, care and treatment options for endometriosis and pelvic pain.

CHN, ACT's PHN, commissioned Sexual Health and Family Planning ACT (SHFPACT) to deliver the Endometriosis and Pelvic Pain GP Clinic. The clinic is delivered using a multipronged approach, designed to improve quality of life outcomes for patients. Through individualised interventions and treatment plans, training and capacity building for GPs and Allied Health clinicians, and improved interconnection, networks and ongoing supports for the sector through the ACT Pelvic Pain Network.

Since service delivery commenced in September 2023, 86 patients have been supported through individualised assessment and treatment during the 9-month period. Patients had an initial appointment with a Pelvic Pain Nurse, focussing on securing patient history and gathering of data, to maximise the value of the time spent in the subsequent session with the Pelvic Pain-trained doctor. Doctor appointments have focussed on education and exploration of pain management strategies, and outcomes have been measured by quality-of-life indicators and pain levels.

Many patients have reported that the treatment and support they received has been 'life changing' and they 'wish they had come to SHFPACT years ago.' The clinic runs approximately one day per week, staffed by both Nurse and Doctor. Since opening there has been approximately 81 clinic hours patient contact with the Nurse, with 126 hours of doctor-led clinic, Since the Pelvic Pain Nurse was employed in January 2024, approximately 115 hours of Pelvic Pain Nurse-led clinic hours have been held.

Testimonial

"Women who have been waiting for a diagnosis or treatment for years, such as surgery, are continuing to have a high level of pain. I believe we need to be doing something in primary care to try to minimise the pain and subsequent affects. At the ACT Pelvic Pain and Endometriosis Clinic, we first focus on validating women's symptoms and educating them about their conditions. It isn't normal or okay to have this pain. There are very achievable things we can do within any general practice setting. The earlier we start; the better control we get, as we can avoid the potential development of secondary consequences to their bodies," said Dr Tara Frommer, GP at SHFPACT and Clinical Lead of the ACT Pelvic Pain and Endometriosis Clinic.



l-r: CHN's Services Relationship Manager, Rachael Baker with Acting CEO, Julie Blackburn and General Manager – Health System Improvement, Anais le Gall at SHFPACT's 50th birthday celebration.

Client story

Ayla* (not her real name) wanted to fall pregnant. She had a background of long-standing painful periods and persistent pelvic pain, with multiple ED presentations. Ayla also had issues with bladder and bowel symptoms, and experienced pain with sex. A private Gynaecologist diagnosed suspected endometriosis, after a specialised ultrasound scan. However, Ayla then had a phone consult with a public hospital endometriosis clinic and was told that she "likely did not have endometriosis". Ayla felt invalidated, unsupported and did not attend that endometriosis clinic again. During her many GP visits, Ayla felt undervalued and had little confidence in medical supports for her condition.

Following the initial Nurse appointment at the Endometriosis and Pelvic Pain GP Clinic, Ayla received education at the initial Doctor appointment around pelvic pain, how it interacts with common comorbid conditions such as painful sex, bladder symptoms and bowel symptoms. S stated that no-one had ever taken the time to educate her on her symptoms like this and she felt validated by the process. The clinician provided an overview of a holistic management plan, including pharmacotherapy, a referral to a pelvic floor Physiotherapist and pain science education (through an online program), and evidence-based management options for her irritable bowel syndrome.

Ayla engaged with a pelvic floor Physiotherapist and attended pain science education programs. An additional evidence-based treatment for her symptoms was Clinician supervised online gut directed hypnotherapy. After 3 months, Ayla reported that her symptoms were the best they had ever been. This included a significant reduction in her pelvic pain, resolution of her bladder symptoms, reduced pain during sex, and ongoing improvements to her irritable bowel syndrome symptoms. A plan was formulated, and it specifically looked at how to manage her symptoms. Ayla described feeling supported and confident in having her IUD removed to move forward with her plans to start a family.

Ayla represents the common pelvic pain patient with multiple comorbid conditions requiring care coordination, individualised patient-centered care and education, which empowers the patient to engage and have agency in their health care journey. Her initial presentation is a demonstration of the fragmentation of care that is common in pelvic pain. These patients often receive segmented care from individual providers, often receive conflicting information from providers and social media, and often disengage from the health care system as a result. She is a good example of why having a primary care service, with providers who are accustomed to providing care coordination, is so important in addressing pelvic pain.





CHN Financial Statements

CAPITAL HEALTH NETWORK LIMITED

ABN 82 098 499 471

DIRECTORS REPORT

The Directors present their report on Capital Health Network Limited, referred to as 'the Company' and 'CHN' for the financial year ended 30 June 2024.

Directors

The following persons were Directors of the company during the whole of the financial year and up to the date of this report, unless otherwise stated:

Ms. Darlene Cox
Dr. Mel Deery
Mr. Peter Quiggin KC
Dr. Niral Shah
Ms. Julie Blackburn
Mr. Steven Baker
Dr. Jess Tidemann
Dr. Vik Fraser
Ms Rachel Fishlock

Operating Results

The result from ordinary activities amounted to a surplus of $70,388 (2023: surplus of $65,562).

Membership in the Company

The Entity is a Company limited by guarantee. If the Entity was wound up, the Constitution states that each member is required to contribute a maximum of $10 each towards meeting any outstanding obligations of the Company. At 30 June 2024 the number of members was 619, (2023:577). Membership is cyclical, requiring renewals every three years.

Significant Changes in State of Affairs

No significant changes in the state of affairs of the company occurred during the financial year.

Principal Activity

The principal activities of the Company involved the administration of government and non-government funded programs during the financial year. These involved:

- Population health and service planning for the ACT region;
- Development of commissioning systems and capacity;
- The provision of training and other support services to general practitioners and primary health care clinicians in the ACT;
- Supporting better coordination of primary health care services across the ACT; and
- The provision of primary health care services to the ACT community.

The Company's activities during the year resulted in the implementation of national and regionally based programs and initiatives that focused on delivering relevant primary health care solutions to meet community needs. These have included improved access to services for disadvantaged communities and those with poor access to primary health care, support to general and allied health practices, and improved integration between general practice, primary health care, hospital, social and aged care systems. The Company continually embraced a culture of quality improvement, engagement and good governance practices in the ACT and surrounding region.

CAPITAL HEALTH NETWORK LIMITED

ABN 82 098 499 471

Objectives and Strategies

Goals and Objectives	Long Term or Short Term Objective	Strategies to meet objectives
Whole person, one system healthcare	Short and long term	• Understand the needs of our communities • Commission for outcomes • Collaborate for aligned, collective results • Channel and leverage resources for maximum benefit • Champion clinical and consumer leadership to inform models of care and services
High performing primary and community care	Short and long term	• Develop the capability of the workforce • Measurably improve consumer experiences • Use information to support evidence based care • Improve service efficiencies and support business practices that yield the most cost effective care • Champion issues leadership, innovations and research

Measurement of Performance

The Company's performance is continually measured by the following means:

- Financial budgets for the Company and the underlying programs are compiled by the Chief Operations Officer, informed by the Executive team and reviewed by the Chief Executive Officer. The Company's Audit and Risk Committee recommend the budget to the Board of Directors who then approve the Budget. Actual results on a monthly basis are measured against the budget on a Company and program level to ensure performance is in line with milestone deliverables, objectives and stakeholder expectations;

- Program and organisational operational and financial performance are reported to funders every twelve months (or as otherwise requested). Staff performance reviews are conducted during the year to measure the staff's actual performance against program deliverables and Company objectives and expectations, identify potential areas of improvement and monitor staff morale and capabilities;

- On an ongoing basis the Audit and Risk Committee, with the approval of the Board, assess, develop, implement, monitor and update the Company's risk management framework to ensure any existing identified and prospective risks are managed, mitigated or prevented to ensure the Company operates in line with performance expectations; and

- On a continual basis the Audit and Risk Committee, with the approval of the Board, assess the effectiveness of the corporate governance framework and strive to implement and maintain good corporate governance practices in order to maintain and strengthen stakeholder relationships and to ensure that the processes, policies and procedures are appropriate in the achievement of the Company's objectives.

CAPITAL HEALTH NETWORK LIMITED

ABN 82 098 499 471

Information on Board Members

Ms. Darlene Cox

Appointment to office	Elected for a 3rd term at the 2020 AGM on 26 November 2020. Term concluded on 26 October 2023. Appointed to an appointed director position on 26 October 2023 for the 1st term.
Qualifications	BADipEd GradDipAppEc BEd
Experience	Darlene is an experienced executive, director and advocate. She has been active in the health consumer movement and community sector since the late 1990s. Darlene has been the Executive Director of Health Care Consumers' Association since 2008. She contributes to local and national health committees including the Australian Commission on Safety and Quality in Healthcare, Australian Digital Health Agency and ACT Government.
Special Responsibilities	Chair Audit and Risk Committee

Dr. Mel Deery

Appointment to office	Elected for a 2nd term at the 2020 AGM on 26 November 2020. Term concluded on 26 October 2023.
Qualifications	MBBS (UNSW).
Experience	Along with her husband John, Mel is a GP and practice owner at YourGP. She is passionate about developing YourGP to better fulfil the vision of 'genuine care, clinical excellence'. She enjoys all areas of general practice with special interests in paediatrics, women's health, pregnancy care and mental health.
Special Responsibilities	Chair Nominations Committee

Mr Peter Quiggin KC

Appointment to office	Appointed for a 1st Term on 17 March 2022
Qualifications	PSM, KC, BSc, LLB, GradDipProfAcc, FAICD
Experience	Peter is a highly experienced former Australian Government agency head and is a Commonwealth King's Counsel. He led the highly respected Australian Office of Parliamentary Counsel for 17 years. As a former First Parliamentary Counsel, Peter has an outstanding understanding of legislation and legislative schemes and the operations of government. Peter has been on a number of Boards including the Board of Taxation and not-for-profit Boards. He was President of an international association – the Commonwealth Association of Legislative Counsel – for a record three terms. He has also been on a range of Finance and Audit Committees in both the public and not-for-profit sectors. He is a Fellow of the Australian Institute of Company Directors, was awarded a Public Service medal for services to legislative drafting and recently awarded a Chief Minister's Canberra Gold Award.
Special Responsibilities	Member Audit and Risk Committee from March 2022 until February 2024, Chair of the Board from 22 January 2024 until 31 August 2024.

CAPITAL HEALTH NETWORK LIMITED

ABN 82 098 499 471

Dr. Niral Shah

Appointment to office	Elected for a 2nd term at the 2022 AGM on 27 October 2022.
Qualifications	MBBS, MS (Orthopaedics), MHSM, DCH, FRACGP
Experience	Niral is a GP medical educator and supervisor. He graduated in medicine from India and relocated to his new home Canberra in 2008. He is passionate about improving access to affordable quality health care for everyone, especially the disadvantaged and underprivileged part of the community. He enjoys all areas of general practice with a specific interest in musculoskeletal health, sports injury and mental health. He has previous governance experience as a medical administrator and board member on Coast City country GP training board.
Special Responsibilities	Chair General Practice Advisory Council

Ms. Julie Blackburn

Appointment to office	Elected for a 2nd term at the 2022 AGM on 27 October 2022.
Qualifications	RN, RM, GAICD
Experience	Julie has a variety of experiences as a registered nurse, midwife, educator and company Director. Julie currently works as a Lecturer of Nursing at the University of Canberra, and supporting the parent education programmes at North Canberra Hospital. She was Deputy Chair and Public Officer for Karralika Programmes until November 2023, and has previous board experience in Private Health Insurance.
Special Responsibilities	Chair of the Board of Directors, appointed October 2020 AGM (on leave of absence from 22 Jan 2024 to 31 August 2024 to cover CEO maternity leave).

Mr. Steven Baker

Appointment to office	Appointed for a 1st term on 5 March 2021
Qualifications	BComm (Acctg), ICAA, MIIA, GAICD
Experience	Steven has served on numerous Boards, Committees, Audit and Finance Committees as a member and/or Chairperson, in addition to participating in many as an observer as either the internal or external audit provider. Steven has over 25 years in professional services delivery in Australia and has worked for Ernst & Young, WalterTurnbull Pty Ltd, PricewaterhouseCoopers and currently for global consulting business Protiviti Pty Ltd. Steven has many years' experience providing professional consulting services, as well as board and committee experience within the health and education sectors.
Special Responsibilities	Member Audit & Risk Committee

CAPITAL HEALTH NETWORK LIMITED

ABN 82 098 499 471

Dr. Jessica Tidemann

Appointment to office	Elected for a 1st term for director position E1 at the 2023 AGM on 26 October 2023
Qualifications	BA MBBS, FRACGP
Experience	Dr Jessica Tidemann is a specialist GP working in roles across clinical practice, medical education and government. She has worked in several roles for the Australian Government Department of Health and Aged Care over a period spanning 20 years. Jess was an invited member of the CHN GP Advisory Council prior to becoming a member of the board and has held several other professional positions, including Board Director, GP Registrars Australia and multiple roles with the RACGP.

Dr. Vik Fraser

Appointment to office	Elected for a 1st term for director position E3 at the 2023 AGM on 26 October 2023
Qualifications	PhD, MTeach (Secondary), GradCertEd (Gifted & Talented Education), BA (Hons),BA (Comms), DipGov
Experience	Dr Vik Fraser has been an advocate for LGBTIQ+ rights since they were 17 years old. They are passionate about the social determinants of health, and the role that human rights has in building good health care. The intersections they experience in their own life, including as a queer person with a hidden disability, drive Vik's understanding of some of the complexities of health access and health needs across the community. Vik is also the Executive Director of A Gender Agenda, and has had a working life that has spanned education, research and government sectors.

Ms Rachel Fishlock

Appointment to office	Elected for a 1st term on 1 February 2024
Qualifications	BSc, MBM
Experience	Rachel is a proud descendant of the Yuin Nation and is the CEO of Gayaa Dhuwi (Proud Spirit) Australia. Rachel has over a decade of experience in the health sector including the optometry industry and community-controlled sector at the National Aboriginal Community Controlled Health Organisation (NACCHO). Rachel was recognised by Lifeline Canberra as the 2022 Rising Woman of Spirit for her outstanding community spirit and resilience in the face of adversity, through continuing to advocate for reforms to ensure other children do not experience systemic neglect.

CAPITAL HEALTH NETWORK LIMITED

ABN 82 098 499 471

Meetings of Directors

The number of meetings of the company's Board of Directors (the board) held during the year ending 30 June 2024, and the number of meetings attended by each Director were:

REGISTER OF DIRECTORS' ATTENDANCE FINANCIAL YEAR 2023 – 2024							
DIRECTOR	**24/8/23**	**21/9/23**	**19/12/23**	**1/2/24**	**2/5/24**	**13/6/24**	**TOTAL**
Darlene Cox	✔	✔	Apology	✔	Apology	✔	4/6
Mel Deery	✔	✔					2/2
Peter Quiggin KC	✔	✔	✔	✔	✔	Apology	5/6
Niral Shah	✔	✔	✔	✔	✔	Apology	5/6
Julie Blackburn	✔	✔	✔				3/3
Steven Baker	✔	✔	✔	✔	✔	✔	6/6
Jessica Tidemann			✔	✔	Apology	✔	3/4
Vik Fraser			Apology	✔	✔	✔	3/4
Rachel Fishlock				✔	Apology	Apology	1/3

Dividends Paid or Recommended

The company is a company limited by guarantee and is prohibited by its objects from distributing to its members.

Indemnification of Officer or Auditor

During or since the end of the financial year, the company has given indemnity or entered an agreement to indemnify or pay or agreed to pay insurance premiums to insure each of the directors and officers against liabilities for costs and expenses incurred by them in defending any legal proceedings arising out of their conduct while acting in the capacity as director. Other than conduct involving wilful breach of duty in relation to the company.

Proceeds on behalf of the company

No person has applied for leave of Court to bring proceedings on behalf of the company or intervene in any proceedings to which the company is a party for the purpose of taking responsibility on behalf of the company for all or any part of these proceedings.

The company was not a party to any such proceedings during the year.

Auditors Independence Declaration

A copy of the auditor's independence declaration is set out immediately after this directors report.

CAPITAL HEALTH NETWORK LIMITED

ABN 82 098 499 471

Signed in accordance with a resolution of the Board of Directors.

Darlene Cox
DIRECTOR

Niral Shah
DIRECTOR

Dated this 23rd day of September 2024

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AUDITOR'S INDEPENDENCE DECLARATION UNDER S60-40 OF THE AUSTRALIAN CHARITIES AND NOT-FOR-PROFITS COMMISSION ACT 2012 TO THE DIRECTORS OF CAPITAL HEALTH NETWORK LIMITED

As lead auditor of Capital Health Network, I declare that, to the best of my knowledge and belief, during the year ended 30 June 2024 there have been no contraventions of:

i. the auditor independence requirements as set out in the *Australian Charities and Not-For-Profits Commission Act 2012* in relation to the audit; and

ii. any applicable code of professional conduct in relation to the audit.

Sart Spinks, CA
Registered Company Auditor
BellchambersBarrett

Canberra, ACT
Dated this 23rd day of September 2024

Liability limited by a scheme approved under Professional Standards Legislation

CAPITAL HEALTH NETWORK LIMITED
ABN 82 098 499 471

STATEMENT OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME
FOR THE YEAR ENDED 30 JUNE 2024

	Note	2024 $	2023 $
Revenue	2	40,018,082	31,835,566
Audit, legal and consultancy expense		(37,264)	(38,100)
Communications		(213,177)	(220,099)
Consultants and contractors		(745,138)	(590,863)
Depreciation and amortisation expense		(203,013)	(183,901)
Right-of-use asset depreciation		(274,231)	(275,301)
Employee benefits expense		(6,246,568)	(5,564,196)
Administrative expenses		(174,732)	(149,491)
Occupancy		(65,184)	(68,637)
Professional development		(218,948)	(180,921)
Service provision		(30,267,244)	(23,553,106)
Other expenses		(1,502,245)	(945,389)
Total expenses		(39,947,744)	(31,770,004)
Current year surplus before income tax		70,338	65,562
Income tax expense		-	-
Net current year surplus		70,338	65,562
Other comprehensive income		-	-
Total comprehensive income for the year		70,338	65,562

The accompanying notes form part of these financial statements.

CAPITAL HEALTH NETWORK LIMITED
ABN 82 098 499 471

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2024

	Note	2024	2023
ASSETS		$	$
CURRENT ASSETS			
Cash and cash equivalents	3	17,033,842	12,639,387
Trade and other receivables	4	744,337	491,448
Other assets	5	2,777,782	2,466,807
TOTAL CURRENT ASSETS		20,555,961	15,597,642
NON-CURRENT ASSETS			
Plant and equipment	6	274,283	447,760
Right of use assets	7	27,307	291,588
TOTAL NON-CURRENT ASSETS		301,590	739,348
TOTAL ASSETS		20,857,551	16,336,990
LIABILITIES			
CURRENT LIABILITIES			
Lease liabilities	8	34,950	341,756
Trade and other payables	9	539,266	370,322
Contract liabilities	10	17,918,743	13,474,614
Provisions	11	449,144	291,847
TOTAL CURRENT LIABILITIES		18,942,103	14,478,539
NON-CURRENT LIABILITIES			
Lease liabilities	8	-	29,203
Provisions	11	167,796	151,934
TOTAL NON-CURRENT LIABILITIES		167,796	181,137
TOTAL LIABILITIES		19,109,899	14,659,676
NET ASSETS		1,747,652	1,677,314
EQUITY			
Retained earnings		1,747,652	1,677,314
TOTAL EQUITY		1,747,652	1,677,314

The accompanying notes form part of these financial statements.

CAPITAL HEALTH NETWORK LIMITED
ABN 82 098 499 471

STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2024

	Retained Surplus	Total
	$	$
Balance at 1 July 2022	1,611,752	1,611,752
Surplus for the year	65,562	65,562
Balance at 30 June 2023	1,677,314	1,677,314
Surplus for the year	70,338	70,338
Balance at 30 June 2024	1,747,652	1,747,652

The accompanying notes form part of these financial statements.

CAPITAL HEALTH NETWORK LIMITED
ABN 82 098 499 471

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2024

	Note	2024	2023
		$	$
CASH FLOWS FROM OPERATING ACTIVITIES			
Receipt from customers, government and others		48,483,716	38,530,588
Payments to suppliers and employees		(43,872,965)	(34,655,800)
Interest received		175,020	130,080
Net cash generated from operating activities		4,785,771	4,004,868
CASH FLOWS FROM INVESTING ACTIVITIES			
Payment for plant and equipment		(29,536)	(141,872)
Net cash used in investing activities		(29,536)	(141,872)
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of lease liabilities		(361,780)	(316,088)
Net cash used in financing activities		(361,780)	(316,088)
Net increase in cash held		4,394,455	3,546,908
Cash and cash equivalents at beginning of financial year		12,639,387	9,092,479
Cash and cash equivalents at end of financial year	3	17,033,842	12,639,387

The accompanying notes form part of these financial statements.

CAPITAL HEALTH NETWORK LIMITED
ABN 82 098 499 471

NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

The financial statements cover Capital Health Network (CHN) Limited as an individual entity, incorporated and domiciled in Australia. CHN is a company limited by guarantee.

The financial statements were authorised for issue on 23 September 2024 by the directors of CHN.

Note 1: Summary of Material Accounting Policies

Basis of Preparation

The financial statements are general purpose financial statements that have been prepared in accordance with Australian Accounting Standards – Simplified Disclosures of the Australian Accounting Standards Board (AASB) and the *Australian Charities and Not-for-profits Commission Act 2012.* The entity is a not-for-profit entity for financial reporting purposes under the Australian accounting Standards.

The financial statements, except for the cash flow information, have been prepared on an accrual basis and are based on historical costs, modified, where applicable, by the measurement at fair value of selected non-current assets, financial assets and financial liabilities. The amounts presented in the financial statements have been rounded to the nearest dollar.

Accounting Policies

a. **Revenue**

Revenue recognition

Operating Grants
When the company receives operating grant revenue it assesses whether the contract is enforceable and has sufficiently specific performance obligations in accordance with AASB 15. When both these conditions are satisfied, the company:

- identifies each performance obligation relating to the grant;
- recognises a contract liability for its obligations under the agreement; and
- recognises revenue as it satisfies its performance obligations.

Where the contract is not enforceable or does not have sufficiently specific performance obligations, the company:

- recognises the asset received in accordance with the recognition requirements of other applicable accounting standards (for example AASB 9, AASB 16, AASB 116 and AASB 138)
- recognises related amounts (being contributions by owners, lease liability, financial instruments, provisions, revenue or contract liability arising from a contract with a customer)
- recognises income immediately in profit or loss as the difference between the initial carrying amount of the asset and the related amount.

If a contract liability is recognised as a related amount above, the company recognises income in profit or loss when or as it satisfies its obligations under the contract.

Sponsorship & event registration
Revenue from the rendering of a service is recognised upon the delivery of the service to the customer. Revenues recognised in respect to registration are utilised to offset the associated expense incurred with the administration of registration.

Non-government funding sources
Funds received from non-government funding sources are recognised as revenue to the extent that the monies have been applied in accordance with the conditions of the terms of agreement between the non-government funding entity and CHN. Any non-government funds received prior to year-end but unexpended as at that date are recognised as a contract liability.

Interest Income
Interest income is recognised using the effective interest method.

CAPITAL HEALTH NETWORK LIMITED
ABN 82 098 499 471

NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 1: Summary of Material Accounting Policies (continued)

b. **Plant and Equipment**

Each class of plant and equipment is carried at cost or fair value as indicated, less, where applicable, accumulated depreciation and any impairment losses.

Plant and equipment are measured on the cost basis and are therefore carried at cost less accumulated depreciation and any accumulated impairment losses. In the event the carrying amount of plant and equipment is greater than the estimated recoverable amount, the carrying amount is written down immediately to the estimated recoverable amount and impairment losses are recognised either in profit or loss or as a revaluation decrease if the impairment losses relate to a revalued asset. A formal assessment of recoverable amount is made when impairment indicators are present (refer to Note 1(i) for details of impairment).

Plant and equipment that have been contributed at no cost, or for nominal cost, are valued and recognised at the fair value of the asset at the date it is acquired.

Depreciation

The depreciable amount of all fixed assets, including buildings and capitalised lease assets but excluding freehold land, is depreciated on a straight-line basis over the asset's useful life to the entity commencing from the time the asset is held ready for use. Leasehold improvements are depreciated over the shorter of either the unexpired period of the lease or the estimated useful lives of the improvements.
The depreciation rates used for each class of depreciable assets are:

Class of Fixed Asset	Depreciation Rate
Plant and equipment	3-10 years
Motor vehicles	4 years
Office equipment	6 years

The assets' residual values and useful lives are reviewed, and adjusted if appropriate, at the end of each reporting period.

Gains and losses on disposals are determined by comparing proceeds with the carrying amount. These gains or losses are recognised in profit or loss in the period in which they arise. Gains are not classified as revenue. When revalued assets are sold, amounts included in the revaluation surplus relating to that asset are transferred to retained surplus.

c. **Leases**
The company as a lessee

At inception of a contract, the company assesses if the contract contains or is a lease. If there is a lease present, a right-of-use asset and a corresponding lease liability is recognised by the company where the company is a lessee. However, all contracts that are classified as short-term leases (lease with remaining lease term of 12 months or less) and leases of low value assets are recognised as an operating expense on a straight-line basis over the term of the lease.

The lease liability is measured at the present value of the lease payments still to be paid at commencement date. The lease payments are discounted at the interest rate implicit in the lease.

CAPITAL HEALTH NETWORK LIMITED
ABN 82 098 499 471

NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 1: Statement of Material Accounting Policies (continued)

c. **Leases (continued)**

Lease payments included in the measurement of the lease liability are as follows:
- fixed lease payments less any lease incentives
- variable lease payments rate, initially measured using the index or rate at the commencement date
- the amount expected to be payable by the lessee under residual value guarantees
- the exercise price of purchase options, if lessee is reasonably certain to exercise the options
- lease payments under extension options if lessee is reasonably certain to exercise the options
- payments for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

The right-of-use assets comprise the initial measurement of the corresponding lease liability as mentioned above, any lease payments made at or before the commencement date as well as any initial direct costs. The subsequent measurement of the right-of-use assets is at cost less accumulated depreciation and impairment losses.

Right-of-use assets are depreciated over the lease term or useful life of the underlying asset whichever is the shortest.

Where a lease transfers ownership of the underlying asset or the cost of the right-of-use asset reflects that the company anticipates exercising a purchase option, the specific asset is depreciated over the useful life of the underlying asset.

d. **Financial Instruments**

Initial recognition and measurement

Financial instruments are initially measured at fair value, when contractual rights or obligations exist. Subsequent to initial recognition these instruments are measured as set out below.

Fair value represents the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Where available, quoted prices in an active market are used to determine fair value. In other circumstances, valuation techniques are adopted.

Classification and subsequent measurement

The classification of financial assets at initial recognition depends on the financial asset's contractual cash flow characteristics and the Association's business model for managing them. All of the Association's other financial instruments are classified and subsequently measured at amortised cost. The Association applies a simplified approach to calculating expected credit losses (ECL's) for financial assets held at amortised cost by recognising a loss allowance based on lifetime ECL's at each reporting date.

Amortised cost is calculated as:

(i) the amount at which the financial asset or financial liability is measured at initial recognition

(ii) less principal repayments

(iii) plus or minus the cumulative amortisation of the difference, if any, between the amount initially recognised and the maturity amount calculated using the effective interest method

(iv) less any reduction for impairment.

CAPITAL HEALTH NETWORK LIMITED
ABN 82 098 499 471

NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 1: Statement of Material Accounting Policies (continued)

d. **Financial Instruments (continued)**

Derecognition

Financial assets are derecognised where the contractual rights to receipt of cash flows expires or the asset is transferred to another party whereby the Association no longer has any significant continuing involvement in the risks and benefits associated with the asset. Financial liabilities are derecognised where the related obligations are either discharged, cancelled or expired. The difference between the carrying value of the financial liability extinguished or transferred to another party and the fair value of consideration paid, including the transfer of non-cash assets or liabilities assumed is recognised in profit or loss.

e. **Impairment of Assets**

At the end of each reporting period, the company reviews the carrying amounts of its tangible and intangible assets to determine whether there is any indication that those assets have been impaired. If such an indication exists, the recoverable amount of the asset, being the higher of the asset's fair value less costs of disposal and value in use, is compared to the asset's carrying amount. Any excess of the asset's carrying amount over its recoverable amount is recognised in profit or loss.

Where the assets are not held primarily for their ability to generate net cash inflows – that is, they are specialised assets held for continuing use of their service capacity – the recoverable amounts are expected to be materially the same as fair value.

Where it is not possible to estimate the recoverable amount of an individual asset, the company estimates the recoverable amount of the cash-generating unit to which the asset belongs.

Where an impairment loss on a revalued individual asset is identified, this is recognised against the revaluation surplus in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation surplus for that class of asset.

f. Employee Benefits

Short-term employee benefits

Provision is made for the company's obligation for short-term employee benefits. Short-term employee benefits are benefits that are expected to be settled wholly within 12 months after the end of the annual reporting period in which the employees render the related service. Short-term employee benefits are measured at the (undiscounted) amounts expected to be paid when the obligation is settled. The company does not have an unconditional right to defer settlement of annual leave obligations and are presented as current liabilities.

The company's obligations for short-term employee benefits such as wage and salaries are recognised as part of current trade and other payables in the statement of financial position.

CAPITAL HEALTH NETWORK LIMITED
ABN 82 098 499 471

NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 1: Statement of Material Accounting Policies (continued)

f. **Employee Benefits (continued)**

Other long-term employee benefits
The company classifies employees' long service leave entitlements as other long-term employee benefits as they are not expected to be settled wholly within 12 months after the end of the annual reporting period in which the employees render the related service. Provision is made for the company's obligation for other long-term employee benefits, which are measured at the present value of the expected future payments to be made to employees. Expected future payments incorporate anticipated future wage and salary levels, durations of service and employee departures, and are discounted at rates determined by reference to market yields at the end of the reporting period on high quality corporate bonds that have maturity dates that approximate the terms of the obligations. Upon the remeasurement of obligations for other long-term employee benefits, the net change in the obligation is recognised in profit or loss classified under employee benefits expense.
The company's obligations for long-term employee benefits are presented as non-current liabilities in its statement of financial position, except where the company does not have an unconditional right to defer settlement for at least 12 months after the end of the reporting period, in which case the obligations are presented as current liabilities.

g. **Income Tax**

No provision for income tax has been raised as the company is exempt from income tax under Div 50 of the *Income Tax Assessment Act 1997*.

h. **Provisions**

Provisions are recognised when the company has a legal or constructive obligation, as a result of past events, for which it is probable that an outflow of economic benefits will result, and that outflow can be reliably measured. Provisions recognised represent the best estimate of the amounts required to settle the obligation at the end of the reporting period.

i. **Economic Dependence**

Capital Health Network Limited is dependent on the Department of Health for the majority of its revenue used to operate the business. At the date of this report, the Board of Directors have no reason to believe the Department will not continue to support Capital Health Network Limited.

j. **Critical Accounting Estimates and Judgements**

The Directors evaluate estimates and judgements incorporated into the financial statements based on historical knowledge and best available current information. Estimates assume a reasonable expectation of future events and are based on current trends and economic data, obtained both externally and within the Company.
Key estimates

(i) *Estimation of useful lives of assets*
The company determines the estimated useful lives and related depreciation and amortisation charges for its plant and equipment and finite life intangible assets. The useful lives could change significantly as a result of technical innovations or some other event. The depreciation and amortisation charge will increase where the useful lives are less than previously estimated or technically obsolete or non-strategic assets that have been abandoned or sold will be written off or written down.

CAPITAL HEALTH NETWORK LIMITED
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NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 1: Statement of Material Accounting Policies (continued)

j. **Critical Accounting Estimates and Judgements (continued)**

Key estimates (continued)

(ii) *Employee benefits provision*
The liability for employee benefits expected to be settled more than 12 months from the reporting date are recognised and measured at the present value of the estimated future cash flows to be made in respect of all employees at the reporting date. In determining the present value of the liability, estimates of attrition rates and pay increases through promotion and inflation have been taken into account.

Key judgements

(i) *Performance obligations under AASB 15*
To identify a performance obligation under AASB 15, the agreement must be sufficiently specific to be able to determine when the obligation is satisfied. Management exercises judgement to determine whether the agreement is sufficiently specific by taking into account any conditions specified in the arrangement, explicit or implicit, regarding the promised goods or services. In making this assessment, management includes the nature/ type, cost/ value, quantity and the period of transfer related to the goods or services agreed.

(ii) *Employee benefits*
For the purpose of measurement, AASB 119: *Employee Benefits* defines obligations for short-term employee benefits as obligations expected to be settled wholly before 12 months after the end of the annual reporting period in which the employees render the related service. As the company expects that most employees will not use all of their annual leave entitlements in the same year in which they are earned or during the 12-month period that follows, the Directors believe that obligations for annual leave entitlements satisfy the definition of other long-term employee benefits and, therefore, are required to be measured at the present value of the expected future payments to be made to employees.

k. **New or Amended Accounting Standards Adopted by the Entity**

AASB 2021-2: Amendments to Australian Accounting Standards – Disclosure of Accounting Policies and Definition of Accounting Estimates

The Company adopted AASB 2021-2 which amends AASB 7, AASB 101, AASB 108 and AASB 134 to require disclosure of "material accounting policy information" rather than significant accounting policies in an entity's financial statements. It also updates AASB Practice Statement 2 to provide guidance on the application of the concept of materiality to accounting policy disclosures. The adoption of the amendment did not have a material impact on the financial statements.

AASB 2021-6 Amendment to Australian Accounting Standards – Disclosure of Accounting Policies: Tier 2 and Other Australian Accounting Standards

AASB 2021-6 amends AASB 1049 and AASB 1060- to require disclosure of "material accounting policy information" rather than significant accounting policies in an entity's financial statements. It also amends AASB 1054 to reflect the updated terminology used in AASB 101 as a result of AASB 2021-2. The adoption of the amendment did not have a material impact on the financial statements.

l. **Comparative Figures**

When required by Accounting Standards, comparative figures have been adjusted to conform to changes in presentation for the current financial year.

CAPITAL HEALTH NETWORK LIMITED
ABN 82 098 499 471

NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 2. Revenue	**Note**	**2024**	**2023**
		$	**$**
Grants received		39,810,927	31,705,861
Non-government funding sources		32,135	3,821
Interest income		175,020	125,884
		40,018,082	31,835,566

Grants Received

Most of the Company's funding is in the form of government grants. The Company has assessed that most of its grant agreements are enforceable and contain sufficiently specific performance obligations. The Company therefore recognises funding received under such agreement as Revenue under AASB 15: *Revenue from Contracts with Customers*. Revenue is recognised as the Company delivers the required services.

Note 3. Cash and Cash Equivalents	**Note**	**2024**	**2023**
		$	**$**
CURRENT			
Cash on hand		488	361
Cash at bank		17,033,354	12,639,026
		17,033,842	12,639,387

Note 4. Trade and Other Receivables			
CURRENT			
Trade debtors		25,636	35,373
Other receivables		39,039	767
Net GST receivables		679,662	455,308
		744,337	491,448

a. **Financial assets at amortised cost classified as trade and other receivables**			
Total trade and other receivables		744,337	491,448
Less net GST receivables		(679,662)	(455,308)
Financial assets as trade and other receivables	12	64,675	36,140

CAPITAL HEALTH NETWORK LIMITED
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NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 5. Other Assets	**2024**	**2023**
CURRENT	**$**	**$**
Deposits paid	5,223	13,033
Prepayments	370,727	476,940
Prepaid service delivery	2,304,269	1,883,984
Term Deposits – greater than 3 months	97,563	92,850
	2,777,782	2,466,807

Note 6. Plant and Equipment		
Plant and equipment - at cost	1,072,460	1,042,924
Less: Accumulated depreciation	(813,268)	(700,040)
	259,192	342,884
Leasehold improvements - at cost	487,342	487,342
Less: Accumulated depreciation	(472,251)	(382,466)
	15,091	104,876
Total plant and equipment	274,283	447,760

Movements in carrying amounts

Movements in carrying amounts for each class of property, plant and equipment between the beginning and the end of the current financial year:

	Plant and equipment	**Leasehold improvements**	**Total**
	$	**$**	**$**
Balance at 1 July 2023	342,884	104,876	447,760
Additions	29,536	-	29,536
Depreciation expense	(113,228)	(89,785)	(203,013)
Balance at 30 June 2024	259,192	15,091	274,283

CAPITAL HEALTH NETWORK LIMITED
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NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 7. Right of Use Assets

CHN's lease portfolio comprises a leased motor vehicle and an office lease.
The office lease agreement expired in July 2024. As of the date of the financial statements, CHN was on a month-to-month arrangement at the existing office.

i. AASB 16 related amounts recognised in the balance sheet

Right of use assets	2024	2023
	$	$
Leased premises	1,393,154	1,385,026
Less accumulated amortisation	(1,365,847)	(1,093,438)
Total right of use asset	27,307	291,588

ii. AASB 16 related amounts recognised in the statement of profit or loss

Amortisation expense		(274,231)	(275,301)
Finance costs		(15,821)	(37,719)
		(290,052)	(313,020)

Note 8. Lease Liabilities

Current		34,950	341,756
Non-current		-	29,203
	12	34,950	370,959

Note 9. Trade and other payables

CURRENT			
Creditors and accrued expenses		539,266	370,322
Financial liabilities as trade and other payables	12	539,266	370,322

Note 10. Contract Liabilities

CURRENT		
Unearned government grant income	17,918,743	13,474,614

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NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 11. Provisions	**2024**	**2023**
	$	**$**
CURRENT		
Provision for annual leave entitlements	349,416	256,179
Provision for long service leave	99,728	35,668
	449,144	291,847
NON-CURRENT		
Provision for long service leave	167,796	151,934
Total employee provisions	167,796	151,934

Note 12: Financial Risk Management

The Company's financial instruments consist mainly of deposits with banks, short-term and long-term investments, accounts receivable and payable and lease liabilities.

The totals for each category of financial instruments, measured in accordance with AASB 9: Financial Instruments as detailed in the accounting policies to these financial statements, are as follows:

Financial assets	**Note**	**2024**	**2023**
Held at amortised cost		**$**	**$**
Cash and cash equivalents	3	17,033,842	12,639,387
Trade receivables	4a	64,675	36,140
Total financial assets		17,098,517	12,675,527
Financial liabilities			
Lease liabilities	8	34,950	370,959
Trade payables	9	539,266	370,322
Total financial liabilities		574,216	741,281

Note 13. Key Management Personnel Compensation

a. Key management personnel compensation	842,540	921,310

Any person(s) having authority and responsibility for planning, directing and controlling the activities of the Company, directly or indirectly, including any director (whether executive or otherwise) of the Company, is considered key management personnel.

CAPITAL HEALTH NETWORK LIMITED
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NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 14. Other Related Parties

Other related parties include close family members of key management personnel and entities that are controlled or jointly controlled by those key management personnel individually or collectively with their close family members. Several Directors are Executives or Directors of other entities which CHN transacts with.

Transactions between related parties are on normal commercial terms and conditions no more favourable than those available to other persons unless otherwise stated. The Company had the following Related Party transactions during the period:

Name of Related Party	Nature of Transaction	Reason for Inclusion	Amount $
Health Care Consumers Association	Provision of consumer representation on CHN committees, support and advice on consumer matters & advice in relation to the Health Pathways Program.	Ms Darlene Cox is the Executive Director of Health Care Consumers Association (HCCA) and a member of CHN Board and ARC.	11,000
Health Care Consumers Association	Multicultural Needs Assessment Consultation		50,313
Meridian Incorporated	Psychological Therapies Targeting Priority Populations		273,611
Meridian Incorporated	Psychological Therapies Targeting Priority Populations		91,204
Meridian Incorporated	Psychological Therapies Targeting Priority Populations		91,204
Meridian Incorporated	Delivery of COVID-19 Vaccination Support Program to At-Risk Populations	Ms Darlene Cox is a Board member and secretary of Meridian Incorporated and a member of CHN Board and ARC	19,800
Meridian Incorporated	Care Finder Program		36,663
Meridian Incorporated	Care Finder Program		36,663
Meridian Incorporated	Care Finder Program		24,442
Meridian Incorporated	Care Finder Program		24,442
Karralika Programs Incorporated	Community Based Alcohol and Other Drug Counselling for those linked with the Criminal Justice System	Ms Julie Blackburn is CHN Board Chair and Deputy Director of Karralika Programs Inc.	135,151

CAPITAL HEALTH NETWORK LIMITED
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NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Name of Related Party	Nature of Transaction	Reason for Inclusion	Amount $
Karralika Programs Incorporated	Community Based Alcohol and Other Drug Counselling for those linked with the Criminal Justice System		45,050
Karralika Programs Incorporated	Community Based Alcohol and Other Drug Counselling for those linked with the Criminal Justice System		33,788
Karralika Programs Incorporated	Community Based Alcohol and Other Drug Counselling for those linked with the Criminal Justice System	Ms Julie Blackburn is CHN Board Chair and Deputy Director of Karralika Programs Inc.	11,263
Karralika Programs Incorporated	Community Health and Hospitals Program		323,663
Karralika Programs Incorporated	Community Health and Hospitals Program		161,832
Karralika Programs Incorporated	Community Health and Hospitals Program		161,832
Karralika Programs Incorporated	Community Health and Hospitals Program		161,832
GP Peer Support Program	GP Peer Support Program	Dr Mel Deery is a Board member and selected as mentor for GP Peer Support Program.	660

CAPITAL HEALTH NETWORK LIMITED
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NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 15. Contingent Liabilities

The Company has provided bank guarantees of $74,877 (2023: $74,877) to the National Australia Bank for its obligations under its office lease.

Note 16. Events After the Reporting Period

No other matter or circumstance has arisen since 30 June 2024 that has significantly affected, or may significantly affect the company's operations, the results of those operations, or the company's state of affairs in future financial years

Note 17: Members' Guarantee

CHN is incorporated under the Corporations Act 2001 and is a company limited by guarantee. If the company is wound up, the constitution states that each member is required to contribute a maximum of $10 each towards meeting any outstanding obligations of the Company. At 30 June 2024, the number of members was 619 (2023: 577). Membership is cyclical, requiring renewals every three years.

Note 18. Company Details

The registered office and principal place of business of the Company is:

Capital Health Network Limited
Unit 2, Geils Court,
Deakin ACT 2600

Note 19. Auditors Remuneration	**2024**	**2023**
	$	**$**
Auditing or reviewing the financial statements	16,700	14,160
Audit of grant acquittals	18,480	17,480
Other	4,700	4,500
	39,880	36,140

Note 20: Capital and Leasing Commitments

As at the date of this report, CHN was in negotiations for a new office lease. CHN has estimated that the costs of relocation and fit-out is approximately $1.8 million. CHN has also received approval from a grant funding provider to utilise unexpended funds from prior years towards the relocation and fit-out costs.

CAPITAL HEALTH NETWORK LIMITED
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DIRECTORS' DECLARATION

In accordance with a resolution of the Directors of Capital Health Network Limited, the Directors of the Registered Entity declare that, in the Directors' opinion:

1. The financial statements and notes, as set out on pages 10-26 satisfy the requirements of the *Australian Charities and Not-for-profits Commission Act 2012* and:
    a. comply with Australian Accounting Standards applicable to the Registered Entity; and
    b. give a true and fair view of the financial position of the registered entity as at 30 June 2024 and of its performance for the year erided on that date.
2. There are reasonable grounds to believe that the Registered Entity will be able to pay its debts as and when they become due and payable.

This declaration is signed in accordance with subsection 60.15(2) of the *Australian Charities and Not-for-profits Commission Regulation 2013*.

Darlene Cox
DIRECTOR

Niral Shah
DIRECTOR

Dated this 23rd day of September 2024

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INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF CAPITAL HEALTH NETWORK LIMITED

Report on the Audit of the Financial Report

Opinion

We have audited the accompanying financial report of Capital Health Network Limited (the Company), which comprises the statement of financial position as at 30 June 2024, the statement of profit or loss, statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of material accounting policies and other explanatory information, and the directors' declaration.

In our opinion, the accompanying financial report of Capital Health Network has been prepared in accordance with Division 60 of the *Australian Charities and Not-for-profits Commission Act 2012* (the ACNC Act), including:

(i) giving a true and fair view of the registered entity's financial position as at 30 June 2024 and of its financial performance for the year then ended; and

(ii) complying with Australian Accounting Standards – AASB 1060: *General Purpose Financial Statements – Simplified Disclosures for For-Profit and Not-for-Profit Tier 2 Entities* and Division 60 of *Australian Charities and Not-for-profits Commission Regulation 2013*.

Basis for Opinion

We conducted our audit in accordance with Australian Auditing Standards. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Report section of our report. We are independent of the registered entity in accordance with the ACNC Act and ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants (including Independence Standards)* (the Code) that are relevant to our audit of the financial report in Australia. We have also fulfilled our other ethical responsibilities in accordance with the Code.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Information Other than the Financial Report and Auditor's Report Thereon

The directors are responsible for the other information. The other information comprises the information included in the annual report for the year ended 30 June 2024 but does not include the financial report and our auditor's report thereon. Our opinion on the financial report does not cover the other information and accordingly we do not express any form of assurance conclusion thereon. In connection with our audit of the financial report, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial report or our knowledge obtained in the audit or otherwise appears to be materially misstated. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Responsibilities of the Directors for the Financial Report

The directors of the registered entity are responsible for the preparation of the financial report that gives a true and fair view in accordance with Australian Accounting Standards – Simplified Disclosures and the *Australian Charities and Not-for-profits Commission Act 2012* and for such internal control as the directors determine is necessary to enable the preparation of the financial report that gives a true and fair view and is free from material misstatement, whether due to fraud or error.

In preparing the financial report, the directors are responsible for assessing the ability of the registered entity to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the registered entity or to cease operations, or has no realistic alternative but to do so.

The directors are responsible for overseeing the registered entity's financial reporting process.

Liability limited by a scheme approved under Professional Standards Legislation

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INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF CAPITAL HEALTH NETWORK LIMITED

Auditor's Responsibility for the Audit of the Financial Report

Our objectives are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report.

As part of an audit in accordance with the Australian Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the registered entity's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the directors.
- Conclude on the appropriateness of the directors' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the registered entity's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the registered entity to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the directors regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

BellchambersBarrett

Sart Spinks, CA
Registered Company Auditor
BellchambersBarrett

Canberra, ACT
Dated this 23rd day of September 2024


CHN