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CENTRAL AND
EASTERN SYDNEY

An Australian Government Initiative

EXECUTIVE SUMMARY

2025-2027 Needs Assessment

EXECUTIVE SUMMARY

Contents

List of tables

List of figures

EXECUTIVE SUMMARY

In this document we have used the terms Aboriginal, Aboriginal person and Aboriginal people/s when referring to Aboriginal and Torres Strait Islander peoples. We chose Aboriginal because it is inclusive of different language groups and areas within the CESPHN region. There will be some instances where the terminology will be different to our preferred terms, as we use the terminology of the data set being used.

EXECUTIVE SUMMARY

Introduction

The purpose of this Needs Assessment is to identify community health and wellbeing needs, gaps in service delivery and to work with partners across the region to address these.

Central and Eastern Sydney Primary Health Network (CESPHN) will use the Needs Assessment to:

- Better meet the health and wellbeing needs of residents
- Inform CESPHN's strategic direction
- Plan for commissioning services and programs
- Prioritise work with partners
- Share insights and data with services and the community
- Build relationships and engage with the community around joint initiatives.

Stakeholder engagement and insights, combined with the rigorous analysis of public datasets, such as Census data and other relevant information, provide us with a comprehensive picture of appropriate and fit-for-purpose responses that support, strengthen, and shape a person-centred primary healthcare system.

CESPHN conducted consultations to gather community and service provider input to identify the health needs of the community as well as the service gaps that exist. This, along with data analysis and a triangulation process has led to the identification of 13 priority needs and two overarching service needs.

These are:

Health issues

- Chronic conditions
- Suicide prevention
- Mental Health
- Use of alcohol and other drugs
- Sexual health

Health of specific populations

- Aboriginal and Torres Strait Islander peoples' health and wellbeing
- Health and wellbeing of people from multicultural communities
- Older individuals' health and wellbeing
- Health and wellbeing of children in the first five years
- Health and wellbeing of people living with a disability
- Health and wellbeing of people affected by domestic, family and sexual violence
- Health and wellbeing of LGBTIQ+ people
- Health and wellbeing of people impacted by homelessness
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Access and Coordination

- Access to primary health care
- Coordinated care.

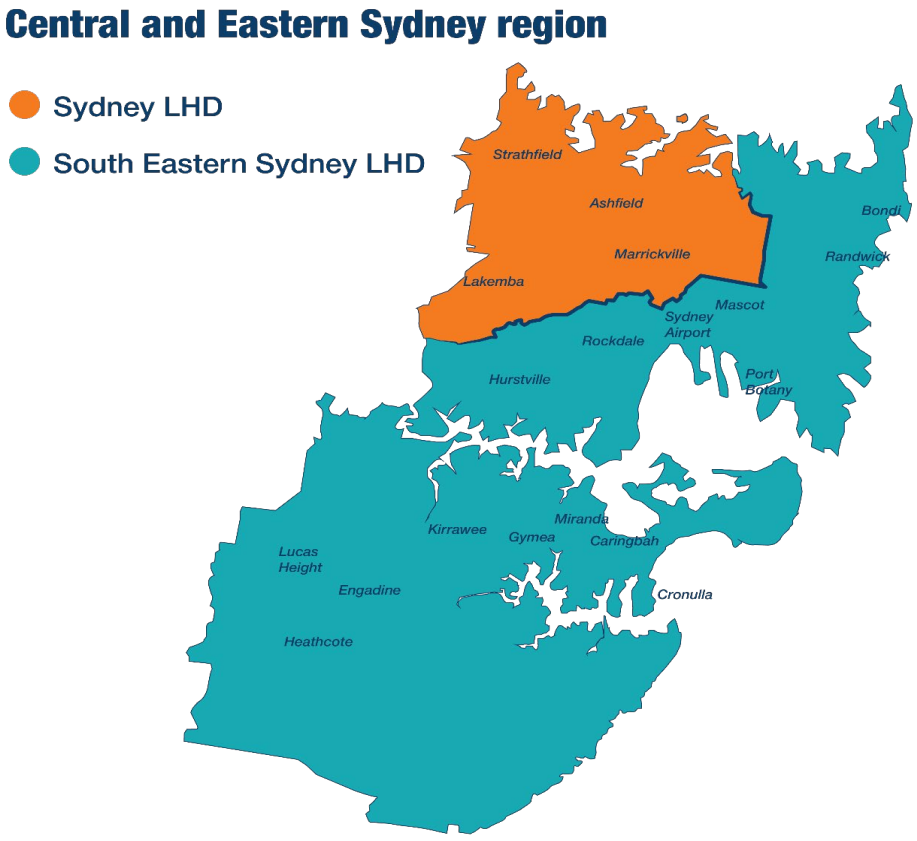
Each priority need and service gap is outlined in a chapter showing the data and outcomes of consultations. Within each chapter priority needs are outlined and service gaps specific to that need are also identified.

Central and Eastern Sydney region

The Central and Eastern Sydney region covers the area of Sydney, south of the Harbour Bridge along the coast as far as the Royal National Park, the city of Sydney itself, extending to the inner western suburbs of Lakemba and Strathfield.

The catchment area includes 12 Local Government Areas (and Lord Howe Island). The region includes the Central Business District.

The region corresponds with the two Local Health Districts of Sydney and South Eastern Sydney as shown in the image below. The Central and Eastern Sydney region is often referred to as the CESPHN region throughout this document.



Demographic profile

The estimated resident population of the central and eastern Sydney region is 1,624,881 in 2024 (approximately 20% of NSW's population) (1). This makes CESPHN one of the largest PHNs by population, comprising 6% of Australia's population (1).

Most areas have urban densities above 4,000 persons per square kilometre, but the region also includes Lord Howe Island with a total population of 452 people. At 9,489.87 people per sq km, Sydney Inner City is the most densely populated SA3 in the central and eastern Sydney region. Other highly dense areas include Leichhardt (5,387.37), Eastern Suburbs – North (5,014.65) and Strathfield-Burwood-Ashfield (4,938.83).

As a major employment, education and entertainment hub for the larger Sydney population, this region also has a large non-resident population with 350,761 people entering the region each day (2021 Census). This non-resident population also make use of the range of health services on offer.

The region contains communities of great wealth and areas of disadvantage. Woollahra is the most advantaged area in Australia. The Canterbury and Hurstville SA3s have the lowest Socio-Economic Indexes for Areas (SEIFA) values in the region, at 914 and 995 respectively and contain 281,130 (17.4%) of people in the region according to the 2023 ERP. The 2021 Census data recorded a high number of people experiencing homelessness or at risk of homelessness in the region (12,799 people). These 12,799 people represent:

- 35% of the NSW homeless population
- 66.2% of the NSW boarding house residents
- 20.8% of NSW social housing residential dwellings and long waitlists for general applicants.

There is significant cultural diversity across the CESPHN region, with the 2021 Census data showing that 40.7% of CESPHN residents were born overseas. The SA3 areas of Canterbury, Sydney Inner City, Strathfield-Burwood-Ashfield, Botany and Kogarah-Rockdale have more than 50% of their population born overseas and Hurstville has 50% of residents born overseas. Overall. 46.8% of the population speak a language other than English at home and 6.3% do not speak English well or at all. (Census, 2021).

The areas with the highest proportions of people who do not speak English well or not at all are Canterbury (14.5%), Hurstville (11.3%), Strathfield-Burwood-Ashfield (10.0%) and Kogarah-Rockdale (8.7%) and Botany (6.3%), compared to the NSW average of 4.5%. The top four languages other than English spoken at home are Mandarin (17.2%), Cantonese (Greek 8.7%) and Arabic (8.2%).

There are 16,265 Aboriginal people living in the region, representing 1.0% of the total population. The Sutherland Shire has the largest Aboriginal population with 3,273 residents (20.1% of Aboriginal population) who identify as Aboriginal or Torres Strait Islander, then Sydney City has 3,009 (18.5%) and Randwick-La Perouse has 2,354 residents (14.5%). (2021 Census). The region is home to 11,382 same sex couples, representing 14.5% of same sex couples living together in Australia. For comparison, the region comprises 6% of the total Australian population.

Table 1: Estimated resident population (ERP) in the CESPHN region by SA3, 2023

SA3	Total Persons	Density (per sq. km)
Botany	61,999	2,230.36
Canada Bay	88,731	4,493.37
Canterbury	144,858	4,834.30
Cronulla-Miranda-Caringbah	121,298	2,180.91
Eastern Suburbs - North	131,308	5,014.65
Eastern Suburbs - South	141,831	4,495.71
Hurstville	136,272	4,013.28
Kogarah-Rockdale	151,988	4,848.43
Leichhardt	57,417	5,387.37
Lord Howe Island	452	27.74
Marrickville-Sydenham-Petersham	56,334	4,446.29
Strathfield-Burwood-Ashfield	168,628	4,938.83
Sutherland-Menai-Heathcote	113,160	471.02
Sydney Inner City	237,855	9,489.87
CESPHN	1,612,131	2,708.38

Source: ABS, 2024

Population growth

There are increased planned housing targets in all LGAs in the CESPHN region over the next five years. This increased housing will allow for more people to live in the region requiring more services.

Table 2: Housing targets by LGA, 2024

LGA	2029 New Housing Target
Bayside	10,100
Burwood	3,300
Canada Bay	5,000
Canterbury-Bankstown	14,500
Georges River	6,300
Inner West	7,800
Randwick	4,000
Strathfield	3,500
Sutherland	6,000
Sydney	18,900
Waverley	2,400
Woollahra	1,900

Source: NSW Department of Planning, Housing and Infrastructure, 2024

Between 2024 and 2041, the population in the CESPHN region is expected to increase by 9.3% to 1,866,105 residents. The greatest population growth is expected in the 85 years and over age group

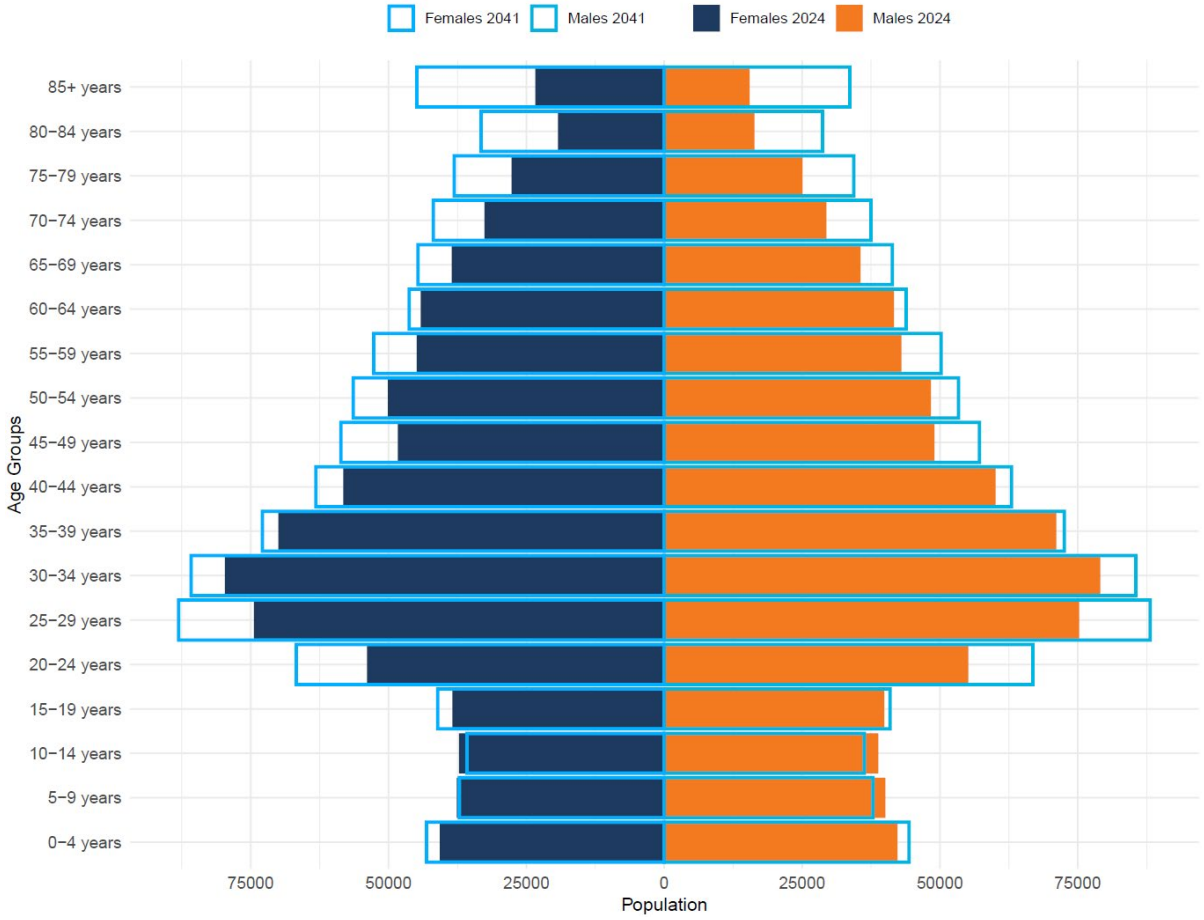
(120.4% increase). These projections are based on assumptions about future trends in fertility, mortality and migration (1).

Table 3: Population projections by age groups, CESPHN region, 2024-2041

Age group	2024	2041	% change	Compound annual growth rate (CAGR)
0-14 years	236,771	234,580	-0.93	-0.05%
15-64 years	1,124,744	1,253,317	11.43	0.64%
65+ years	346,348	378,208	9.20	0.52%
Total	1,707,863	1,866,105	9.27	0.52%

Source: HealthStats NSW, 2024

Figure 1: Population projections by sex and five-year age groups, CESPHN region, 2024-2041



Source: HealthStats NSW, 2024

Health status

The CESPHN region overall has a generally better health profile than the rest of Australia. Obesity and smoking rates are lower, people drink fewer standard drinks per day than in the rest of Australia, exercise more and suffer less mental health distress. There are less avoidable deaths and less

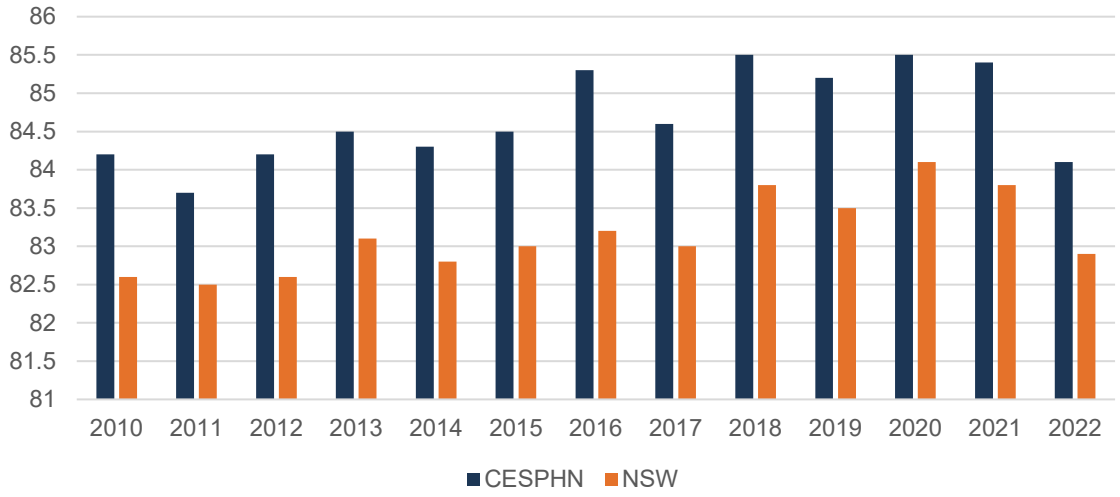
cancer diagnoses. However, there are many areas where there is room for improvement. These include immunisation rates, rates of cancer screening and rates of sexually transmissible infections.

Life expectancy

In 2022, the life expectancy at birth for those living in the CESPHN region was 84.1 years, which was higher than that of NSW by 1.2 years (2).

Life expectancy in both CESPHN and NSW have been generally trending upwards over the past 10 years, however a marked decline was seen between 2020 and 2022. (2) This decline was observed Australia wide and could be attributed to the increase in deaths in 2022, of which close to half were due to COVID-19 (3).

Figure 2: Life expectancy, CESPHN and NSW, 2010-2022



Source: HealthStats, 2024

Within the CESPHN region the female life expectancy is slightly higher (86.1 years) than male life expectancy (82.2 years). This is higher than the NSW life expectancy of 84.9 for females and 80.9 for males (2).

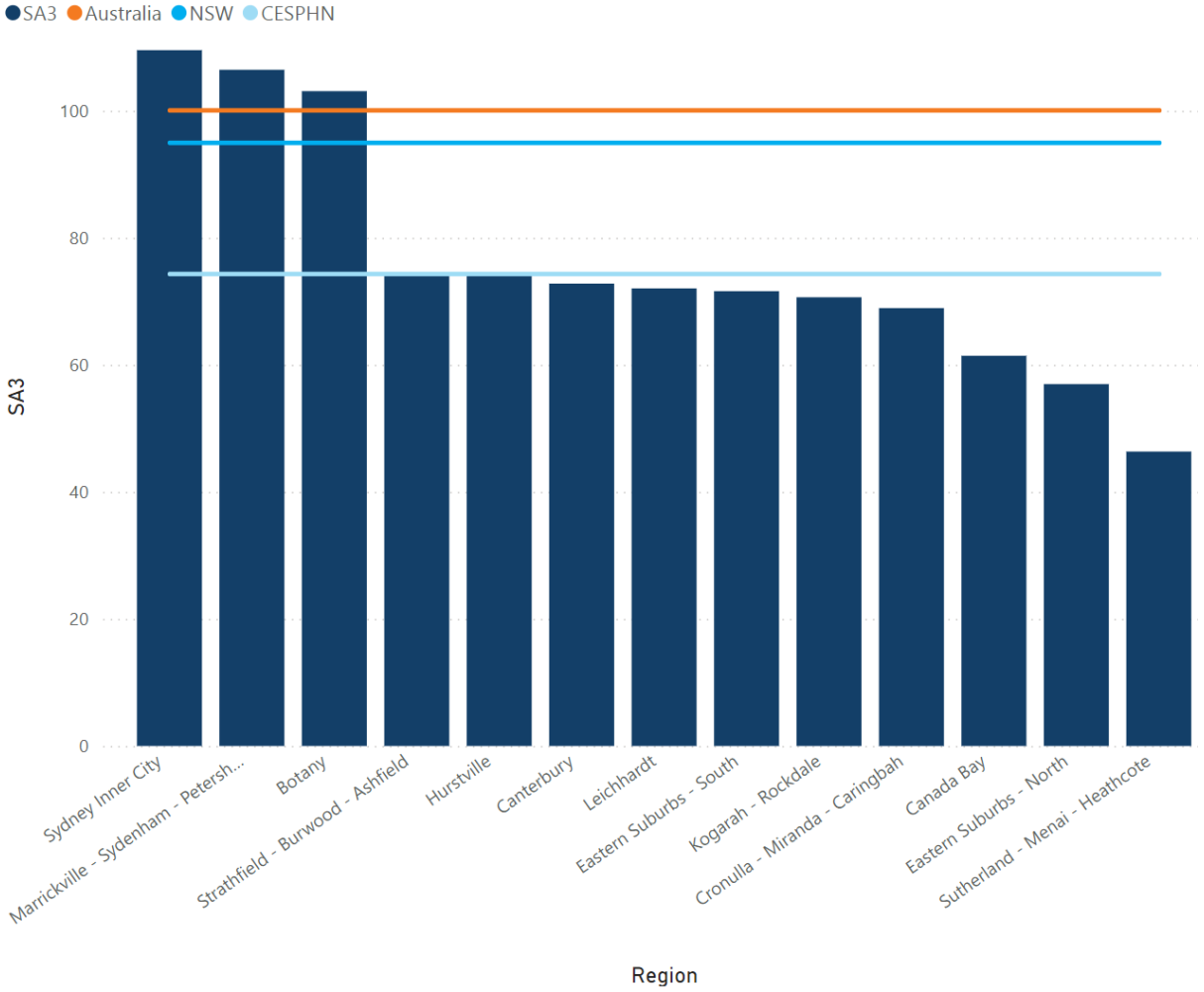
Potentially avoidable deaths

Potentially avoidable deaths are deaths below the age of 75 years from conditions that are potentially preventable through primary or hospital care.

In 2022, the age-standardised rate (ASR) of potentially avoidable deaths for males in the CESPHN region was 97.64 per 100,000 people which was significantly higher than that of the female ASR of 52.04 per 100,000 people. This is reflective of the national rates with the avoidable death rate in males and females accounting for 129.76 per 100,000 and 71.50 per 100,000, respectively.

Sydney (Inner city), Marrickville-Sydenham-Petersham, and Botany had the highest rate of potentially avoidable deaths, exceeding that of the CESPHN, NSW and Australia averages.

Figure 3: Potentially avoidable deaths in the CESPHN region (ASR per 100,000) by SA3, 2022



Source: AIHW, 2023
***Lord Howe Island is not included as there is no published data available.*

Child mortality

Perinatal deaths have stayed relatively constant across both the CESPHN region and NSW from 2012 to 2022, with CESPHN perinatal deaths accounting for 17.11% of the total NSW perinatal deaths. (4)

Across 2013 to 2022, there were on average approximately 474 deaths each year among NSW infants and children aged 0 to 16 years. Most child deaths occurred in those aged under 1 year, accounting for 65% of all these deaths in NSW over the 10-year period of 2013-2022 (4).

The leading cause of death for children aged under 1 year over this period was maternal, neonatal and congenital causes (80% of deaths). In older children, the leading cause of death was injury and poisoning (59% for those aged 15 years and 54% for those aged 16 years) (5).

Premature mortality

Premature mortality refers to deaths that occur among people aged under 75 years. In 2016-20, premature mortality rates in the CESPHN region (188.5 per 100,000 people) were lower than both NSW (235.1 per 100,000 people) and national rates (236.1 per 100,000 people) (6).

The male rate (236.3 per 100,000 people) was much higher than the female rate (140.7 per 100,000 people) in the CESPHN region. Botany SA3 (226.4 per 100,0000 people) had the highest rate of premature mortality for both genders (6).

The three highest causes of premature mortality were cancer (82.6 per 100,000), circulatory system diseases (32.4 per 100,000) and external causes (20.3 per 100,000). Canterbury SA3 has higher premature mortality rates for circulatory disease (45.6 per 100,000), ischaemic heart disease (21.8 per 100,000) and cerebrovascular disease (7.0 per 100,000) than state and national rates (6).

Table 4: Premature mortality per 100,000 people by cause and by SA3, 2018-22

SA3	Cancer	Cerebrovascular disease	Circulatory disease	COPD	Diabetes	External causes	Ischaemic heart disease	Respiratory system disease	Road traffic	Suicide
Botany	93.6	8.3	39.8	11.4	8.8	24.3	22.0	15.1	3.5	9.4
Canada Bay	79.5	5.0	22.4	4.0	3.7	19.2	8.7	6.3	1.9	8.2
Canterbury	85.8	7.5	40.2	5.6	5.1	17.9	19.4	12.1	1.3	5.1
Cronulla - Miranda - Caringbah	80.9	5.1	27.0	4.4	3.7	18.7	11.9	10.1	0.9	8.6
Eastern Suburbs - North	70.5	5.8	23.0	2.3	2.8	21.0	9.6	5.4	2.7	8.9
Eastern Suburbs - South	86.7	8.6	34.9	6.8	5.1	23.4	16.6	9.4	0.7	8.5
Hurstville	79.6	7.4	29.1	3.9	5.4	16.9	11.9	8.7	2.5	7.2
Kogarah - Rockdale	86.2	7.1	33.5	4.3	7.3	16.5	13.6	9.4	1.1	6.3
Leichhardt	84.9	9.1	34.0	9.1	5.3	22.6	14.3	15.6		11.3
Marrickville - Sydenham - Petersham	91.6	9.2	44.7	8.4	8.3	26.7	19.7	14.0	1.8	11.7
Strathfield - Burwood - Ashfield	81.9	7.2	34.4	6.4	3.0	20.2	17.2	13.8	1.8	7.1
Sutherland - Menai - Heathcote	88.1	4.7	29.9	4.7	4.9	21.0	15.8	9.4	2.9	8.8
Sydney Inner City	93.7	6.7	38.5	11.7	6.6	32.7	18.3	17.2	0.9	12.8
CESPHN	84.3	6.8	32.5	6.0	5.1	22.1	15.0	10.9	1.6	8.8
NSW	98.4	8.0	41.6	10.2	7.4	26.7	19.2	16.3	3.4	11.2
Australia	96.5	7.9	42.8	9.7	7.1	30.4	21.6	15.3	4.2	12.6

Source: PHIDU 2022

** Lord Howe Island is not included as there is no published data available.

Psychological distress

Rates of psychological distress in NSW have grown significantly since 2013 as well as the severity of psychological distress. In 2013, 72% of people experienced low levels of distress in 2023, 26.8% of people experienced low levels of distress with a corresponding increase in the population experiencing moderate levels of distress. Similarly, the levels of high or very high psychological distress increased in the same period (7).

Table 5: Proportion of psychological distress experienced, CESPHN and NSW, 2013, 2023

Psychological distress	2013 NSW Proportion	2013 CESPHN Proportion	2023 NSW Proportion	2023 CESPHN Proportion
Very high levels	3.10%	2.5%	4.20%	4.2%
High levels	7.0%	6.3%	11.0%	11.0%
Moderate levels	17.9%	17.8%	58.0%	26.8%
Low levels	72.0%	73.4%	26.8%	58.0%

Source: HealthStats NSW, 2024

In 2021-2023, 15.8% of persons aged 18 years and over in the CESPHN region reported experiencing high or very high psychological distress compared to 16.9% in NSW. (8)

Primary care landscape

As of September 2024, the central and eastern Sydney region has 564 general practices, of which 69.5% are accredited or registered for accreditation (CESPHN CRM). The region has 2,166 general practitioners, giving a rate of 138.7 fulltime equivalent (FTE) per 100,000 population (9). In 2023, the region had 238 Australian General Practice Training (AGPT) registrars. In 2022, central and eastern Sydney had 515 primary care nurses.

In 2022, there were 13,604 Australian Health Practitioner Regulation Agency (AHPRA) registered allied health professionals (AHPs) working in the central and eastern Sydney region (12,565.9 FTE), giving a rate of 895.8 per 100,000 population (827.3 FTE per 100,000 population). This is made up of the following:

- 581 Chinese medicine practitioners
- 436 chiropractors
- 1,790 dental practitioners
- 1,055 medical radiation practitioners
- 1,216 occupational therapists
- 502 optometrists
- 114 osteopaths
- 697 paramedicine practitioners
- 1,785 pharmacists
- 2,334 physiotherapists
- 380 podiatrists
- 2,777 psychologists.

In 2023-24, CESPHN commissioned 93 programs and services, delivering 229,206 occasions of service to 62,070 people.

Future directions and priorities

There is a range of national reforms in the planning that will impact the delivery of care and create disruptions to the usual way of doing business for primary and social care providers over the next five years. The Commonwealth has flagged primary health care's key role in prevention and early intervention. Changes to the way health care is funded will impact primary health and consumers.

With an aging population and the resultant increase in health needs, there is increased focus on healthy ageing. Additionally, there is an increased push for strengthened collaboration between primary care and other parts of the system, as well as collaboration with all arms of government.

In primary health care, ongoing digital health developments should improve continuity of care through system interoperability and the incentivisation of system integration. At the state level, the Single Digital Patient Record (SDPR), which is currently in development, will replace the numerous electronic medical record, patient administration and laboratory systems in use across the state public health system with a single source of clinical information. The implementation of cloud-based health systems is also a priority. Efforts are also being made to enhance communication between state and commonwealth systems, ensuring more cohesive healthcare delivery.

The cost of primary health care for consumers has been a key issue raised in the consultations. Community service survey responses identified that people are struggling to afford to live in the Sydney region and health and wellbeing costs are expenses they will forgo if possible. Delaying or foregoing treatment has implications for the longer term health of the population given that early intervention and prevention lead to the best outcomes. Differential access to care also leads to increasing disparities in health between those who can afford to pay for services and those who cannot.

Methodology

The 2025-2027 Needs Assessment development process involved four key phases. It involved a more comprehensive approach to gathering qualitative and quantitative evidence from broader sources and identifying key priorities. We considered feedback from our staff and stakeholders involved in consultations on the current use of the Needs Assessment and opportunities for improvement. We focused on increasing stakeholder engagement throughout the process and providing more of opportunities for consultation.

Planning and design

- Feedback from CESPHN staff and leadership on the previous Needs Assessment process and report
- Documentation review of key national and regional guides, strategies and policies
- Review of 2022-2024 CESPHN Needs Assessment and Strategy (includes other CESPHN strategies on key areas since 2021)
- Review of Needs Assessments from other PHNs and organisations
- Engagement with Local Health Districts ad Networks (LHDs/LHNs)
- Engagement with local Councils
- Project plan developed to include key timeframes, deliverables, processes, roles and responsibilities
- Market analysis
- Revised Needs Assessment structure to guide writing during the reporting phase

Data collection and engagement

- Quantitative data collection/updates e.g., ABS, AIHW, Population-level statistics, health indicators, etc.,
- Primary care level data through POLAR, LUMOS, NADA (AOD) and primary mental health data
- Qualitative data collection
- Service mapping
- Use of academic articles
- Use of reports from other organisations

Analysis and triangulation

- Initial analysis of quantitative and qualitative data to identify key themes and trends
- Internal sensemaking analysis sessions triangulate data and prioritise needs/gaps identified
- Sense check priorities with CESPHN leadership, staff and key stakeholders
- Confirm priorities

Reporting feedback and submission

- Draft Needs Assessment report and executive summary
- Feedback from relevant CESPHN staff and leadership
- Updated Needs Assessment based on feedback
- Prepare and submit Needs Assessment to the Department
- Develop 2-3 page snapshots on priorities and for different audiences post submission and approval
- Update CESPHN website to make it more interactive

EXECUTIVE SUMMARY

A mixed methods approach was used to capture, analyse and triangulate data to obtain an understanding of the health needs and services gaps for the region. Quantitative data were derived from internal, administrative, primary care data, and census-based sources, while qualitative data collected from stakeholder consultations and engagement was considered and, where contextually relevant, included in the data synthesis. Additionally, progress made since the last needs assessment has been considered, together with new data, emerging literature, policies, and plans to provide contextual information and insights not obvious from quantitative data sources.

Both quantitative and qualitative methods were used to both gather data and then to cross check. The table below provides an overview of the quantitative and qualitative data gathered during the data collection phase of the Needs Assessment process.

The **quantitative data** gathered and assessed included demographic and epidemiological data predominantly from the following sources: • Australian Bureau of Statistics (ABS) • Australian Institute of Health and Welfare (AIHW) • Public Health Information Development Unit (PHIDU) • HealthStats • Department of Health • National Disability Insurance Scheme (NDIS) • Lumos dataset on emergency department presentations • Primary Mental Health Care Minimum Data Set • headspace Tableau We also used data and insights from internal databases used across our steams, including: • Salesforce, CESPHN's CRM • The Network of Alcohol and Drugs Agencies (NADA) • POLAR primary care data from over 381 GP clinics in the region •	The **qualitative data** gathered and assessed included: • Survey of 32 community service organisations • Consultations with CESPHN staff • Roundtable disability discussions • Consultations with selected subject matter experts across priority areas • Consultations with CESPHN advisory committees including the Aboriginal advisory committee and alcohol and other drugs advisory committee • Insights from 11 in-language focus groups conducted with recently arrived immigrants • Consultations with the Clinical Leaders Network, Clinical Council, Community Council and Member Chairs • Strategy workshop with 60 health and community stakeholders • Insights from local council reports on the overall wellbeing of their population and reports of consultations with community members run by community organisations • Document review of academic articles on key topics • Priority areas summary distributed to South Eastern Sydney Local Health District, Sydney Local Health District and St Vincent's Health Network for review and final input

Strategic alignment

Alongside development of the Needs Assessment 2025-2027, CESPHN has developed a strategic plan that aligns with the broader Department of Health and Aged Care direction and priorities.

Key strategies that have an increased emphasis in the strategic plan:

- Be a data-driven organisation

- Improve the way we show our impact
- Actively promote CESPHN in the community and the work we do
- Increase our reach with more stakeholders
- Address health needs more holistically, such as domestic and family violence, gambling harm and social isolation and loneliness
- Increase community involvement in the planning and delivery of services to address needs
- Increase focus on navigation to assist multicultural communities
- Use commissioning to improve equity.

Stakeholder engagement and consultation process

Table 6 Stakeholder engagement process

Stakeholder Engagement	Process
Consultation with CESPHN staff and board	All staff and separately all of the CESPHN board and member networks were involved in initial consultation to identify health needs and service gaps. CESPHN teams working across these priority areas provided insights from strategy-level discussions, and an initial exploration of quantitative data.
Service mapping	Salesforce, CESPHN's CRM, was used to report on data pertaining to the region's general practices, including size, accreditation status and digital health capability. Health Workforce Data (HWD) was used to determine the number and distribution of key primary care services, in particular general practices and general practitioner (GP), GP registrar, practice nurse and allied health professional data. Service mapping undertaken by program teams as part of their program activities has also been utilised.
Market analysis	As part of CEPHN's Strategic Planning process that was also being conducted at the same time, a market analysis, including SWOT and PESTLE analysis were conducted to understand internal and external driving forces for the needs assessment and future strategic directions for our work.
Consultations with experts in specific priorities	Nine paid in-person/online group consultations were held in June and July 2024, consisting of a mix of established stakeholders and stakeholders new to CESPHN. The individual consultations targeted the following: • LGBTIQ+ • Homelessness • Aged care • Domestic and family violence • Sexual health • Maternal and child health • Mental health • AOD • Disability

	The consultations followed a semi-structured approach that included both general questions and questions specific to each area. Deductive thematic analysis was then applied on key points of discussion.
Community Services survey	A 19-question electronic survey was distributed to Community Services in the region in June 2024. The aim of the survey was to gather insights on the health and social needs, as well as services gaps in the community's they work. There were 32 responses, and this information has informed the development of the priority areas addressed.
Aboriginal Consultation	Rather than over consult the community, the writers of this needs assessment attended a consultation held by South Eastern Sydney Local Health District with the Aboriginal community in March with 25 people consulted and gathered the insights from that session to apply to the needs assessment. CESPHN's Aboriginal Advisory Group were consulted throughout this process and members were invited to the Strategy Workshop.
LHD/LHN and Council engagement insights and reports	Invited to subject matter expert consultations, involved in councils and committees, and additional meetings on certain topics, such as LGBTIQ+. An extensive summary of health needs and service gaps was shared with LHDs and LHNs for input.
Consultations with LHDs, Community and Clinical Councils, Clinical Leaders Network, Member Chairs, Multicultural Advisory Group	212 stakeholders were involved in consultations, semi-structured questions designed to gather insights on what community needs and service gaps stakeholders see in their work and engagement with the community they work with, and where the opportunities for improvement are. We used these engagements as an opportunity to gather qualitative and quantitative data that people were using to make statements on community needs and service gaps.
Strategy workshop	A strategy workshop was held in July 2024 with 60 stakeholders from health and community services across the region as a sense checking opportunity. During the workshop, the draft priorities from stakeholder engagements and an initial analysis of quantitative data were put forward to stakeholders, who were then asked to discuss if they agreed with the draft priorities and what priorities, if any, were missing.
In-language focus groups with newly arrived immigrants	Data were collected between 22 June 2024 and 20 July 2024 via 11 in-person, in-language focus groups (125 participants). The focus groups were conducted in: Arabic (2x), Mandarin (2x), Nepali (2x), Bengali (2x), Urdu, Mongolian (women) and one focus group run in English for Indian speaking participants. A report was prepared for each focus group which summarised the conversations and observations for each question outlined in the discussion guide and included translated quotes from the participants. The data were then analysed using a deductive approach, in line with the research questions identified. Quotations from these focus groups are incorporated into the needs assessment.
Consultation with Local Health District Executives	Local Health Districts and Local Health Networks were invited and involved at every consultation. The executives from the Local Health Districts and St Vincent's Hospital received a detailed summary of the Needs Assessment in October and provided feedback.

Analysis, triangulation, and prioritisation of community needs and service gaps

Once data collection ended, CESPHN began the analysis, triangulation, and prioritisation phase of the Needs Assessment process. This involved, using a robust analysis process to identify key community needs and service gaps appearing across both quantitative and qualitative data and insights.

Approach to data analysis

Quantitative data was updated as data became available to use. For most public datasets, data was downloaded, cleaned and then connected to Power BI for transformation, analysis and interpretation. Qualitative data that was gained through consultation was collected with prior informed consent from participants. A CESPHN staff member also took notes. Both recordings and notes were used to summarise key points and conduct an initial thematic analysis of the discussion.

Approach to data triangulation and prioritisation and insights

The writers of this document looked at themes across multiple sources of data and considered.

- Is the key need/gap mentioned across more than one data source?
- If an issue was raised during consultations – is there robust data to back it up and confirm its importance?

Data limitations

Whilst every effort to include all relevant and up-to-date data as part of the analysis of the needs assessment, there are a number of data limitations that need to be acknowledged. These limitations are both around new data sources used and the way previously used data sources have changed.

- Introduction of general practice level data collected through the data extraction tools. CESPHN currently use two data extraction tools, POLAR and CAT4, with POLAR having the highest usage rate of 40.7% of practices. For the Needs Assessment, POLAR and CAT4 were only used to identify Aboriginal and/or Torres Strait Islander patients.
- Utilisation of POLAR for chronic disease, cancer screening and other statistics were investigated, however the following limitations were encountered:
- Lack of consistent data on ethnicity data, making analysis difficult
- Limited pickup of free text information, which as a result underreports diagnoses and other figures
- Reduced functionality when linking with Power BI compared with calculations, free text translation, etc. built into the Qlik portal
- The ability to use data linkage insights though Lumos:
- There is low frequency of data refreshes (six monthly)
- There is no breakdown of ethnicity level data
- Not all general practices in the region participate in Lumos so the numbers may not be 100% representative
- Not possible to perform state or national comparison analysis because CESPHN only receives data for patients within its catchment.
- Changes in AIHW reporting levels from SA3 to SA4 across some datasets, has reduced the ability to compare across time periods and identify smaller geographic areas of higher need
- Previously available MBS data is no longer consistently available across most priority areas
- PBS data only available for mental health related prescriptions and granularity has changed
- Slow adoption of the ABS Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables demographics questions across surveys and datasets This impacts the ability to identify the health needs of trans and gender diverse people.

- Continued limited availability of recent local level data for Aboriginal peoples including:
    - Lifestyle risk factors
    - Infant and child mortality
    - Cancer screening participation
    - Mental health and suicide prevention
- Ongoing limited usage of the National Mental Health Service Planning Framework tool (limited access and cannot publish findings)
- Local level data on dementia and palliative care – local dementia data is still being developed in AIHW
- GEN Aged Care Data is available at LHD level and not at SA3 level.

Health Needs analysis

Identified need	Key issue	Description of evidence
Chronic conditions	**Key issues** • Increased usage of vaping • Prevalence of hepatitis B virus is the fourth highest in Australia • Prevalence of chronic hepatitis C is above the national average. • High burden of chronic disease in the region • Higher age-standardised rates of melanoma in Sutherland, Woollahra and Waverley LGAs when compared with NSW • High prevalence of behavioural risk factors for chronic disease highlighting the need for risk reduction strategies • Low uptake of cancer screening. **Key gaps** • Early detection and prevention of Type II diabetes • Strategies to address increased rates of liver cancer • Variability in prevention and screening behaviours and need to work specifically with multicultural and Aboriginal populations to increase uptake. • Scaled up local lifestyle programs that are effective in reducing risk factors for chronic disease • Engagement with priority population groups that have low health literacy regards chronic disease • Effective monitoring of cerebrovascular risk factors such as hypertension • Need for increased focus on preventive factors and early intervention strategies in primary care	• Quantitative sources include AIHW, NDS and Cancer Institute NSW • Qualitative sources include stakeholder consultation and surveys on cancer management
Mental health	**Key issues**	• Quantitative sources include AIHW, Mental Health MDS, RACGP and headspace

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Identified need	Key issue	Description of evidence
	• 71% of GPs report psychological issues in their top 3 reasons for patient presentation • There is an increase in severity of mental health related issues • Self-reported prevalence of a mental health condition varies across the region from 11.7% in Marrickville-Sydenham-Petersham SA3 to 5.0% in Hurstville SA3 • There are a number of vulnerable population groups who experience a higher prevalence of mental health concerns. These include Aboriginal people, children and young people, LGBTIQ+ peoples, older people, veterans, people experiencing social isolation and people engaging in harmful levels of gambling • In 2021-21 there were 106 mental health related emergency department presentations per 10,000 population and 102.4 overnight admitted mental health-related hospitalisations per 10,000 population **Key gaps** • Access to child mental health services (including a multidisciplinary approach) • Access to psychiatrists across all speciality areas including children, older people, ADHD and autism • Availability of psychological therapies for people experiencing severe and complex mental illness • Affordable access to services for eating disorders • Availability of longer-term therapy for eye movement desensitisation and reprocessing (EMDR) therapy and dialectical behavioural therapy (DBT) • Therapy for children who have experienced Domestic and Family Violence and people who have left a relationship that experienced Domestic and Family Violence • Access to therapy in language	• Qualitative sources include Community Services survey, Strategy Workshop, mental health provider and GP consultations

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Identified need	Key issue	Description of evidence
Suicide prevention	**Key issues** • Modelled rates of suicidal thoughts and behaviours in the last 12 months are highest in young people aged 16-24 years (5.4 per 100 population) • Individuals in the 25-44 year age group had the highest proportion of individual self-harm hospitalisations in the CESPHN region (39.4%), followed by 0-24 year-olds (30.6%) • High rates per 100,000 of suicide in older people aged 80+ **Key gaps** • Primary care professionals identified a lack of appropriate services, including barriers to accessing acute services, to support/refer individuals at risk of attempting suicide • Primary care professionals face challenges in identifying individuals at risk of attempting suicide.	• Quantitative sources include AIHW, Mental Health MDS • Qualitative sources include consultations with expert panel

Use of alcohol and other drugs	**Key issues**
	• Within the CESPHN region, the primary drugs of concern are methamphetamines, alcohol, cannabinoids, and heroin.
	• The populations most impacted by AOD use include:
	  ○ Aboriginal and Torres Strait Islander people
	  ○ Multicultural communities
	  ○ Young people
	  ○ LGBTQI+ communities
	  ○ People experiencing homelessness
	  ○ Individuals in contact with the criminal justice system
		• Quantitative sources include Health Stats NSW, AIHW, NSW Ministry of Health, CESPHN survey and IDRS
		• Qualitative sources include consultations with internal staff and an expert panel of Local Health District and local service providers

Identified need	Key issue	Description of evidence
	Key gaps • Limited access to holistic support and care coordination, as well as a lack of pathways for patients navigating AOD services. • A need for additional prescribers to transition patients from public Opioid Treatment Programs (OTP) to private care. • Insufficient services for priority populations, particularly women and multicultural communities. • A shortage of residential rehabilitation beds. • High prevalence of co-occurring mental health and substance use concerns, with a need for further capacity-building initiatives. • Limited access to culturally appropriate rehabilitation for Aboriginal participants. • Workforce shortages and the need for ongoing training and development.	
Sexual health	• From October 2023 to October 2024, the CESPHN region recorded the highest number of notifications in NSW for chlamydia (11,812), gonorrhoea (565) and non-congenital syphilis (2652). The region accounted for 36.7% of chlamydia NSW notifications, over half (51.2%) of gonorrhoea notifications and 46.3% of non-congenital syphilis notifications. Notification rates in males for syphilis and gonorrhoea are the highest in NSW. **Key issues** • Early identification of cases and liaison with general practitioners • Engagement with local at-risk populations to encourage uptake of preventive strategies and promotion of testing • Knowledge of antimicrobial resistance in the treatment of gonorrhoea • Low health literacy that limits access to sexual and reproductive health services	• Quantitative sources include NSW Health, Department of Health and Aged Care, and National Viral Hepatitis Mapping Project • Qualitative sources include stakeholder consultation

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Identified need	Key issue	Description of evidence
	Key gaps • Level of general practitioner confidence in diagnosing, testing and treatment prescription • Stronger active identification of cases and engagement with general practitioners • Antenatal screening for syphilis twice for each pregnancy • Promotion of vaccination to increase protection against Mpox • Stigma-free health care provision • Improved accessibility of sexual and reproductive health services.	
Aboriginal and Torres Strait Islander peoples' health and wellbeing	• There were an estimated 16,265 Aboriginal people within the Central and Eastern Sydney PHN (CESPHN) region in 2021, accounting for 1.05% of the total population. **Key issues** • The impact of past traumas, injustices and the effects of intergenerational trauma • Aboriginal children in NSW are significantly over-represented in the child protection system • Aboriginal adults in NSW are over-represented in the criminal justice system and the youth justice system • Suicide is 3 times more prevalent in this population than the general population in the region • High rates of ED presentations for mental and behavioural disorders • 30% of all Aboriginal people in the CESPHN region, had at least one long term health condition • High rates of smoking at some time during pregnancy • High rates of domestic violence • Low uptake of preventative health measures such as 715 assessments, cancer screening	• Quantitative sources include AIHW, ED data, HD Australia, MBS data, PHIDU, HWA, NDIS, POLAR, PenCS, Cancer Institute NSW, HealthStats NSW, National Aboriginal and Torres Strait Islander Health Survey, the Aboriginal and Torres Strait Islander Health Performance Framework, and GEN • Qualitative sources included members of the CESPHN Aboriginal Advisory Committee

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Identified need	Key issue	Description of evidence
	• The percentage of Aboriginal people living with overweight or obesity increased from 57% in 2014 to 72% in 2023 • Pressures on unpaid carers of people with disabilities and older people due to reluctance to access support services. **Key gaps** • Continuity of healthcare transition from correctional facilities to general practice and other primary care services • Reducing disparities in preventable health measures and trying to improve health outcomes • Promote better use of Urgent Care Centres and primary care to the community to avoid ED and hospital admissions • Appropriate culturally safe care throughout the health system that is tailored to the needs of this community.	
Health and wellbeing of people from multicultural communities	• 40.7% of residents were born overseas, 46.8% speak a language other than English at home, and 6.3% do not speak English well or at all **Key issues** • People from CALD backgrounds don't access CESPHN commissioned mental health services at the same rate as non-CALD community. • People from CALD backgrounds attend services later, resulting in more involuntary admissions • Less likely to access preventable screening for breast cancer • International students in the CESPHN region needing support for health and wellbeing issues • Impact of global events on local communities (Gaza conflict) **Key gaps** • There is a need to understand better the experiences shaping health outcomes for multicultural communities	• Quantitative sources include ABS, AIHW, Department of Education, Skills and Employment, Cancer Institute NSW, and Diabetes Australia • Qualitative data includes CESPHN consultations and in-language focus groups

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Identified need	Key issue	Description of evidence
	• Health navigation assistance can assist people to understand and access the complex health and social support system • Need for culturally responsive care	

Older individuals' health and wellbeing	• In 2022, 14.9% of the estimated resident population (ERP) in the CESPHN region were aged 65+, and 7.1% were aged 75+
	• The number of people aged 65 years and over is expected to increase by 56% between 2021 and 2041.
	
	Key issues
	• Lower uptake of all recommended vaccines - COVID-19, pneumococcal and shingles (herpes zoster) as well as flu
	• Older individuals (65+ and 85+) experience a range of health issues, including:
	  ○ Higher rates of fall-related hospitalisations
	  ○ Mental health issues
	  ○ Higher use of health care services for those living with dementia and living in the community
	  ○ Chronic conditions and comorbidities
	  ○ Higher levels of disability (2 in 5 people aged 65+)
	  ○ Growing levels of elder abuse by family members/carers
	
	Key gaps
	• Better coordination of primary care and other services in the community to ensure timely access to care and continued/seamless support
	• Reduced access to affordable primary care and aged care services (cost of primary care and aged care services, and long wait times for home care packages and Commonwealth Home Support Program services)
	• Difficulties in service navigation with poor awareness of available support services
		• Quantitative sources include AIHW, HealthStats NSW, ABS, DSS, POLAR, DOH and GEN
		• Qualitative sources include stakeholder and subject matter individual consultations

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Identified need	Key issue	Description of evidence
	• Social isolation, exacerbated by language and cultural barriers. • Underutilisation of general practice preventative health services (health checks, CDM care plans, vaccination) • Residential age care places are reducing against increasing number of people (many of whom will have dementia) with social dislocation occurring as older people have to move out of their locality and social networks to access residential aged care. • Meeting ageing needs of people with a disability in group homes • Older people report barriers to accessing mental health support • Diagnosis and services are limited for people living with dementia, and services vary across the CESPHN region • Increasing difficulties for older people in residential aged care being able to access GPs.	
Health and wellbeing of children in the first five years	**Key issues** • In some parts of the CESPHN region there are high levels of socio-economic disadvantage • Child immunisation rates are less than the national target • Some SA3s with the highest developmental vulnerability in one or more domains • The proportion of women with their first antenatal visit recorded during the first 14 weeks of gestation is below the NSW average • Aboriginal babies are less likely to be born within a healthy weight range compared with Non-Aboriginal babies (88% versus 95%) **Key gaps** • Immunisation rates in children in several regions within CESPHN have fallen below 90% • Treatment delays for children newly diagnosed with a disability • Access to affordable paediatric care.	• Quantitative sources include ABS, Department of Health and Aged Care, HealthStats NSW, CESPHN internal database, and Department of Social Services • Qualitative sources include stakeholder and subject matter individual consultations

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EXECUTIVE SUMMARY

Identified need	Key issue	Description of evidence
Health and wellbeing of people living with a disability	• High numbers of people living with a disability in the CESPHN region • Approximately 2 in 5 people aged 65 years and over living within the CESPHN region have some level of disability • NDIS participant numbers across service districts within the CESPHN region increased from 16,950 in December 2020 to 19,715 on 30 June 2023 • The rate of psychosocial disability within the Sydney service district is 1.7 times the national rate • 7-to-14-year age band made up the highest proportion of NDIS participants across the CESPHN region **Key issues** • Access to well-coordinated care between primary, secondary and tertiary for those with a disability • Timely participation in preventive health and screening services for those with a disability • Inadequate Medicare funding models can deter extended consultations for complex medical and psychosocial care. GPs may be financially disincentivised to provide long consults, home visits to group homes, and prepare care plans which are paid at a lower rate or unbillable. • Knowledge of primary care providers and provision of tools and resources to engage in conversations about disability. • Those from priority population groups with a disability are particularly vulnerable because of low health literacy and economic disadvantage • Intersection between aged care and disability. For example, there is a lack of palliative care support for those in group homes. People receiving NDIS who transfer to residential aged care after age 65 will lose access to the NDIS. • Lack of support for teenagers living with a disability experiencing poor mental health e.g. suicidal thoughts and tendencies.	• Quantitative sources include AIHW, ABS, NDIA and Department of Social Services • Qualitative sources include stakeholder and subject matter individual consultations, and round table discussions with disability specialists

Identified need	Key issue	Description of evidence
	Key gaps • Lack of service navigation support tailored to the needs of those with intellectual disability • Lack of support for people with a disability when they receive dental care • Lack of community-based child behavioural management programs for those with ADHD and autism • Provision of support for carers to manage their own health needs • Need for ongoing patient-centred, multidisciplinary and integrated models of care • Support general practices to help address financial barriers to optimal care for people with a disability • Development of tailored strategies to address health inequity • Limited mental health services available for people with intellectual disability with poor mental health • Lack of access to NDIS and psychosocial services for people experiencing severe mental ill health • People with a disability leaving incarceration lose support and access to care and are at high risk of reoffending	
Health and wellbeing of people affected by domestic, family and sexual violence	• Domestic, Family and Sexual Violence (DFSV) has increased over the 12-month period to March 2024 across NSW. • In CESPHN, 5,936 domestic violence related assault incidents were recorded between April 2022 and March 2023, with the Canterbury-Bankstown LGA reporting the highest number of incidents. • Domestic violence-related murders:16 adult women in NSW (12 months to March 2024) • People with disabilities, older people, Aboriginal and Torres Strait Islander peoples, and LGBTIQ+ people experience increased risk, severity and frequency of DFSV and other types of abuse. **Key issues** • Need for continuous DFSV education and support for primary care	• Quantitative sources include BOSCAR

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Identified need	Key issue	Description of evidence
	• Service design and delivery needs to prioritise children and young people **Key gaps** • Fragmented support for the intersecting issues of sexual violence and child sexual abuse. • Support for children impacted by DFSV • Wider range of service options that reduce DFSV.	
Health and wellbeing of LGBTIQ+ people	The Central and Eastern Sydney PHN region has a high number of same sex couples living together (n=11,382), representing 14.5% of same sex couples living together in Australia. By comparison, this region comprises 6% of the total Australian population **Key issues** • LGBTIQ+ people experience higher levels of mental distress and poor mental health • LGBTIQ+ people drink more alcohol and use illegal drugs at higher levels than non-LGBTIQ+ people • Can have higher instances of sexually transmitted diseases, though PReP use remains high amongst gay men • High levels of loneliness and social isolation, especially amongst older adults (see mental health chapter of this Needs Assessment) • The community can experience stigma harassment and discrimination in their daily lives **Key gaps** • Easy access to gender affirming care for transgender patients • Specific services for intersex people • Delivery of trauma-informed care and sexual diversity training for clinical staff and community services	• Quantitative sources include ABS and Rainbow Realities Report • Qualitative sources include consultation with internal staff and local service providers

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EXECUTIVE SUMMARY

Identified need	Key issue	Description of evidence
Health and wellbeing of people impacted by homelessness	• In the CESPHN region in 2022-23, 8,084 people experienced homelessness (a slight increase from 7,627) **Key issues** • Further investment in access to affordable primary health care services for people experiencing, or at risk of homelessness. • Upskilling of the primary care workforce; refinement of assessment processes, raised awareness of pathways out of homelessness for people at risk of homelessness • Enhanced data management; improved technological solutions and frameworks for capturing and prioritising and referring clients • Strengthening collaboration between housing providers, specialist homelessness service providers and health service providers based around a housing first approach • Embedding of primary health care services with other health, housing, and homelessness support services • Improving coordination between primary mental health and domestic violence support services • Need for more innovative localised responses to priority cohorts including Aboriginal people and those leaving correctional centres and mental health services. **Key gaps** • Integration of the health, housing and homelessness service system • Access to primary care homelessness friendly GPs, pharmacists, allied health, dentistry, mental health, and drug and alcohol detox and support services) • Access to post-crisis support (mental health and drug and alcohol detox and support services) • Capacity of workforce to deliver respectful and person-centred care • Geographic location and reach of specialist homelessness services with most providers choosing to work in the inner-city regions. • Access to coordinated chronic care management	• Quantitative sources include ABS, AIHW and Department of Communities and Justice and SLHD • Qualitative sources include subject matter expert consultations

Identified need	Key issue	Description of evidence
	• Innovative models that deliver flexible integrated care.	

Service Needs Analysis

Identified Need	Key Issue	Description of Evidence
Access to primary health care	• GP workforce will reduce as many GPs are retiring and yet there will be more demand for services with an ageing population and predicted population growth • The GP FTE in the CESPHN region has decreased despite the increase in population. Analysis of FTE between 2021 and 2023 shows a peak of 1,903.9 FTE in 2021 and a reduction to 1,730.4 FTE in 2023, a decrease of 9.1% • In 2022 an average of 27% of GPs intending to work only another five years in the region • Reduction in the number of registrars, with a 34.8% decrease in AGPT registrars between 2018 and 2023 • Rising out-of-pocket costs for individuals accessing GP services: $78,244,065 (2022-23) across CESPHN, a 69% year-on-year increase • Lack of affordability for GP care, dental care and mental health care was the major concern raised in CESPHN consultations held • Access to psychiatry for a diagnosis for ADHD or other conditions is difficult to get and expensive. • Long waiting lists for public outpatient services. **Key gaps** • Expected ongoing reduction in GP workforce when measured against numbers, FTE and years intending to work against the	• Quantitative sources include ABS, NSW Health stats and DoH statistics, MBS data • Quantitative sources include UNSW research and stakeholder consultation

	expected increase in health service needs as the population increases and ages • Reduction in number of GP registrars • Rising out of pocket costs for individuals accessing GP services and subsequent lack of affordability	
Coordinated care	**Key issues** • Limited communication between providers due to lack of integration across primary care system, attributed to limited increase in uptake of My Health Record registration, fragmented allied health professional software landscape and limited health system interoperability • Low interoperability across platforms used by primary and acute care providers • Need to improve transitions for people moving between systems i.e. the justice system to primary care, Defence Force personnel becoming veterans, paediatric to adult services, community to residential care, disability and primary care services • Need for more integrated approach to disaster management. • Low health literacy particularly among vulnerable and priority groups • Provider and consumer challenges with identifying and navigating services **Key gaps** • Improved engagement of primary care in disaster management • Supporting care transitions across the lifecycle • Need for increased focus on multidisciplinary team work • More effective communication and information sharing among healthcare providers including system interoperability that enables continuity of care • Utilisation of My Health Record.	• Quantitative sources include ADHA Collaborate data, CESPHN's CRM and Lumos

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Priorities and opportunities

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
Stepped care	Mental Health	Access	• Consumers have streamlined access to the most appropriate services to support individuals at the stage they are at	• CESPHN to work with partners of the Mental Health and Suicide Prevention Regional Plan to ensure clear and accessible pathways to care at all levels of intensity/acuity, in which consumers, referrers and service providers understand how to navigate, refer to and provide services using a stepped care approach • CESPHN to work with our LHD and LHN partners to fulfill the requirements of the bilateral schedule regarding the promotion of the Initial Assessment and Referral Decision Support Tool. • Promote the use of the Mental Health Services Directory to referrers and service providers to further promote services that are offered in our region across all levels of care.
Workforce Development	Mental Health	Access	• Built a sustainable workforce that is skilled, well distributed and supported to deliver mental health treatment, care and support that meets the current and future population needs	• CESPHN to work with our LHD and LHN partners to fulfill the requirements of the bilateral schedule regarding the actions relating to workforce planning and development, focusing on priorities such as bilingual mental health clinicians, Aboriginal workforce and lived experience workforce.

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EXECUTIVE SUMMARY

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
Low intensity mental health services	Mental Health	Access	• Increased proportion of population receiving Nationally funded low intensity services and successful promotion of these services	• CESPHN to work with referrers and community members to promote access to low intensity mental health services, including the newly established national low intensity service, other online services, and resources
Child and youth mental health services	Mental Health	Access	• Increase proportion of population receiving PHN-commissioned youth specific services	• CESPHN to continue to commission headspace centres to provide youth mental health services in line with the headspace model integrity framework (hMIF) and within a stepped care approach • CESPHN to continue to commission early intervention services for young people with or at risk of severe mental illness (e.g., psychosis, major depression, severe anxiety, eating disorders and personality disorders) in the primary care setting • CESPHN to support commissioned providers to use telehealth and other technologies to facilitate access to services • CESPHN to work with our LHD and LHN partners to fulfill the bilateral schedule regarding the headspace enhancement initiatives, and child mental health and social and emotional wellbeing commitments. • CESPHN to commit to actions from the joint Mental Health Regional Plan

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Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
				relating to child mental health and emotional wellbeing.
Psychological therapies for priority populations	Mental Health	Access	• Increase proportion of population receiving PHN-commissioned psychological therapies and have improved clinical outcomes	• CESPHN to continue to commission services to ensure access to a range of evidence based psychological therapies for priority groups in the CESPHN region
Severe and complex mental illness	Mental Health	Access	• Increase proportion of population receiving PHN-commissioned care coordination services and have improved functional and clinical outcomes	• CESPHN and LHDs to implement learnings from the evaluation of the Mental Health Shared Care program to improve service access and provision. • Commit to actions from the joint Mental Health Regional Plan relating to the development of the mental health workforce, including increasing the peer workforce • CESPHN to continue to commission care coordination services and other services aimed at supporting the physical and mental health and wellbeing of individuals with severe and/or complex mental illness.
Suicide prevention	Mental Health	Access	• Increase number of people who are supported by PHN-commissioned services following a recent suicide attempt and during a crisis.	• CESPHN to commission universal aftercare services in line with the requirements of the bilateral schedule regarding Universal aftercare. • CESPHN to commission suicide prevention services, and training to increase workforce and community capacity.

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EXECUTIVE SUMMARY

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
				• Support the promotion and awareness of prevention and postvention support services.
Access to alcohol and other drug treatment services	Alcohol and Other Drugs	Access	• Increase access to treatment services	• CESPHN to commission drug and alcohol treatment services that address gaps, are evidence based and accessible to our priority populations • CESPHN to work with service providers to ensure services are accessible and meet the needs of priority populations
Access to alcohol and other drug treatment in the primary care setting	Alcohol and Other Drugs	Care Coordination	• Increase engagement of GPs in responding to AOD problems and shared care arrangements between specialist AOD services and GPs • Increase numbers of GPs prescribing and pharmacy engagement in OTP	• CESPHN to provide support, resources and education to GPs • CESPHN to work with LHD/LHNs to implement the GLAD shared care project with GPs across the region • CESPHN to partner with PHNs to co-fund Primary Care Telehealth Alcohol Withdrawal and Recovery Service Proof of Concept
Capacity to address high need populations and clinical complexity	Alcohol and Other Drugs	Vulnerable Population (Non-Aboriginal Specific)	• Services meet the needs of priority populations and address co-occurring mental health in the context of AOD use	• CESPHN to work with peak bodies and champions to develop effective service models to meet the needs of multicultural communities, gender and sexuality diverse communities, individuals recently released from prison and individuals with co-occurring mental health needs
Sexual health	Population Health	Early Intervention and Prevention	• Increase number of GP prescribers for HVB, HIV S100 medications, HCV and PrEP S85 medications	• CESPHN to support primary care providers to address STIs and other blood borne (HIV and Viral Hepatitis) conditions by building confidence in

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
			• Enhance GP capability to deliver hepatitis B and C, syphilis and Mpox treatment	diagnosing, testing and treatment prescription • CESPHN to support engagement with local at-risk populations to encourage uptake of preventive strategies and promotion of testing • Promotion of vaccination to increase protection against Mpox
Chronic conditions	Population Health	Chronic Conditions	• Increase cancer screening rates • Reduce prevalence of risk factors • Increase number of patients with chronic diseases managed under GP Management Plan and/or Team Care Arrangements • Reduce potentially preventable hospitalisations for chronic conditions • Increase the number of practices sharing data for quality improvement • Increase the number of practices participating in quality improvement activities •	• Improving the uptake of evidence-based cancer screening programs, specifically, breast, cervical and colorectal cancers where rates are low in the region. Work with LHDs to review availability of mobile screening units across the region. • From July 1, 2025, a National Lung Cancer Screening Program will be launched targeting high risk smokers or ex-smokers accessed through general practice and Aboriginal Health Services. • Promote new smoking and vaping cessation clinic at Concord Hospital. • Continue supporting general practices to connect to the National Cancer Screening Registry and promoting share care and quality improvement activities for cancer screening and prevention. • Work with LHDs to address lifestyle risk factors such as excessive intake of alcohol, lack of physical exercise and poor diet.

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EXECUTIVE SUMMARY

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
Older individuals' health and wellbeing	Aged Care	Chronic Conditions, Care Coordination, Workforce	• Increase MBS services provided by primary care providers in residential aged care facilities • Increase rate of people aged 75 and over with a GP health assessment • Improve communication, coordination and integration of services within the health system and at the interface of the health and aged care systems • More informed consumers and carers • Build primary health care workforce capacity and capability to address the health needs of older people	• CESPHN to commission community-based options for palliative care and to support healthy ageing, social connection and people living at home for longer • CESPHN to work with social interaction models of service • CESPHN to support GPs to complete MBS health checks and medication reviews in the community and in aged care • CESPHN to work with GPs to develop local dementia care and frailty pathways • CESPHN to commission community care finders to assist older Australians accessing and navigating the aged care system. • CESPHN to work with the Department of Health and Aged Care and LHD/ LHNs to identify gaps in system accessibility and opportunities for improved coordination, integration and reform across the aged care and health systems • CESPHN to support GPs and RACF staff with digital technologies including telehealth care for aged care residents, MyHR adoption, and sharing Advance Care Directives and care plans for transitions between health and aged care systems • CESPHN to support Geriatric Flying Squads/E Health programs to enable

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Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
				deteriorating older people to stay at home and out of hospital • CESPHN to provide/ commission training for general practice, allied health and RACF staff on local clinical and service pathways, dementia care, palliative care, mental health, and medication and wound management
Health and wellbeing of people affected by domestic, family and sexual violence	Population Health	Vulnerable Population (Non-Aboriginal specific)	• Primary care providers are better able to identify and respond to DFV presentations • DFV victims receive appropriate services	• CESPHN to provide training to primary care providers to identify and appropriately respond to DFV presentations from patients or colleagues • CESPHN to link primary care providers with appropriate DFV services and secondary consultations to assist health professionals to support their patients
Aboriginal and Torres Strait Islander peoples' health and wellbeing	Aboriginal and Torres Strait Islander Health	Vulnerable Population (Aboriginal specific)	• Increase general practice IHI PIP uptake • Increase rate of patient records with Aboriginal status recorded • Increase rate of Aboriginal population receiving health assessments and follow-ups • Increase rates of service use for: maternal and child services, chronic disease, mental health and AOD services • Increase proportion of PHN-commissioned services delivered to the regional	• CESPHN to support general practice to enrol in the IHI PIP, identify Aboriginal patients and provide health checks • CESPHN to work with the Aboriginal community and LHD/LHNs to address access issues to culturally appropriate maternal and child health, chronic disease, mental health and AOD services • CESPHN to work with commissioned providers to ensure the workforce is culturally competent and continues to upskill in this area • CESPHN to continue providing education to GPs to promote cultural safety and

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Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
			Aboriginal population that are culturally appropriate • Increase cultural awareness training participation rates among the primary care workforce • Increase support for the Aboriginal workforce	understanding of intergenerational trauma and ongoing impacts • CESPHN to support the Aboriginal workforce through the Aboriginal workers circle and training opportunities • CESPHN to promote urgent care as an alternative to attending Emergency departments for non-urgent care • CESPHN to work with partners to deliver community education on accessing relevant health care, domestic violence and sexual abuse resources, mental health and antenatal care
Health and wellbeing of people from multicultural communities	Population Health	Vulnerable Population (Non-Aboriginal Specific)	• Culturally appropriate commissioned services • Increase access to services among multicultural communities	• CESPHN to work with community organisations to build health literacy among consumers and their carers so they can be actively involved in decisions about their health • CESPHN to ensure translation and interpreting services are available to allied health professionals and promote TIS National interpreting services to medical practitioners and pharmacies • CESPHN to work with its commissioned service providers to co-design culturally appropriate services, employment of staff from multicultural backgrounds and providing cultural competency training for service providers • CESPHN to commission multicultural health navigators to increase access to health care

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EXECUTIVE SUMMARY

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
Health and wellbeing of people impacted by homelessness	Population Health	Vulnerable Population (Non-Aboriginal Specific)	Improve health outcomes and access to health care among people experiencing homelessness or at risk of homelessness	• CESPHN to work with partners to implement the Intersectoral Homelessness Health Strategy 2020-2025 • CESPHN to support general practices and allied health professionals working with people experiencing homelessness • CESPHN to work with registered training organisations to enable and support GP registrars to work in homelessness health clinics during their training • CESPHN to provide training to general practices and allied health professionals on the skills and knowledge required to engage and care for people at risk of, or experiencing, homelessness • CESPHN to explore with the primary care sector the feasibility of new models of primary care in key locations to improve service navigation
Health and wellbeing of people living with a disability	Population Health	Vulnerable Population (Non-Aboriginal Specific)	• Primary care providers are better able to provide best practice care for people with a disability • People with an intellectual disability receive appropriate specialist services • Improved access to behavioural interventions for children with ADHD •	• CESPHN to provide training to primary care providers on best practice care for people with a disability, including annual Medicare assessments and access to NDIS care plan • CESPHN to link primary care providers with the most appropriate specialist services for their patients with intellectual disability • CESPHN to work with LHDs to increase the availability and capacity of mental health services for people with

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
				intellectual disability with poor mental health • CESPHN to advocate for disability needs during development of the Single Digital Patient Record • CESPHN to lead an annual disability roundtable to bring together key stakeholders in health and primary care and the broader disability sector to showcase progress and highlight areas for further intervention • CESPHN to develop strategies to address needs of people living with a disability who are older, members of multicultural communities, impacted by alcohol and other drugs or exiting the Justice system.
Health and wellbeing of LGBTIQ+ people	Population Health	Vulnerable Population (Non-Aboriginal Specific)	• Increase access to LGBTQI inclusive primary care • Distinction between specific LGBTIQ+ sub-groups as priority populations within CESPHN program areas	• CESPHN to arrange provision of training and education for primary care and mental health workforce on LGBTQI+ inclusive care • CESPHN to support upskilling of aged care workforce and adoption of LGBTQI+ person-centred approaches • CESPHN to promote gender affirming care • CESPHN and partners to work on provision of greater support for transgender children and adolescents • Support adoption of trauma informed care approach

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Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
				• CESPHN to support ACON in the development of an integrated general practice specializing in LGBTIQ+ health • Promotion of LGBTIQ+ services in CESPHN service directories and HealthPathways • CESPHN to ensure commissioned services are accessible for LGBTQI+ people.
Health and wellbeing of children in the first five years	Population Health	Early Intervention and Prevention	• Reduce percentage of children with childhood developmental delays • Increase percentage of women attending antenatal visits	• CESPHN to improve collaborations, pathways and partnerships with child and family health services • CESPHN with work with LHD/ LHNs to maintain access to maternal primary care services, including the GP antenatal shared care program • CESPHN to commission activities to address developmental delay, particularly for multicultural communities • CESPHN to work with LHD/LHNs, Department of Communities and Justice, Department of Education, local government and community providers on implementation of First 2000 days framework
Access to primary health care	Health Workforce	Other	• Increased number of general practices receiving the after hours PIP • Reduce low urgency care emergency department presentations	• CESPHN to support general practice to participate in the after hours PIP • CESPHN to commission services to ensure an appropriate use, mix and distribution of after hours services for the population, including enhanced out of hours support for residential aged care

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Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
			• Increase the number of unique health professionals accessing professional development opportunities • Increase in number of accredited general practices • Increase the number of practices sharing data for quality improvement • Increase the number of practices participating in quality improvement activities	• CESPHN to work with key stakeholders to identify and implement relevant professional development opportunities for GPs, practice nurses, practice staff, mental health and AOD workforce and allied health professionals • CESPHN to commission, deliver and promote training and education to the primary care workforce specific to our priority areas and priority populations • CESPHN to collaborate with universities to train the health workforce • CESPHN to support general practices with accreditation and continuous quality improvement activities (e.g., PIP QI, Lumos) • CESPHN to implement health promotion strategies to improve awareness of after hours services (including HealthDirect helplines), appropriate use of emergency departments/urgent care and options for after hours services, particularly frequent users such as people aged 65 years and over, families with young children and priority populations such as people experiencing homelessness
Coordinated care	Population Health	Care Coordination	• Increase rate of regular uploads to My health Record • HealthPathways sessions of use, unique page views, different users	• CESPHN to support increased uptake of digital health systems (smart forms, e-referrals, eprescribing, telehealth) • CESPHN to work with LHD/LHNs and medical specialists to improve the integration of care through the

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Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
			• Increase rate of discharge summaries uploaded to My Health Record • Increase rate of health care providers using specific digital health systems (smart forms, ereferrals, telehealth) • Improved identification and support of veterans	meaningful use of MyHR (e.g., electronic discharge summaries and e-referrals) in the hospital sector and access to Single Digital Patient Record • CESPHN to work with LHD/LHNs and general practice on virtual care models and management of patients following discharge to prevent readmissions • CESPHN to promote improved identification and support of veterans in primary care • CESPHN to work with partners on implementation of a centralised mental health intake and assessment model to combine intake, assessment and referral services • CESPHN to commission program to support smaller general practices to connect to local allied health providers through a multidisciplinary approach • Promotion of service directories and HealthDirect • Re-engage general practice, allied health and specialists on use of My Health Record • Work with partners to improve engagement of primary care in disaster management

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Checklist

Requirement	✓
Provide a brief description of the PHN's Needs Assessment development process and the key issues discovered.	✓
Outline the process for utilising techniques for service mapping, triangulation and prioritisation	✓
Provide specific details on stakeholder consultation processes.	✓
Provide an outline of the mechanisms used for evaluating the Needs Assessment process.	✓
Provide a summary of the PHN region's health needs.	✓
Provide a summary of the PHN region's service needs.	✓
Summarise the priorities arising from Needs Assessment analysis and opportunities for how they will be addressed.	✓
Appropriately cite all statistics and claims using the Australian Government Style Manual author-date system.	✓
Include a comprehensive reference list using the Australian Government Style Manual.	✓
Use terminology that is clearly defined and consistent with broader use.	✓
Ensure that development of the Needs Assessment aligns with information included in the PHN Needs Assessment Policy Guide.	✓

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CENTRAL AND
EASTERN SYDNEY

An Australian Government Initiative

CHRONIC CONDITIONS

2025-2027 Needs Assessment

Table of contents

List of tables

List of figures

Overview

The prevalence, incidence, and risk factors of chronic disease serve as key indicators of the overall health and wellbeing of the CESPHN community. Where and how the care of those with a chronic disease are supported identifies opportunities for service improvement. This chapter describes how primary care working with other health partners can support those at risk of and living with chronic disease. A combination of disrupted healthcare services, increasing fee for service, worsening population health, inequities, and systemic strain has amplified the challenges of managing chronic disease in the post-COVID era. There is a need to re-engage and empower the community to participate in preventive care and lifestyle modification and chronic disease management programs.

Chronic diseases are a leading cause of disability and are often progressive and life-limiting. Chronic diseases and their consequent conditions are neither entirely preventable nor inevitable. Ageing carries risks of deteriorating health, however, irrespective of age, the burden of chronic disease is not evenly distributed across members of the community. Greater socio-economic disadvantage correlates with increased risk of chronic disease.

This inequitable distribution suggests both social determinants of chronic disease and adverse impacts of chronic disease on social and economic functioning. Within the CESPHN region, there is significant variability in the management of chronic diseases and prevalence with differences in both socioeconomic status and age across the region likely accounting for some of this variability

The primary prevention of chronic disease requires identifying and treating known risk factors as well as the prevention of the risk factors themselves. Chronic diseases such as cardiovascular and cerebrovascular disease, dementia, diabetes and cancer have shared behavioural and lifestyle risk factors (which include, smoking, physical inactivity and high dietary intake of fats, sugar and salt). These behavioural risk factors lead to the development of proximal risks, such as obesity, hyperlipoidemia, diabetes and hypertension, which in turn can be prevented and/or treated using non-pharmaceutical and/or pharmaceutical interventions. Variability in these behaviours across the region are notable.

Key issues

- High burden of chronic disease in the region
- Higher age-standardised rates of melanoma in Sutherland, Woollahra and Waverley LGAs when compared with NSW
- High prevalence of behavioural risk factors for chronic disease highlighting the need for risk reduction strategies
- Low uptake of cancer screening.

Key gaps

- Early detection and prevention of Type II diabetes
- Strategies to address increased rates of liver cancer.
- Effective monitoring of cerebrovascular risk factors such as hypertension
- Variability in prevention, delayed screening behaviours and need to work specifically with multicultural and Aboriginal populations to increase uptake
- Scaled up local lifestyle programs that are effective in reducing risk factors for chronic disease
- Engagement with priority population groups that have low health literacy regards chronic disease
- Ensuring that general practice and other primary care providers have a stronger focus on preventive factors and early intervention rather than on treating and responding to chronic disease.

Lifestyle modification

Modifiable behavioural risk factors are shared by a broad spectrum of chronic diseases including, but not limited to conditions such as cancer, circulatory diseases, lung diseases and diabetes (1).Tobacco smoking, alcohol intake in excess of recommended levels, physical activity, high body mass and diet have been estimated to account for 36.9% of the burden of disease in people who identify as Aboriginal and 31.5% of other residents within Australia (1).

The prevalence of some modifiable risk factors, such as current smoking tracks lower in the CESPHN region compared with NSW as a whole (Table 1) (8.2% versus 11.7%), however, prevalence is high for drinking more than the recommended number of standard drinks (34.1%), being overweight (32.4%) and obese (16.0%), and insufficient physical activity (26.1%) (2). Recommended daily intake of fruit is achieved by only 42.6% of residents, while intake of recommended serves of vegetables is low (5.7%) (2). Vaping is an emerging issue that has the potential to significantly impact the health of our communities with some population groups particularly at risk.

Table 1: Prevalence of modifiable risk factors in CESPHN region NSW 2023

Modifiable Behavioural Risk Factors	CESPHN	NSW
Current Smoking in Adults	8.2%	11.7%
Daily Smoking in Adults	5.0%	8.2%
Drinking more than 2 standard drinks on a day when drinking (long-term risk of harm)	34.1%	33.5%
Eating recommended serves of fruit daily	42.6%	37.8%
Eating recommended serves of vegetables daily	5.7%	5.3%
Overweight	32.4%	34.9%
Obese	16.0%	24.6%
Insufficient physical activity in adults	26.1%	35.5%

Source: NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence. NSW Ministry of Health

Overall, the CESPHN population practices healthier behaviours compared to the rest of the state. However, variation is seen across the SA3 areas (3).noting that the data available at a small area level is much older. The highest and lowest percentages (respectively) for the following behaviours were:

- Adequate fruit intake – Eastern Suburbs – North (59.1%) and Marrickville – Sydenham – Petersham (48.8%).
- Current smokers – Canterbury (15.3%) and Leichhardt (8.7%).
- Low, very low or no exercise in past week – Canterbury (74.3%) and Eastern Suburbs – North (49.7%).
- More than two standard alcoholic drinks per day **–** Eastern Suburbs – North (20.3%) and Canterbury (7.8%).(5)

Table 2: Health behaviour rates of people aged 18 years and over by SA3 (ASR per 100), 2017-18

SA3	Adequate fruit intake	Current smokers	Low, very low or no exercise	More than two alcoholic drinks per day
Botany	52.0	14.5	68.9	11.4
Canada Bay	54.6	10.0	60.6	14.2
Canterbury	56.8	15.3	74.3	7.8
Cronulla - Miranda – Caringbah	54.8	11.7	59.0	19.5
Eastern Suburbs – North	59.1	9.0	49.7	20.3
Eastern Suburbs – South	55.8	12.1	60.7	14.9
Hurstville	52.5	12.4	65.6	12.1
Kogarah – Rockdale	54.0	13.7	68.4	10.3
Leichhardt	50.5	8.7	55.6	18.5
Marrickville - Sydenham - Petersham	48.8	14.2	61.3	14.7
Strathfield - Burwood - Ashfield	53.7	13.1	65.0	10.2
Sutherland - Menai - Heathcote	53.2	9.3	61.5	19.0
Sydney Inner City	50.3	13.5	58.1	15.3
CESPHN	53.7	12.3	62.0	14.3
NSW	52.5	14.4	65.3	15.5
Australia	51.3	15.1	66.1	16.1

Source: PHIDU 2021

In 2023 (4), the proportion of overweight and obese adults was higher in:

- Men compared with women (65% and 54%, respectively)
- 55-65 year age group (51%)
- Disadvantaged areas (69%)
- Australians or people from English -speaking countries had a slighter higher proportion than the CALD communities (63%, 59%, 48%, respectively).

Over the last ten years, the percentage of Aboriginal people living with overweight or obesity also increased from 57% in 2014 to 72% in 2023.

Prevalence of select chronic diseases

The modelled prevalence estimates for other chronic conditions 2017-18 showed that rates for the CESPHN region were below both state and national rates for all conditions, except for osteoporosis (3). These estimates despite being 2017-2018 are likely to be stable given the absence of population health interventions during this period that would have affected their prevalence.

Table 3 highlights the prevalence of chronic conditions in CESPHN as well as disparities by geography.

Table 3: Rate of people aged 18 years and over with selected chronic diseases, ASR per 100, by SA3, 2017-18

SA3	Arthritis	Asthma	COPD	Circulatory disease	Osteoporosis
Botany	12.8	7.5	2.1	5.1	3.5
Canada Bay	12.4	7.2	1.6	4.5	4.8
Canterbury	14.5	7.8	2.0	5.0	5.4
Cronulla - Miranda – Caringbah	14.2	11.3	2.0	4.4	4.0
Eastern Suburbs – North	12.2	8.0	1.8	3.6	4.1
Eastern Suburbs – South	12.2	9.8	2.2	4.3	4.3
Hurstville	12.1	7.0	1.8	4.4	5.7
Kogarah - Rockdale	12.1	6.6	1.9	4.7	4.7
Leichhardt	11.3	8.6	2.3	4.4	4.4
Marrickville - Sydenham - Petersham	11.4	9.6	2.2	4.5	4.5
Strathfield - Burwood – Ashfield	11.7	7.3	2.0	4.5	5.1
Sutherland - Menai – Heathcote	14.4	10.8	2.1	4.8	4.0
Sydney Inner City	10.8	7.2	2.4	4.0	4.2
CESPHN	12.5	8.2	2.0	4.4	4.6
NSW	15.5	10.6	2.2	4.9	4.2
Australia	15.0	11.2	2.5	4.8	3.8

Source: PHIDU 2021

Heart, stroke and vascular diseases

Heart, stroke and vascular diseases are conditions which cause chronic disability and poor-health and are themselves caused by the development of biomedical risk factors and lifestyle factors. The most recent modelled incidence is from AIHW (for 2017 and 2018). At that time, an estimated 60,602 residents of CEPSHN were living with health, stroke or vascular disease, representing 4.7% of all adult residents.

Almost one-in-ten (9.7%) residents aged 55-74 were living with these conditions. One-in-four (25.3%) residents aged more than 75 years of age were affected by heart, stroke and vascular diseases, similar to Australia-wide estimated prevalence (25.7%). Heart, stroke and vascular disease was higher in males than females, particularly in the over 75-year age group (31.7% versus 20.1%) (5).

Diabetes

In 2024, there were 99,777 registrants in the National Diabetes Services Scheme (NDSS) living with any type of diabetes in the CESPHN region, 4.25% of the population. The majority of registrants have Type 2 diabetes (N=84,817; 85.0%), followed by Type 1 (N=11,006; 11.0%), gestational (N=2,858 2.9%), and other types (N=1,096; 1.1%) ((6). People identifying as Aboriginal are three times more likely to develop diabetes than someone with a non-Aboriginal background (7). In 2020, the crude incidence of insulin-treated diabetes within the CESPHN region was 6.4 per 100,000 and the age-adjusted incidence is 6.8, which was lower than the age-adjusted incidence for New South Wales (8).

Diabetes is still largely undiagnosed in the community and early detection and prevention strategies are required to reduce the impact and likelihood of diabetic-related complications. The detection of pre-diabetes is recommended in national guidelines via use of validated risk assessment scores, routine assessment of HbA1c blood levels with more frequent annual screening recommended for people identified as meeting the pre-diabetes threshold (9).

Adverse outcomes due to diabetes are shown in the table below, specifically, diabetes related hospitalisations, amputations and causes of death. Variability in these rates by LHD are evident for amputations and cause of death (higher in Sydney LHD) (10).

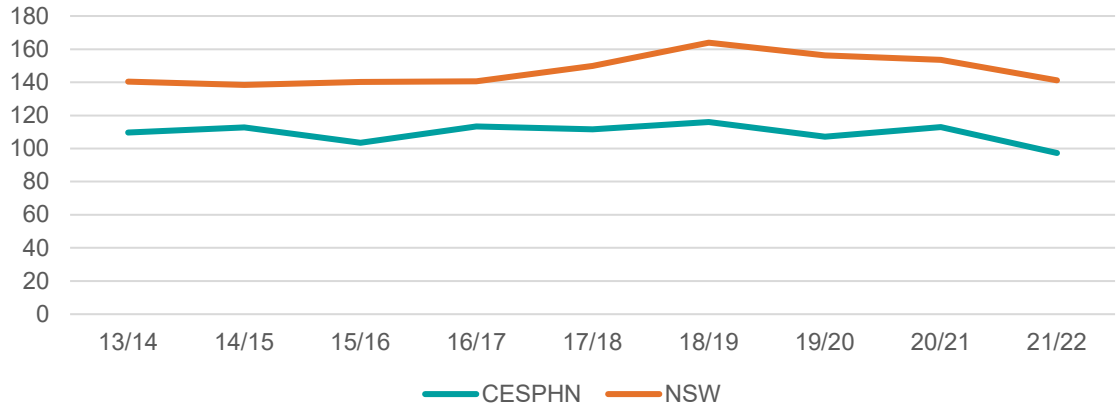
Table 4: Rate of adverse outcomes attributed to diabetes (per 100,000 population), CESPHN by LHD

Adverse outcome	Sydney LHD	South Eastern Sydney LHD	Total CESPHN
Diabetes related hospitalisations (21/22)			
Type 1 Diabetes	21.3	24.1	23.1
Type 2 Diabetes	67.4	66.6	67.1
Other	9.8	4.8	7.1
Total	98.5	95.5	97.3
Amputations due to Diabetes (20/21-21/22)			
Toe/Foot/ankle	12.4	9.2	10.5
Below knee	1.9	0.9	1.3
Above knee	0.6	0.4	0.5
Total	14.9	10.6	12.3
Underlying or associated cause of death (2021)	56.0	48.5	51.2

Source: HealthStats, NSW (2024)

The rate of diabetes-related hospitalisations has fallen consistently since 2018 to 2022, from 116 per 100,000 to 97.3 per 100,000. This an indicator of improved management and prevention within the primary care system (10).

Figure 1: Rate of total diabetes hospitalisations per 100,000, CESPHN and NSW, 2013-2022



Source: HealthStats, NSW Health

In the CESPHN region, there were 428 diabetes-related deaths in 2019, which increased to 519 in 2021, which could relate to inadequate management because of the COVID waves (10).

Diabetic-related amputations had increased during the COVID pandemic to a rate of 11.3 per 100,000 before decreasing to 10.5 per 100,000 in 2022. The rate of below the knee and above the knee amputations has remained relatively unchanged since 2012 (10). The annual diabetes cycle of care is for patients with established diabetes and includes diabetes management and general health checks. In 2021-22, 3,169 patients in the CESPHN region received an annual diabetes cycle of care (0.20 per 100 people compared to 0.45 per 100 people nationally). Hurstville SA3 had the highest rate of people receiving this MBS item (0.34 per 100 people) (11).

Chronic kidney disease

Hospitalisations per 100,000 population for chronic kidney diseases in 2021/2022 were higher in residents within the Sydney Local Health District, compared with the NSW average (N=6216.3, 95% CI=6157.7-6275.4 versus 5878.4, 95% CI=5863.1 to 5893.7), and are lower in the South Eastern Sydney LHD (N=5058, 95% CI=5015.3 to 5101.4) (12).

Deaths for chronic kidney diseases shows variation across the CESPHN region, according to Local Government Area. Relatively higher crude rates are seen in residents of the Canterbury-Bankstown LGA (partially within CESPHN), and Randwick, Botany and Rockdale (10).

Table 5: Chronic kidney disease deaths, by Local Government Areas and Total CESPHN, 2018 to 2020

Local Government Area (LGA)	Rate per 100,000
Botany LGA	50.8
Burwood LGA	44.8
Canada Bay LGA	39.0
Canterbury-Bankstown LGA*	56.4
Georges River LGA	43.4
Inner West LGA	45.4
Randwick LGA	50.4
Rockdale LGA	50.0
Strathfield LGA	44.1
Sutherland Shire LGA	40.6
Sydney LGA	37.5
Waverley LGA	35.0
Woollahra LGA	30.5
CESPHN Total	43.8

Source: HealthStats, NSW Health
**Bankstown is not within the CESPHN region*

Data from NSW Health were not disaggregated according to Aboriginality. NSW Health reports higher death rates for chronic kidney diseases for Aboriginal people (113.9 per 100,000). Since the reporting period of 2013-2015, mortality has decreased within CESPHN from 50.2 per 100,000 to 43.8 per 100,000 between 2018-2020.

Cancer

During 2021, 8,294 CESPHN residents were newly diagnosed with cancer and 2,384 had died from the disease. Cancer mortality was highest in the Inner West LGA, which is partly within the CESPHN region, mainly attributable to a higher risk of lung cancer mortality (4; 4; 13; 4). Within the region, residents of Woollahra, Sutherland Shire and Randwick LGAs had an elevated risk of being diagnosed with cancer.

In the Sutherland Shire and Woollahra LGA's, this is attributable in part to an increased risk of melanoma of the skin which is 60% and 16%, respectively, above the expected age-standardised rate (4). Detailed breakdown of incidence and mortality by region are available from the Cancer Institute, NSW.

In females, the most frequently diagnosed cancers in the CESPHN region are breast (N=5,374), followed by melanoma of the skin (N=1,627), lung (N=1,424), colon (N=1,398), thyroid (N=1,176) and uterine cancers (N=845). Deaths from lung cancer (N=834), breast cancer (N=828), pancreatic cancer (N=452), colon cancer (N=388), ovarian cancer (N=269), and cancer with unknown primary (N=251) were the most prevalent causes of mortality.

Amongst males within the CESPHN region, cancers of the prostate (N=6,336), melanoma of the skin (N=2259), lung (N=1,849), colon (N=1,430), non-Hodgkin's lymphoma (N=1,077) and rectal cancer (N=984) were the most frequently diagnosed. Prevalent cancer causes of death in males were lung (N=1,299), prostate (N=755), pancreatic (N=440), colon (N=420), liver (N=359) and rectal (N=329) (4).

Table 6: Number of incident cancers and age-standardised rates (ASR) of incidence by Local Government Areas within CESPHN, 2021

Local Government Area (LGA)	Cases	ASR per 100,000	ASR lower 95% CI	ASR High 95% CI
Botany LGA	257	462.2	407.0	522.8
Burwood LGA	202	458.5	395.5	528.5
Canada Bay LGA	495	449.5	410.2	491.4
Canterbury-Bankstown LGA*	800	462.1	430.2	495.7
Georges River LGA	853	454.1	423.4	486.3
Inner West LGA	945	472.4	442.6	503.8
Randwick LGA	814	528.9	492.8	567.0
Rockdale LGA	610	452.1	416.2	490.2
Strathfield LGA	178	403.7	345.2	469.1
Sutherland Shire LGA	1,547	514.9	488.9	541.9
Sydney LGA	834	466.3	434.3	499.9
Waverley LGA	344	487.5	436.8	542.6
Woollahra LGA	415	553.9	499.8	612.1
CESPHN Total	8,294	478.7	468.4	489.3

Source: Cancer Institute, NSW

Note: LGA boundaries do not perfectly align with CESPHN boundaries- Canterbury-Bankstown partially overlaps with CESPHN boundary.

The age-standardised cancer mortality rates were highest in Inner West LGA (ASR=139.4), Canterbury-Bankstown LGA (ASR=145.6) and Sydney LGA (ASR=136.4). (4).

Table 7: Number of cancer deaths and age-standardised rates (ASR) of mortality by Local Government Areas within CESPHN, 2021

Local Government Area (LGA)	Cases	ASR per 100,000	ASR lower 95% CI	ASR High 95% CI
Botany LGA	75	134.2	105.5	168.3
Burwood LGA	58	115.3	86.2	150.7
Canada Bay LGA	155	128.2	108.5	150.4
Canterbury-Bankstown LGA*	258	136.4	120.0	154.4
Georges River LGA	260	123.2	108.2	139.6
Inner West LGA	286	139.4	123.5	156.6
Randwick LGA	224	133.9	116.6	153.0
Rockdale LGA	204	133.4	115.3	153.5
Strathfield LGA	46	103.1	75.0	138.1
Sutherland Shire LGA	427	125.7	113.8	138.6
Sydney LGA	212	129.7	112.6	148.7
Waverley LGA	95	130.4	105.2	159.9
Woollahra LGA	83	91.7	72.6	114.3
CESPHN Total	2,384	128.1	122.9	133.4

Source: Cancer Institute, NSW

Note: LGA boundaries do not perfectly align with CESPHN boundaries – Canterbury-Bankstown partially overlaps with CESPHN boundary.

Cancer prevention and control

Approximately 42% of cancers, including skin cancers, are attributable to modifiable behavioural, environmental and biochemical risk factors (14). Of note, smoking and obesity are implicated in thirteen different cancers, diabetes increases the risk of seven cancers and alcohol intake is causally linked to five cancers (14). Reducing the prevalence of modifiable risk factors in the community provides an opportunity for large gains in terms of cancer prevention.

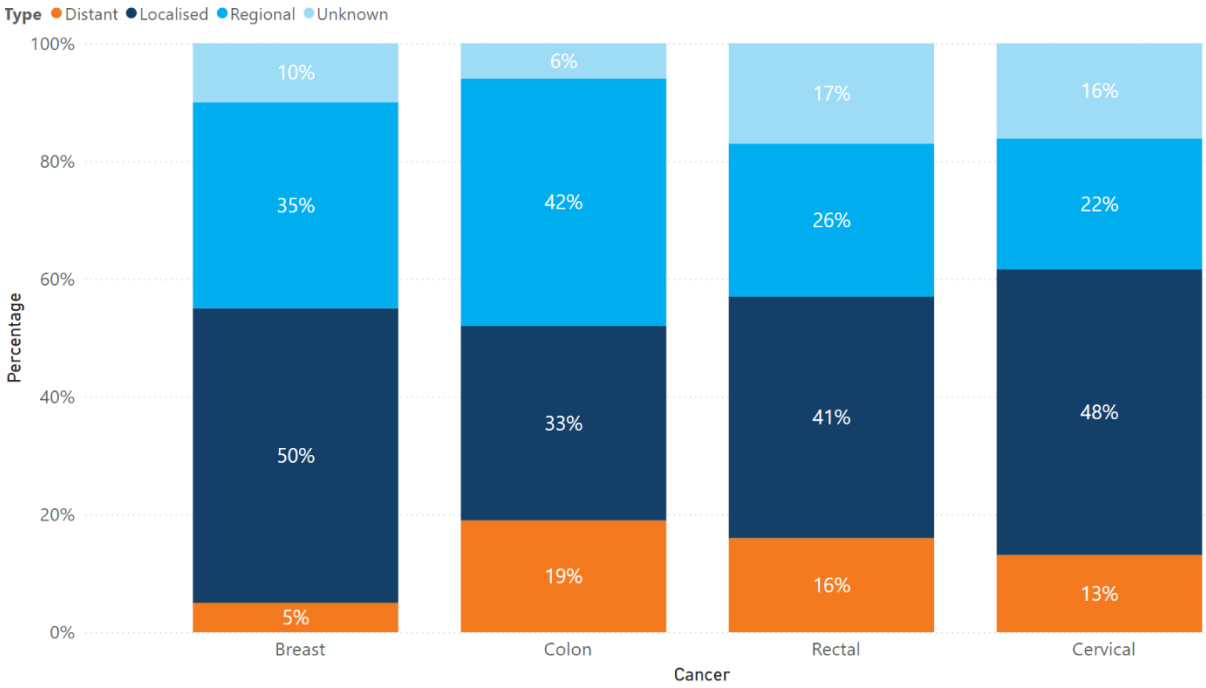
Evidence-based screening and early detection of cancer provide more immediate gains in cancer control, specifically, in reducing the risk of cancer-related mortality. There are four national Cancer Screening programs: breast, cervical and for colon and rectal cancers ("bowel" cancer screening). Each program aims to detect cancers early to reduce treatment-related morbidity and maximise the likelihood of survival. Therefore, the proportion of cancers diagnosed as localised provides a measure of the extent to which cancer screening has met its aims. However, one limitation of this measure is that cancer statistics available at PHN level are not limited to the screening target age-group and encompass all ages.

Cervical cancer screening also aims to identify pre-cancerous lesions and together with universal vaccination in adolescence against Human Papilloma Viruses (implicated in causing almost all cervical cancers) has the potential to eliminate cervical cancer incidence. Colorectal cancer screening

will also detect pre-cancerous polyps. Therefore, a decline in incidence can be expected with screening, although this may be offset by higher detection rates.

Currently, within the CESPHN region, around 49.8% of breast cancers are diagnosed at the localised stage, slightly below the NSW average of 52.0%. Almost half of cervical cancers are detected at the localised stage (48.1%), similar to the NSW average (48.3%). One-third and 40% of colon and rectal cancers, respectively, are diagnosed as localised on par with NSW averages (33.8% and 41.7%), respectively (4).

Figure 2:Spread of disease at diagnosis for cancers with a national funded screening program, CESPHN region, 2017-2021



Source: Cancer Institute, NSW

Vaccination against HPV is a central component of cervical cancer prevention. The NSW School Vaccination Program offers free vaccination for adolescents as part of the National Immunisation Program (NIP). In 2021, the HPV immunised rates (first dose) for females and males in the CESPHN region were higher than the NSW rates (6).

Table 8: Percentage of first dose adolescent vaccination coverage rates by school year, 2021

LHD	HPV Female (Year 7) (%)	HPV Male (Year 7) (%)
SLHD	87	83
SESLHD	85	86
NSW	83	80

Source: HealthStats NSW 2023

Nationally funded screening programs for breast, cervical cancer and colorectal cancers are all under-utilised within CESPHN amongst eligible participants, compared with national and state averages. Variability in the region raises concerns about equitable access to services. The most recently available data spans the COVID-19 pandemic era (2020-2021). During that time period, only four SA3 regions within CESPHN had bowel cancer screening participation rates above the state average (Sutherland-Menai-Heathcote, Cronulla-Miranda-Caringbah). The lowest uptake was seen in Canterbury (32.8%), followed by the Eastern Suburbs North (33.7%), Sydney Inner City (33.6%), Botany (34.9%) and Kogarah-Rockdale (35.4%) (15).

Table 9: Percentage of breast screening participation by and SA3, 2019-2020

SA3	Breast (%)
Botany	n.p
Canada Bay	45.6
Canterbury	41.4
Cronulla – Miranda – Caringbah	50.0
Eastern Suburbs – North	40.7
Eastern Suburbs – South	50.4
Hurstville	45.8
Kogarah – Rockdale	45.3
Leichhardt	51.0
Marrickville – Sydenham – Petersham	46.1
Strathfield – Burwood – Ashfield	42.5
Sutherland – Menai – Heathcote	52.2
Sydney Inner City	40.0
CESPHN	45.5
NSW	46.8
National	49.6

Source: AIHW, 2023

Five SA3 areas exceeded the national average of uptake of breast screening (49.6%)- Cronulla-Miranda-Caringbah, Eastern Suburbs South, Leichhardt and Sutherland-Miranda-Heathcote.

However, around half of eligible women are not taking up the offer of a BreastScreen funded mammogram in these areas. Uptake below 45% was seen in Canterbury (41.4%), Eastern Suburbs North (40.7%), Strathfield-Burwood-Ashfield (42.2%), and Inner Sydney (40.0%) SA3 regions. Several of these areas are home to culturally and linguistically diverse communities ((15).

The Cancer Institute, NSW, reports that only 34% and 34.5% of eligible women identifying as culturally and linguistically diverse residing in the Sydney Local Health District and South-Eastern Sydney Local Health District, respectively, participated in breast cancer screening between July 2021 and June 2023 (16). Two issues need to be highlighted. First, these proportions are substantially below those seen prior to the COVID-19 pandemic era- more than 40% had participated between July 2016 and June 2018. Second, these proportions rank 8th (South Eastern Sydney) and 9th (Sydney) amongst all fifteen NSW Local Health Districts raising concerns about unwarranted variation in screening amongst Culturally and Linguistically Diverse women across Primary Health Networks in NSW (16).

The reason for the low uptake in the Eastern Suburbs, North SA3 is unclear. Between 2017-2021, the age-standardised incidence in females is 28% higher than the NSW average within the Woollahra LGA, although mortality is not significantly elevated. As the region is home to a high concentration of residents identifying as Jewish (13% according to the latest National Census figures) (17), a higher proportion of people in this region compared with elsewhere may be accessing screening via a high-risk pathway given the elevated risk of hereditary breast cancer in both men and women with Jewish ancestry (18). However, data on private access to high-risk screening mammography is not available to confirm this suggested reason. It therefore is unclear if the low uptake of publicly funded breast cancer screening in this region reflects an unmet need in breast cancer prevention.

The regions also differ in terms of the population's baseline risk of breast cancer, health-seeking behaviours and the prevalence of priority groups such as recent migrant communities who continue to face barriers to access.

Participation in bowel cancer screening in CESPHN of 37.2% is slightly below the NSW rate (39.5%) and national rate of 40.9%. Uptake is lowest in the Canterbury SA3 (32.8%), followed by Botany (34.9%), Sydney Inner City (33.6%), and Eastern Suburbs North (33.7%). Four SA3s had screening rates above the NSW average of 39.5% (Canada Bay, Cronulla-Miranda-Caringbah, Leichhardt, and Sutherland-Menai-Heathcote. Participation rates in all SA3s were below 45%.

Table 10: Percentage of bowel screening participation by SA3, 2020-2021

SA3	Bowel (%)
Botany	34.9
Canada Bay	40.1
Canterbury	32.8
Cronulla – Miranda – Caringbah	42.8
Eastern Suburbs – North	33.7
Eastern Suburbs – South	36.9
Hurstville	38.6
Kogarah – Rockdale	35.4
Leichhardt	41.8
Marrickville – Sydenham – Petersham	37.5
Strathfield – Burwood – Ashfield	36.9
Sutherland – Menai – Heathcote	44.3
Sydney Inner City	33.6
CESPHN	37.2
NSW	39.5
National	40.9

Source: AIHW, 2023

Uptake of cervical cancer screening is higher than that for bowel and breast cancer screening. However, there is also wide variation in uptake across the CESPHN region. Uptake exceeds the state average of 67.2% in three SA3 regions: Leichhardt (77.2%), Eastern Suburbs North (77.3%) and Eastern Suburbs South (70.0%). Uptake in Botany and Canterbury is less than 60% (59.7% and 57.2%, respectively) (15).

Table 11: Percentage of cervical screening participation by SA3, 2018-2021

SA3	Cervical (%)
Botany	59.7
Canada Bay	66.5
Canterbury	57.2
Cronulla – Miranda – Caringbah	66.1
Eastern Suburbs – North	77.3
Eastern Suburbs – South	70.0
Hurstville	60.6
Kogarah – Rockdale	57.2
Leichhardt	77.2
Marrickville – Sydenham – Petersham	66.9
Strathfield – Burwood – Ashfield	61.3
Sutherland – Menai – Heathcote	67.0
Sydney Inner City	62.0
CESPHN	64.5
NSW	67.2
National	68.3

Source: AIHW, 2023

Cancer care and Aboriginal People in South Eastern Sydney Local Health District and Sydney Local Health District

Between 2018 and 2020, 5,556 people identifying as Aboriginal in NSW were diagnosed with cancer and 1,941 died from it (19). Five-year all-cause survival in Aboriginal people diagnosed with cancer was estimated to be 56% for the years 2013-2019. In NSW, the most commonly diagnosed cancers between 2016-2020 were cancer of the lung (16% of the population identifying as Aboriginal), breast (12%), prostate (10%), bowel (9.8%) and melanoma (6%).

The Cancer Institute NSW reported that amongst Aboriginal people with cancer in NSW, 60% reported fatigue, 50% reported worry and 41% reported nervousness. Just one-third (30%) reported receiving support or the offer of support, from an Aboriginal Health Worker.

Significant gaps in health assessment and prevention indicators for Aboriginal people in the region have been identified. These related to participation in an Aboriginal specific health assessment (MBS 715), breast cancer screening, and receipt of a Chronic Care Management plan. Rates in the South Eastern Sydney part of the region are typically lower.

Table 12: Health assessment and prevention indicators for Aboriginal residents

Outcomes	Sydney LHD	South-East Sydney LHD	NSW
Participation in Aboriginal specific health assessment	15%	10%	26%
Received follow-up services within 12 months of an Aboriginal specific health assessment	37%	29%	39%
5 or more standard GP consultations in the year before cancer diagnosis if did not participate in an Aboriginal specific health assessment	76%	83%	72%
Participated in Breast screening	36%	36%	45%
Chronic Care Management plan in 12-months after cancer diagnosis	68%	44%	52%
5 or more standard GP consultations in the 12-months after cancer diagnosis	78%	80%	81%

Source: AIHW, 2024

The Cancer Institute NSW reports reduced participation in breast cancer screening in women identifying as Aboriginal from July 2016-June 2018 to July 2021-June 2023 in both the Sydney LHD (over 40% to 33.1%) and South Eastern Sydney LHD (~40% to 31.8%). Moreover, screening uptake between July 2021-June 2023 amongst women identifying as Aboriginal ranked 9th (Sydney LHD) and 12th (South East Sydney LHD) out of 15 LHDs (20)- reflecting variation amongst LHDs for cancer screening participation.

Participation in bowel and cervical cancer screening is lower amongst people identifying as Aboriginal in NSW: 27% and 40%, respectively (15). Further, national statistics report that fewer than half of people identifying as Aboriginal received diagnostic assessment after a positive bowel cancer screening result (43.5%), compared with 62.4% of non-Aboriginal participants (21), conferring the potential for delayed bowel cancer at an advanced stage if positive FOBT results are proven to be cancer-related.

Lung cancer screening

From July 2025 the Australian Government will fund a National Lung Cancer Screening Program for people aged 50 to 70 years of age with a history of cigarette smoking who are either currently smoking or who had quit within the last ten years. General Practitioners and Aboriginal Health Services will provide access to a fully Medicare funded biennial low-dose computed tomography scan. If applicable, providers will arrange referrals to specialist care (22). Primary health care, therefore, provides a crucial role in the implementation of the Lung Cancer screening program.

Liver cancer

Liver cancer incidence and mortality has been increasing in the CESPHN region, reflecting an increase seen across Australia. Overall, males in the CESPHN region have seen a faster increase in new liver cancer cases and in 2021 had a higher incidence rate (12.9 ASR per 100,000 males) compared to females (5.1 ASR per 100,000 females). Similarly, to all cancer data, number of cases was highest in persons aged 60-69 years and those aged 80+ (4).

The figure below indicates the growth of liver cancer from 2017 to 2020. The slight decrease in 2021 may be the result of COVID waves or a decrease in screening and testing. More data from recent years is necessary to confirm more recent trends.

Eight out of 13 LGAs in the CESPHN region have a higher liver cancer incidence rate compared to the NSW rate, with Burwood and Sydney LGAs having the highest rates (15.2 ASR per 100,000 people and 11.7 ASR per 100,000 people respectively) (4).

Table 13: Incidence of liver cancer in the CESPHN region by LHD, 2021

LHD	ASR per 100,000
South Eastern Sydney LHD	8.1
Sydney LHD	10.4
CESPHN	9.0

Source: Cancer Institute NSW 2023
Note: Lord Howe Island is not included as there is no published data available.

Key prevention/management issues are as follows:

1. Vaccination against hepatitis B is key to support prevention.
2. For those already infected with hepatitis B, regular monitoring and early detection can significantly reduce the risk of liver cancer.
3. There is no vaccine for hepatitis C, but effective treatments can cure the infection and lower the risk of liver cancer.
4. Aboriginal people in NSW are more likely to be diagnosed with liver cancer and at a younger age compared to non-Indigenous people. The higher rates of hepatitis B and C among people identifying as Aboriginal contribute to the increased risk of liver cancer. Factors such as limited access to healthcare, stigma, and socio-economic challenges exacerbate these health disparities.

Chronic Hepatitis B

Just over one percent (1.22%) of residents in the CESPHN region are living with chronic Hepatitis B (CHB). This prevalence is higher than the national average (0.78%) (23). The prevalence of CHB infection in eight of the 13 regions is elevated compared with the national average (Table 1). More can be done to improve the delivery of treatment and care for people living with CHB- 15.8% of people with CHB in CESPHN region are receiving treatment while 30.5% receive CHB care

(treatment or monitoring) (23). These rates are above the national average (12.9% and 25.5%, respectively), yet are sub-optimal when compared with the national strategic targets of 20% for treatment and 50% for care (23). Moreover, only Hurstville SA3 met the national target for treatment (24). None of the SA3 areas met the national target for care (24).

Overseas born residents account for 70% of all prevalent cases of CHB, with 23% of all people living with CHB born in North East Asia and 22.5% born in South East Asia (23). Residents born in sub-Saharan Africa (4.3%), Southern and Eastern Europe (5.9%), North Africa and the Middle East (3.4%) and in Oceania region (other than Australia) (4.6%) experience an elevated risk of CHB. Amongst people living with CHB who were born in Australia, Aboriginal and Torres Strait Islander peoples (6.7%), people who inject drugs (3.1%) and men who have sex with men (4.1%) are disproportionately affected. In the CESPHN region, people born in China, Vietnam and Greece are most commonly represented in overseas born people affected by CHB (23).

Table 14: Prevalence of CHB and percentage receiving care and treatment by SA3, CESPHN region, 2022

Statistical Area Level 3	CHB prevalence (%)	CHB treatment (%)	CHB care (%)
Botany	1.4	8.8	16.4
Canada Bay	1.3	15.3	30.1
Canterbury	1.8	18.4	36.8
Cronulla – Miranda – Caringbah	0.6	11.0	21.1
Eastern Suburbs – North	0.7	10.4	19.0
Eastern Suburbs – South	0.9	11.5	23.0
Hurstville	1.9	23.8	42.2
Kogarah – Rockdale	1.5	18.1	33.3
Leichhardt	0.6	11.2	21.6
Marrickville – Sydenham – Petersham	1.1	18.6	33.7
Strathfield – Burwood – Ashfield	1.7	17.1	34.1
Sutherland – Menai – Heathcote	0.6	11.4	22.0
Sydney Inner City	1.3	10.6	23.3

Source: National Viral Hepatitis Mapping Project, Online Portal

Chronic Hepatitis C

Despite Chronic Hepatitis C (CHC) prevalence in the CESPHN region being 16.7% higher than the national average, uptake of treatment between March 2016 and October 2023 was 19.4% lower than the national average (25) highlighting a significant unmet need in the community. Uptake of treatment in the region ranks as the third lowest in Australia.

There is significant variability in CHC prevalence within the CESPHN region- Sydney Inner City (2.4%), Leichhardt (1.2%), Marrickville-Sydenham-Petersham (1.3%) and Eastern Suburbs (South) (1.1%) have elevated prevalence rates (24). However, higher prevalence within those geographical areas does not correspond to higher rates of CHC treatment underscoring the need for targeted strategies in higher-risk regions (Table 15) (25). It is also important to acknowledge that men who

have sex with men and people in receipt of PrEP to prevent HIV infection are concentrated within CESPHN Statistical Areas with a higher Hep C prevalence- this suggests higher risk of Hep C infection due to demographic characteristics of residents. However, the higher prevalence may also be partly due to higher detection rates.

Table 15: Prevalence of CHC and percentage receiving treatment by SA3, CESPHN region, 2020

Statistical Area Level 3	CHC prevalence (%)	CHC treatment (%)
Botany	0.6	64.0
Canada Bay	0.4	45.5
Canterbury	0.8	42.0
Cronulla – Miranda – Caringbah	0.4	58.4
Eastern Suburbs – North	0.6	43.1
Eastern Suburbs – South	1.1	36.0
Hurstville	0.5	42.6
Kogarah – Rockdale	0.6	41.4
Leichhardt	1.2	42.0
Marrickville – Sydenham – Petersham	1.3	45.1
Strathfield – Burwood – Ashfield	0.7	39.5
Sutherland – Menai – Heathcote	0.3	58.6
Sydney Inner City	2.4	33.4

Source: National Viral Hepatitis Mapping Project, Online Portal

Potentially preventable hospitalisations

Potentially preventable hospitalisations (PPHs) are hospital admissions that could have been prevented by timely and adequate health care in the community. It offers a measure of unmet needs and is therefore a useful summary of gaps in chronic care prevention and management. In 2021/2022, there were 12,317 potentially preventable hospitalisations attributable to chronic diseases in the CESPHN region, corresponding to 802 per 100,000 people hospitalised for potentially preventable reasons for common chronic care conditions (26).

When compared with the overall CESPHN age-standardised rate of PPHs of 695, regions with higher age-standardised rates were Sutherland-Menai-Heathcote (871, per 100,000), Eastern Suburbs South (861 per 100,000), Canterbury (821 per 100,000), Cronulla-Miranda-Caringbah, 808 per 100,000) and Botany (738 per 100,000) (26).

Table 16: CESPHN Potentially Preventable Hospitalisations (PPH) Due to Chronic Conditions,2021-2022

Condition	ASR PPH	Crude Rate	Number PPHs	Av LOS
Asthma	76	66	1,011	2.4
Congestive cardiac failure	145	193	2,965	7.2
Diabetes complications	97	109	1,673	7.6
COPD	88	106	1,620	6.5
Bronchiectasis	14	17	254	NP
Angina	103	118	1,807	1.7
Iron deficiency anaemia	127	142	2,186	1.7
Hypertension	33	39	595	2.7
Nutritional deficiencies	2	2	30	NP
Rheumatic heart disease	10	12	177	8.3
Total CESPHN	695	802	12,317	4.8

Source: AIHW, 2024
ASR=Age Standardised Rate. ASR and Crude Rates are per 100,000 people
Av LOS=Average LOS
COPD=Chronic Obstructive Pulmonary Disease

Table 17: Total Potentially Preventable Hospitalisations (PPHs) due to Chronic Conditions by CESPHN SA3 region, 2021-2022

SA3	ASR PPHs	Crude Rate	Av LOS
Botany	738	689	5.1
Marrickville-Sydenham-Petersham	579	593	5.9
Sydney Inner City	637	483	5.8
Eastern Suburbs-North	537	664	4.4
Eastern Suburbs-South	861	1,015	4.3
Canterbury	821	931	5.1
Hurstville	631	814	5.1
Kogarah-Rockdale	714	892	4.8
Canada Bay	614	816	5.2
Leichhardt	503	547	5.8
Strathfield-Burwood-Ashfield	614	698	5.2
Cronulla-Miranda-Caringbah	808	1,166	4.0
Sutherland-Menai-Heathcote	871	1,095	3.9
Total chronic	695	802	4.8

Source: AIHW, 2024
ASR=Age Standardised Rate. ASR and Crude Rates are per 100,000 people
Av LOS=Average LOS
COPD=Chronic Obstructive Pulmonary Disease

Management of chronic diseases

During the 2022/2023 financial year, almost one in seven residents (13.9%) within the region had consulted a General Practitioner (GP) at least once for a chronic care management plan service with a total of 506,302 services rendered (27). Most of this activity involved people aged over 65 years, with 38.8% of 65- to 79-year-olds and over half (52.0%) of those aged 80 years or older consulting their primary health care practitioner for chronic care management. However, almost 20% of working-aged residents between 45 and 64 years (17.7%) and 6.8% people aged 25 to 44 years also received chronic care management services via their primary health care provider (27). Metrics measuring the delivery of chronic care management plans is an imperfect proxy for chronic disease prevalence and is likely a function of both underlying prevalence and ease of access to care. Nonetheless, these data suggest the high burden of chronic disease in the region.

Opportunities

- Improving the uptake of evidence-based cancer screening programs, specifically, breast, cervical and colorectal cancers where rates are low in the region. Work with LHDs to review availability of mobile screening units across the region.
- From July 1, 2025, a National Lung Cancer Screening Program will be launched targeting high risk smokers or ex-smokers accessed through general practice and Aboriginal Health Services.
- Promote new smoking and vaping cessation clinic at Concord Hospital.
- Continue supporting general practices to connect to the National Cancer Screening Registry and promoting share care and quality improvement activities for cancer screening and prevention.
- Encouraging and supporting men to engage in early screening activities such as prostate checks.
- Liver cancer is one of the fastest growing types of cancer in Australia and it is linked to lifestyle risk factors such as excessive intake of alcohol, obesity, diabetes, and non-alcoholic fatty liver disease. The burden of liver cancer falls disproportionately on populations which may experience disadvantage. These groups often face barriers to accessing healthcare and preventive measures.

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phn
CENTRAL AND
EASTERN SYDNEY

An Australian Government Initiative

MENTAL HEALTH

2025-2027 Needs Assessment

Table of contents

List of tables

List of figures

Overview

The World Health Organisation defines mental health as a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It has intrinsic and instrumental value and is integral to our well-being. At any one time, a diverse set of individual, family, community and structural factors may combine to protect or undermine mental health. Although most people are resilient, people who are exposed to adverse circumstances – including poverty, violence, disability and inequality – are at higher risk of developing a mental health condition (1).

The term mental illness describes conditions diagnosed by a medical professional that significantly affect how a person thinks, feels and interacts with other people. Mental health problems or concerns can also interfere with a person's cognitive, emotional or social abilities; however the severity of their impact does not meet thresholds for a mental illness or mental health disorder.

In the context of primary health care, an individual's mental health care pathway is founded upon a stepped care approach. Stepped care aims to match a person presenting to the health system with the least intensive level of care that most suits their current treatment need, with the ability to monitor treatment experiences and outcomes to enable a step up or down in treatment intensity as necessary.

To identify the most appropriate level of care, the Initial Assessment and Referral Decision Support Tool (IAR-DST), an evidence-informed tool, has been implemented by PHNs since 2022 to support the initial assessment and referral of individuals presenting with mental health concerns in primary health care settings (2). The IAR-DST is rated across 8 domains including symptom severity and distress, risk of harm, functioning, impact of co-existing conditions, service use and response history, social and environmental stressors, family and other supports, and engagement and motivation. A level of care, between 1 to 5, is recommend based on the ratings entered by the referrer into the IAR-DST after a comprehensive mental health assessment.

The five levels of care in the IAR are defined to sit across the spectrum of mental health concerns:

1. **IAR Level 1: Self-management.** Evidence based digital interventions and other forms of self-help.
2. **IAR Level 2: Low intensity services.** Services that can be accessed quickly & easily and include group work, phone & online interventions and involve few or short sessions.
3. **IAR Level 3: Moderate intensity services**. Moderate intensity, structured and reasonably frequent interventions (e.g., psychological interventions)
4. **IAR Level 4: High intensity services.** Periods of intensive intervention, typically, multidisciplinary support, psychological interventions, psychiatric interventions, and care coordination.
5. **IAR Level 5: Specialist and Acute Community Mental Health Services.** Specialist assessment and intensive interventions (typically, state/territory mental health services) with involvement from a range of mental health professionals (3).

Key needs

- 71% of GPs report psychological issues in their top 3 reasons for presentation
- There is an increase in severity of mental health related issues
- Self-reported prevalence of a mental health condition varies across the region from 11.7% in Marrickville-Sydenham-Petersham SA3 to 5.0% in Hurstville SA3
- There are a number of vulnerable population groups who experience a higher prevalence of mental health concerns, including:
    - Aboriginal people
    - Children and young people
    - LGBTIQ+ peoples
    - Multicultural communities
    - Older people
    - Veterans
    - People experiencing social isolation
    - People engaging in harmful levels of gambling
- In 2021-21 there were 106 mental health related emergency department presentations per 10,000 population and 102.4 overnight admitted mental health-related hospitalisations per 10,000 population.

Key gaps

- Access to child mental health services (including a multidisciplinary approach)
- Access to Psychiatrists across all speciality areas including Children, older people, ADHD and autism
- Availability of psychological therapies for people experiencing severe and complex mental illness
- Affordable access to services for eating disorders
- Availability of longer-term therapy for Eye movement desensitisation and reprocessing (EMDR) therapy and dialectical behavioural therapy (DBT)
- Therapy for children who have experienced Domestic and Family Violence and people have left a relationship that experienced Domestic and Family Violence
- Access to therapy in language.

Prevalence of mental health issues

Mental health in adults

The 2021 Census reported the number of people with selected long-term health conditions across the CESPHN region. A total of 102,526 people responded that they had a mental health condition (including depression or anxiety). This accounted for 6.6% of the CESPHN population and 5.9% of long-term health condition responses; the highest proportion for specific, identified long-term health conditions.

Within the CESPHN region, Marrickville-Sydenham-Petersham SA3 had the highest proportion of the population respond in the Census that they had a mental health condition (11.7%), followed by Leichhardt SA3 (8.9%) and Sydney Inner City SA3 (8.7%) (4).

Table 1: Number and proportion of population with mental health condition by SA3, CESPHN region, 2021

SA3	People with mental health condition	Proportion of people in SA3 with mental health condition
Botany	3,313	5.6%
Canada Bay	4,689	5.4%
Canterbury	6,683	4.7%
Cronulla-Miranda-Caringbah	7,684	6.5%
Eastern Suburbs – North	7,298	5.7%
Eastern Suburbs – South	8,694	6.5%
Hurstville	6,614	5.0%
Kogarah-Rockdale	7,505	5.1%
Leichhardt	5,029	8.9%
Lord Howe Island	10	2.2%
Marrickville-Sydenham-Petersham	6,427	11.7%
Strathfield-Burwood-Ashfield	10,914	6.8%
Sutherland-Menai-Heathcote	8,667	7.8%
Sydney Inner City	18,999	8.7%
CESPHN	102,526	6.6%

Source: ABS, 2022

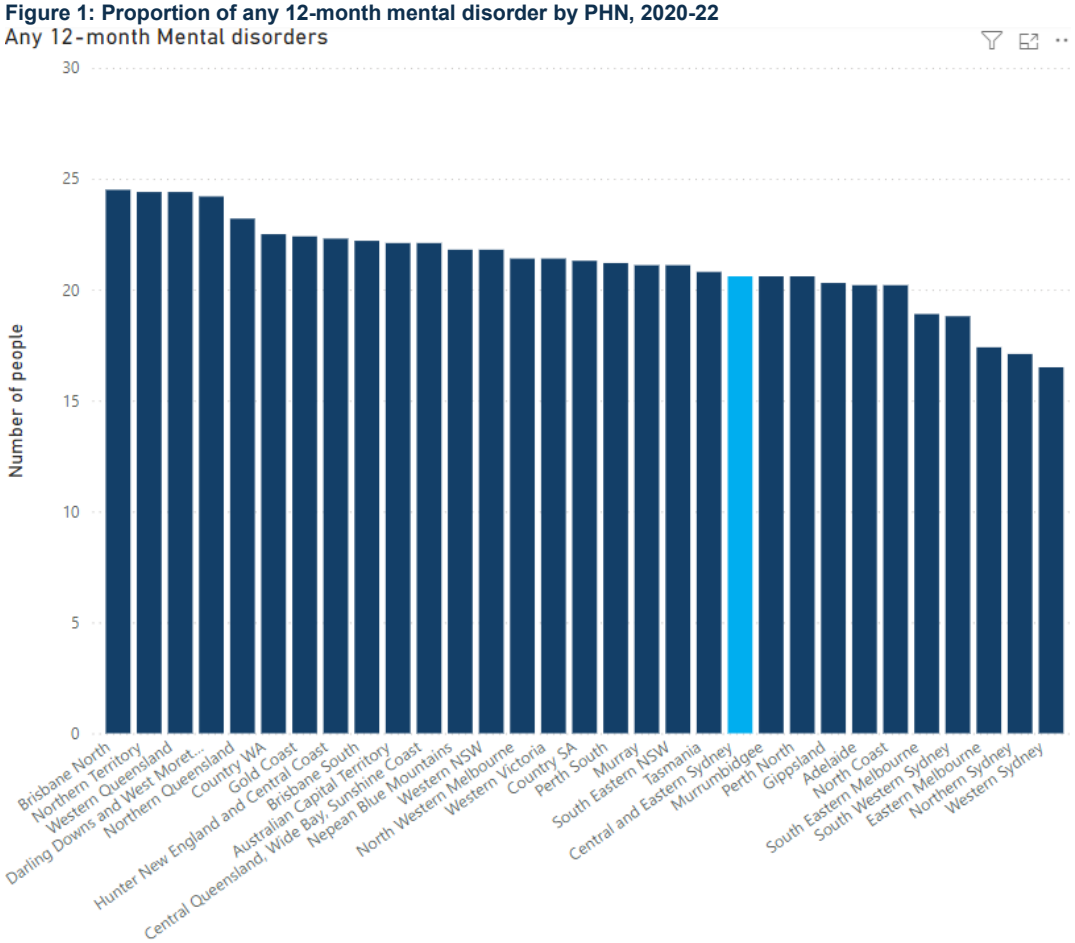
Mental health by condition

In 2024, the ABS released PHN level data from the National Study of Mental Health and Wellbeing report which measures the prevalence of mental health disorders among Australians aged 16-85 years old. The analysis of data at a PHN level used for this needs assessment has been derived using modelled estimates for people who have had symptoms of a disorder in the 12 months prior to completing the survey.

Any mental disorder

The modelled estimates show that 20.6% of the CESPHN population have been diagnosed or had symptoms of a mental disorder in the last 12 months. This is above the New South Wales rate of 19.8% but below the national rate of 21.5% (5).

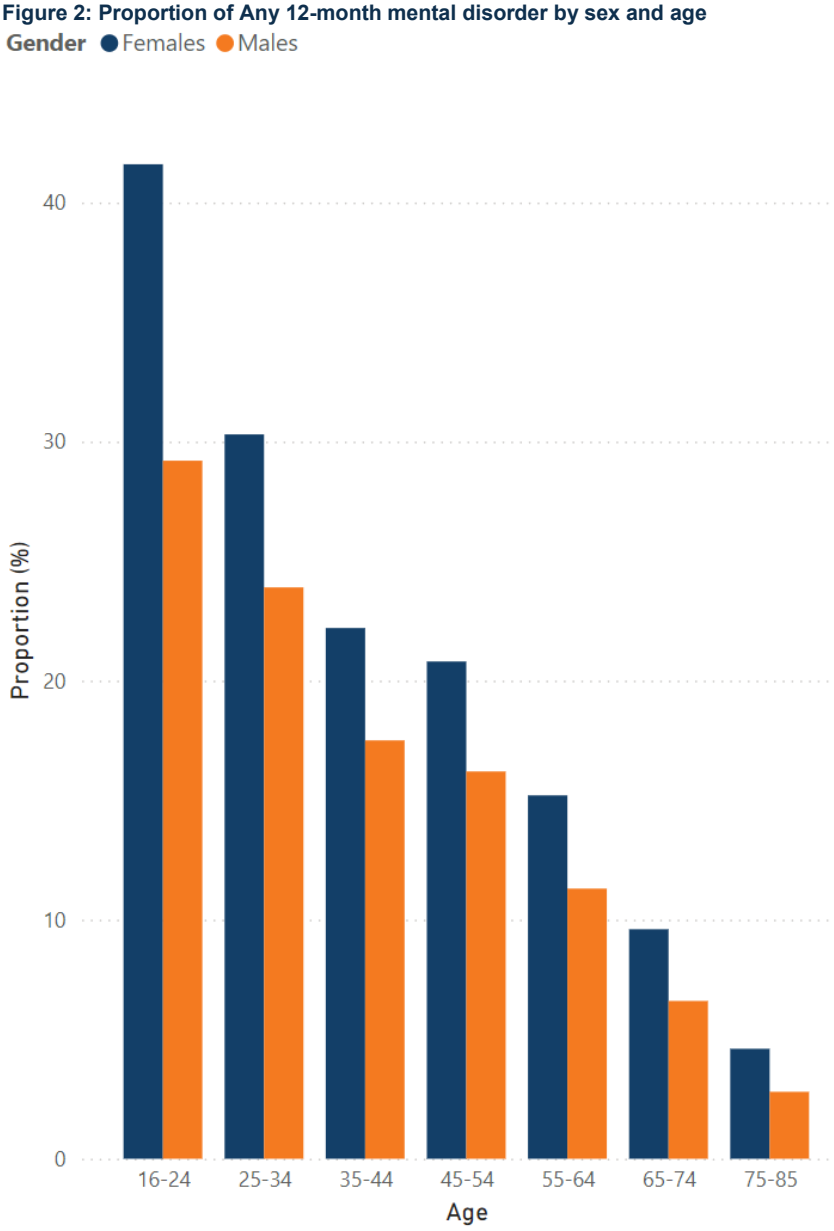
Figure 1: Proportion of any 12-month mental disorder by PHN, 2020-22



Source: ABS, 2024

Looking at the CESPHN population, prevalence is highest in the youngest age group, with 41.6% of females and 29.2% of males aged 16 – 24 years having a mental disorder. Prevalence progressively decreases across age ranges, to the oldest age group of 75-86 years where 4.6% of females and 2.8% of males have a mental health condition. Females have a higher prevalence across all age groups (5).

Figure 2: Proportion of Any 12-month mental disorder by sex and age

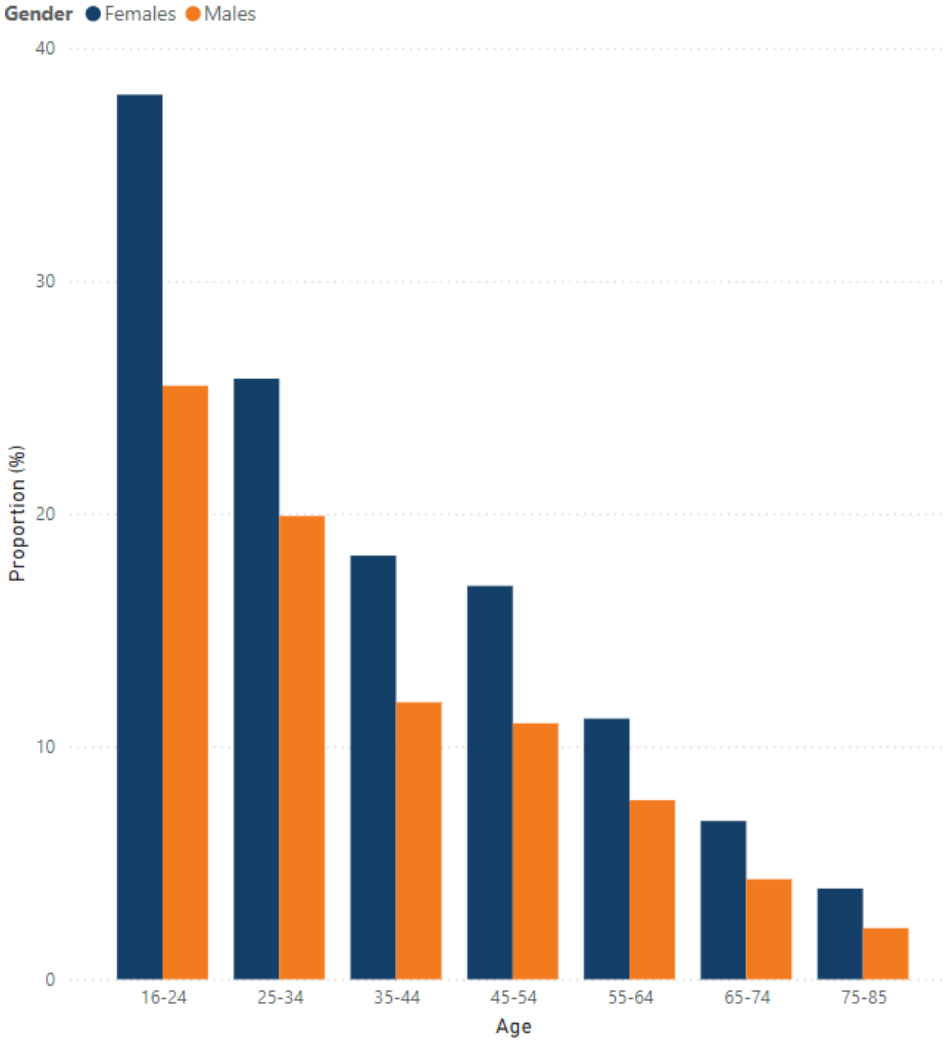


Source: ABS, 2024

Anxiety disorder

Anxiety disorders can include but are not limited to panic disorder, agoraphobia, social phobia, generalised anxiety disorder, obsessive-compulsive disorder, and post-traumatic disorder. Consistent with any mental disorder, anxiety disorder is more prevalent in younger age groups where 38.0% of females 25.5% of males aged 16-24 years report having had an anxiety disorder in the last 12 months, with only 3.9% of females and 2.2% of males aged 75-85 years old having had an anxiety disorder. Across all age groups females have a higher prevalence of an anxiety disorder (5).

Figure 3: Proportion of 12-month anxiety disorders by age and sex

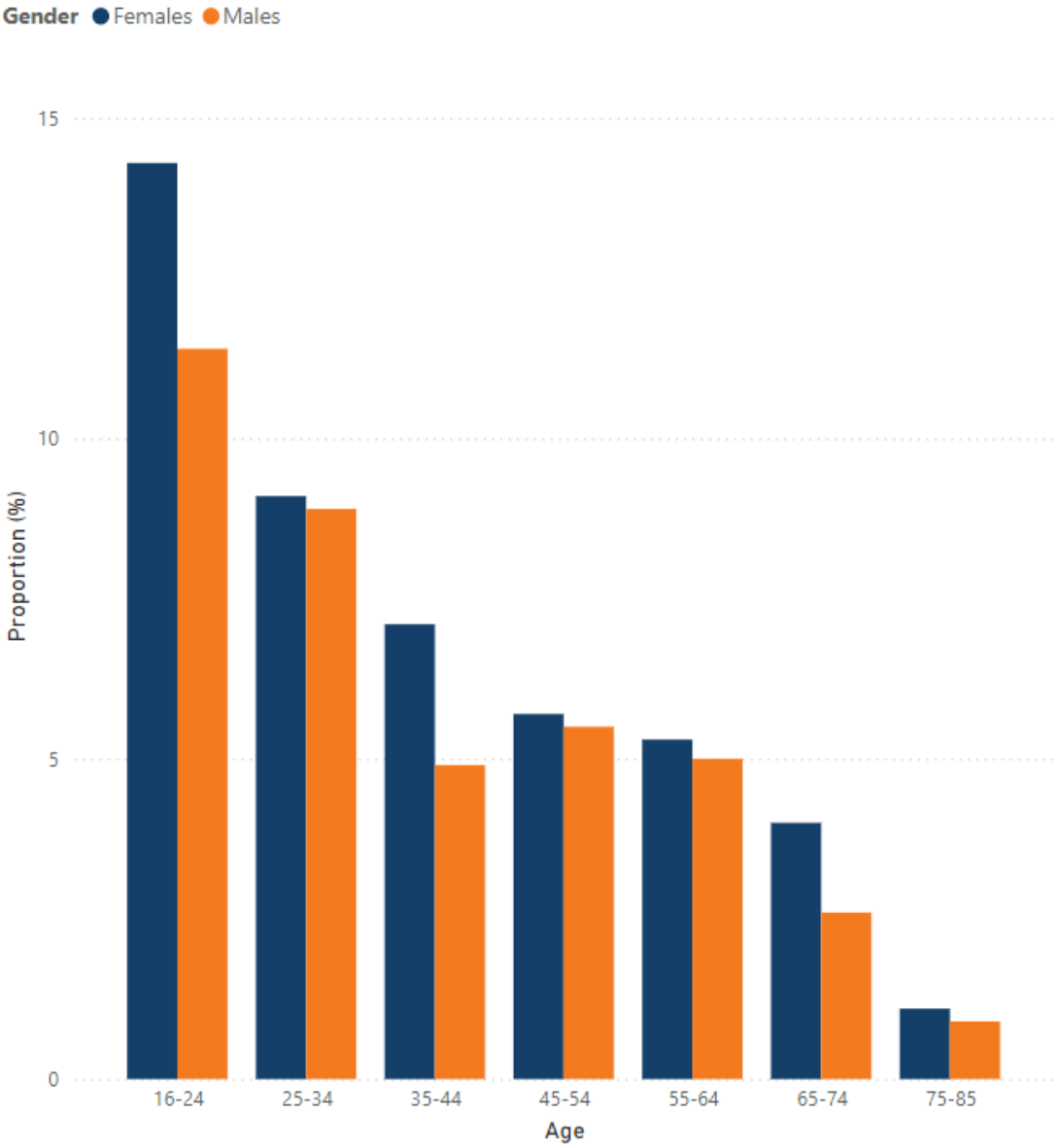


Source: ABS, 2024

Affective mood disorders

Affective mood disorders can include Depressive episodes, dysthymia and bipolar affective disorder. Affective mood disorders are also more prevalent in younger age groups where 14.3% of females and 11.4 % of males aged 16-24 years in the CESPHN region have had an affective mood disorder in the last 12 months, with only 1.1% of females and 0.9% of males aged 75-85 reporting the same (5).

Figure 4: Proportion of 12-month affective mood disorders by age and sex



Source: ABS, 2024

Comorbidity of mental disorders and physical health conditions

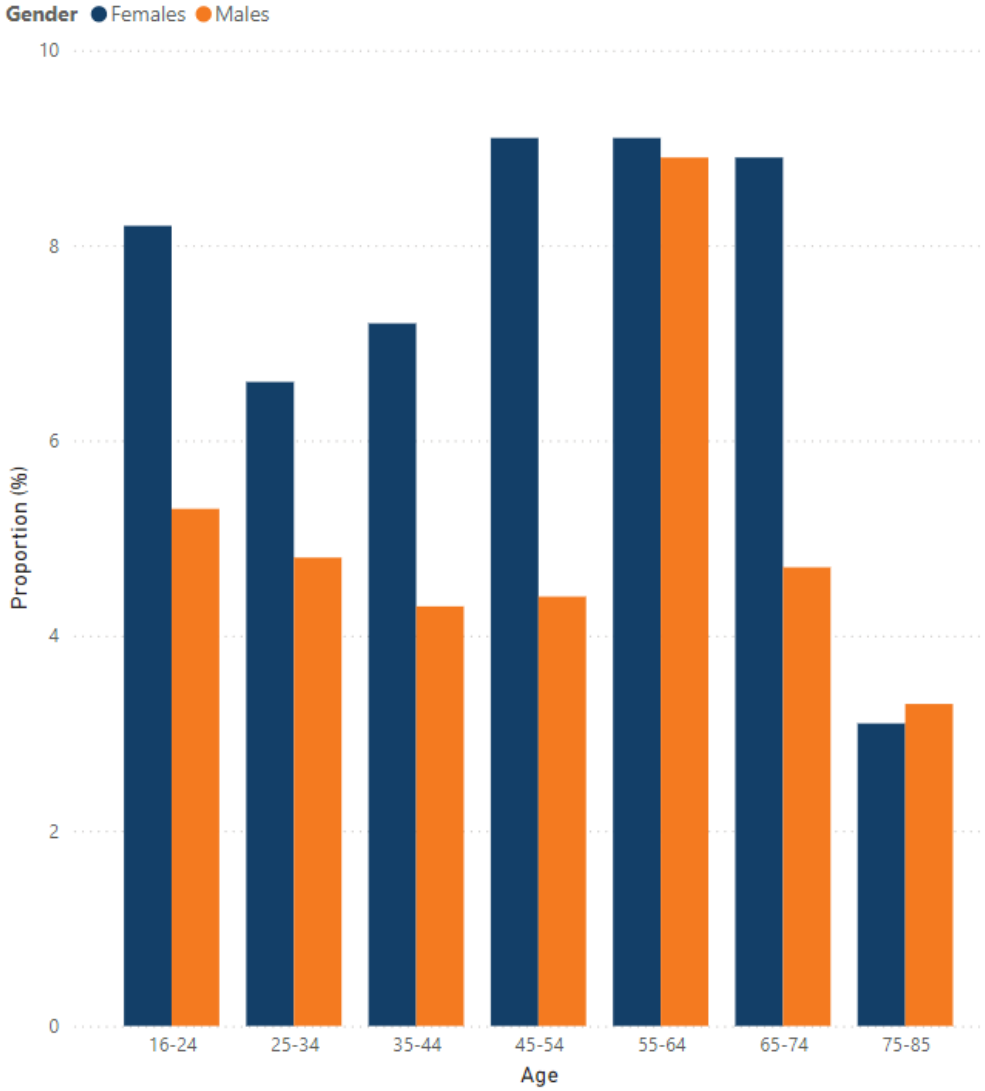
Comorbidity is the co-occurrence of more than one disease and/or disorder in an individual. A person with co-occurring diseases or disorders is likely to experience more severe and chronic medical, social and emotional problems than if they had a single disease or disorder (6).

Within the CESPHN region, 6.4% of the population have a comorbidity of a mental disorder and a physical condition. This is lower than the NSW and Australian rates of 7.5% and 8.4% respectively. Across females, the 45-54 and 55-64 age groups have the highest rate with 9.1% of people in both age groups having a comorbidity of a mental disorder and a physical condition. Among males those

aged 55-64 have the highest rate with 8.9% of this age group experiencing comorbidity of a mental disorder and a physical condition.

For the analysis, the measure of having physical conditions has only been included where a person reported having been told by a doctor or nurse that they currently had the long-term physical health condition, which had lasted, or was expected to last, for 6 months or more. The physical conditions for the analysis are arthritis, osteoporosis, asthma, cancer (including remission), dementia, diabetes (excluding during pregnancy), heart disease, effects of a stroke, chronic kidney disease, and bronchitis or emphysema (5).

Figure 5: Proportion of co-morbidity and mental health disorders by age and sex



Source: ABS, 2024

Mental health in children and young people

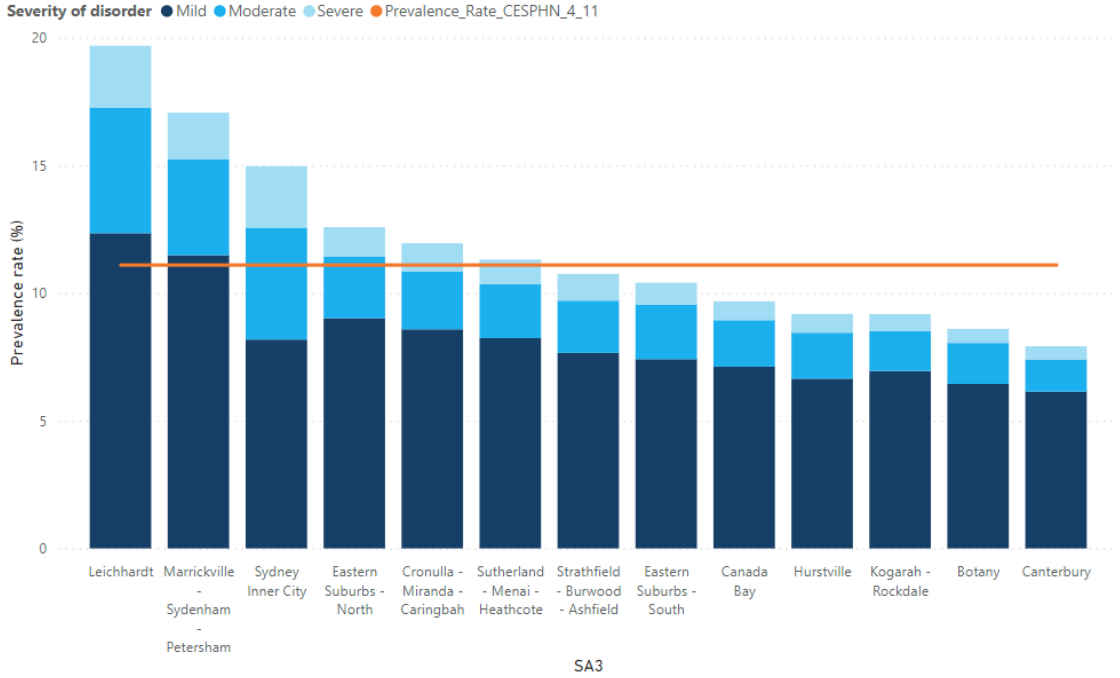
Mental illnesses have a peak age of onset at 15 years, with 63–75% of onsets occurring by 25 years (7). This is also whilst an individual is going through a period of profound biological (hormonal and neural), psychological, and social change. Being able to identify and treat young people within the 12-25 years age range can have a profound effect on the rest of their lives.

The synthetic prevalence estimates of mental health issues among 4-17 year-olds in the CESPHN region is 11.7%, which is lower than the national rate (14.9%) across all severity levels (8).

However, there are SA3 areas where the prevalence estimates are higher:

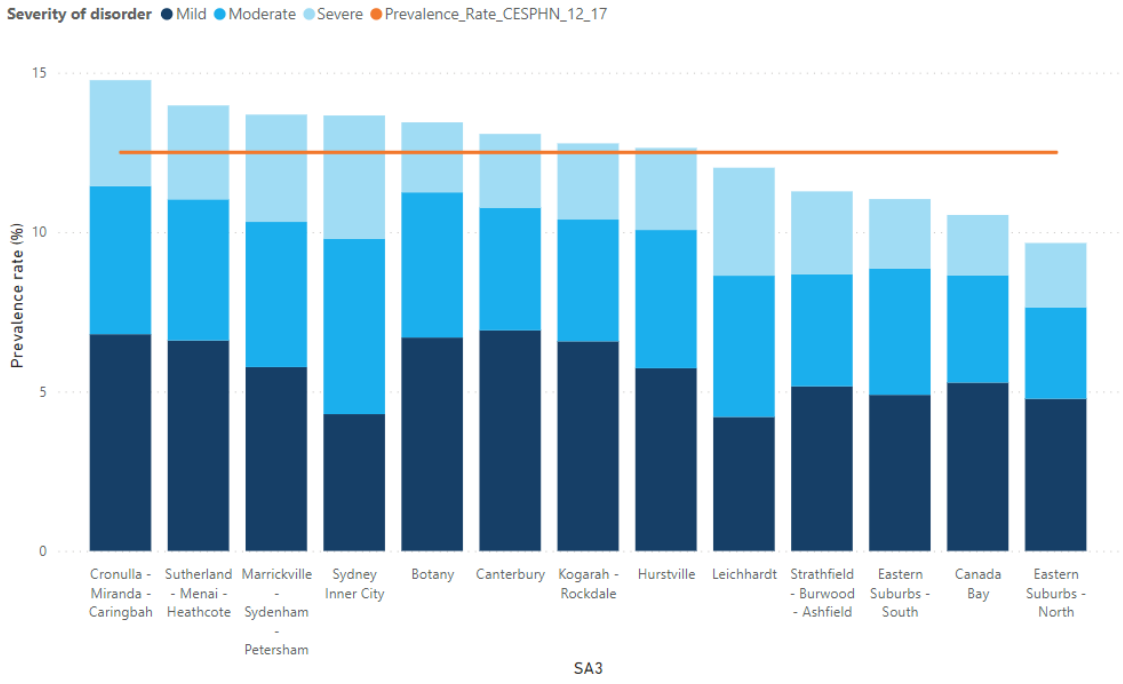
- For children aged 4-11 years old with any disorder:
  - Leichhardt (19.6%), Marrickville–Sydenham–Petersham (17.7%), Sydney Inner City (15.0%), Eastern Suburbs–North (12.6%), Cronulla–Miranda–Caringbah (12.0%), and Sutherland-Menai-Heathcote (11.3%) SA3 had higher prevalence estimates than the CESPHN rate (11.1%)
- For young people 12-17 years old with any disorder:
  - Cronulla-Miranda-Caringbah (14.8%), Sutherland-Menai-Heathcote (13.9%), Marrickville–Sydenham–Petersham (13.7), Sydney Inner City (13.66), Botany (13.4), Canterbury (13.1), Kogarah-Rockdale (12.8%), and Hurstville (12.6%) had higher prevalence estimates than the CESPHN rate (12.5%)
- For children aged 4-11 years old with moderate mental health issues:
  - Leichhardt (4.9%), Sydney Inner City (4.4%), Marrickville-Sydenham-Petersham (3.8%), and Eastern Suburbs North (2.4%) had higher prevalence estimates than the CESPHN moderate mental health rate (2.3%)
- For children aged 12-17 years old with moderate mental health issues:
  - Sydney Inner City (5.5%), Cronulla-Miranda-Caringbah (4.6%), Botany (4.6%), Marrickville-Sydenham-Petersham (4.6%), Leichardt (4.4%), Sutherland-Menai-Heathcote (4.4%), and Hurstville (4.3%) had higher prevalence estimates than the CESPHN moderate mental health rate (4%)
- For children aged 4-11 years old with severe mental health issues:
  - Leichhardt (2.4%), Sydney Inner City (2.4%), Marrickville-Sydenham-Petersham (1.8%), Eastern Suburbs North (1.2%), Cronulla-Miranda-Caringbah (1.1%), and Strathfield-Burwood-Ashfield (1.05%) had higher prevalence estimates than the CESPHN severe mental health rate (1%)
- For children aged 12-17 years old with severe mental health issues:
  - Sydney Inner City (3.9%), Leichhardt (3.4%), Marrickville-Sydenham-Petersham (3.4%), Cronulla-Miranda-Caringbah (3.3%), and Sutherland-Menai-Heathcote (2.9%) had higher prevalence estimates than the CESPHN severe mental health rate (2.6%)

Figure 6: Prevalence of mental health illness in children aged 4-11 years, by severity of disorder and SA3, 2021



Source: Young Minds Matter, 2023

Figure 7: Prevalence of mental health illness in young people aged 12-17 years, by severity of disorder and SA3, 2021



Source: Young Minds Matter, 2023

Children's mental health difficulties can present differently to adult mental health difficulties. Mental health vulnerabilities or difficulties in infants and children might include frequent or intense struggles with their emotions, thoughts, behaviours, learning or relationships. They might have trouble calming

down, struggle to control their moods, find it challenging to be separated from a parent, or have problems sleeping, eating or engaging at school.

Aboriginal people

It is well documented that Aboriginal people have poorer mental health outcomes than non-Aboriginal people. A social and wellbeing approach that is sensitive to the unique needs and experiences of Aboriginal people can promote mental health in a way that is both culturally relevant and holistic. By acknowledging the impact of historical trauma, emphasising cultural connection, strengthening community bonds, and providing access to culturally appropriate services, this approach can lead to meaningful improvements in mental health and overall wellbeing and needs to be considered when service planning.

In the 2021 Census, 2,241 people aged 15 years and over who identified as being Aboriginal and/or Torres Strait Islander reported that they had a mental health condition (including anxiety or depression). This equates to 19.5% of the CESPHN Aboriginal population. Within the CESPHN region, Leichhardt IARE had the highest rate of mental health conditions among Aboriginal and/or Torres Strait Islander peoples aged 15 and over (25.2 per 100 people), followed by Sydney – City IARE (24.2 per 100 people) and Marrickville (22.4 per 100 people) (9). In contrast the CESPHN rate is 7.5 per 100 people in the population aged 15 years and over (4).

Mental health in multicultural communities

There are considerable gaps in data and information on the prevalence of mental illness in people from CALD backgrounds and their experiences with the mental health system. Generally, people from CALD backgrounds are at greater risk of developing a mental health condition and seek treatment later. They also tend to have a higher number of involuntary admissions.

CALD populations accessing mental health support are at times unaware of mental health services that could assist, meaning that significant opportunities for early intervention are absent. For newer migrant and refugee populations, the adjustment to a new country, separation from family and past traumas can lead to mental health conditions that, when finally assessed by a mental health professional, may appear complex and enduring due to the delay in early help-seeking.

With many newer refugees arriving having been exposed to conflict, there is a higher risk of suicidality and a strong need for services that can provide a culturally led and trauma-informed response.

This is discussed in further detail in the Health and Wellbeing of people from Multicultural Backgrounds chapter of the needs assessment.

LGBTQI+ Community

The Lesbian, Gay, Bi-sexual, transgender and gender diverse, intersex, and queer community (LGBTIQ+) is a diverse cohort a with range of different health and service needs. Whilst local mental health specific data for the region for LGBTIQ+ peoples is not available, national level research is available and is applicable to this region. Research has found that compared to non-LGBTIQ+ individuals, LGBTIQ+ individuals across virtually all societal contexts experience elevated rates of

psychological distress, mood-related disorders such as depression, and anxiety, and demonstrate high rates of suicidal ideation and attempts (10). In a survey report which captures the data from six surveys across the population, established that in the LGBTIQ+ adults cohort, 57.2% (n=3,818) of respondents reported high or very high levels of psychological distress in the 10-item Kessler Psychological Distress Scale (K10). This proportion is four-times greater than the 13.0% reported among the general population in Australia (10). It is also important to recognise that within the LGBTIQ+ community there are mental health disparities between Sexually Diverse Populations, Trans and Gender Diverse Populations and Intersex population.

Research has also established that participation in LGBTIQ+ community or social events/activities may promote social protective effects against or reduce feelings of distress among trans and gender diverse individuals and contribute to improvements in their subjective sense of wellbeing (10).

This is discussed in further detail in the LGBTIQ+ chapter of the Needs Assessment.

Older people including those in aged care facilities

Mental distress and mental health conditions are common in later life (11). The modelled estimates at a PHN level from the National Study of Mental Health and Wellbeing identified that 8.2% of the population aged 65-74 years of age and 3.8% of the population aged 75-85 years have been diagnosed with or experienced symptoms of a mental disorder in the last 12 months (5).

Some of the key issues that older Australians face that may impact their mental health include:

- Depression and anxiety triggered by factors such as loss of independence, bereavement and other chronic health conditions
- Social isolation and loneliness associated with either living alone or moving away from family
- Access to mental health services where barriers such as availability of services, lack of awareness or stigma may exist.
- Access to clinicians and support systems that have experience working with older people and may not be aware of the nuanced concerns and/or support needs of older people.

Veterans

The NSW Office for Veterans Affairs 2021 census data showed that there are 42,900 veterans living in the Sydney Metropolitan area, with 9350 active Australian Defence Force (ADF) members (12). It is estimated that close to 40% of discharged members in NSW move to the Sydney area, and the CESPHN region hosts a number of military bases and facilities.

Psychosocial factors are considered one of the main risk factors in suicide ideation amongst veterans and serving members of the ADF. A 2022 report showed that rates of suicide are 27% higher amongst ex-serving males compared to currently serving members, and 107% higher amongst female veterans.

Transitional difficulties can centre around lack of civilian support systems, a perceived lack of purpose and a lack of social circles for veterans to move into upon discharge (13). The 2020-21 National Health Survey also showed that nearly 40% of veterans were living with a disability and faced several health risk factors, such as poor diet, smoking and lack of physical exercise (14).

People experiencing social isolation

Loneliness and isolation can be caused by several factors, including living alone, lack of community, economic reasons, retiring or a change in personal circumstances, or being a carer. Social isolation is universally understood to be a chronic health condition which negatively affects both physical and mental health, leading to physical symptoms such as headaches, tiredness and problems with sleeping, as well as negative mental health conditions including anxiety and depression (15).

Social isolation was identified as a key issue affecting residents of the Sydney region through CESPHN's consultation with stakeholders. Social isolation was a cause for concern amongst the priority groups identified in this Needs Assessment, such as the LGBTQI+ population, the multicultural community and the older-adults cohort.

The Voices of Solitude: Loneliness and Social Isolation Among Older Adults in NSW report (16) found that 60% of those surveyed were lonely, and 50% socially isolated. For older LGBTQI+ people this increased to 71%. This report also showed that carers, people living with a disability and First Nations residents often experienced the most severe impacts of loneliness.

Gambling harm

Gambling harm was also identified as a significant issue in the region. Australians have the largest per capita gambling losses per capita in the world, losing approximately $25 billion on legal forms of gambling each year (17).

Gambling often co-occurs with other mental health disorders such as depression, anxiety, insomnia or drug and alcohol use and smoking. The impact of gambling harm can impact family, friends and community. These harms can include financial insecurity and loss of accommodation, employment disruption or loss, coercive control and domestic and family violence, relationship breakdowns, increased suicidality and criminal behaviour. Gambling harm has been associated with an increased risk of suicidality. Gambling harm disproportionally impacts Aboriginal communities, and the greatest number of electronic gaming devices (poker machines) are in the most disadvantaged communities (17).

In 2023, people residing in the Central and Eastern Sydney region lost $5.5 million to electronic gaming machines (18). In Quarter 4 of 2022, the Canterbury-Bankstown local government area recorded the highest losses than any other local government area in NSW with over $178 million (19). Part of this LGA, the Canterbury SA3 is in the CESPHN region and it has the lowest Socio-Economic Indexes for Areas (SEIFA) values in the region at 914.

CESPHN recently commissioned a multicultural health navigator service. This program aims to provide in-language health navigation support to four multicultural communities, and as part of this support, the navigators will be trained to support people with gambling related issues access services. Navigators will also be attuned to supporting people experiencing social isolation and be able to link them with supports, services and groups in the community.

Other vulnerable groups

Additional groups who are at elevated risk and/or facing unique challenges are:

- Asylum seekers and refugees

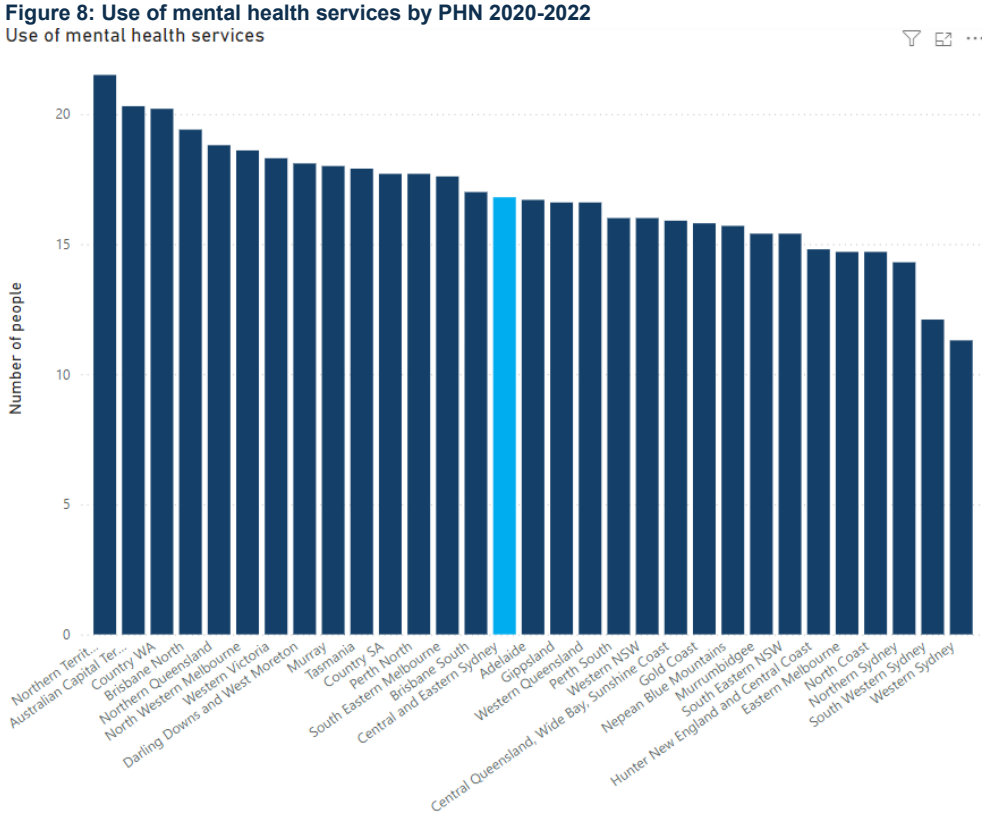
- Parents experiencing perinatal mental health issues
- People who are homeless or at risk of homelessness
- People with an intellectual disability (discussed in disability chapter)
- People living in highly disadvantaged areas
- People with co-existing alcohol and other drug issues
- Family and carers of people experiencing mental illness
- Neurologically divergent people.

Access and utilisation of mental health service

For people experiencing mental health symptoms, a General Practitioner (GP) is often the first health professional they will disclose to. The 2024 RACGP's General Practice Health of the Nation report stated that 71% of GPs (up from 61% in 2017) have reported that psychological conditions are in their patients' top three reasons for presentation. In addition, 38% of GP consultations in a typical week include a mental health component (20).

As part of the national study of Mental Health and Wellbeing, the ABS have provided modelled estimates for individuals who accessed any health professional over a 12-month period. Within the CESPHN population we can expect 16.8% of the population to have accessed any health professional for their mental health. This is lower than the national rate of 17.4% (5).

Figure 8: Use of mental health services by PHN 2020-2022

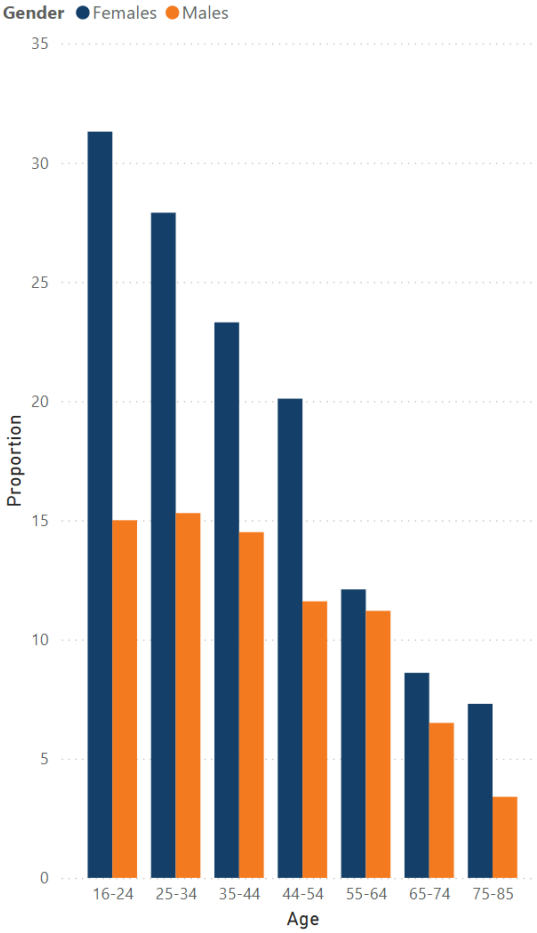


Source: ABS, 2024

When looking at age and sex breakdowns of mental health related consultations, the rate of females accessing services is higher in every age group, and younger people are more likely to access health professionals for their mental health. The rate of people accessing health professionals is decreasing across every age grouping. The same trend is seen when accessing digital technologies, with young females the most likely to access digital technologies and males aged 65-85 least likely to access digital technologies. The use of digital technologies is defined as using a phone, internet or another digital technology to access services such as crisis support or counselling services, online treatment programs and tools to improve mental health, and mental health support groups and forums. However, internet based CBT programs such as This Way Up have been found to be acceptable to

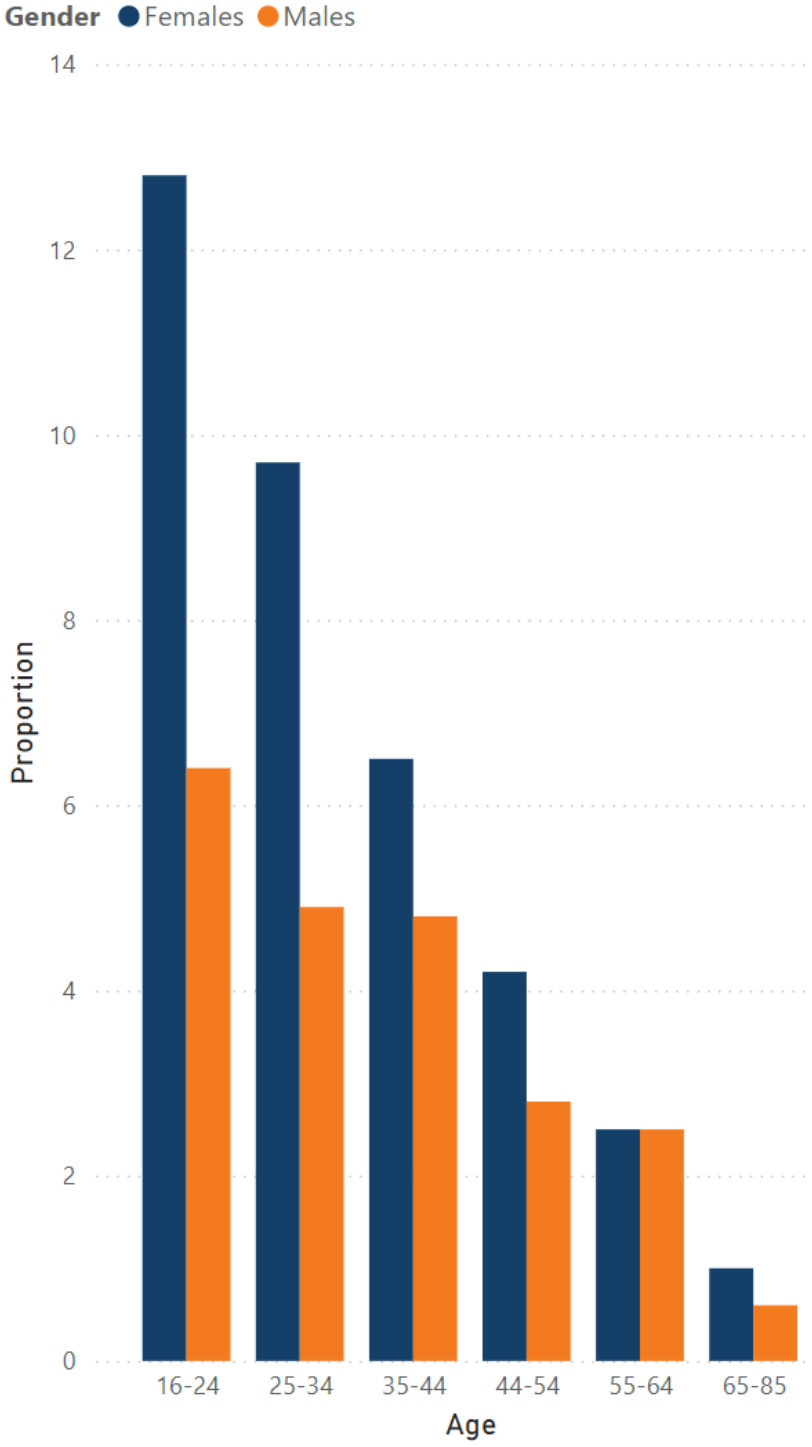
and effective with older adults. In fact, older adults have been shown to have higher completion rates of these programs which is related to a commensurate decrease in distress (21).

Figure 9: Mental health related consultations, by sex and age 2020-2022



Source: ABS, 2024

Figure 10: Mental health access using digital technologies, by sex and age 2020-2022



Source: ABS, 2024

CESPHN commissioned services

Over the 12 months July 2023 to June 2024, the Primary Mental Health Care Minimum Data Set shows that approximately 9,000 individuals have accessed CESPHN commissioned mental health services (excluding headspace) and received 130,950 service contacts. This is on average 14 service contacts each across all levels of service intensity. Across all levels of care, 48.9% of clients demonstrated a significant improvement.

When looking at access to services in the CESPHN primary care setting, mental health supports can be broken down into the following categories:

1. Young people accessing headspace services
2. Low intensity mental health services
3. Moderate intensity services
4. High intensity services
5. Psychosocial/Support services

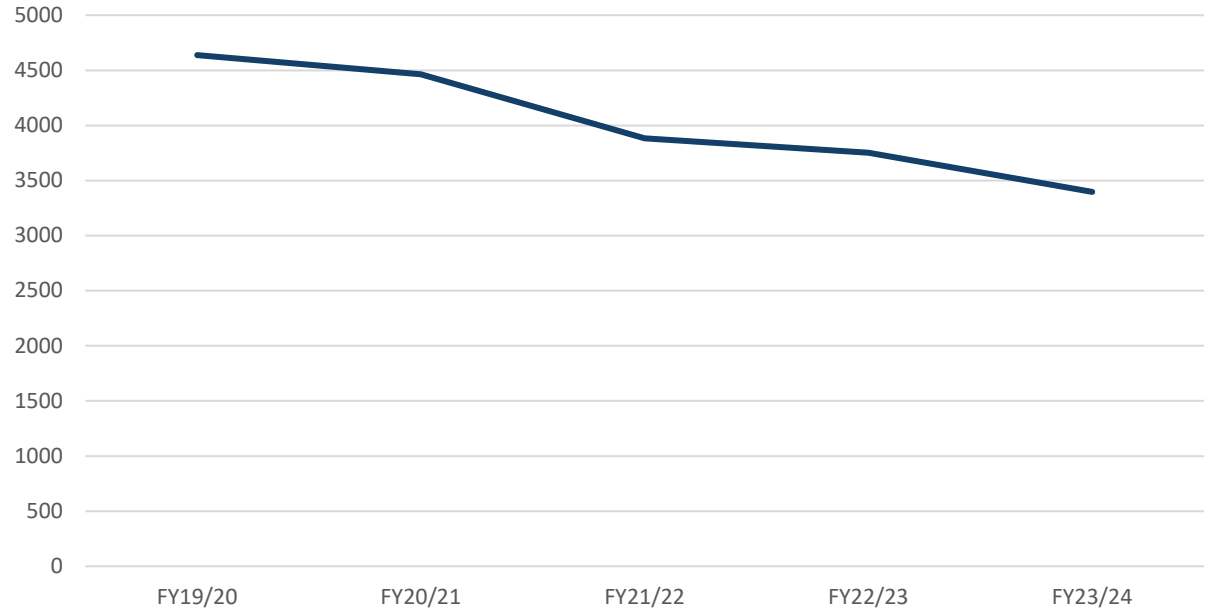
Young people accessing headspace services

Due to prevalence data, which indicates that young people aged 12 -25 are most vulnerable with greatest incidence of mental health issues, and the availability of data from headspace centres that are funded by CESPHN we can explore help seeking behaviour for this cohort.

headspace is Australia's National Youth Mental Health Foundation, providing early intervention mental health services to 12-25 year olds. headspace can help young people with their mental health, physical health (including sexual health), alcohol and other drug services, and work and study support. Within the CESPHN region there are five headspace services that service young people both within and outside the region. These services are located in Ashfield, Bondi Junction, Camperdown, Hurstville and Miranda. It is important to note the size of each headspace centre varies so comparison between centres is not appropriate. However, trends in the sector can be identified.

Across 2023-24, 3,396 young people accessed a headspace centre in the CESPHN region. This is a slight decrease on the previous three years where 3,752 young people accessed a headspace centre in 2022-23.

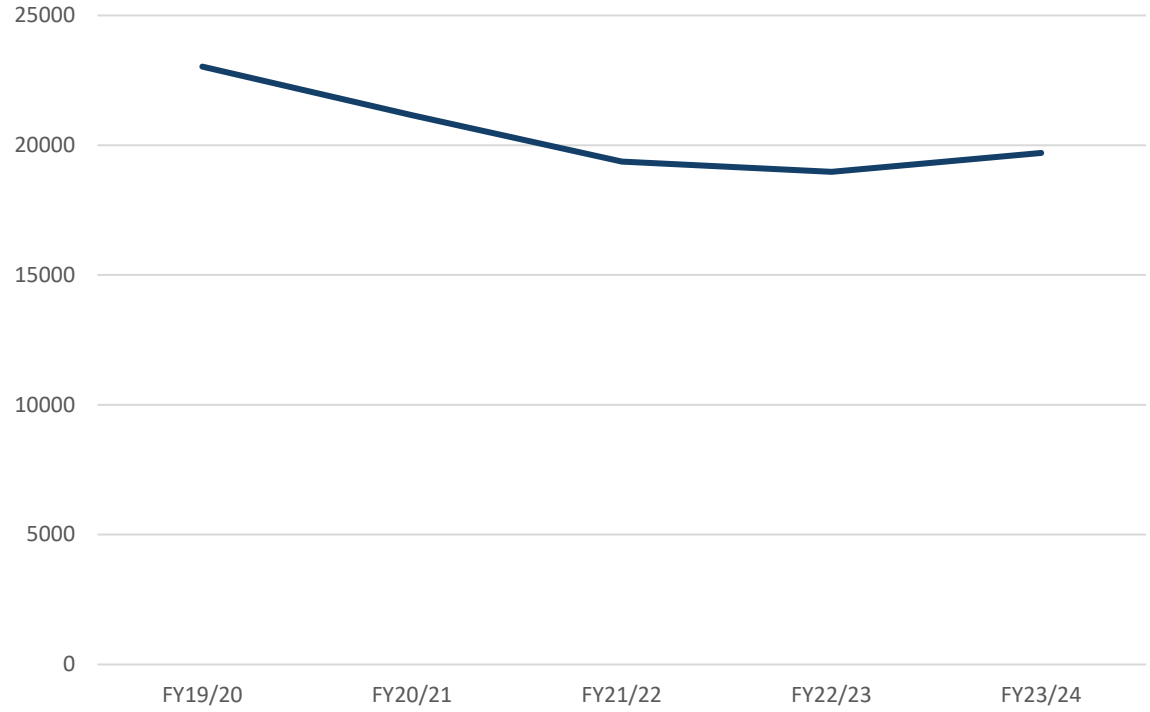
Figure 11: Number of new young people attending a headspace centre 2021-22 to 2023-34



Source: headspace Tableau, 2024

Occasions of service data also show a similar trend with a reduction in the total number of occasions of service across all headspace centres over the last four years.

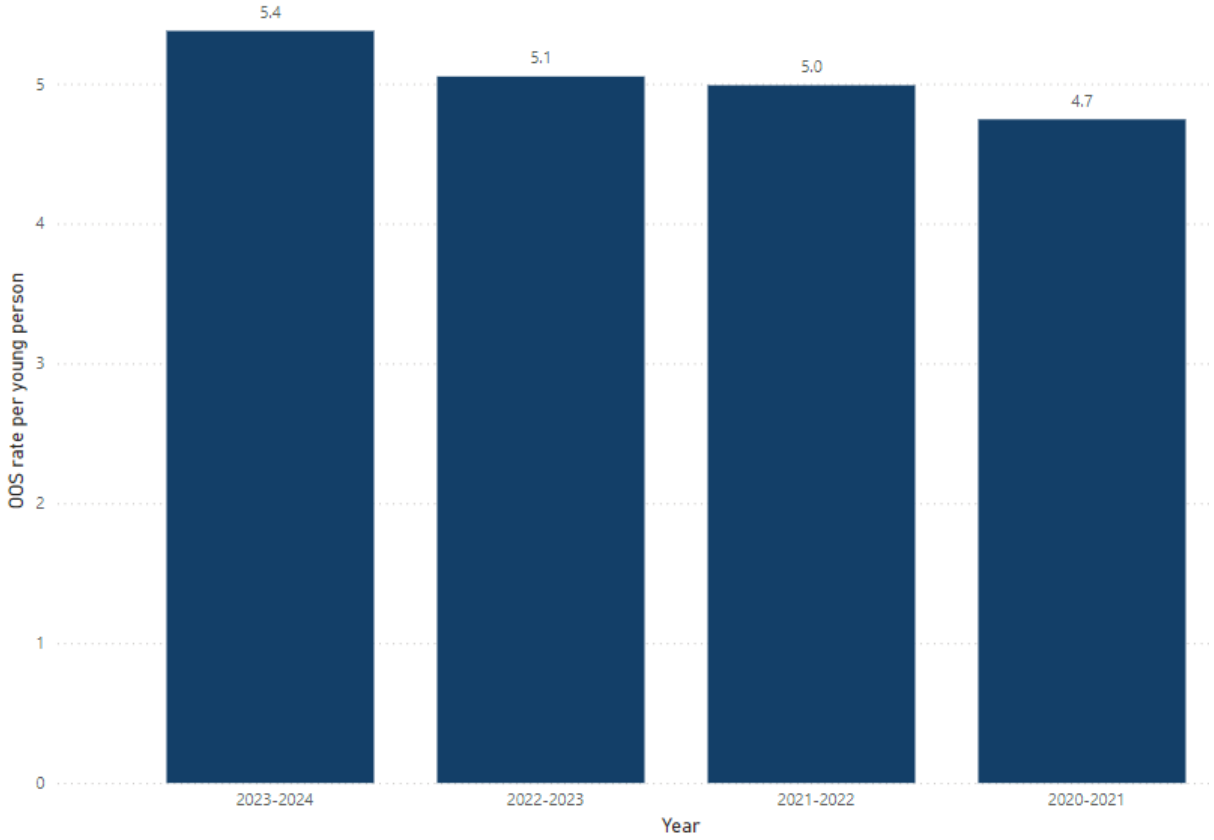
Figure 12: Occasions of service for CESPHN region, 2019-20 to 2023-24



Source: headspace Tableau, 2024

The decreases in the number of young people attending headspace centres and overall occasions of service are part of a change in how young people are being supported. Across all centres young people are receiving support for a longer period. This can be seen by an increase in the average number of services a young person receives a year. This suggests a greater intensity of support possibly due to greater client complexity which has been anecdotally reported by headspace clinicians in our region. In addition, fluctuations in occasions of service may be attributed to workforce instability with clinical and administrative staff shortages reported across all headspace centres in our region.

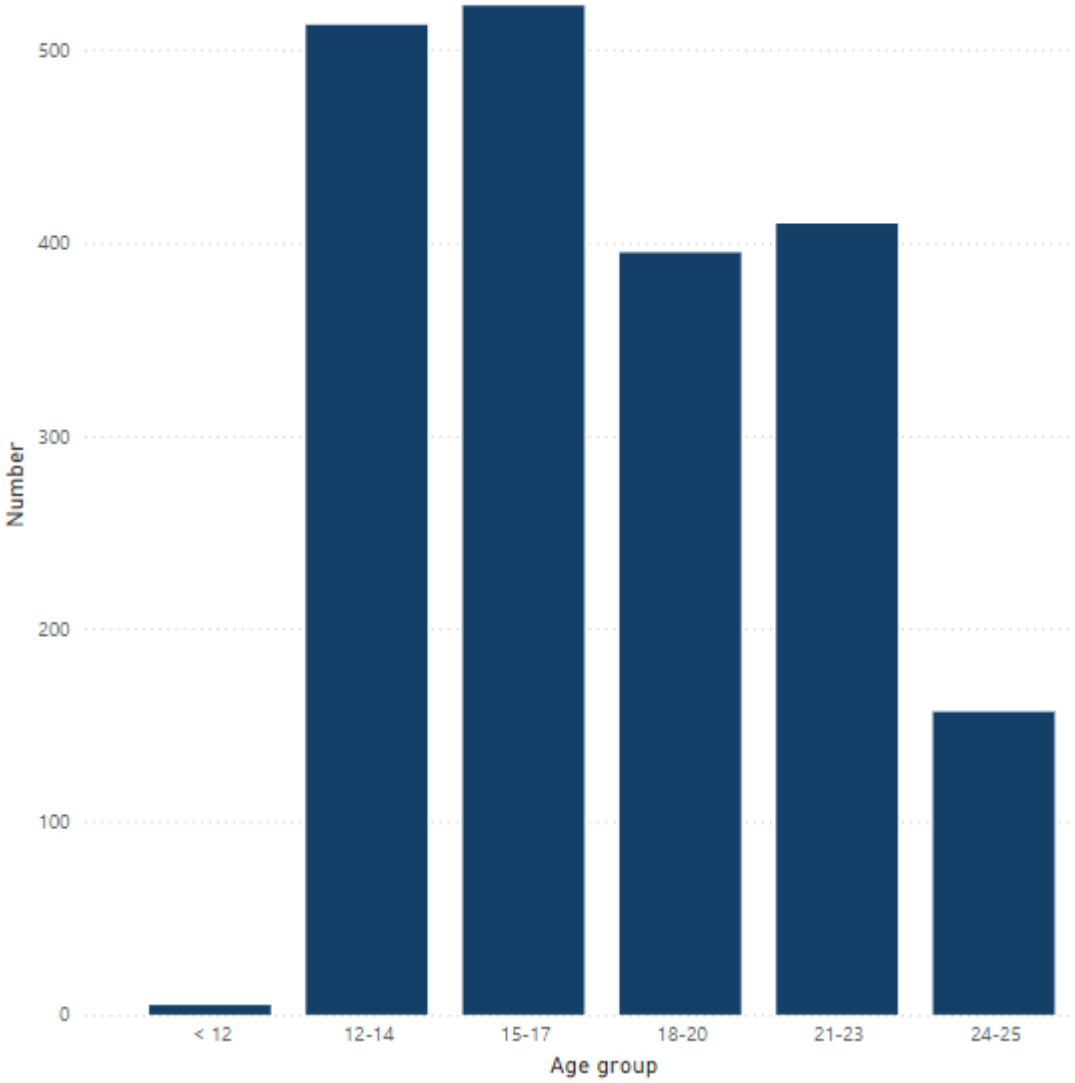
Figure 13: Average number of services received by a young person, by all centres in CESPHN, 2020-21 to 2023-24



Source: headspace Tableau, 2024

The age groups that predominantly access headspace centres are different across the region. Across all five centres 52.0% of young people accessing services are aged 17 years or younger, and 48.0% are aged 18-25 years.

Figure 14: Age range of young people accessing headspace services for all centres in CESPHN, 2023-24

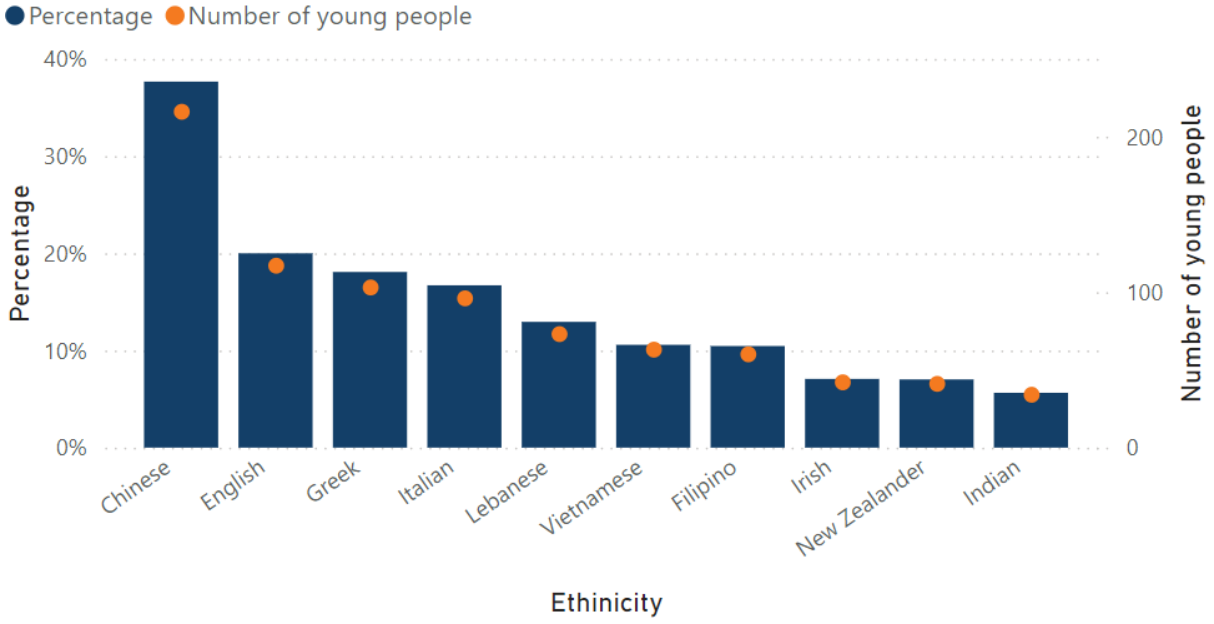


Source: headspace Tableau, 2024

1.3% of young people who attended a service in 2023-24 identified as being Aboriginal and/or Torres Strait Islander.

Young people who attend headspace centres identify as belonging to a wide variety of ethnicities outside of Australian. In 2023-24, across all headspace centres in the CESPHN region, Chinese was the ethnicity most commonly identified (37.7% of young people), followed by English (20.0%) and Greek (18.1%).

Figure 15: Identified ethnicities attending headspace centres, 2023-24

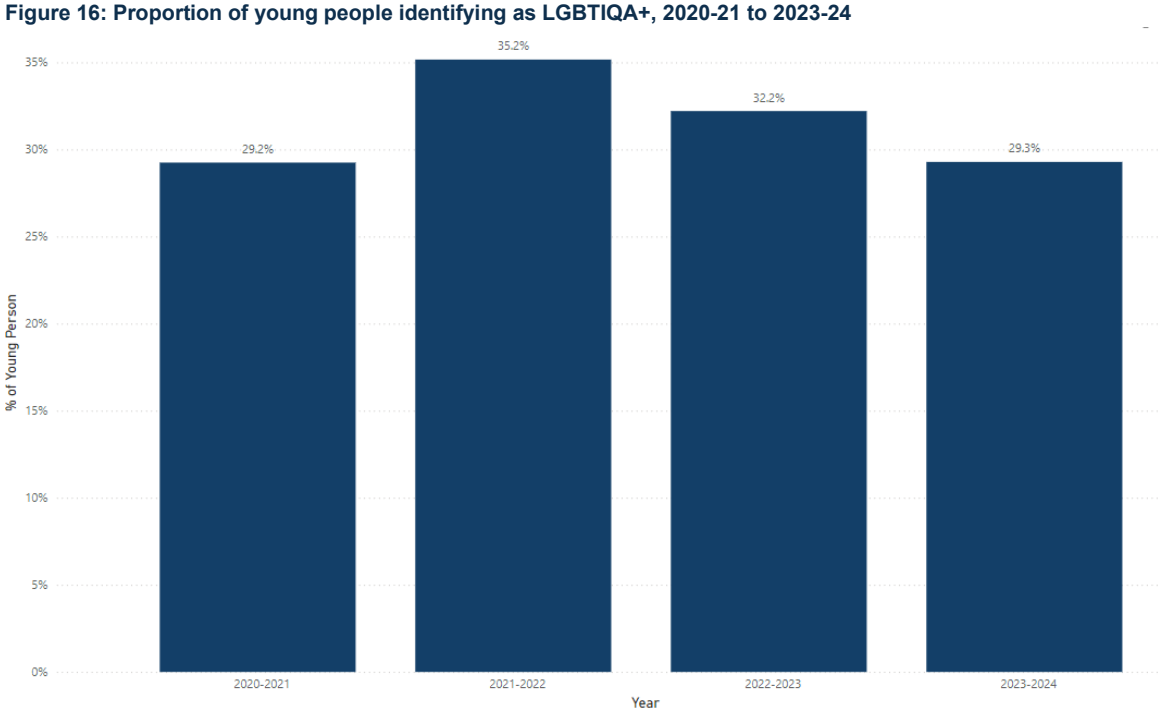


Source: headspace Tableau, 2024

Across all headspace centres in 2023-24, 72.5% of young people identified that they only spoke English at home.

Across the region, over the period between 2021-22- to 2023-24 the proportion of young people identifying as being LGBTIQA+ using a headspace service has remained stable at around 30%.

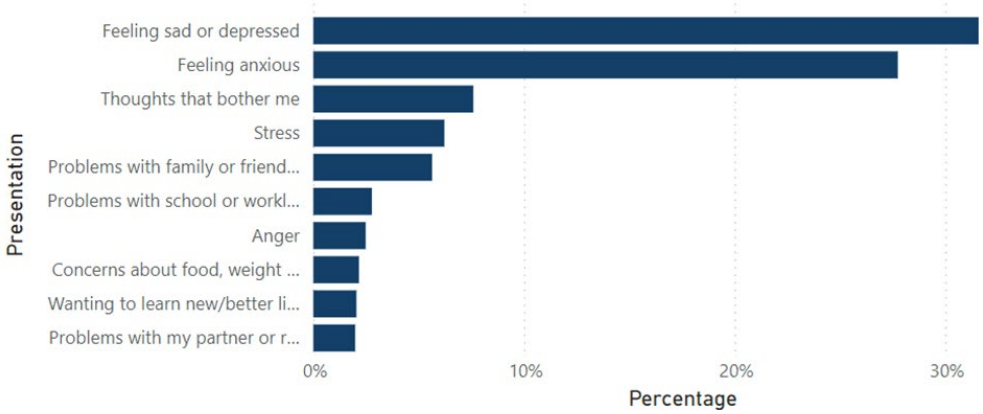
Figure 16: Proportion of young people identifying as LGBTIQA+, 2020-21 to 2023-24



Source: headspace Tableau, 2024

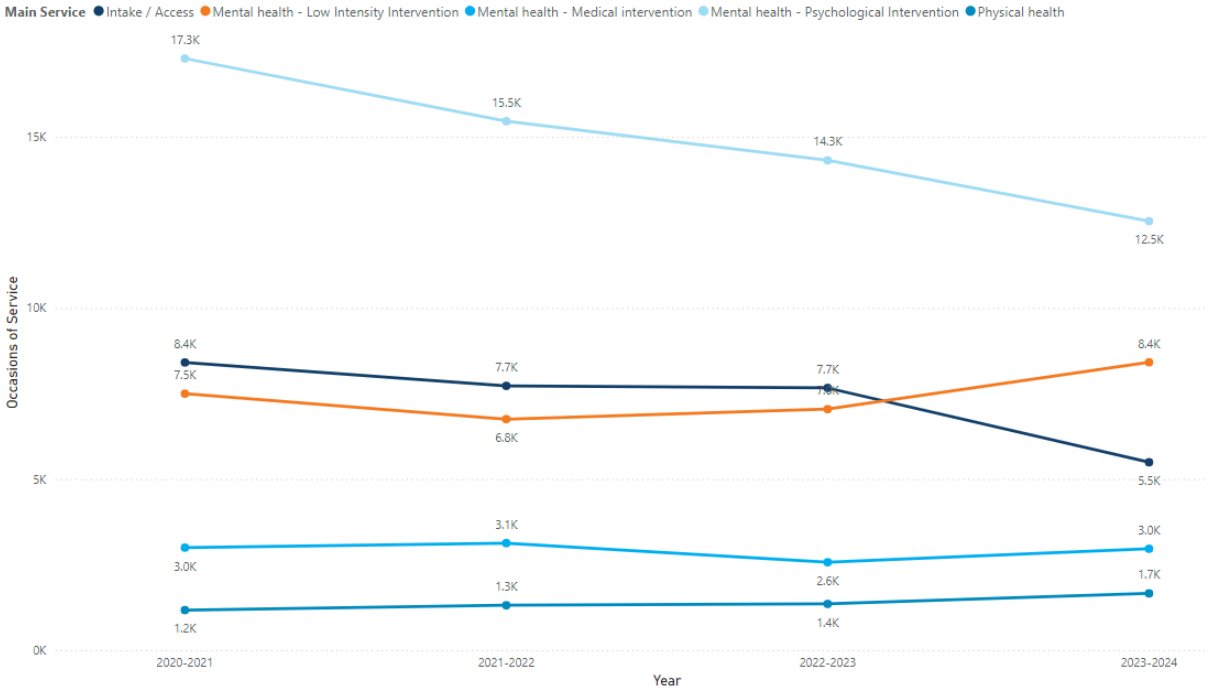
In 2023-24, feeling sad or depressed and feeling anxious were the most common reasons for presentation at a headspace centre, accounting for 56.8% of all presentations across the region. The top ten self-reported reasons for a young person to access a headspace centre within the CESPHN region are listed on the graph below.

Figure 17: top 10 self-reported reasons for presenting across headspace centre, 2023-24



Source: headspace Tableau, 2024

Figure 18: Number of the top five types of services across all headspace centres, 2020-21 to 2023-24



Source: headspace Tableau, 2024

Whilst the number of most types of services by service type have been consistent over the 4-year period, there has been a 27% decrease in psychological interventions from 2020-21 to 2023-24. This is largely due to the reduction of the MBS workforce at headspace centres since the pandemic. The headspace model heavily relied on private practitioners working under MBS to provide the main therapy interventions at the centres, however this workforce has largely ceased working from headspace centres due to other more desirable employment opportunities. Most centres have faced

recruitment and retention challenges of mental health trained allied health professionals to be able to consistently provide these services.

Younger children

Needs assessment consultations in 2024 with both internal and external staff highlighted several other areas within the child and youth mental health sector that show areas of need**.** These include the need for child mental health to be approached using a multidisciplinary team care approach, and not to be treated in silos and consideration of the role that social media plays in the incidence, diagnosis and treatment in children and young people**.**

Additionally, consultation with key stakeholders on Child and Mental Health and Wellbeing (aged 5-12 years) at CESPHN's 2023 Strategy workshop identified the following gaps:

- Flexibility is required for age-based eligibility criteria to access services, as often 12-14 year olds require child specific services.
- Access to culturally appropriate services for young people and children with severe mental health issues
- Children with Eating Disorders/Body Dysmorphic Disorder are presenting at Emergency Departments due to lack of services to support this cohort
- Ability to provide a timely safe and effective alternative to an emergency department care.
- Workforce development – the need for more training for allied health professionals, nurses and GPs in child mental health assessment and treatment.
- Improved mental health support in the juvenile justice system
- Lack of prioritisation in service of children with disabilities
- There are insufficient services for children requiring more intensive psychological support than what can be supported by current primary care services e.g. via CESPHN commissioned Psychological Support Services program, and services offered by public hospitals e.g. inpatient services, and CAMHS. This service gap is widening as community mental health services scope for service provision is narrowing and workforce shortages contribute to these challenges.
- Mental health services/programs need improved integration with schools/ education department.
- Need for timely and affordable access to paediatricians and allied health professionals, particularly to support diagnosis and treatment for children presenting with neurodivergence.

The CESPHN Joint Mental Health and Suicide Regional Plan, has several activities relating to improving access to care for children experiencing developmental and mental health related difficulties, which will be one of the key areas of focus in 2025/2026 for CESPHN and our joint partners. The gaps identified at our previous Strategy Day workshop in 2023, will be central to discussion and action as part of this regional planning process.

Low intensity mental health services

Low intensity mental health services can be accessed quickly and easily and include group work, phone and online interventions and involve few or short sessions. CESPHN commissions the following services:

- **Emotional Wellbeing for Older Persons** - This program provides psychological and psychosocial services for older people with a variety of mental health needs who reside in Residential Aged Care Facilities. In 2023-24 the program supported 581 clients at 97 aged care facilities.
- **Your Coach Plus** – This program provides coaching using low intensity CBT as well as social prescribing for people experiencing life stressors or low support needs. It has had particular

success in attracting clients from diverse cultural backgrounds, with 59% of clients born outside Australia.

- **Support for communities impacted by the Israel/ Gaza, conflict** – The Wellbeing and Resilience initiative has commissioned a range of Palestinian, Muslim and Arabic organisations in offering mental health and wellbeing supports that include assessment, referral and navigation, physical activity and community connection, traditional art and dance, healing circles for schools and community and support for Imams and faith leaders. In addition, support through Jewish Care ensures that vital care coordination services are available for Jewish communities including support for mental health, accommodation, visa issues and referral to additional support services.
- Medicare Mental Health Centres (MMHC) – (see mild-moderate section below)

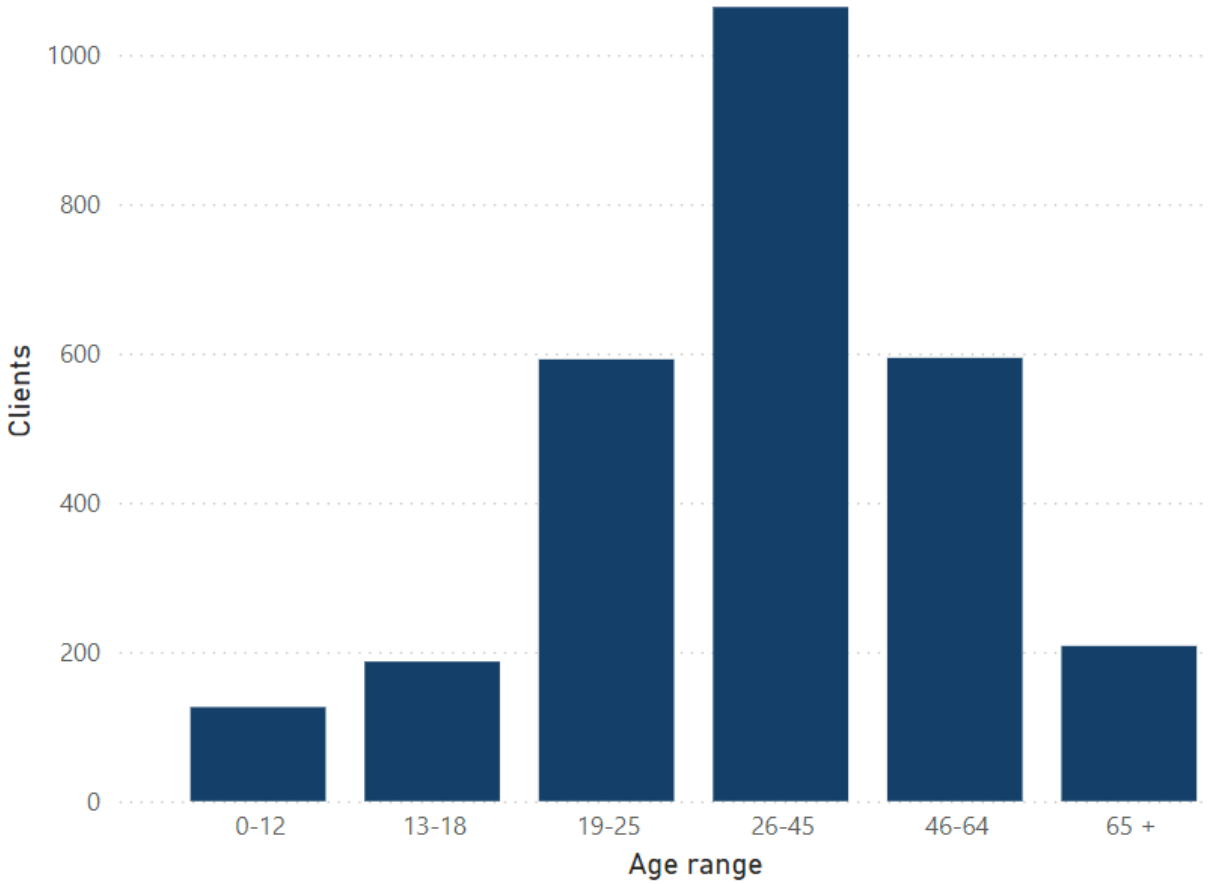
Mild - moderate intensity mental health services

For people experiencing mild to moderate intensity mental health conditions, structured and reasonably frequent interventions (e.g., psychological interventions) are utilised. CESPHN commissions the following services:

- **Cognitive Behavioural Therapy (CBT) Group for people with Autism Spectrum Disorder** – this program provides young people (16 years or older) who are on the Autism Spectrum access to an eight-week group CBT program with the aims of reducing anxiety and improving skills in social situations
- **Emotional Wellbeing for Older Persons (EWOP)** (described in low-intensity section above).
- **headspace** (see headspace section)
- **Medicare Mental Health Centre** - previously called Head to Health Centres, CESPHN commissions a service in Canterbury. MMHCs are a safe and welcoming space to talk to someone for people in distress or needing help finding the right mental health support to meet their needs. Centres have multidisciplinary teams and can provide different levels of support based on client needs. The Canterbury MMHC provided a service to 369 clients and delivered 3996 occasions of service in 23/24. Despite being predominantly a service for adults, almost 10% of clients presenting to the service were children, highlighting the significant need for child mental health services. 39% of the clients seen were born overseas.
- **Psychological Support Services (PSS)** – this program provides people with short term focussed psychological therapies and is aimed at those who would not otherwise be able to access the Better Access scheme. It supported 2,771 people in 2023-24 and:
    - In 2023-24, 14.2% of clients identified as First Nations, this was an increase from 13.4% in 2022-23. This is also a high representation with 1.05% of the CESPHN population identifying as First Nations.
    - Women make up the largest proportion of clients across both 2023-24 and 2022-23 (61.9% and 64.5% respectively). This is consistent with prevalence and service utilization data presented earlier in the chapter.
    - In 2023-24 there was an increase in number of clients identifying as either; Genderqueer/Non Binary (9.3% increase), Transgender Female/Male-to-Female (35% increase), Transgender Male/Female-to-Male (72.7%) from 2022-23. Whilst the number of clients is low, the increase suggests that there is an increase in gender diverse people engaging with services, or are more comfortable identifying their gender with a service.
    - In 2023-24, 26.0% of clients identified that their country of birth was outside of Australia, in which 93 Countries were identified. China had the highest proportion of clients (5.2%, followed by England (2.2%, New Zealand (1.1%) and Indonesia (0.9%). This is an increase from 2022-23, where 22.8% of clients identified a country of birth outside of Australia. However, this is lower than the overall CESPHN population where 40.7% of people were born overseas (Census 2021)

- When asked preferred language, following English (77.0%), Mandarin was the most preferred language (3.1%), followed by Cantonese (1.2%), Spanish (0.6%) and Arabic (0.3%).
- 0.9% of clients identified they did not speak English at all and 3.5% identified they did not speak English well.
- Clients in the 26-45 age range remain the largest group. However, this has decreased from 39.10% (2022-23) to 38.38% (2023-24). The 46-64 age range saw an increase from 18.67% (2022-23) to 21.43% (2023-24), which suggests a shift in demand among middle-aged clients. This increase may be attributable to increased need among this demographic The full age range breakdown can been seen in the Figure below.

Figure 19: Client age range in PSS program, 2023-24



Source: CESPHN, PMHC MDS

From the services that are commissioned by CESPHN that provide care to people who require a mild to moderate level of care, it has been reported that over the last 1-2 years there has been an increase in the complexity of clients who have been accessing mild to moderate commissioned services. One of the outcomes of this is a higher resource requirements per client, reducing the number of clients that can access services.

High intensity services

Periods of intensive intervention typically include multidisciplinary support, psychological interventions, psychiatric interventions, and care coordination. CESPHN commissions the following services:

- GP Mental Health Shared Care Program - aims to enhance the recovery and physical wellbeing of consumers whose care is shared by a GP and a Local Health District/Network. The focus of the program is to provide support for GPs to improve physical health outcomes for those experiencing severe mental health in primary care. CESPHN funds Sydney LHD, South Eastern Sydney LHD and St Vincents Health Network to provide Shared Care, supporting a combined total of 680 consumers and delivering 3,080 hours of support.
- GP Mental Health Shared Care – Clozapine – aims to improve the care of patients prescribed clozapine by establishing a partnership between their GP and the clozapine clinic. Patients are supported to transition smoothly between different healthcare teams while ensuring they continue to receive safe clozapine treatment. CESPHN funds SESLHD to deliver this service to 264 people per year, delivering 1,890 hours of support.
- Youth Enhanced Services- aims to provide multidisciplinary supports to young people who have more complex needs than headspace centres could normally support, and whose needs cannot be supported by the local public health service.
- Medicare Mental Health Centre (described in low-intensity section above)
- Primary Integrated Care Supports (PICS) Program - provides clinical and recovery-oriented mental health services. All participants are paired with a credentialed mental health nurse for clinical mental health supports, and with a peer worker for psychosocial supports if needed. The program offers care coordination between a person's GP and psychiatrist, liaising with family and carers, monitoring and promoting adherence to medication, and supporting self-management of mental and physical health. The PICS program supports 1,000 people experiencing severe mental illness per year and mental health nurses and peer workers deliver a combined total of 21,500 hours of essential supports per year. With rising costs of living, workforce shortages, workforce pay increases, and increased distress in the community, the program has been unable to maintain initial levels of contracted supports, which across 2019-20 to 2020-21 were to support 3,000 people and deliver 44,850 hours of support cumulatively.
- Telehealth Psychiatry Service (TPS) – provides free telehealth psychiatry services to people experiencing severe mental illness who due to socioeconomic barriers are unable to access private psychiatry support. Clinical Care Coordinators provide pre- and post-appointment psychosocial support to consumers and a large component of the program focuses on capacity building and upskilling GPs to ensure people's mental health can be effectively supported through primary care. Eligibility criteria for TPS has had to tighten since its inception in April 2022 due to increased complexity of client needs and an overwhelming demand for ADHD support. The program has had to implement compulsory Health Care Card requirements for people requiring ADHD support and cap this support to a total of 20% of accepted referrals. In 2024-25 this cap was reached within the first quarter.

Psychosocial support services

Through the Commonwealth Psychosocial Support (CPS) program, CESPHN commissions a number of psychosocial support services. These programs assist people experiencing severe mental illness who are not receiving psychosocial supports through the NDIS. Supports are non-clinical and non-therapeutic, aiming to build a person's capacity to meaningfully participate in their community and be an active part of their own recovery journey. To access psychosocial supports, people living, working, or studying in the CESPHN region must experience severe mental illness with reduced psychosocial functional capacity, however, no formal mental health diagnosis is required to be eligible. Supports are generally for people aged 16 or over, but some of CESPHN's commissioned programs have

specific age criteria (e.g., a youth group is 14-25, and an older persons' program is 65+). The psychosocial support services CESPHN commissions are:

- **Service Navigation for Psychosocial Support Services** - provides a central point in the region for information about accessing psychosocial services. It provides information and offers referral pathways to mental health services and supports that will best suit a person's needs. Service Navigation can be accessed by consumers, their families and carers, as well as GPs, Allied Health and community practitioners.
- **Yarning Circles -** Participating in a traditional Yarning Circle enables a return to historical Aboriginal cultural practices of coming together as a community, sharing, and expanding knowledge. Sitting in a Circle allows conversation and sharing to flow naturally - allowing all members of the group to be seen clearly, facing each other, and placed equally around the Circle. The Yarning circle offers an opportunity for Aboriginal and/or Torres Strait Islander men to gather on a monthly basis to network and receive psychosocial and culturally safe support.
- **Connect and Thrive** - provides individual psychosocial support with a mental health worker or peer worker to support people experiencing severe mental illness. Group support programs such as art therapy are provided, and regular social activities are planned to combat the emerging gap of social isolation. The program also offers targeted strategies supporting employment and physical health needs, as well as assisting people to test eligibility for NDIS supports.
- **Keeping the Body in Mind** - a life skills and lifestyle program offering free exercise physiology and dietician services for people living with severe mental illness. The program has recently added a Tobacco Treatment Specialist for smoking cessation support, and a Mental Health Peer Worker to support engagement across the three services offered.
- **Making Space** - supports people living with moderate hoarding disorder/compulsive acquiring who may be living in squalid conditions and/or be at risk of losing tenancy. Supports include case management, living skills training, practical 1:1 support, and support via the Buried in Treasures 16-week group program. Presently the program only runs in the SLHD area of the CESPHN region.
- **Social Rx ® -** comprises a combination of individual care coordination and group-based activities to which aims to support individuals to build capacity in functional and recreational capacities and reduce social isolation and capability, so individuals are able to of people to thrive, reconnect with, meaningfully participate in, and contribute to their community.
- **Growing Resilience** - a 6-week peer-to-peer program that aims to help people to build increase their resilience, confidence, and skills for coping with life's daily stressors. The program also supports people to combat social isolation, improve relationships with family and friends, and improve daily life coping skills.
- **Active8 Physical Health and WorkWell Employment Support** - Active8 aims to support people living with severe mental illness to also focus on their physical health needs and the overall positive health and wellbeing improvements that can come with bettering physical health. It involves Coaching for Physical Health, Eat Plant Learn, and Kick The Habit Tobacco Management.
- **WorkWell** - supports recovery through the social inclusion that occurs in the workplace and through the confidence, resilience, and self-management that comes from employment. Opportunities are found that align with a person's needs, interests, and recovery goals, and unlimited support is provided to the participant and employer while the person is working.
- **Connect with Healthy Minds and Bodies -** comprises eight group programs focusing on a range of mental and physical health supports, as well as social connection and life skills. Groups include Circles of Security, Outdoor Therapy for Disadvantaged Youth, Art Therapy, Trauma-Informed Pilates, Walk and Talk Outdoors with a Therapist, and more.
- **Older Person's Wellbeing Network** - a voluntary peer workforce model supporting older people with moderate to complex mental health challenges. A mental health worker offers 1:1 counselling and referral support, and trains 'Befrienders' (voluntary older peer supporters) for 1:1 engagement with people supported and to co-facilitate mental health workshops. The program addresses the large gap in mental health supports for older people, who find it difficult

to engage in structured and clinical support provided by people younger than them. The program is for people aged 65+ (55+ for Aboriginal and/or Torres Strait Islander peoples).

Data collected as part of the CPS program has shown that there is a continued increase in clients who are accessing CESPHN's CPS services with 991 clients accessing services in 2023-24, a 67.1% increase from 2022-23 (593), and more than double the number of clients in 2021-22 (415) and 2020-21 (485).This data is reflective of increased funding from the Commonwealth to the CPS program schedule allowing for increased capacity of programs through higher staffing levels and available client places. Additionally, a change in the commissioning approach to a consortium model, which has increased capacity through the number of available staff. Waitlist times have also progressively decreased as capacity for service delivery has increased, with 74 clients on the waitlist on 30 June 2024, compared to 117 in 2022-23 and 140 in 2021-22.

As part of the CPS program, clients are supported to test their eligibility to receive psychosocial supports through the National Disability Insurance Scheme (NDIS). The NDIS supports people who are living with psychosocial disability. In 2023-24, 112 clients were supported to test eligibility for the NDIS, however of this only 18 clients (16.1%) were found eligible. This is consistent with commentary provided by stakeholders as part of consultation of the needs assessment, where it was reported that a limited number of people experiencing severe mental illness are able to access NDIS funding to support their functional requirements. Those who are able to access NDIS funding do not receive funding towards any psychological therapies.

Under the service navigation program, in the last 2 years there has been a decrease in the number of clients who have been supported by service navigation. In 2023-24, 42 clients were supported, down from 73 clients in 2022-23 and 120 clients in 2021-22. Rather than demonstrating a decreased need for supports in navigating psychosocial services, this is attributed to the roles of mental health workers and peer workers in sourcing alternate referral pathways, providing warm handovers, and ensuring the people they support are receiving high quality care that meets their needs. As awareness of and access to CESPHN's psychosocial support services increases, the need for navigation support has decreased.

This shows that there is the demand for the services under the CPS program, and that the program is helping to meet the needs of the community. However, due to the complexity of mental health support needs experienced by people living in the central and eastern Sydney region, and the service gaps emerging with regards to lack of supports available, further investment in the provision of psychosocial supports is needed. Nationally, it is estimated that throughout 2022-23, there were 230,500 people with severe mental illness aged 12 to 64 years who required, but were not provided, psychosocial support. The total number of hours that would have been required to support this cohort is estimated to be 14.07 million. For people experiencing moderate mental illness, 263,100 people aged 12 to 64 did not receive required psychosocial supports, estimated at 2.76 million hours of unmet support (22).

Through stakeholder consultation as part of the Needs Assessment process, in relation to severe mental health and psychosocial reports, areas that have been identified as gaps, or requiring additional resourcing include being able to involve the family more in the support of clients with high needs, access to case management for coordination of services for people with higher needs that also have lower levels of function, greater resourcing to support the different intersectionalities of people with severe mental health such as housing and homelessness support, hoarding and squalor

support and alcohol and other drug support services. From a service provision perspective, it was also identified that the ability to be stepped between different levels of care within the same service to provide continuity of care and not having to move between multiple services, with the likelihood of having to join a long waitlist is a need. An additional challenge that impacts this is the short-term funding of programs, which can lead to uncertainty for clients and staff.

Access through integration

Whilst all the program areas above are designed to meet targeted specific needs of the CESPHN population, being able to access these services in an integrated approach is a gap within the community. Whilst there are models of integrated care within the region such as headspace and Medicare mental health centres, these services are not designed as a one-stop approach to support the mental health needs of the whole population.

In 2022 CESPHN undertook an analysis and consultation to co-design a service model for an Integrated mental health hub. Insights as part of the analysis showed that:

- National strategies, policies and frameworks point to a need for an integrated mental health system that provides accessible and equitable mental health services that focus on improving health and recovery outcomes through funding models such as community mental health hubs.
- There are a multiple hub-based models that are being delivered nationally that deliver support to adults with moderate to severe mental health challenges through a mix of person-centred clinical and non-clinical supports that link individuals with social supports, services and clinical care. These hub models have mixed eligibility criteria, are place-based with outreach services and are delivered by a diverse workforce.
- A review of the evidence-base and evaluation of hub models found that there has been success in models that pooled their funding, however there is an opportunity and need to improve integration at a service and system level.
- Establishment could introduce an effective data collection systems and strengthening the use of outcome measures to demonstrate recovery outcomes and overall impact.

The hub should deliver person-centred support by connecting people with the right mix of services and supports based on their individuals needs and preferences. This should be supported through an initial assessment of an individual's needs that is undertaken by a trained mental health professional, and using supported decision-making strategies to determine the service that is the best fit for the individual. Integration of the hub should be achieved through the establishment of partnerships with external agencies that are essential for connecting people to services and supports (23).

Access for vulnerable populations

Access to mental health services across all service levels does not look the same for all members of the community. There are groups in particular who face higher access issues. These groups include:

- LGBTIQ+ communities
- Culturally and linguistically diverse communities
- First nations communities
- Older people
- People with Drug and Alcohol addiction
- Veterans.

Whilst all these groups face their own unique challenges in accessing mental health services, there are some commonalities. The main barrier faced is being able to access services that are culturally appropriate and safe for their individual needs. Both individuals and communities report that there is

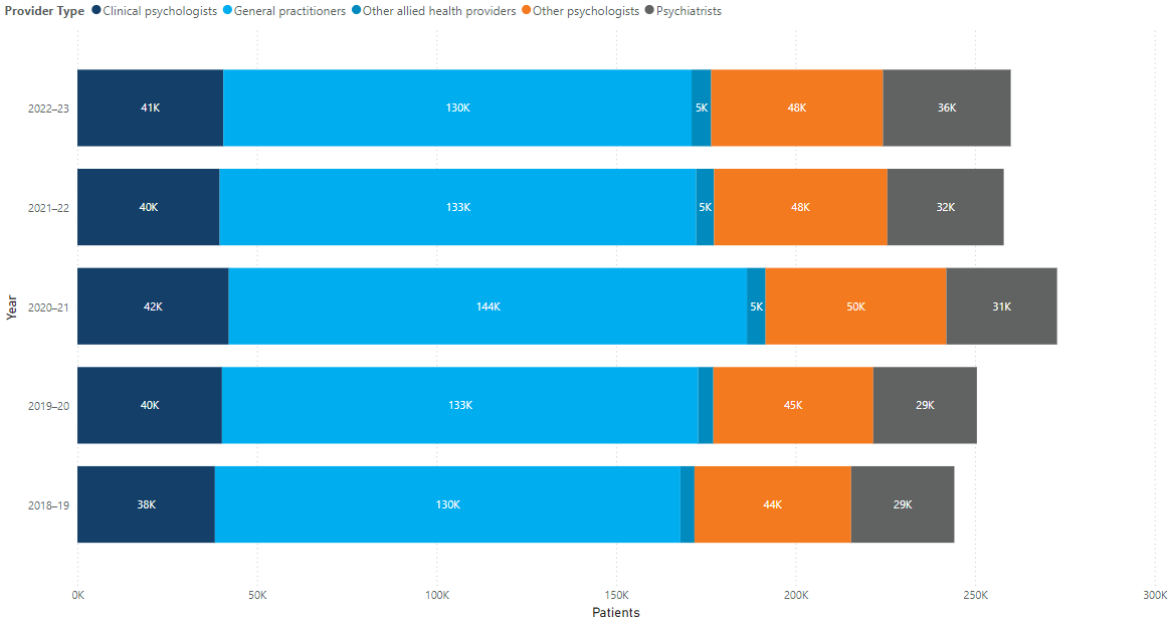
both a lack of knowledge around services they can attend, and a lack of providers that are able understand their needs outside of the clinical presentation. Being able to embed different level of cultural safety for vulnerable population groups will improve both access and quality of care.

Medicare-subsidised mental health services

Outside of the services that are commissioned by CESPHN, members of the community have access to Medicare-subsidised mental health services.

In 2022-23, 167,363 people (10.4% of the population) accessed Medicare-subsidised mental health services in the CESPHN region. This is an increase of 7,656 people (4.8%) from 2018-19. Over a five-year period from 2018-19 to 2022-23 the highest number of people accessing Medicare-subsidised mental health services was in 2020-21.

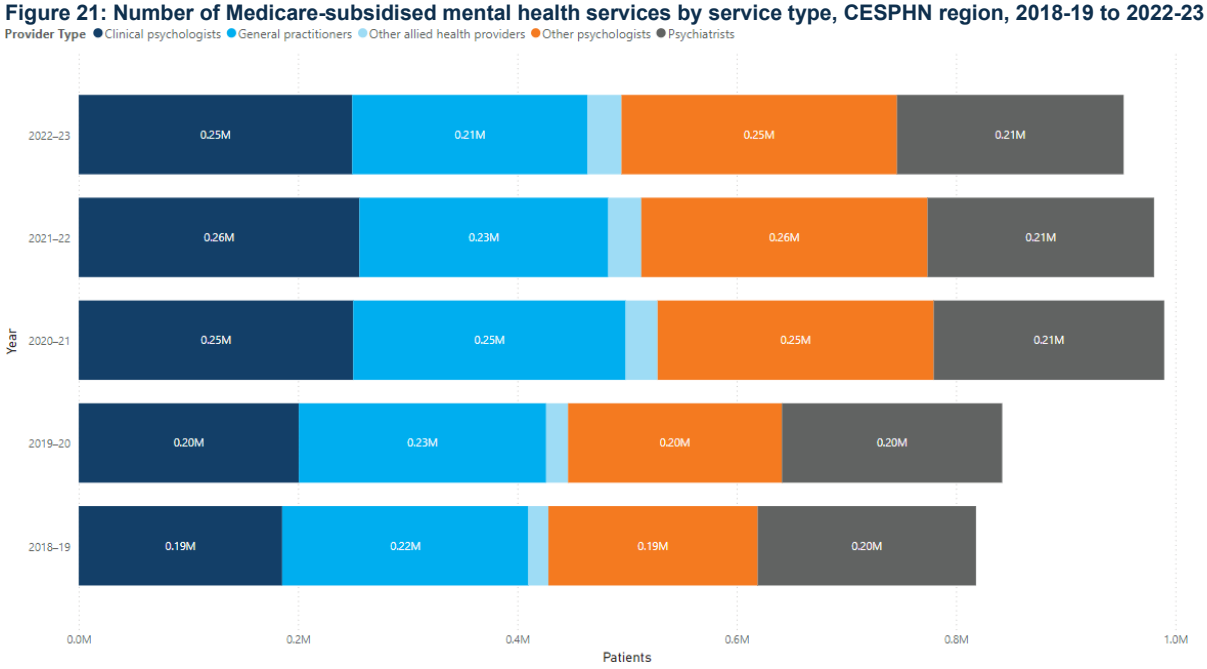
Figure 20: Number of people accessing Medicare-subsidised mental health services by service type, CESPHN, 2018-19 to 2022-23



Source: AIHW, 2023

Over the 5-year period from 2018-19 to 2022-23 the highest number of services accessed was in 2020-21 (989,796), with slight decreases in the number of services in 2021-22 (980,496) and 2022-23 (952,777).

Figure 21: Number of Medicare-subsidised mental health services by service type, CESPHN region, 2018-19 to 2022-23

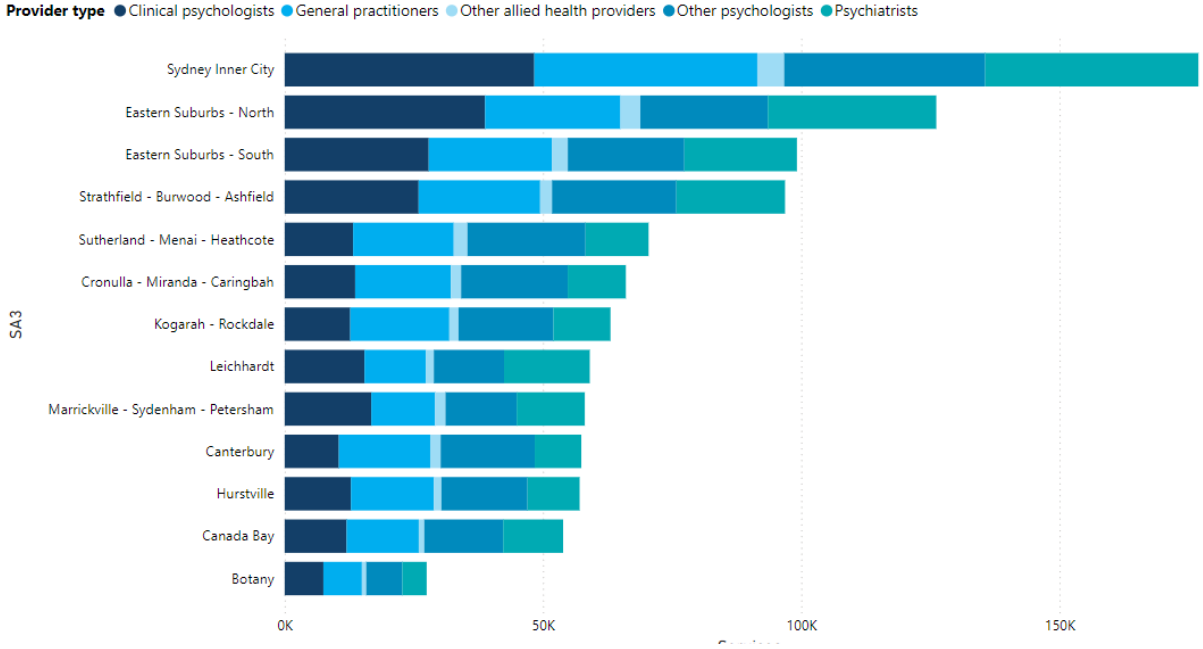


Source: AIHW, 2023

There are considerable variations in the number of Medicare-subsidised mental health services between SA3s. Sydney Inner City SA3 had the highest number of patients (45,028), followed by Eastern Suburbs-North SA3 (31,014) and Eastern Suburbs-South SA3 (26,385) across all service types. Botany SA3 had the lowest number of services (8,090) (24).

Approximately 50% of patients across all SA3s saw a general practitioner for Medicare-subsidised mental health services. (24) Across the CESPHN region, 25% of services were provided by general practitioners, within the region there is variation in the proportion of services provided by general practitioners ranging from 20.1% in Leichhardt SA3 to 30.8% in Canterbury SA3. Leichhardt SA3 had the highest proportion of services provided by a psychiatrist (28.1%).

Figure 22: Number of Medicare-subsidised mental health services by service type, by SA3, 2021-2022



Source: AIHW, 2023

Mental health related prescriptions

In 2022-23, across the CESPHN region, there were 221,864 people who had a mental health related prescription under the PBS, giving a rate of 14 per 100 population. Almost 58.9% of patients were female and 41.1% were male. In this same year, almost 1.9 million mental health related prescriptions were filled, at a rate of 1,213 per 1,000 population (24).

Across the five years to 2022-23, rates of patients per 100 population have remained stable. In contrast rates of mental health related prescriptions per 1,000 population increased by 13.3% in the same time period, indicating that the patients using mental health related prescriptions have increased their usage (24).

Table 2: Patients and mental health prescriptions, CESPHN region, 2018-19 to 2022-23

Measure	2018–19	2019–20	2020-21	2021-22	2022-23
Number of patients	206,642	212,049	209,605	216,505	221,864
Patients per 100 population	13	13	13	14	14
Number of prescriptions	1,704,464	1,814,320	1,809,141	1,868,554	1,886,722
Prescriptions per 1,000 population	1,070	1,137	1,139	1,204	1,213

Source: AIHW, 2024

Within the CESPHN region in 2022-23, patients aged 45-54 years of age accounted for 16.4% of the patient profile, and 16.9% of mental health prescriptions; this population group accounted for 12.4% of the CESPHN population. Those aged 55-64 years made up a further 14.5% of patients and 15.1% of mental health prescriptions; this population group accounted for 10.5% of the CESPHN population. Similarly, those aged between 35-44 years made up a further 14.9% of patients and 14.6% of prescriptions; this population group accounted for 15.1% of the CESPHN population (24). The

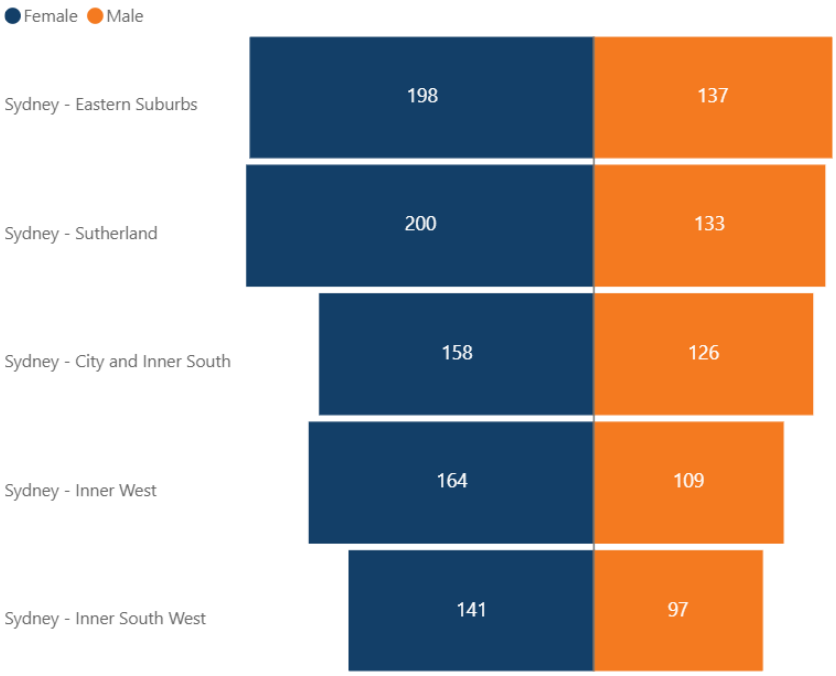
population aged 65+ has previously been reported in 10 year increments (65-74, 75-84 and 84+), with the 2022-23 65+ patient percentage and prescription percentage are lower than the 2021-22 combined age group totals. This decrease shows that the older age groups do not have the highest rates when separated out.

Table 3: Patients and prescriptions by age group, CESPHN region, 2022-23

Age Group	Patients (n)	Patients (%)	Prescriptions (n)	Prescriptions (%)
0–17 years	14,569	6.57%	114,569	6.11%
18–24 years	14,041	6.33%	114,363	6.10%
25–34 years	29,866	13.46%	232,756	12.42%
35–44 years	32,984	14.87%	270,085	14.42%
45–54 years	35,776	16.13%	311,826	16.64%
55–64 years	31,803	14.33%	277,934	14.83%
65+ years	62,825	28.32%	552,082	29.47%
Total	221,864	100.0%	1,873,615	100.0%

Source: AIHW, 2024

Figure 23: Patients sex per 1,000 population by SA4, CESPHN region, 2022-23

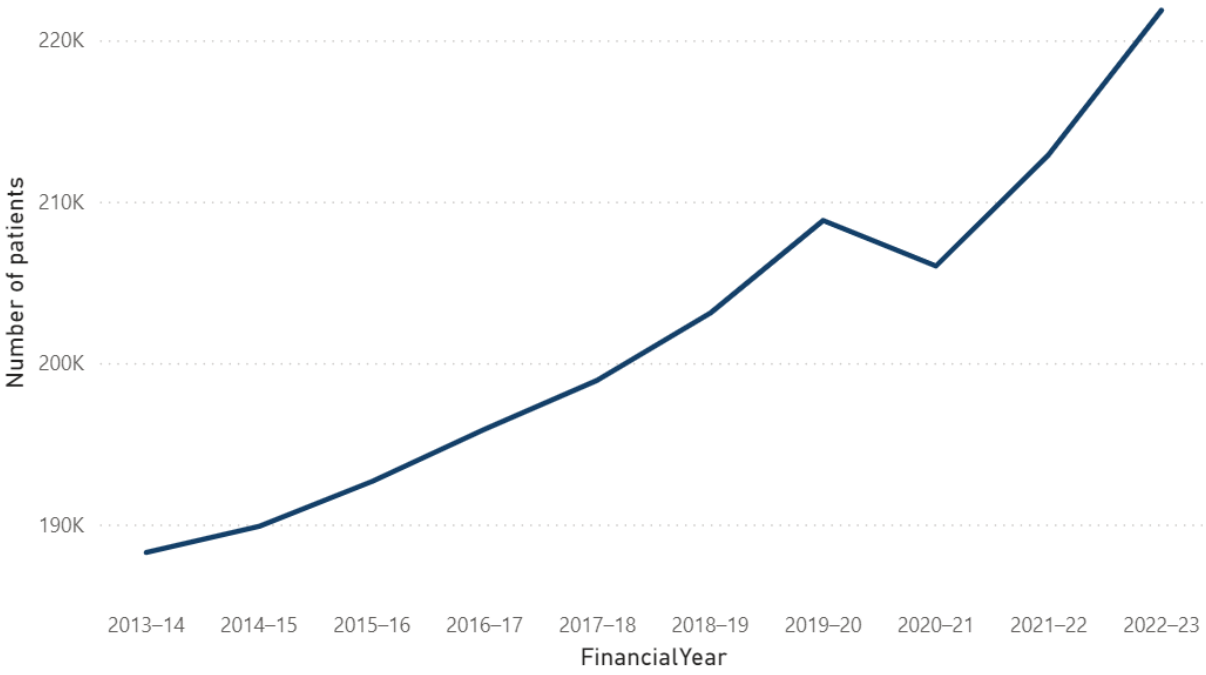


Source: AIHW, 2024

Figure 24: Prescriptions by sex per 1,000 by SA43, CESPHN region, 2022-23

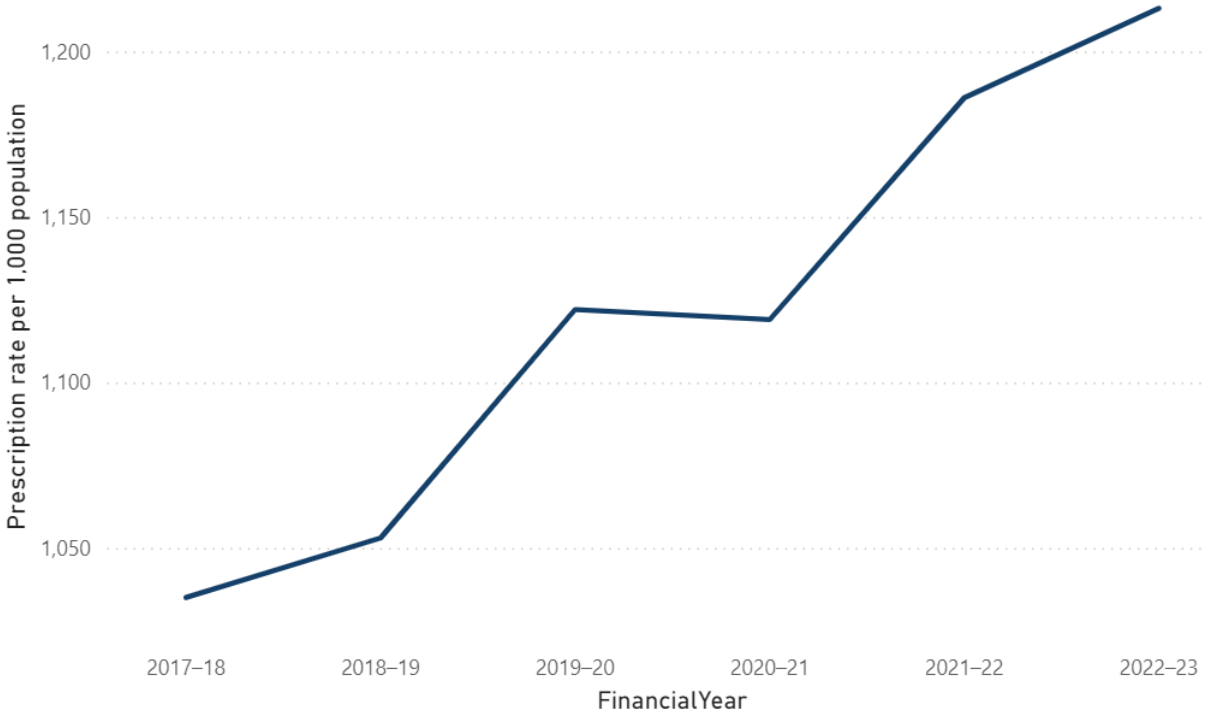
Source: AIHW, 2024

Figure 25: Number of Patients, 2013-14 to 2022-23



Source: AIHW, 2024

Figure 26: Rate of prescriptions per 1,000 population, CESPHN, 2017-18 to 2022-23

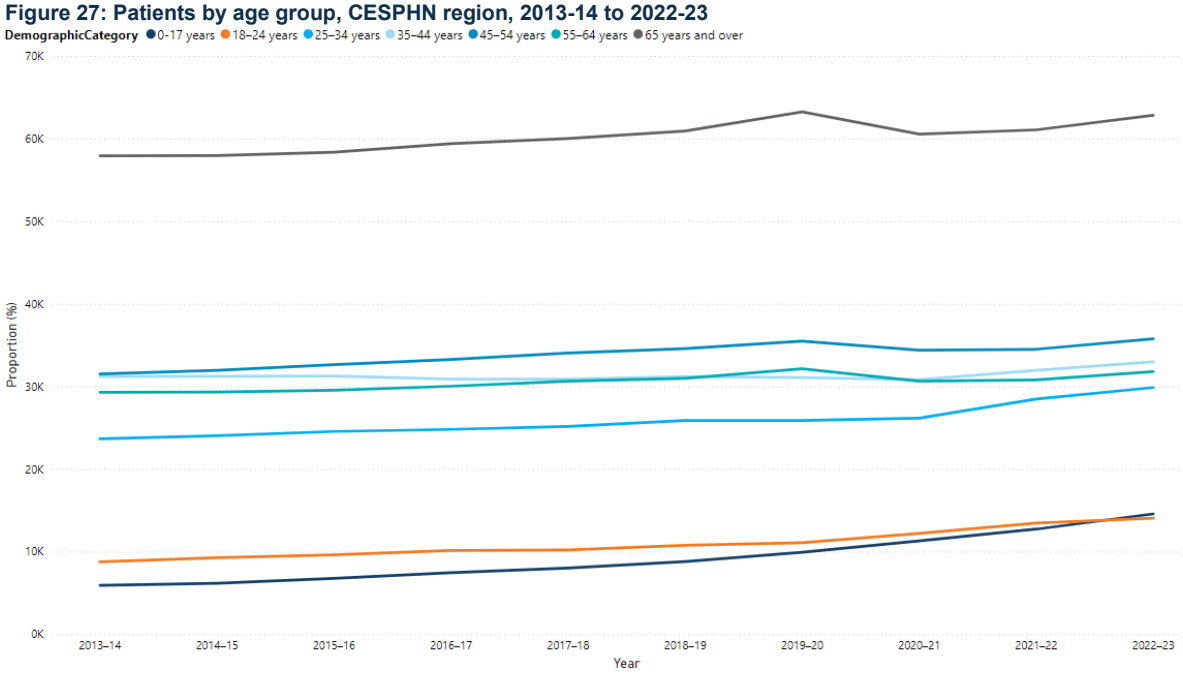


Source: AIHW, 2024

Looking at the total number of patients and prescriptions across the CESPHN region over a six -year period from 2017-18 to 2022-23, prior to 2019-20 number of people who are accessing PBS medication and the number of prescriptions dispensed were increasing between 1.5-2.0%, in 2019-20 there was an increase of 2.9% and 6.7% respectively. In 2019-20, at the start of the COVID pandemic there was a 2.9% increase in people accessing the PBS and a 6.7% increase in prescription on the PBS. Across both number of people and number of prescriptions 2020-21 saw a decline from 2019-20, however, both the 2021-22 and 2022-23 numbers have continued to increase by 3.0% and 2.9% in 2021-22 and 3.9% and 2.3% in 2022-23.

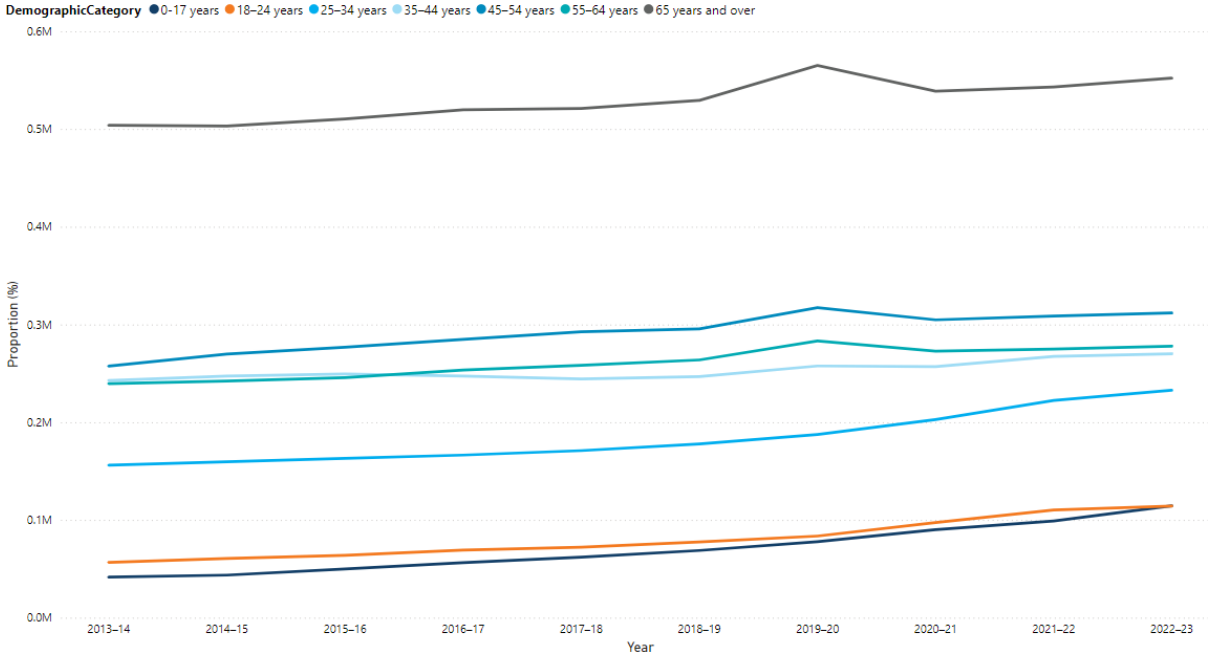
Figures 27 and 28 below show that the number of people and number of prescriptions across each age group is increasing. Across both the number of people and number of prescriptions we can see a spike in the three eldest age groups; 65 years and over, 55-64 years and 45-54 years in 2019-20.

Figure 27: Patients by age group, CESPHN region, 2013-14 to 2022-23



Source: AIHW, 2024

Figure 28: Prescriptions by age group by SA4, CESPHN region, 2013-14 to 2022-23



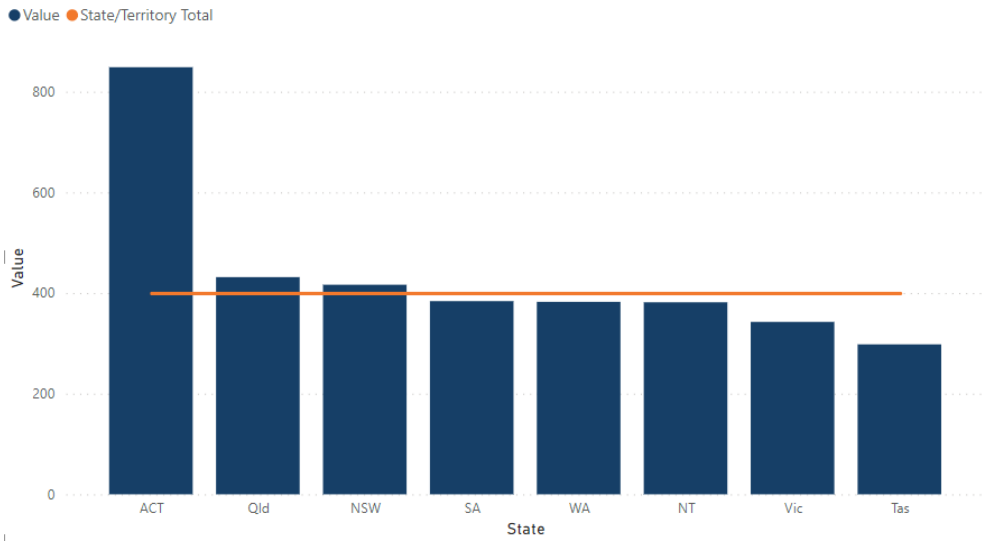
Source: AIHW, 2024

Community mental health care

Community mental health care refers to NSW government-funded and operated specialised mental health care provided by community mental health care services and public hospital-based outpatient and day clinics.

In 2021-22 there were 2,178,616 service contacts provided in major cities in NSW by community mental health care. This equates to a rate of 359.0 service contacts per 1,000 population, slightly higher than national major cities totals of 343 per 1,000 population (24). Over a 10-year period from 2011-12 to 2021-22 the rate per 1,000 population saw a spike in service contacts in 2015-16 to a rate of 409 per 1,000 population. 2016-17 and 2020-21 saw higher rates at 384 and 381 per 1,000 population respectively. All other years remained consistent at around 460 per 1,000 population. With the incidence of mental illness increasing over time, and the rate of service contacts per 1,000 population remaining stable, along with and ED related presentations and hospitalisations increasing, it could be suggestive that these individuals requiring support are either relying on the primary care system to support them, or presenting at emergency departments. This is consistent with feedback provided by primary care providers that there is greater acuity, complexity and demand for mental health services in primary care.

Figure 29: Community mental health service contacts per 1,000 population, by state, 2021-22



Source: AIHW, 2023

Figure 30: Rate per 1,000 - NSW Major cities Community mental health care service contacts, 2005–06 to 2021–22

Source: AIHW, 2023

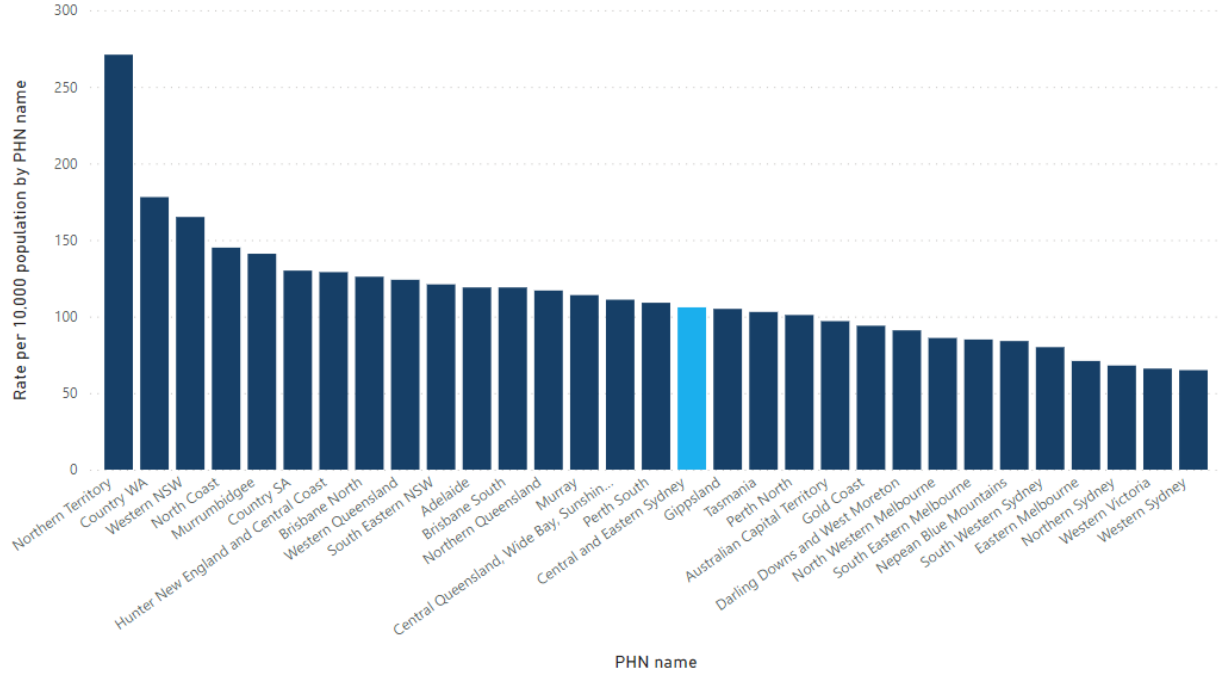
Hospitalisations for mental health conditions

Hospital emergency services

Between 2017-18 to 2021-22, there was a 9.2% increase in the number of mental health related emergency department presentations, with an average annual change of 2%. During this same period, we saw a 4.2% increase in the number of total emergency department presentations in the CESPHN region, with an average annual change of 1% (24).

In 2021-22, there were 16,418 mental health related emergency department presentations across the CESPHN region, equating to 106 mental health related emergency department presentations per 10,000 population. This is slightly higher than rates from 2018- 2019 and 2019-20 (103 and 104 per 10,000 population) but lower than the 2020-21 rate (111 per 10,000 population) (24).

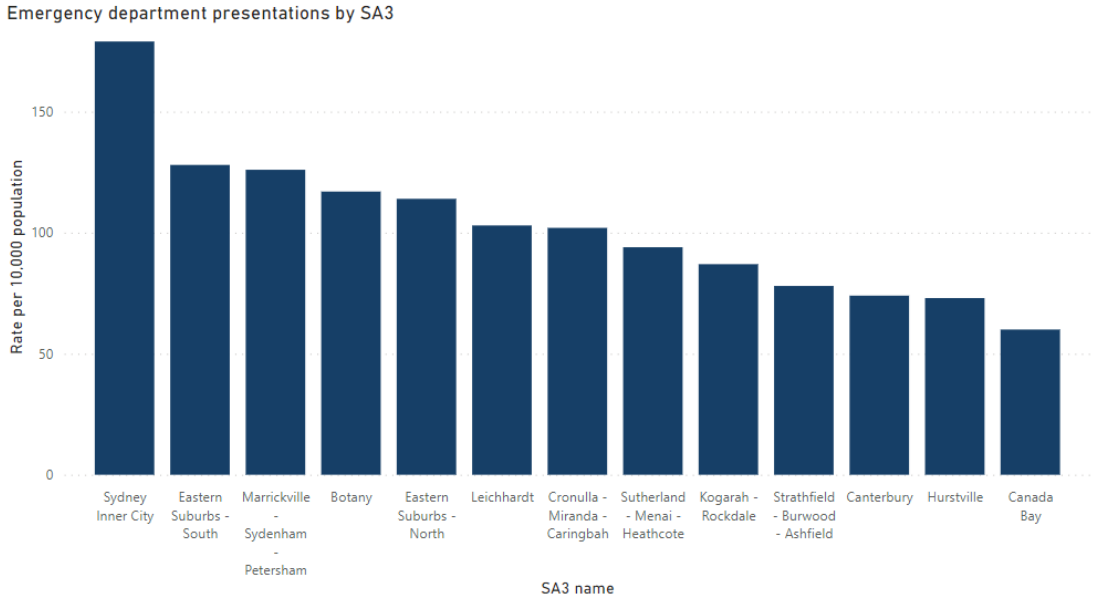
Figure 31: Mental health related emergency department presentations, PHN, 2021-22



Source: AIHW, 2023

In 2021-22 across the CESPHN region, Sydney Inner City SA3 had the highest proportion of mental health related emergency department presentations per 10,000 population (179), followed by Eastern Suburbs – South (128) and Marrickville - Sydenham-Petersham SA3 (126) (24).

Figure 32: Emergency department presentations by SA3, 2021-22



Source: AIHW, 2023

Overnight admitted mental health-related care

In 2020-21, there were 102.4 overnight admitted mental health-related hospitalisations per 10,000 population in the CESPHN region, slightly lower than the national average (109.5 per 10,000 population). There was a total of 1,655.4 patient days per 10,000 population, higher than the national average (1,245.4 per 10,000 population) (24).

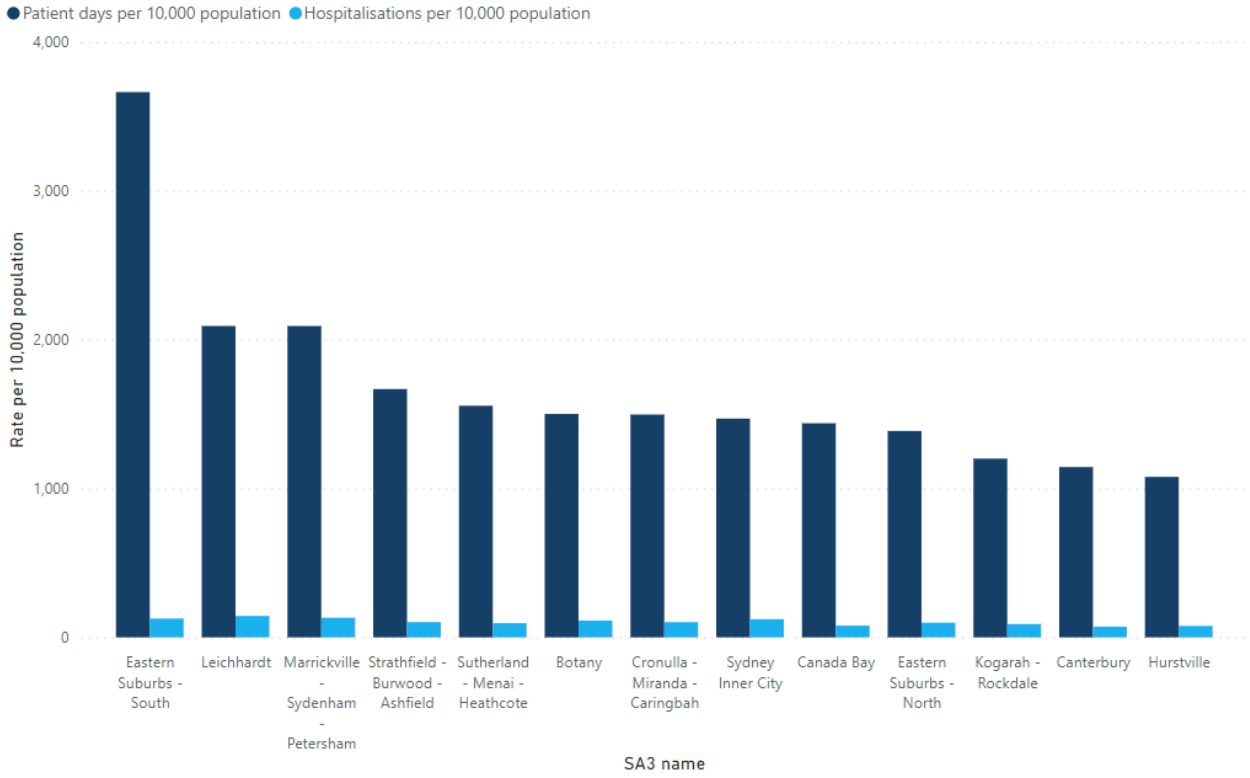
Table 4: Overnight admitted mental health related rates in the CESPHN region, 2020-21

PHN	Patient days per 10,000 population	Procedures per 10,000 population	Psychiatric care days per 10,000 population	Hospitalisations per 10,000 population
Central and Eastern Sydney	1,655.4	288.6	1,267.8	102.4

Source: AIHW, 2023

The highest rate of overnight admitted mental health-related hospitalisations were recorded in Leichhardt SA3 (144.10 per 10,000 population), Marrickville-Sydenham-Petersham SA3 (131.8 per 10,000 population), and Eastern Suburbs South SA3 (126.4 per 10,000 population) (24).

Figure 33: Overnight admitted mental health related rates by SA3, 2021-22



Source: AIHW, 2023

Residential mental health care

Residential mental health care services provide specialised mental health care on an overnight basis in a domestic-like environment and may include rehabilitation, treatment or extended care. (25)

Whilst there is no local level data available on residential mental health care, national level data is available that can provide insights into the CESPHN community. In 2021-22 it was reported that that:

- people aged 18-24 years of age have the highest rate of access (6 per 10,000 population)
- Women account for 56% people who access residential mental health care
- Aboriginal people access residential mental health at a rate of 8 per 10,000 population compared to the other Australians rate of 3 per 10,000
- 58% of people who access residential mental health care usual place of residence is a major city
- People from SEIFA quintile 1 (most disadvantaged) access residential mental health care at the highest rate (4 per 10,000) (25).

The 5 most commonly reported mental health-related principal diagnoses for residential mental health care episodes were:

- Schizophrenia (about 2,030 episodes, 22% of all episodes),
- Specific personality disorders (about 1,450, 16%),
- Schizoaffective disorders (about 900, 10%),
- Depressive episode (760, 8%), and
- Reaction to severe stress and adjustment disorders (about 730, 8%).

Psychosocial disability (NDIS) services

The CESPHN region is covered by two NDIS service districts, South Eastern Sydney and Sydney. As of 31 December 2021, 12% of participants from South Eastern Sydney and 18% of participants from Sydney had a primary disability of psychosocial disability. Both service districts have rates higher than the benchmark rate of 11% of participants (26).
Data shows that both service districts had lower average number of participants per provider where the primary disability was psychosocial disability compared to the benchmark – South Eastern Sydney (2.85), Sydney (2.82) and benchmark (3.27) (26).

Nationally, where psychosocial disability was the primary disability, there was a 72% plan utilisation. Within the CESPHN region, this varied between service districts (73% in South Eastern Sydney and 66% in Sydney) (26).

There were slightly lower proportions of participants who reported that they chose who supported them within the service districts in CESPHN region; South Eastern Sydney had 52% of participants with primary disability of psychosocial disability who chose who supported them compared to 50% in Sydney and 54% nationally. NDIS participants within the service districts in the CESPHN region reported higher proportions of participants who felt NDIS helped them have more choice and control over their life (South Eastern Sydney 75%, Sydney 79%) compared to national benchmark (75%).

Specialist homelessness services

In 2021-22, there were 85,200 clients with a mental health issue receiving specialist homelessness services in NSW. This accounts for 31% of all clients receiving specialist homelessness services in

NSW. In 2021-22 the main reasons that clients with a current mental health issue sought assistance from a specialist homelessness services agency were not commonly related to mental health issues (4.1% or 3,500 clients). Instead, the main reasons for seeking assistance were for housing crisis (21% or 18,200 clients), family and domestic violence (19% or 16,500 clients), or inadequate or inappropriate dwelling conditions (13% or almost 11,100 clients) (24).

Additional access and service gaps

Further to the above, a number of additional access and service gaps have been identified through consultation processes with **internal and external stakeholders.**

- People are not accessing or delaying the renewing their Mental Health Care Treatments Plans as the cost of seeing a GP increases with the reduction of bulk billing, and the increased cost of living
- The reduction in better access sessions from 20 to ten sessions in December 2022 is impacting clients who were already in the program, but it has allowed for an increase in new clients to be seen.
- Psychologists are being attracted to more privately run services due to better working conditions. This reduces the amount of practitioners available for publicly funded/subsidised service. Also increase staff turnover, which increases the burden of training more staff and impacts continuity of care.
- The short term funding of services has flow on effects from attracting and retaining suitable staff, to continuity of care for clients
- There is a limited availability in programs when a client needs to step up a level of care, this results in either long wait times or limited treatment options at a lower intensity.

Workforce

The mental health workforce consists of both clinically trained professionals, such as psychiatrists, psychologists and mental health nurses and non-clinical roles, such as peer support workers. Other professions that work within the mental health field include: General Practitioners, Social workers, Occupational therapists, Counsellors, Community Mental Health Workers, Aboriginal health workers, dieticians, youth workers, art therapists, pharmacists, alcohol and other drug health workers, primary care physicians, recovery and rehabilitation workers, housing specialists, Justice Health, family therapists, mental health coaches, Acute Care Teams. These professions can all play a valuable role as part of a multidisciplinary team to support individuals for improved outcomes.

There are four main mental health sectors where support can be accessed:

1. The public health system – Local Health Districts or Local Health Networks
2. The primary care system – General Practitioners and Allied Health Providers
3. The private sector – Clinicians working either in private practice or within private hospitals
4. Non-government organisations – this includes Community Managed organisations and helplines and counselling services such as Lifeline and beyond blue.

Psychiatry workforce

In 2022, there were 380 psychiatrists working in a clinician role in the CESPHN region (351.6 FTE) giving a rate of 24.3 per 100,000 population (22.5 FTE per 100,000 population), higher than the state and national rates for number of practitioners (13.4 and 14.6) and FTE (10.8 and 11.9) per 100,000 population respectively (27).

Within the region, there is an uneven distribution of psychiatrists. Sydney Inner City SA3 has the highest rate of psychiatrists (58.4 per 100,000 population), followed by Leichhardt (42.7 per 100,000) and Eastern Suburbs – South (39.8 per 100,000). The SA3s of Botany, Hurstville, Marrickville-Sydenham-Petersham and Sutherland-Menai-Heathcote all have 0 or three or less psychiatrists. For this reason, they are excluded from parts of the below analysis.

Table 5: Psychiatrists by location, 2022

Measure	CESPHN	NSW	Australia
Number of Practitioners	380	1,091	3,784
Number of Practitioners (rate per 100,000 population)	24.3	13.4	14.6
FTE Total	351.6	1,013.5	3,563.3
FTE Total (rate per 100,000 population)	22.5	12.4	13.7
FTE Clinical	301.7	882.7	3084.3
FTE Clinical (rate per 100,000 population)	19.3	10.8	11.9

Source: HWA, 2023

Years intended to work

In 2022, 39.5% of psychiatrists in the CESPHN region intended to only work up to another 10 years. Just over 59.4% of psychiatrists in Strathfield - Burwood – Ashfield and 54.1% in Leichhardt SA3 indicate that they do not intend to work more than ten years (27).

Table 6: Psychiatrist years intended to work by SA3, 2022

SA3	0-5 years (%)	6-10 years (%)	11-15 years (%)	16-20 years (%)	21-30 years (%)	31-40 years (%)	41+ years (%)
Botany	100	0	0	0	0	0	
Canada Bay	12.5	15.6	18.8	9.4	31.3	12.5	
Canterbury	50.0	0.0	0.0	0.0	50.0	0.0	
Cronulla-Miranda-Caringbah	0.0	21.4	28.6	28.6	21.4	0.0	
Eastern Suburbs – North	28.9	20.0	6.7	17.8	26.7	0.0	
Eastern Suburbs – South	17.0	9.4	15.1	20.8	28.3	9.4	
Hurstville	100.0	0.0	0.0	0.0	0.0	0.0	
Kogarah-Rockdale	12.0	12.0	24.0	28.0	12.0	12.0	
Leichhardt	33.3	20.8	12.5	12.5	20.8	0.0	
Marrickville-Sydenham-Petersham							
Strathfield-Burwood-Ashfield	29.7	29.7	8.1	18.9	13.5	0.0	
Sutherland-Menai-Heathcote	0.0	0.0	0.0	0.0	0.0	0.0	
Sydney Inner City	28.6	15.1	10.3	15.9	24.6	5.6	
CESPHN	23.5	16.0	12.3	17.4	24.1	5.6	1.1
New South Wales	22.9	16.8	15.1	19.5	19.7	4.7	1.3
Australia	21.4	18.8	14.1	20.0	20.2	4.4	1.1

Source: HWA, 2023
Note: No data available for Marrickville-Sydenham-Petersham and Sutherland-Menai-Heathcote SA3. Results for Botany and Hurstville are based on small numbers and are to be interpreted with caution.

Psychologist workforce

In 2022 there were 2,777 psychologists working in a clinical role in the CESPHN region (2,354.0 FTE) giving a rate of 177.8 per 100,000 population (150.8 FTE per 100,000 population), higher than the state and national rates for number of practitioners (116.1 and 112.6) and FTE (97.7 and 95.2) per 100,000 population respectively (27).

Sydney Inner City SA3 has the highest rate of psychologists at 425.7 per 100,000 population, followed by Eastern Suburbs – North (276.8 per 100,000) and Leichhardt (247 per 100,000). The SA3s of Canterbury, (53.9 per 100,000) and Botany (55.8 per 100,000) have a rate 3 times lower than the CESPHN rate which shows the differential physical access to psychologists across the region.

Table 7: Psychologists by region, 2021

Measure	CESPHN	NSW	Australia
Number of Practitioners	2,777	9,481	29,272
Number of Practitioners (rate per 100,000 population)	177.8	116.1	112.6
FTE Total	2,354.0	7,978.8	24,764.6
FTE Total (rate per 100,000 population)	150.8	97.7	95.2
FTE Clinical	1,844.5	6,372.8	19,781.0
FTE Clinical (rate per 100,000 population)	118.1	78.0	76.1

Source: HWA, 2023

Years intended to work

Data on psychologist years intended to work suggests Leichhardt, Marrickville-Sydenham-Petersham and Sutherland-Menai Heathcote may experience shortages in psychologists given the high proportions of psychologists intending to leave within 5 years.

Table 8: Psychologist years intended to work by SA3, 2022

Geography	0-5	6-10	11-15	16-20	21-30	31-40	41+
Botany	14.3%	8.6%	17.1%	25.7%	11.4%	14.3%	8.6%
Canada Bay	18.7%	13.4%	14.2%	21.6%	21.6%	10.4%	
Canterbury	11.6%	20.3%	7.2%	26.1%	29.0%	5.8%	
Cronulla - Miranda - Caringbah	13.9%	17.4%	18.8%	21.5%	20.8%	7.6%	
Eastern Suburbs - North	17.1%	21.4%	8.1%	19.7%	22.3%	7.2%	4.1%
Eastern Suburbs - South	15.2%	17.5%	12.6%	15.5%	23.6%	13.6%	1.9%
Hurstville	11.5%	14.4%	11.5%	24.0%	24.0%	11.5%	2.9%
Kogarah - Rockdale	13.1%	20.0%	12.3%	21.5%	23.1%	7.7%	2.3%
Leichhardt	21.9%	17.5%	16.8%	15.3%	20.4%	5.8%	2.2%
Marrickville - Sydenham - Petersham	26.4%	20.8%	4.2%	16.7%	31.9%		
Strathfield - Burwood - Ashfield	17.9%	21.0%	12.3%	13.0%	22.2%	11.1%	2.5%
Sutherland - Menai - Heathcote	22.8%	16.7%	14.9%	14.0%	18.4%	13.2%	
Sydney Inner City	12.0%	16.0%	12.0%	20.2%	27.9%	9.2%	2.6%
Central and Eastern Sydney	15.2%	17.5%	12.2%	19.1%	24.4%	9.3%	2.2%
New South Wales	16.5%	18.1%	11.8%	20.2%	22.9%	8.4%	2.1%
Australia	15.8%	18.3%	12.3%	20.4%	22.7%	8.5%	2.1%

Source: HWA, 2023

Mental health nurse workforce

In 2022 there were 1,480 mental health nurses working in a clinician role in the CESPHN region (1,461.1 FTE) giving a rate of 94.8 per 100,000 population (93.6 FTE per 100,000 population), higher than the national and state rates for number of practitioners (80.5 and 90.7) and FTE (78.8 and 87.7) per 100,000 population respectively (27).

There is an uneven distribution of mental health nurses across the region. Eastern Suburbs – South SA3 has the highest rate of mental health nurses 311.7 per 100,000 population, followed by Canada Bay (243.7 per 100,000) and Sydney Inner City (153.3 per 100,000). Sutherland-Menai-Heathcote

SA3 has the lowest rate of mental health nurses (8.9 per 100,000) with Leichhardt and Botany also having low rates (14.2 and 16.4 per 100,00, respectively).

Table 9: Mental health nurses by region, 2022

Measure	CESPHN	NSW	Australia
Number of Practitioners	1,480	6,577	23,580
Number of Practitioners (rate per 100,000 population)	94.8	80.5	90.7
FTE Total	1,461.1	6,433.0	22,807.1
FTE Total (rate per 100,000 population)	93.6	78.8	87.7
FTE Clinical	1,413.8	6,223.7	22,047.0
FTE Clinical (rate per 100,000 population)	90.5	76.2	84.8

Source: HWA, 2023

Years intended to work

In 2022, 45.2% of mental health nurses in the CESPHN region intended to only work up to another 10 years. Of note, 57% of the mental health nurses in Botany do not intend to work more than 5 years and all of the mental health nurses in Leichhardt do not intend to work more than 15 years.

Table 10: Mental health nurse years intended to work by SA3, 2022

SA3	0-5 years (%)	6-10 years (%)	11-15 years (%)	16-20 years (%)	21-30 years (%)	31-40 years (%)	41+ years (%)
Botany	57.1	0.0	0.0	0.0	42.9	0.0	0.0
Canada Bay	17.0	21.3	9.6	16.0	20.2	9.6	6.4
Canterbury	16.0	36.0	16.0	20.0	12.0	0.0	0.0
Cronulla – Miranda – Caringbah	21.5	18.5	7.7	20.0	21.5	10.8	0.0
Eastern Suburbs – North	25.8	22.6	9.7	16.1	16.1	0.0	9.7
Eastern Suburbs – South	27.6	21.0	8.8	17.0	13.8	7.7	4.2
Hurstville	0.0	23.1	23.1	0.0	30.8	0.0	23.1
Kogarah – Rockdale	22.2	22.2	10.0	18.9	16.7	10.0	0.0
Leichhardt	0.0	0.0	100.0	0.0	0.0	0.0	0.0
Marrickville – Sydenham – Petersham	0.0	33.3	0.0	0.0	33.3	33.3	0.0
Strathfield – Burwood – Ashfield	31.1	23.3	9.7	14.6	12.6	5.8	2.9
Sutherland – Menai – Heathcote	0.0	0.0	0.0	0.0	100.0	0.0	0.0
Sydney Inner City	25.5	18.4	9.4	18.0	16.9	7.5	4.3
CESPHN	24.4	20.8	9.2	17.0	16.6	7.9	4.0
NSW	23.9	20.9	10.1	18.5	16.6	7.2	2.9
Australia	21.9	20.4	11.1	17.7	18.6	7.4	2.8

Source: HWA, 2023

Lived Experience workforce

The Lived Experience workforce is made up of people who are employed in paid positions that require Lived Experience as an essential employment criterion, regardless of position type or setting. This is a professional approach in which diverse personal experience-based knowledge is applied within a consistent framework of values and principles (28). The lived experience workforce is essential to delivering quality, recover-focused mental health services in Australia. Workers act as "change agents," supporting both individual recovery and broader cultural and practice changes within services.

The Lived Experience workforce offers significant benefits to service users, families, service providers, and the broader community. Their role improves service engagement, treatment outcomes, and staff retention, while reducing critical incidents and healthcare costs. In community settings, it can relieve pressure on other services, such as GPs and youth mental health services.

The central and eastern Sydney Mental Health and Suicide Prevention Regional Plan (2024-2026) identifies the need to support and grow the mental health peer (lived experience) workforce. Currently peer workers are engaged with several of CESPHN's commissioned services including, but not limited to, the Canterbury Medicare Mental Health Centre, headspace Camperdown, the Youth Enhanced Service, CASPAR, Connect and Thrive, Active8 andAvtive9 & WorkWell, Growing Resilience, PICS, and KBIM-p and Keeping the Body In Mind.

Community managed workforce

The Community managed mental health workforce is the workforce that provides mental health services outside of the public sector (Local Health District/Network managed services). Whilst there is no local level data available for the CESPHN region we can use NSW data to provide insights into what may be happening within the CESPHN region.

The Mental Health Coordinating Council (MHCC) undertakes an annual survey of the community managed mental health workforce in NSW. In 2023 it found that:

- 25% of the total mental health workforce in NSW works at a community managed organisation
- 70% of the workforce is less than 45 years of age
- There is 2-3% growth in the workforce each year
- 72% of all workers in the sector are female
- 40% of direct support mental health worker are causal or contract employee
- 19% of the workforce has lived experience of mental health, both in peer and non-peer roles (29).

The report also highlights a reduction in psychiatrists and other medical practitioners working in the CMO sector. This category has dropped by more than 70% with only 13 Psychiatrists working in the CMO sector in NSW in 2023. Respondents of the survey reported that recruiting psychiatrist to the sector is extremely challenging (29). This was echoed by participants in CESPHN Mental Health Stakeholder consultation held in July 2024.

A breakdown of workers by the type of direct support from the survey can be seen below.

Table 11: Number of workers by type of direct support roles in NSW, 2023

Type of worker/occupation	Headcount	Proportion of total workforce (%)	FTE	Proportion of FTE workforce (%)
Identified Consumer Peer Worker	406	12.3	309.2	12.9
Identified Carer Peer Worker	51	1.5	37.4	1.6
Recovery Coach	23	0.7	16.4	0.7
Mental Health Support Worker	1236	37.5	945.3	39.3
Support Coordinator	273	8.3	240.1	10
Nurse	57	1.7	38.2	1.6
Psychiatrist	13	0.4	5.5	0.2
Psychologist/counsellor	315	9.6	137.8	5.7
Other medical practitioner	23	0.7	5	0.2
Allied Health	233	7.1	157.9	6.6
Other	663	20.1	512.1	21.3
Total	3293	99.9	2404.9	100.1

Source: MHCC, 2023

A highlight in the sector is the increase in Identified Consumer Peer Workers, who are now the second largest workforce in the community managed sector representing 12.3% of all workers. Participants at the CESPHN Mental Health Stakeholder consultation also highlighted the important role that Peer workers play in the workforce, however concerns were raised at how this sector of the workforce is supported including the need for different levels of support across different levels of experience, much like how clinicians are supported based on their skills and experience.

The MHCC annual survey also identified that CMO were finding it difficult to fill vacancies, particularly with psychiatrists, followed by psychologists and councillors. Reasons suggested for this include insufficient workers with relevant qualifications, can only offer short-term contracts and unable to offer competitive salaries (29). As PHN commission services within the CMO space, it is important to note that these challenges need to be taken into consideration for ongoing commissioning.

Service gaps within the workforce

Consultation with both external stakeholders, CESPHN staff and a community services survey have identified a number of service gaps within the workforce:

- Concerns that clinical current workforce shortages may be amplified as the number of psychiatrists and psychologists plan to retire in the next five years
- The lived experience workforce is a valuable resource but is currently underutilised or under resourced
- Psychologists are being attracted to more privately run services due to better working conditions. This reduces the amount of practitioners available for publicly funded/subsidised service. Also increase staff turnover, which increases the burden of training more staff and impacts continuity of care.
- There is a lack of Occupational Therapists to assist in Multidisciplinary Teams as most work withing the NDIS system.

- The workforce is either not supported or does not have steps in place to support vicarious trauma
- There is a high turnover of staff, and difficulty recruiting new staff with the right skills

CESPHN's current work

CESPHN is currently undertaking a large range of initiatives and commissioning to meet the needs of the community. These initiatives and services are described in the relevant sections throughout this chapter are listed below:

Low intensity services

- Medicare Mental Health Centres (MMHC)
- Emotional Wellbeing for Older Persons
- Your Coach Plus
- Support for communities impacted by the Israel/ Gaza, conflict

Mild to moderate services

- Cognitive Behavioural Therapy (CBT) Group for people with Autism Spectrum Disorder
- Emotional Wellbeing for Older Persons (EWOP)
- headspace
- Medicare Mental Health Centre
- Psychological Support Services (PSS)

High intensity services

- GP Mental Health Shared Care
- GP Mental Health Shared Care – Clozapine
- Youth Enhanced Services
- Medicare Mental Health Centre
- Primary Integrated Care Supports (PICS) Program
- Telehealth Psychiatry Service (TPS)

Psychosocial supports:

- Service Navigation for Psychosocial Support Services
- Yarning Circles
- Connect and Thrive.
- Keeping the Body in Mind
- Making Space
- Social Rx ®
- Growing Resilience -
- Active8 Physical Health and WorkWell Employment Support:
- WorkWell
- Connect with Healthy Minds and Bodies
- Older Person's Wellbeing Network

Opportunities to address health and service needs

- **Increased access to providers:** this can be achieved by expanding the mental health workforce, peer support workforce, and OTs.

- **Integrate mental health into primary health care:** this can help identify mental health issues early and allows for easier and more universal access to care
- **Establish integrated mental health hubs:** Allow for clients to access services to meet all of their recovery needs in one place
- Additional training and support for friends and families e.g., via approaches such as Open Dialogue.

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phn
CENTRAL AND
EASTERN SYDNEY
An Australian Government Initiative

SUICIDE PREVENTION

2025-2027 Needs Assessment

In this document we have used the terms Aboriginal, Aboriginal person and Aboriginal people/s when referring to Aboriginal and Torres Strait Islander peoples or people that identify as from the First Nations community. We chose Aboriginal because it is inclusive of different language groups and areas within the CESPHN region where this Needs Assessment will be used. There will be some instances where the terminology will be different to our preferred terms, as we use the terminology of the data set being used.

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Table of contents

List of tables

List of figures

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Content warning: The following chapter contains information about suicide that may be distressing. Please consider your wellbeing and reach out to services and supports as required.

Overview

Over 3000 suicides occur in Australia each year (1) and in 2022, there were 132 deaths by suicide within the central and eastern Sydney region. According to the Australian Institute of Health and Welfare, suicide is the leading cause of death for young people (1).

Key issues

- Individuals in the 0-24 year age group had the highest proportion of self-harm hospitalisations in the CESPHN region (41.2%), followed by 25-44 year-olds (29.2%)
- High rates per 100,000 of suicide in older people aged 80+

Key gaps

- Primary care professionals identify a lack of appropriate services, including barriers to accessing acute services, to support/refer individuals at risk of attempting suicide
- Primary care professionals face challenges in identifying individuals at risk of attempting suicide

Social determinants and risk factors

A multitude of social determinants and individual risk factors contribute to how suicidal thoughts and behaviours and ultimately, suicide might arise as outlined below:

Social determinants include:

- Macroeconomic policies (e.g., taxation policies and austerity measures)
- Public policies (e.g., policies that limit the consumption of alcohol)
- Social policies (e.g., active labour market policies and housing policies)
- Legislative or regulatory frameworks (e.g., firearm ownership laws and online regulatory frameworks)
- Healthcare coverage and health system capacity and responsiveness (e.g., workforce constraints and waiting lists)
- Local environment (e.g., rural or remote location, neighbourhood deprivation and availability of means of suicide)
- Cultural and societal values (e.g., colonisation, racism, discrimination and views of, attitudes towards, and communication and suicide and self-harm)
- Social cohesion and social capital

Commercial determinants include:

- Firearm, pesticide, alcohol and gambling industries

Individual risk factors include:

- Demographic factors (e.g., age, sex, gender identity, sexual orientation, ethnicity and cultural heritage)
- Socioeconomic factors (e.g., education, employment, occupation and income)

Other risk factors include:

- Contextual factors (e.g., stressful life events; job insecurity; homelessness; housing; bereavement by suicide; lack of family support; adverse early life experiences; trauma

including intergenerational trauma; exposure to conflict, violence, and war; involvement with the criminal justice system; and access to means used for suicide)
- Clinical factors (e.g., mental illness drug and alcohol use, previous episodes of self-harm and chronic physical illness)
- Personality-based factors (e.g., impulsivity, impressionability, and coping style)
- Genetic or familial factors (e.g., family history of suicide)
- Neurobiological factors (e.g., DNA methylation)

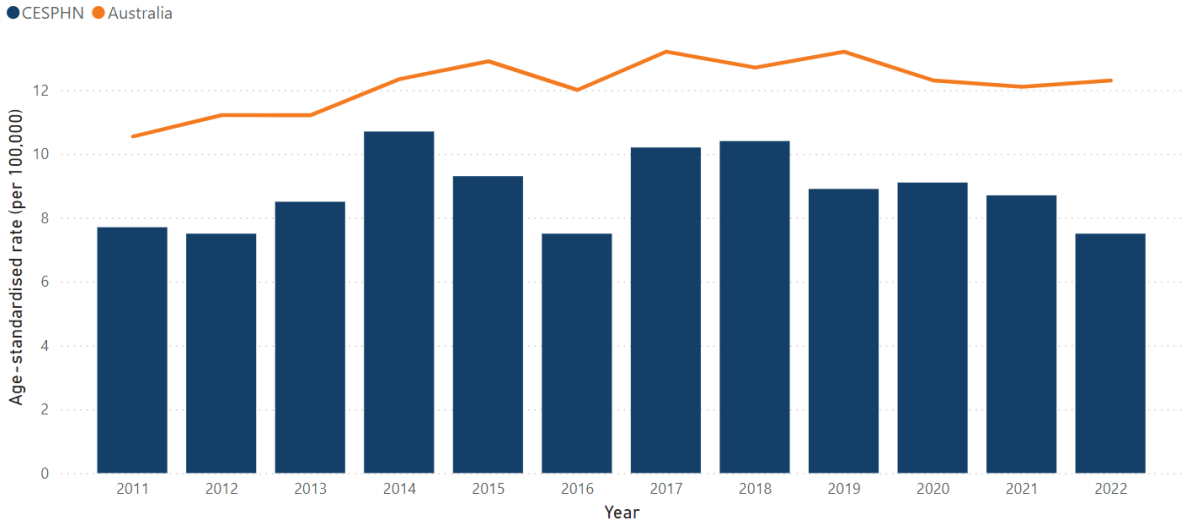
For those bereaved by suicide, the health impacts can be significant and can include further suicidality, complicated grief, PTSD, depression, and substance use disorders (2).

Prevalence of suicide and intentional self-harm

Suicide

Suicide rates in the CESPHN region fluctuate across time with no overt upwards or downwards trend.

Figure 1: Suicide rate per 100,000 population, CESPHN region, 2011 – 2022



Source: AIHW, 2024

Suicide data for 2018-2022 shows that Sydney Inner City SA3 had the highest rate of suicide within the CESPHN region (13.6 per 100,000 population) with rates higher than both NSW (11.1 per 100,000 population) and Australia (12.4 per 100,000 population), followed by Marrickville -Sydenham-Petersham SA3 (11.6 per 100,000 population) and Leichhardt SA3 (11.3 per 100,000 population) (3).

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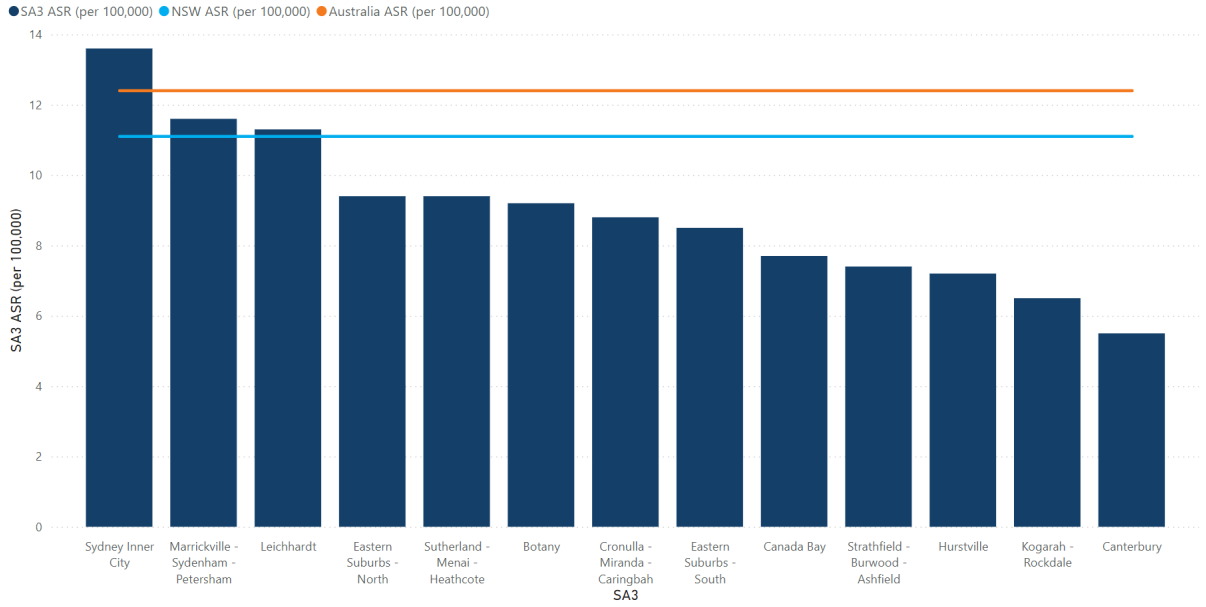
Figure 2: Suicide rate by SA3, 2018-2022



Source: AIHW, 2024

The NSW Suicide Monitoring System reported 940 suspected or confirmed deaths by suicide in NSW in 2023 (4). Monthly frequency data ranges from 92 suspected or confirmed deaths in July to 66 suspected or confirmed deaths in February.

Suicidal thoughts and self-harm behaviours

The National Study of Mental Health and Wellbeing (NSMHW) report provides modelled estimates for both suicidal thoughts and self-harm behaviours. Suicidal thoughts and behaviours in the NSMHW report refer to whether a person had ever seriously thought about taking their own life, made a plan to take their own life, or attempted to take their own life, and whether they had done so in the last 12 months. A person must have said they had seriously thought about taking their own life to be asked if they had made a plan and/or attempt (5).

In 2020-2022, 2.2% of people aged between 16-85 years in the CESPHN region had experienced suicidal thoughts and behaviours in the previous 12 months. This is below the state and national rates of 2.9% and 3.3% respectively. At a national level, 74.9% of people who had reported any suicidal thoughts or behaviours in the last 12 months also had reported having a mental health disorder in the last 12 months.

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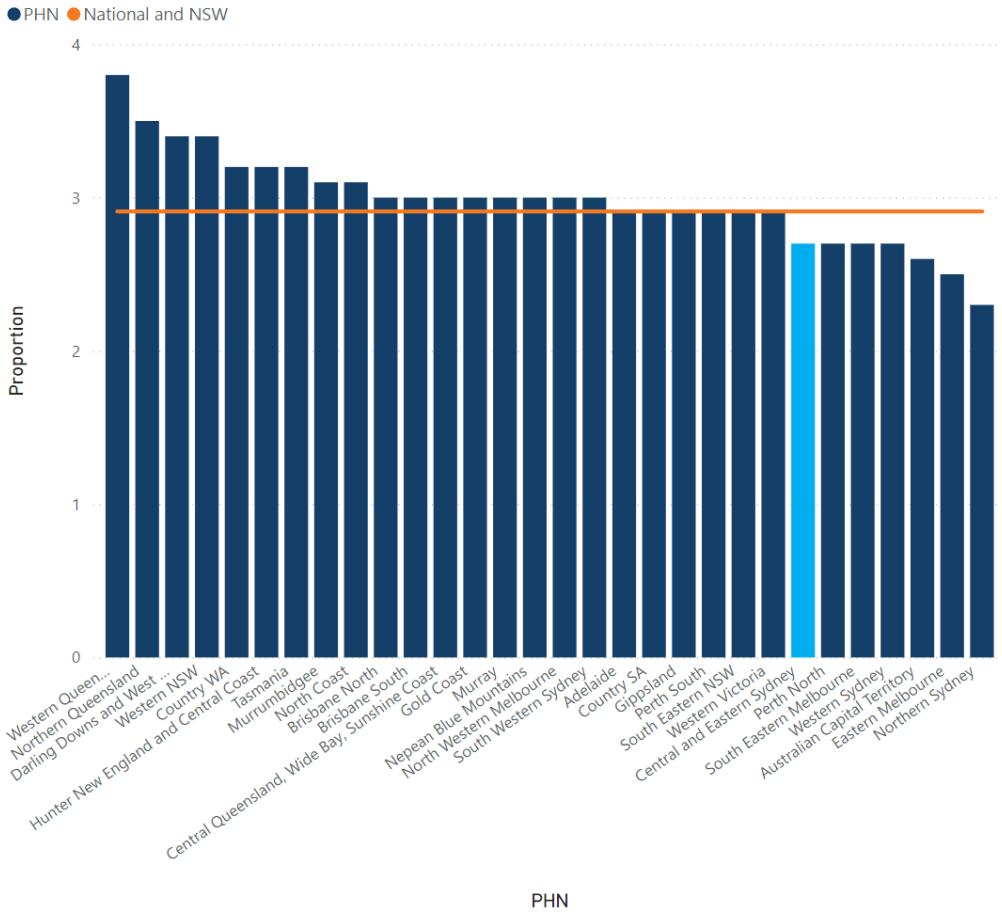
Figure 3. Suicidal thoughts and behaviours in the last 12 month by PHN, 2020-2022



Source ABS, 2024

Within the CESPHN region, the modelled rate of suicidal thoughts and behaviours in the last 12 months is higher in females than males. Modelled rate of suicidal thoughts and behaviours in the last 12 months are highest in young people aged 16-24 years (5.4 per 100 population) with a decline in every age range until 74-85 years where there is an increase (2.0 per 100 population) from 1.7 per 100 population in the 65-74 years.

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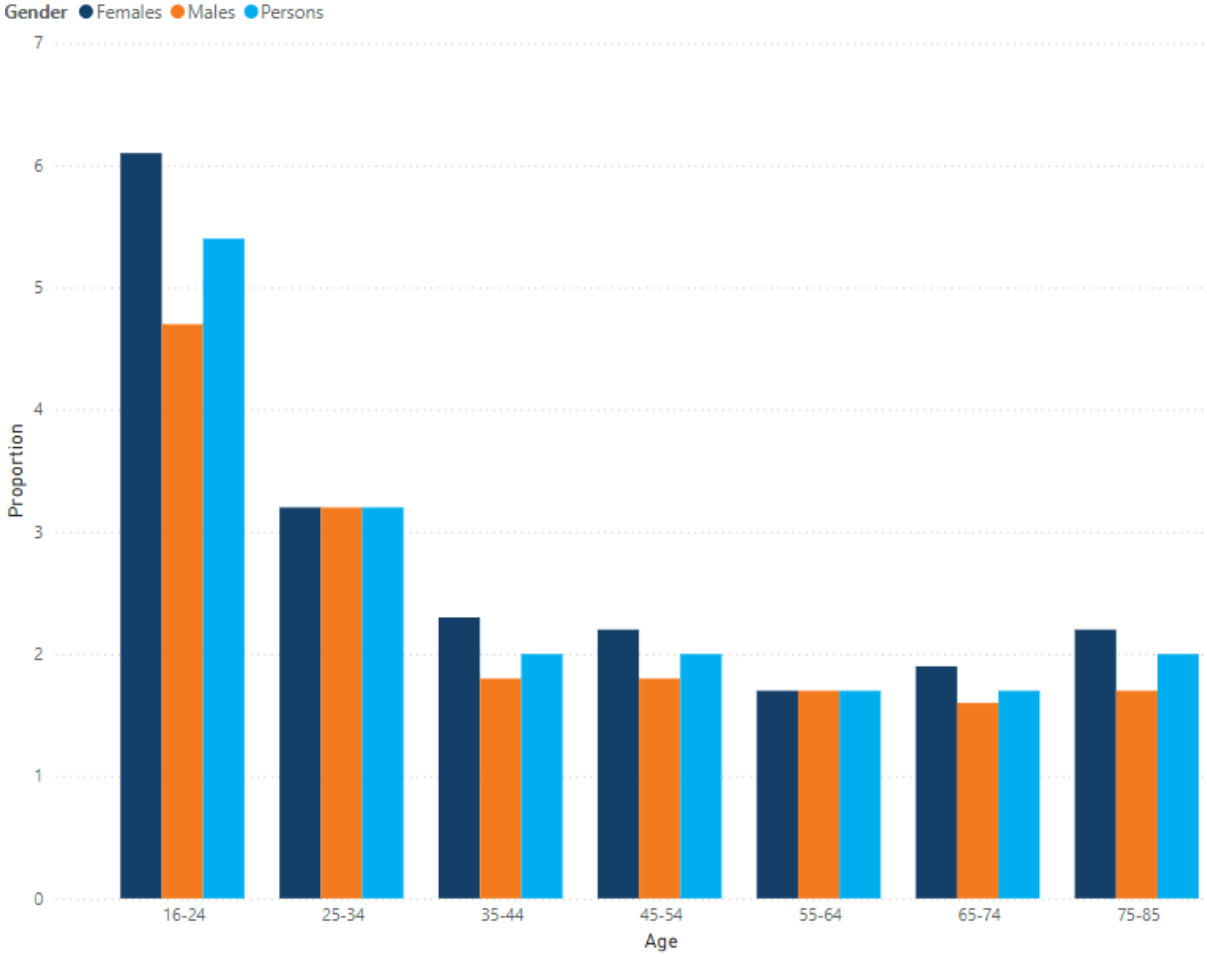
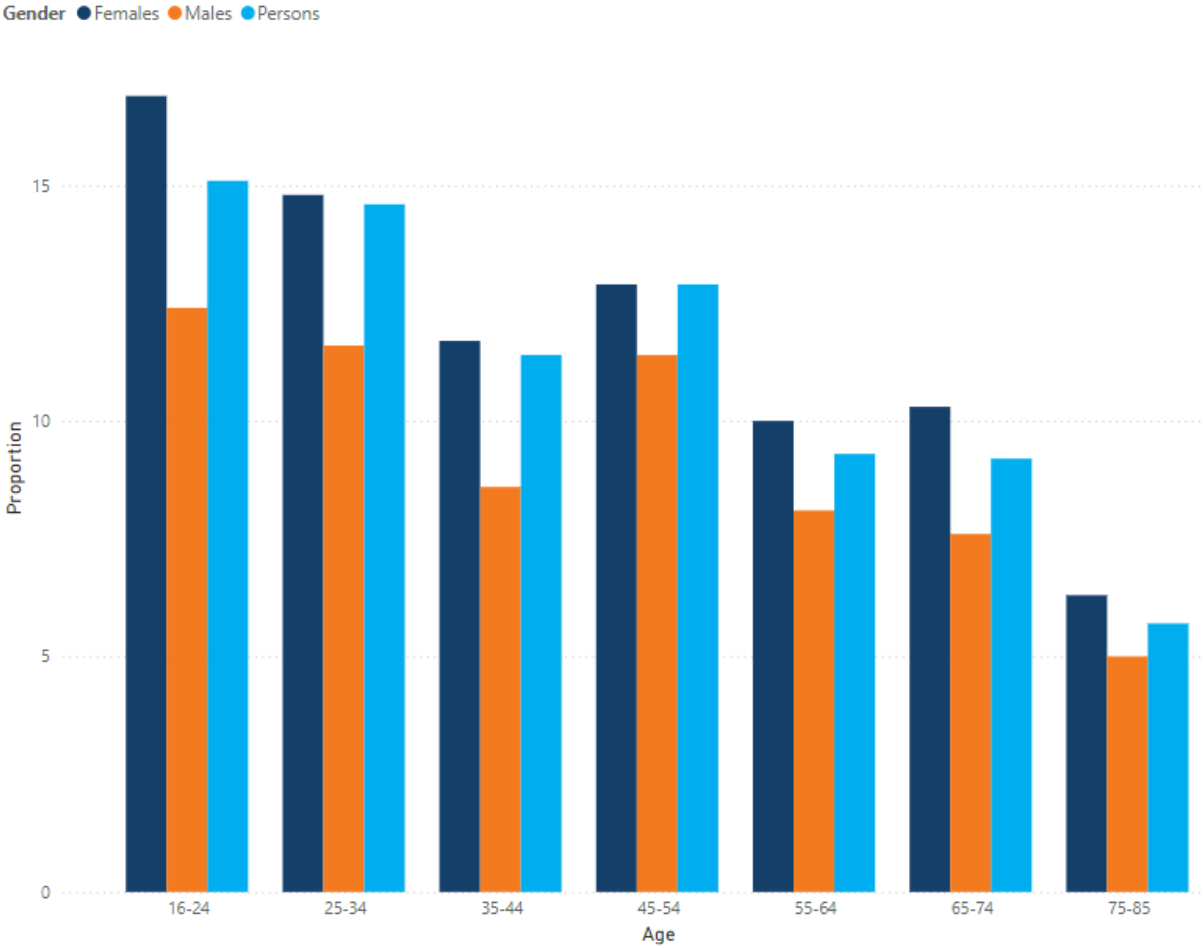
Figure 4: Suicidal thoughts and behaviours in the last 12 month by age and sex, 2020-2022



Source: ABS, 2024

Figure 5: Suicidal thoughts and behaviours by lifetime, by age and sex, 2020-2022



Source: ABS, 2024

Intentional self-harm behaviours

In 2020-22, modelling indicated that 1.7% of the CESPHN population aged 16-85 years displayed self- harm behaviours, which is defined as intentionally causing pain or damage to their own body (5). This behaviour may be motivated as a way of expressing or controlling distressing feelings or thoughts. Self-harm and suicide are distinct and separate acts although people who self-harm are at an increased risk of suicide (6). Due to the way the data is categorised and collected, there is no distinction in the data between intentional self-harm and suicide attempts. It is therefore impossible to accurately quantify suicide attempts. An awareness of this challenge should apply when interpreting the data. In the previous 12 months CESPHN had the 17th highest rate of self-harm behaviours across PHNs nationally.

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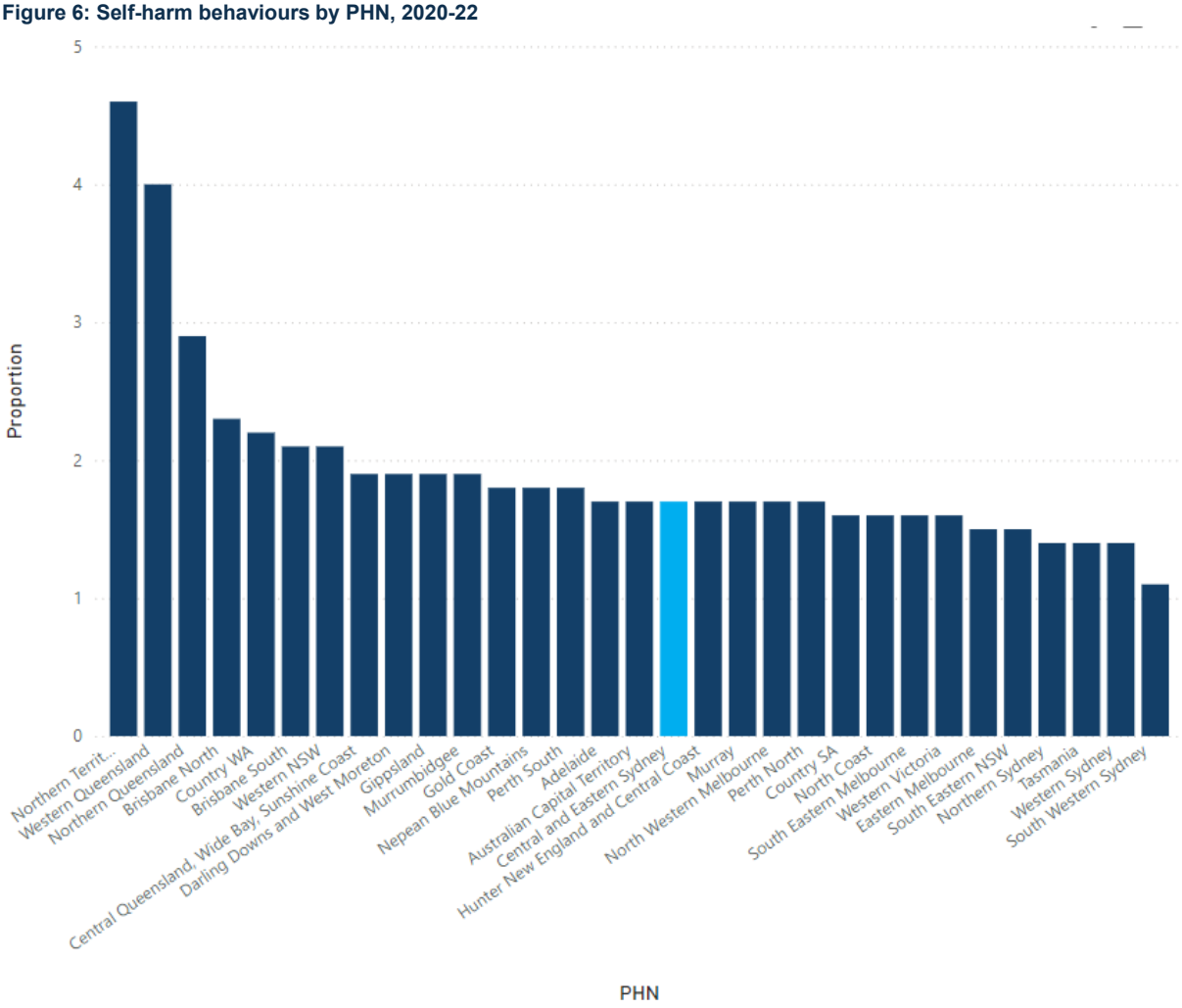
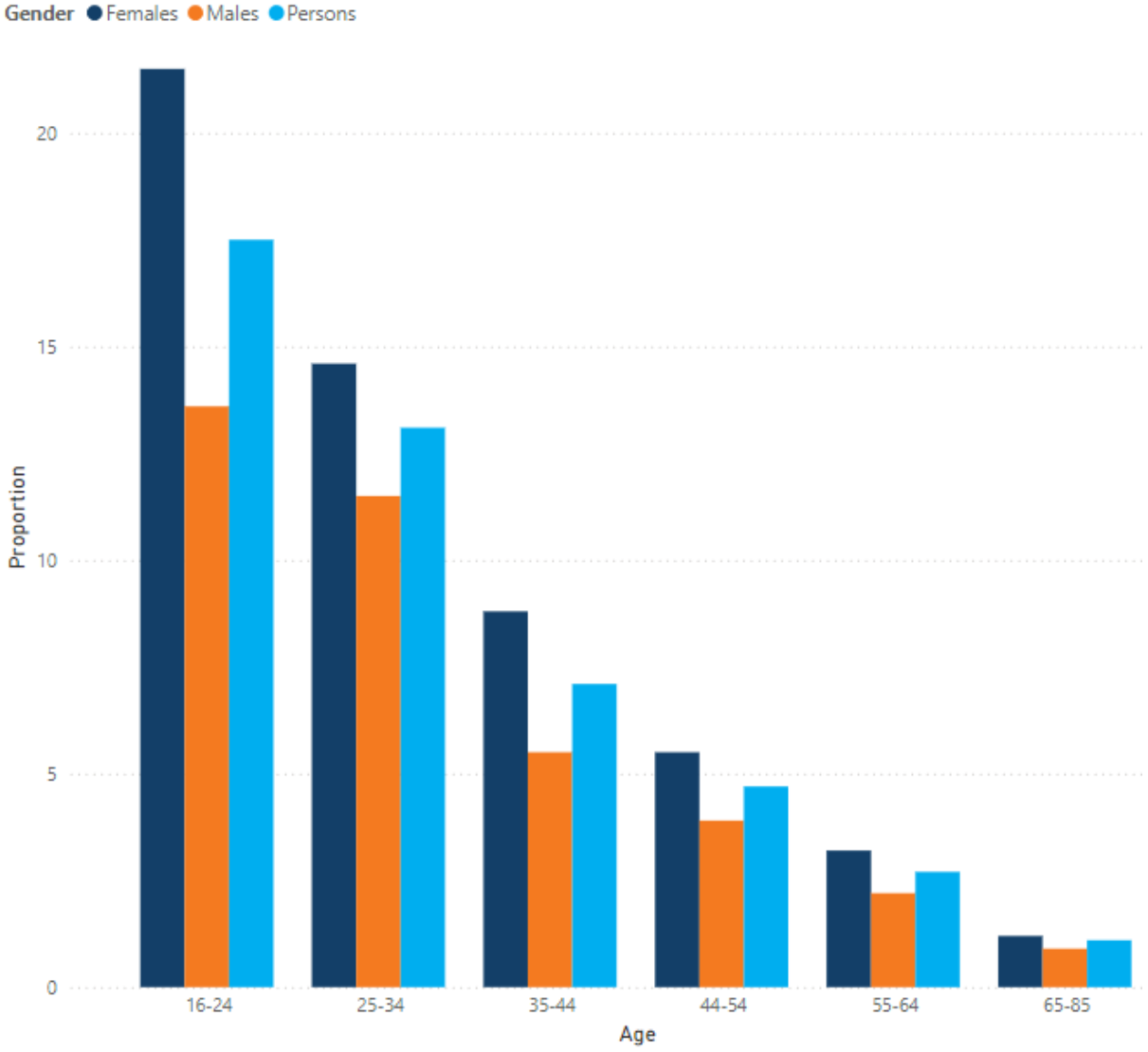
Figure 6: Self-harm behaviours by PHN, 2020-22



Source: AIHW, 2024

Within the CESPHN region, the modelled rate of self-harm behaviours (including both intentional self-harm and suicide attempts) in the last 12 months is higher in females than males. This is also consistent across the self-harm behaviours over a lifetime. Modelled rates of self-harm behaviours in the last 12 months are highest in young people aged 16-24 years (5.4 per 100 population, compared to the total population (1.7 per 100 population). Over a lifetime, 17.5% young people aged 16-24 years have displayed self-harm behaviours, compared to 8.1% of the CESPHN population aged 25-85 years.

Figure 7: Rate of Self Harm behaviours in the CESPHN region by lifetime by age and gender



Source: ABS, 2024

Intentional self-harm hospitalisation

In 2022-23, there were 900 intentional self-harm hospitalisations (which include both intentional self-harm and suicide attempts) in the CESPHN region giving a rate of 57.9 per 100,000 population, down from 71.1 per 100,000 in 2019-20. This is lower than both the NSW and national rates (62.2 per 100,000 population and 95.2 per 100,000 population respectively).

Across CESPHN, 61% of self-harm hospitalisations in 2022-23 were for females (7).

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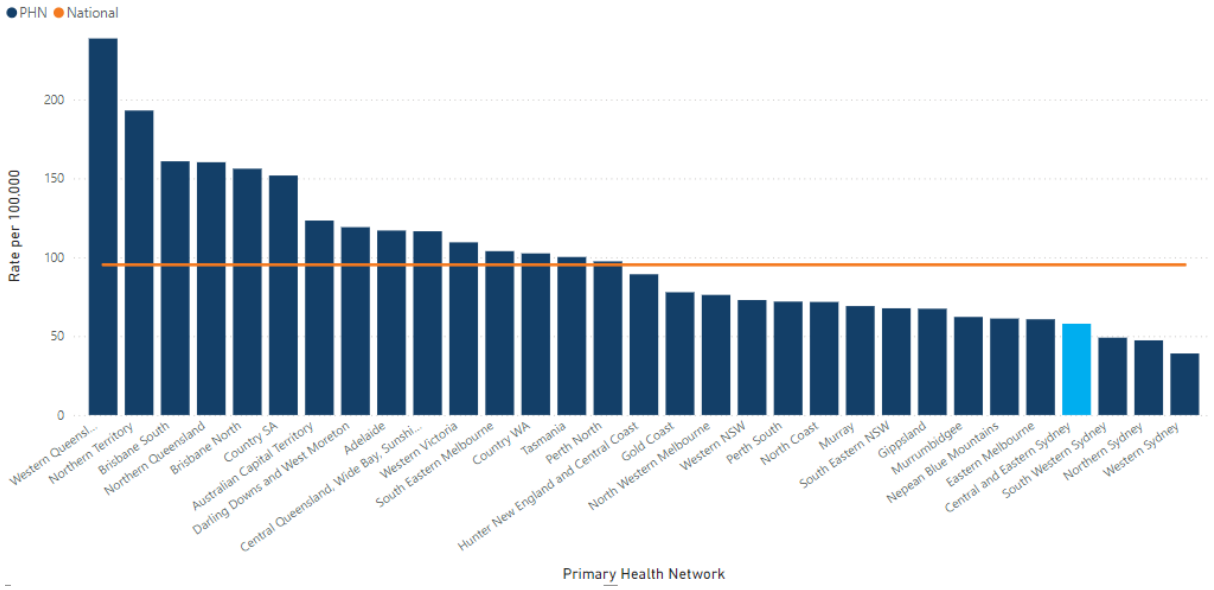
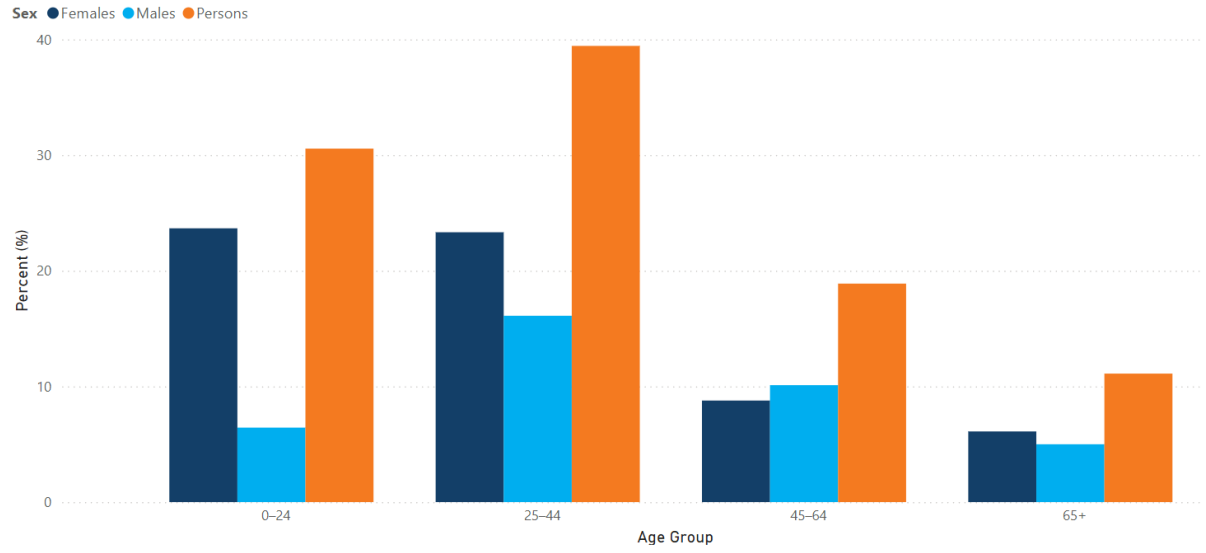
Figure 8: Self harm rate by PHN, 2022-23



Source: AIHW, 2024

Individuals in the 25-44 age group had the highest proportion of individual self-harm hospitalisations in the CESPHN region (39.4%), followed by 0–24-year-olds (30.6 %). This is a shift from 2021-22 where 0-24 year age group had the highest proportion of individual self-harm hospitalisations in the CESPHN region (41.2%), followed by 25-44 year-olds (29.2%) (7).

Figure 9: Intentional self-harm hospitalisations by age group and gender, CESPHN, 2022-23



Source: AIHW, 2024

Females in the Leichhardt SA3 had the highest intentional self-harm hospitalisation rates (150.9 per 100,000 population) within the CESPHN region, followed by Sydney Inner City SA3 (128.8 per 100,000 population). Across all SA3s, females had higher rates of intentional self-harm hospitalisations than males (7).

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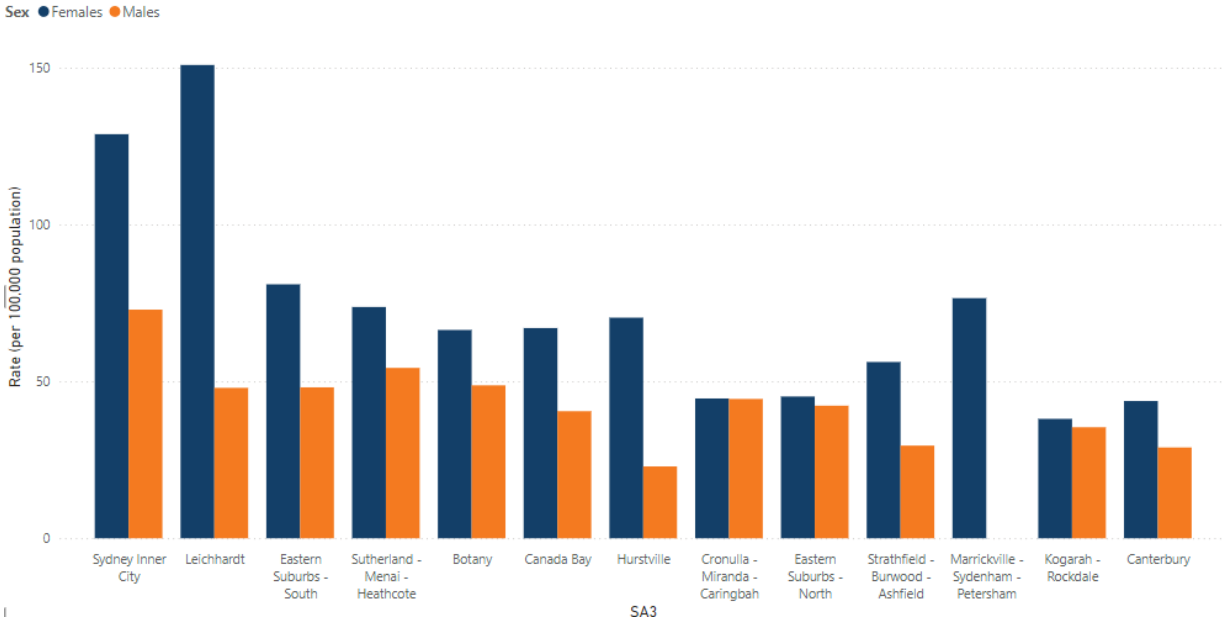
Figure 10: Intentional self-harm hospitalisations rate by sex, by SA3, 2022-23



Source: AIHW, 2024

Means restriction

Restriction of means of suicide plays an important role in reducing suicides. Whilst this is not the focus of suicide prevention activities for CESPHN, important data on suicide means is available at the Australian Institute of Health and Welfare website. Discussion of suicide means and methods has not been included in this Needs Assessment due to the documented risk of contagion.

Groups disproportionately affected

Aboriginal and Torres Strait Islander people

- Nationally in 2023, the rate of suicide in Aboriginal and Torres Strait Islander peoples has increased to 30.8 per 100,000 people from 23.6 per 100,000 people in 2018. This is the highest rate in the last five years and represents an increase of about 30% (8).
- By comparison, in 2023, the suicide rate across all Australians was 12.1 per 100,000 population.

Children and young people

Nationally, suicide is the leading cause of death in young people aged 15-24 years. In 2022:

- 304 Australian young people (aged 18–24 years) took their own lives
- 77 deaths by suicide occurred among children and adolescents (aged 17 and below) with the majority occurring in those aged 15–17 (83.1%)
- Deaths by suicide represented 30.9% of all deaths in young people aged 15–17 years and 32.4% of all deaths in those aged 18–24 years—up from 16.5% and 23.9% respectively of all deaths in these age groups in 2001.

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Suicide among humanitarian entrants and other permanent migrants

Whilst multicultural communities who include refugee, humanitarian entrants and other permanent migrants have varied experiences, they may also have some shared experiences that contribute to suicide risk factors. These include difficulties adjusting to a new culture, experiences of stigma, and changes in social and family networks a result of migration (9). Australians from multicultural backgrounds who are refugees or humanitarian entrants may experience additional or more pronounced challenges due to past experiences of persecution or human rights abuses within their country of origin, or trauma associated with war or their refugee journey (9).

Amongst humanitarian entrants who arrived on or after 2000:

- Between 2007 and 2020, the Age-standardised rate (ASR) of death by suicide was 6.7 per 100,000.
- This was higher in males (11.0 per 100,000) than in females (3.0 per 100,000) (9)
- The ASR increased with increased time since arrival in Australia (4.2 deaths per 100,000 person-years for less than 5 years since arrival, 7.3 per 100,000 person-years for 5–10 years since arrival, 11 per 100,000 person-years for more than 10 years since arrival.

Amongst other permanent migrants who arrived on or after 2000:

- Between 2007 and 2020, the ASR of death by suicide is 4.0 per 100,000
- This was higher in males (5.8 per 100,000) than in females (2.3 per 100,000)
- The ASR increase with increased time since arrival in Australia (2.6 deaths per 100,000 person-years) for less than 5 years since arrival, 2.6 per 100,000 person-years for 5–10 years since arrival, 11 per 100,000 person years for more than 10 years since arrival.

This data highlights the difference between the two migrant groups, with humanitarian entrants having higher rates. No specific data is available on refugee status within the National Mortality Database or the National Hospital Morbidity Database

LGBTIQ+ peoples

There is no local national dataset that captures suicide or intentional self-harm rates amongst the whole LGBTIQ+ community. However, research has been undertaken through two surveys which provide aggregated data by state/territory, age-group, gender and sexual orientation. These surveys, Private Lives 3 (PL3) and Writing Themselves In 4 (WTI4) were both undertaken in 2019 and target LGBTQ+ adults and LGBTQA+ young people. Both surveys form part of the 2024 Rainbow Realities report, commissioned by the Department of Health and Aged Care to inform the National LGBTIQ+ strategy. This report is discussed in more detail in the LGBTIQ+ chapter.

The PL3 survey found that for suicidal thoughts

- 75% of people from the LGBTQ+ community in NSW reported having experienced suicidal thoughts in their lifetime
- 91% of trans men nationally reported having experienced suicidal thoughts in their lifetime
- 90% of non-binary people nationally reported having experienced suicidal thoughts in their lifetime
- 86% of trans women nationally reported having experienced suicidal thoughts in their lifetime

The PL3 survey also found that for suicide attempts:

- 28% of people from the LGBTQ+ community in NSW reported having attempted suicide
- 53% of trans men nationally reported having attempted suicide
- 46% of trans women nationally reported having attempted suicide
- 40% of non-binary people nationally reported having attempted suicide

The WTI4 survey of lesbian, gay, bisexual, trans and gender diverse, queer and Asexual (LGBTQA) young people, aged 14 to 21 years found that:

- 79.6% of participants in NSW had experience of suicidal thoughts
- 49.2% of participants in NSW had experience of a suicide plan
- 26.2% of participants in NSW had experience of suicide attempt
- 62.4% of participants in NSW had experience of self-harm
- 92.1% of trans men, 90.7% of trans women and 87.5% of non-binary people had experience of suicidal thoughts
- 73.2% of trans men, 61.3% of trans women and 58.4% of non-binary people had experience of suicide plan
- 46.9% of trans men, 40.0% of trans women and 34.8% of non-binary people had experience of suicide attempt
- 85.8 % of trans men, 68.0% of trans women and 76.1% of non-binary people had experience of self-harm
- Over 80% of pansexual (84.8%), Queer (83.1%), and lesbian (81.5%) peoples had experience of suicidal thoughts
- Over 50% of pansexual (57.2%), Queer (53.8%), and lesbian (50.1%) peoples had experience of suicide plan
- Over 30% of pansexual (35.1%), Queer (30.0%), and lesbian (30.0%) peoples had experience of suicide attempt
- Over 60% of pansexual (74.3%), Queer (70.8%), lesbian (68.4%), and bisexual (62.8%) peoples had experience of self-harm
- Cisgender men and cisgender women had lower rates across every measure (10).

Further groups disproportionately impacted by suicide

Additional priority population groups identified in the Department of Health and Aged Care's Program Guidance for Targeted Regional Initiatives for Suicide Prevention are:

- Aboriginal and Torres Strait Islander peoples
- LGBTQIA+SB people
- Culturally and linguistically diverse communities and refugees
- People experiencing homelessness or housing instability
- Children and young people, including those in out-of-home care
- Older Australians (over 65, or over 50 for Aboriginal and Torres Strait Islander peoples)
- People living in regional, rural and remote areas of Australia
- People experiencing or at risk of abuse and violence, including sexual abuse, neglect and
- family and domestic violence
- People with a disability
- Australian Defence Force members and veterans
- People experiencing socioeconomic disadvantage
- People who are (or were previously) in contact with the criminal justice system
- People with complex mental health needs, including people with co-occurring mental health
- and cognitive disability and/or autism.
- People with harmful use of alcohol or other drugs, or people with substance use disorders

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- People who have made a previous suicide attempt or who have been bereaved by suicide.

Suicide and self-harm prevention services

Within the CESPHN region, extensive work has been undertaken to map out suicide prevention services across the region. These include services that are commissioned by CESPHN as well as services funded by other organisations include state government and local health districts. Services in the region have been categorised into six different categories all of which have a distinct purpose.

1. Crisis support and aftercare services
2. Treatment and support services for people experiencing suicidality or distress
3. Community awareness, mental health literacy and resilience
4. Joint governance and system change
5. Health and other frontline services
6. Community capacity building.

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SUICIDE PREVENTION

Table 1: Suicide prevention services, CESPHN region

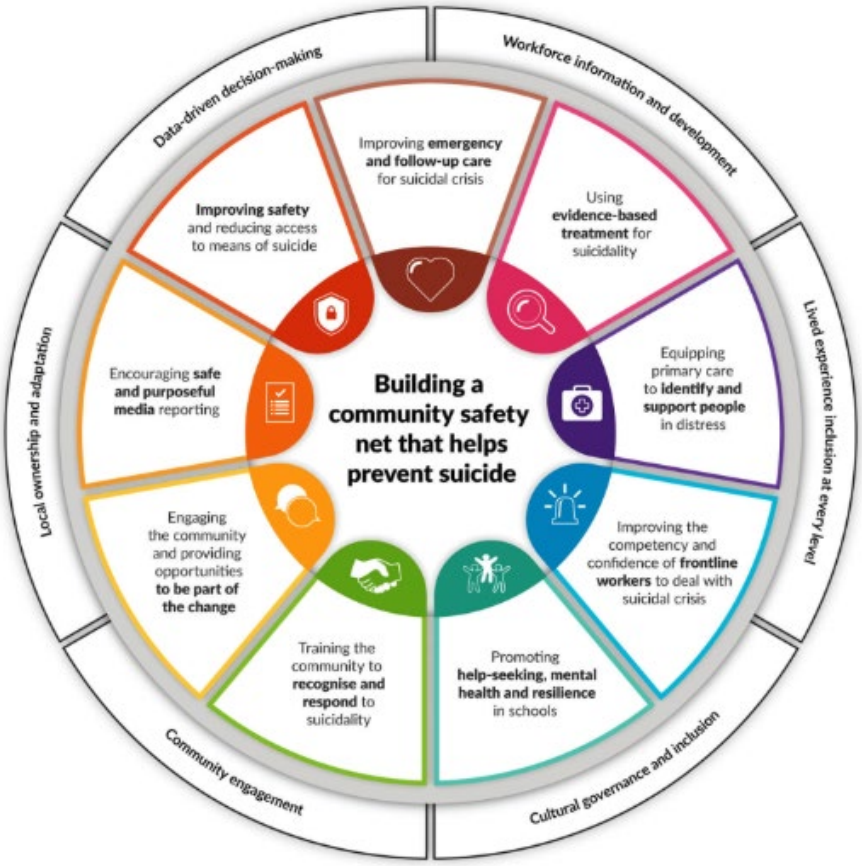
Crisis support and aftercare	Treatment and support services for people experiencing suicidality or distress	Community awareness, mental health literacy and resilience
Zero Suicides in Care initiative The Way Back NSW Crisis lines (Lifeline, Suicide Call Back, 13 YARN) Acute Care Teams in hospitals ACON SP Aftercare Support Service Support lines - Kidshelpline, Qlife, Mensline, eheadspace CAMHS [Child and Adolescent Mental Health Service] Canterbury Medicare Mental Health Centre NSW Mental Health Line SafeGuards team (0-17 years) Safe Havens StandBy Support After Suicide Suicide Prevention Outreach Teams PACER – Police, Ambulance, Clinical, Early, Response Thirrili Indigenous Suicide Postvention Service	Psychological Support Services (PSS) Suicide Prevention Services [CESPHN] Head to Health Centre (Canterbury) headspace centres Tribal Warrior Connector Service Support groups (e.g., Alternatives to Suicide; Gender Centre) Support Groups; local council social groups) Social Prescribing Models Your Coach Plus delivered by PCCS Babana Aboriginal Mens Group Digital tools and apps (e.g.,WellMob, Beyond Now)	Suicide Prevention Australia Doing It Tough website Babana community awareness days and yarning circles Heal Our Way campaign headspace centres and beyondblue Be You outreach programs into schools Community engagement programs run by local councils (e.g. youth groups, gardens, clubs, activities for older people) World Suicide Prevention Day, R U OK Day (Sep) and Mental health month activities (October) HERE, ACON's LGBTQ+ Suicide Prevention Digital Hub UrHere, social media campaign by Wellways STOP campaign for SESLHD Promotion of Mindframe guidelines
Joint governance and systems change	**Health and other frontline services**	**Community capacity-building**
Inner West Suicide Prevention Collaborative St George Suicide Prevention Collaborative Establishment of Eastern Suburbs Suicide Prevention Collaborative	Black Dog Institute Suicide Prevention Training for GPs HETI Mental Health Training for GPs Vicarious trauma training for youth mental health providers Mandatory training for PHN-contracted Suicide Prevention Services (SPS) providers Suicide Prevention Training in Systems Outside of Mental Health Anglicare older people gatekeeper QPR training	Suicide Prevention for Seniors training (Anglicare) Workplace Mental Health Coaching

Source: Adapted from Beacon Strategies Report: Targeted Regional initiatives in Suicide Prevention (TRISP) Consultation and Co-Design for CESPHN, October 2023

The system's approach to preventing suicide

To support the community at a local level, a systems approach should be used. Lifespan is an integrated framework for suicide prevention that combines nine strategies that have evidence for suicide prevention into one community-led approach.

Figure 11: Lifespan framework



Source: Black Dog Institute 2020

Implementing a systems-based approach is highly complex and requires strong local partnerships and community buy-in. Strategically planned, well-resourced stakeholder engagement, community consultation and genuine co-design with adequate timeframes to build and maintain relationships and community trust are essential to the successful implementation of systems-based suicide prevention (11).

Between 2016-17 and 2020-21 the Department of Health and Aged Care undertook the National Suicide Prevention Trial across 12 PHN sites. This trial was then evaluated with the findings implemented across all PHN regions across Australia by the Targeted Regional Initiatives for Suicide Prevention (TRISP) funding. In 2023, CESPHN commissioned Beacon Strategies to undertake a consultation and co-design project under TRISP.

The consultations and lived experience interviews identified the following areas of need:

1. Strengthen the **services that already exist** to make them more effective in responding to people's needs and preferences — particularly around being flexible, effective, compassionate and inclusive.
2. Increase **awareness** about what services and supports are available, what someone might expect when accessing them and who can help with navigating the system.
3. Easier **access** to the right type of services and supports, in the right place, at the right time — particularly pathways so people don't have to present to a hospital and can avoid barriers like eligibility criteria, travel and cost.
4. Acceptance and promotion of **non-clinical services** and approaches that focus on assisting people through the situations or difficulties that cause distress.
5. Increased engagement of people and groups in the community who have limited supports in place or experience **barriers to seeking help** based on their circumstances, identity or background — particularly making existing services more culturally appropriate for people from culturally diverse backgrounds and Aboriginal communities.
6. Increase effective **community engagement** to create support mechanisms outside of professional services (e.g. schools, workplaces), to reduce stigma in how people communicate about suicide, and train community gatekeepers to identify and respond to people in distress.
7. Effective mechanisms of **local collaboration, governance and networking** to plan and take collective action on suicide prevention.
8. Better engagement and involvement of people with **lived experience** centrally within the suicide prevention system, including more peer support.
9. Increase support to the suicide prevention **workforce to build the capacity, capability and confidence** to respond to people in distress, and to provide the training and professional support they need and have an increased tolerance of 'risk'.

In response to the identification of the above, CESPHN co-designed and commissioned a suite of initiatives and services throughout 2023-24 to address unmet needs with the aim of decreasing suicide in the region.

Further consultation with CESPHN staff in 2024 has identified additional areas of need. These needs are both systems-level and service delivery needs. System level needs include:

1. Increased recognition that systemic issues are causing suicidal distress and attempts and the roles that holistic support can play to reduce this. Examples of systemic issues include but are not limited to:
    - being under financial distress or instability
    - experiences of racism
    - experiences of domestic and family violence
    - homelessness
    - LGBTIQ+ discrimination
2. More research needs to be undertaken on female suicide attempts and intentional self-harm. The data we have shows higher levels of deaths by suicide in males due to the lethality of means males use on average in comparison to females. However, the data also show that females attempt suicide and engage in intentional self-harm at a higher rate than males.
3. Further work needs to be undertaken in the multicultural space that recognises individual disparate cultural needs, including the needs of refugees and the impact of trauma on these communities

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4. Continual reviewing, improvement, availability and communication of information about available services and how to navigate them for service users, their carers and people working across the system
5. Increased service integration to improve interface between primary care (particularly GPs) and acute/crisis mental health services.

Service level needs include:

1. An increase in publicly funded Dialectical behaviour therapy (DBT) therapy to build skills that don't require a diagnosis or admission into a broader program, and ideally located in community locations
2. Increased affordable accessibility to general practitioners. A reduction in bulk billing at general practices has decreased access to GPs and has impacts on both the creation and maintenance of Mental Health Care Plans.
3. Continued co-location of CESPHN funded Psychological Support Services (PSS) within culturally safe and engaging environments
4. Recruiting clinicians working in PSS who are capable and comfortable working with a person who is suicidal and across a range of presentations (e.g. clinical, trauma, situational stressors).

Workforce

The clinical workforce that works to support people experiencing suicidality is the mental health workforce. A detailed analysis of the composition of this workforce can be found in the mental health chapter of the Needs Assessment.

The non-clinical suicide prevention workforce consists of non-clinical community or support workers and the suicide prevention lived experience workforce. There has been significant focus on the lived experience workforce in recent years, as emerging research has evidenced the benefits of interventions from lived experience or peer workers.

Relevant documents demonstrating the importance and relevance of suicide prevention lived experience workforce, and the need to support its development, include the following:

- Draft Advice on the National Suicide Prevention Strategy (12)
- The National Mental Health Commission National Lived Experience (Peer) Workforce Development Guidelines (13)
- LELAN Lived Experience Leadership for Organisation and System Change: A scoping review of concepts and evidence (14)
- Leading the Change, A Toolkit to Evaluate Lived Experience Inclusion and Development, Mental Health Commission of NSW (15)
- Roses in the Ocean's Suicide Prevention Peer Workforce paper (16)

CESPHN currently commissions the Suicide Prevention Lived Experience Workforce Development Initiative, enabling funding to be utilised for identified workforce development activities.

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Opportunities to address health and service needs

Evidence-based service improvement opportunities:

- Enhance data and clinical document sharing between service providers
- Increase awareness of available services to reduce hospital emergency admissions
- Provide bilingual or culturally appropriate services to address diverse needs
- Build capacity, capability and confidence of the workforce to respond to people in distress and have a higher tolerance of suicide “risk”

Promote suicide prevention education:

- Increase the community’s awareness of suicide prevention and what resources are available

Partnerships and engagement including with people with lived experience:

- Continue to partner with people with lived experience to gain further suicide prevention insights, reduce stigma and improve services.
- Continue facilitating the CES Suicide Prevention Working Group, focusing on promotion, prevention, postvention, pathways, and aftercare and maintaining a strong connection with key agencies.
- Support regional oversight and coordination of regional, state, and federal suicide prevention strategies, including the NSW Ministry of Health’s Towards Zero Suicides initiatives and the Department of Health and Aged Care’s Targeted Regional Initiatives for Suicide Prevention.

Workforce:

- Continue to jointly review and update the Mental Health and Suicide Prevention Training and Professional Development resource with regional partners.

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An Australian Government Initiative

USE OF ALCOHOL AND OTHER DRUGS

2025-2027 Needs Assessment

Table of contents

List of tables

List of figures

Overview

Substance use, (including tobacco, alcohol, and illicit drugs) accounts for 16.1% of the nation's disease burden, with 1 in 3 Australians aged 14 and over engaging in alcohol consumption that puts their health at risk. In 2022-2023, 47% of Australians reported having used illicit drugs at some point in their lives (1).

The consequences of substance use are broad and can impact (directly and/or indirectly) on all Australian communities, families and individuals. Health impacts can range from injury and chronic conditions to preventable diseases and mental health disorders. Socially, substance use can exacerbate crime, domestic violence, childhood trauma, and strain on the criminal justice system. Economically, it can impose significant costs through healthcare, law enforcement, and lost productivity.

Within the CESPHN region, the primary drugs of concern are methamphetamines, alcohol, cannabinoids, and heroin.

Key issues

- Illegal drug use in the CESPHN region is predicted to continue to increase
- Instances of reported drug dealing are increasing
- The CESPHN region has higher hospitalisation rates for alcohol compared to other regions
- Priority populations remain the most impacted by AOD use including
    - Aboriginal and Torres Strait Islander people
    - Multicultural communities
    - Young people
    - LGBTQI+ communities
    - People experiencing homelessness
    - Individuals in contact with the criminal justice system.

Key gaps

- Limited access to holistic support and care coordination, as well as a lack of pathways for patients navigating AOD services.
- Absence of specific AOD Medicare Benefits Schedule (MBS) items for general practitioners to track service use.
- A need for additional prescribers to transition patients from public Opioid Treatment Programs (OTP) to private care.
- Insufficient services for priority populations, particularly women and multicultural communities.
- A shortage of residential rehabilitation beds.
- High prevalence of co-occurring mental health and substance use concerns, with a need for further capacity-building initiatives.
- Limited access to culturally appropriate rehabilitation for Aboriginal participants.
- Workforce shortages and the need for ongoing training and development.

Opportunities

To address these gaps, opportunities for CESPHN include:

- Gauge sector willingness and capacity to re-establish an AOD and mental health working group to enhance collaboration across services.
- Support the increase in the number of general practitioners (GPs), nurse practitioners, and pharmacists trained to prescribe opioid treatments.
- Encourage co-location of services, leveraging nurse practitioners to improve accessibility.
- Support the upskilling of peer workers to expand the AOD workforce.
- Support a review and alignment of the AOD Minimum Data Set (MDS) with the Primary Mental Health Care (PMHC) MDS for more integrated service monitoring and improvement.

Prevalence

Drug and alcohol services planning model

The national Drug and Alcohol Services Planning (DASP) model predicts that for every 100,000 people in a broadly representative population:

- 8,838 will have an alcohol use disorder
- 646 will have a methamphetamine use disorder
- 465 will have a benzodiazepine use disorder
- 2,300 will have a cannabis use disorder
- 793 will have a non-medical opiate (including heroin) use disorder.

The table below translates these rates to the current and future populations (aged 10 years and over) of the CESPHN region (2). Higher prevalence rates are expected in areas that have higher than average numbers of people experiencing homelessness, people recently released from prison or people who identify as Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ).

Table 1: Estimated prevalence of drug disorders in the CESPHN region, 2023 and 2041

Drug disorder type	Standard rate (per 100,000 people)	2023 prevalence *	2041 prevalence **
Alcohol	8,838	142,480	150,562
Methamphetamine	646	10,414	11,005
Benzodiazepine	465	7,496	7,922
Cannabis	2,300	37,079	39,182
Non-medical opiate	793	12,784	13,509

*Sources: CESPHN 2020, *ABS 2024, **HealthStats 2022*

National drug strategy household survey

The National Drug Strategy Household survey asks people in Australia about their use and opinions of licit and illicit drugs. The most recent survey was conducted in 2022-23. Data for this survey is currently only available at a national level. It shows that nationally:

1 in 3 people (31%) drank **alcohol** in ways that put their health at risk

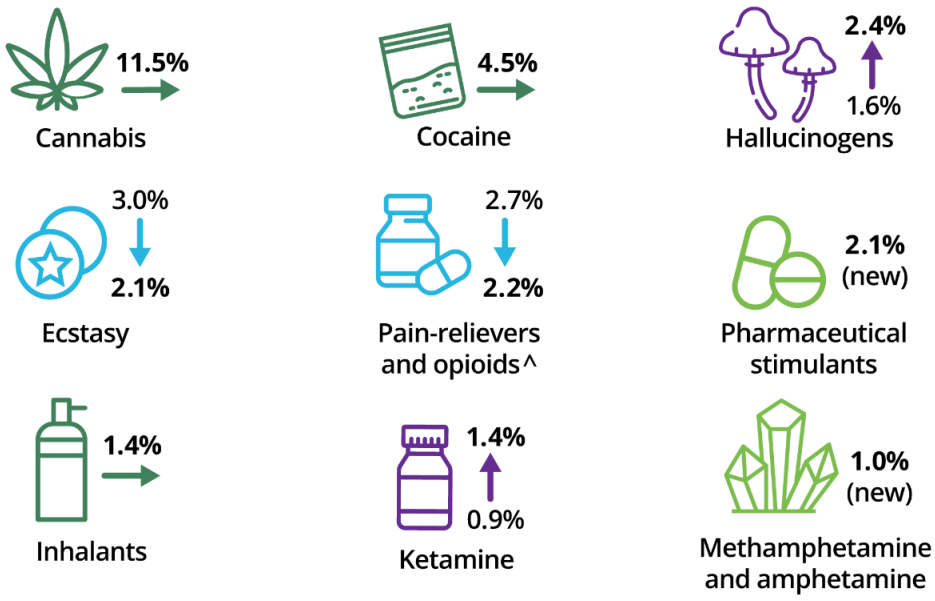
1 in 2 people (47%) have used an **illicit drug** in their lifetime, with **cannabis** being the most used (4.1%)[1]

1 in 5 people (17.9%) had used an **illicit drug** in the previous 12 months in 2022-23. The changes in recent illicit drug use can be seen in the figure below.

Source: AIHW, 2024

Additionally, the daily tobacco smoking rate has dropped from 11.0% to 8.3% from 2019 to 2022-23 and the use of electronic cigarettes and vapes had nearly tripled between 2019 (2.5%) and 2022-23 (7.0%) (1). Changes in illicit drug use from 2019 to 2022-23 saw increases in hallucinogens (1.6% to 2.4%) and ketamine (0.9% to 1.4%).

Figure 1: Changes to recent use of illicit drugs from 2019 to 2022-23



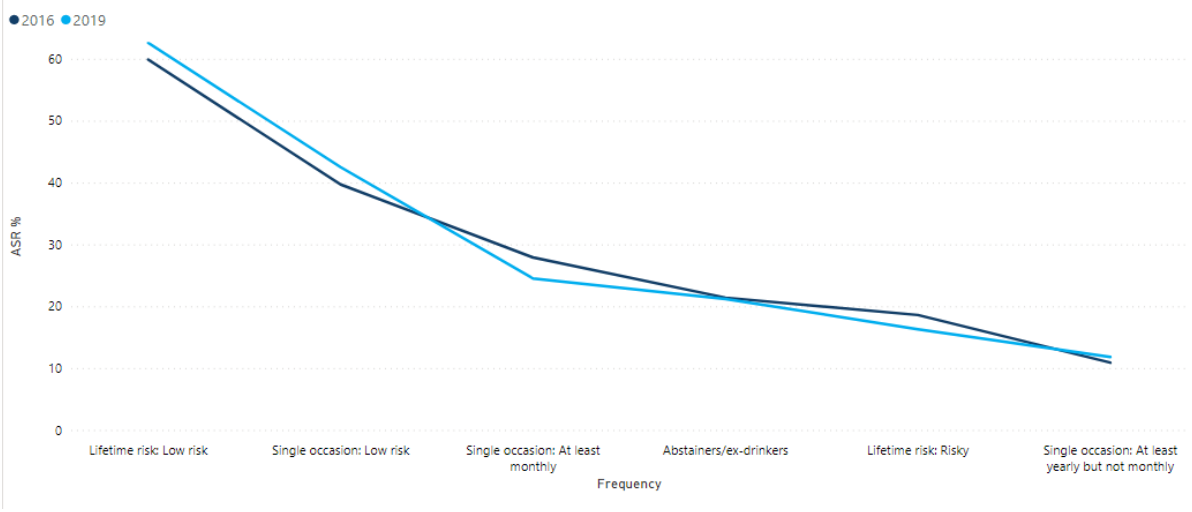
Source: AIHW 2024

The 2019 survey data is available at a PHN level. It showed that 24.5% of people aged 14 years and over in the CESPHN region drank at a risky level on a single occasion at least monthly, while 16.3%

exceeded the lifetime risk guideline. Since 2016, the proportion exceeding the single occasion risk and lifetime risk guidelines has declined slightly (27.9% and 18.6% respectively) (3).

The illicit drug use among people aged 14 years and over within the CESPHN region has declined from 22.0% in 2016 to 18.7% in 2019.

Figure 2: Alcohol consumption and risk, CESPHN region, 2016 and 2019



Source: AIHW 2019

Illicit drug reporting system

The Illicit Drug Reporting System (IDRS) is a national illicit drug monitoring system intended to identify emerging trends of local and national concern in illicit drug markets. The data is reported at national level as well as capital cities around Australia. The 2023 Sydney IDRS sample comprised 153 people aged 18 years or older who injected illicit drugs ≥6 days in the preceding six months and resided in Sydney (4).

Two thirds (67%) of the Sydney sample reported recent (i.e., past six month) use of heroin, the lowest per cent since monitoring commenced, although stable relative to 2022 (71%). Among those who reported recent use, almost half (47%) reported using heroin daily, also stable relative to 2022 (54%). The majority (86%) of the sample reported recent use of any methamphetamine in 2023, stable from 87% in 2022. Almost one quarter (23%) of the sample reported recent use of cocaine (16% in 2022). The use of methamphetamine has gradually been increasing while cocaine use has generally decreased since the beginning of monitoring. Two thirds (65%) of the Sydney sample reported non-prescribed cannabis and/or cannabinoid-related product use in the six months preceding interview in 2023 (72% in 2022), of which 56% reported daily use (57% in 2022). The most common non-prescribed pharmaceutical opioids recently used by participants were methadone (12%; 18% in 2022) and oxycodone (12%; 11% in 2022) (4).

Recent use of any new psychoactive substance was reported by 6% of participants, stable relative to 2022 (4% in 2022). One third (33%) of the Sydney sample reported recent use of any non-prescribed benzodiazepines, a significant increase from 21% in 2022.

The IRDS also identifies drug related harms and other behaviours:

- Almost two thirds (63%) of the sample reported using two or more drugs on the day preceding interview (excluding tobacco and e-cigarettes).
- Almost one fifth (17%) of the sample reported experiencing a non-fatal overdose in the 12 months preceding interview (20% in 2022), with 'any opioids' (12%) being the most common substance involved (14% in 2022).
- A significant decrease was observed in participants indicating awareness of naloxone in 2023 (81%; 95% in 2022; $p<0.001$)
- Five per cent of participants reported receptive needle sharing in the past month, stable relative to 2022 ($n\leq5$).
- One quarter (24%) of the sample reported having an injection-related health issue in the month preceding interview (28% in 2022), with significantly fewer participants reporting experiencing an artery injection in 2023 ($n\leq5$; 8% in 2022; $p=0.031$).
- Thirty-nine per cent of the sample reported currently being in some form of drug treatment at the time of the interview (43% in 2022), most commonly methadone treatment (22%; 30% in 2022).
- Among those who had recently used opioids and commented, 61% scored five or above on the Severity of Dependence (SDS) scale, indicating possible dependence. Of those who had recently used methamphetamine and commented, 48% scored four or above on the SDS scale, indicating possible dependence.
- The percentage of participants who reported having had a hepatitis C (HCV) antibody test in the last year significantly increased from 34% in 2022 to 58% in 2023
- Half (52%) of the Sydney sample self-reported that they had recently experienced a mental health problem, a significant increase relative to 2022 (38% in 2022; $p=0.015$), with the most common reported problem being depression (65%). Almost one third (32%) of the Sydney sample scored 30 or more on the K10 scale (33% in 2022), indicating high psychological distress.
- The majority (95%) of participants reported accessing any health service for alcohol and/or drug support in 2023, a significant increase from 80% in 2022, with significantly more participants accessing NSPs (86%; 66% in 2022)
- In 2023, three quarters (76%) of the sample reported experiencing stigma related to their illicit drug use in any setting in the six months preceding interview. These experiences of stigma most commonly occurred when visiting a non-health setting (66%).
- The vast majority (87%) reported that they had received at least one COVID-19 vaccine dose (88% in 2022) at the time of interview, with participants receiving a median of 3 doses. Among those who had driven in the last six months, almost two third (63%) of participants reported driving within three hours of consuming an illicit or nonprescribed drug (83% in 2022). Seven per cent of participants reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the last year (11% in 2022).
- In 2023, almost half (47%) of the Sydney sample reported engaging in 'any' crime in the past month (38% in 2022; $p=0.152$). Selling drugs for cash profit remained the most common self-

reported crime in the month preceding interview and significantly increased from 23% in 2022 to 36% in 2023 (p=0.030). Two in three (63%) participants reported a drug-related encounter with police which did not result in charge or arrest in the past 12 months, a significant increase from 39% in 2022 (p<0.001) (4).

Ecstasy and related drugs reporting system

The Ecstasy and Related Drugs Reporting System (EDRS) is a national monitoring system for ecstasy and related drugs that is intended to identify emerging trends of local and national interest in the markets for these drugs. The 2023 NSW EDRS sample comprised 100 people who regularly use ecstasy and other illicit stimulants in Sydney (4).

Just under one third (29%) of the NSW sample reported cocaine as their drug of choice. Ecstasy was the next most common drug of choice (22%), followed by cannabis (16%) and alcohol (12%) (4).

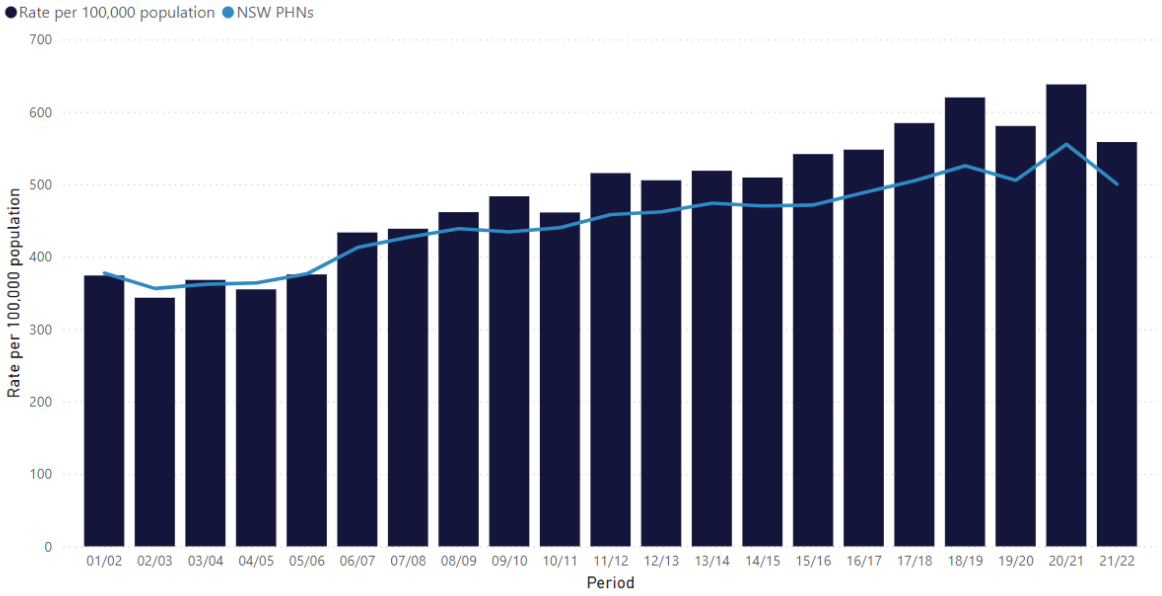
There was a significant increase in recent use of any form of ecstasy between 2022 (83%) and 2023 (99%) Capsules remained the most common form of ecstasy consumed in the six months preceding interview, with a significant increase observed in 2023 (69%; 52% in 2022;). This was followed by pills (49%), which also increased in 2023 (33% in 2022), and crystal (47%).

Recent use of any methamphetamine has been declining since monitoring commenced. In 2023, one fifth (21%) of the sample reported recent use (2022 29%). The largest percentage of participants reported using crystal methamphetamine (14%), followed by powder (8%). Frequency of crystal and powder use (≤monthly), as well as their perceived purity and availability, remained stable between 2022 and 2023.

Hospitalisations

In 2021-22, there were 9,473.4 alcohol-related hospital admissions in the CESPHN region. Over half (58.6%) of hospital admissions were males. CESPHN has a higher rate of hospitalisations (558.3 per 100,000 population) than the NSW rate (500.2 per 100,000 population) (5).

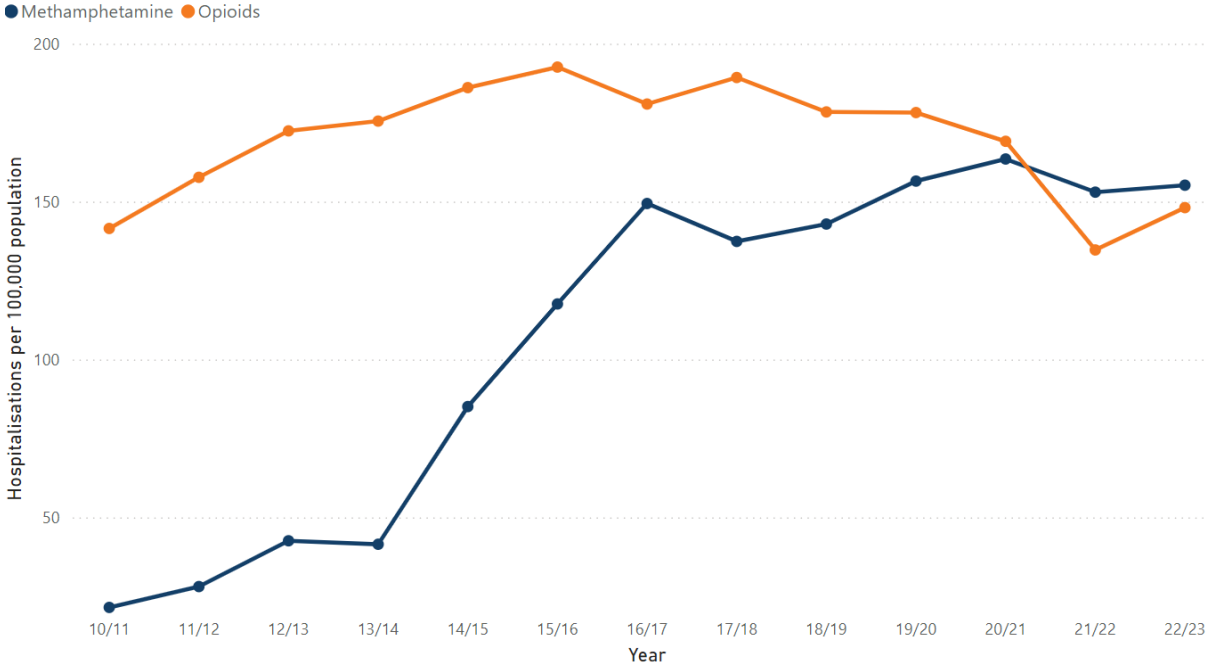
Figure 3: Alcohol related hospitalisations, CESPHN region, 2001-02 to 2021-22



Source: HealthStats NSW, 2024

Hospitalisation rates for methamphetamine (155.2 per 100,000 population) have now overtaken hospitalisation rates for opioids (141.5 per 100,000 population). Opioid hospitalisations peaked in 2017-18 at 192.6 per 100,000 population and have decreased every year since. Methamphetamine hospitalisations had a sharp growth between 2013-14 and 2016-17 and have continued to gradually increase since. The same trends are seen in NSW (5).

Figure 4: Hospitalisation rates for methamphetamine and opioids, CESPHN region 2010-11 to 2022-23



Source: HealthStats NSW, 2023

Treatment

There are two local health district (LHD) run specialist alcohol and other drug (AOD) programs in the CESPHN region, along with government services provided by the St Vincent's Health Network. There are also non-government organisations (NGOs) who have both widely applicable models of care and specifically targeted models of care. A list of NGOs and the type of service they provide are included in Table 2 below. In addition, there are alcohol and other drug interventions provided by general practice and community pharmacy, and some residents can access private treatment programs although these are mainly located outside the CEPHN region.

Finally, there are community drug action teams (CDAT's) and local drug action teams (LDAT), organised by interested members of the community, who undertake population style interventions. There is little difference in intent between CDATs and LDATs, however LDATs are supported by Commonwealth funding and policy frameworks and CDATs are supported by the NSW state Government.

Table 2: Non-government AOD providers in CESPHN region

Agency Name	Service Type
2Connect Youth and Community	AOD Counselling, Youth AoD service
ACON	AOD Counselling
Aboriginal Medical Service Redfern	AOD Counselling, Pharmacotherapies
Alf Dawkins Detoxification Unit (Inner city Detox)	Withdrawal service

Catholic Care Family Recovery (formerly Holyoake)	AOD Counselling
Co.As.It	AOD Counselling
Community Restorative Centre	AOD Counselling
Deadly Connections Community & Justice Services	Case Management
Foundation House	Residential Rehabilitation
Guthrie House	Residential Rehabilitation
Haymarket Foundation Residential Rehabilitation	Residential Rehabilitation
Headspace	Youth AOD service
Jarrah House	Residential Rehabilitation, Withdrawal service and AOD Counselling
Kathleen York House	Residential Rehabilitation
Leichhardt Women's Community Health Centre	AOD Counselling
Lou's Place	Case Management
Mission Australia, Drug and Alcohol Program	AOD Counselling
Odyssey House Community Programs	Case Management, AOD Counselling
PALM East - Ted Noffs Foundation	AOD Counselling
Pathways Maroubra	Case Management
Pathways Miranda	Case Management
Phoebe House	Residential Rehabilitation
Rainbow Lodge Program	Case Management
Salvation Army Oasis Youth Services	Case Management, Youth AOD service and AOD Counselling
St George Youth Services Inc - 2Connect Youth and Family	Case Management
St Vincent De Paul - Frederic House	Case Management
St Vincent de Paul Society - Continuing and Coordinated Care C&E Sydney	Continuing and Coordinated Care Program, Case Management
St Vincent's Alcohol and Other Drug Service	Assertive Case Management, AOD Counselling, Youth AOD service and Withdrawal service
Sydney Women's Counselling Centre	AOD Counselling
Ted Noffs Foundation: PALM	Residential Rehabilitation, Youth AOD service
The Gender Centre	AOD Counselling
The Haymarket Centre	Case Management, AOD Counselling and Residential Rehabilitation
The Salvation Army William Booth and Detoxification Unit	Withdrawal service
The Station Drug and Alcohol Service	AOD Counselling, Case Management
Uniting Medically Supervised Injecting Centre (MSIC)	AOD Counselling, Case Management

Waverley Action for Youth (WAYS)	Youth AOD service
Waverley Action for Youth Services (WAYS)	Case Management
Waverley Drug and Alcohol Centre	Case Management
Waverley Drug and Alcohol Centre	AOD Counselling
WAYS Youth and Family	AOD Counselling
We Help Ourselves (WHOS): Gunyah	Residential Rehabilitation
We Help Ourselves (WHOS): New Beginnings	Residential Rehabilitation
We Help Ourselves (WHOS): OSTAR	Residential Rehabilitation
We Help Ourselves (WHOS): RTOD	Residential Rehabilitation
Weave Youth and Community Services	AOD Counselling, Case Management, Youth AoD service
WHOS Hub Lilyfield (We help ourselves)	AOD Counselling, Case Management
William Booth House: The Bridge Program	Residential Rehabilitation

Source: NSW Ministry of Health Centre for Alcohol and Other Drugs

Treatment need

The DASP model anticipates that the majority of those with only mild disorders will not seek treatment and will resolve the disorder without specialist intervention, that around 50% of those with a moderate disorder will require treatment and 100% of those with a severe disorder will require treatment. The table below estimates the treatment required for each drug type for the current CESPHN population (aged 10 years and over) (6).

Table 3: Estimated drug and alcohol treatment required in the CESPHN region

Drug type	Assumption of Use Treated rate Mild (%)	Mod (%)	Severe (%)	Assumption of overall prevalence Treated Rate (%)	Estimated quantum needed 2020
Alcohol	20	50	100	35	46,377
Amphetamine	0	50	100	95	9,201
Benzodiazepines	20	50	100	45	3,137
Cannabis	20	50	100	35	12,069
Opiates – non-medical use	0	50	100	95	11,295

Source: CESPHN 2016

The DASP modelling also provides estimates of population level requirements for screening of at-risk patients in the primary care setting. It does this through estimates of risk by drug type and age group. It is estimated for the CESPHN population (aged 10 years and over) there were:

- 219,148 people who needed screening and brief intervention for alcohol use in 2020, increasing to 262,891 people in 2036
- 13,433 who needed screening and brief intervention for amphetamines in 2020, increasing to 16,115 in 2036, and

- 138,982 people who needed screening and brief interventions for cannabis use in 2020, increasing to 166,724 in 2036 (2).

Table 4: Estimated number of screening interventions required in the primary care setting in the CESPHN region by drug type

Drug Type	Standard rate (per 100,000 people)	Estimated no. of screening interventions 2020	Estimated no. of screening interventions 2036
Alcohol	14,617	219,148	262,891
Amphetamine	896	13,433	16,115
Cannabis	9,270	138,982	166,724

Source: CESPHN 2019

Mellor *et al*, used the DASP model to predict bed estimates by LHD in NSW. The below table shows the bed estimates using the original DASP model unmodified parameters, these estimates do not consider potential differences in prevalence rates, severity distributions and treatment rates (7).

Table 5: DASP predicted bed numbers by LHD, bed type, CESPHN region, 2019

Bed type	Sydney LHD	South Eastern Sydney LHD
Detoxification	29	38
Residential rehabilitation	187	248
Inpatient	7	9
Total	222	294

Source: Mellor, R and Ritter, A, 2019. Note: the bed numbers reported here are rounded. Total estimates are calculated by summing the non-rounded bed numbers.

Government funded AOD treatment services

In 2022-23, there were 68 government funded AOD treatment services in the CESPHN region that provided 6,434 closed treatment episodes. This equates to 217.7 episodes or 138.4 clients per 100,000 population.

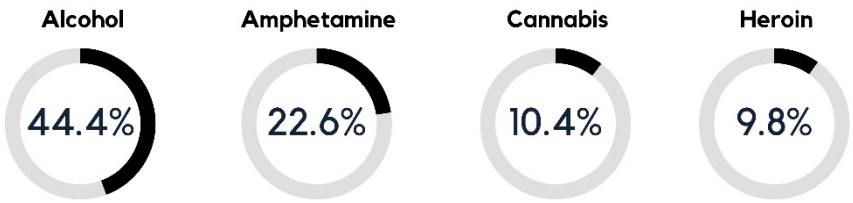
Client demographics

Of the publicly funded AOD treatment services in the CESPHN region in 2022-23:

- 98.5% of clients attended for their own drug use
- 61.3% were male and 34.8% female, 3.9% undisclosed
- 27.7% were aged 30-39 years, 25.39 % aged 40-49 years, 19.9% aged 20-29 years, 15.3% aged 50-59 years, 5.2% aged 10-19 years and 6.6% aged 60+ years
- 12.7% were Aboriginal and Torres Strait Islander people (here in referred to as Aboriginal people) (8).

Principal drug of concern

In 2022-23, the four most common principal drugs of concern for which clients sought treatment in the CESPHN region were:

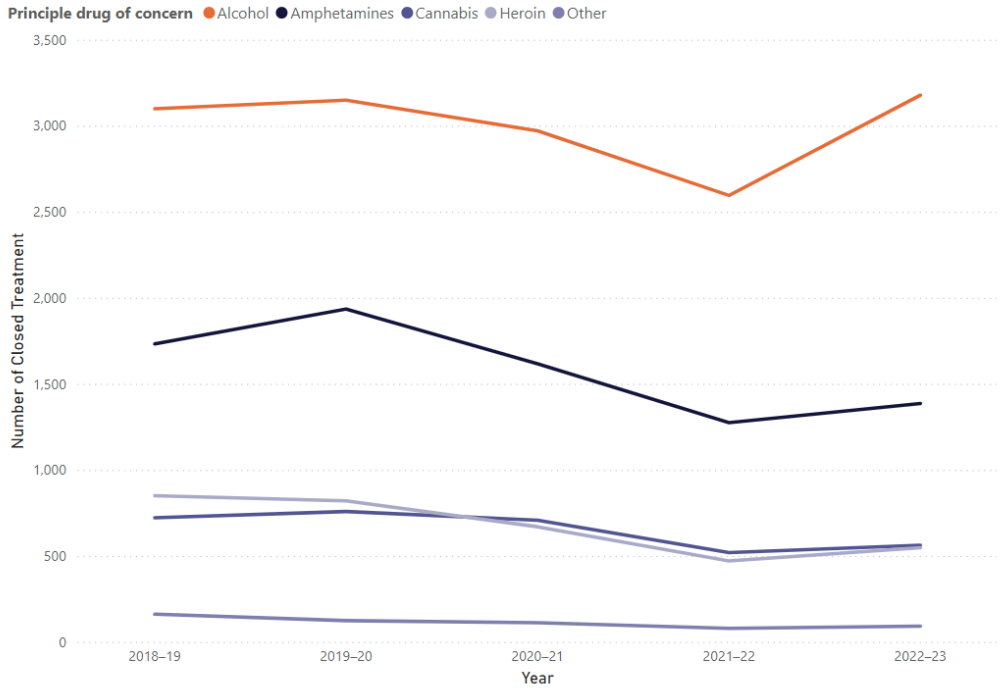


These were also the top four principal drugs of concern nationally – alcohol (42.5%), amphetamines (23.9%), cannabis (17.5%) and heroin (4.5%) (8).

Between 2018-19 and 2022-23, the number of closed treatment episodes with alcohol as the principal drug of concern increased overall by 2.6% (from 3,098.9 to 3,178.0 episodes). This is despite a decrease in 2021-22. Amphetamines were the second highest principal drug of concern and follow the same trend as alcohol.

Across all principal drugs of concern between 2018-19 and 2022-23 we saw a decrease in closed treatment episodes from 2019-20 to 2021-22 then an increase in 2022-23 (8). Data is not available across the total number of episodes to allow for conclusion as to why there was a dip in closed treatments episodes.

Figure 5: Number of closed treatment episodes by principal drug of concern, CESPHN region, 2018-19 to 2022-23

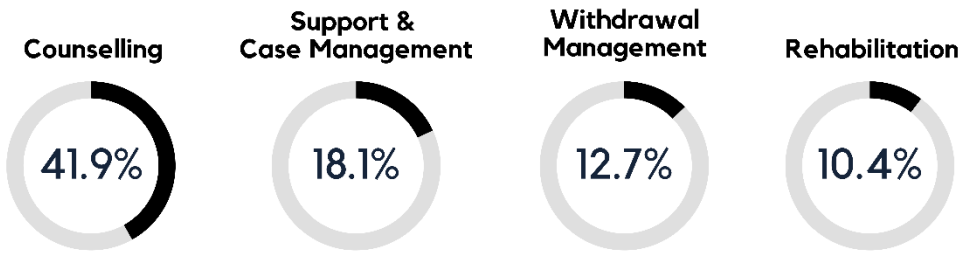


Source: AIHW, 2024

Stakeholders have confirmed that methamphetamines and alcohol are the two most commonly occurring sources of substance related concerns within the CESPHN region. Most commissioned service providers have stressed that alcohol is still the drug of primary concern and the source of greatest harm to their clients. Consultations also highlighted an emerging increase in Nitazene usage and overdoses, with a need to expand the take home Naloxone program.

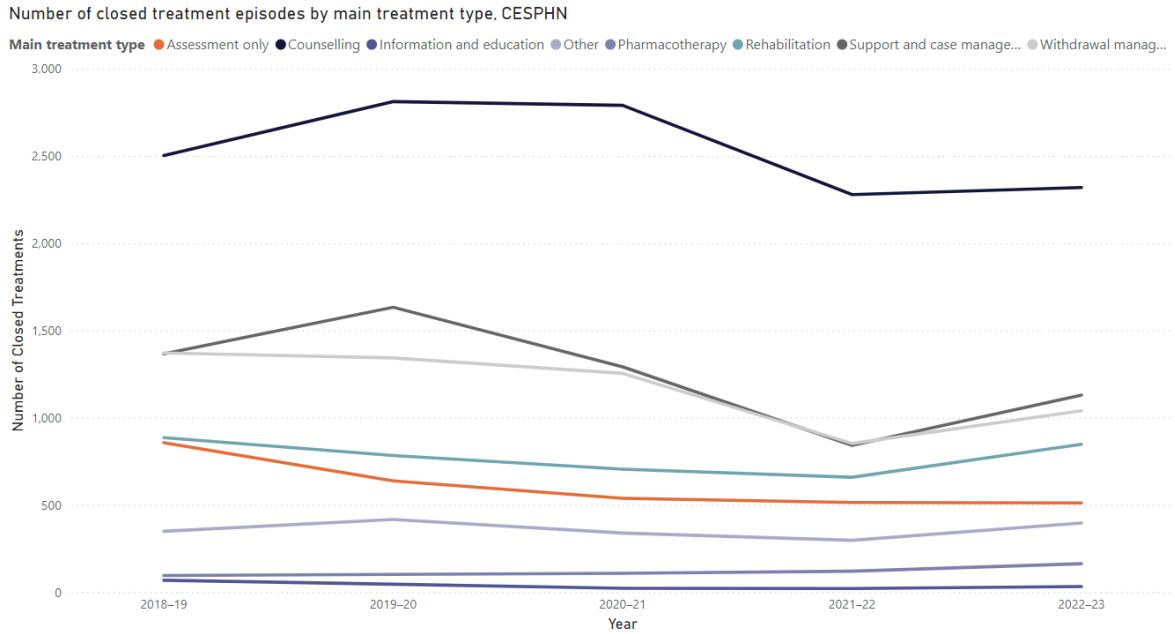
Treatment type

In 2022-23, the most common treatment types provided to clients in CESPHN were:



Compared to national figures, the CESPHN region had a much higher percentage of clients whose main treatment type was withdrawal management (12.7% compared to 6.3%) and rehabilitation (10.4% compared to 5.4%) (8).

Figure 6: Number of closed treatment episodes by main treatment type, CESPHN region, 2018-19 to 2022-23



Source: AIHW, 2024

Source of referral

In 2022-23, over half (56.4 %) of all closed treatment episodes had a source of referral as self/ family. The next most common source of referral was a health service (19.4% of closed treatment episodes) (8).

Treatment setting

In 2022-23, the majority (74.9%) of closed treatment episodes were provided in non-residential treatment facilities, followed by residential facilities (23.3%). There were very low numbers of treatment episodes provided in outreach settings (1.1%) and in the client's home (0.4%) (8).

Primary care

There are no specific alcohol and other drug MBS items for general practice to quantify service use. While there are MBS items for addiction medicine specialists to provide care, this data is not available at the PHN level.

It is expected that most GPs would be seeing patients who have alcohol and other drug concerns in their day-to-day practice. With over 200,000 people estimated to need screening and brief intervention for alcohol use, this would require every GP in the CESPHN region to undertake almost 200 interventions per year.

Opioid Treatment Program (OTP) prescribers and dosing points

The National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection provides state-wide data on clients receiving pharmacotherapy treatment, dosing sites and prescribers but does not allow comparisons across PHNs. NSW Health advised in November 2024 that there were 196 OTP dosing points located in the CESPHN region, including 159 pharmacies.

In November 2024, NSW Health also advised that there were 304 unique OTP prescribers in the CESPHN region. Some prescribers prescribe at multiple locations. Further breakdown of prescriber groups can be seen below.

Table 6:OTP Prescriber groups, CESPHN region, 2024

Prescriber group	Total Number	Unique Number
All prescribers: OTP accredited and not OTP accredited	394	304
OTP accredited and not OTP accredited prescribers - excluding registrars	367	287
OTP accredited prescribers only – excluding registrars	216	143

Source: Safescript NSW

For a prescriber to provide OTP to a patient they can prescribe unaccredited with limited capacity or complete the opioid treatment accreditation (OTAC) course followed by a half day clinical placement to become accredited with the NSW Ministry of Health Opioid Pharmacotherapy Subcommittee.

Stakeholder consultations in July 2024 highlighted that there is an ongoing need to increase the number of OTP prescribers in the region. It was highlighted that nurse practitioners and pharmacists also play an important role as OTP prescribers, and focus shouldn't only be on increasing GP numbers. This is coupled with previous consultations where it was identified that there is a need to safely transition clients from the public OTP clinics to the primary care sector (general practices, private practices and pharmacy). Strategies to improve rates of prescribing and administration could include:

- Training in shared care
- Communication with GPs and pharmacies
- Further investigating how depot buprenorphine can be administered outside of public clinics
- Incentivising the uptake of clients on OTP for GPs who have recently completed the OTAC course
- Adequate renumeration (i.e., MBS) for what is often complex and time-consuming work
- Ongoing support, mentoring and CPD/training
- Stigma and discrimination training.

Priority populations

Priority populations within the Alcohol and Other Drug sector are similar to those across all areas of health. Within the AOD space, localised data for priority population groups is often unavailable but we are able to look at national level data to understand key issues and trends within these groups.

Aboriginal and Torres Strait Islander people

In 2018-19, an estimated 55.1% of the Aboriginal population in the CESPHN region exceeded the NHMRC guidelines for single occasion risk (short term alcohol consumption), ranking CESPHN highest amongst all PHNs. The rate was much lower for lifetime risk (long term alcohol consumption) at 19.4% of the Aboriginal population, ranking CESPHN 13th amongst all PHNs.

In 2022-23, an estimated 22% of the Aboriginal population in NSW had used substance(s) in the previous 12 months (9).

Table 7: Aboriginal Substance use in NSW, 2022-23

Substance use	Males (%)	Females (%)	Total NSW (%)
Used substance(s) in last 12 months	32.4	13.9	22.1
Has not used substance(s) in last 12 months	67.0	84.1	76.6

Source: ABS, NATSIHS 2024

The proportion of Aboriginal clients receiving publicly funded treatment for their own drug use has increased nationally from 14% in 2015-16 to 17% in 2019-20.

Further detail on Alcohol and Other Drug use in Aboriginal populations can be found in the Aboriginal and Torres Strait Islander peoples health and wellbeing section.

Multicultural communities

It is difficult to identify rates of alcohol and other drug use in multicultural communities as national surveys tend to be administered in English and there are limitations in the way data is collected.

While both the 2022-23 and the 2019 NDSHS suggests that overall AOD rates amongst culturally and linguistically diverse (CALD) respondents are lower than non-CALD communities, people from multicultural communities are underrepresented in AOD treatment and when in treatment are less likely to be connected to appropriate support services (10). The 2022-23 NDSHS found that nationally:

- People with non-English speaking backgrounds are less likely to drink alcohol at risky levels with 43% of people born in non-main English-speaking countries having not consumed alcohol in the previous 12 months, compared to 18.5% of people born in Australia.
- People with diverse backgrounds are much less likely to have used illicit drugs.

There is a growing body of literature that discusses barriers faced by people from CALD backgrounds to accessing these services including stigma, limited health literacy and concerns about the cultural responsiveness of services. To improve the capacity of AOD treatment services to support multicultural communities, CESPHN co-commissioned the Network of Alcohol and Other Drugs Agencies (NADA) to carry out the CALD Audit Project across four sites, of which two were in the CESPHN region. This pilot project aimed to devise, implement and evaluate an auditing process to enhance the cultural inclusion of mainstream AOD treatment services in supporting people from multicultural communities accessing treatment. The auditing process sought to optimise service experiences by identifying organisational factors that support best practice cultural inclusion. A rapid review of the role and importance of cultural inclusion in AOD services identified 16 recommendations and four key themes:

- Service delivery and the settings in which treatment is delivered: Flexible service delivery (including outreach) to match clients' help seeking preferences/behaviours; Offering longer timeframes for engagement and treatment; building capacity to navigate the AOD treatment landscape and associated support services; Responding to other language needs within treatment provision.
- Self and Community perception: Addressing the impact of particularly high levels of stigma surrounding AOD use in some communities at both an individual client and community level; Providing education on AOD-related health issues to help address generational attitudinal and knowledge differences within families that shape and support help seeking attitudes.
- Community engagement and service collaboration: Building relationships with cultural/religious leaders, key community members and CALD specific services.
- Workforce development and cultural competence of staff: the training of staff in cultural inclusion practices; Recruitment and use of skilled bi-cultural workers and translators (11).

This project was evaluated by UNSW Centre for Social Research in Health in 2022 and assessed how AOD services fare in terms of cultural inclusion and to describe the acceptability of the cultural inclusion audit process from the perspective of staff and auditors at the four pilot sites. Overall, the evaluation demonstrated low levels of cultural inclusion across the various services. Although participants generally perceive both themselves and their services as culturally competent, the survey responses highlight significant gaps, showing that many services are not fully inclusive across several key service areas. On a positive note, the interview data revealed a strong acceptance of the audit process, with participants recognising areas where improvements are needed. Ultimately all services showed an improvement across all domains.

To further address these needs, CESPHN has commissioned a follow up Multicultural Audit Project which aims to increase capacity of alcohol and other drugs (AOD) treatment services to support multicultural people and their communities in collaboration with the Network of Alcohol and other Drug Agencies Inc. (NADA). The primary outcome for this project is to further the work conducted in the audit above and to ultimately increase awareness and workforce capacity of generalist NGO AOD services in supporting clients from multicultural communities. This project will take place across a further five sites within the CESPHN region.

Research has highlighted that people who inject performance and image enhancing drugs (PIEDs) in Australia are a younger and more culturally and linguistically diverse group. People who inject IPEDs

may be more vulnerable to blood-borne virus transmission and/or less likely to know their blood-borne virus status. From design to delivery, IPED harm minimisation strategies should pay attention to the needs of multicultural communities (12). Northern Sydney PHN has developed a GP guide on harm minimisation (13) that could be used for this community.

Young people

In the 2022-23 NDSHS, at a national level young people (aged 14-24):

- 1 in 5 (20%) drank alcohol less than often monthly, and 16.3% had never had a full glass of alcohol (up from 7.5% in 2001)
- The proportion of daily drinkers and ex-drinkers among people aged 18–24 has remained stable since 2001 and did not change between 2019 and 2022–2023
- Between 2019 and 2022-23 there was an increase of 5% in females aged 18-24 consuming alcohol at risky levels (35% to 40%) narrowing the gap to males (47% in 2019 and 45% in 2022-23).
- The proportion of young people who drank alcohol monthly decreased from 34% to 29%
- Fewer younger people than reported smoking daily than ever before with a 50% decrease in young people aged 18-24 years smoking daily. Males aged 18-24 years were 1.4 times more likely to smoke cigarettes than females
- The use of vapes and electronic cigarettes has had a sharp increase from 2019 to 2022-23 with an increase from 1.8% to 9.7% in 14-17 year olds and an increase from 5.3% to 21% in 18-24 olds.
- Around 1 in 3 people aged 18-24 (35%) had used an illicit drug in the previous 12 months and almost 1 in 2 (49%) had done so at some point in their lifetime
- For the first time females aged 18-24 were just as likely to use illicit drugs as males
- Cannabis is the most commonly used illicit drug across all ages. Inhalants are the next most common in young people aged 14-17 and cocaine usage has increased to become the second most commonly used illicit drug among 18-24 year olds (14).

Table 8: Most commonly used illicit drugs in the previous 12 months by young people, 2019 and 2022–2023

People aged 14-17 2019	People aged 14-17 2022-2023	People aged 18-24 2019	People aged 18-24 2022-2023
Marijuana/ cannabis (8.2%)	Marijuana/ cannabis (9.7%)	Marijuana/ cannabis (25%)	Marijuana/ cannabis (25.5%)
Inhalants (*1.8%)	Inhalants (*2.2%)	Ecstasy (10.8%)	Cocaine (11.3%)
Ecstasy (*1.2%)	Pain-relievers and opioids (*1.6%)	Cocaine (10.8%)	Ecstasy (6.7%)
Hallucinogens (*1.1%)	Pharmaceutical stimulants (*1.0%)	Hallucinogens (5.2%)	Hallucinogens (6.4%)
Tranquilisers/ Sleeping pills (*0.7%)	Hallucinogens (*0.9%)	Inhalants (5.2%)	Inhalants (5.2%)

** Estimate has a relative standard error between 25% and 50% and should be interpreted with caution.*
Source: AIHW 2024

Data from CESPHN commissioned service providers working with young people confirm that alcohol and cannabis remain the primary drugs of concern for young clients, followed by methamphetamine.

Service providers have seen an increase in the use of benzodiazepines and inhalants in younger clients.

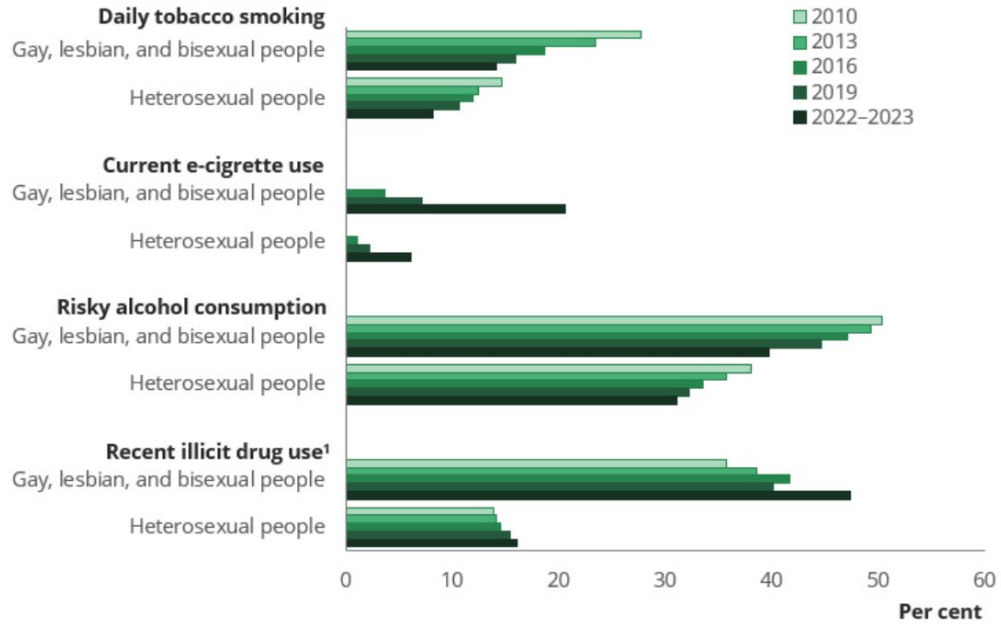
LGTBIQ+ communities

The NDSHS includes questions on gender and sex recorded at birth. Within the 2022-23 sample 5.1% of people aged 14 years and over reported that they were gay, lesbian or bisexual. The 2022-23 survey was the first to include questions representing people who are transgender or gender diverse, with 0.9% of people aged 14 and over reporting that they were trans or gender diverse. Findings for gay, lesbian, and bisexual people are grouped together for data quality purposes, but it is important to note that there are differences in substance use between each population. Similarly, transgender people and other gender diverse people are grouped together for data quality purposes.

For gay, lesbian and bisexual people:

- Rates of drug use across daily tobacco smoking, current e-cigarette use, risky alcohol consumption and recent illicit drug use are all higher than heterosexual people
- Daily tobacco smoking rates continue on a long-term decline from 28% in 2010 to 14.2% in 2022-23
- 1 in 5 people (21%) report using electronic cigarettes and vapes. This has tripled since 2019 (7.1%)
- The proportion of people drinking alcohol at risky levels has declined from 50% in 2010 to 40% in 2022-23
- In 2022-23 almost 1 in 2 people (47% has used an illicit drug in the previous 12 months, an increase from 40% in 2019 (15).

Figure 7: Drug use among people aged 14 and over, by sexual orientation, 2010 to 2022–2023



1. Used any illicit drug in the previous 12 months.

Source: AIHW, 2024

The most commonly used illicit drug is cannabis (33%) followed by cocaine (15.1%) and inhalants (11.0%).

For trans and gender diverse people:

- The use of tobacco, e-cigarettes and alcohol reflected use in the general population
- 1 in 3 trans and gender diverse people had used an illicit drug during the previous 12 months. After adjusting for differences in age, compared to cisgender people, trans and gender diverse people were 1.6 times as likely to have used any illicit drug in the previous 12 months (15).

The Rainbow realities report (2024) commissioned by the Department of Health and Aged Care provides a synthesis of more than 50 new analyses derived from six surveys of LGBTQA+ populations in Australia. In relation to alcohol and other drugs the report found that:

- While only a relatively small proportion of LBQ+ women were currently using tobacco, those who were current smokers were more likely to have ever used or felt concern regarding drug consumption or who have felt concern in the past 12 months regarding alcohol consumption
- The concentration of reported vape use within younger age groups demonstrates a clear cohort effect
- The connections observed between vaping and prior drug and alcohol use among LBQ+ women may indicate a tendency among LBQ+ women to engage in polysubstance use and reflect social engagement within spaces where these are commonly occurring substances.

- Almost one-fifth of participants who held a preference for alcohol support service provider, expressed a preference for a service that catered specifically to LGBTQA+ people, with a further 55% holding a preference for a service that is mainstream but known to be inclusive of LGBTQA+ people (16).

One of the surveys synthesised as part of the Rainbow Realities report, the Sydney Women and Sexual Health (SWASH) Lesbian, Bisexual and Queer Women's Health Survey 2020 has collected data form the Sydney region. Respondents reported that they were more likely to drink alcohol (86%) and drink at levels that put them at risk of lifetime harm (48%), compared to women in general (71% and 25% respectively) (17).

Among current drinkers, 21% had been concerned about their alcohol use in the past year, and 5% had sought help to manage their alcohol use in the last 12 months. In 2020 more than half (54%) of respondents had used an illicit drug in the last six months, an increase from 47% in the 2018 survey (17).

Recently, CESPHN funded ACON to produce LGBTIQ+ Inclusive Guidelines for AOD services. The purpose of the guidelines is to increase the understanding of AOD workers about the needs of LGBTIQ people and communities and how to provide an inclusive service response. The guidelines were launched in February 2023, coinciding with World Pride.

People experiencing homelessness

Within the CESPHN region, on census night in 2021, 12,799 people were experiencing homelessness. This was 10.4% of the national figure. There is a strong association between problematic alcohol or other drug use and experiences of homelessness. It can lock people into homelessness and compound the effects of limited-service engagement and increased social isolation (18). Problematic alcohol or other drug use is related to several homelessness risk factors, including low socioeconomic status and family and domestic violence. Problematic drug and/or alcohol users are also at great risk of serious and preventable health issues and death, particularly those who are homeless.

The Specialist homelessness services annual report 2022-23 found that nationally, around 23,500 Specialist Homelessness Services (SHS) clients were clients with problematic drug or alcohol issues. This represented 8.6% of all SHS clients. Of this, 23,500 clients:

- 32% identified as Aboriginal or Torres Strait Islander
- 79% had previously been assisted by SHS at some point since July 2011
- 57.3% were homeless and 42.7% were at risk of experiencing homelessness (18).

Additionally, people experiencing homelessness may not have access to mobile phones, data or technology to connect with services that provide support via telehealth. Many services have supported their clients to engage with their AOD counselling and case-management by providing data and credit on mobile phones to support clients to continue to engage.

People in contact with the criminal justice system

In 2023, 19,932 individuals were released from full time custody (19). 51.5 per cent of those released had returned to corrective services within two years in 2021-22 (20). This number is significantly higher for people who have experienced prior imprisonment and is almost twice as high for populations experiencing multiple and complex disadvantage including mental health and AOD issues, cognitive disability, and homelessness.

The relationship between alcohol and other drug use and incarceration is well established. The 2022 National Prisoner Health Data Collection found that:

- Almost 3 in 4 (73% of prison entrants) reported using illicit drugs in the previous 12 months before incarceration
- Almost one-third of prison entrants reported they had injected drugs at some stage in their lives (21)
- People entering prison were more than 4 times as likely to report illicit drug use in the preceding 12 months as people in the general community.
- Almost 2 in 5 (37%) of prison discharges reported using illicit drugs in prison, this increases to 41% in Aboriginal and Torres Strait Islander dischargees
- About 1 in 7 (15%) of male dischargees and about 1 in 20 (6.2%) of female dischargees reported injecting substances in prison.

The Community Restorative Centre (CRC) – a provider of specialist throughcare, post-release, and reintegration programs for people transitioning from prison into the community in NSW – has raised that a number of their clients have cognitive impairments, intellectual disabilities, and acquired brain injuries that are sometimes first identified and diagnosed in prison. CRC staff have highlighted the importance of diagnosis because it can have a significant impact on how clients are treated and how they function in the community.

Previous consultation with service providers revealed:

- Clients are commonly using heroin and methamphetamines.
- The importance of culturally safe services, in particular to be staffed by people with lived experience of AOD and the criminal justice system in frontline positions.
- Cognitive functioning and offending history are often barriers to accessing withdrawal and residential rehabilitation programs. Clients on bail or without stable accommodation to return to following treatment are also barriers. Case management support is essential to assist clients to access these treatments.
- Relationships with local GPs and pharmacies who are willing to provide OTP and work together to support a client have enabled clients to receive the treatment they need and avoid returning to custody.
- Since the onset of the pandemic, OTP services have transferred large numbers of clients to depot buprenorphine treatment. There are also increasing numbers of people exiting custody who have been commenced on depot buprenorphine. This has been a positive change with clients not having to travel to attend regular appointments. There are, however, reports of residential rehabilitation services being reluctant to accept people who are on depot buprenorphine.

- People on OTP that were previously attending clinics for dosing have now had their collection point changed to a local pharmacy. This means that people can miss out on the comprehensive support that a clinic provides.
- The need for a phone service to provide connection and assist with case management needs would be beneficial.
- Funding is needed to prepare clients for release from custody such as cognitive remediation, communication, and other self-management skills to support clients to successfully engage in AOD treatment once exiting to community. Funds are also needed for inclusion of AOD programs within prisons, including individual counselling, psycho-educational programs, group therapy, transitional assistance programs and harm reduction education like that in Victoria.

People with co-occurring mental health conditions

The relationship between substance use and mental health is complex and bidirectional. The 2022–2023 National Drug Strategy Household Survey (NDSHS) found that, compared with adults without a mental illness, those with a mental illness were:

- more likely to drink alcohol at risky levels (37% compared with 32%)
- twice as likely to smoke daily (15% compared with 7.4%)
- 1.8 times as likely to use any illicit drug (29% compared with 16%) (22)

A recent study of Australian general practice records (23) showed the rate of moderate to heavy drinking among patients with severe mental illness and/or long-term mental illness was 4.7%, more than double that for the population without (2.2%). The same study also showed almost half (47%) of people with severe or long-term mental illness are current or past smokers, compared with almost one third (30%) of the population without (23).

Consultation with stakeholders heavily emphasised the need for better systems to be in place to address the needs and provide suitable treatment options people who have co-occurring substance use and mental health conditions.

People with other co-occurring conditions

It is well established that substance use can increase the risk of physical injury. Between 36% and 51% of hospital admissions for traumatic brain injury (TBI) are due to incidents that occurred while intoxicated (24).

Between 48% and 68% of heroin users will experience at least one non-fatal overdose.16,17 A nonfatal opiate overdose is defined by a loss of consciousness and hypoventilation, which can result in hypoxic brain injury and severe cognitive impairment (25) (26).

According to NSW emergency department records, 40-50% of admissions for seizures are alcohol-related (27). Seizures are common following withdrawal from alcohol and typically present 6-48 hours after discontinuation of use, but not all alcohol-related seizures are the result of withdrawal (24). It has been suggested that with each additional episode of withdrawal in people with chronic alcohol

dependence, seizures increase in both frequency and intensity causing permanent epileptogenic alterations in the brain that can result in recurring seizures long after the cessation of alcohol (24).

Other conditions that are often found to co-occur with AOD use disorders are physical health conditions (e.g., cirrhosis, hepatitis, heart disease, diabetes), intellectual and learning disabilities, cognitive impairment, and chronic pain (27). Consultations with stakeholders identified the challenges with collecting data around co-occurring conditions and how that impacts their ability to treat clients.

Older people

Consultation with stakeholder and service providers found that the age of people accessing local services is continuing to increase. With this increase in age, comes more complexities with both physical and mental health issues that need to be treated simultaneously. The increased complexity can be a barrier to accessing care, in particular aged care services.

Service gaps

Service availability and navigation

Themes across consultations with stakeholders have been similar to consultations held in previous needs assessment processes. For people in this cohort, being able to access free primary health care to manage health concerns remains an issue and service gap. The concept of holistic support, with wraparound service provision for employment and education needs along with day to day living support were all acknowledged as positive aims. There remains a need for increased access to support services that addressed the multitude of problems generally associated with a significant substance use concern.

Care co-ordination and team-based service provision continue to be raised as models of care that should be pursued. Further enhancements of services are required to treat the full complexity of clients. In particular to be able to address the various intersectionalities of an individual client in one place by having access to a range of clinical services including psychology, nutrition, medical and social work were all necessary to provide holistic care. Co-location with mental health services, and the ability to benefit from the two funding steams working together would improve outcomes for clients. A role for pharmacists as potential treatment co-ordinators was also suggested. Services to support people experiencing gambling harm were noted by stakeholders as an emerging need.

Stakeholders also commented that there is often no funding available for follow-ups within the community, once clients leave a service there is no way knowing the status of that person and if further treatment is required.

A steadily rising need for opioid treatment was noted by stakeholders, with increasing demand placed on public health OTP clinics. This is exacerbated by large numbers of people exiting custody who have been placed on depot buprenorphine who need ongoing treatment, with limited options for community-based OTP.

Increased access to treatment is needed for people seeking to address their alcohol use given the large number of people requiring treatment as estimated by the DASP model. Treatment options should provide for those with mild to moderate needs through to more intensive supports.

To address some of the above needs, CESPHN has commissioned The Rehabilitation Project Connect-Discover-Recover program working extensively with people from culturally and linguistically diverse communities and particularly with the Islamic and Arabic-speaking community. In addition to this, CESPHN has also commissioned specialised multicultural AOD services at Odyssey House, specifically targeting areas with diverse multicultural communities, such as the Chinese population in Hurstville, in the St George region.

Methamphetamine use and interventions

The effective treatment of problematic methamphetamine use involves the treatment of both the physical and psychological effects of its use, and the underlying causes of its use, which can include comorbid mental health issues, trauma history, homelessness, unemployment (25). However, most current services are constructed to deal with alcohol and heroin which have very different psychological and physical withdrawal profiles than stimulants. The lack of any substitution therapy for stimulant drugs was also noted.

In 2020 the report of the NSW Special Commission of Inquiry into the drug ice was released, with the NSW government committing to support 86 of the 109 recommendations. The NSW Ministry of Health Centre for Alcohol and Other Drugs is responsible for the implementation of these recommendations and progress against these recommendations is reported by NSW Health.
Implementation of the recommendations will address treatment gaps and improve health and social outcomes through a suite of cross-government initiatives, including:

- Evidence-based prevention, treatment, support and early intervention services.
- Integrated care for people with multiple and complex needs.
- Enhancing digital capability, system navigation and virtual healthcare.
- Enhancing the AOD workforce, including Aboriginal health practitioners and peers.
- Better utilisation of data and evidence to inform system priorities, management, monitoring and evaluation.
- Expanded justice initiatives.

Residential rehabilitation beds

The general lack of availability of residential rehabilitation beds across the state continues to be a concern. In addition, the need for culturally appropriate rehabilitation for Aboriginal people was raised in consultations. The length of waiting periods to access a bed and the poor service continuity with withdrawal services was frequently raised. Transitions between services could be improved between most service modalities however the withdrawal/rehabilitation link was the primary focus of most commentary.

Co-occurring conditions associated with substance use

Dealing with co-occurring mental health conditions in the context of AOD use continues to be a central theme. More than 1 in 3 with a substance use disorder have at least one mental health condition and the rates are even higher among people in substance use treatment (28). People with co-occurring mental health and substance use often have a variety of other medical, family, and social issues (e.g., housing, employment, welfare or legal concerns). Together, all these factors can impact a person's treatment and recovery progress. Because of this, there is a need for health practitioners to adopt a holistic approach to the management and treatment of co-occurring mental health and substance use disorders that focus on treating the person. Ongoing capacity building activities to support the local workforce understanding in co-occurring mental health and alcohol and other drug needs is important. In a survey of community organisations multiple AOD services identified co-occurring mental health conditions as a high area of concern for their clients.

Services for Aboriginal people

Previous consultation with Aboriginal service providers raised access issues in specific locales including La Perouse, Mascot and Botany. Difficulty accessing rehabilitation, and particularly accessing culturally appropriate rehabilitation was referenced by all Aboriginal participants. Since previous consultations there have been no additional Aboriginal AOD Service. Rehabilitation services should be culturally specific healing centres and include connection to community. There was a general preference for medically supervised inpatient withdrawal services instead of withdrawal managed in the home, and greater access to detoxification services staffed by Aboriginal people.

Aboriginal service providers also previously highlighted the relationship between suicide and drug use and the need for specific service responses to this. This link was similarly emphasised by other stakeholders, with a reference to those aged 18-24 years in the context of the 'come down' from binge stimulant use. It was also noted that there are limited supports available for people who are exiting custody and a lack of culturally appropriate services for this group.

Addressing stigma associated with AOD use

There is often a lot of stigma associated with the use of alcohol and other drugs outside of recreational use. There is a need to not only reduce this stigma at a population level, but more specifically within frontline services who are engaging with the community outside of the service/treatment setting. Up to two-thirds of Australians entering AOD treatment services also experience post-traumatic stress disorder (PTSD) (29) and knowing how to identify this and manage this in a community setting may help with reducing the stigma associated with this cohort.

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Workforce development

Workforce development and capacity building continues to remain an area of need for stakeholders within the AOD sector. The consultation process identified that an increase in the number of general practitioners who prescribe opioid treatments was required, as well as upskilling of nurse practitioners and pharmacies to provide opioid treatment as this is within their scope of practice.

The report of the Special Commission of Inquiry into crystal methamphetamine and other amphetamine-type stimulants recommends that all NSW government employees and NGO partners be trained in trauma-informed practice. Such training should be co-designed and delivered by people with lived experience of trauma, including Aboriginal people.

In August 2024, NSW Health released the NSW Alcohol and Other Drugs Workforce Strategy 2024-2032 (30). The aim of the strategy is that the AOD workforce meets the needs of the NSW community. The strategy lists the following areas in which the AOD sector are experiencing workforce challenges:

- shortages of suitably qualified and skilled staff
- burnout and change fatigue
- fewer entrants to the sector
- limits on professional development opportunities, training and education, particularly in regional settings
- absence of coordinated recruitment and retention strategies
- disparities in remuneration and employment conditions between public sector and nongovernment services.

CESPHN consultation with stakeholders within the AOD sector also identified these workforce challenges amongst the local workforce. Consultation also highlighted that:

- the local workforce found that networking opportunities have continued to decrease since COVID-19 where meetings moved online and have remained online and this has limited the ability to create meaningful relationships across the sector.
- The need for increased opportunities for cross-sector collaboration with the mental health workforce as clients often have co-occurring mental health conditions.

Lived and living experience workforce

External stakeholder consultations identified that there needs to be further support for the lived and living experience workforce. Whilst programs exist including ConnectedED from NSW Users and AIDS Association (NUAA) and NADA's Peer Worker Community of Practice to support lived and living experience workers, it was identified that a model of supervision within the workforce similar to clinical professions may enhance the capabilities of the workforce.

Opportunities to address health and service needs

- Support an increase in the number of general practitioners (GPs), nurse practitioners, and pharmacists trained to prescribe opioid treatments.
- Encourage co-location of services, leveraging nurse practitioners to improve accessibility.
- Continue to support provision of treatment services that address co-occurring mental health and AOD needs.
- Continue to address barriers to treatment faced by multicultural populations.
- Support networking opportunities among the local AOD workforce.
- Support the upskilling of peer workers to expand the AOD workforce.
- Provision of culturally appropriate rehabilitation for Aboriginal Torres Strait Islander clients.
- Support a review and alignment of the AOD Minimum Data Set (MDS) with the Primary Mental Health Care (PMHC) MDS for more integrated service monitoring and improvement.

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CENTRAL AND
EASTERN SYDNEY

An Australian Government Initiative

SEXUAL HEALTH

2025-2027 Needs Assessment

SEXUAL HEALTH

Table of contents

List of tables

List of figures

SEXUAL HEALTH

Overview

Sexual health services are central to public health measures aimed at infection control and effective management of sexually transmissible diseases. In 2024 NSW Health announced a public health emergency with regards to mpox, for which vaccination has since become a focus among sexual health services this year.

The sexual health of CESPHN's population is a key priority for the coming years. The CESPHN population continues to increase as people move to the Sydney area to live and work. The largest proportion of LGBTQI+ people in Australia live in the region, which also has some of the highest numbers of foreign-born residents moving to the region who may lack sexual health literacy or need the most support.

Overall, the CESPHN region has an effective response supporting the management of its population's sexual health and this continues to be a focus looking forward to 2027.

Key issues

- Early identification of cases and liaison with general practitioner
- Engagement with local at risk populations to encourage uptake of preventive strategies and promotion of testing
- Knowledge of antimicrobial resistance in the treatment of gonorrhoea
- Promotion of vaccination and education to increase protection against Mpox
- Low health literacy that limits access to sexual and reproductive health services

Key gaps

- Level of general practitioner confidence in diagnosing, testing and treatment prescription
- Stronger active identification of cases and engagement with general practitioners
- Antenatal screening for syphilis twice for each pregnancy
- Knowledge of antimicrobial resistance in the treatment of gonorrhoea
- Promotion of vaccination to increase protection against Mpox
- Stigma-free health care provision
- Improved accessibility of sexual and reproductive health services.

SEXUAL HEALTH

Chlamydia, Gonorrhoea and Syphilis

High burden of disease within CESPHN region

From October 2023 to October 2024, South-Eastern Sydney and Sydney Local Health Districts recorded the highest number of notifications in NSW for chlamydia (11,812), gonorrhoea (565) and non-congenital syphilis (2652) (1). The central and eastern Sydney region accounted for 36.7% of chlamydia NSW notifications, over half (51.2%) of gonorrhoea notifications and 46.3% of non-congenital syphilis notifications (1). Notification rates in males for syphilis and gonorrhoea are the highest in NSW (2). The CESPHN community has a higher concentration of men who have sex with men and these elevated rates reflect the higher need for STI prevention within this group. 2)

Trends in rates

The 2023 NSW Sexually Transmissible Infections Data Report, released in July 2024, shows increases in crude notification rates for syphilis and gonorrhoea from 2014 until 2019 (2). Notification rates fell during the COVID-19 pandemic period (2022-2021). Notification rates for gonorrhoea rebounded in both Sydney LHD and South Eastern Sydney LHD in 2022 and have climbed above pre-COVID-19 levels in South Eastern Sydney LHD.

Notifications for syphilis also rebounded within both LHDs, however, these remained below pre-pandemic levels in 2023. Syphilis notifications rates fell more steeply in South Eastern Sydney (8.6%) than in Sydney (1.5%). While notification rates of gonorrhoea are considerably higher in males than females, both groups experienced increases in 2023 compared with 2022. For all residents, gonorrhoea notification rates increased by just over 20% in both Local Health Districts (2).

Key issues and evidence

Total crude notifications rates of Gonorrhoea and Syphilis and rates in males significantly exceed target rates.

The NSW Health target notification rate for gonorrhoea is less than 132.1 notifications per 100,000 by 2026 (3). In 2023, notification rates were 390.3 and 374.6 per 100,000 in South-Eastern Sydney and Sydney Local Health Districts, respectively (2). While rates for females were below the target (98.1 and 87.9), detection rates in females have increased over time (2). In 2023, crude notification rates for males were 682.1 per 100,000 in South Eastern Sydney and 663.2 in Sydney (2), well more than the target.

The 2023 Syphilis notification rate for men far exceeded the NSW target notification rate of less than 22 per 100,000 population (1,2). In 2023, the notification rate for men was 127 per 100,000 in South Eastern Sydney and 120 per 100,000 in the Sydney Local Health District (2). The rate in females is below target (7.8 for South Eastern Sydney and 8.6 for Sydney) (2). While not reported by PHN, notification rates in transgender people comprised fewer than 1.0% of notifications in NSW (2), however, informative notifications data for trans and gender diverse people are generally lacking (4).

Gonorrhoea and syphilis in men who have sex with men are more likely to be ascertained as high uptake of pre-exposure prophylaxis (PrEP) for HIV infection within this community provides opportunities for regular screening (2) to optimise detection and infection control.

In 2023 the Consensus Statement on doxycycline prophylaxis (Doxy-PEP) for the prevention of syphilis, chlamydia and gonorrhoea among gay, bisexual, and other men who have sex with men in Australia was released (5). The role of Doxy-PEP in reducing bacterial STIs, including how to prescribe it and its implications for antimicrobial resistance is an emerging area of which GP need to stay informed.

Universal antenatal testing of syphilis is needed to achieve the goal of eliminating the re-emergence of congenital syphilis.

In NSW, notification rates of syphilis have been increasing amongst women of reproductive age (2). In 2023, almost 20% of men with infectious syphilis in NSW report female-only sexual partners, a ten-year high. These epidemiological trends highlight the growing risk of congenital syphilis (2). Compared with 2022, the number of pregnant women in NSW diagnosed with syphilis was 27% higher in 2023, with 28 women diagnosed during pregnancy and 155 women within reproductive age contracted syphilis, an increase from 120 (2).

Congenital syphilis can result in miscarriage, stillbirth or neonatal death with surviving babies at risk of life-long complications (6). Babies born to Aboriginal mothers have a higher risk of congenital syphilis and their outcomes are worse than babies born to non-Aboriginal mothers with active syphilis infection . While case numbers are small, all cases of congenital syphilis are considered health system failures of antenatal services and infectious diseases surveillance and are subject to a health investigation (6).

In 2023, NSW Health recently updated advice on syphilis screening during pregnancy. Screening tests must be offered at two time points during pregnancy: at the first antenatal visit and between 26 to 28 weeks' gestation, with more frequent testing required for higher risk pregnancies (6). The strategic target is for at least one administered test in 100% of pregnancies. In 2023, 95% of women delivering in public hospitals had been screened during the first trimester of their pregnancy while early data showed that 67% of women delivering in public hospitals during December 2023 had been tested during the second trimester of gestation (2).

In 2022 within the South-Eastern Sydney Local Health Network, 78.5% Of Aboriginal mothers and 79.9% of non-Aboriginal mothers giving birth in public hospitals presented for their first antenatal visits within 14 weeks. By 20 weeks, 94% of Aboriginal mothers and 95.4% of non-Aboriginal mothers presented for an initial visit. Corresponding figures for the Sydney Local Health District are not available. These figures suggest potential gaps in opportunities for antenatal screening.

A need to increase comprehensive STI testing in target priority populations: Men who have Sex with Men, sex workers, trans and gender diverse people and Aboriginal People.

According to the 2024 GBQ+ Community Periodic Survey for Sydney of 2,761 respondents, 77.9% of HIV-negative respondents and 79.4% of respondents living with HIV had reported any STI test in previous twelve months . As the survey is not representatively sampled, it is unclear to what extent participation in STI testing can be generalised to the target priority populations. These estimates could

be at the higher end as respondents to health surveys may be more likely to participate in preventive sexual health behaviour.

The Sydney survey provides relevant data for CESPHN given men who have sex with men are highly represented within the region, however respondents are not exclusively CESPHN residents. Respondents to the survey were predominately cisgender men (94.5%), reporting a gay identity (82.7%) with few identifying as transgender (1.5%). Over half (58.0%) were born in Australia. Few identified as Aboriginal (3.0%). Data on priority groups other than those represented in the survey are therefore needed to identify needs.

Facilitating equitable and accessible care

Two core targets have been set in the NSW Sexually Transmissible Infections Strategy (3). Reducing stigma is a core and explicit aim in national and state strategies to dismantle barriers to health services (3) . The 2023 National Debrief Survey of 2,338 people aged 18-29 years (77% heterosexual) included 8% who had ever been diagnosed with an STI . More than half (58%) of people diagnosed with an STI reported negative experiences by a heath care worker. In an online survey of 1000 Health Care Workers across Australia, a sizeable minority reported anticipated behaving negatively towards people due to their sexual orientation (21%), or if affected by HIV (30%), Hep B (28%) and Hep C (27%). The prevalence of self-reported negative attitudes towards sex workers and people who inject drugs were higher (37% and 53%, respectively).

Inaccurate reporting and missing data on Aboriginal status has hampered surveillance and infection control in Aboriginal communities. Therefore, NSW health has called for health workforce education to improve reporting as part of its strategy to optimise equity of sexual health service delivery to the Aboriginal community.

Antimicrobial Resistance in the treatment of Gonorrhoea

Antimicrobial resistant (AMR) gonorrhoea of concern in NSW are strains resistant to azithromycin and ceftriaxone and/or with decreased susceptibility to ceftriaxone (2). On June 13, 2024, NSW Health notified GPs of rapid increases in drug resistance to azithromycin and ceftriaxone within the jurisdiction. AMR gonorrhoea is an issue for CESPHN given the demographic characteristics of cases. Of the 17 notifications of AMR gonorrhoea of concern in NSW almost all were from metropolitan Sydney (N=16) while ten cases (58%) were in men who had sex with men. Bisexual males were affected in two cases (2).

Multi-drug-resistant strains are prevalent in some overseas born communities who reside in the region whilst temporarily contributing to educational and employment activities. Therefore, this evolving and urgent threat to gonorrhoea infection control requires strategies that assist international visitors, travellers and students to access sexual health services.

SEXUAL HEALTH

Mpox

CESPHN has recorded the highest number of Mpox notifications since Mpox was introduced to Australia in 2022. In 2024, Sydney experienced its largest Mpox outbreak. From June 1 to November 30, there were 508 notifications of Mpox amongst residents in the South Eastern Sydney and Sydney Local Health Districts, representing 64.7% of all NSW notifications.

In NSW, local transmission now accounts for 90% of incident cases. Most cases have occurred in individuals aged between 25 to 49 years. The latest Mpox Surveillance Report shows eleven cases notified in the week to November 30, similar to the previous week and a decline from around 30 cases in the previous two weekly reporting periods after notifications had peaked at more than 50 for each of the last three weeks of September. In the last week of November, nine of the eleven notifications for NSW occurred in residents within the two local health districts of CESPHN.

Mpox is not a sexually transmitted disease, although sexual activity increases transmission risk due to close physical contact. In NSW, Mpox predominately affects males and men who have sex with men. However, any person is at risk if exposed to the virus via any close contact with infectious people or shared household items such as towelling and bedding. Mpox can spread even if “safe sex” is practiced.

Vaccination is freely available to at risk groups and requires two doses 28 days apart to maximise effectiveness (that is, protection against infection) (2). Most urban vaccination centres in NSW are located within CESPHN. Vaccine effectiveness with the JYNNEOUS vaccine is estimated to be 75.2% for a single dose and 85.9% for two doses. Protection against infection through vaccination is 70.2% in immunocompromised people (such as might occur with HIV infection), compared with 87.8% in immunocompetent people.

Vaccine uptake between June 1 to November 30, 2024, 4.6% (N=32) of NSW cases were hospitalised of which 23 (72%) were unvaccinated and 16% were only partially vaccinated. Of all cases diagnosed, 59.9% were not vaccinated or partially vaccinated. While representative estimates of vaccine uptake are not available for the CESPHN region, the 2024 GBQ+ Community Periodic Survey, Sydney, found that half (49.7%) were unvaccinated, while 10.4% had received one dose , broadly corroborating prevalence of vaccination in NSW Health case notifications. However, there is a need for better quality representative data on vaccine uptake in all at-risk populations.

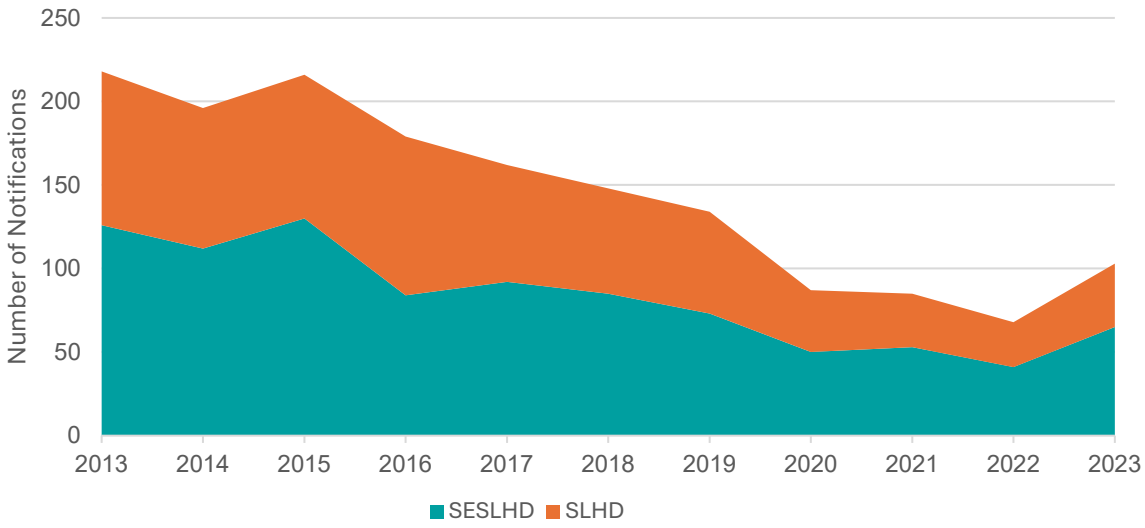
As of December 5, 2024, health authorities continue to report that all cases in Australia are caused by the relatively less severe Clade IIb strain of the virus. Currently, there is a Public Health Emergency of International Concern due to spread of the Clade 1b strain in Western Africa. The Clade 1b strain has the potential to cause more serious disease. Increasing vaccination and public education is needed to prepare for the possible introduction and transmission of the Clade 1b strain in Australia.

Human immunodeficiency virus

In 2023, 231 people were newly diagnosed with human immunodeficiency virus (HIV) in NSW of which 103 (45.5%) were residents of CESPHN. South Eastern Sydney LHD recorded 65 notifications (28.1%) and Sydney LHD recorded 38 (16.5%). HIV Notifications have been falling in NSW to 2019

and decreased further during the COVID-19 pandemic. In 2023, notifications increased above 2019 levels (Figure 1).

Figure 1: HIV Notifications by Year, 2023



Source: NSW Health, 2023

For NSW, there was an 26% increase in notifications from an average yearly number of 184 during the COVID-19 pandemic years (2020-2022). However, incident diagnoses were 20% lower than the pre-pandemic era of 2017-2019. Of the 231 newly diagnosed cases in NSW, 168 (71.7%) were in men who had sex with men with 64.9% born overseas. One-fifth (20.3%) of new cases occurred with heterosexual transmission.

Numbers of new cases in Australian-born men who have sex with men were lower in 2023 (N=59) when compared with pre-pandemic (93.3 average cases) and COVID-19 pandemic eras (64.3 average cases). In contrast, cases in overseas born men who have sex with men and in people reporting heterosexual transmission have increased compared with the COVID-19 pandemic years and when compared with the pre-pandemic years .

Within Sydney areas designated as “gay postcodes” (defined as areas of Sydney where greater than 5% of the adult male population are estimated to be gay, most of which are located within the CESPHN region), there was a larger decrease in notified cases from pre-pandemic to 2023 levels amongst Australian born men who have sex with men (57% decrease) compared with overseas born men with have sex with men (27% decrease).

As acknowledged in CESPHN’s previous Needs Assessment report, access to sexual and reproductive health services may be limited by unfamiliarity with the Australian health care system, financial barriers due to Medicare ineligibility and limited knowledge of sexual health. Lack of social support, language barriers and culturally embedded stigma of STIs may further exacerbate alienation from local health services amongst overseas born men who have sex with men.

SEXUAL HEALTH

Men who have sex with men born in South-east and other regions of Asia are anecdotally identified as an at-risk group for HIV notifications. Young female international students are identified as a vulnerable demographic as sexual assault is under-reported and knowledge about sexual health and contraception may be lacking. Sex workers and people who inject drugs report high levels of stigmatisation within health-care settings, therefore creating and sustaining barriers to accessing care and accessing timely care.

In NSW, two of the three UNAIDS 95-95-95 targets have been met: 98% of HIV diagnosed people are receiving treatment and 99% have an undetectable viral load- these targets mean reduced incidence of morbidity associated with HIV infection and reduced transmission rates. It is estimated that 93% of all people living with HIV are aware of their HIV status. Other metrics compared with strategic targets are shown in the table below which highlight service goals in need of improvement.

Table 1: Select prevention, testing and treatment goals

Strategy	2023	Target
MSM casual partners reporting at least one form of HIV Prevention	83%	90%
HIV negative MSM who have sex with male casual partners without a condom taking PrEP	76%	90%
20% or lower reported receptive syringe sharing among people who inject drugs	17%	<20%
People living with HIV in NSW are diagnosed (2022 data)	93%	95%
New diagnoses who initiated ART within 2 weeks of diagnosis	55%	90%
People diagnosed with HIV in care are on treatment	96%	95%
People on treatment with undetectable viral load at 6-month follow-up (Jan-Jun 2023)	84%	95%
People living with HIV report a good quality of life (2022 data)	75.5%	75%

Source: NSW Health, 2023

Opportunities

- Provision of education and further support to build general practitioner confidence in diagnosing, testing and treatment prescription
- Engagement with local at-risk populations to encourage uptake of preventive strategies and promotion of testing.
- Stronger active identification of cases and engagement with general practitioners
- Increase knowledge of antimicrobial resistance in the treatment of gonorrhoea
- Promotion of vaccination to increase protection against Mpox
- Improve accessibility of sexual and reproductive health services.

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CENTRAL AND
EASTERN SYDNEY
An Australian Government Initiative

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES' HEALTH AND WELLBEING

2025-2027 Needs Assessment

In this document we have used the terms Aboriginal, Aboriginal person and Aboriginal people/s when referring to Aboriginal and Torres Strait Islander peoples or people that identify as from the First Nations community. We chose Aboriginal because it is inclusive of different language groups and areas within the CESPHN region where this Needs Assessment will be used. There will be some instances where the terminology will be different to our preferred terms, as we use the terminology of the data set being used.

Contents

List of tables

List of figures

Overview

There were an estimated 16,265 Aboriginal people within the Central and Eastern Sydney PHN (CESPHN) region in 2021, accounting for 1.05% of the total population. The areas where most Aboriginal live is in Sutherland Shire (20.1%) Sydney-City IARE (18.5%) and Randwick-La Perouse IARE (14.1%). More than half (52.7%) of the Aboriginal population within the CESPHN region is under 30 years of age.

The strength of Aboriginal communities in the CESPHN region is rooted in their rich cultural heritage, strong family and social networks, effective community leadership, and growing engagement in health, education, and economic development. While there are significant challenges, Aboriginal people continue to demonstrate remarkable resilience, empowerment, and unity in their efforts to address disparities and promote the wellbeing of their communities. Their ongoing work to preserve and celebrate culture, improve health outcomes, and advocate for social change is a testament to the strength of these communities.

Key issues

- The impact of past traumas and injustices and the effects of intergenerational trauma
- Aboriginal children in NSW are significantly over-represented in the child protection system
- Aboriginal adults in NSW are over-represented in the criminal justice system and the youth justice system
- Suicide is 3 times more prevalent in this population than the general population in the region
- ED presentations and hospital admissions are high in the region
- 30% of all Aboriginal people in the CESPHN region, had at least one long term health condition
- High rates of smoking at some time during pregnancy
- Aboriginal babies are less likely to be born within a healthy weight range compared with Non-Aboriginal babies (88% versus 95%)
- High numbers of carers of people with disabilities
- High rates of domestic violence and abuse
- The percentage of Aboriginal people living with overweight or obesity increased from 57% in 2014 to 72% in 2023.

Key gaps

- Continuity of healthcare transition from correctional facilities to general practice and other primary care services
- Reducing disparities in preventable health measures and trying to improve health outcomes
- Promote better use of Urgent Care Centres and primary care to the community to avoid ED and hospital admissions
- Appropriate culturally safe care throughout the health system that is tailored to the needs of this community
- Uptake of 715 assessments.

Background

Prior to the colonisation of Australia, the health and wellbeing of the Aboriginal and Torres Strait Islander population was robust, holistic and centred around the balance between physical, emotional and spiritual wellbeing. Primary health care in the traditional sense consisted of traditional healers, bush medicine, healing songs and spiritual practices (1) (1).

Colonisation had a profound impact on the Aboriginal population including:

- Displacement from their land
- Introduction of European disease
- Intergenerational trauma
- Cultural and spiritual disconnection
- Violence and conflict.

These factors have contributed greatly to health disparities and challenges faced by Aboriginal and Torres Strait Islander peoples.

Many Aboriginal people in the CESPHN region maintain a strong connection to the land, or Country which is central to their identity and spirituality. This connection to land contributes to mental and physical health, as people draw strength from their ancestral ties and the natural environment. The local communities have a deep understanding of the land, passed down through generations, and engage in environmental stewardship as evidenced by the Gamay Rangers service in the La Perouse area. This relationship with nature helps promote sustainability and wellbeing within these communities.

Aboriginal communities in the CESPHN region are focused on engaging young people and providing opportunities for empowerment, education, and leadership development. Programs such as the La Perouse Strengthening Our Mob Program and Tribal Warrior's youth mentoring services help to foster a sense of pride in cultural heritage and can offer pathways to employment and education.

With the consultation and support of the Aboriginal Advisory committee, CESPHN Aboriginal health programs focus on providing care that respects cultural practices while addressing both physical and mental health needs. These initiatives play a critical role in tackling the health inequities faced by Aboriginal people, particularly in areas like chronic disease management, mental health, and preventative care.

Aboriginal elders and community leaders in the region continue to guide and advocate for their communities. Their leadership plays a critical role in ensuring that community members' needs are met and that their voices are heard in decision-making processes.

Communities continue to be deeply connected through extended family and kinship systems. These structures are vital in maintaining strong social cohesion and ensuring that families support each other. Family is central to Aboriginal culture, and these relationships are a key strength in community life.

Stolen Generations

The Stolen Generations refers to the Aboriginal and Torres Strait Islander children who were forcibly removed from their families by Australian federal and state government agencies and church missions between approximately 1910 and 1972 This policy aimed to assimilate these children into white society, often placing them in foster homes, orphanages, or institutions (2).

The historical injustices and trauma inflicted upon Aboriginal communities through the forced removal of children, and the negative impacts this has had, not only on the individuals removed but on subsequent generations through intergenerational trauma needs to be understood by health care providers. Recognising these past wrongs is a vital step towards healing and reconciliation between Aboriginal and non-Aboriginal Australians.

Intergenerational trauma

Intergenerational trauma has had profound and lasting impacts on Aboriginal and Torres Strait Islander communities in Australia. This is the transmission of trauma and its effects from one generation to the next. This can happen through various mechanisms, including genetic changes, behavioural patterns, and emotional responses.
Some of the effects that intergenerational trauma can have on Aboriginal people:

- Difficulty forming secure attachments
- Increased risk of poor mental health
- Suicidal ideation and self-harm
- Chronic health concerns due to prolonged stress
- Family and community disruption
- Loss of cultural identity
- Educational disadvantage
- Economic hardship (3).

Programs that focus on cultural continuity and community-led healing are essential in supporting the recovery and wellbeing of Aboriginal and Torres Strait Islander peoples (4) (5) (6).

Closing the Gap

Closing the Gap is an Australian government strategy aimed at reducing the disparities between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians across several key areas, including health, education, employment, and life expectancy. Closing the Gap is crucial for ensuring that Aboriginal and Torres Strait Islander peoples have equal opportunities to thrive and maintain their cultural heritage while achieving better life outcomes (7).

Table 1: Closing the Gap targets that CESPHN contributes to

Target	CESPHN activity
Everyone enjoys long and healthy lives (Outcome 1)	Work with primary health services to ensure they provide services in a culturally sensitive way
Children are born healthy and strong (Outcome 2)	GP Antenatal Shared Care Program
Children thrive in their early years (Outcome 4)	Aboriginal young people's speech pathology program; Sydney Children's Hospital ITC program, place-based Healthy Schools program
Students achieve their full learning potential (Outcome 5)	Deadly Choices Program to promote healthy lifestyle initiatives
Students reach their full potential through further education pathways (Outcome 6)	Youth health and wellbeing programs
Young people are engaged in employment or education (Outcome 7)	Babana Aboriginal employment days
Adults are not overrepresented in the criminal justice system (Outcome 10)	Community Restorative Centre Alcohol and Other Drug Transition Program
Aboriginal and Torres Strait Islander families and households are safe (Outcome 13)	DFV Assist Program
People enjoy high levels of social and emotional wellbeing (Outcome 14)	Multiple mental health programs, I-ASIST training
Cultures and languages are strong, supported and flourishing (Outcome 16)	Cultural awareness training program

Source: Closing the Gap, 2024

Geography and demographics

There were an estimated 16,265 Aboriginal people within the Central and Eastern Sydney PHN (CESPHN) region in 2021, accounting for 1.05% of the total population.

There are 12 Indigenous Areas (IARE) within the CESPHN region. The region's Aboriginal population is concentrated in Sutherland Shire IARE (20.1%) Sydney-City IARE (18.5%) and Randwick-La Perouse IARE (14.1%) (8).

Table 2: Usual resident population (URP) in the CESPHN region by IARE, 2021

Indigenous Area (IARE)	Aboriginal persons	% of region
Botany Bay	1,103	6.8
Canterbury -Bankstown (part a)	1,133	7.0
Hurstville-Kogarah	1,040	6.4
Leichhardt	611	3.8
Marrickville	1,253	7.7
Randwick-La Perouse	2,354	14.5
Rockdale	863	5.3
Sutherland Shire	3,273	20.1
Sydney-City	3,009	18.5
Sydney Inner West	1,169	7.2
Woollahra-Waverley	452	2.8
CESPHN	16,265	100

Source: PHIDU, 2024

The La Perouse Aboriginal community is a vital and resilient community in the heart of Sydney, with a rich cultural history and strong connections to its land and traditions. La Perouse was one of the earliest places where Aboriginal people were settled by the British after colonisation, often as a result of displacement from their traditional lands. The community remains culturally strong. Through advocacy and cultural preservation, the community continues to foster a strong sense of identity and empowerment while working to overcome the barriers that have historically marginalised Aboriginal people.

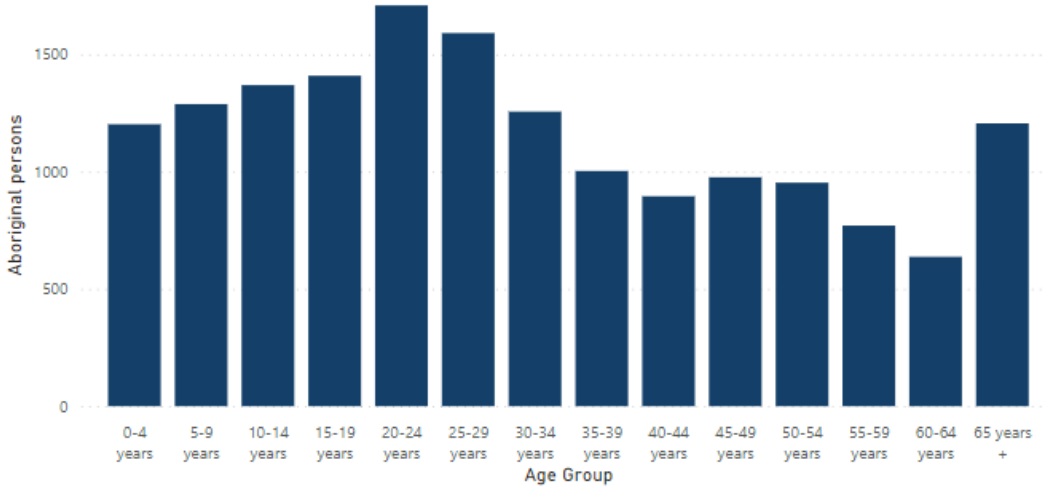
The Redfern Aboriginal community remains one of the most significant and resilient urban communities established in Australia. It has a rich history of activism, cultural expression, and social justice advocacy. Despite the challenges posed by social disadvantage, housing issues, and systemic racism, the Redfern Aboriginal community continues to thrive through its strong networks, cultural pride, and ongoing efforts for empowerment and equality. The community serves as a model for urban Aboriginal life, showing the strength of identity, culture, and solidarity in the face of adversity.

Age

More than half (52.7%) of the Aboriginal population within the CESPHN region is under 30 years of age. One in five (20.3%) Aboriginal people are aged between 20-29 years (n= 3,581) (8).

The highest proportion of the population are within the working age-group brackets of 15-34. This young population offers an opportunity to engage in preventative health initiatives and screening with a view to tackling the prevalence of chronic disease rates that currently exist in the older population.

Figure 11: Aboriginal Population by 5-year age groups, CESPHN region, 2021 URP



Source: PHIDU, 2024

Births

Aboriginal mothers who gave birth in the CESPHN region in 2022 accounted for 1.5% of births (NSW 5.5%). 1.9% of babies born in the region in 2022 identified as Aboriginal (NSW 7.4%).

Determinants of health

Lifestyle risk factors

Diet

Dietary risk factors are one of the leading risk factors contributing to ill health and premature deaths after tobacco use, overweight and obesity in Australia. They contribute to coronary heart disease, bowel cancer, type 2 diabetes and stroke.

Table 3: Dietary risk factors of Aboriginal residents by sex, NSW

Risk Factors	Sex	
	Males	Females
Did not meet recommended fruit guideline	69.9%	65.3%
Did not meet recommended vegetable guideline	96.6%	91.3%
Usually consumes sugar sweetened or diet drinks	78.1%	71%
Usually consumes sugar sweetened drinks	69.4%	52.3%
Usually consumes diet drinks	26.3%	25.7%

Source: National Aboriginal and Torres Strait Islander Health Survey, 2022–23

Smoking

The percentage of daily smokers in NSW has decreased among both Aboriginal and non-Aboriginal people. In 2023, the percentage of daily smokers in NSW that identify as Aboriginal is 21.9% (non-Aboriginal population 7.7%).

The reasons for the high smoking rates in the Aboriginal community are multifaceted and include:

- Social norms constructed around smoking culture
- Socioeconomic disadvantage
- Coping mechanisms to combat life stressors such as housing concerns, poor mental health, grief and loss
- Community bonding and sharing of tobacco products (9)

Despite this, the percentage of Aboriginal daily smokers has decreased by 43.3% since 2016 reflecting a strong focus on health and wellbeing within the community and the success of government initiatives (10).

Vaping

Although there is no data on vaping within the Aboriginal population within the CESPHN region, anecdotally we have heard that there has been an increase across the CESPHN region among both Aboriginal and non-Aboriginal communities.

In NSW across the combined years 2022-2023, people aged 16-24 years had the highest rate of current e-cigarette use (19%) of any age group. This was a significant increase 2019-2020, when the rate of current use in this age group was 4.5%. According to HealthStats NSW, the 16-24 age group had the highest rate of ever having used e-cigarettes (45%) of any age group. This was a significant increase since 2019-2020, when the rate of ever using e-cigarettes in this age group was 21% (11).

In 2022-2023, among Aboriginal people in NSW:

- 15% were currently using e-cigarettes. This was an increase from 2.0% in 2019-2020.
- 31% had used e-cigarettes at some time. This was an increase from 13% in 2019-2020 (11).
- CESPHN has funded a Tackling Indigenous Smoking program, Nah Joomelah which is delivered through the La Perouse Local Aboriginal Land Council to provide smoking and vaping prevention and health promotion messaging across the CESPHN region. Feedback on additional needs in relation to this program is an acknowledgement of the support of traditional Nicotine Replacement Therapy (NRT) being more readily available than the supports to stop vaping, with a distinct lack of local GPs/ Pharmacies willing to provide access to vapes as regulated within Australia.
-

Socioeconomic disadvantage

The Centre for Aboriginal Economic Policy Research (CAEPR) developed the Indigenous Relative Socioeconomic Outcome (IRSEO) index to measure relative advantage or disadvantage at the Indigenous Area level, where a score of 1 represents the most advantaged area and a score of 100 represents the most disadvantaged area.

The IRSEO index for the CESPHN region reflects a relatively advantaged area (IRSEO = 10). None of the IAREs within the CESPHN region have an IRSEO index equal to or lower than the national or

NSW index. Within the CESPHN region, Canterbury-Bankstown (part a) has the highest IRSEO score at 26 (8).

While the population is relatively advantaged in comparison to other areas cost of living in the region is high and housing affordability is a major issue. Approximately half of low-income Aboriginal households are under financial stress from their mortgage or rent (8).

Table 4: Indigenous Relative Socioeconomic Outcome (IRSEO) index score by IARE, 2021

Indigenous Area (IARE)	IRSEO Index score
Botany Bay	15
Canterbury - Bankstown (part a)	26
Hurstville - Kogarah	12
Leichhardt	7
Marrickville	5
Randwick - La Perouse	14
Rockdale	7
Sutherland Shire	3
Sydney - City	11
Sydney - Inner West	6
Woollahra - Waverley	1
CESPHN	10
New South Wales	35
Australia	41

Source: PHIDU, 2024

Contact with the criminal justice system

Adult imprisonment

In March 2024, there were 3,841 Aboriginal and Torres Strait Islander adults in custody in New South Wales, making up 30.8% of the adult prison population despite the Aboriginal population making up 4.2% of the total NSW population (12).

The over-representation of Aboriginal and Torres Strait Islander individuals in the criminal justice system is a significant concern and reflects:

- Social and economic disadvantage
- Systemic racism and discrimination
- Mental health and substance abuse concerns
- Lower levels of education and employment opportunities (13) (14)

The NSW Aboriginal and Torres Strait Islander people imprisonment rate in September 2024 was 2,150.9 persons per 100,000 Aboriginal and Torres Strait Islander adults in the September Quarter 2024. There has been an increase over the past two quarters (15).

Community-based correction allows individuals convicted of crimes to serve their sentences outside of prison. There were 21,701 Aboriginal and Torres Strait Islander persons serving community-based correction orders in Australia in September 2024 (15).

Youth justice

A large proportion of young people admitted to Youth Justice NSW identify as Aboriginal and Torres Strait Islander.

- 44.5% (493) young people attending Youth Justice conference
- 52.5% (2,262) young people under community supervision
- 55.1% (1,821) young people remanded in custody
- 66.9% (107) young people sentenced to detention (16).

Consultations identified that cultural connection plays a significant role in reducing criminal involvement among Indigenous youth by fostering a sense of identity, belonging, and resilience through:

- Strengthening identity and self-esteem
- Improving mental health
- Building resilience
- Providing social support (17).
-

The Youth Koori Court (YKC) in New South Wales (NSW) is a specialised division within the Children's Court designed to address the over-representation of Aboriginal and Torres Strait Islander young people in the criminal justice system. The court operates in Surry Hills and involves Aboriginal elders and respected community members in the court process to provide cultural guidance and support to focus on underlying issues such as homelessness, substance abuse and disengagement from education to reduce reoffending. The Youth Koori Court is a great example of how community involvement and a holistic approach has a much more meaningful impact (18).

Child protection

Aboriginal children in NSW are significantly over-represented in the child protection system.

In June 2023, 45% of children in out-of-home care were Aboriginal, despite Aboriginal children making up only about 7% of the child population in NSW. This highlights the urgent need for culturally sensitive and community-led approaches to child welfare (19).

In NSW in 2022-2023:

- Aboriginal children were three times more likely than non-Aboriginal children to be reported at risk of significant harm
- Approximately 6,500 Aboriginal children were in out-of-home care
- Approximately 25,000 reports about Aboriginal children were made to the helpline that reached the threshold for suspected Risk of Significant Harm, which represented 22% of all reports made
- Approximately 1,000 Aboriginal children were deemed unsafe and entered out of home care, representing 44% of all children deemed unsafe
- Approximately 9,000 Aboriginal children were seen by a case worker, representing 31% of all children seen (19).

The high rates of Aboriginal children in the child protection system and the trauma experienced by children removed from their families in past decades has been passed down through generations, influencing their health, wellbeing, and parenting practices. Ongoing involvement with child protection services can exacerbate this trauma by creating:

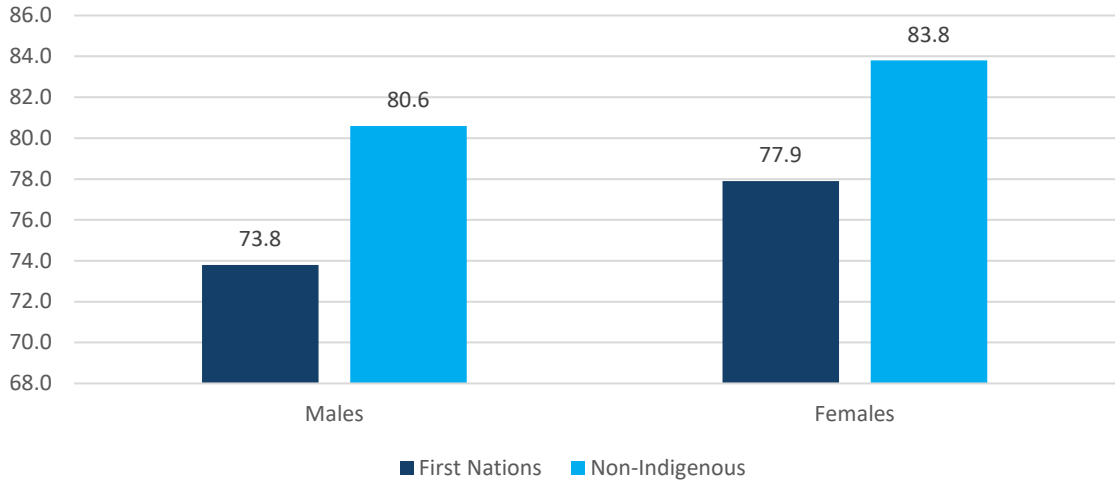
- Distrust of authorities
- Chronic stress
- Higher suicide risk
- Social Isolation
- Cultural disconnection
- Cultural barriers.

Health status

Life expectancy

Aboriginal females born in NSW have a life expectancy of 77.9 years (5.9 years lower than Non-Indigenous residents of NSW) while males have a life expectancy of 73.8 years (6.8 years lower than Non-Indigenous residents of NSW) (20).

Figure 2:2 Life expectancy in NSW by Indigenous status, 2020-2022



Source: Aboriginal and Torres Strait Islander Health Performance Framework, 2024

Median age at death

Within the CESPHN region, Aboriginal males have a median age at death of 60 years and females have a median age at death of 67 years. For females, this is consistent with the Greater Sydney and NSW median age at death, however for males the median age at death is 2 years lower than NSW (8).

Table 5: Median age at death by gender and regions, 2018-22

Region	Females (yrs)	Males (yrs)
CESPHN	67	60

Greater Sydney	67	62
NSW	67	62
NSW, QLD, SA, WA & NT	64	59

Source: PHIDU, 2024

Infant and child mortality

Perinatal mortality

Perinatal mortality is defined as deaths commencing from at least 20 weeks of gestation (foetal deaths or 'stillbirths') and deaths of live-born babies within the first 28 days after birth (neonatal deaths) (21).

In NSW there were 789 Aboriginal perinatal deaths in 2022 a rate of 12 per 1,000 births (non-Aboriginal babies' rate of 7.8) (22).

Addressing perinatal deaths requires a comprehensive approach that includes improving healthcare services, addressing social determinants of health, and ensuring equitable access to care for Aboriginal people.

Infant mortality

Infant mortality is defined by deaths in children under 1 year of age. Between 2017 and 2021 there were 3.9 infant deaths per 1,000 Aboriginal live births, compared to 3.0 infant deaths per 1,000 non-Aboriginal live births across NSW (23).

Child mortality

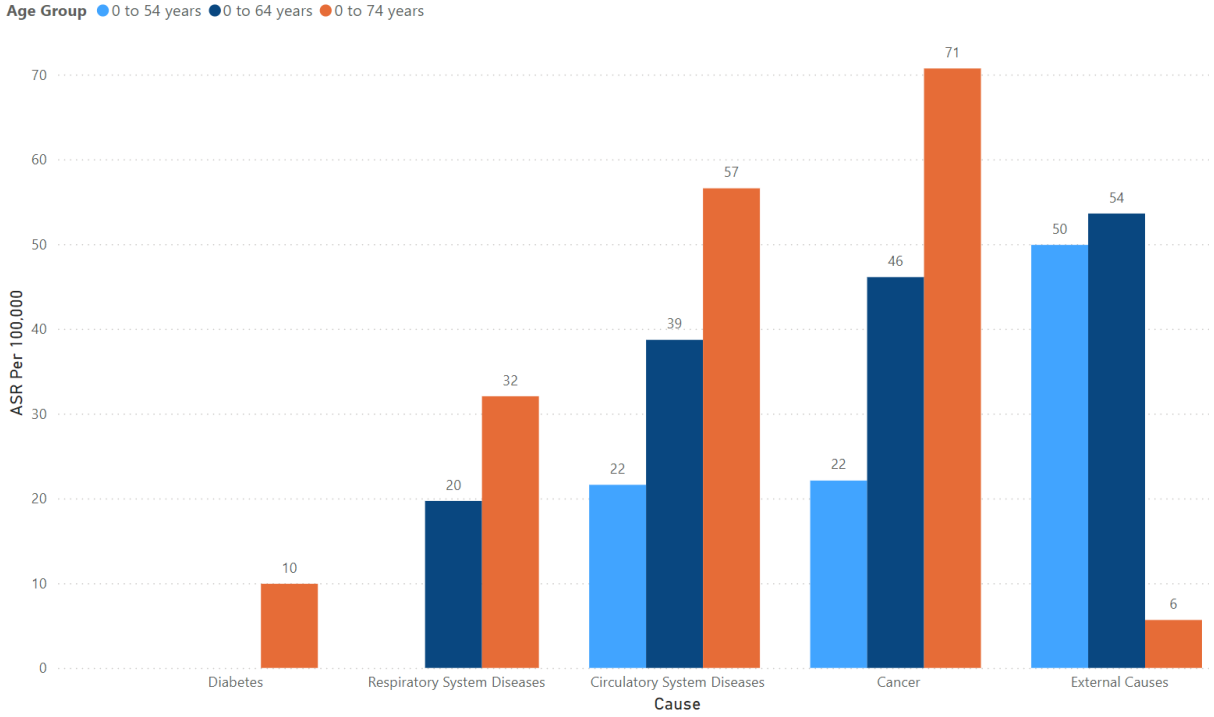
The child (0-4 years) mortality rate among Aboriginal children in NSW between 2017 and 2021 was 98.7 per 100,000 compared to 69 for non-Indigenous children.

Although the rate of child death was significantly lower for NSW in comparison to other states and territories, there is still substantial work that needs to be done to close the gap between Aboriginal and non-Indigenous child mortality rates.

Premature mortality

Premature mortality refers to deaths that occur among people aged under 75 years. As seen in the below graph, the three main causes of preventable deaths that occurred within the CESPHN region were cancer, circulatory system diseases and respiratory system diseases.

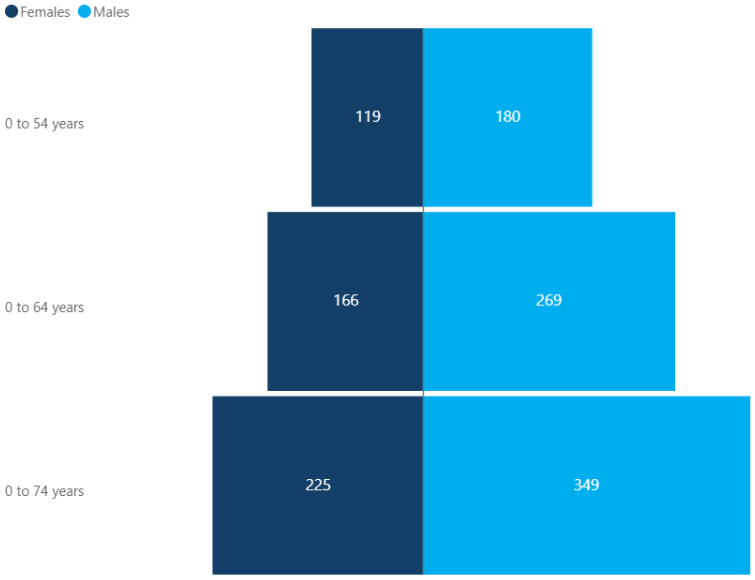
Figure 33: Premature deaths by age group and cause for Aboriginal people, CESPHN region, 2018-22



Source: PHIDU, 2024

Males within all age brackets had a higher age standardised rate (ASR) of premature deaths per 100,000 population than females. In the 0 to 64 years age bracket, the ASR of premature deaths in males was 1.3 times the rate for females (8).

Figure 44: Premature deaths by age group and gender, CESPHN region, 2018-22



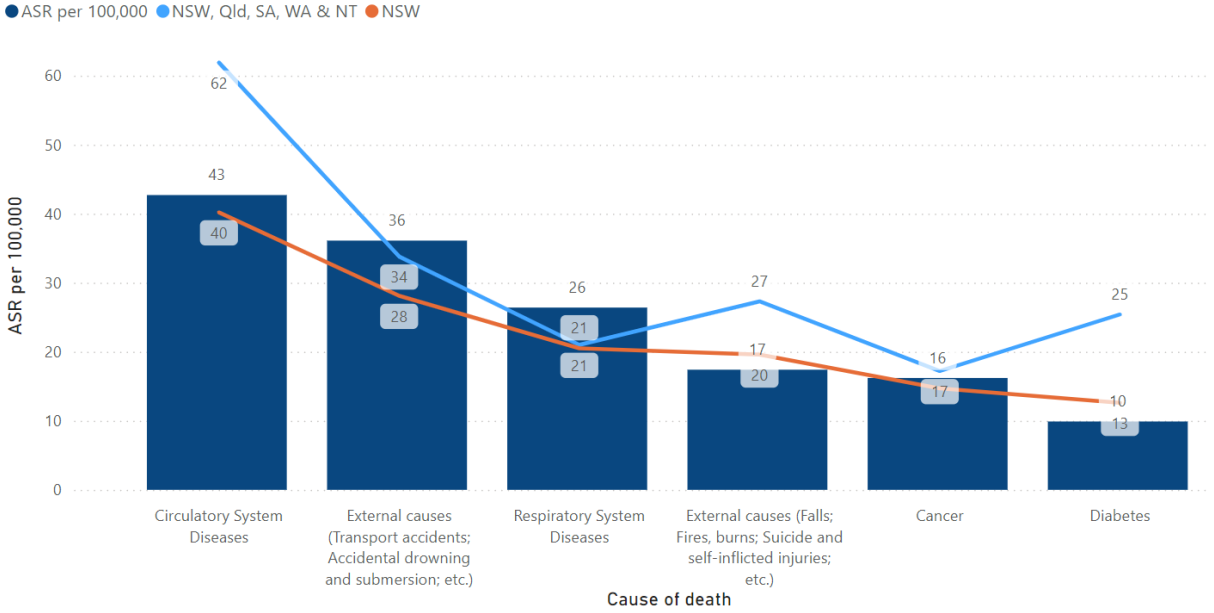
Source: PHIDU, 2024

Avoidable deaths

Potentially avoidable deaths are deaths before the age of 75 years from conditions that are potentially preventable through primary or hospital care. The rate of potentially avoidable deaths was the lowest in NSW in comparison to the other states and territories in 2015-2019 at 149 per 100,000 (21).

Avoidable deaths from circulatory system diseases had the highest age standardised rate (ASR) within the CESPHN region (43 deaths per 100,000), followed by avoidable deaths from external causes (36 deaths per 100,000) (21).

Figure 55: Avoidable deaths by cause of death, CESPHN region, 2018-22



Source: PHIDU, 2024

Long term health conditions

In the CESPHN region, just over 30% of all Aboriginal people had at least one long term health condition (8).

Table 6: Percentage of people who self-reported long term health conditions, 2021

Number of selected chronic conditions*	CESPHN (%)	NSW (%)	Aust (%)
No selected chronic conditions	59	54.6	56.9
One	21.4	22.3	20.6
Two	6.1	7.3	6.7
Three or more	3.3	4.4	4.0
Has one or more selected chronic conditions	30.8	34.1	31.3

Source: PHIDU, 2024

CESPHN commissions Sydney and South Eastern Sydney local health districts and Sydney Children's Hospital Network to deliver the Integrated Team Care program to support Aboriginal people with chronic conditions. The program provides care coordination, outreach and supplementary services.
The Practice Incentives Program – Indigenous Health Incentive (PIP IHI) encourages health services to meet the health care needs of Aboriginal and Torres Strait Islander people with a chronic disease. Health services include general practices, Aboriginal Medical Services and Aboriginal Community Controlled Health Services.

Disability

There were 1,180 Aboriginal people in the CESPHN region with a profound or severe disability according to the 2021 census. 904 were aged 0-64 years and 282 were 65 years or older.12.9% of Aboriginal persons aged 15 years and over were providing unpaid assistance to people with a disability.

NDIS participation

As of June 2024, there were a total of 52,449 First Nations participants on the NDIS across Australia, with a growth rate of 32.85% since September 2022. In NSW, there were a total of 17,753 Aboriginal participants in June 2024, representing 33.8% of the total Aboriginal participants across Australia (24).

Within the CESPHN region, a total of 922 participants identified as Aboriginal (25).

Table 7: NDIS participants by Aboriginal status and service district, CESPHN region, 2023-2024

	Aboriginal	Non-Indigenous	Not Stated
South Eastern Sydney	510	10,689	2,214
Sydney	412	5,939	1,287
Australia	52,449	513,370	95,448

Source: National Disability Insurance Scheme, 2024

Demographics

Gender

Across the CESPHN region the rates of hospital admission were higher than NSW rates but lower than the national for both genders. Within the CESPHN region there were IAREs with admission rates higher than NSW rates:

- Leichhardt, Marrickville, Randwick-La Perouse, Sydney-City and Woollahra-Waverley IAREs had admission rates for females all higher than the CESPHN rates.
- Botany Bay, Canterbury – Bankstown, Leichhardt, Marrickville, Randwick-La Perouse and Sydney City IAREs had admission rates for males all higher than the NSW rates (8).

Table 8: Average annual ASR per 100,000 by gender and IARE, 2017-18 to 2020-21

Region	Female	Male
Botany Bay	28,417.3	28,145.1
Canterbury - Bankstown (part a)	27,411.8	21,810.8
Hurstville - Kogarah	20,485.3	18,217.7
Leichhardt	37,973.9	33,326.9
Marrickville	33,980.9	26,397.1
Randwick - La Perouse	40,381.3	34,390.6
Rockdale	22,568.7	18,743.0
Sutherland Shire	22,513.7	17,118.6
Sydney - City	37,410.0	32,041.9
Sydney - Inner West	24,521.2	20,992.4
Woollahra - Waverley	34,052.0	23,083.3
CESPHN	30,748.1	25,795.8
New South Wales	28,524.3	21,534.9
Australia	38,066.4	27,658.0

Source: PHIDU, 2024

Emergency department presentations

The three main causes of ED presentations in 2020/21 were injury poisoning and other causes, mental and behavioural disorders and respiratory disease. Rates of Emergency department presentations for mental and behavioural disorders are well above the Greater Sydney and NSW rates suggesting a need for culturally safe alternatives to ED support.

ED presentation rates overall are higher than the rates for Greater Sydney and NSW. Of particular note is the high rate of non-urgent ED presentations. Promotion of new urgent care services to the Aboriginal population will be important.

Table 9: ED presentations for mental and behavioural disorders for Aboriginal people, ASR per 100,000 2020/21

Age	CESPHN	Greater Sydney	NSW
15-24	929.1	731.6	967.4
25-44	2567	1289.8	1422.3
45-64	1398.8	625.5	619.2

Source: PHIDU, 2024

Table 10: ED presentations by triage category, ASR per 100,000 2020/21

Triage category	CESPHN	Greater Sydney	NSW
Resuscitation and emergency	9,238	8,430.9	8,295.8
Urgent	26,086.7	18,581.9	21,707.4
Semi-urgent	18,195.4	14,226	26,576.9
Non-urgent	26.125.6	16,463.6	20,770.7

Source: PHIDU, 2024

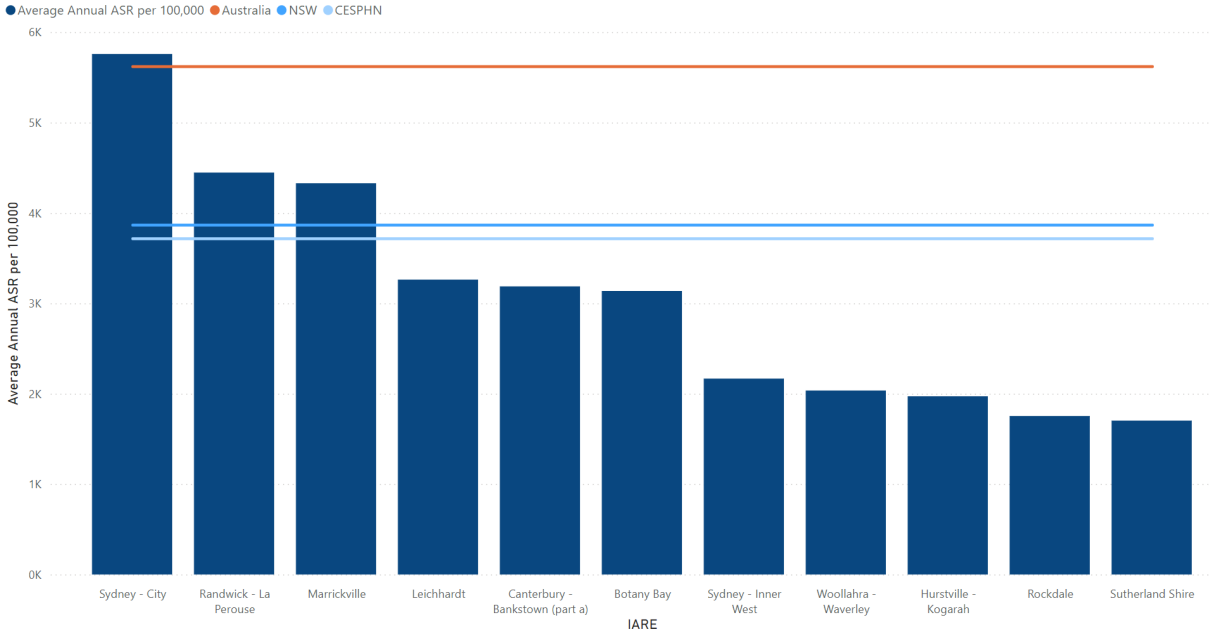
Potentially preventable hospitalisations (PPH)

Total potentially preventable hospitalisations

The rate of potentially preventable hospitalisations by IARE in the CESPHN region was 3,714.9 per 100,000 between 2017-2018 and 2020-2021. This was slightly lower than the NSW rate of 3,865.5 per 100,000 (8).

Within the CESPHN region, Sydney-City IARE, Randwick – La Perouse IARE and Marrickville IARE had higher rates than NSW, with Sydney-City IARE rates also higher than national rates (8).

Figure 66: Total potentially preventable hospital admissions, by IARE, 2017/18 to 2020/21



Source: PHIDU, 2024
Note: There is no published data available for Lord Howe Island IARE.

Within the CESPHN region, the IAREs with the highest rate of potentially preventable hospitalisations (PPHs) were:

- Marrickville IARE for the 0 to 14-years, 15 to 24 years and 65 years and over age groups.
- Randwick-La Perouse for the 25 to 44 years
- Sydney-City IARE for the 45-to-64-year age group (8)

Table 11: Potentially preventable hospital admissions. by IARE and age group, 2017-18 to 2020-21

IARE/Region	0 to 14 years	15 to 24 years	25 to 44 years	45 to 64 years	65 years and over
Botany Bay	1,835.9	1,107.5	3,169.6	4,884.1	13,571.4
Canterbury - Bankstown (part a)	1,853.0	982.9	3,280.6	5,169.6	11,491.9
Hurstville - Kogarah	1,122.0	609.0	1,637.4	3,287.9	8,430.2
Leichhardt	2,507.4	1,229.8	2,502.1	6,171.5	10,169.5
Marrickville	3,750.3	2,913.1	2,977.0	6,589.5	16,019.4
Randwick - La Perouse	2,191.0	1,775.0	4,415.7	8,361.6	13,666.7
Rockdale	1,231.9	1,404.1	1,492.2	2,531.1	5,357.1
Sutherland Shire	953.8	934.9	1,490.5	2,353.6	7,532.8
Sydney - City	3,418.7	1,287.0	4,301.5	14,218.0	14,843.8
Sydney - Inner West	1,509.4	922.3	1,799.3	4,138.6	6,521.7
CESPHN	1945.7	1299.8	2959.6	6873.7	11242.9
Greater Sydney	1895.9	1471.4	2372.1	4934.1	10555.3
New South Wales	2075.8	1658.3	2458.3	5354.3	11052.5
Australia	2810.1	2297.8	4397.8	9120.7	13239.7

Source: PHIDU, 2024

Note: Lord Howe Island IARE is not included as there is no published data available.

Acute potentially preventable hospital admissions

Acute dental conditions had the highest ASR of all acute PPH admissions (354.8 per 100,000 population) in the CESPHN region; higher than the NSW rate of admission (321.8 per 100,000) (8).

Table 12: Potentially preventable hospital admissions by acute condition, 2017-18 to 2020-21

Region	Acute cellulitis	Acute convulsions and epilepsy	Acute dental conditions	Acute ear, nose and throat infections	Acute urinary tract infections
CESPHN	349.9	300.9	354.8	268	273.8
Greater Sydney	266.3	259.5	298.8	276.1	259.5
New South Wales	285.2	272.9	321.8	288.8	264.8
Australia	515.5	404.8	402	385.4	402.8

Source: PHIDU, 2024

Chronic preventable hospital admissions

Chronic Obstructive Pulmonary Disease (COPD) had the highest ASR of all chronic PPH admissions in the CESPHN region (444.2 per 100,000 population).

Table 13: Potentially preventable hospital admissions by chronic condition, 2017-18 to 2020-21

Region	Chronic angina	Chronic asthma	Chronic congestive cardiac failure	Chronic diabetes complications	Chronic Obstructive Pulmonary Disease (COPD)
CESPHN	89.4	206.3	154.5	274.6	444.2
Greater Sydney	55.8	167.7	131.1	239.6	421.5
New South Wales	72.4	155.4	145.3	294.2	457.9
Australia	134.5	189.8	222.6	419.3	536

Source: PHIDU, 2024
Note: Lord Howe Island IARE is not included as there is no published data available.

Preventive health

Immunisation

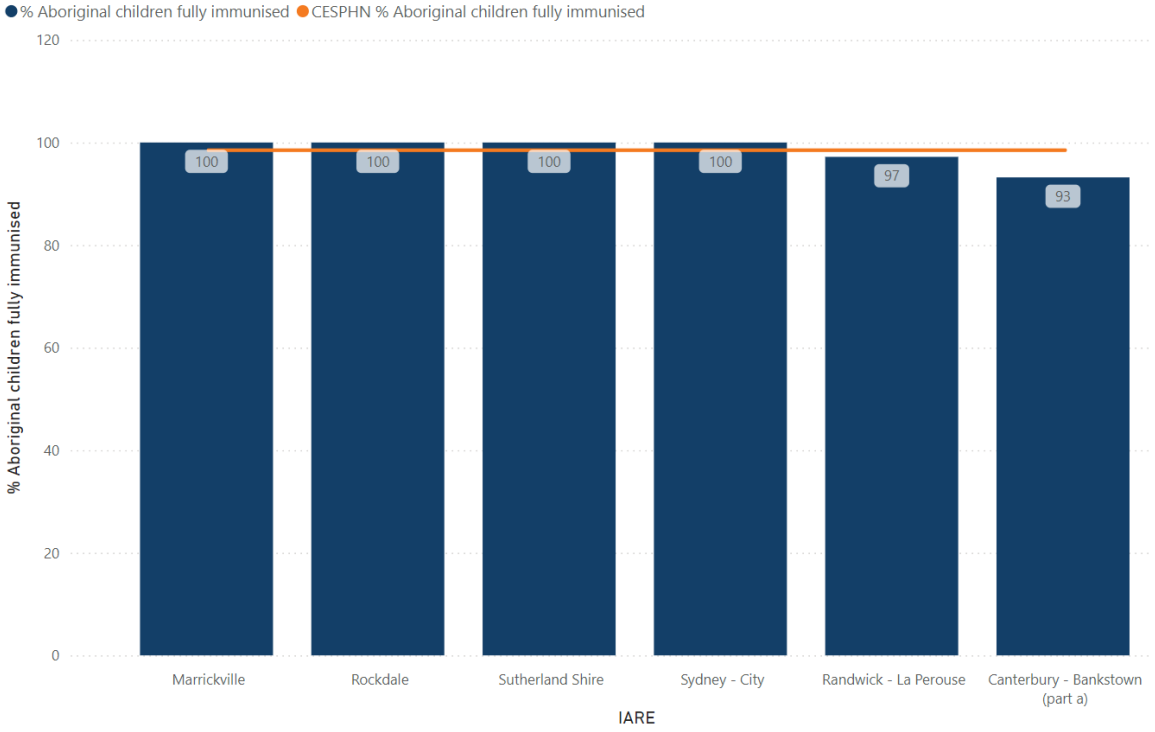
Table 14: Immunisation status of Aboriginal children, by age and region, 2021

Region	1-year-olds	5-year -olds
CESPHN	91.0	98.5
Greater Sydney	94.7	97.2
NSW	94.7	97.6
Australia	93.8	96.8

Source: PHIDU, 2023

In 2021, immunisation rates amongst Aboriginal children aged 1 years old in the CESPHN region were below the target of 95% (91%). Randwick-La Perouse, Canterbury-Bankstown and Marrickville IARE areas had 1 year old immunisation rates well below target.
By the time children reach 5-years old the CESPHN immunisation rates for Aboriginal children exceed state and national rates.

Figure 77: 5-year-olds fully immunised by IARE, 2021



Source: PHIDU, 2023
*** Data not available for Botany Bay IARE, Hurstville - Kogarah IARE, Leichhardt IARE, Sydney - Inner West IARE or Woollahra - Waverly IARE.*

Potentially preventable hospitalisations (vaccine preventable)

Between 2017-2018 and 2019-2021, there were 511.5 potentially preventable admissions for vaccine preventable conditions in the CESPHN region per 100,000 population. This rate is lower than the national rate (597.8 per 100,000), however higher than the NSW rate (292.9 per 100,000).

Within the CESPHN region, Sydney-City IARE had high rates for all vaccine preventable conditions. Rates per 100,000 population were:

- 1.9 times the national rate, and
- 3.9 times the NSW rate (8).

Table 15: Potentially preventable hospitalisations, vaccine preventable per 100,000 population, by IARE, 2017-18 to 2020-21

IARE/Region	Pneumonia and influenza	Total
Botany Bay	90.6	506.0
Canterbury - Bankstown (part a)	134.3	311.8
Hurstville - Kogarah	-	139.4
Leichhardt	260.7	327.9
Marrickville	244.8	650.5
Randwick - La Perouse	216.7	639.8
Rockdale	-	-
Sutherland Shire	51.9	96.6
Sydney - City	263.4	1,133.6
Sydney - Inner West	105.0	276.6
CESPHN	158.9	511.5
Greater Sydney	138.2	340.2
New South Wales	151.1	292.9
Australia	231.6	597.8

Source: PHIDU, 2024

Note: Lord Howe Island IARE is not included as there is no published data available.

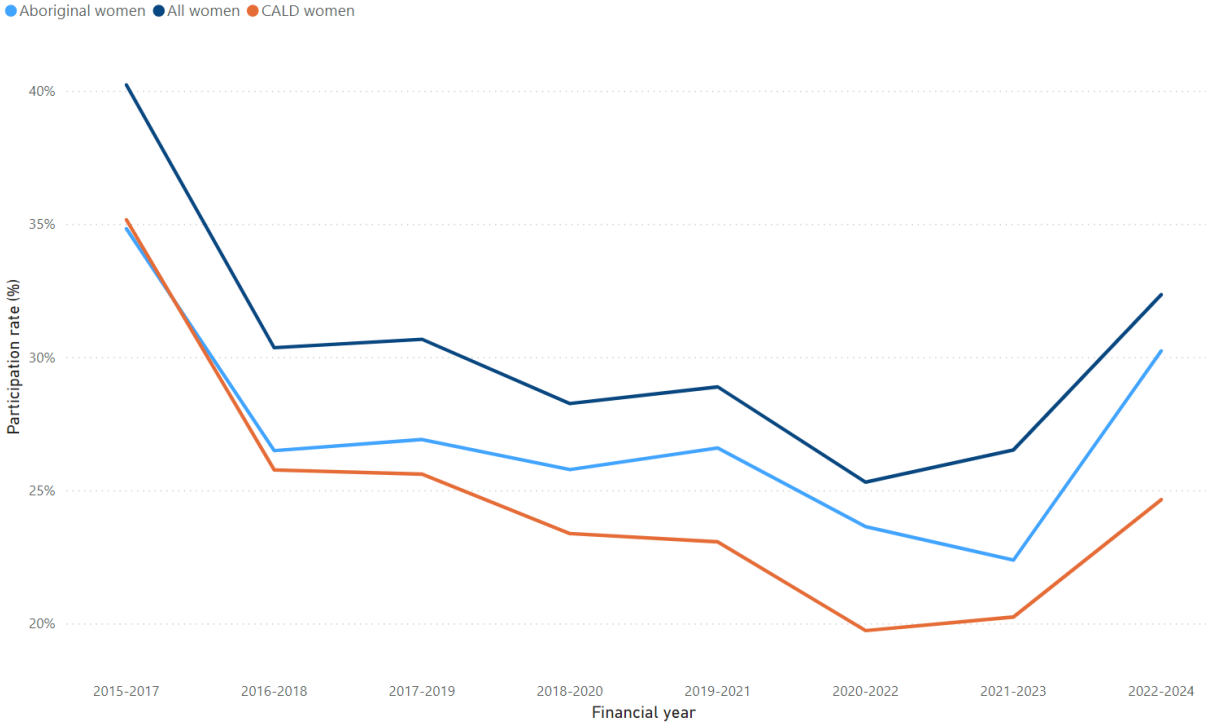
Cancer screening

There is limited local level data on cancer screening participation by Aboriginal people.

BreastScreen

Within the CESPHN region, breast screening participation rates for Aboriginal women aged 50-74 years have been consistently rising since 2021, as demonstrated in the graph below. (26) However screening rates are well below the rate for the eligible CESPHN population of 50.5%.

Figure 88: BreastScreen participation rate, Aboriginal, CALD and all women, CESPHN region, 2020-2024



Source: Cancer Institute NSW, 2024

National Bowel Cancer Screening Program

The annual bowel cancer screening participation rate for people aged 50-74 in the CESPHN region in 2023 is 35.6% slightly below the NSW rate of 37.5%. There is no recent screening participation data for Aboriginal people (27).

Hearing screening

In 2018-19, 42.6% of Aboriginal people aged 7 years and older had a hearing impairment in one or both ears, with 22.7% having a hearing impairment in both ears. In NSW, the proportions were slightly lower, with 37.5% having a hearing impairment and 19.3% with an impairment in both ears. The proportion of people with a hearing impairment in one or both ears increased with age, those aged 15-24 years had the lowest proportion at 28.7%, those aged 55 years and over had the highest proportion at 81.8% (28).

Maternal and child health

Aboriginal women and babies often face significant health challenges, including higher rates of maternal mortality, low birth weights, and early childhood health issues. Services like the Malabar Midwives in the CESPHN region are vital for addressing these disparities and improving the quality of care for Aboriginal mothers.

The Malabar Midwives Service provided by SESLHD and the SLHD Aboriginal Maternal Health Service offer a model of care that is culturally sensitive and designed to address the specific needs of

Aboriginal mothers in Sydney. By combining midwifery care with Aboriginal health workers, the services improve outcomes for both mothers and babies through continuity of care, community involvement, and culturally safe services. This approach helps build trust and provides better support for Aboriginal women throughout pregnancy, birth, and postnatal care. The services take a holistic approach to care, addressing not just the physical health of the mother and child but also emotional, mental, and cultural wellbeing.

The focus is on preventive health and early intervention, aiming to address issues before they become more serious. Midwives work with other health professionals to monitor both maternal and fetal health during pregnancy.

Antenatal care

In 2022, 79.1% of Aboriginal mothers across NSW attended their first antenatal visit by 14 weeks gestation. Within the CESPHN region, only 64.1% of Aboriginal mothers had attended their first antenatal visit by 14 weeks gestation (23). There is a need for additional health strategies and initiatives to close this gap.

In 2022, 88.4% of Aboriginal mothers across NSW attended their first antenatal visit by 20 weeks gestation. Within the CESPHN region the proportion increased to 89% of Aboriginal mothers (23).

Smoking during pregnancy

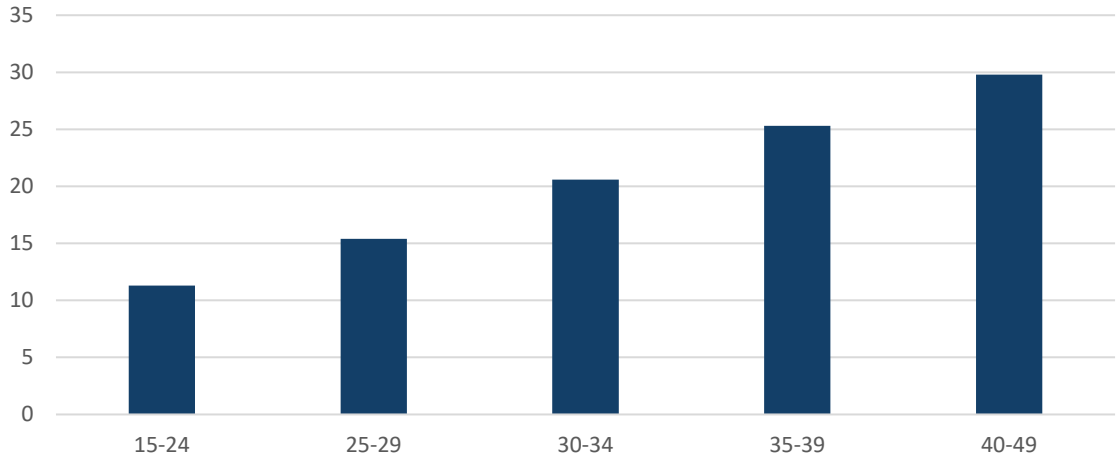
In 2022, 39.6% of Aboriginal mothers in NSW smoked at any time during their pregnancy. Within the CESPHN region, the rate was lower with 35.5% of Aboriginal mothers smoking at any point during their pregnancy (23).

Gestational diabetes mellitus

In 2021-2022, there were around 2,400 new cases of gestational diabetes among Aboriginal and Torres Strait Islander women, equating to 16% of Indigenous women who gave birth in hospital in Australia. The incidence of gestational diabetes was slightly higher in the First Nations community (20.8%) in comparison with the Non-Indigenous community (17.8).

As seen in the figure below, the 40-49 age group had the highest incidence of gestational diabetes (29.8) (29).

Figure 9:9 Incidence of gestational diabetes among Indigenous women nationally by age, 2020–21



Source: Australian Institute of Health and Wellbeing, 2024

Low birthweight babies

In 2022, 11.4% of all babies born to Aboriginal mothers in the CESPHN region had a low birth weight; approximately double the proportion born to non-Aboriginal mothers (5.5%) (8) and higher than the reported 2019 to 2021 national rate for babies born to Aboriginal mothers of 10.9% (21).

Breastfeeding

Across NSW in 2022, 55.8% of Aboriginal mothers were full breast feeding their babies at discharge (from hospital, or discharge from home birth care), a decrease from 61.2% in 2018. This compares to 66.6% of Non-Indigenous mothers that were full breast feeding their babies at discharge in 2022 (30).

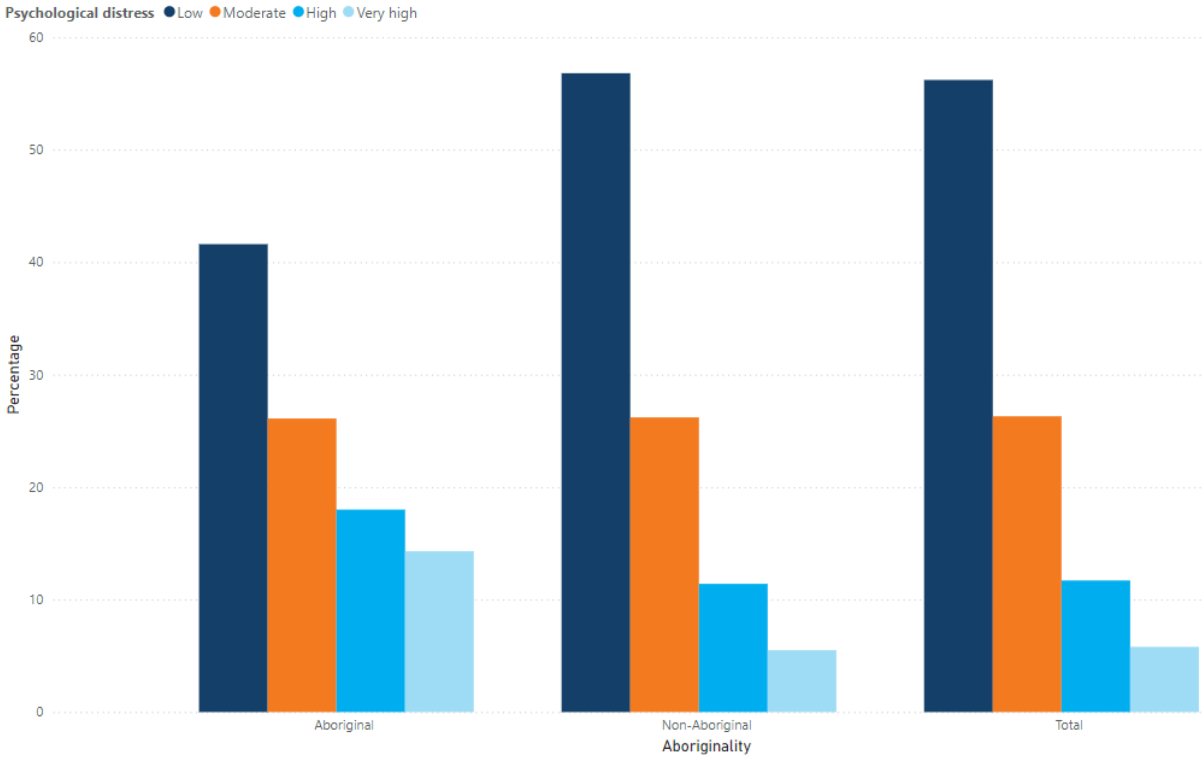
Within the CESPHN region, 54.9% of Aboriginal mothers were full breast feeding and 26% were offering some level of breast feeding at time of discharge (21).

Social and emotional wellbeing

Psychological distress

Between 2021-2023, the Aboriginal population in NSW had levels of very high psychological distress at twice the rate of the non-Aboriginal population (11% compared to 5.3%) (23).

Figure 10:10 Psychological distress experienced by Aboriginal-status, NSW, 2021-23



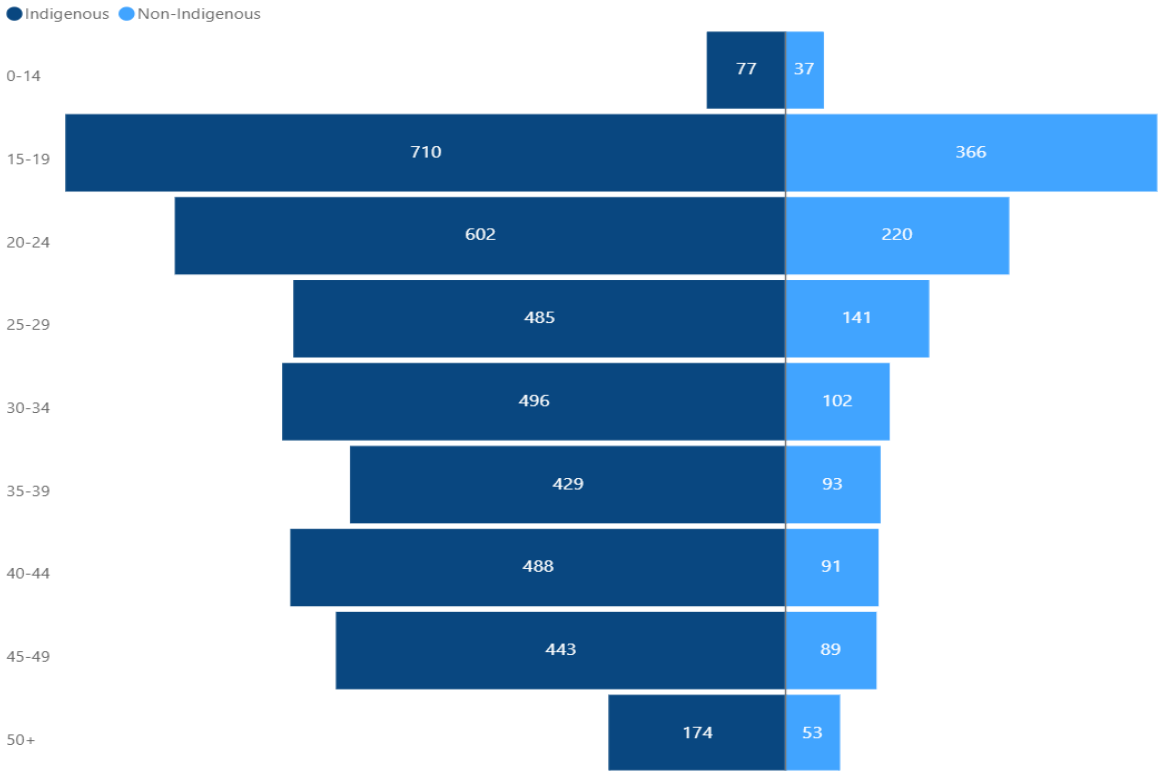
Source: HealthStats NSW, 2024

CESPHN commissions a range of Aboriginal mental health and social and emotional wellbeing programs. These include Babana Aboriginal Health and Wellbeing Events, Yarning Circles, Youth Health and Wellbeing Programs at La Perouse, and in the inner city. In addition to these services the Psychological Support Services program provides free short-term psychological services.

Self-harm

Nationally, individuals aged 15-19 years have the highest rates per 100,000 population of intentional self-harm hospitalisations; the rate for Aboriginal persons is 1.9 times the rate of non-Aboriginal persons (31).

Figure 1111: Self-harm by age group per 100,000 population, Australia, 2021-22



Source: AIHW, 2024

Females have a higher rate of intentional self-harm hospitalisations per 100,000 population than males (536.2 compared to 352.2). However, Aboriginal females have rates of intentional self-harm hospitalisations 2.8 times that of non-Aboriginal females and Aboriginal males have rates of intentional self-harm hospitalisations 3.4 times that of non-Aboriginal males (31).

Suicide

In 2022, 4.6% of deaths in the Aboriginal population were by suicide, a rate which is almost three times that of the non-Aboriginal population (1.6%). The age-standardised rate (per 100,000 population) for those who died by suicide was more than twice as high in the Aboriginal population than the non-Aboriginal population (29.9 compared to 11.7) (32).

Table 16: Suicide rates, Aboriginal and non-Aboriginal, Australia, 2022

Measure	Aboriginal	Non-Aboriginal
Number	212	2,117
Per cent of all causes of death	4.6	1.6
Age-standardised rate (per 100,000)	29.9	11.7

Source: AIHW, 2024

In NSW, the rate of suicide across all age groups is significantly higher among the Aboriginal population with the 35-44 years age group having the highest age-specific rate (48.6 per 100,000) (31).

Table 17: Suicide rate by age, Aboriginal and non-Aboriginal, NSW, 2012-2022

Aboriginality and Age Group	Age-specific rate (per 100,000)	Deaths	Lower age specific rate (per 100,000)	Upper age specific rate (per 100,000)
				Aboriginal
0–24	8.5	64.0	6.4	10.6
25–34	34.7	73.0	26.8	42.7
35–44	48.6	68.0	37.1	60.2
45+	21.8	71.0	16.7	26.8
				Non-Aboriginal
0–24	4.5	524.0	4.1	4.9
25–34	12.6	725.0	11.7	13.5
35–44	13.8	735.0	12.8	14.8
45+	13.9	2270.0	13.3	14.5

Source: AIHW, 2024

CESPHN commissions Tribal Warrior to deliver the Connector Service an Aboriginal-specific culturally safe care coordination service for Aboriginal people affected by suicide. The service is for those who have been bereaved by suicide or those who have a recent experience of suicidality.

Alcohol and substance use

Addressing alcohol and substance abuse is essential in order to address the underlying intergenerational trauma experienced by these individuals and the resultant health impacts, social and economic consequences, and the community's cultural and spiritual well-being.

Alcohol

Consultations identified that alcohol-related rehabilitation and detoxification services were a gap in care within the CESPHN region.

An estimated 15.9% of Aboriginal people in NSW did not consume alcohol in the twelve months preceding the National Aboriginal and Torres Strait Islander Health Survey – the rate was higher in the female population compared to the male population (16.9% compared to 14.7%). Males exceeded females in alcohol consumption that exceeded the guidelines by 29.3% (28).

Table 18: Alcohol consumption status proportion, by gender, NSW, 2022-23

Alcohol consumption	Males	Females	Total NSW
Exceeded guideline	54.9	25.6	39.6
Consumed alcohol less than 12 months ago but did not exceed guideline	25.4	49.0	38.0
Consumed alcohol 12 or more months ago	14.7	16.9	15.9

Source: ABS, NATSIHS 2024

Substance use

In 2022-2023, an estimated 22.1% of the Aboriginal population in NSW had used substance(s) in the previous 12 months. It is evident from the below table that the proportion of males that had used one or more substances within the prior 12 months was over two-folds greater than the female proportion, underscoring a need for gender-specific approaches to addressing substance abuse (28).

Table 19: Substance use proportion, NSW, 2022-23

Substance use	Males (%)	Females (%)	Total (%)
Used substance(s) in last 12 months	32.4	13.9	22.1
Has not used substance(s) in last 12 months	67.0	84.1	76.6

Source: ABS, NATSIHS 2024

CESPHN commissions a range of drug and alcohol support services and programs. These include the Redfern Aboriginal Medical Service Drug and Alcohol Treatment Program, the Community Restorative Centre drug and alcohol program, Weave Youth and Community Services 'Speak Out' Dual Diagnosis Program, We Help Ourselves and Odyssey House.

Older people

Demographics

2021 Census data showed that 21.9% of the CESPHN Aboriginal population were aged 50 years and over and 7.4% were aged 65 years and over.(16) Leichhardt IARE had the highest proportion of Aboriginal persons aged 50 years and over (26.2%), followed by Canterbury-Bankstown IARE (23.5%) and Marrickville IARE (22.9%) (8).

Table 20: Usual resident population (URP) aged 50 years and over, by IARE, 2021

IARE	50-54	55-59	60-64	65yrs +	Total	% Total IARE population
Botany Bay	63	59	48	68	238	21.6
Canterbury -Bankstown (part a)	64	55	49	98	266	23.5
Hurstville-Kogarah	46	53	48	78	225	21.7
Leichhardt	41	37	27	55	160	26.2
Marrickville	76	64	56	92	288	22.9
Randwick-La Perouse	129	110	87	201	527	22.5
Rockdale	56	37	34	66	193	22.2
Sutherland Shire	182	140	109	224	655	20.0
Sydney-City	208	148	121	210	687	22.8
Sydney Inner West	69	50	40	83	242	20.8
Woollahra-Waverley	19	17	18	31	85	18.6
CESPHN	953	770	637	1206	3566	21.9

Source: PHIDU, 2022

Aged care

Home care

In 2022-2023 there were 117 admissions to home care in the CESPHN region who identified as Aboriginal (33).

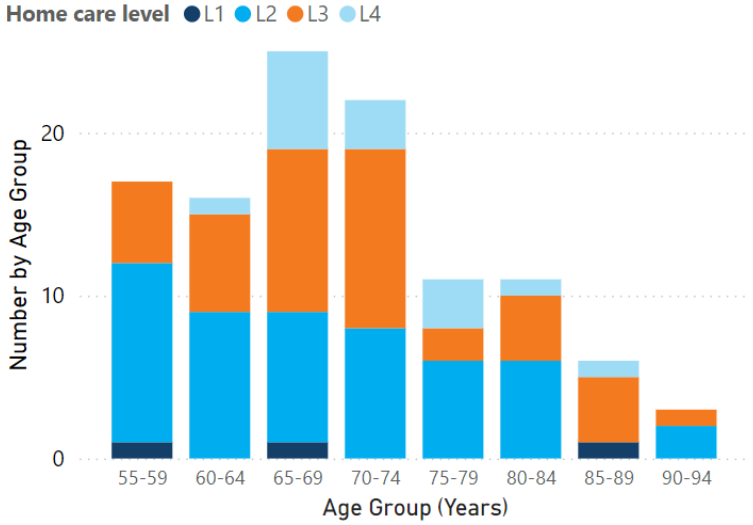
Table 21: Home care admissions by ACPR, 2022-23

Aged care planning region	Home care
Inner West	9
South East Sydney	108
CESPHN	117

Source: GEN, 2024

The highest number of Aboriginal home care recipients were aged 65-69, followed by the 70-74 years old age group (33). Wyanga, Guriwal and Kurranulla offer Aboriginal specific home care, transport and respite within the region.

Figure 1212: Home care admissions by age group, CESPHN region, 2022-23



Source: GEN, 2024

Residential care

In 2022-2023, there were 74 residential care admissions for people who identified as Aboriginal in the CESPHN region. Approximately one third of these admissions were for permanent places (33).

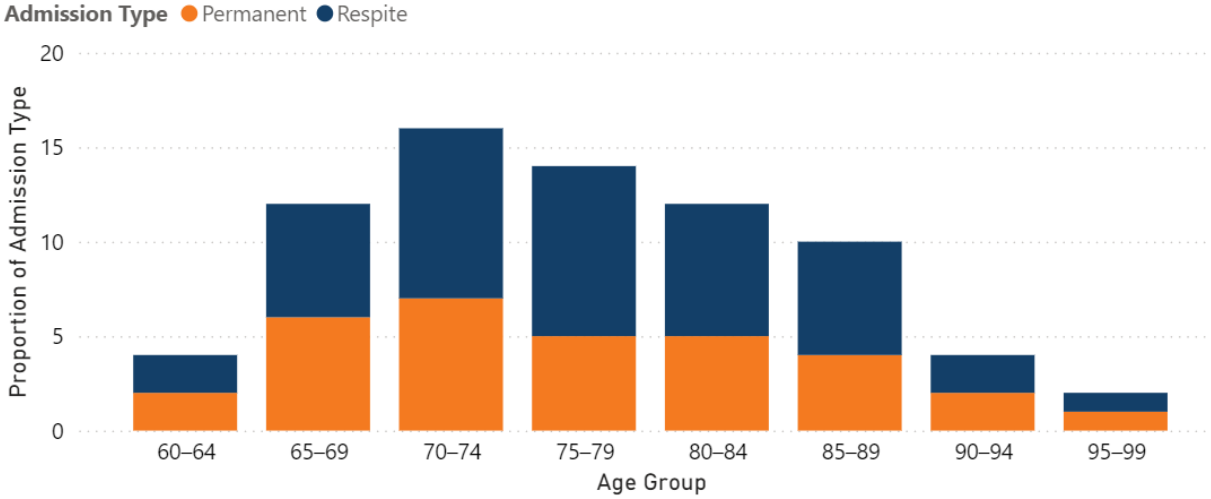
Table 22: Residential care admissions by ACPR, 2022-23

Aged care planning region	Permanent	Respite	Total residential care
Inner West	6	8	14
South East Sydney	26	34	60
CESPHN	32	42	74

Source: GEN, 2023

The majority of residential care admissions were in the 70-74 year age group, followed by the 75-79 year age group (33).

Figure 1313: Residential care admissions, by admission type and age group, CESPHN region, 2022-23



Source: GEN, 2024

The role of carers

Caring in Aboriginal communities is deeply influenced by historical and cultural factors. Many Aboriginal carers do not self-identify with the term "carer" and may be reluctant to access mainstream support services due to past experiences and cultural differences. Family structures and values also play a significant role, with extended family often involved in caregiving. The pressures of taking on caring roles with little formal support need to be recognised.

Access to primary care

There is one Aboriginal Community Controlled Health Service in the region located in Redfern. Aboriginal people access general practice care throughout the region with the largest numbers of patients in the LGAs of Sydney, Sutherland, Randwick, Inner West and Bayside. There are 360 practices sharing data with CESPHN and among these practices there are approximately 14,500 active Aboriginal patients meaning they have attended the practice three or more times in the past two years. The number of active Aboriginal patients per general practice varies with close to 30% of practices having less than 10 patients and almost 50% of practices having between 11 and 50 active patients. CESPHN works to support general practices within the region to provide culturally sensitive care. CESPHN regularly offers cultural awareness training for GPs followed up with practice support visits.

Table 23 Number of active Aboriginal patients in general practice, 2024

LGA	RACGP Active Patients	No. of Practices
Sydney	3865	64
Sutherland Shire	2411	51
Randwick	1989	24
Inner West	1798	42
Bayside	1180	38
Georges River	961	36
Canterbury-Bankstown	877	39
Canada Bay	541	20
Waverley	413	17
Burwood	329	13
Woollahra	115	7
Strathfield	89	8
Total	14568	359

Source: POLAR and PenCS, CESPHN held data.

Table 24 Number of active Aboriginal patients by practice, 2024

Practices	10 or less	11-50	51-100	101-200	200+
Number	102	174	50	24	9
Percentage	28	48	14	7	3

Source: POLAR and PenCS, CESPHN held data.

MBS item 715 health assessments

The MBS item 715 health assessment supports initial and ongoing engagement of Aboriginal people in primary healthcare in a culturally safe way. They are an important means to encourage early detection and treatment of common conditions. Aboriginal people are eligible for an annual health assessment as well as follow-up services for preventative health care and education between health assessments.

Despite considerable efforts to increase the uptake of MBS item 715 assessments the rate of assessments remains low. Barriers to greater uptake include:

- Many healthcare providers and community do not understand the benefits and availability of the 715 assessment
- System and process barriers to systematically identifying Aboriginal status, insufficient time and workforce resources, and complicated billing procedures
- 715 assessments can only be undertaken annually, which also impacts access to other health services.

The proportion of the Aboriginal population in the CESPHN region who received an MBS 715 health assessment (14.6%) has remained relatively constant since 2018-19 (23) and is the 4th lowest of all PHNs and well below the national rate of 27%.

Table 25: Health assessment (MBS 715) by financial year, CESPHN region, 2018-19 - 2021-22

Year	Total (No.)	Total (%)
2018–19	2,392	13.9
2019–20	2,412	14.1
2020-21	2,460	14.6
2021-2022	1,699	9.9
2022-2023	2,567	14.6

Source: AIHW, 2024

The rate of follow up of patients who received a health assessment in the CESPHN region was 28.01% in 2021-2022, 8th lowest of all PHNs (34).

After hours care

In 2021, 2.6% of calls to the HealthDirect After Hours Helpline from the CESPHN region were from callers who identified as Aboriginal (35).

The after hours period is broken down into 4 timeframes, based on practice incentive program (PIP) time periods.

- T1 = 6pm through to 11pm weeknights
- T2 = 11pm through to 8am weekdays
- T3 = outside 8am to 12 noon on Saturdays
- T4 = all day on Sunday and public holidays.

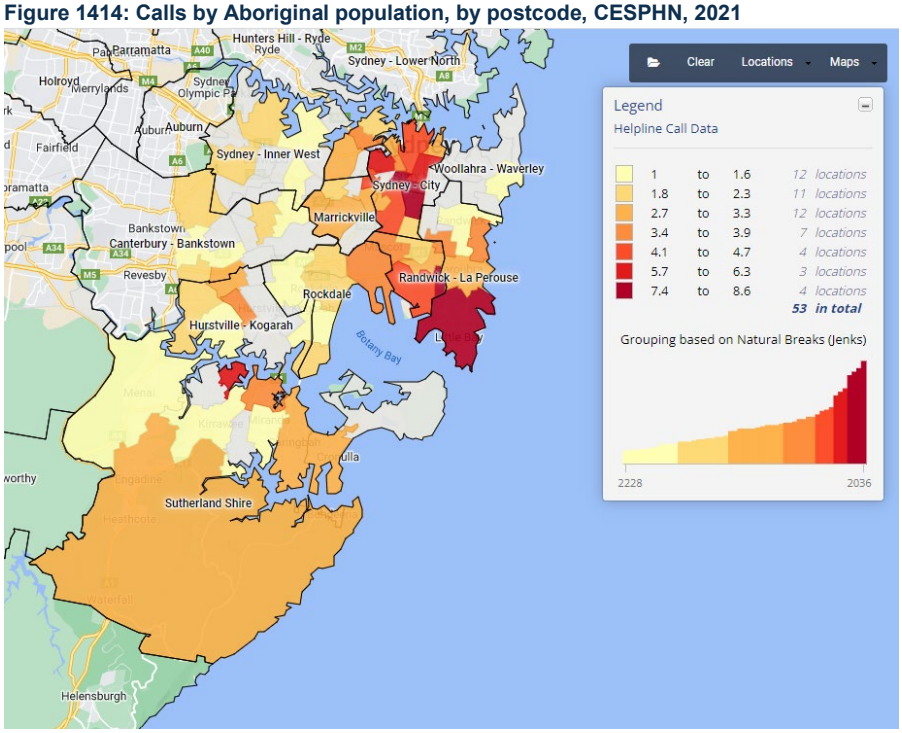
Table 26: Callers to HealthDirect After Hours Helpline, by PIP timeframe, Aboriginal and non-Aboriginal, CESPHN region, 2021

PIP timeframe	Aboriginal (%)	Non-Aboriginal (%)	Total (%)
T1	0.8	31.3	32.1
T2	0.5	19.7	20.2
T3	0.4	17.1	17.5
T4	0.7	29.4	30.1
Total	2.6	97.4	100.0

Source: HealthDirect Australia, 2022

Within the CESPHN region, there were seven postcodes where 5% or more of calls to the After Hours Helpline were by callers who identified as Aboriginal: 2036 (8.6%) 2008 (8.0%) 2016 (7.7%) 2017 (7.4%) 2037 (6.3%) 2010 (6.0%) 2225 (5.7%). These postcodes predominantly fall under two IAREs (Randwick-La Perouse and Sydney-City).

Figure 1414: Calls by Aboriginal population, by postcode, CESPHN, 2021



Source: HealthDirect Australia, 2022

Opportunities

- Continued support of programs addressing care of chronic conditions
- Continued focus on supporting the mental health and wellbeing of Aboriginal people
- Promotion of urgent care as an alternative to attending Emergency departments for non-urgent care
- Work with Justice Health to improve healthcare transition from correctional facilities to general practice and other primary care services
- Continued GP education to promote cultural safety and understanding of intergenerational trauma and ongoing impacts.
- Community education on:
    - Accessing relevant healthcare including MBS 715 health assessments
    - Domestic violence and sexual abuse resources
    - Mental health and resources
    - Antenatal care
- Stigma Reduction Campaigns: Design culturally sensitive initiatives.
- Programs addressing impact of intergenerational trauma including supporting those impacted by child protection and out of home care
- Alcohol and other drugs and mental health services for young people.

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phn
CENTRAL AND
EASTERN SYDNEY

An Australian Government Initiative

HEALTH AND WELLBEING OF PEOPLE FROM MULTICULTURAL COMMUNITIES

2025-2027 Needs Assessment

Table of contents

List of tables

List of figures

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Central and Eastern Sydney PHN is a business division of EIS Health Limited.
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Overview

The population of the Central and Eastern Sydney region is diverse and continually evolving with new migrants from different countries adding to the cultural mix.

The 2021 Census data showed that 40.7% of CESPHN residents were born overseas compared to the NSW average of 29.3%. Overall, 46.8% of the population speak a language other than English at home and 6.3% do not speak English well or at all (1). This shows the need for health services specifically tailored to meet the needs of culturally and linguistically diverse (CALD) residents, such as culturally safe spaces, more interpreters and translated health information to help make living in the CESPHN region easier for these residents.

Key issues

- People from CALD backgrounds don't access CESPHN commissioned mental health services at the same rate as non-CALD community.
- People from CALD backgrounds attend services later, resulting in more involuntary admissions
- Less likely to access preventable screening for breast cancer
- International students in the CESPHN region needing support in health and wellbeing issues
- Impact of global events on local communities (War in Gaza).

Key gaps

- There is a need to understand better the experiences shaping health outcomes for multicultural communities
- Health navigation assistance can assist people to understand and access the complex health and social support system
- Need for culturally responsive care.

In-language focus group feedback

For primary health care to be responsive to the needs of this large proportion of the population, there is a need to understand better the experiences shaping health outcomes for multicultural communities. To gain a deeper insight into the health experiences of recently arrived communities (past five years) CESPHN engaged a specialist multicultural consulting organisation to conduct 11 in-language focus groups in person in June and July 2024. The focus groups engaged 125 participants across 7 languages: in Arabic (2x), Bengali (2x), Mandarin (2x), Nepali (2x), Urdu (1x) Mongolian women (1x), and a group held in English for people from an Indian background (2).

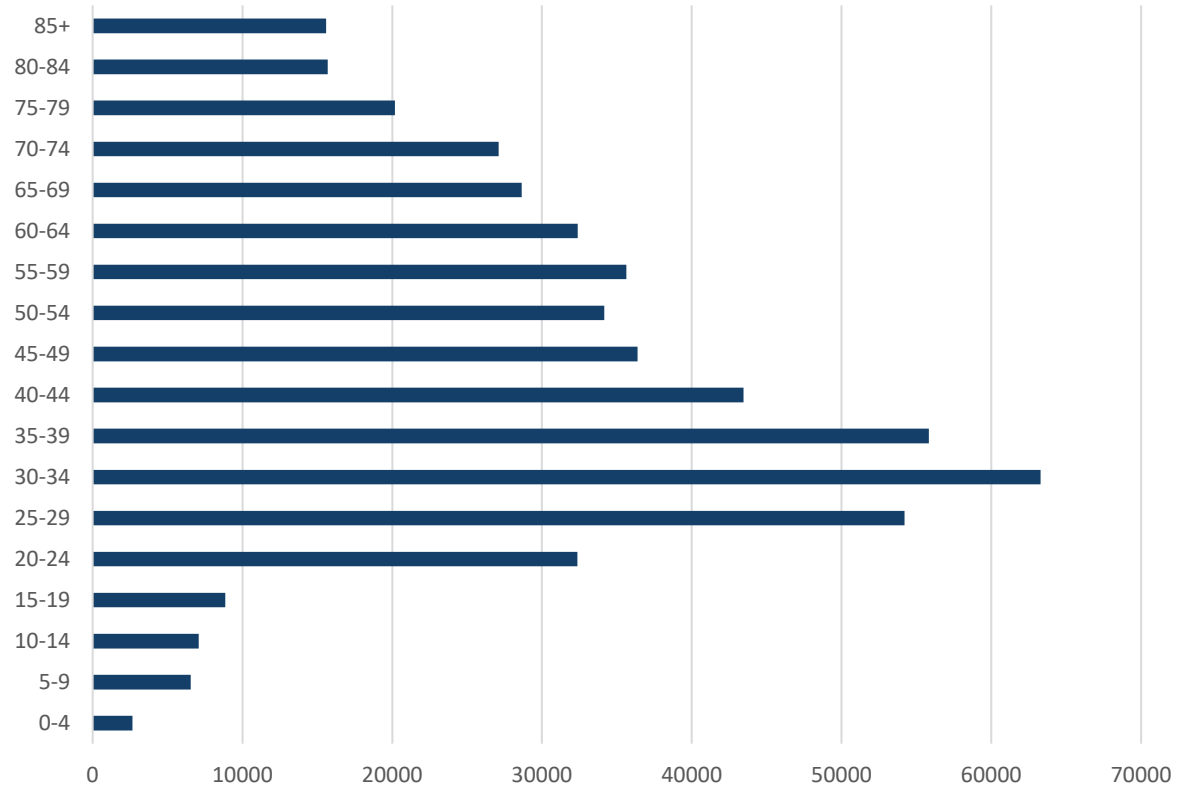
Although this sample is not representative, the quotations from the individuals involved have been integrated into this chapter and provide a lived-experience perspective to multicultural needs in the CESPHN region. They also provide a glimpse into the strengths of these communities, their understanding of the health care system and how their experience has been.

"We are spiritually connected, and our community is very helpful and has strong family ties. It is remarkable that the connection we maintain is very strong, even from thousands and thousands mile across."
Bengali-speaking resident of the CESPHN region

Demographics

There is significant cultural diversity across the CESPHN region, with the 2021 Census data showing that 40.7% of CESPHN residents were born overseas. The SA3 areas of Canterbury, Sydney Inner City, Strathfield-Burwood-Ashfield, Botany Kogarah-Rockdale and Hurstville have more than 40% of their population born overseas compared to the NSW average of 29.3% (3). This population represents a mix of well-established generations of migrants in the region as well as newly arrived asylum seekers and international students.

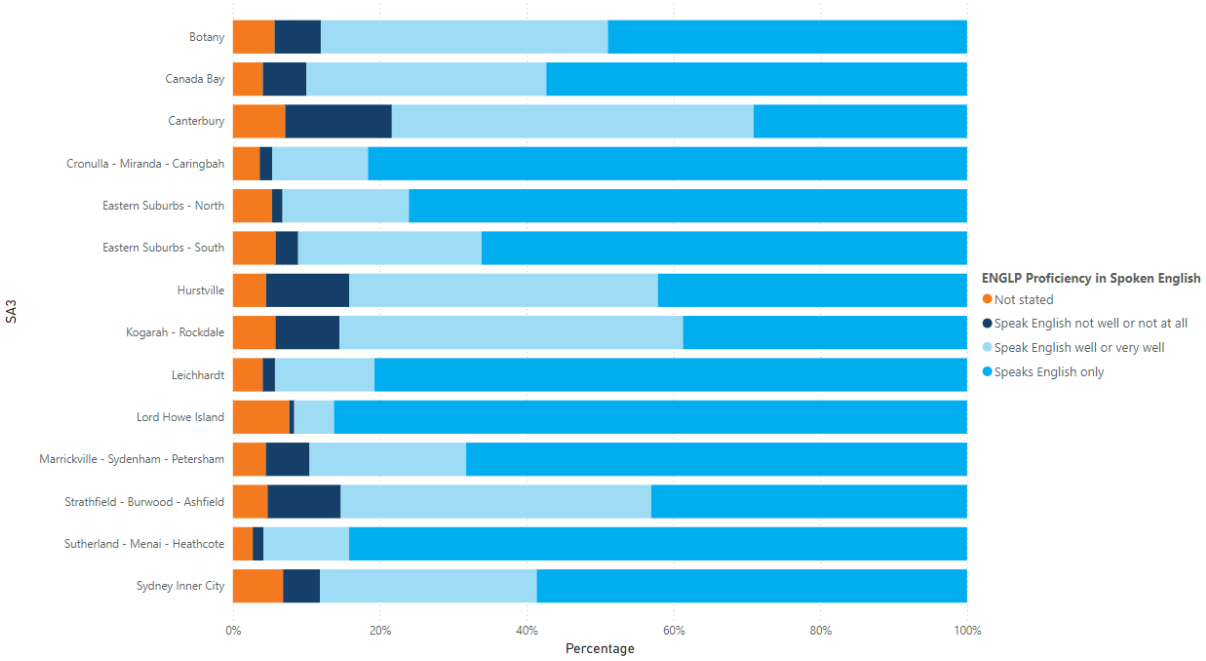
Figure 1: Total people born overseas by age-groups, CESPHN region, 2021



Source: ABS, 2022

Overall, 46.8% of the population speak a language other than English at home and 6.3% do not speak English well or at all. The areas with the highest proportions of people who do not speak English well or at all are Canterbury (14.5%), Hurstville (11.3%), Strathfield-Burwood-Ashfield (10.0%), Kogarah-Rockdale (8.7%) and Botany (6.3%), compared to the NSW average of 4.5%. The top four languages other than English spoken at home are Mandarin (17.2%), Cantonese (9.4%), Greek (8.7%) and Arabic (8.2%) (4).

Figure 2: English proficiency by SA3, CESPHN region, 2021



Source: ABS, 2022

Areas with a high concentration of speakers of these languages are:

- Greek: 22% of Greek speakers live in Canterbury, 21.6% live in Kogarah-Rockdale and 11.5% live in Hurstville.
- Arabic: 39.5% of Arabic speakers live in Canterbury, 21% live in Kogarah-Rockdale and 11.2% live in Hurstville.
- Nepali: 31.8% of Nepali speakers live in Strathfield-Burwood-Ashfield, 26.2% live in Hurstville and 23.9% live in Kogarah-Rockdale.
- Cantonese: 25% of Cantonese speakers live in Hurstville, 16.1% live in Strathfield-Burwood-Ashfield and 12.6% live in Kogarah-Rockdale
- Mandarin: 18.6% of Mandarin speakers live in Hurstville, 18.5% live in Sydney Inner City and 18.3% live in Strathfield-Burwood-Ashfield. (5)

The 2021 census showed that other commonly spoken languages spoken across the CESPHN region include Spanish, Italian, Vietnamese, Indonesian, Portuguese, Korean, Bengali, Thai, Macedonian, Hindi, Russian, French, Tagalog, Urdu and Japanese (6).

International students

Between January and April 2023, there were more than 900,000 international students studying in Australia split evenly between universities and other educational institutions (7). As there are many major universities based in the Central and Eastern Sydney region, we host many international students. According to the most recently available data, there were 258,766 international students enrolled across NSW with 76.2% studying in the CESPHN region (8). The top five countries international students came from were China, Nepal, India, Indonesia and Thailand. International students at the time of this data might still have been impacted by COVID restrictions in commencing their studies (9).

Table 1: Enrolments and commencements of international students, CESPHN region, 2021

Nationality	Enrolments	Commencements
China	71,364	26,531
Nepal	22,241	6,497
India	14,168	4,052
Indonesia	8,231	3,171
Thailand	8,037	3,337
Korea, Republic of (South)	909	412
Hong Kong	818	283
Brazil	741	320
Philippines	200	62

Source: Department of Education, Skills and Employment, 2021

The in-language focus groups contained international students of all ages. Responses showed that whilst health insurance is mandatory for all students studying in Australia, there is a lack of understanding of how to access primary health care and a lack of understanding in navigating the health system.

"For the first 2 years as a student, I did not go to any healthcare/medical facility as I was concerned about cost of accessing healthcare."
Indian background participant

"I had a good experience at my university medical centre when I was suffering from fever. However, the prescription they provided was very expensive. So instead, I used similar medicines I was carrying from India."
Indian background resident

A 2024 International Students Roundtable held at the University of Sydney highlighted the challenges faced by students which are often more pronounced or serious for international students, including:

- Social isolation, loneliness, homesickness
- Cultural adaptation and language proficiency challenges
- Personal finances
- Precarious housing
- Discrimination, racism and exploitation
- Dealing with authority figures and 'systems'
- Wage-theft, underpayment in part-time/causal employment
- Health and mental health issues.

The 2020 Productivity Commission inquiry report into mental health recommended strengthening the accountability of tertiary education providers to include expanded mental health support to their students, including international students, such as ensuring that counselling services are able to meet the language and cultural diversity needs of their international students (10).

International students fall under the headspace priority group of young people from a refugee or migrant background and as such in recent years headspace National has developed resources for headspace services to improve access to health care for international students. In the CESPHN region, our headspace centres are equipping themselves with the resources they need to support students with Overseas Student Health Cover (OSHC) access the support they need. Other CESPHN commissioned services including the Psychological Support Services program and The Way Back Support Service, have seen an increase in the number of international students accessing care.

Refugees and asylum seekers

A refugee is someone who has a well-founded fear of persecution because of their race, religion, nationality, membership of a particular group, or political opinion and is outside of their country of origin. An asylum seeker is someone who has left their country of origin, has applied for recognition as a refugee in another country and is awaiting a decision on their application (11).

Between 2014 and 2023 2,329 people settled in the region on a humanitarian visa (12). Approximately 46% of humanitarian arrivals to the CESPHN region resided in Canterbury (13).

As at March 2022, 451 people who came seeking asylum by boat, and were granted a Bridging Visa E, resided in the CESPHN region (14). Approximately 70.2% resided in Canterbury SA3, 14.9% in Strathfield-Burwood-Ashfield SA3 and 14.9% in Botany SA3. Asylum seekers could be on a range of visa types and might not always have access to Medicare which has implications for access to health services and the health status of this population group.

There are limited data on the health of refugees or humanitarian entrants, but they may experience additional or more pronounced physical and mental health challenges due to past experiences of war, persecution or human rights abuses in their country of origin, or trauma associated with their journey to Australia and awaiting the granting of refugee status which can often take years.

Gaza conflict

More recently, there have been people arriving to the region from Gaza, Lebanon and Israel, but it is difficult to get localised data on resettlement numbers. These people are generally on tourist visas which do not give them access to Medicare and public health services. The ongoing conflict in the Gaza region has led to trauma, distress, and a range of mental health needs, with many experiencing a shared sense of anxiety, helplessness, and hopelessness.

In 2024, CESPHN consulted with community leaders, NGO's, mental health services and government services to understand the key supports required by the Palestinian, Muslim and Arabic communities and the Jewish community and found there was a genuine need to vocalise distress in safe non-clinical environments and a difficulty in providing mental health support when basic needs aren't covered (food, housing, healthcare). They expressed a need for service navigation support, mental health literacy and proactive help-seeking skills, and access to services designed and offered by organisations who understand and have experience supporting communities affected by conflict.

CESPHN has worked with Northern Sydney PHN, Western Sydney PHN and South Western Sydney PHN to distribute funds to community organisations which work directly with these communities. Some of the activities commissioned were healing circles, tailored health education for new arrivals to the region, or training religious leaders in mental health to better support their congregations.

Common health issues for multicultural communities

People born in Australia had the highest prevalence of at least one long-term health condition (36%) compared with people living in Australia born overseas. For asthma, cancer, mental health and lung conditions as well, the Australian-born population had a similar or higher age-standardised prevalence than that of the overseas born population. The year of arrival in Australia and level of English proficiency are interacting factors that relate to the prevalence of many long-term health conditions for people born overseas.

A higher age-standardised prevalence of arthritis, asthma, mental health and lung condition was observed among people who first arrived in Australia more than 10 years ag, particularly for those with low English proficiency. This points to the need for interpreter use and information in other languages to be made available for these communities.

The prevalence of chronic health conditions increased with time since migration across all conditions for most countries of birth. However, Iraq had a higher prevalence among more recent arrivals for multiple conditions, including dementia, heart disease and kidney disease.

There were many countries of birth with a higher prevalence than for the Australian-born population for dementia, heart disease, stroke, diabetes and kidney disease, particularly for people born in countries from regions such as Polynesia, South Asia and the Middle East. Bangladesh-born Australians had the highest prevalence of both diabetes and heart disease (12% and 4.6%, respectively). Kidney disease was highest in people born in Polynesian countries such as Tonga (1.9%) and Samoa (1.5%) (15).

People born in Pakistan had the highest prevalence of heart disease (4.6%), those born in Iraq (4.0%) and Sri Lanka (3.9%), compared to Australian born prevalence of 3.6%. Those born in Italy had the highest prevalence of dementia (0.9%), those born in Iraq (0.8%) and Vietnam (0.8%) compared to people born in Australia had a prevalence of (0.6%)

People born in Australia, English-speaking and European countries generally had a higher prevalence of arthritis, asthma, cancer, lung conditions and mental health conditions. People born in Asian countries generally had a higher prevalence of diabetes, heart disease and kidney disease than for other conditions.

Just over one percent (1.22%) of residents in the CESPHN region are living with chronic Hepatitis B (CHB). This prevalence is higher than the national average (0.78%). Overseas born residents account for 70% of all cases of CHB (16). In the CESPHN region, people born in China, Vietnam and Greece are most commonly represented in overseas born people affected by CHB.

There are also low participation rates in screening for breast cancer by women from CALD backgrounds aged 50-74, at 34.7% in 2021-2023 (17).

These findings may reflect the diverse cultures, languages, migration trajectories, social and economic circumstances among culturally and linguistically diverse people in Australia.

Alcohol and other drugs

It is difficult to identify rates of alcohol and other drug use in multicultural communities as national surveys tend to be administered in English and there are limitations in the way data is collected.

While data tends to indicate that drug and alcohol use in culturally and linguistically diverse (CALD) respondents is lower than non-CALD communities, people from these communities are underrepresented in treatment and when in treatment are less likely to be connected to appropriate support services. Further information about alcohol and other drug use in multicultural communities is available in the chapter titled, Alcohol and other drugs.

Health of Refugees and Humanitarian Entrants

The Australian Institute of Health and Welfare 'Health of Refugees and Humanitarian Entrants Report 2023' shows that humanitarian entrants had different long-term health conditions compared with other migrants (18). These were:

- 40% decrease in cancers
- 50% increase in mental health conditions
- 130% increase in kidney disease
- 70% increase in diabetes.

People from the above communities are also at higher risk of hospitalisation for certain diabetes-related conditions when compared to people born in Australia. In 2021, 7.6% of humanitarian entrants reported having diabetes compared with 4.3% of the rest of the population (19). CESPHN commissioned the Community Diabetes Education Program to educate and promote early intervention for people at high risk of Type 2 diabetes targeting high risk people from Asian, Middle Eastern and Southern European countries.

Almost 9 in 10 humanitarian entrants had a GP attendance in 2021, highlighting the opportunity in primary care to promote prevention and early intervention. In addition, accidental drowning deaths of humanitarian entrants were 2.4 times as high as the rest of the population, in 2007-2020 this is significant for CESPHN given the Central and Eastern Sydney region is fringed by a coastline (20).

"Back in Nepal mental health is not considered a big thing. But when I came to Australia, it was a huge thing. If you talk about it [in Nepal], you are considered 'crazy'. Here [in Australia] we have help but we don't use it."
Nepali speaking resident

"If anyone hears someone is facing mental health problems the first thing they say is perform prayers [and] everything will be solved. There is nothing called mental health issues, those are foul talk."
Bengali speaking resident

"Mental health is a luxury, only rich people talk about it but we as people who are working hard to just be able to pay rent and food, there is no time to think about mental health, we just need to keep going."
Arabic speaking resident

Access issues

Multicultural communities are underrepresented in the use of CESPHN commissioned mental health services relative to the general population. This data is discoverable because country of birth, self-identified cultural background and language spoken at home is data that is routinely collected.

People who have migrated to Australia tend to:

- Have lower rates of mental health service usage
- Have lower rates of screening for breast and bowel cancers (17)
- Be overrepresented in involuntary acute inpatient admissions
- Seek help much later than the general population.

CESPHN's 2024 in-language focus groups also revealed the barriers that can prevent CALD residents from seeking medical care when necessary. This delay in help seeking and prevention can lead to more acute presentations and may be due to a range of factors. Feedback from the in-language focus groups also highlighted that many communities are used to visiting a pharmacist as a first port of call rather than a local doctor (GP). CESPHN resources both GPs and pharmacists to play this role in the community by keeping them informed of relevant services in the area.

Participants in the focus groups in 2024 provided a lived experience perspective confirming barriers such as:

- Language
- Lack of use of interpreters*
- Difficulty navigating the health system
- Risk of re-traumatisation
- Fear of not being granted resident status if they are unwell
- Not having access to Medicare funded health care
- Financial hardship
- Limited trust of health service providers
- Not knowing the costs involved
- Believing that health care was better in their home country
- Stigma associated with certain conditions

*The Translating and Interpreting Services provides free interpreting services to medical practitioners, pharmacies and PHN commissioned mental health providers, but it is not available to all allied health professionals. To address this gap, CESPHN funds the Access to Interpreting Service for Allied Health Professionals Program. Private allied health professionals that register in the program are provided access to interpreting services from TIS National at no cost.

Consultations with CESPHN's stakeholders in 2024 reaffirmed the need for increased support with system navigation and health literacy for multicultural communities, especially recently arrived residents. In 2024 CESPHN commissioned a multicultural navigator service which will support patients in Mandarin, Cantonese, Arabic, Korean and Nepali to engage more easily with health and community services.

"I came to Australia over five months pregnant, and there were cases where my appointments were cancelled at the hospital because there were no available Mongolian interpreters. It's not easy for a pregnant person to come and go again and again."
Mongolian speaking resident

Opportunities

- Implementation of PHN Multicultural Health Framework
- Ensure multicultural community members are involved in co-design for new services
- Ongoing cultural competency training for GPs, allied health and commissioned service providers
- Support the role of pharmacists, which was identified often as the first point of call for some communities
- Develop culturally sensitive health outcome measures.
- Trauma informed care training offered to GPs
- Initiatives to increase rate of cancer screening and immunisation
- Data collection and research:
  - Investigate health disparities and inequities
  - Assess cultural competency in healthcare settings
  - Evaluate effectiveness of multicultural health programs
  - Identify best practices in multicultural healthcare

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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

OLDER INDIVIDUALS' HEALTH AND WELLBEING

2025-2027 Needs Assessment

Table of contents

List of tables

List of figures

Overview

In the CESPHN region 14.9% of the estimated resident population are aged over 65 and this number will increase by 43.6% between 2024 and 2041. The number of people aged 85 and over is expected to increase by 101.8% between 2024 and 2041 (1). For this reason, focusing on healthy ageing where people can live a fulfilling life and be supported in the community with primary care and integrated health and social services is of benefit to all.

In parallel with the focus of United Nations Decade of Healthy Ageing Plan of Action (2021-2030) and Sustainable Development Goals, to achieve improved health outcomes and social participation for older people, local services will need to be more strongly integrated and other community partners will need to be engaged by CESPHN.

Good health in older age is not distributed equally. People experiencing the most disadvantage are the ones that also experience the worst health outcomes as they age. One challenge will be to have a primary care workforce and aged care workforce equipped to support the needs of the community as they age.

Key issues

- Older individuals (65+ and 85+) experience a range of health issues, including:
  - Higher rates of fall-related hospitalisations
  - Mental health issues
  - Higher use of health care services for those living with dementia and living in the community
  - Chronic conditions and comorbidities
  - Higher levels of disability (2 in 5 people aged 65+)
- Poorer uptake of all age-recommended vaccines - COVID-19, pnuemococcal and shingrix as well as flu.

Key gaps

- Better coordination of primary care and other services in the community to ensure timely access to care and continued/seamless support
- Reduced access to affordable primary care and aged care services (cost of primary care and aged care services, and long wait times for home care packages and Commonwealth Home Support Program services)
- Difficulties in service navigation with poor awareness of available support services
- Social isolation, exacerbated by language and cultural barriers.
- Underutilisation of general practice preventative health services (health checks, CDM care plans, vaccination)
- Residential age care places are reducing against increasing number of people (many of whom will have dementia) with social dislocation occurring as older people having to move out of their locality and social networks to access residential aged care.
- People with a disability ageing in group homes rather than aged care facilities

- Older people report barriers to accessing mental health support by clinicians with knowledge of the unique experiences and concerns of older people.
- Diagnosis and services are limited for people living with dementia, and services vary across the CESPHN region
- Increasing difficulties for older people in residential aged care being able to access GPs.

Demographics

In 2022, 14.9% of the estimated resident population (ERP) in the CESPHN region were aged over 65, and 7.1% were aged over 75 years. The number of people aged 65 years and over is expected to increase by 43.6% between 2024 and 2041. The number of people aged 85 and over is expected to increase by 101.8% between 2024 and 2041 (1) (2).

Table 1: Population estimate by age group, CESPHN region, 2024 – 2041

Age Group	2024	2041	Increase %	Compound Annual Growth Rate (CAGR) %
65+	263,366	378,208	43.6	2.15
75+	189,234	292,205	54.4	2.59
85+	38,895	78,505	101.8	4.22

Source: HealthStats, 2024

The areas with the most notable proportions of older people include the following SA3s:

- Cronulla-Miranda-Caringbah (20.0%)
- Hurstville (17.8%)
- Sutherland-Menai-Heathcote (17.7%)
- Canada Bay (17.2%).

Table 2: Estimated resident population (ERP) aged 65 years and over by SA3, CESPHN region, 2023

SA3	Age group (years)					Total	% Total SA3 population
	65-69	70-74	75-79	80-84	85+		
Botany	2,105	1,765	1,519	1,017	941	7,347	11.9
Canada Bay	4,187	3,712	3,095	2,067	2,242	15,303	17.2
Canterbury	6,077	4,751	4,133	3,061	3,296	21,318	14.7
Cronulla-Miranda-Caringbah	6,487	5,521	4,909	3,327	3,980	24,224	20.0
Eastern Suburbs – North	4,954	4,746	4,586	2,929	3,296	20,511	15.6
Eastern Suburbs – South	5,425	4,810	4,245	2,890	3,242	20,612	14.5
Hurstville	7,233	5,739	4,527	3,136	3,681	24,316	17.8
Kogarah-Rockdale	6,412	5,463	4,725	3,292	3,766	23,658	15.6
Leichhardt	2,493	2,235	1,745	911	877	8,261	14.4
Lord Howe Island	30	31	13	23	0	97	21.5
Marrickville-Sydenham-Petersham	1,929	1,709	1,363	948	1,003	6,952	12.3
Strathfield-Burwood-Ashfield	6,620	5,348	4,251	3,151	3,975	23,345	13.8
Sutherland-Menai-Heathcote	5,766	4,999	4,200	2,532	2,545	20,042	17.7
Sydney Inner City	6,752	5,732	4,136	2,561	2,374	21,555	9.1
CESPHN	66,470	56,561	47,447	31,845	35,218	237,541	14.7
NSW	421,301	365,038	297,527	188,627	186,806	1,459,299	17.5
Australia	1,327,42	1,155,61	931,313	583,158	560,822	4,558,327	17.1%

Source: ABS ERP, 2024

Multicultural population aged 65 years and over

The CESPHN region is very multicultural with residents from many diverse cultures and countries. There are a total of 107,206 people aged over the age of 65 born overseas within the CESPHN region. Of the CESPHN residents aged over 65 and born overseas, the highest proportion of multicultural residents include Canterbury (69%), Kogarah-Rockdale (56%), Strathfield-Burwood-Ashfield (56%), Marrickville (51%) and Botany (50%). The major languages spoken at home by those aged over 65 in the CESPHN region include Greek (7.72%), Mandarin (4.8%), Cantonese (5.35%), and Italian (4.21%) (3).

Recognition for the language spoken by older people is key to enabling effective communication, respect and dignity of older people, access to services, improving mental health and social inclusion. Specific cultural measures assist older people from multicultural communities to achieve greater access to local health services.

Consultations held as part of the Need's Assessment highlighted that this group is least inclined to access primary health care and aged care services, with reasons such as:

- Lack of awareness or trust in services
- Financial strains
- Lack of health insurance
- Lack of culturally sensitive care
- Stigma and discrimination
- Language barriers
- Cultural beliefs and practices.
-

LGBTIQ+

People who identify as lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) experience a significant stigma and discrimination which ca impact their health outcomes and health service encounters, particularly in relation to mental health.
Older LGBTIQ+ individuals in New South Wales (NSW) face unique challenges and issues, including, discrimination and stigma, health disparities, social isolation, and economic challenges. Two key concerns for older LGBTIQ+ individuals face include:

- Significant challenges when entering residential aged care homes run by religious organisations due to discrimination and prejudice, lack of inclusive policies, social isolation and fear of re-closeting (4) (5)
- Significant challenges when faced with cognitive diseases such as dementia due to a lack of specialised care resulting in inadequate and inappropriate care, often leading to historical trauma, invisibility of LGBTIQ+ carers, social isolation and fear of re-closeting (6).
-

Significant challenges when faced with cognitive diseases such as dementia due to a lack of specialised care resulting in inadequate and inappropriate care, often leading to historical trauma, invisibility of LGBTIQ+ carers, social isolation and fear of re-closeting (6).

Financial status

The below table is indicative of the overall financial status of the older people within the region and highlights the areas of concentrated need, showing the percentage of CESPHN population aged 65 years and over as of December 2023 (7). Forty eight percent were receiving the age pension – Canterbury and Kogarah-Rockdale had the highest amount of age pension recipients 14.5% were receiving the Commonwealth Seniors Health Card (CSHC), which provides recipients with benefits such as cheaper medicines under PBS and bulk billed doctor visits (at doctor's discretion).

Table 3: DSS recipients by SA3, June 2024

SA3	Age Pension	Age Pension (%)	Commonwealth Seniors Health Card	Commonwealth Seniors Health Card (%)
Botany	4,530	61.7	675	9.2
Canada Bay	6,260	40.9	2,850	18.6
Canterbury	13,905	65.2	1,725	8.1
Cronulla-Miranda-Caringbah	10,295	42.5	4,870	20.1
Eastern Suburbs – North	5,105	24.9	2,870	14.0
Eastern Suburbs – South	8,980	43.6	3,540	17.2
Hurstville	12,795	52.6	3,595	14.8
Kogarah-Rockdale	13,735	58.1	3,000	12.7
Leichhardt	3,010	36.4	1,365	16.5
Lord Howe Island	30	30.9	15	15.5
Marrickville-Sydenham-Petersham	4,030	58.0	735	10.6
Strathfield-Burwood-Ashfield	12,060	51.7	3,165	13.6
Sutherland-Menai-Heathcote	10,075	50.3	3,755	18.7
Sydney Inner City	9,250	42.9	2,385	11.1
CESPHN	114,060	48.0	34,545	14.5
NSW	801,545	54.9	179,565	12.3
Australia	2,606,195	57.2	523,380	11.5

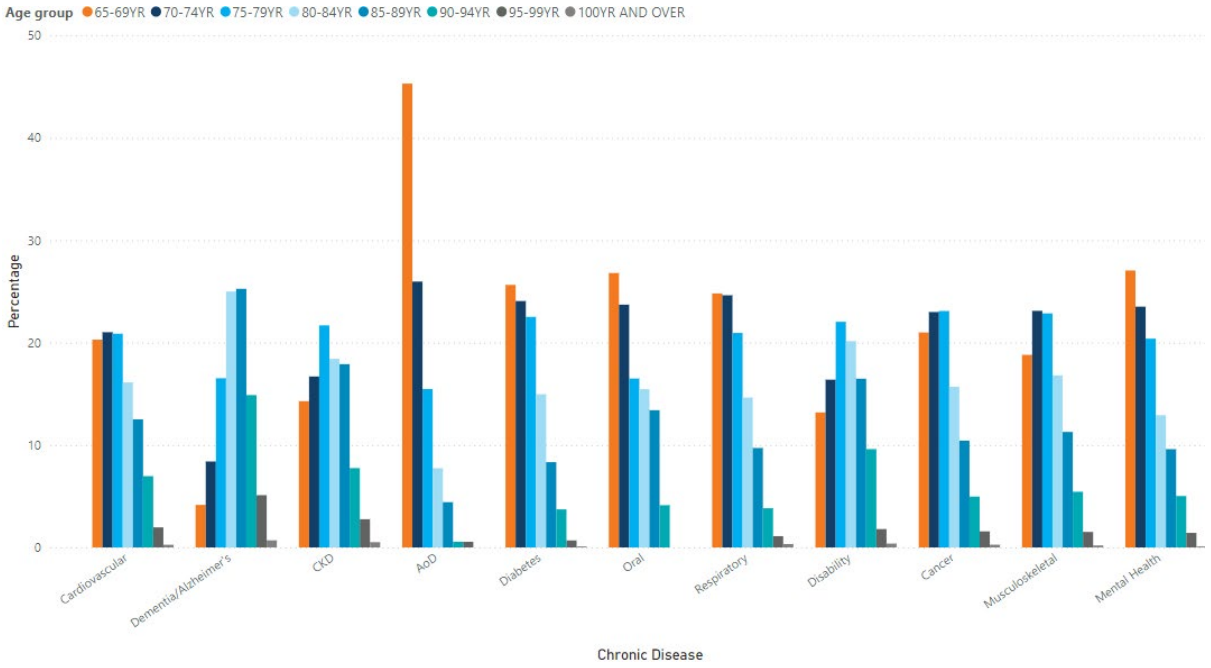
Source: Department of Social Services, 2024, ABS 2024

Health status

Burden of disease

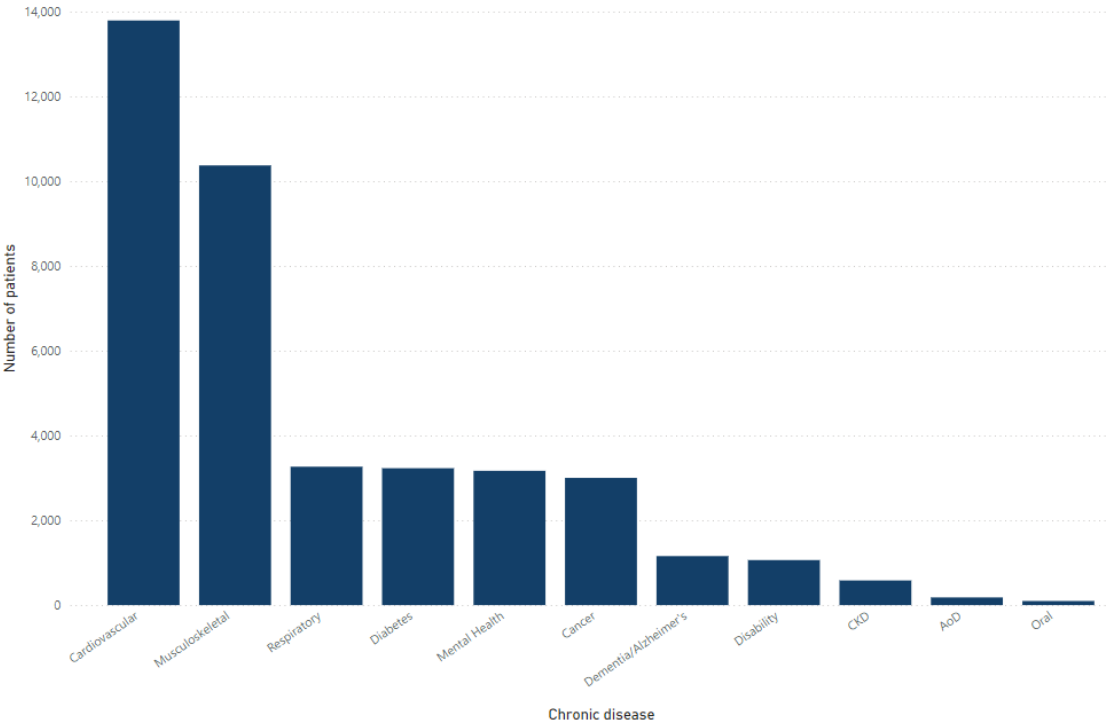
The figure below indicates the real-world burden of disease impact based on the number of patients presenting to the primary care system. Cardiovascular and musculoskeletal concerns are some of the biggest concerns within the CESPHN region, almost accounting for 24,000 presentations in the year 2023. This represents GP presentations for the catchment population above the age of 65 based on POLAR data.

Figure 1: Percentage of patients over the age of 65 by disease-type, CESPHN, 2023



Source: POLAR Database, 2024

Figure 2: Number of patients over the age of 65 by disease-type, CESPHN, 2023



Source: POLAR Database, 2024

Social isolation

Understanding the unique needs of older people to increase their quality of life has been a priority following the Royal Commission into Aged Care. One of those elements includes social isolation, depression and loneliness as they significantly impact on physical and mental health. Emotional distress can negatively impact the immune system.

Almost a quarter of older people in the CESPHN region live alone, of which 11% have poor English proficiency. Notably, Canterbury SA3 accounted for 17.94% of the population aged over 65, living alone with poor English proficiency within the CEPHN region (6). Living alone does not automatically mean someone is lonely; loneliness is a 'subjective unpleasant or distressing feeling of a lack of connection to other people, along with a desire for more, or more satisfying, social relationships (8). Older people however, often live alone, and due to determining factors such as mobility issues or a smaller social circle, can lead to isolation.

Table 4:Population living alone by SA3, 2021

SA3	Population 65 year +	Population 65 years+ living alone	Population 65+ living alone with poor English proficiency
Botany	7,136	1,738	260
Canada Bay	14,952	3,190	380
Canterbury	20,895	3,950	1122
Cronulla-Miranda-Caringbah	23,445	5,272	111
Eastern Suburbs-North	20,705	5,677	149
Eastern Suburbs-South	20,937	5,418	439
Hurstville	23,448	4,617	798
Kogarah-Rockdale	23,726	5,011	816
Leichhardt	8,201	2,265	104
Lord Howe Island	109	15	0
Marrickville-Sydenham-Petersham	7,052	1,648	347
Strathfield-Burwood-Ashfield	23,261	4,949	893
Sutherland-Menai-Heathcote	19,703	3,634	72
Sydney Inner City	20,615	7,074	762
CESPHN	234,185	54,503	6,253

Sources: ABS, 2023

Social isolation also affects vulnerable and priority populations differently. According to a 2024 study of over 2200 adults aged over 50 living in NSW (9), Aboriginal people over the age of 50 reported feeling less socially isolated compared to the non-Aboriginal population (47% to 60%). Older

LGBTIQ+ residents conversely experience much higher levels of social isolation, with 71% of respondents reporting feeling lonely.

The same report revealed that carers can feel severely isolated (11% reporting as always), in comparison with non-carers (7% reporting always). Likewise, those with disabilities self-reported more severe levels of social isolation compared to those without a disability.

Healthy ageing

Given that many people aged over 65 live in their own homes we want to ensure healthy ageing in the community for the vast majority of people. CESPHN has recently commissioned three neighbourhood centres in the region to establish Healthy Ageing Hubs. The Hubs provide practical support, service navigation and guidance to older people living in the community to help people maintain their independence and social connection. It also offers a pathway for GPs and health care providers to refer their patients who might be socially isolated or in need of support on a range of matters.

Falls

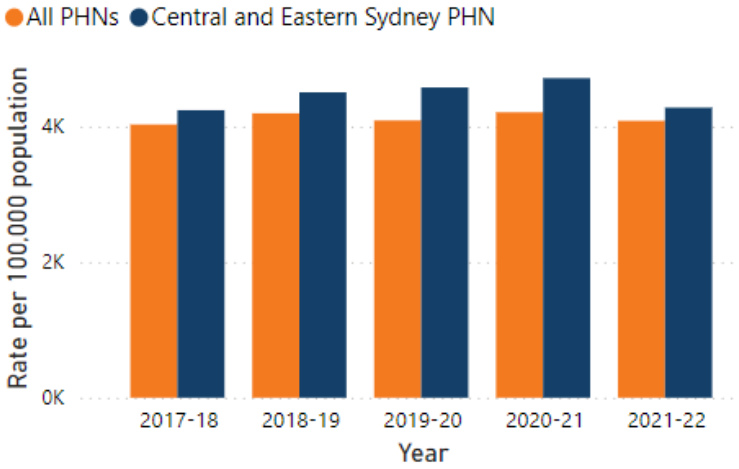
Falls are a key concern in the older population because of their potential to cause permanent harm, disability, earlier admission to residential aged care, and premature death. Understanding high falls risk population is crucial to avoid preventable incidents and hospitalisations.

Falls can result in physical injuries, loss of independence, psychological effects, financial strain and they can lead to increased mortality. They can also lead to more dependence on carers and carer strain.

The rate of fall-related injury hospitalisations (excluding rehabilitation admissions) in those aged 65 years and over has remained relatively consistent across the five years to 2019-20, both within NSW PHNs and CESPHN. Within the CESPHN region, there is a marked decrease in falls since financial year 2020-21, which could be because of health services no longer being disrupted because of the COVID pandemic and now being able to provide better provision of fall-assisted care to the elderly (10).

In 2022, falls-related hospitalisations decreased slightly to a rate of 894 per 100,000 within the CESPHN region, which represents a total of 16,638 total falls. The slight decrease from the 2020-2021 financial year may be representative of the care placed on falls during the COVID waves. More recent data is required to understand the trend movement (10).

Figure 3: Fall-related hospitalisations in the CESPHN region, 2017-18 to 2021-2022



Source: HealthStats NSW, 2023

Dementia

Dementia is a general term used to describe declines in cognitive functioning impacting daily life and activities. It affects memory, thinking, reasoning, and behaviour.

Based on national rates, there are an estimated 23,163 people aged 65+ years in the CESPHN region have dementia, which accounts to 15.4% of all people over 65 (11). As shown in Table 5, the prevalence of dementia increases significantly as people age. Dementia rates across CESPHN, and Australia have been consistently rising and increase as people age. This rise in dementia rates is projected to significantly impact healthcare costs, carer stress, and mortality (12).

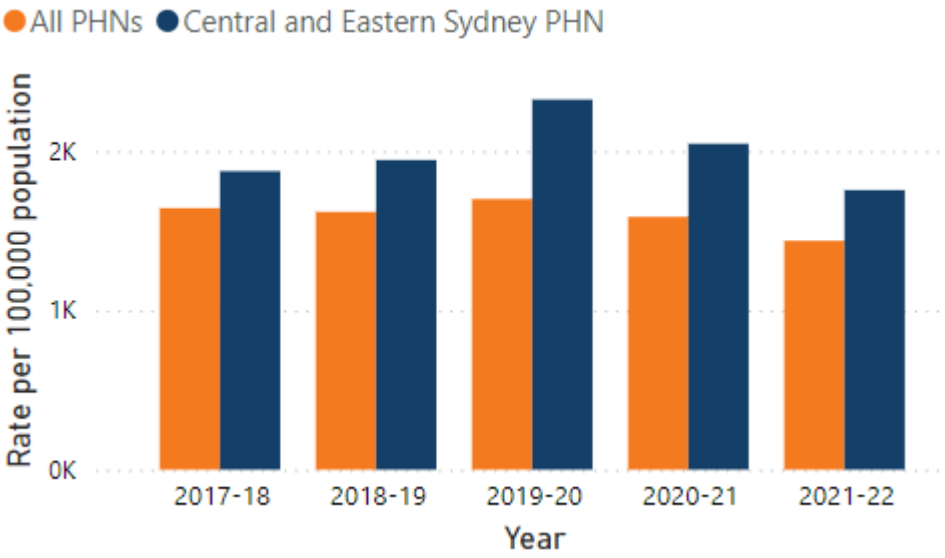
Table 5: Estimated prevalence of dementia, by age group, CESPHN region, 2022

Age group (years)	Estimated people with dementia	
	Number per 1,000 nationally	Number estimated CESPHN
65–69	24.8	1,809
70–74	40.9	2,485
75–79	70.6	3,608
80–84	123.2	4,192
85-89	209.5	11,069
90+	428.7	11,069
Total	15.4	23,163

Source: AIHW, 2023 and ABS, 2024

In 2021-22, across NSW PHNs there was a decrease in the rate of dementia-related hospitalisations for those aged 65 years (11).

Figure 4: Dementia-related hospitalisations in the CESPHN region, 2017-18 to 2021-22



Source: HealthStats NSW, 2024

Homelessness

Homelessness in the aged care population is an emerging issue in NSW due to the growing population, and the increasing costs associated with the housing market. This is a significant intersectionality due to the additional health and wellbeing risks faced by the older homeless population.

Homelessness among older women has become increasingly widespread, growing by almost 40% between 2011 and 2021. There were 465 women aged 65 years and over that accessed a service in NSW in June 2024, which was a 71% increase when compared with June 2019 (272). This is often due to lower lifetime earnings and savings, making them more vulnerable to housing instability (13).

Figure *5*: Homelessness above the age of 65 in the CESPHN region, 2021

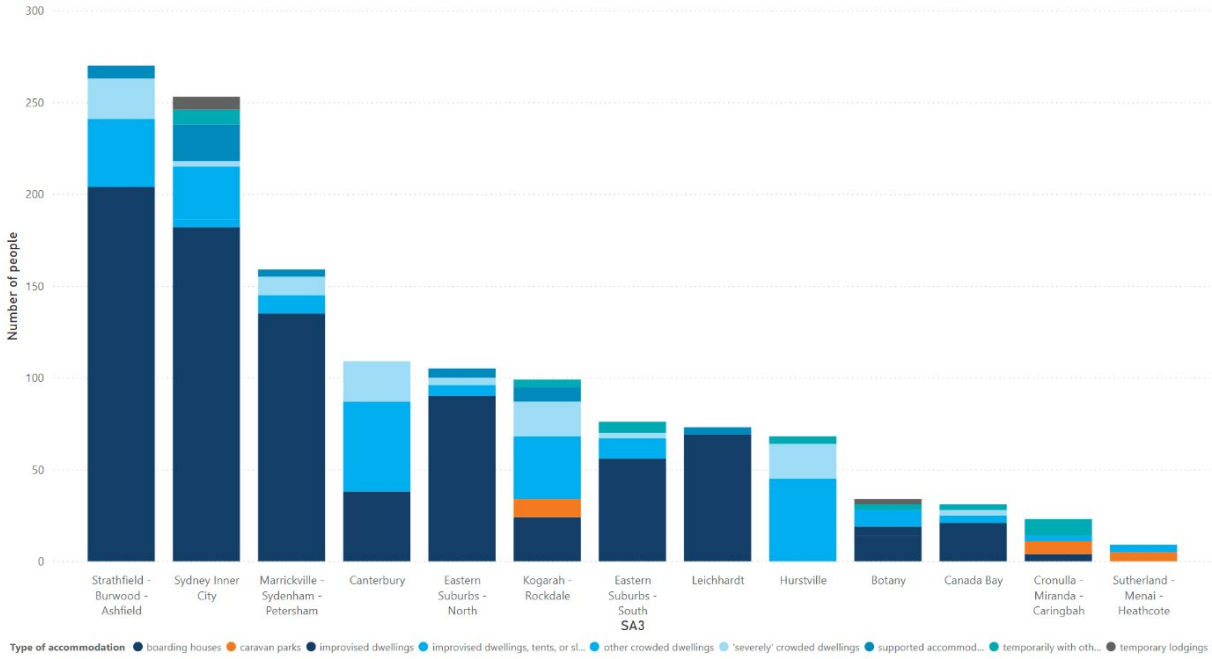


Table 6: Homelessness above the age of 65 by accommodation type and SA3, 2021

Location	Number of people									
	Type of accomodation									
	Boarding houses	Caravan parks	Improvised dwellings	Improvised dwellings, tents, or sleeping out	Other crowded dwellings	'severely' crowded dwellings	Supported accommodation for the homeless	Temporarily with other households	Temporary lodgings	Total
Strathfield - Burwood - Ashfield	204	0	0	0	37	22	7	0	0	270
Sydney Inner City	182	0	0	4	29	3	20	8	7	253
Marrickville - Sydenham - Petersham	135	0	0	0	10	10	4	0	0	159
Canterbury	38	0	0	0	49	22	0	0	0	109
Eastern Suburbs (North)	90	0	0	0	6	4	5	0	0	105
Kogarah - Rockdale	24	10	0	0	34	19	8	4	0	99
Eastern Suburbs (South)	56	0	0	0	11	3	0	6	0	76
Leichhardt	69	0	0	0	0	0	4	0	0	73
Hurstville	0	0	0	0	45	19	0	4	0	68
Botany	14	0	5	0	9	0	0	3	3	34
Canada Bay	21	0	0	0	4	3	0	3	0	31
Cronulla - Miranda - Caringbah	4	7	0	0	3	0	0	9	0	23
Sutherland - Menai - Heathcote	0	5	0	0	4	0	0	0	0	9
CESPHN	837	22	5	4	241	105	48	37	10	1309

Source: ABS, 2023

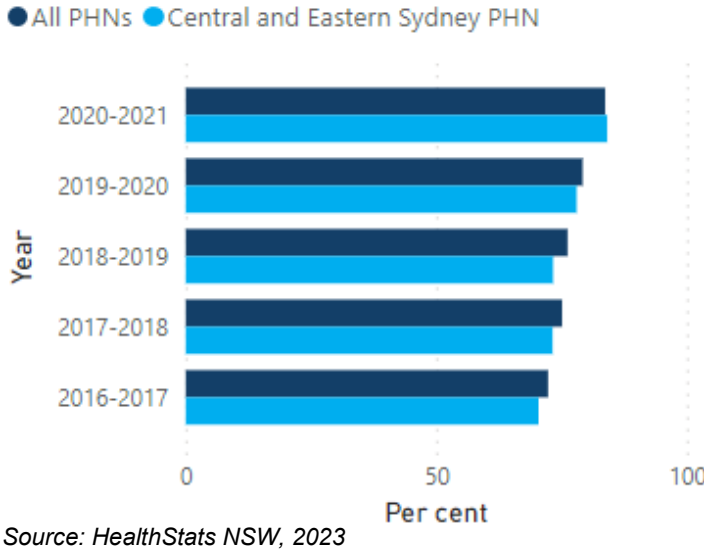
The SA3s with the highest proportion of homelessness are Strathfield-Burwood, Sydney Inner City, and Marrickville-Sydenham-Petersham. Consultations conducted by CESPHN highlight the need for more intervention in the primary care industry to not only identify and treat medical conditions, but to assist in social and wellbeing needs of this proportion of CESPHN's population. The impacts of doing

so will allow for a more integrative approach to primary health, improve their quality of life and break homelessness patterns.

Immunisation rates

In the five years to 2020-21, individuals aged 65 years and over within the CESPHN region have had influenza immunisation rates slightly lower than or on par with NSW PHN rates. CESPHN rates have risen consistently over this period, with rates increasing from 70.4% to 84.1% over the past 5 years (10).

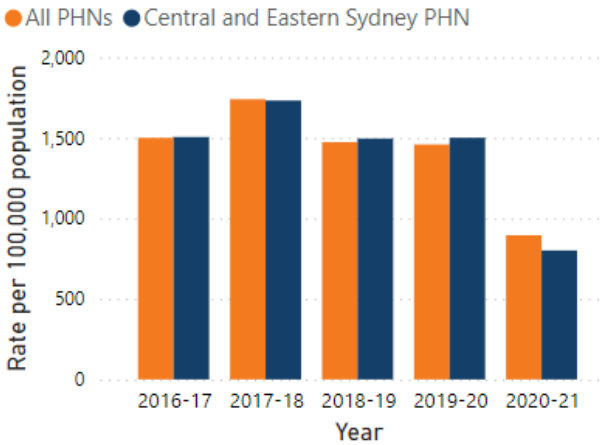
Figure 6: Influenza immunisation rates by year, CESPHN region, 2016-17 to 2020-21



Source: HealthStats NSW, 2023

There was an increase in the rate of hospitalisations from 2015-16 to 2017-18 (1,290.3 to 1,734.4 per 100,000 population respectively), followed by a decline in the rate from 2020-21 (14).

Figure 7: Influenza and/or pneumonia hospitalisation rates by year, CESPHN region, 2016-17 to 2020-2021



Source: HealthStats NSW, 2022

75+ health assessment

75+ health assessments are a comprehensive evaluation of a person aged over 75 conducted by a GP to identify any health issues early, manage any recurring problems and promote health ageing. This comprehensive assessment includes a review of the patient's medical history, physical examination, various screening tests and an assessment of the patient's lifestyle. This assessment enables a more tailored approach to the primary and community care received by the older population and prevent hospitalisations and premature RACF care (15).

In 2022-23, 29,367 health assessments were completed in the CESPHN region, accounting for 24.6% of the total eligible population and has potential to be significantly increased. The SA3 areas requiring a greater focus on the provision of interventions include Lord Howe Island (0%), Botany (7.8%) and Eastern Suburbs – North (17.3%) (15).

Table 7: Proportion of population 75 years and over who had a health assessment completed, CESPHN region, 2022-23

SA3	Health Assessments^	Population*	Proportion with Health Assessment completed (%)
Botany	258	3,311	7.8
Canada Bay	2,148	7,065	30.4
Canterbury	2,166	10,143	21.4
Cronulla-Miranda-Caringbah	3,878	11,867	32.7
Eastern Suburbs – North	1,807	10,451	17.3
Eastern Suburbs – South	2,438	10,255	23.8
Hurstville	3,136	11,047	28.4
Kogarah-Rockdale	3,441	11,588	29.7
Leichhardt	916	3,369	27.2
Lord Howe Island	-	29	0.0
Marrickville-Sydenham-Petersham	1,443	3,247	44.4
Strathfield-Burwood-Ashfield	2,823	11,263	25.1
Sutherland-Menai-Heathcote	2,950	8,987	32.8
Sydney Inner City	1,963	8,480	23.1
CESPHN	29,367	111,102	24.6

Source: Department of Health, 2024

Carer strain

Carer strain refers to the emotional, physical and mental exhaustion that carers face when caring for the elderly. This is not limited to family and friends of the older person but can also impact professional support workers. Addressing carer strain is crucial to the wellbeing of the care giver of older people so that they can better care for an elderly person.

Signs include feeling burdened, irritated sleeping too much/ not enough, gaining/ losing weight, losing interest in activities, feeling sad, having frequent headaches or other pains, substance abuse and missing their own medical appointments. The 2022 National Carer Survey showed (16):

- 47.5% of respondents of carers were experiencing high to very high levels of psychological distress
- 56.3% of respondents were experiencing social isolation or highly socially isolated
- 57% of respondents were experiencing financial stress

Aged Care Service Sector

Royal Commission into Aged Care Quality and Safety

In February 2021, the Royal Commission into Aged Care Quality and Safety delivered its final report which outlined 148 recommendations for reforming the aged care system in Australia (13). The Commission found that people receiving aged care, particularly those in residential aged care, do not consistently receive the health care they need including GP visits, mental health services, oral and dental health care, and preventative care. It also found that there is often a lack of clarity about health care responsibilities and communication between aged care providers and health care providers. The report also highlighted gaps that occur when older people transition between multiple health and social care systems.

A report commissioned by the Australian Government Department of Health in response to issues identified by the Royal Commission found the need for services that:

- Support people accessing information and navigating the aged and health care systems
- Focus on prevention and early intervention
- Are culturally safe for Aboriginal and Torres Strait Islander people, people from multicultural communities, refugees, and LGBTIQ+ communities
- Support information sharing to facilitate clinical handover between aged care and health care providers (14).

Changes to the new Aged Care System

The Aged Care System is currently undergoing significant changes to improve the quality of care and the sustainability of the entire health system underpinned by the new Aged Care Act and bolstered by the new Aged Care Quality Standards. The changes include a new regulatory system that holds providers accountable for the care they provide, new fee structure changes ensuring that participants into the system will be means tested appropriately, more accessible and tailor-made solutions to the care and service type relevant for the participant and increased funding for staff retention and job-satisfaction.

Current Aged Care system

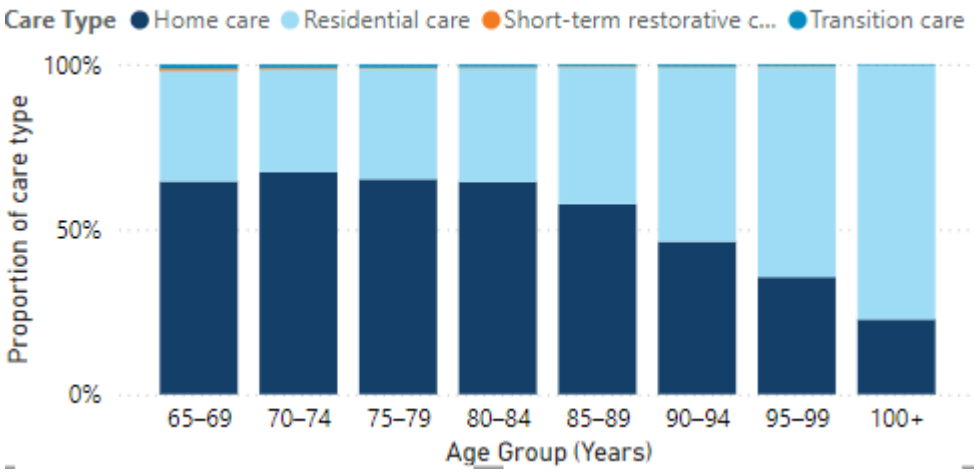
The aged care target population is defined as all people aged 65 years and over and Aboriginal and Torres Strait Islander Australians (here in referred to as Aboriginal people) aged 50–64 years. Aged care is delivered through a variety of programs such as the Commonwealth Home Support Program, Residential Aged Care Program, Home Care Packages Program and the Transitional Aged Care Program.

In the CESPHN region in 2024, there were:

- 149 RACHs offering 10,975 places
- 118 services providing home care packages, offering 14,498 places
- 3 services providing transition care
- 6 short-term restorative care, and
- 1 multi-purpose centre.

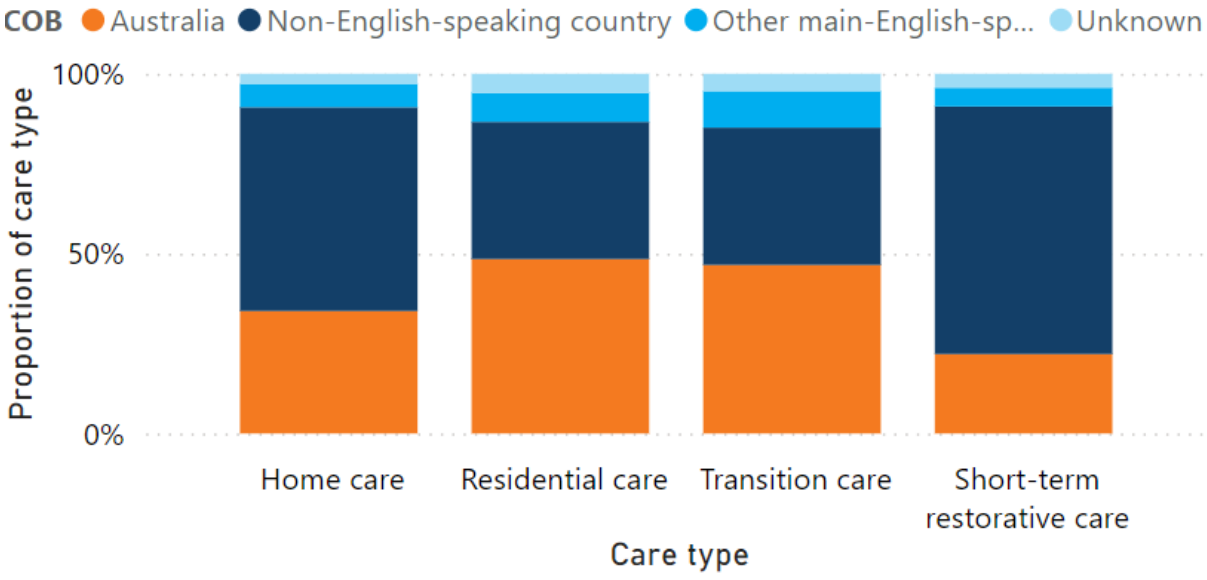
Up until 80-84 years of age, there is a slightly higher proportion of home care participants in comparison to residential care. The use of residential care grows almost at an exponential rate after the age of 85. This is reflective of the high level of care necessary to keep older adults experiencing increased frailty, chronic health conditions and complex comorbidities, safe.

Figure *8*: Care type by age group, CESPHN region, 2023



Source: AIHW GEN, 2023

Figure *9*: Country of birth by care type, CESPHN region, 2023

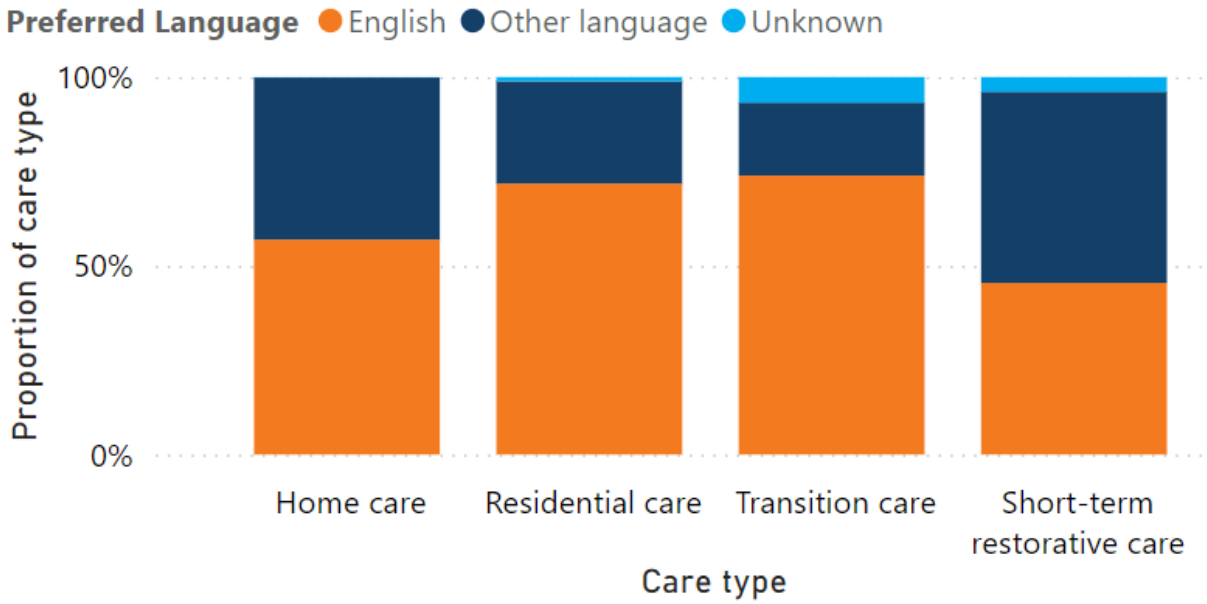


Source: AIHW GEN, 2023

The CESPHN region has a higher proportion of older people with a preferred language other than English (33.5%) compared to NSW (20.4%). Home care packages are more frequently used by this group with 42.5% of people using these services reporting a preferred language other than English (17).

Short-term restorative care and home care services cater to more aged care recipients that speak a language other than English. This presents an opportunity for the primary care system to work closely with the aged care industry to assist this proportion of the population in accessing relevant and culturally appropriate services.

Figure *10*: Preferred language by care type, CESPHN region, 2023



Source: AIHW GEN, 2023

Home care services

In 2023, there were a total of 15,100 recipients of home care services in the CESPHN region. Of these, majority of the packages approved and provided were Level 2 and Level 3 (18).

Table *8*: Number of home care recipients, CESPHN region, 2023

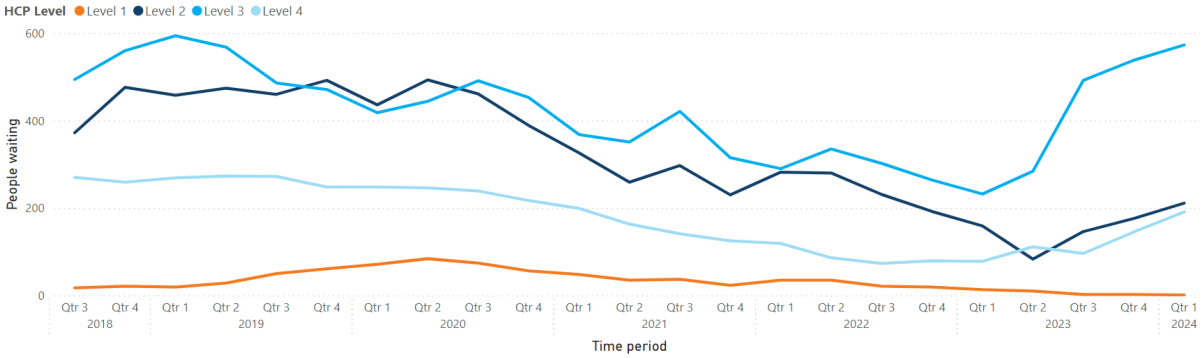
Level	Number
Level 1	860
Level 2	6,424
Level 3	5,184
Level 4	2,632
Total CESPHN Region	15,100

Source: AIHW GEN, 2024

Of the total home care packages approved in the CESPHN area, 283 were for Aboriginal recipients, and 6,484 recipients preferred to speak a language other than English. Home care packages were utilised the most by the 80-84 age group (18).

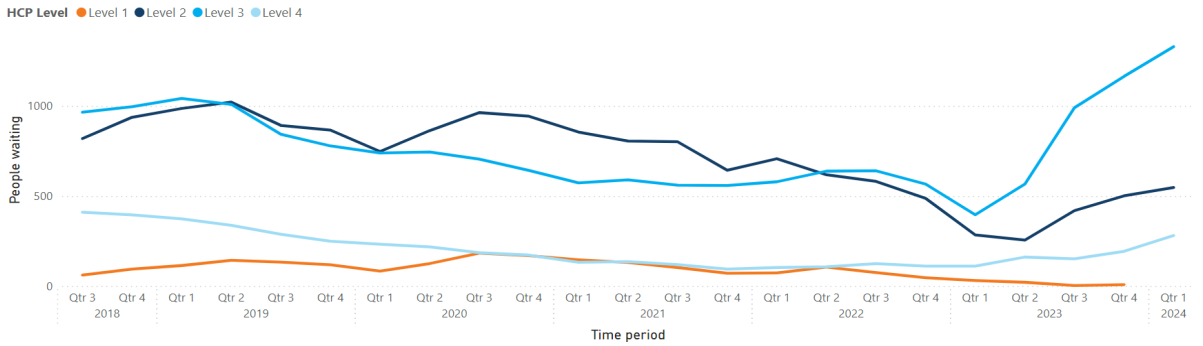
Waitlists for all package levels has increased drastically and consistently within the last year across the CESPHN region. As seen in the Figures below there are more people on the waitlist for Level 3 and 2 packages respectively across the Inner West and South East Sydney. In the first quarter of 2024, there were almost 600 people on the waitlist for a Level 3 package in the Inner West, compared to the approximate 1,600 on the waitlist for a Level 3 package in South East Sydney. This figure is highly representative of the population density of South East Sydney in comparison to the Inner West (18).

Figure *11*: Wait list for home care packages by care level, Inner West ACPR, March 2018 – March 2024



Source: AIHW GEN, 2024

Figure *12*: Wait list for home care packages by care level, South East Sydney ACPR, March 2018 – March 2024



Source: AIHW GEN, 2024

Residential care

In 2022-23, CESPHN had a total of 10,383 permanent residential care recipients aged over the age of 65. There was a total of 58,508 permanent residential care recipients in NSW demonstrating the population density of the CESPHN area (19).

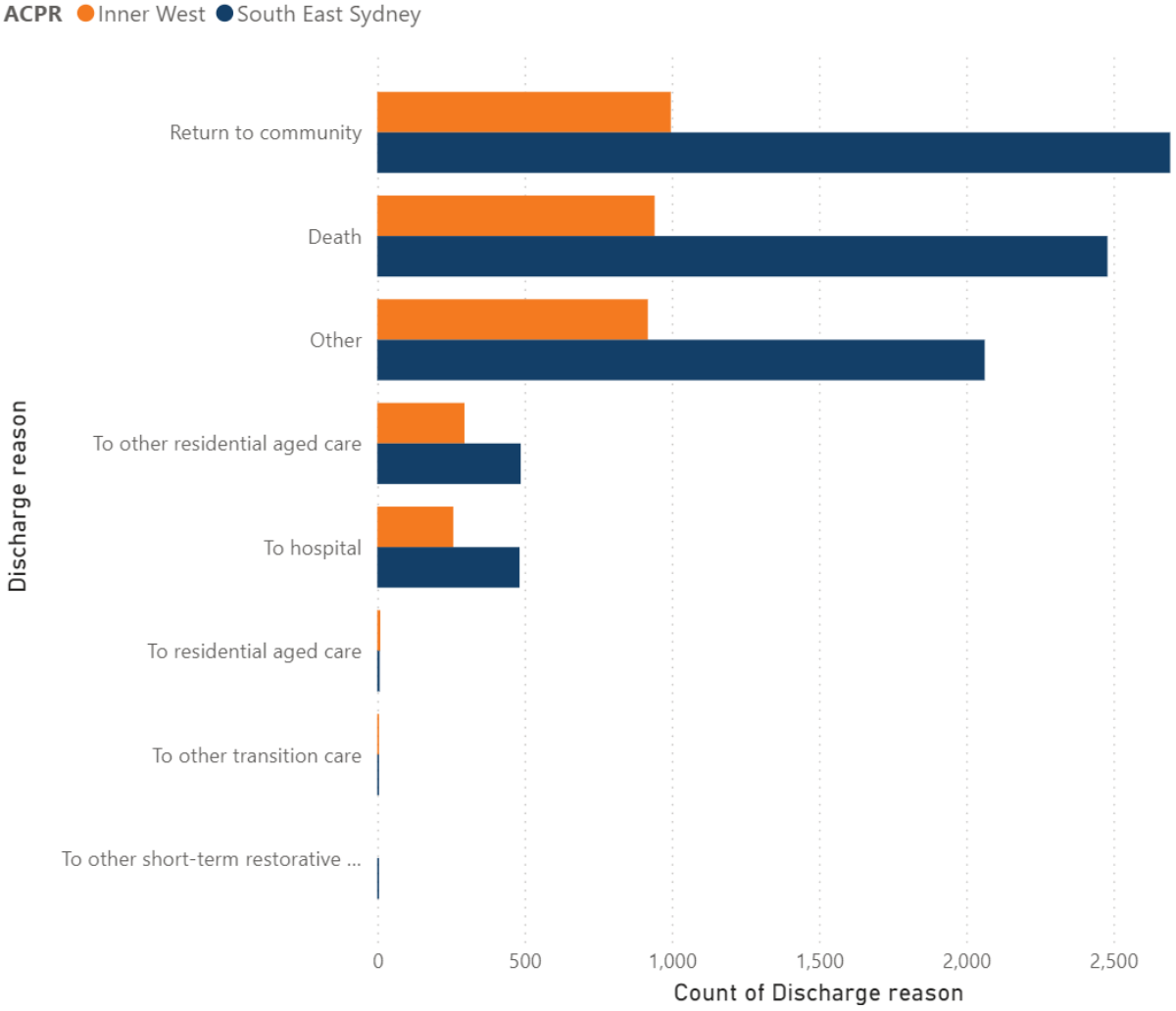
Table 9: Number of permanent residential care recipients above the age of 65, CESPHN region, as at June 2022-23

Region	Residential Care Recipients
CESPHN	10,355
NSW	58,508
Australia	182,643

Source: AIHW GEN, 2023

In 2022-23, there were a total of 621 residential respite recipients across the CESPHN region: 447 in the South East Sydney area, and 174 in the Inner West (19). In 2022-23, there were just over 11,000 exits from residential care in the CESPHN region for people aged 65 years and over. The key reasons for exiting permanent residential care across both SA2 regions were "Return to community" and "Death."

Figure *13*: Discharge reason by Aged Care Planning Region (ACPR), CESPHN region, 2022-23



Source: AIHW GEN, 2023

Transition care

In 2022-23, 207 people aged 65 years and over were admitted to transition care within the CESPHN region with1 being an Aboriginal community member, and 40 were CALD community members. The majority of exits from transition care were people entering home/community care, followed by hospital which made up approximately one-fifth of exits (19).

End of Life Care

Advance care planning

Despite the benefits to end-of-life care, less than 30% of Australians have completed an advance care plan (20). This could be due to poor patient experience and psychological distress associated with this phase. Other barriers for uptake of advance care plans may be due to lack of infrastructure and time for discussions to be had and limited workforce capacity in addressing difficult end of life conversations (21). This is important to note, as people do not usually return home after admission to RACFs. Additionally, patient attitudes, cultural differences, and clinician self-efficacy regarding establishing plans have been highlighted as barriers and should be considered when implementing strategies.

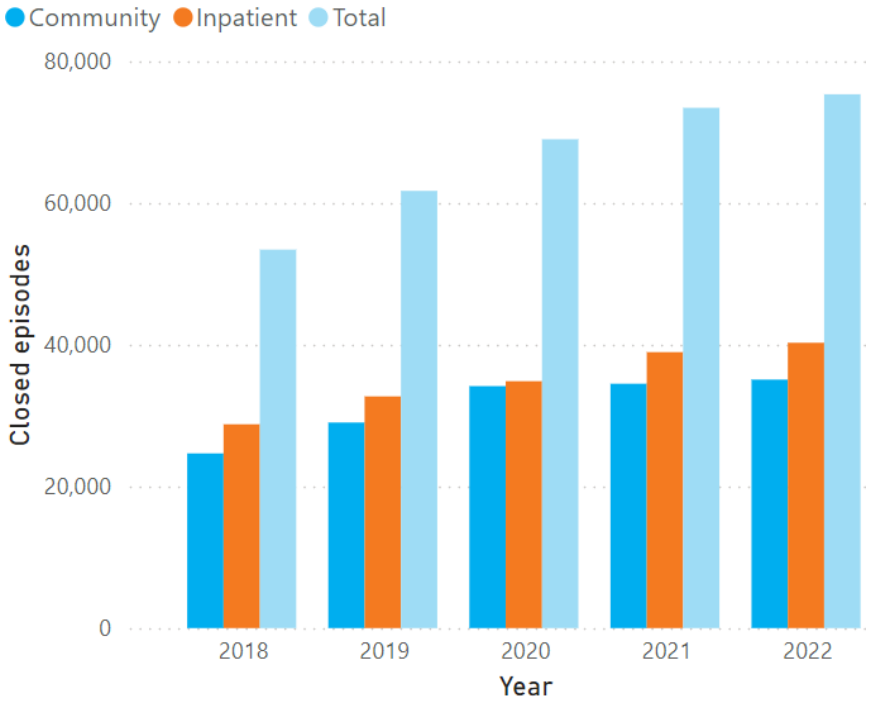
A 2021 CESPHN survey highlighted the barriers faced by RACFs in preparing advance care plans for their residents. The largest barrier is 'language and cultural' at 32%, followed by 'family/ relative reluctance' at 29%, 'capacity - cognitive impairment/ mental illness preventing informed decision' and 'too early to discuss' both at 9%. Other barriers identified included: 'too much information on admission'; 'dementia'; 'spiritual beliefs of staff'; 'unwilling resident'; 'poor skills'; and 'too little time' (22).

Palliative care

Palliative care can be provided in inpatient settings and community settings by a range of care providers. Capacity of GPs to co-ordinate care for these patients, in particular those with advanced cancer, is impacted by factors including lack of confidence in providing care due to the complexity of these patients, insufficient resources and training, problems with communication with specialists and treating teams, and barriers in successfully transitioning patients from acute hospital to home/community settings (23).

Nationally, in 2021, 58,710 patients received palliative care services across 77,531 episodes of care; almost half of which (49.2%) were in community settings. There were 175,166 phases of care with just over half (51.6%) being provided in the community. (24) Nationally, in 2021, 58,710 patients received palliative care services across 77,531 episodes of care; almost half of which (49.2%) were in community settings. There were 175,166 phases of care with just over half (51.6%) being provided in the community (24). The number of closed episodes of palliative care have increased between 2017 and 2021, with a 9.5% annual average change between this period (24).

Figure *14*: Number of closed episodes by palliative care setting, Australia, 2018 to 2022



Source: AIHW, 2023

Approximately one in four (24.1%) episodes in inpatient palliative care closed at 1-2 days, conversely 20.4% of community care palliative care episodes closed at >90 days. The majority of phases in palliative care for both inpatient and community settings were for deteriorating care phase (36.5% and 45% respectively). Inpatient palliative care had a relatively even split between stable, unstable and terminal phases, however community palliative care had much higher proportion of care in stable (35.4%) followed by lower rates of unstable (10.7%) and terminal (8.9%) (24).

Overall, community palliative care had an average episode length almost 4 times that of inpatient palliative care (36.8 days compared to 8.4 days), with a median episode length of 20 days compared to 5 days (25).

Table 10: Palliative care phase count by setting, Australia, 2021

Palliative care phase	Inpatient		Community	
	Number	Percentage (%)	Number	Percentage (%)
Stable	21,298	25.1	32,058	35.4
Unstable	13,255	15.7	9,692	10.7
Deteriorating	30,912	36.5	40,706	45.0
Terminal	19,231	22.7	8,014	8.9
Total	84,696	100.0	90,470	100.0

Source: AIHW, 2023

Over three-quarters (77.7%) of individuals in palliative care were aged 65 years and over, this is true for both inpatient palliative care (77.5%) and community palliative care (77.7%). Individuals from least disadvantaged IRSAD quintiles had the highest proportion of palliative care episodes (28.7%), this was reflected across both inpatient palliative care (26.4%) and community palliative care (31.1%) (25).

Almost three-quarters of palliative care episodes in 2021 were for individuals with a cancer diagnosis. Of these, lung, colorectal and other gastro-intestinal cancer were the three most common cancer diagnoses for palliative care patients (26).

The Australian Palliative Care Outcomes Collaboration (PCOC) is a national palliative care outcomes and benchmarking program. The PCOC benchmark results for the period of July - December 2022 show that overall community setting for palliative care does not reach benchmark levels for 11 of the 12 measures, and inpatient setting for palliative care does not reach benchmark levels for 3 of the 12 measures (27).

Nationally there was 302 employed palliative medicine specialists in 2020, giving a rate of 1.1 FTE per 100,000 population. Of these specialists, 225 worked in a hospital setting. Palliative medicine specialists worked an average of 36.9 hours per week, 28.9 of which were in a clinical capacity. New South Wales had 107 palliative medicine specialists, with a rate of 1.3 FTE per 100,000 population.

In 2020, there was 3,798 employed palliative care nurses nationally, giving a rate of 12.8 FTE per 100,000 population; 87.4% were registered nurses. Palliative care nurses worked an average of 32.8 hours per week, with 30.9 hours per week being in a clinical role. More than half of the palliative care nurses nationally worked in a hospital setting. New South Wales employed almost a third of the palliative care nurses nationally (n=1,054; 27.8%) (25).

CESPHN's current work

Older person care is an ongoing strong focus with CESPHN involved in the following areas of work:

- After hours action plans for RACHs
- Healthy Ageing Hubs
- Care finder Program
- Aged care and dementia pathways
- Development of dementia consumer resources
- Emotional wellbeing of Older Persons (EWOP) program
- Older Persons' Wellbeing Network
- MyMedicare General Practice in Aged Care Incentive (GP ACI)
- Increasing RACH resident vaccination coverage projects
- Electronic National Residential Medication Chart (eNRMC)
- Immunisation QIAs in general practice to increase coverage of recommended vaccinations in older adult
- Support RACHs with virtual consultations and use of health tracking and monitoring tools.

Opportunities

- Community-centred care
    - Age friendly communities assist with the building age-inclusive communities through stronger partnerships with local government
    - Better training tools for GPs and community on navigating aged care services.
    - Community-based models of care to reduce isolation and depression.
    - Educate GPs and the community on the new Single assessment service to access My Aged Care
- Workforce development
    - New models of care to encourage GPs to work in RACHs
    - Programs to hire older adults for specific roles
    - Training for healthcare professionals on elder care
    - Dementia-care programs
    - Improved awareness of dementia and palliative care community support services for GPs to refer their patients
- Digital health
    - Integration of MyAgedCare with My Health record
    - Implementation of MHR into remaining RACHs in our region
    - Expanded use of Telehealth (estimated 30% of all future primary care consults could be managed through telehealth) may be held back by lower IT literacy in older people
- Collaboration and integration
    - Interoperable platform for organisations, LHDs, PHNs, and LHNs
    - Standardised communication protocols
- System navigation
    - Simplified pathways for accessing aged care services
    - Personalised support navigation
    - Streamlined assessment processes

    - Single point of entry
- Innovation and research
    - Funding for aged care research and innovation
    - Evaluation and dissemination of best practices.

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phn CENTRAL AND EASTERN SYDNEY

An Australian Government Initiative

HEALTH AND WELLBEING OF CHILDREN IN THE FIRST FIVE YEARS

2025-2027 Needs Assessment

Table of contents

List of tables

List of figures

Overview

Experiences during the early years of a child's life can have lasting impacts on physical and mental well-being. What happens during this time of early development can influence a child's future social, emotional and intellectual development (1). A key health service aim of early childhood years is to eliminate or mitigate the risk factors of adverse health effects and identify children at risk.

This chapter reviews some of the risk factors that can compromise childhood development. It is acknowledged that these indicators are not comprehensive. Further, the indicators reported here, such as maternal smoking, birthweight and maternal access to early antenatal care narrow the focus on proximal causes of adverse child health-related outcomes. These indicators are useful because these are easily measured and have direct effects on outcomes. Insofar as these indicators arise from broader socio-economic determinants of health, it follows that improving the social determinants of health can bring positive changes to mothers' and children's standards of living and wellbeing.

Key issues

- In some parts of the CESPHN region there are high levels of socio-economic disadvantage
- Child immunisation rates are less than the national target
- Some SA3s with the highest developmental vulnerability in one or more domains
- The proportion of women with their first antenatal visit recorded during the first 14 weeks of gestation is below the NSW average
- Aboriginal babies are less likely to be born within a healthy weight range compared with Non-Aboriginal babies (88% versus 95%)

Key gaps

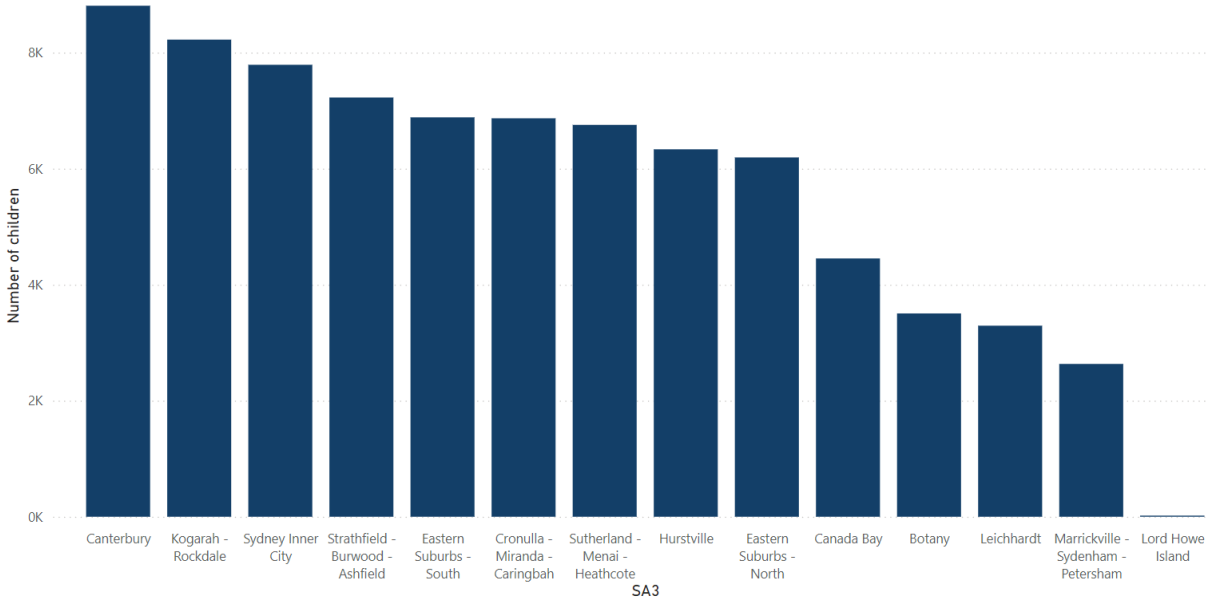
- Full immunisation rates in children in several regions within CESPHN have fallen below 90%
- Treatment delays for children newly diagnosed with a disability
- Access to affordable paediatric care

Demographics

Population aged 0-4 years

In 2024, there were 82,982 children aged between 0 to 4 years in the CESPHN region. Numbers are expected to grow at a rate of 0.31% annually reaching 87,493 by 2041. Figure 1 shows the estimated residential CESPHN population of children aged 0-4 by SA3. Canterbury SA3 had the highest number (N=8,808), accounting for 11.4% of children 0-4 years across the CESPHN region, followed by Kogarah-Rockdale SA3 (N=8,224) accounting for 9.7% and Sydney Inner City (N=7,790), accounting for 9.5% of the CESPHN population (2).

Figure 1: Estimated resident population (ERP) of children aged 0-4 years by SA3, CESPHN region, 2023



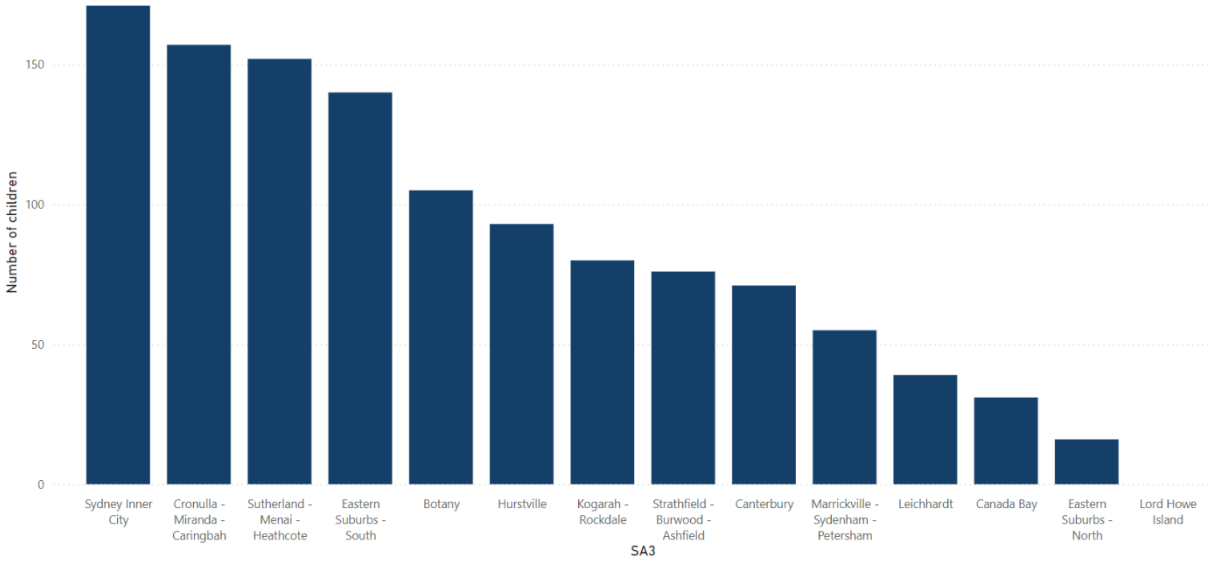
Source: ABS ERP, 2024

Demographic characteristics on Aboriginality, children born overseas or born to overseas born parents, and main language spoken at home have been identified from the most recent National census data from 2021. Therefore, these data remained unchanged from the previous Needs Assessment Report. However, Census data provide the most representative estimates currently available.

Population aged 0-4 years who identify as Aboriginal

In 2021, there were 1,186 children aged 0-4 years who identify as Aboriginal in the CESPHN region. Sydney Inner City was the SA3 with the highest number of children identifying as Aboriginal (N=171), accounting for 14.4% of Aboriginal children in the CESPHN region followed by Cronulla-Miranda-Caringbah SA3 (N=157) and Sutherland-Menai-Heathcote SA3 (N=152) (3).

Figure 2: Number of children aged 0-4 years who identify as Aboriginal by SA3, CESPHN region, 2021



Source: ABS, 2022

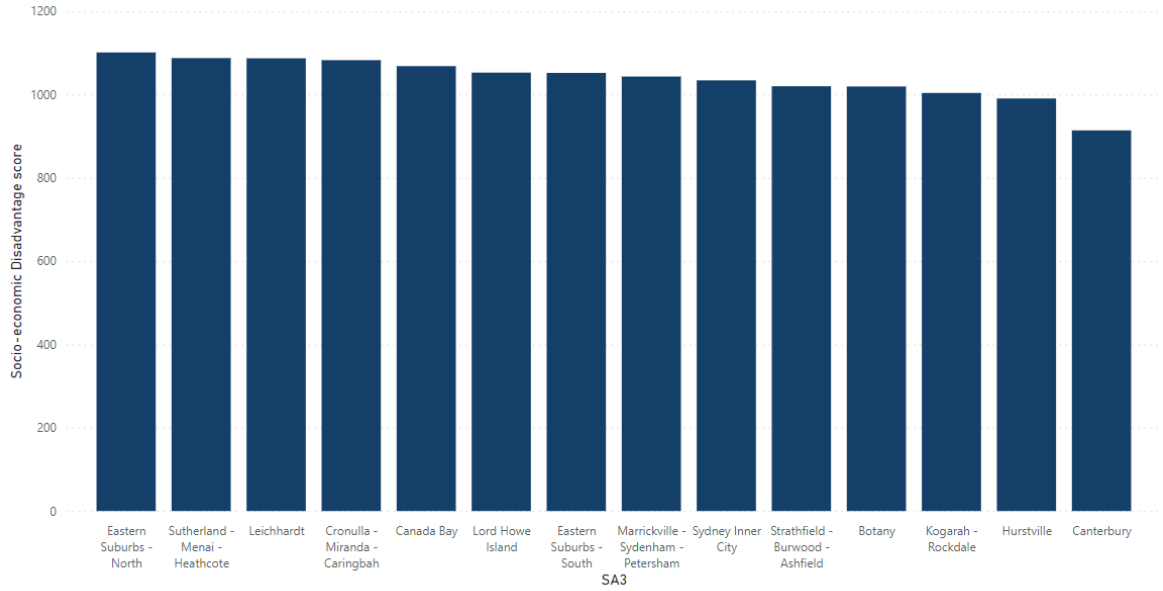
Population born overseas or have parents who were born overseas

In 2021, 6,096 children residing in the CESPHN region between the ages of 0 to 4 were born overseas. Canterbury, Sydney Inner City and Kogarah-Rockdale SA3s had the highest numbers of overseas born children <5 years (3).

Socio-economic disadvantage

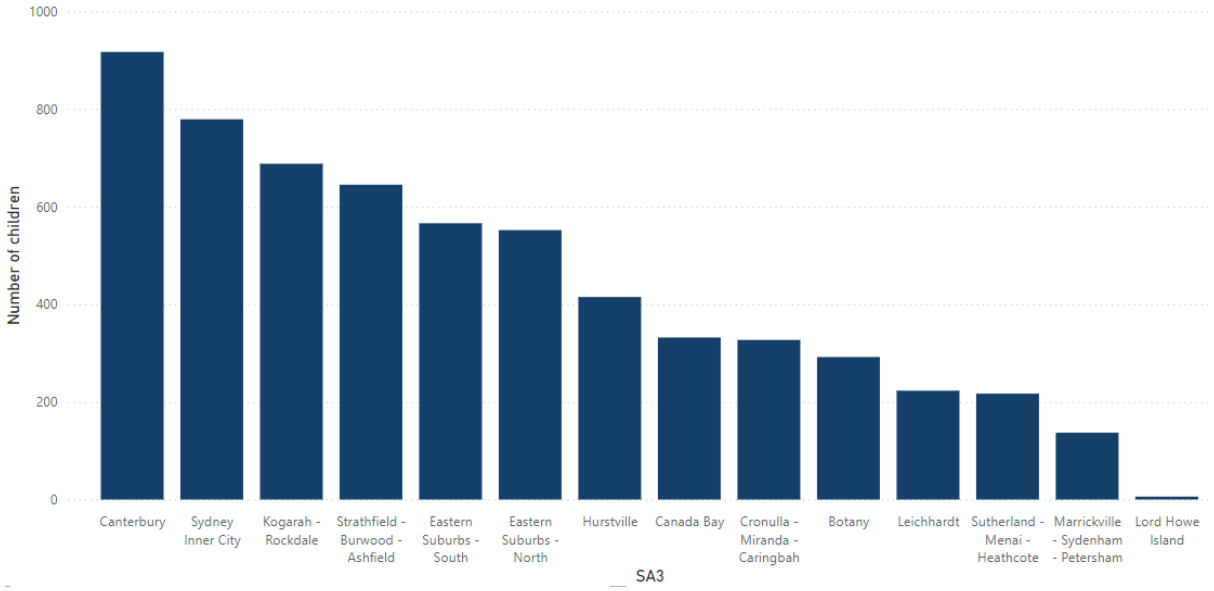
According to the 2021 Census data, twelve out of fourteen SA3s in the CESPHN region ranked above 1,000 on the SEIFA Index of Relative Socioeconomic Disadvantage rankings, meaning the areas have a lower proportion of relatively disadvantaged people than the Australian average. Two SA3s ranked below 1,000: Hurstville SA3 (990.6) and Canterbury SA3 (913.9) - highlighting pockets of relative disadvantage in the CESPHN region (4).

Figure 3: Socio-economic disadvantage score by SA3, CESPHN region, 2021



Source: ABS, 2022

Figure 4: Number of children aged 0-4 years born overseas by SA3, CESPHN region, 2021

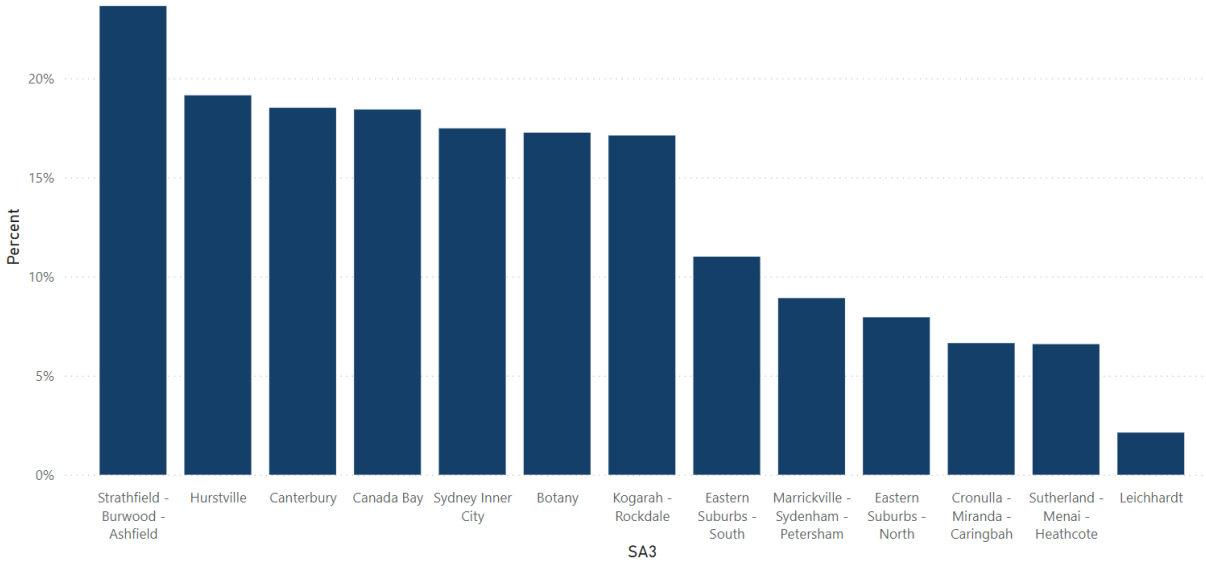


Source: ABS, 2022.

Over thirty percent (31.6%) of children across the CESPHN region speak a language other than English at home with more than half of children (58.6%) in the Canterbury SA3 speaking a language other than English at home (58.6%). Almost half of children younger than 5 years residing in Kogarah - Rockdale SA3 (49.7%) and Hurstville SA3 (47.6%) speak a language other than English at home respectively (3).

In 2021, 4.2% of children aged 0-4 years in the CESPHN region did not speak English well or at all. This proportion is highest in Botany SA3 (7.4%), followed by Strathfield-Burwood-Ashfield SA3 (7.4%) and Canterbury (6.9%) (3).

Figure 5: Proportion of children aged 0-4 years born in non-English speaking countries with reported low English proficiency by SA3, CESPHN region, 2021



Source: ABS, 2022

Health status

Population aged 0-4 years who need core activity assistance

Data from the 2021 census showed that 711 children aged 0-4 years required core activity assistance in the CESPHN region, representing 2.2% of children in the region. Canterbury SA3 had the highest number of children aged 0-4 years requiring core activity assistance (N=103), followed by Sutherland - Menai - Heathcote SA3 (N=86) and Kogarah - Rockdale SA3 (N=77) (3).

Table 1: Number of children aged 0-4 years who need core activity assistance by SA3, CESPHN region, 2021

SA3	Number of children who need core activity assistance
Botany	29
Canada Bay	41
Canterbury	103
Cronulla - Miranda – Caringbah	48
Eastern Suburbs – North	50
Eastern Suburbs – South	52
Hurstville	70
Kogarah – Rockdale	77
Leichhardt	20
Marrickville - Sydenham – Petersham	20
Strathfield - Burwood – Ashfield	62
Sutherland - Menai – Heathcote	86
Sydney Inner City	53
CESPHN	**711**

Source: ABS, 2022

Immunisation

As at June 2024, annual full immunisation rates in the CESPHN region were below the target of >95% for 1-, 2- and 5 year olds (5). Rates were lower in Aboriginal children compared with rates for all children aged 1 and 2 years old and were slightly higher in Aboriginal children at 5 years of age (5).

When compared with 2019 rates (pre-Covid), full immunisation rates for all children are similar in the twelve months to June 2024, indicating a return to pre-pandemic levels. However, for Aboriginal children, current rates are below pre-pandemic levels and are markedly below pre-pandemic levels for 1-year olds (90.27% versus 95.05%) and 5- year olds (93.15% and 97.65%). Full immunisation rates in Aboriginal children in CESPHN are lower than the NSW average for Aboriginal children (5).

Table 2: Percentage of children fully immunised (uptake of National Immunisation Program funded vaccines), by region and age, January to December 2019 (pre-Covid) and July 2023 to June, 2024

	1 year olds		2 year olds		5 years olds	
	CESPHN	NSW[a]	CESPHN	NSW[a]	CESPHN	NSW[a]
2019						
All	93.79%	94.17%	90.42%	91.33%	92.43%	94.66%
Aboriginal	95.05%	94.44%	90.44%	91.96%	97.65%	97.86%
2024						
All	93.69%	92.98%	91.03%	91.15%	92.96%	94.04%
Aboriginal	90.27%	92.18%	90.29%	90.38%	93.15%	96.11%

Source: Australian Government: Department of Health and Aged Care

Marrickville-Sydenham-Petersham and Sutherland-Menai-Heathcote were the only SA3 regions within CESPHN to achieve the national target for full immunisation (>95%) across all three standard age assessment milestones. More than 95% of 1-year olds within Leichhardt and Sydney Inner City SA3s

were fully vaccinated. Of concern, in four SA3 regions, fewer than 90% of children were vaccinated at 2 years of age- Botany, Canterbury, Eastern Suburbs North and Kogarah-Rockdale (5).

In the Eastern Suburbs North SA3, only 89.53% of 5-year olds were fully vaccinated. The variability in demographic characteristics across the CESHPHN region suggests that the barriers may differ for different SA3 regions and public health interventions will likely need to be tailored to redress area-specific barriers (5).

Table 3: Percentage of fully vaccinated children by CESPHN SA3

SA3	% Fully Vaccinated		
	1 year-olds	2 year-olds	5-year olds
Botany	93.61	89.71	93.05
Canada Bay	94.03	92.66	92.94
Canterbury	90.68	87.75	93.11
Cronulla - Miranda – Caringbah	94.32	90.55	94.99
Eastern Suburbs – North	92.41	89.18	89.53
Eastern Suburbs – South	91.87	90.01	90.96
Hurstville	93.25	90.69	92.67
Kogarah – Rockdale	92.72	89.34	92.94
Leichhardt	95.99	93.97	93.81
Marrickville - Sydenham – Petersham	97.16	95.45	96.58
Strathfield - Burwood – Ashfield	94.74	91.97	93.70
Sutherland - Menai – Heathcote	95.32	95.36	96.97
Sydney Inner City	95.01	91.09	89.34

Source: Department of Health and Aged Care, 2024

Research from surveys of Australian parents demonstrate that vaccine hesitancy has increased since the COVID-19 pandemic (6) (7). The National Vaccination Insights Project identifies barriers to childhood vaccination as reported by parents. Parents of children who do not receive vaccinations are more likely to cite concerns about safety and doubts about the scientific efficacy of vaccination than parents of fully or partially vaccinated children.

Parents of partially vaccinated children are more likely to cite practical difficulties in arranging vaccination appointments and financial barriers (8). Local data from within the CESPHN SA3 regions may assist in identifying reasons for less vaccination uptake and better target strategies to the needs of the community.

Childhood development

The Australian Early Development Census (AEDC) is completed once every three years by teachers in children's first year of school. Five domains are assessed:1) physical health and wellbeing, 2) social competency, 3) emotional maturity, 4) communication skills and general knowledge, and 5) language and cognitive skills.

The most recent AEDC was conducted from May to July inclusive, 2024 with results due to be reported in 2025. This section reports results from the 2021 AEDC and therefore is not changed from the last Needs Assessment. SA3s with the highest developmental vulnerability in one or more domains that were above the NSW rate (21.2%) were Canterbury (24.7%) and Strathfield – Burwood

– Ashfield (22.4%) (9). Additionally, Eastern Suburbs - South (19.7%) had rates higher than the CESPHN rate (17.3%). AEDC data shows that some SA3s have seen an increase in language vulnerability, mainly Canterbury, Kogarah – Rockdale, Strathfield - Burwood - Ashfield and Hurstville (9).

Between 2021-23, CESPHN was a primary partner in the NHMRC partnership funded grant – Strengthening Care for Children (SC4C) project. The project trialled a new general practitioner (GP) – paediatrician integration model of care designed to:

- reduce the need for paediatric referrals to hospital services
- support and improve GP confidence to manage a broad range of child health concerns, and
- strengthen primary relationships and trust with family and/or care givers to deliver high quality of paediatric care close to home.

The project also sought to develop relationships between GPs and paediatricians, with ongoing support and education opportunities provided to GPs from the SC4C project team over a 12-month period. This included:

- GP-led co-consultation with SC4C paediatricians (weekly for six months, fortnightly for the following six months)
- SC4C paediatricians led monthly case discussions, and
- SC4C paediatrician weekday phone and email support.

Key indicators against which needs were identified include participation in antenatal care, health behaviours during pregnancy (namely smoking and alcohol intake), incidence of preventable pregnancy complications (gestational diabetes), and birth outcomes (birth weight) and breastfeeding.

Issues raised during the external consultations conducted by CESPHN with clinical and community leaders included:

- Treatment delays for children newly diagnosed with a disability
- Growing concerns about identifying and managing children with speech delays due to missed preventive health care assessments
- The impact of maternal mental health on child development.

Maternal health

Conception and pregnancy

Antenatal care

There is strong evidence to support the efficacy of routine antenatal care on childhood outcomes (1) particularly the first trimester. Antenatal care offers opportunities for education around life-style modifications, such as smoking, the early detection of pregnancy complications and vaccination during pregnancy.

Recent data from the Australian Institute of Health and Welfare reports on antenatal care up to 2022 by PHN and SA3 levels (10). The proportion of women with their first antenatal visit recorded during the first 14 weeks of gestation is below the NSW average with 66.3% of women in CESPHN meeting this National Core Maternity Indicator compared with 80.3% in NSW. This proportion was higher in 2019, (74.9%), dropping to two-thirds in 2020, and has remained steady since. In contrast, the overall NSW estimate did not show variation between 2019 to 2022.

Table 4: Proportion of women receiving antenatal care during the first 14 weeks of pregnancy, 2019-2022

Year	CESPHN	NSW
2022	66.3%	80.3%
2021	67.2%	80.9%
2020	66.5%	80.7%
2019	74.9%	80.2%

Source: HealthStats NSW, 2024

Differences in this core indicator are evident across the CESPHN region. High proportions of women receive their first antenatal care visit during the first trimester of pregnancy in Sutherland-Menai-Heathcote (84.9%), Cronulla-Caringbah-Miranda (84.1%), and Eastern Suburbs North (80.0%) SA3 regions. Low proportions are seen in Canterbury (44.6%), Marrickville-Sydenham-Petersham (48.1%) and Strathfield-Burwood-Ashfield SA3 regions (49.0%) (10).

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Table 5: Proportion of women receiving antenatal care during the first 14 weeks of pregnancy, 2019-2022 by SA3

SA3	% receiving care
Botany	76.1
Canada Bay	59.5
Canterbury	44.6
Cronulla - Miranda – Caringbah	84.1
Eastern Suburbs – North	80.0
Eastern Suburbs – South	77.2
Hurstville	68.1
Kogarah – Rockdale	67.9
Leichhardt	60.2
Marrickville - Sydenham – Petersham	48.1
Strathfield - Burwood – Ashfield	49.0
Sutherland - Menai – Heathcote	84.9
Sydney Inner City	62.1

Source: HealthStats NSW, 2024

Data from NSW Health reports antenatal care by Aboriginality of mothers. However, figures for the Sydney Local Health District are unavailable. Using data for South Eastern Sydney Local Health District, antenatal care by Aboriginal status can be reported, however. In 2022, there were minimal differences between Aboriginal and Non-Aboriginal mothers and delivery of antenatal care. A slightly higher percentage of Aboriginal mothers attended their first antenatal visit before 14 weeks gestation (79.9%) compared with non-Aboriginal mothers (78.5%), while 94% of Aboriginal mothers had done so by before 20 weeks compared with 95.4% of other mothers (11).

Table 6: Percentage of mothers with first antenatal visits before 14 weeks by LHD, 2020

Region	All mothers (%)	Aboriginal mothers (%)
Sydney LHD	56.2	49.3
South Eastern Sydney LHD	73.4	66.7
CESPHN	66.1	59.3
NSW	80.0	76.3

Source: HealthStats NSW 2020

CESPHN's Antenatal Shared Care (ANSC) Program partners with local hospitals to co-ordinate three ANSC programs – RPA Women and Babies/Canterbury (RPA/Canterbury), The Royal Hospital for Women (RHW) and St George/Sutherland (STGS). These programs aim to improve maternal and child wellbeing by supporting clinicians in the provision of integrated antenatal and postnatal care, particularly in areas and demographics of need. As at July 2023, there were 1,319 GPs registered and actively participating in a program. GPs can be registered in a single local hospital or with multiple local hospitals.

Table 7: GP registrations in the CESPHN region by ANSC program, as at December 2023

ANSC program	No. GPs registered	No. of births with ANSC as model of care (2022)	Proportion of total hospital births with ANSC as model of care (2022) (%)
Royal Hospital for Women	445	1,620	51.4
RPA Women and Babies and Canterbury Hospital	577	225	4.6
St George and Sutherland Hospital	318	187	2.8

Source: CESPHN database, 2024

Smoking during pregnancy

A high proportion of women not identified as Aboriginal report not smoking at all during pregnancy (96.7%), compared with Aboriginal women (58.4%), which is slightly higher than all women residing in NSW PHN areas (93.0%). However, non-smoking rates are similar for Aboriginal women from the CESPHN region compared with other Aboriginal women across the state (58.4% versus 59.6%, respectively) (11).

Maternal medical conditions

The prevalence of common maternal medical conditions is lower than that seen in other NSW PHN regions yet provides an indicator of women requiring specialist ante-natal care and closer monitoring during pregnancy. Gestational diabetes is the most prevalent condition (14.9%) in CESPHN mothers

(11). Diabetes in pregnancy increases the risk of adverse outcomes for the mother and baby including large birth weight, stillbirth and pre-term birth. For mothers, gestational diabetes is a risk factor for cardiovascular risk in later life and does not always resolve after delivery. Diabetes in pregnancy increases the risk of adverse outcomes for the mother and baby including large birth weight, stillbirth and pre-term birth. For mothers, gestational diabetes is a risk factor for cardiovascular risk in later life and does not always resolve after delivery.
The introduction of new diagnostic guidelines for gestational diabetes in 2015 increased ascertainment and hence a large jump in prevalence was seen in CESPHN in a short period of time: from 7.1% in 2015 to 12.9% in 2016. Rates peaked in 2019 (14.1%), then fell during the COVID-19 pandemic, before returning to 2019 levels in 2022 (11).
Therefore, current rates may reflect the true underlying prevalence of gestational diabetes detected with optimised antenatal care rather than a true increase. However, with almost one in eight pregnancies affected the burden of care on antenatal specialist services is substantial.
Rates by Aboriginal status of mothers according to PHN are not available from NSW Health. In 2022, the NSW prevalence of gestational diabetes for all Aboriginal mothers was 14.0%, compared with 16.0% for all mothers (11). However, lower rates of testing in Aboriginal women may account for this difference and under-reporting of Aboriginal status may also obscure differences, although these explanations are speculative in the absence of informative data.

Overweight and obesity in pregnancy

Obesity is associated with an increased risk of pregnancy complications and adverse pregnancy outcomes. According to the most recent data from NSW Health, 34.2% of women residing in the SLHD catchment were obese or overweight during the first trimester of gestation, compared with 31.4% of women living in the South Eastern Sydney Local Health District boundaries (11).

Birth and development

Healthy birth weight

Birth weight is a predictor of future health. A healthy baby is born between 2,500 and 4,999 grams. The National Agreement on Closing the Gap has set a target that by 2031 91% of Aboriginal and Torres Strait Islander babies are born within the healthy weight range.
In 2022, 95.1% of non-Aboriginal babies within CESHN were born within a healthy weight range, a proportion that has been stable over time. However, only 88.2% of Aboriginal babies within the CESPHN region were born at a healthy weight. This below target proportion is lower than that recorded for Aboriginal babies in 2019 (92.3%) (11).

CESPHN's current work

CESPHN is actively engaged in improving the health and wellbeing of children and have commissioned a range of services that include:

- Antenatal Shared Care
- Early intervention speech pathology
- Schools based care coordination program
- CESPHN's work in immunisation assists general practices to identify children requiring vaccination.

Opportunities

- Promote the importance of the early years of life and antenatal care
- Increase childhood immunisation rates
- GPs encouraged to do a family welfare session on mother, partner and baby to check on perinatal mental health
- Train GPs to identify perinatal mental health concerns
- Increase resources for school-aged children who have missed the early-childhood surveillance.

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CENTRAL AND
EASTERN SYDNEY

An Australian Government Initiative

HEALTH AND WELLBEING OF PEOPLE LIVING WITH A DISABILITY

2025-2027 Needs Assessment

Table of contents

List of tables

List of figures

Overview

Summary

People living with a disability experience high unmet health needs and poor health outcomes. Just over 18% (over 180,000) of people live with a disability within the central and eastern Sydney region. Providing appropriate and relevant primary care to people living with a disability is a key focus for CESPHN. This chapter identifies the specific health requirements, barriers to accessing services, and the support systems necessary for enhancing the quality of life for people with disabilities and their care supports.

Key issues

- Access to well-coordinated care between primary, secondary and tertiary for those with a disability
- Timely participation in preventive health and screening services for those with a disability
- Inadequate Medicare funding models can deter extended consultations for complex medical and psychosocial care. GPs may be financially disincentivised to provide long consults, home visits to group homes, and prepare care plans which are paid at a lower rate or unbillable.
- Knowledge of primary care providers and provision of tools and resources to engage in conversations about disability.
- Those from priority population groups with a disability are particularly vulnerable because of low health literacy and economic disadvantage
- Intersection between aged care and disability. For example, there is a lack of palliative care support for those in group homes. People receiving NDIS who transfer to residential aged care after age 65 will lose access to the NDIS.
- Lack of support for teenagers living with a disability experiencing poor mental health e.g. suicidal thoughts and tendencies.

Key gaps

- Lack of service navigation support tailored to the needs of those with intellectual disability
- Lack of support for people with a disability when they receive dental care
- Lack of community-based child behavioural management programs for those with ADHD and autism
- Provision of support for carers to manage their own health needs
- Need for ongoing patient-centred, multidisciplinary and integrated models of care
- Support general practices to help address financial barriers to optimal care
- Development of tailored strategies to address health inequity
- Limited mental health services available for people with intellectual disability with poor mental health
- Lack of access to NDIS and psychosocial services for people suffering from severe mental health illnesses
- People with a disability leaving incarceration lose support and access to care and are at high risk of reoffending

Prevalence

In 2023, approximately 18.2% of the population in central and eastern Sydney had some form of disability. The prevalence of disability increases with age with 7.6% of children aged 0–14 having a disability while 50% of people aged 65 and over have a disability. About 1 in 4 (23%) reported a mental or behavioural disorder as their main condition (the condition causing them the most problems) and 3 in 4 (77%) reported a physical disorder as their main condition while 1 in 3 (32%) had severe or profound disability. In NSW of those with a disability 57.8% had a physical disability while 31.3% had a psychosocial disability, 22.9% had a sensory or speech disability and 20.9% had an intellectual disability (1).

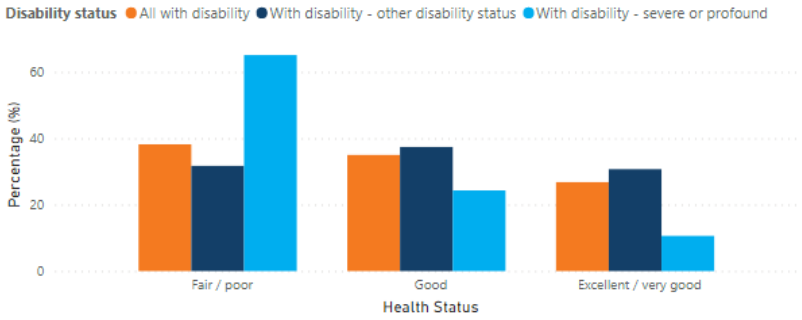
Canterbury SA3 has the highest proportion of both males and females with any disability (2). Approximately 2 in 5 persons aged 65 years and over living within the CESPHN region have some level of disability (2). Within the CESPHN region, a total of 1,057 active NDIS participants identified as having an Indigenous status in 2024.

Health status and risk factors

Self-reported health status

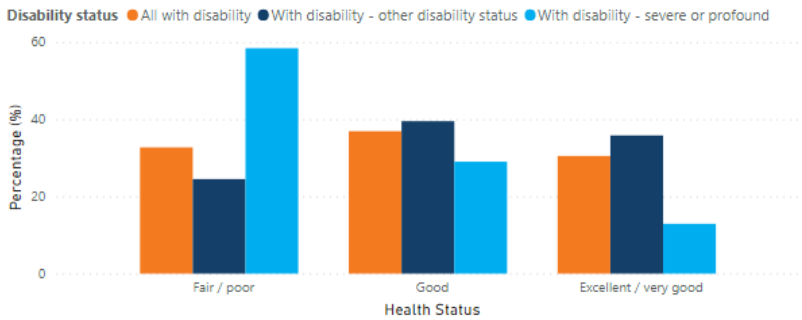
Those with severe or profound disability report poorer health status than all people with disability and those with other disability status. This is true for both 18-64 year old age group and 65 years+ age group (1).

Figure 1: Health status by disability status, 18-64 years, 2018



Source: AIHW, 2020

Figure 2: Health status by disability status, 65 years+, 2018



Source: AIHW 2020

Persons aged 18-64 years with severe or profound disability have higher levels of psychological distress (K10 scores) compared to persons aged 65 years and over with severe or profound disability (1).

Table 1: Psychological distress by age and disability severity group, 2018

Psychological distress level	18-64 years			65 years +		
	All disability	With disability – other disability status	With disability – severe or profound	All disability	With disability – other disability status	With disability – severe or profound
Low distress level	33.2	37.7	15.9	57.0	64.5	32.7
Moderate distress level	24.5	25.9	18.8	24.5	22.7	30.3
High distress level	21.2	19.8	27.2	12.5	9.1	23.2
Very high distress level	20.9	16.6	38.5	6.1	3.6	13.5

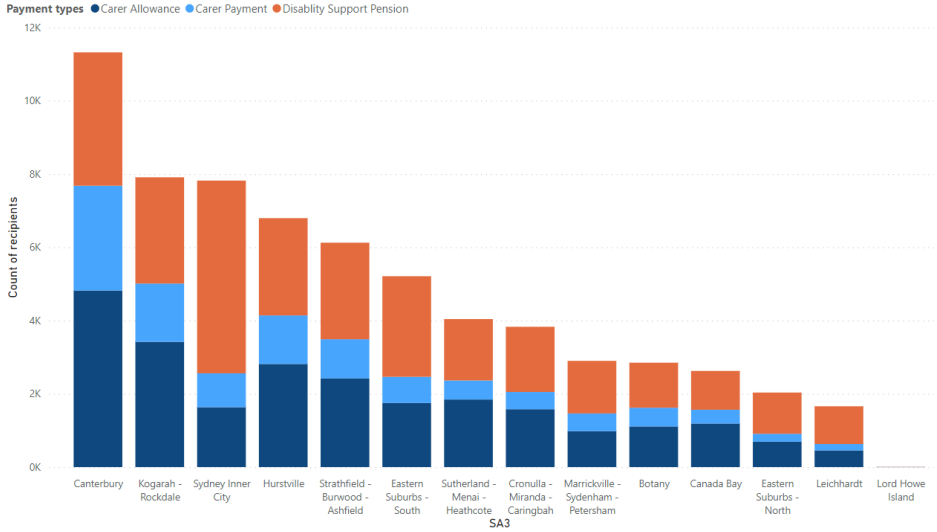
Source: AIHW, 2020

Support pensions and allowances

As at June 2023, there were approximately 29,175 individuals within the CESPHN region receiving a disability support pension, 24,720 individuals receiving a carer allowance and 11,235 individuals receiving a carer payment (3). Across the CESPHN region, Sydney Inner City SA3 had the highest number of recipients of disability support pensions (5,260), followed by Canterbury SA3 (3,640) and Kogarah-Rockdale SA3 (2,900) (3).

Canterbury SA3 had the highest number of recipients of carer payments and carer allowance (2,860 and 4,820 respectively), followed by Kogarah-Rockdale SA3 (1,590 and 3,410 respectively) (3).

Figure 3: Count of recipients by payment types, by SA3, 2023

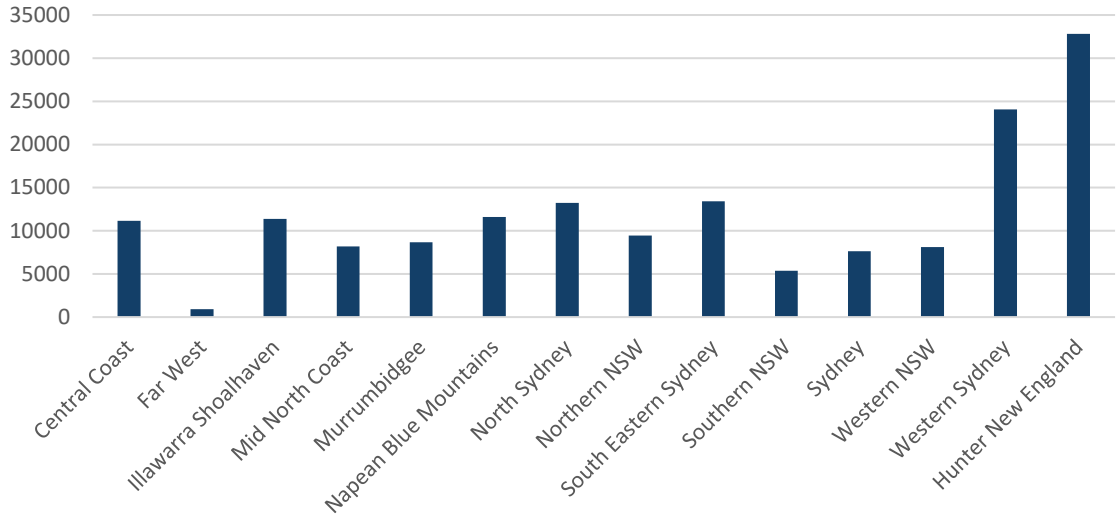


Source: DSS, 2023

National Disability Insurance Scheme participant numbers

As of June 2024, there were a total of 196,870 active participants in the NDIS across NSW, 10.7% (26,864) residing in central and eastern Sydney with 13,413 within SESLHD and 7,638 in SLHD.

Figure 4. NDIS participants in NSW by LHD, September 2024



Source: NDIS, 2024

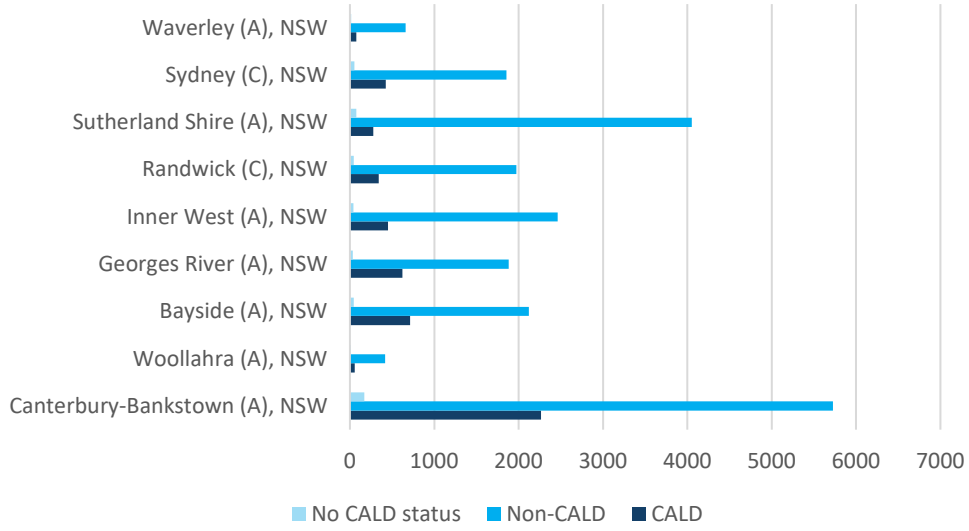
Of all active participants in the CESPHN region in 2024, the highest proportion of participants are within the 0-14 aged groups. Of note, the Canterbury-Bankstown LGA 0-14 age groups have the highest proportion of active participants, representing 13.78% of the total CESPHN participants. Of all active participants in the central and eastern Sydney region in 2024, the primary disabilities included autism (7898), psychosocial disability (3305) and intellectual disability (3249).

CALD participants

In 2024, there were a total of 21,741 NDIS participants that identified as from a CALD background in NSW, representing a total of 10.8% of the total NSW participants. This has grown by an annual rate of 14.2% between 2020 and 2024. (4)

The highest number of CALD participants within the CESPHN region is located within the Canterbury-Bankstown Area with a total of 2,264 participants as of June 2024.

Figure 5. Active number of NDIS participants by LGA and CALD status, CESPHN, 2024



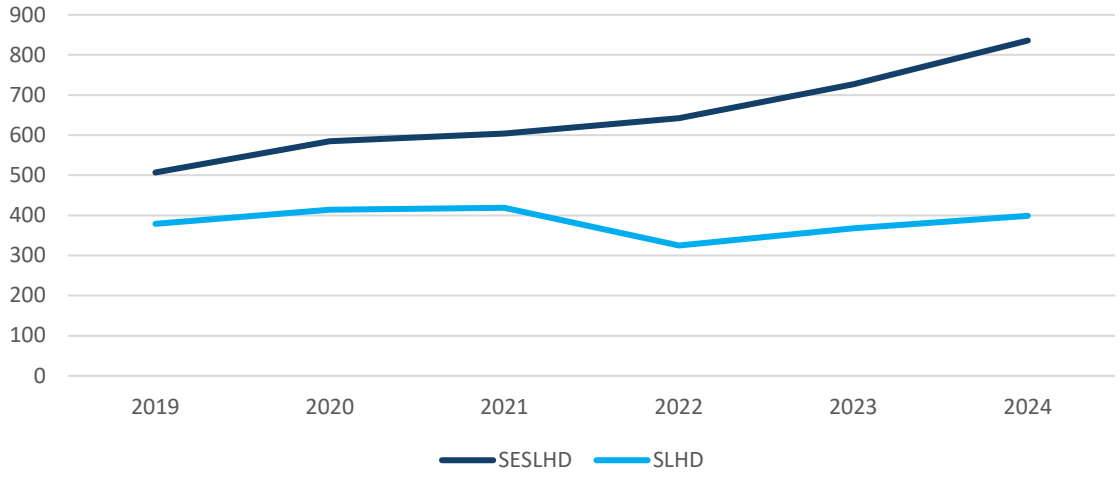
Source: NDIS, 2024

Supported independent living participants

Supported Independent Living (SIL) is a type of support funded by the National Disability Insurance Scheme (NDIS) in Australia. SIL is designed for individuals with higher support needs who require significant assistance throughout the day, including overnight support. This support can include help with personal care, cooking, cleaning, and other daily activities. SIL funding is typically used for: Personal care: Assistance with bathing, dressing, and grooming; Household tasks: Help with cooking, cleaning, and laundry; Skill development: Support to build independence in daily activities.

As of June 2024, there were a total of 1,235 participants living in SIL facilities across the CESPHN region, growing by a rate of 6.87% annually from 2019 (5).

Figure 6. Active SIL participants by LHDs, CESPHN, 2019-2024



Source: NDIS, 2024

National Disability Insurance Scheme Providers

Within the CESPHN region, there were a total of 27,129 NDIS providers active as of June 2024. The highest number of providers were located within the Canterbury-Bankstown LGA, proportional to the total number of active participants in the area (4). Provider growth reflects numbers of providers receiving higher payments over the period whereas provider shrinkage reflects those receiving payments that are 25% or less than the previous period.

Table 2: Number of active NDIS providers, provider growth and provides shrinkage by LGA, CESPHN, 2024

LGA	Active providers	Provider growth	Provider shrinkage
Canterbury-Bankstown	5,867	5	59
Woollahra	822	1	60
Bayside	3,262	4	58
Georges River	2,878	4	56
Inner West	3,320	4	58
City of Randwick	2,921	4	60
Sutherland Shire	3,560	3	59
City of Sydney	3,121	4	63
Waverley	1,378	3	61

Source: NDIS, 2024

Access to services

Through CESPHN's internal and external consultations, accessibility to primary and acute care systems was identified as a crucial need in the care of people with a disability.

Nationally, of people with disability living in households:

- 6% aged 64 years and under with a severe or profound disability delayed seeing or did not see a GP due to cost with 5% not seeing a medical specialist because of cost
- 11% aged 64 years and under with a severe or profound disability who attended a hospital emergency department thought the care could have been provided by a GP
- 5.7% aged 64 years and under with a severe or profound disability attended a hospital emergency department because their GP does not have required equipment/facilities
- 26.4% aged 64 years and under, with a severe or profound disability, who saw 3 or more health professionals for the same condition felt the health professional did not help coordinate care
- 26.8% aged 15-64 years with a severe or profound disability waited longer than they felt acceptable to see a GP, with 38.3% waiting longer than they felt acceptable to see a medical professional with 21.5% delaying or not seeing a dental professional because of cost
- 12.8% aged 5 to 64 years with a severe or profound disability had difficulty accessing medical facilities (including GP, dentist, hospital) (1).

Younger people aged under 65 with a disability in aged care facilities

At 30 June 2022, 178 individuals aged under 65 years with a disability were in residential aged care in the CESPHN region; 175 were permanent residents (6). Eight of the 175 residents (4.6%) identified

as Aboriginal, all of whom were aged 50 years and older and were in permanent care (6). Just over 15% of those with a disability living in residential aged care were aged 0-54 years.

MBS utilisation

Of NDIS participants 95.6% used at least one MBS service in 2019-20, compared to 87.1% of the total population. NDIS participants whose primary disability was multiple sclerosis had the highest proportion of MBS use (99.6%), followed by participants whose primary disability was stroke (98.7%) (7).

NDIS participants had an average of 21 MBS subsidised visits in 2019-20, compared to 18.4 MBS subsidised visits for the total population. NDIS participants whose primary disability was psychosocial had, on average, 40.5 MBS subsidised services in 2019-20, followed by participants whose primary disability was multiple sclerosis with 38.1 visits (7).

CESPHN's current work

The provision of primary care that is relevant and sensitive to people with a disability is a key focus area of CESPHN. Our current work includes implementing Project GROW. CESPHN launched Project GROW in 2021 as part of the Primary Care Enhancement Program (PCEP) to address barriers to equitable health care faced by people with intellectual disability. The PCEP is an initiative under the National Roadmap for Improving the Health of People with Intellectual Disability.

The activities in Project GROW aim to:

- increase the capacity of primary care providers to deliver accessible and inclusive, quality healthcare to patients with intellectual disability
- increase health literacy and participation of the community and disability support sectors in preventative health measures and primary care initiatives for people with intellectual disability
- establish mechanisms to improve primary care data, and data collection to advance service planning and delivery for people with intellectual disability.

The Connect and Thrive program led by Flourish Australia supports people with severe mental illness and reduced psychosocial functional capacity who are not receiving support through the NDIS with one-on-one psychosocial support and group support programs.

Opportunities

- Investment in programs to improve health literacy and service knowledge
- Need for ongoing patient-centred, multidisciplinary and integrated models of care
- Opportunities in workforce development and training
- Support general practices to help address financial barriers to optimal care
- Development of tailored strategies to address health inequity
- Develop strategies to address needs of people living with a disability who are older, members of multicultural communities, impacted by alcohol and other drugs or exiting the Justice system.
- Encourage and support disability-focused health clinics and services
- Increase the availability and capacity of mental health services for people with intellectual disability with poor mental health
- Lead an annual disability roundtable: to bring together key stakeholders in health and primary care and the broader disability sector to showcase progress and highlight areas to prioritise for further intervention
- Advocate for disability needs during development of the Single Digital Patient Record
- The reform of the National Disability Insurance Scheme and the implementation of recommendations from the Disability Royal Commission will provide opportunities for new and existing partnerships to progress local initiatives.

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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

HEALTH AND WELLBEING OF PEOPLE AFFECTED BY DOMESTIC, FAMILY AND SEXUAL VIOLENCE

2025-2027 Needs Assessment

Table of Contents

List of Tables

Content warning: The following chapter contains information that may be distressing. Please consider your wellbeing and reach out to services and supports as required.

Overview

Domestic, Family and Sexual Violence (DFSV) has increased over the 12-month period to March 2024 across NSW. Furthermore, in CESPHN, 5,936 domestic violence related assault incidents were recorded between April 2022 and March 2023, with the Canterbury-Bankstown LGA containing the highest number of incidents.

People with disabilities, older people, Aboriginal and Torres Strait Islander peoples, and LGBTIQ+ people experience increased risk, severity and frequency of DFSV and other types of abuse as well as challenges to accessing support due to the context of oppression and discrimination in which they live. DFSV has been thought of as a social issue, however due to the impact of DFSV on a person's health and wellbeing it is now understood to be a health issue.

Key issues

- Need for continuous DFSV education and support for primary care
- Service design and delivery needs to prioritise children and young people

Key gaps

- Fragmented support for the intersecting issues of Sexual Violence and Child Sexual Abuse.
- Support for children impacted by DFSV
- Wider range of service options that reduce DFSV

Prevalence

New South Wales Health defines DFSV as: *"any behaviour by a person directed against another person with whom they have a domestic relationship that is:*

- violent or threatening behaviour
- behaviour that coerces or controls the other person
- behaviour that causes the other person to fear for their safety or wellbeing, or the safety and wellbeing of others (1).

Domestic relationships can include intimate partner relationships, family relationships or kinship relationships. DFSV includes but is not limited to physical abuse, sexual abuse, financial abuse, emotional abuse, spiritual abuse, medical neglect, technology-facilitated abuse and stalking (2).

Intimate partner violence alone is the leading contributor to death, disability and illness in Australian women aged 18-44. DFSV can also lead to mental health issues, substance abuse, homelessness and impact a person's employment and participation in society. Legislation criminalising coercive control came into effect in NSW in July 2024, serving to recognise the impact of non-physical and sexual forms of DFSV.

There were approximately 2,500 reports of domestic violence to the police in NSW every month. This is likely only to represent 40% of the actual incidents due to underreporting.
Sixteen adult women in NSW were victims of a domestic violence murder in the 12 months to March 2024 an increase of seven women from the previous 12-month period and down nine from 10 years ago (12 months to March 2015).

Women and children experience DFSV more than men:

- An estimated 1.1 million women in New South Wales (37%) have experienced violence (physical or sexual) since the age of 15, including:
    - 21% (640,200) who experienced sexual violence

- 29% (911,800) who experienced physical violence
- Sexual assault rates experienced by women have also increased across Australia, with the largest increase in NSW (up 2,296 victims or 19%) in 2023.
- An estimated 524,200 women in New South Wales (17%) have experienced abuse (physical and/or sexual) by an adult before the age of 15, including:
- 11% (343,300) who experienced sexual abuse
- 9.1% (285,500) who experienced physical abuse
- An estimated 486,700 women in New South Wales (16%) witnessed violence towards a parent by a partner before the age of 15 (3).

In the central and eastern Sydney region, 6,290 domestic violence related assault incidents were recorded between July 2023 – June 2024. Canterbury-Bankstown ranked highest in the CESPHN region with 1,807 recorded incidents (485.7 per 100,000 population) and ranked 47 out of 130 LGAs in NSW. This LGA saw a two-year increase of 25%. Conversely, the Bayside LGA saw a two-year decrease of 14.9%, while other LGAs remained stable over this period (4).

Table 1 Number of recorded domestic violence related assault incidents by Local Government Area: number, rate and rank, July 2023 to June 2024

LGA	No. of incidents	Rate per 100,000 population	CESPHN Rank	NSW Rank	Two-Year Trend (%)
Canterbury-Bankstown	1,807	485.7	1	61	17.6
Bayside	609	342.2	2	79	-14.9
Strathfield	150	324.5	3	90	Stable
Waverley	222	320.2	4	91	Stable
Burwood	129	315.9	5	94	Stable
Inner West	539	294.4	6	96	Stable
Randwick	383	282.3	7	97	Stable
Georges River	370	241.5	8	102	Stable
Sutherland Shire	556	239.8	9	103	Stable
Woollahra	108	201.9	10	106	Stable
Canada Bay	177	198.4	11	108	Stable
City of Sydney	*1,240*	*568.6*	*12*	*52*	*Stable*

Source: NSW Bureau of Crime Statistics and Research, 2024

Domestic and family violence is a complex, multifaceted issue; while the aim of this section is to provide a thorough assessment of domestic and family violence in central and eastern Sydney, it should be noted that not all aspects of this area are addressed by this needs assessment.

Factors driving DFSV

Our Watch, the peak Australian body on the prevention of gender-based violence, identifies the following gendered drivers:

- Condoning of violence against women
- Men's control of decision-making and limits to women's independence in public and private life
- Rigid gender stereotyping and dominant forms of masculinity
- Male peer relations and cultures of masculinity that emphasise aggression, dominance and control (5).

There are also reinforcing factors including:

- Condoning of violence in general

- Experience of, and exposure to, violence
- Factors that weaken prosocial behaviour such as financial stress
- Resistance and backlash to prevention and gender equality efforts (5).

Other forms of violence

Sexual Violence and Child Sexual Abuse often intersect with DFSV; however, support continues to be fragmented. An integrated approach to addressing these forms of violence is necessary to provide the best possible holistic support for impacted families.

Emerging research highlights that an under-reported form of assault that has enormous medical impacts is non-fatal strangulation. In addition to immediate and ongoing risks such as injury to the larynx and anoxic brain injury, women who have been strangled by their partner are 7.5 times more likely to be killed by the same partner (6).

Anecdotally, DFSV Assist has seen an increase in disclosures to primary care providers in the region with patients having experienced non-fatal strangulation and sexual choking.

Intersectionality with other priorities

- People with disabilities, older people, Aboriginal and Torres Strait Islander people and LGBTIQ+ people experience increased risk, severity and frequency of DFSV and other types of abuse as well as challenges to accessing support due to the context of oppression and discrimination in which they live. Women and children on precarious visas experience are particularly vulnerable with many services not offering support to this cohort, increasing their risk of homelessness.
- DFSV is the leading cause of homelessness for women and girls. In Australia, in 2022-23, 38% of all clients in specialist homelessness services identified family and domestic violence as the cause of their homelessness (7).
- The reduction of general practices in the region offering bulk billing as well as waiting times are affecting access to primary healthcare.
- Subject matter expert consultations discussed how a key issue is women and children that do not have timely access to housing support services in the CESPHN region.

The role of primary healthcare

DFSV has historically been thought of as a social issue, however due to the impact of DFSV on a person's health and wellbeing it is now understood to be a health issue. Intimate partner violence is the largest contributor to the burden of disease for Australian women aged 18-44 years (8).
In Australia, it is estimated that a full-time GP will unknowingly see five women a week who have experienced DFSV (9). GPs are second only to friends and family members, in relation to receiving disclosures of current partner violence (Safer Families evidence brief #2: Identifying and responding to domestic abuse and family violence: Implications for the health sector).

Accordingly, there has been a policy-level shift towards enhancing primary care's role in prevention and early intervention in DFSV. The NSW Health Strategy for Preventing and Responding to Domestic and Family Violence 2021-2026 recognises that primary care is often the first port of call for people in the community and, therefore, has a role in recognising DFSV and ensuring appropriate action and care is provided to people experiencing it.

The Strategy calls for a more coordinated approach between primary care and domestic violence support services, increased training and support provided to primary care services to respond better to DFSV, and provide trauma informed and culturally safe care to victims.

Gaps and needs

Need for continuous DFSV education and support for primary care

GPs and other primary care professionals have an important role to play in addressing DFSV in the Central and Eastern Sydney region as they are often the first point of contact for people experiencing domestic violence due to physical injuries and mental health issues resulting from the violence.

In early 2021, Central and Eastern Sydney PHN facilitated 15 key informant interviews and distributed a survey to GPs, allied health professionals, practice nurses and practice managers to gather information about their professional experiences related to domestic and family violence. The largest barrier to supporting patients experiencing DFSV was a lack of knowledge, followed by the presence of a partner or child and lack of time. Feedback from GPs also reported that their behaviour is often driven by:

- a reluctance to interfere
- wanting to avoid victim-blaming attitudes
- fear of offending patients
- not knowing what to do
- having inadequate training
- experiencing a lack of time
- a lack of referral options or limited knowledge of referral options
- victims are accompanied by a child or partner
- language and cultural barriers.

In an ongoing Sax Institute baseline survey offered to primary care providers in CESPHN prior to attending DFSV training, of 113 respondents, 47.5% of respondents mentioned they have not received any training in relation to recognising and responding to DFSV. However, on a scale of 0 to 10, respondents scored an average of 8.5 when asked whether they agree the primary care sector has a role to play in identifying and supporting patients experiencing DFSV.

To support primary care with the capability to intervene early and mitigate risk, training and education to health professionals on the following needs to be provided:

- Creating a safe environment for disclosure
- How to recognise the signs of DFSV

- How to start the conversation
- How to respond to disclosures appropriately
- An understanding of the support available and referral pathways.

Given the lack of time and remuneration for GPs and other health care providers to engage in this work, navigating the DFSV service sector in order to seek support for a patient can be challenging. Health professionals need one simple, streamlined referral pathway to access support for patients.

Service design and delivery needs to prioritise children and young people

Subject matter experts during a consultation facilitated by Central and Eastern Sydney PHN in July noted that that people who use violence often have a history of witnessing or experiencing DFSV as a child. Working with children, in healing and recovery, in and of itself is prevention work as it has the potential to reduce the prevalence of intergenerational trauma.

The consultation also reinforced links established between DFSV and developmental delays, which can be addressed through better integration between the DFSV sector, primary care and community health, particularly as specialist costs and waiting times can be prohibitive.

CESPHN's current work

CESPHN was one of six PHNs initially funded by the Australian Government Department of Health to address DFSV, and this work has recently expanded to include another six PHNs nationwide. The region's DFSV Assist service provides training to GPs, allied health professionals and practice staff to enhance their capacity to identify and appropriately respond to DFSV presentations from patients. Training is offered in-practice as well as through continuing professional development (CPD) events.

DFSV Assist also provides a navigation support service exclusively for health professionals to better support their patients experiencing DFSV through:

- A singular local referral pathway, accessible by phone, email or secure messaging.
- Providing secondary consultations (guidance and advice for supporting specific patients).
- Improving connection and coordination between primary care and DFSV services to support health professionals to provide seamless support to victims
- Closing the feedback loop and providing (with consent) referral outcome information to referring practitioners.

The Navigation service has seen better outcomes for patients experiencing abuse as its singular referral pathway limits the risk re-traumatisation due to retelling stories to multiple agencies in order to seek various types of support.

Primary healthcare professionals also have ready access to the DFSV pathways on HealthPathways.

Opportunities

CESPHN received funding as part of a consortium with Hunter New England Central Coast and Nepean Blue Mountains PHNs to expand their DFSV Assist program to include Sexual Violence and Child Sexual Abuse training and navigation support. Service delivery is due to commence in early 2025.

The subject matter expert consultation noted the need to commence DFSV-related training earlier in healthcare professional career pathways. For example, training should commence during medical school or during GP registrar training. This is an area DFSV Assist will explore in 2025.

The introduction of new MBS Level E consultation item numbers for consultations lasting 60 minutes or more could help improve outcomes by allowing more time to be spent supporting patients impacted by DFSV.

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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

HEALTH AND WELLBEING OF LGBTIQ+ PEOPLE

2025-2027 Needs Assessment

Table of contents

List of tables

List of figures

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Overview

The Lesbian, Gay, bisexual, transgender and gender diverse, intersex and queer community is a diverse cohort. The acronym includes significant variations in gender identities and expression, sexual orientation and bodily diversity.

LGBTIQ+ will be used throughout this document as appropriate. Individuals who have multiple intersecting identities often face marginalisation resulting in additional barriers to their physical or mental health. This chapter will capture the health priorities, gaps, barriers and opportunities for the LGBTIQ+ community.

Key issues

- LGBTIQ+ people experience higher levels of mental distress and poor mental health
- LGBTIQ+ people drink more alcohol and use illegal drugs at higher levels than non-LGBTIQ+ people
- Can have higher instances of sexually transmitted diseases, though PReP use remains high amongst gay men
- High levels of loneliness and social isolation, especially amongst older adults (see mental health chapter of this Needs Assessment)
- Vulnerability amongst LGBTIQ+ people who are members of priority population groups
- The community can experience harassment, stigma and discrimination in their daily lives.

Service gaps

- Easy access to gender affirming care for transgender patients
- Services that understand the social and health needs of intersex people
- Delivery of trauma-informed care and sexual diversity training for clinical staff and community services.
- Access to mental health supports.

Demographics

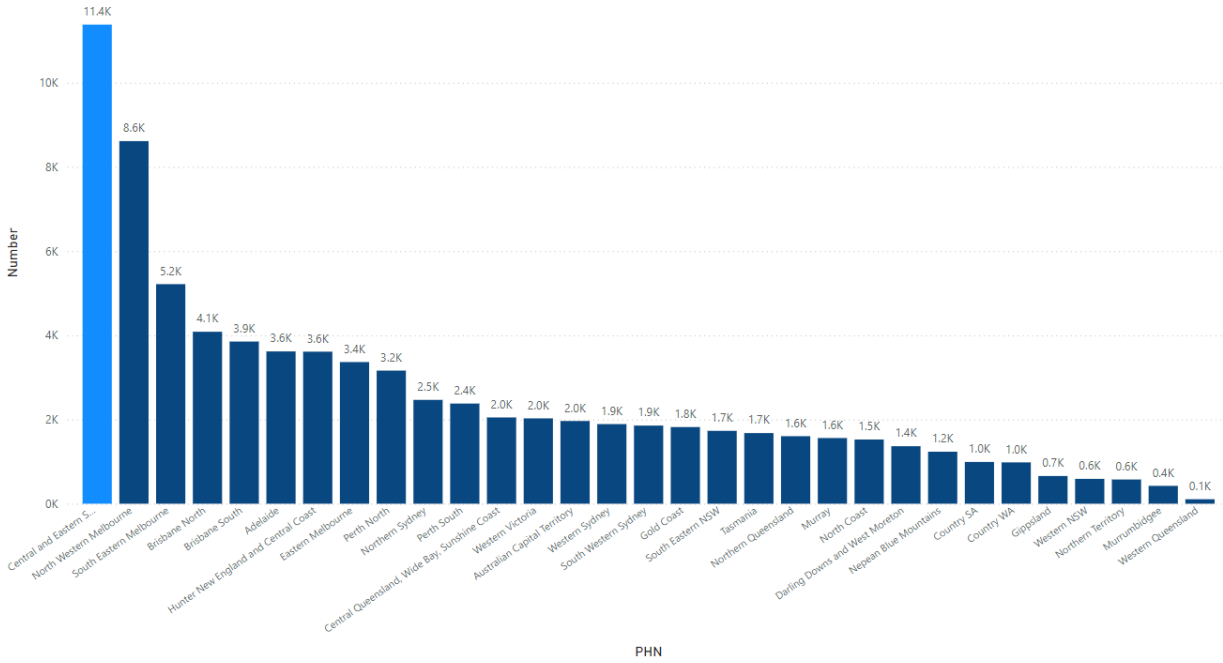
Census

The 2021 Census captures the number of same sex couples who live together in Australia. The Central and Eastern Sydney PHN region has a high number of same sex couples living together (n=11,382), representing 14.5% of same sex couples living together in Australia. By comparison, this region comprises 6% of the total Australian population' (1).

However, this information does not provide detailed information on individuals who may be single, in relationships with the same sex but do not cohabitate, or members of the LGBTIQ+ community who do not have relationships with the same sex. It can be assumed that this high number of people within

the CESPHN region compared to other parts of Australia is consistent with where the rest of the LGBTIQ+ community reside.

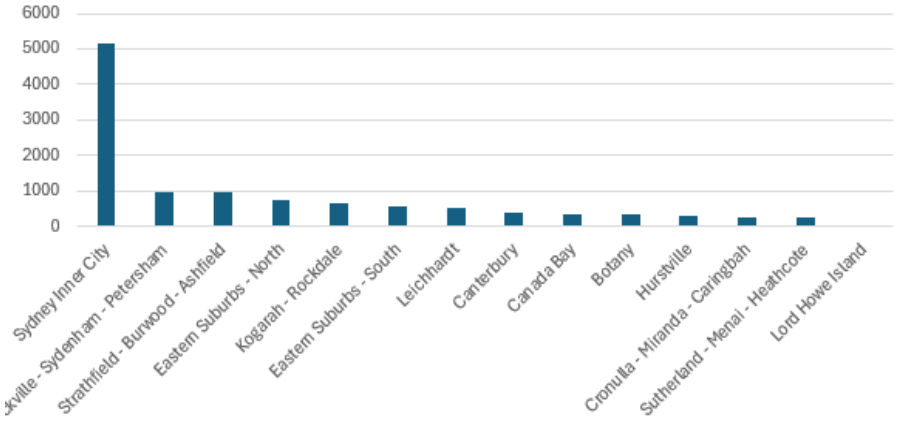
Figure 1: Distribution of Same sex couples across Australia, 2021 by PHN



Source: ABS, 2022

CESPHN's demographic data shows that the highest concentration of same sex couples reside within Sydney Inner City SA3 area. This area had the highest number of same sex couples for both male and female, representing 68.3% of same sex couples in the CESPHN region.

Figure 2: Distribution of same sex couples across the CESPHN region by SA3. 2021



Source: ABS, 2022

Census data does not capture trans and gender diverse or intersex peoples living within the region and is likely to significantly underestimate the number of LGBTIQ+ people. It is estimated that between 1% to 2% of people in Australia are intersex (2).

LGBTIQ+ people as a priority population

Achieving optimal health and wellbeing for LGBTIQ+ people can only be achieved when plans and strategies are developed with LGBTIQ+ people at the centre. Current examples include:

- The NSW LGBTIQ+ Health Strategy 2022-2027 (2).
- The formalisation of the Commonwealth Department of Health and Aged Care National LGBTIQA+ Health and Wellbeing 10-Year Action Plan. As of October 2024, this plan is slated for release at the end of 2024 (3).

LGBTIQ+ peoples are defined as priority populations within numerous physical, social and mental health strategies, frameworks, action plans and reforms. The below strategies are examples of areas that highlight the community as a priority population.

National strategies

- Commonwealth Department of Health and Aged Care Diversity Framework (4)
- The Australian Government's National Mental Health and Suicide Prevention Plan (5)
- National Drug Strategy 2017-2026 (6)
- National Framework for Alcohol, Tobacco and Other Drug Treatment 2019-29 (7).
- The Fifth National Mental Health and Suicide Prevention Plan (8).
- The National Palliative Care Strategy 2018 (9).
- National Framework for Action on Dementia 2015-2019 (10). (updated strategy set to launch at end of 2024).
- Eighth National HIV Strategy 2018–2022 (ninth National HIV Strategy currently underway) (11)
- Australian Cancer Plan (12)

NSW focused strategies

- NSW Youth Health Framework 2017-2024 (13)
- Strategic Framework for Suicide Prevention in NSW 2022-2027 (14)
- NSW Alcohol and Other Drugs Workforce Strategy 2024-2032 (15).

Health and wellbeing of lesbian, gay, bisexual and queer people

The section refers to the health and wellbeing outcomes of Lesbian, Gay, Bisexual and Queer (LGBQ+) cohorts under the LGBTIQ+ umbrella.

Mental health

Data collated from the National Study of Mental Health and Wellbeing 2020-2022 reports on modelled prevalence for LGBTQ+ Australians. In general, LGBQ+ people were more likely to experience a mental disorder than heterosexual people. Three in four (74.5%) LGB+ individuals had experienced a mental illness at some time in their life – compared with 41.7% of heterosexual people (16). This includes:

- 63.5% of gay or lesbian people
- 80.1% of bisexual people
- 93.1% of people who used a different term to describe their sexual orientation.

Nearly three in five (58.7%) LGB+ people had experienced a mental health illness that spanned across a 12-month period, in comparison to 19.9% of heterosexual people including:

- 42.8% of gay or lesbian people
- 64.4% of bisexual people

The sexually diverse cohort experience higher rates of poor mental health that is linked to experiences of discrimination due to their sexual orientation, bullying, violence, exclusion and devaluation of their identity and their relationships both interpersonally and within broader social discourse. (17) These experiences may lead to challenges with work, relationships, finances and housing.

Poor mental health is not innate to LGBQ+ experience, and is influenced by social and cultural factors, which often compound over the lifespan.

Suicidality and suicide prevention

LGBQ+ people have significantly higher rates of suicidality than their heterosexual counterparts. An analysis of the Private Lives 3 National Survey of 5,174 cisgender LGBQ participants aged 18+ years across Australia found that over one-third (37.2%) of participants reported having experienced suicidal ideation in the past 12 months and 3.9% of the participants reported a suicide attempt within the 12-month time frame (18).

Data from the 2020-2022 National Study of Mental Health and Wellbeing indicates that half of LGBQ+ people (43.9%) had high or very high levels of distress. In comparison, 15.4% of heterosexual people experienced this level of distress. One in 4 (28.6%) lesbian or gay individuals or 1 in 2 (51.5%) bisexual people had high or very high levels of psychological distress (16). Nearly half of LGBTQI+ people (47.8%) had seriously considered suicide at some point within their lifetime compared to

15.3% of heterosexual people. Nearly half of LGBTQI+ people (47.8%) had seriously considered suicide at some point within their lifetime compared to 15.3% of heterosexual people.

Non-suicidal self-harm rates (including suicide attempts) are also significantly higher within the cohort, 41.2% had self-harmed compared to 7.4% of heterosexual people. This includes 27.1% of gay or lesbian people and 47.5% of bisexual people.

Alcohol and other drug use

Alcohol and other drug use rates amongst LGBQ+ people are significantly higher than their heterosexual counterparts. The below data on Alcohol and Other Drug Use has been extracted from the Rainbow Realities Report from 2023 (19).

Alcohol

Alcohol use is higher within LGBQ+ communities, with risk factors including:

- Age 35-54 years
- Earned income in the highest brackets ($1,000+ net weekly income)
- Had been sexually assaulted
- Had been treated unfairly based on their LGBQ+ identity in the past 12 months
- Had ever experienced homelessness
- Reported high or very high levels of psychological distress

The Private Lives 3, Pride and Pandemic survey characterised alcohol use patterns of LGBTQA+ adults (20). It found that:

- 26.8% (n = 1,815) of LGBTQA+ adults reported drinking monthly or less
- 27.5% (n = 1,866) drinking 2-4 times per month
- 18.7% (n = 1,268) drinking 2-3 times per week and
- 13.3% (n = 902) drinking four or more times per week

Of those who reported drinking alcohol:

- 71.6% (n = 4,183) reported ever drinking six or more drinks on one occasion
- 16.4% (n = 960) of these individuals reported drinking six or more drinks monthly
- 12.4% (n = 727) weekly and 2.1% (n = 123) daily

In terms of impact on daily life, 16.9% (n = 991) reported that they had struggled to manage their alcohol use or that it negatively impacted their everyday life in the past 12 months:

- 18.3% (n = 182) of those who expressed some struggle with alcohol consumption had sought professional support. 68.5% (n = 135) of those had sought support from a mainstream service that is not known to be LGBTQA+-inclusive, 33.0% (n = 65) from a mainstream service that is known to be LGBTQA+-inclusive, and only 7.6% (n = 15) from a service that caters only to LGBTQA+ people.
- 46.0% (n = 1,198) of LGBTQA+ adults who consumed alcohol during the Covid-19 pandemic reported their drinking had increased during the pandemic and 25.1%, (n = 654) reported drinking less during the pandemic.

- 17.4% (n = 432) of LGBTQA+ adults reported struggling to manage their alcohol consumption or where it negatively impacted their life during the pandemic.

Nicotine use

Data collated from Private Lives 3 (20) reports the following breakdown of current cigarette smokers:

- 21.9% gay
- 21.1% queer
- 20.7% pansexual
- 20.7% bisexual
- 14.6% lesbian

The National Drug Strategy Household Survey (NDSHS) 2022-23 found that (21):

- more than 21% of gay, lesbian and bisexual people reported currently using electronic cigarettes and vapes
- The proportion of people using electronic cigarettes and vapes tripled between 2022 -2023 from the 2019 (7.1%) survey
- 46% of gay, lesbian, and bisexual people had used e-cigarettes at some point in their lifetime

Illicit drug use

The NDSHS 2022-23 found that gay, lesbian, and bisexual people were 2.4 times more likely than heterosexual people to have used any illicit drug in the previous 12 months (21). This higher rate of overall use was evident in almost all individual illicit drugs reported. Differences between gay, lesbian and bisexual people can be seen in the table below:

Table 1: Most commonly used illicit drugs in the previous 12 months, by sexual orientation, 2022–2023

Gay, lesbian, and bisexual people	Heterosexual people
Cannabis (33%)	Cannabis (10.4%)
Cocaine (15.1%)	Cocaine (4.0%)
Inhalants (11.0%)	Hallucinogens (2.1%)
Ecstasy (9.6%)	Pain-killers/pain-relievers and opioids* (2.0%)
Hallucinogens (8.0%)	Ecstasy (1.7%)

*Used for non-medical purposes.
Source: AIHW 2024

The 2020 SWASH report (22), which focuses on LBQ+ women who reside in Sydney, reported that

- 54.0% of LBQ+ women had ever used illicit drugs.
- 4% reported injecting drug use ever in their lifetimes.
- 54% reported poly drug use (2 or more on one occasion) in the last 6 months.
- 17% indicated they have been concerned about their drug use or felt that it negatively impacted their life, and 7% said they had sought help to manage their use.

Sexual health

The Gay Community Periodic Survey: Sydney 2023 reported the proportion of non-HIV-positive participants who reported testing for HIV in the previous 12-months increased sharply between 2022 and 2023 (to 73.1% from 61.6%) (23).

Awareness of pre-exposure prophylaxis (PrEP) increased among all survey participants between 2019 and 2023 (from 91.7% in 2019 to 95.1% in 2023), with the proportion of non-HIV-positive participants who reported using PrEP in the six months prior to the survey also increasing over the same period (31.0%, 45.5%) (23).

Testing rates for sexually transmitted infections (STIs) declined between 2019 and 2023 for both non-HIV-positive (79.3%, 73.4%) and HIV-positive participants (87.2%, 83.1%). COVID-19 is likely to have affected STI testing frequency since 2020, however this effect remained in 2023 (23).

In 2023, non-HIV-positive participants commonly reported that their last HIV test was at a general practice (50.2%) or a sexual health clinic or hospital (36.9%). The proportions of non-HIV-positive persons who most recently tested at a general practice or at home increased between 2019-2023, while the proportions who last tested at a sexual health clinic, hospital or community-based service decreased (23).

Health and wellbeing of trans and gender diverse people

Mental health

Trans and gender diverse people in Australia have significantly poorer mental health outcomes than cisgender heterosexual people and LGBQ+ cohorts.

The Rainbow Realities NSW Briefing paper: LGBTQA+ Mental Health and Suicidality identifies that among trans and gender diverse peoples high or very high psychological distress was more likely to be reported by Private Lives 3 (PL3) participants who had a disability compared to those without a disability, and also among trans and gender diverse participants compared with cisgender participants.

Anglo-Celtic and multicultural participants did not differ on levels of psychological distress. In Writing Themselves In 4 (WTI4), the rates of reporting high or very high psychological distress were significantly elevated for trans and gender diverse young people (compared with cisgender participants), as well as for young LGBTQA+ participants with a disability (compared to those without).

Suicidality and suicide prevention

Trans Pathways is the largest study ever conducted of the mental health and care pathways of trans and gender diverse young people in Australia (859 participants). It is also the first Australian study to incorporate the views of parents and guardians of trans young people (194 participants). The report found that:

- 48.1% of trans and gender diverse young people reported having ever attempted suicide
- 74.6% reported having been diagnosed with depression
- 60.1% reported that they felt isolated from mental health support services

Trans and gender diverse PL3 participants were more likely to report both recent and lifetime suicidal ideation than cisgender participants. Similarly, trans and gender diverse young people from WTI4 were more likely than their cisgender counterparts to have either recently or in their lifetime had suicidal ideation (24) (25).

Alcohol and Other Drugs

The NHSHS 2022-23 found that the use of tobacco, e-cigarettes and alcohol in trans and gender diverse people reflected the use in the general population. However, 1 in 3 trans and gender diverse people had used an illicit drug during the previous 12 months. After adjusting for differences in age, compared to cisgender people, trans and gender diverse people were 1.6 times as likely to have used any illicit drug in the previous 12 months (21) (26).

Gender affirming health care

Gender affirming care is a non-judgemental, respectful, shared-decision making model that tailors support based on the individual and their health goals. Gender affirming can care include any single or combination of a number of social, psychological, behavioural or medical interventions designed to explore, support and affirm an individual's gender identity (27) (26).

Gender affirming care is a practice that should be available to all trans or gender diverse people within the region. Whist there is currently no way to measure access to gender affirming care, it is reported that trans and gender diverse people often report misgendering and that there is a lack of basic awareness of primary care services around gender affirming practices. There is also a reported lack of understanding from primary care professionals about the availability and accessibility of specialist gender affirming services.

Consultation with stakeholders also found that trans and gender diverse people are often not presenting to primary care professionals for health concerns either related or unrelated to their gender identity out of fear of misgendering or stigma associated their identity.

Autism

A growing body of research has identified an overrepresentation of autism spectrum diagnosis (ASD) or autistic traits among trans and gender diverse individuals. This provides additional challenges with access to mental, physical and disability healthcare.

Sexual health

The 2018 Australian Trans and Gender Diverse Sexual Health Survey (28) reported that 69.3% of respondents had ever been tested for STIs, of whom 57.6% had been tested in the year prior to this

survey. People who experienced gender insensitivity within sexual health care were less likely to have been tested recently and reported testing less often (28).

Health and wellbeing of intersex people

There is limited data available to identify the cohort of the intersex population in Australia. The most recent data source; Intersex: Stories and statistics from Australia (29), released in 2016, had 272 people with intersex variations participate in the 'Australians born with Congenital Variations in Sex Characteristics (Intersex/DSD/hormonal, chromosomal or other biological variations/conditions)' project. This explores the data on people with intersex variations' experiences of physical health and medical services showing that:

- A majority of people with intersex variations considered themselves to be moderately to extremely healthy at the time of the survey.
- Most participants (60%) reported that they had experienced a medical treatment intervention related to their intersex variation.
- On average, they had experienced at least two interventions. The most commonly reported interventions were hormonal treatments and genital surgeries of varying kinds.
- Over half of all treatments were delivered to participants when they were aged under 18yrs.
- One fifth of the participants had been given no information at all about any surgical or hormonal treatments they had received and the majority were not told about risks related to the interventions, their right to not have these often life-changing treatments or other related information.
- Participants reported various physical, mental and psychological impacts from treatments.
- Most participants considered their mental health as good (or positive) at the time of the survey. The most frequently reported mental health diagnoses included depression, anxiety and PTSD.
- Wellbeing risks were high – 42% of participants had thought about self-harm and 26% had engaged in it; 60% had thought about suicide and 19% had attempted it – specifically on the basis of issues related to having a congenital sex variation.
- The group mostly attributed their wellbeing risks to negative social responses from others, difficulties around having undergone interventions or issues around gender/identity.
- Overall their mental health service experiences were mixed. 44% of the group reported receiving counselling/ training/pressure from institutional practitioners (doctors, psychologists etc.) on gendered behaviour; and 43% from parents. Many participants desired improvements in training for mental health services/workers.

Intersectionalities

There are many population groups within the LGBTIQ+ community who face additional challenges because of their intersectionalities. This section describes some of the issues that have been identified within these groups.

SisterGirls, BrotherBoys and LGBTIQ+ Aboriginal peoples (LGBTIQSB+) experience significant discrimination and marginalisation in Australia. This includes marginalisation from the broader Australian community, and discrimination from within both Aboriginal and LGBTIQ+ communities. These include:

- Experiences of racism, discrimination and isolation.
- Difficulty in maintaining cultural and family ties and experiencing support or recognition of their LGBTIQ+ sexual orientation, sex variation or gender identity.
- Invisibility within research around LGBTIQ+ issues, or, within Aboriginal and Torres Strait Islander focused research.
- Gaps in service accommodation within Aboriginal and Torres Strait Islander specific services or, within LGBTIQ+ specific services.

Culturally and Linguistically Diverse Communities

Services need to be provided in-language including:

- Using LGBTIQ+ friendly translators.
- Posters and banners “you are safe here” provided in language help clients feel safer.
- Finding interpreters for non-English speaking people is easy for planned appointments, but not when people present in a crisis.
- Services need to provide a culturally appropriate response that is immediate, however, an interpreter needs to be booked ahead of time.

Service utilisation/access

Consultation with external stakeholders and consultation findings shared from Sydney Local Health District have identified the following service utilisation and access issues within the primary care sector for LGBTIQ+ peoples:

- Barriers to accessing services include the cost to access a GP, as often multiple consultations are required initially to find a GP who has the knowledge and understanding to work with the patient.
- The limited number of experienced providers are fully booked, people need to find alternatives and there is often no continuity of care.
- Experienced providers are burning out due to overwhelming numbers trying to seek their services. These GPs need to be provided with greater support.
- There is a need for primary care intake forms to be consistently updated to include all areas of the community. Improvements also need to be made to medical software used in general practice
- Social workers and peer workers could be further utilised in this sector as part of a Multidisciplinary Team Care approach.
- A large proportion of aged care services and providers are affiliated with religious organisations impacting older LGBTIQ+ people’s anxiety around accessing services
- There needs to be upskilling of translation services to avoid bias (either conscious or unconscious) when providing services
- A need for access to wrap around services, particularly for trans and gender diverse people.

Other issues raised by the community in consultations:

- Trauma associated from earlier in the lifespan
- HIV and aging is complex with limited housing options
- People going back into the closet when they access hospital or aged care
- Partners not being recognised as their support person
- Forms not allowing for connections not from next of kin/family
- Bisexual people mistaken by health providers as straight

Opportunities to address health and service needs

- Provision of training and education for primary care and mental health workforce on LGBTQI+ inclusive care
- Support upskilling of aged care workforce and adoption of LGBTQI+ person-centered approaches
- Promote gender affirming care
- Provision of greater support for transgender children and adolescents
- Support adoption of trauma informed care approach
- CESPHN to support ACON in the development of an integrated general practice specializing in LGBTIQ+ health
- Promotion of LGBTIQ+ services in CESPHN service directories and HealthPathways
- Ensure commissioned services are accessible for LGBTQI+ people.

Definitions

Below is a breakdown of the acronym with broad definitions used within the cohort.

- **Lesbian:** an individual who identifies as a woman and is sexually and/or romantically attracted to other people who identify as women.
- **Gay:** an individual who identifies as a man and is sexually and/or romantically attracted to other people who identify as men. The term gay can also be used in relation to women who are sexually and romantically attracted to other women.
- **Bisexual:** Describes individuals who are attracted to more than one gender.
- **Transgender and Gender Diverse:** This is an umbrella term which refers to people whose sex at birth does not match with their gender identity. Within this report gender diversity does not automatically refer to individuals who have accessed surgical or legal interventions to affirm their gender identity. But for any individuals whose sex at birth does not match with their identified gender.
- **Intersex:** Intersex is an umbrella term that refers to individuals who have anatomical, chromosomal and hormonal characteristics that differ from medical and conventional understandings of male and female bodies. Variation on sex characteristic may be apparent at different life stages or may remain unknown to the individual and their medical practitioners.
- **Queer:** a term used to describe a range of sexual orientations and gender identities. Queer is a term that has been reclaimed by many LGBTIQ+ people from its history of being utilised as a derogatory term. Queer is often used to pertain to the broader LGBTIQ+ community and is founded on political ideas of resistance to heteronormativity. Queer is less commonly used in literature pertaining to older LGBTIQ+ people due to its recent history as a derogatory term used to label LGBTIQA+ people within those generations and can cause distress.
- **+ (Plus):** Represents other identities that fall outside of the cohorts listed within the acronym, and captures experience of individuals who have sex, gender or sexual orientations that does not align with endosex, cisgender or heteronormative experience.

Other acronyms may be found where they are referencing a specific published report. Below definitions have been extracted from the Australian Institute of Family Studies (30).

- **AFAB/AMAB:** an acronym for Assigned or presumed Female/Male at Birth. Often used as a description of the lived experience of Trans and Gender Diverse peoples.
- **Dysphoria:** the distress or unease sometimes experienced from being misgendered and/or when someone's gender and body personally don't feel connected or congruent. Many trans people do not experience gender dysphoria at all and, if they do, they may cease with access to gender affirming healthcare and/or peer support. With or without the presence of gender dysphoria, being trans is not a mental illness. Gender dysphoria does not equal being trans (31).
- **Dead name:** an informal way to describe the former name a person no longer uses because it does not align with their current experience in the world or their gender. Some people may experience distress when this name is used.
- **Endosex:** a term used to describe people whose innate sex characteristics meet medical and conventional understandings of male and female bodies (32).

- **Gender affirmation:** the personal process or processes a trans person determines is right for them in order to live as their defined gender and so society recognises this. This may involve social, medical and/or legal steps that affirm a person's gender. A trans person who hasn't medically or legally affirmed their gender is no less the man, woman or non-binary person they've always been. A person's circumstances may inhibit their access to steps they want to take to affirm their gender (33).
- **Gender:** Using the ABS's nominal definition of Gender (34) 'Gender is a social and cultural concept. It is about social and cultural differences in identity, expression and experience as a man, woman or non-binary person. Non-binary is an umbrella term describing gender identities that are not exclusively male or female. Gender includes the following concepts:
    - Gender identity is about who a person feels themself to be
    - Gender expression is the way a person expresses their gender. A person's gender expression may also vary depending on the context, for instance expressing different genders at work and home
    - Gender experience describes a person's alignment with the sex recorded for them at birth i.e. a cis experience or a trans experience.
- **Sex:** a classification that is often made at birth as either male or female based on a person's external anatomical characteristics. However, sex is not always straightforward, as some people may be born with an intersex variation, and anatomical and hormonal characteristics can change over a life span.
- **Sex characteristics:** a term used to refer to physical parts of the body that are related to body development, regulation and reproductive systems. Primary sex characteristics are gonads, chromosomes, genitals and hormones. Secondary sex characteristics emerge at puberty and can include the development of breast tissue, voice pitch, facial and pubic hair, etc.
- **Sistergirl and Brotherboy**: terms used for trans people within some Aboriginal or Torres Strait Islander communities. How the words Sistergirl and Brotherboy are used can differ between locations, countries and nations. Sistergirls and Brotherboys have distinct cultural identities and roles. Sistergirls are Indigenous people assigned male at birth but who live their lives as women, including taking on traditional cultural female practices (17). Brotherboys are Indigenous people assigned female at birth but are a man or have a male spirit (30).

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phn
CENTRAL AND
EASTERN SYDNEY

An Australian Government Initiative

HEALTH AND WELLBEING OF PEOPLE IMPACTED BY HOMELESSNESS

2025-2027 Needs Assessment

Table of contents

List of tables

List of figures

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Central and Eastern Sydney PHN is a business division of EIS Health Limited.
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Overview

On Census night in 2021, 11,496 people experienced homelessness in CESPHN, equating to 35% of the state's homeless population (1). Homelessness is influenced by complex interplay of social, economic, and health-related drivers and contributes to poorer health, exacerbation of mental and emotional health issues, an increased risk of injury due to violence, and greater difficulty in managing chronic health conditions.

The CESPHN region has the highest proportion of homelessness in the NSW with large numbers of people sleeping rough in the City of Sydney and Inner West council regions. The CESPHN region also has the highest number of boarding houses in NSW along with some of the highest numbers of people from the list of National priority homelessness cohorts, which include youth, older adults, and Aboriginal and Torres Strait Islander peoples.

The Specialist Homelessness Services program is the primary NSW government response to homelessness, providing a wide range of supports to people experiencing, or at risk of homelessness. In 2022-23, Specialist Homelessness Services in CESPHN provided support to over 8,000 people experiencing, or at risk of homelessness, representing approximately 13% of all Specialist Homelessness Services delivered across NSW (2).

As evidenced by demographic and epidemiological data and consultation with health, housing, and homelessness providers and consumers highlighted there has been progress in many key areas, but further supports are required to address the unmet health needs of people experiencing and at risk of homelessness in our region. The following key needs and gaps for the CESPHN region were identified:

Key issues

- Access to affordable primary health care services
- Upskilling of the primary care workforce
- Enhanced data capture methodologies are required to capturing clients, prioritise needs, and improve the overall service system.
- Strengthened collaboration between housing providers, specialist homelessness service providers and health service providers based around a housing first approach
- Embedding of primary health care services with housing and specialist homelessness support services
- Need for more localised place-based responses for priority homelessness cohorts, e.g. Aboriginal people and those leaving correctional centres.

Key gaps

- Integration of the health, housing and homelessness service system
- Access to homelessness friendly GPs, pharmacists, allied health, dentistry, mental health, and drug and alcohol detox and support services
- Access to post-crisis mental health and drug and alcohol detox and support services
- Capacity of workforce to deliver respectful and person-centred care
- Geographic location and spread of Specialist Homelessness Services with most providers working in the inner-city regions.
- Access to ongoing coordinated chronic care management

Central and Eastern Sydney PHN is a partner in the regional Intersectoral Homelessness Health Strategy 2020-2025 for its region, which identifies shared strategic priorities for improving health outcomes among people experiencing homelessness. Key action areas of this strategy have been reviewed and consolidated into the CESPHN Needs Assessment. Conversely, gaps identified from

the Needs Assessment will be used to inform and update the regional Intersectoral Homelessness Health Strategy 2020-2025.

CESPHN homelessness profile

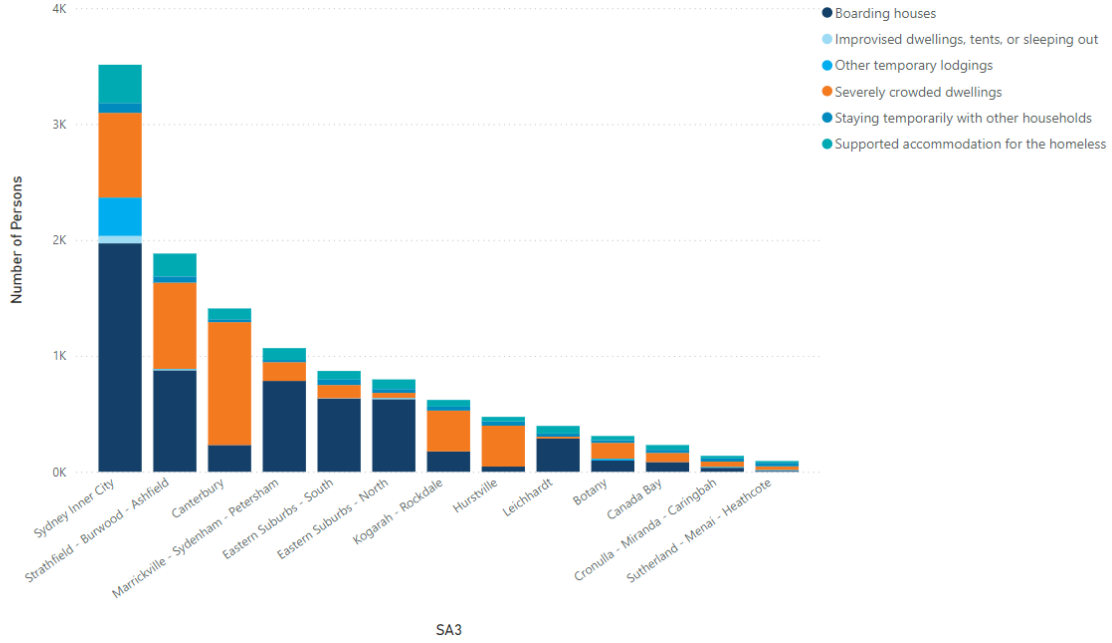
On Census night in 2021, approximately 11,496 people in the CESPHN region were estimated to be experiencing homelessness in the Central and Eastern Sydney region. This equates to approximately 32% of the State's homeless population of 35,011 people, and just under 10% of the National homeless population of 122,494 (1).

Table 1: Homeless operational groups by place of enumeration by SA3, CESPHN region, 2021

SA3	People living in improvised dwellings, tents, or sleeping out	People in supported accommodation for the homeless	People staying temporarily with other households(d)	People living in boarding houses(e)	People in other temporary lodgings(e)	People living in 'severely' crowded dwellings(f)	All homeless persons
Bayside	6	62	22	28	0	27	147
Botany	0	35	24	97	16	137	316
Canada Bay	0	41	27	84	0	79	231
Canterbury	0	93	25	231	0	1,060	1,408
Cronulla - Miranda - Caringbah	0	23	27	35	8	45	142
Eastern Suburbs - North	7	83	33	627	4	43	802
Eastern Suburbs - South	3	75	46	633	0	113	868
Kogarah - Rockdale	0	58	34	176	0	352	623
Leichhardt	0	66	27	287	0	16	400
Marrickville - Sydenham - Petersham	0	102	19	784	0	162	1,069
Strathfield - Burwood - Ashfield	6	198	53	876	6	744	1,882
Sutherland - Menai - Heathcote	0	15	31	9	7	31	103
Sydney Inner City	64	330	85	1,971	331	731	3,505

Source: ABS Homelessness, 2024

Figure 1: Homeless operational groups by place of enumeration by SA3, CESPHN region, 2021

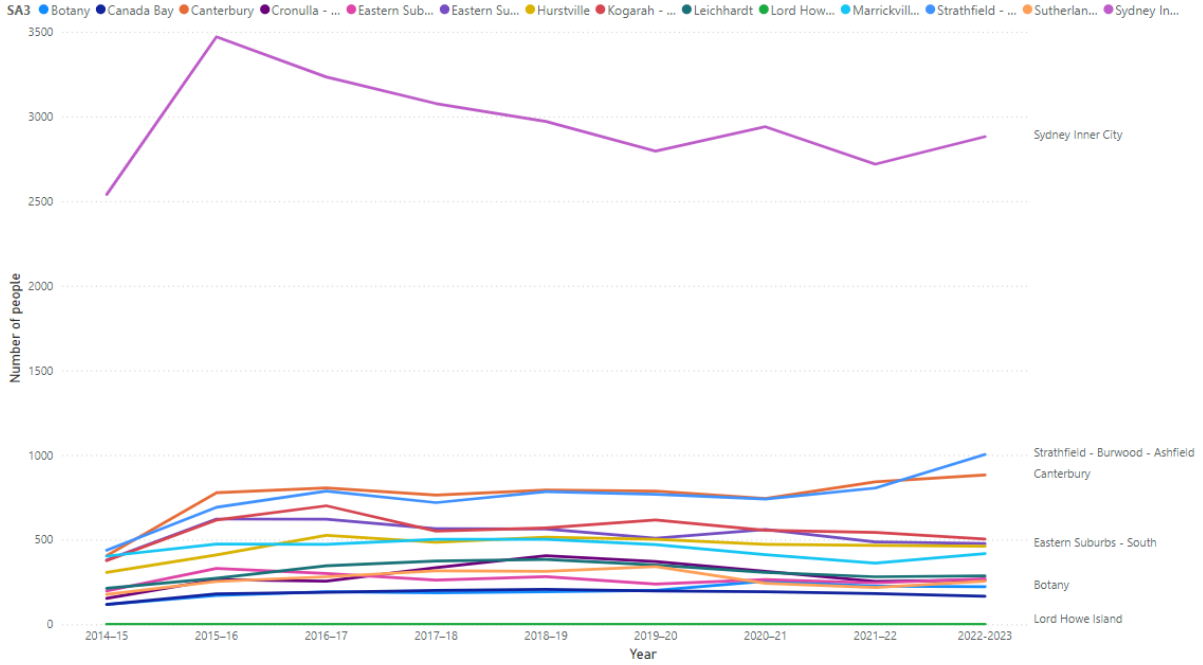


Source: ABS Homelessness, 2024

The number of people experiencing homelessness in CESPHN has remained relatively stable over the period 2013/4 – 2022/23. Of note:

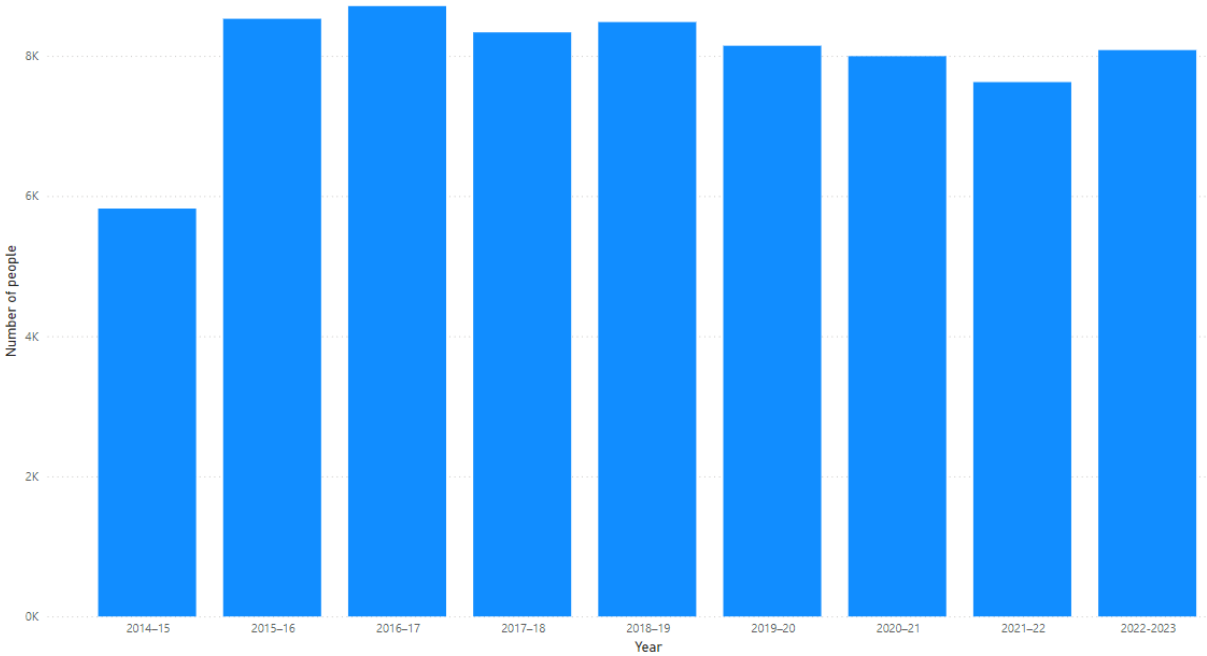
- The highest rates of homelessness for this region were in the Inner-City area (37% of the population experiencing homelessness), followed by the Strathfield-Burwood-Ashfield area (15%).
- Rough sleeping was most common in the Inner City of Sydney but makes up only 5% of people experiencing homelessness in the region.
- Ten percent (10%) of those experiencing homelessness across the region were residing in supported crisis accommodation on the night of the Census.
- People residing in Boarding Houses make up a sizeable portion of people experiencing homelessness in both the Inner West and Inner City (24% in total) and account for over half of those experiencing homelessness in the Eastern Suburbs (59%) and
- People living in 'severely' overcrowded dwellings form the most common experience of homelessness across most areas. Twenty two percent (22%) of the regional total was in the Inner City and Strathfield, Ashfield, and Burwood areas.

Figure 2: Number of people experiencing homelessness in the CESPHN region by year and SA3, 2014-2023



Source: AIHW, 2023

Figure 3: Number of people experiencing homelessness in the CESPHN region by year, 2014-2023



Source: AIHW, 2023

Priority populations in our region

People experiencing homelessness are often members of priority populations, that may not be fully met by current services. Priority populations within the CESPHN region include:

Aboriginal and Torres Strait Islander people

- This group is overrepresented in homelessness services, with 20 percent all people homeless Aboriginal and Torres Strait Islander (Census 2021) and 30 percent of people accessing SHS identifying as Aboriginal (3) (4).

People from multicultural backgrounds

- This group is particularly overrepresented in severely overcrowded dwellings such as Boarding Houses in the inner west region (5).

People with a disability

- This group is considered a priority population, with many people in this group experiencing higher levels of persistent homelessness becoming an ongoing feature of their lives (6) (7).

LGBTIQ+ people

- Members community members are more than twice as likely to experience homelessness than the rest of the population (8).

Refugees and asylum seekers

- The hardships and trauma endured by many refugees prior to resettlement coupled with their lack of financial resources means that they are often vulnerable to housing stress, insecurity and homelessness (9).

Older people

- The number of people aged 65 and older who are experiencing homelessness has been increasing, exacerbated by increasing cost of housing and rent. One in seven people (16 per cent) experiencing homelessness were aged 55 years and over (1).

Victims of Domestic Violence

- Family and domestic violence is the main reason women and children leave their homes in Australia (AHURI 2021). 43.8% of women accessing Specialist Homelessness Services in 2024 had experienced domestic or family violence (10).

Homelessness health services

Primary care is a critical site for preventative health care, early diagnosis and management of acute and chronic disease and access to specialist health care. Primary health care providers play a key role in coordinating the health care provided to individuals with complex needs, enabling patients to access the right care at the right time and place. There are a range of primary care services in the CESPHN region with a dedicated focus in providing holistic care to people experiencing homelessness. These include:

- General Practices (providing patient centred care for homelessness)
- Homeless Health Service at St Vincent's Hospital
- Aboriginal Medical Service Redfern
- Kirketon Road Centre
- Mission Australia Clinic
- Streetside Medics
- Primary health care clinics at the Matthew Talbot Hostel and the Exodus Foundation

- Primary health care outreach clinics into crisis accommodation shelters

There are several local public health initiatives in place for people experiencing homelessness. These include annual programs to:

- distribute influenza vaccines,
- targeted initiatives to address strategic priorities (e.g. hepatitis C health promotion), and
- responses to extreme weather, and
- local arrangements for managing public health emergencies such as outbreaks of communicable diseases in specialist homelessness services.

Supporting the delivery of primary health in the community in our region is linkage to specialist homelessness health hospital staff including clinicians, ward and administrative staff and health service managers from a range of clinical service streams including Emergency Departments, Mental Health, Drug and Alcohol and Social Work

Potential exists to increase the capacity of homelessness health primary care services in our region. This includes the number of greater accesses to homelessness friendly general practices, allied health, mental health and alcohol and other drug practitioners working with the homeless population particularly in areas further afield from the inner-city region.

Specialist homelessness services

Supporting the delivery primary care services and clinics across the region is a diverse and sizable Specialist Homelessness Service workforce responsible for the provision of specialist homelessness supports services for people experiencing or at risk of homelessness. These include:

- Specialist Homelessness Service providers delivering services to both specific target groups such as: older women, people experiencing family and domestic violence, refugee and migrants, youth and Aboriginal and Torres Strait Islander people
- A range of more general Specialist Homelessness Services assisting people facing housing crises

Many Specialist Homelessness Services in our region provide integrated access to primary care mental health and drug and alcohol support workers. They also report ongoing issues linking clients without a GP to a homelessness friendly GP practice for ongoing affordable primary care, particularly those who are rough sleeping.

The CESHN region contains 67% of NSWs' boarding houses (11). Within the Specialist Homelessness Service sector in our region specialist case management support to people residing in Boarding Houses in our region is provided by Newtown Neighbourhood centre.

The total number of clients who received support from the program each month in NSW has slowly increased to 23,976 clients in June 2024, with women making up 61.5% of clients during this period (2). Data as of June 2024 shows that over this time:

- 43.8% of women accessing Specialist Homelessness Services had experienced domestic or family violence
- 11.7% of clients had problematic drug or alcohol issues

The highest proportion of clients accessing Specialist Homelessness Services in our region come from the Inner City and Inner West regions. Specialist Homelessness Services in our region are operating in the inner-city region and the need for greater access to services further from the inner-city region has been reported.

Table 2: SHS clients by SA3, 2022-2023

SA3	No. clients
Marrickville - Sydenham - Petersham	418
Sydney Inner City	2881
Botany	223
Eastern Suburbs - North	269
Eastern Suburbs - South	477
Canterbury	883
Hurstville	461
Kogarah - Rockdale	504
Cronulla - Miranda - Caringbah	261
Sutherland - Menai - Heathcote	255
Canada Bay	166
Leichhardt	286
Strathfield - Burwood - Ashfield	1004

Source: AIHW, 2024

In June 2024 Specialist Homelessness Services across NSW provided a variety of services to assist people who are experiencing homelessness or who are at risk of homelessness, ranging from general support and assistance to immediate crisis accommodation.

Table 3: NSW SHS clients by client group, June 2024

Row Labels	Female	Male	Total
Number of clients accommodated in short-term/emergency accommodation	1,281	933	2,214
Number of clients financially assisted with payments for short term/emergency accommodation	103	43	146
Number of clients who are at risk of homelessness	6,912	3,753	10,665
Number of clients who are homeless	7,294	5,345	12,639
Number of clients who have experienced family and domestic violence	6,390	2,095	8,485
Number of clients with a current mental health issue	5,257	2,839	8,096
Number of clients with problematic drug or alcohol issues	826	874	1,700
Number of Indigenous clients	4,828	2,954	7,782
Number of nights in short-term/emergency accommodation	28,841	19,813	48,654
Total	**61,732**	**38,649**	**100,381**

Source: Australian Institute of Health and Welfare, 2024

Feedback from stakeholder consultation with peak bodies in June 2024 revealed that the region is experiencing issues with services being at capacity, and complex cases in which clients are experiencing multiple health and social issues. Additionally, specialist homelessness services also told of increased uptake by women between the ages of 18 to 24.

Housing

Social and supported housing providers within the CESPHN region include Homes NSW, the Aboriginal Housing Office, and a diverse range of Community housing providers. Within the CESPHN region access to social housing consists of:

- 24,741 Public housing residential dwellings and 7,082 Community housing residential dwellings across the CESPHN region accounting for 28.8% and 14.4% of all NSW Public and Community housing residential dwellings, respectively (12).
- The Aboriginal Housing Office and several Aboriginal housing providers operate within our region to provide culturally appropriate and affordable housing, and rental assistance for the Aboriginal people in our region.

The main Community housing providers of social and affordable housing in the region include:

- Bridge housing,
- Metro community housing,
- St George community housing,
- Mission Australia housing
- Women's housing company

Wait times for social housing remain high. Of general housing applicants, there is an expected minimum 5 to 10 years wait for a social housing property for allocation zones within our region.

In 2024, Applications for social housing across the CESPHN region, with the highest numbers of applicants originating from the Leichhardt/Marrickville, Inner West and St George regions (12).

Table 4: Applicants on NSW Housing register, CESPHN region, as at June 2024

Allocation zone	General Applicants, 2024	Priority Applicants, 2024
Inner City	521	195
Eastern Suburbs	894	292
Leichhardt/Marrickville	1,092	363
Canterbury	711	147
Inner West	1,256	356
Sutherland	578	168
St George	1,421	327
Riverwood	129	20
NSW	**46,904**	**9,428**

Source: Communities and Justice, 2024

There are several programs that provide rapid access to temporary accommodation housing for homeless people in our region. These include:

- The Homelessness Outreach Support Team (HOST) and the Homelessness Assertive Response Team (HART) street-based patrols fast tracking clients into temporary accommodation
- The Together Home Program which allocates high needs housing support packages to people with complex needs, including those with severe mental health conditions
- Implementation of No Exits from Government Services into Homelessness framework, which work to coordinate and focus efforts across government agencies to prevent exits into homelessness

Of note, for 6 out of 10 people in social housing where a movement from social housing to another status was recorded was recorded returned to some form of homelessness. Reported contributing factors include (13):

- A lack of ongoing access to homelessness support services once a person is placed into social housing

- A disconnect from social networks that often occurs with people being placed in locations away from their longer standing community and support networks.

The CESPHN region contains approximately 67% of NSW's boarding houses. In May 2022, 711 of 1,062 (67%) of boarding house registered with NSW Fair Trading were located within the CESPHN region (11). Of these, the largest majority were:

- General boarding houses with a small number of assisted boarding houses.
- Rent for traditional boarding houses averaging between $120-270 per week.

Regional drivers of homelessness

The key drivers of homelessness in NSW are (14) (15):

Poverty and financial disadvantage

- Accounting for 21% of homelessness in NSW (15).

Undersupply of affordable and appropriate housing

- Rising rental prices that have seen many low-income households spend over 30% of their income on housing cost. A lack of affordable housing is pushing more people into homelessness with reports of increasing numbers of people in our region living out of cars.

Social housing

- The supply of social housing has been outpaced by the population growth and need for affordable and suitable housing.

Employment

- Unemployment in different region in our area is high and may be attributable to economic factors that contribute to homelessness

Socioeconomic status

- CESPHN contains some of the lowest socio-economic status regions in Sydney. The link of association between risk of homelessness and SES is high and provide an indication of risk of homelessness

Domestic violence

- In 2023-2024 people experiencing family and domestic violence were the largest cohort of Specialist Homelessness Service clients, making up over 39% of all clients.

Mental health and alcohol and other drugs

- People experiencing mental health issues, alcohol and drug addictions, family or relationship breakdown, issues with sexual identity and other addictions like gambling are more likely to experience homelessness, and homelessness can increase the risk of mental illness.

Access to primary healthcare

Key barriers to accessing primary healthcare include (15):

Cost of services

- Lack of awareness and confusion over which GPs and general practices bulk bill is impacting access and desire to engage with general practice and other primary care services. The limited access to affordable GP services also extends to allied health services.

Cost of medications

- Upon discharge from a general practitioner, homeless people are unable to follow the prescribed treatment protocol due to the cost of medications

Wait lists

- Longer wait times to see a bulk-billing general practitioner were highlighted as a key barrier across our region. This limited access to GP services also extends to allied health services.

Digital health literacy

- Online booking systems have identified as a barrier to accessing general practitioner services if no alternative booking mode is available, as people experiencing homelessness may not have access to a digital device or have the skills to make an online booking

Transport

- People experiencing homelessness may not have access to a car or be able to afford petrol and public transport to attend medical appointments

Shame and stigma

- People experiencing homelessness report shame in accessing a GP due to issues such as personal hygiene and clothing. Stigma from general practice staff, in particular reception staff, has been highlighted by service providers and consumers as a barrier to access

Lack of understanding and awareness of services

- Many people who are homeless lack understanding of the health system and the skills to navigate it. This often results in presentations to Emergency Departments for issues that could be addressed in primary care

Lack of care coordination

- Providers have identified difficulty in engaging with GPs and general practices to provide arrange referrals and coordination care for their clients

Identified needs, gaps and opportunities

Key needs

Access to timely and affordable primary health care services

- Greater access to crisis supports and support for people experiencing secondary and tertiary homelessness (Improved access to mobile primary care clinics and GP Homelessness friendly practices)
- Codesign and coproduction of strategically placed Homeless GP practices supported by business models that subsidise the use of longer consultation times (Item C and D MBS items) and health assessment plans for the management of chronic and complex conditions and reduction of persistent homelessness
- Strengthened collaboration and integration of GP homelessness friendly practices with health, housing, and homelessness sectors, in particular case workers facilitating patient attendance and follow up with GP clinics
- Stakeholder consultations highlighted the need for general practices to be better equipped to provide care to Aboriginal and Torres Strait Islander people and young people experiencing homelessness.
- Provision of education and training to GP reception staff to help reduce shame and stigma experienced by people who are homeless.
- Commissioning to support expansion of existing primary care outreach clinics and services into homelessness crisis accommodation and shelters (GP's, nurses, mental health and drug

and alcohol practitioners, sexual health workers, peer support workers, Aboriginal and multicultural health workers, allied health workers)

Coordinated chronic care management

- Prioritised connection with a regular GP and general practice for people transitioning from shelter accommodation to independent housing or post discharge from government agencies such as hospitals and the criminal justice systems to improve general health and chronic disease management
- Prioritised health assessments and chronic disease management plans in general practice for the management of chronic and complex conditions which can lead to recurring or. persistent homelessness
- Greater use of case management services and peer support networks and other integrated approaches in general practice to assist follow up primary care and strengthen community support networks for people at risk of or experiencing homelessness.
- The codesign and coproduction homelessness friendly GP practices needs to incorporate a plan to promotes the integration of these new models of primary care, through the building strong relationships across the housing homelessness and health system that facilitate referrals to the services

Workforce development

- Upskilling of the primary care workforce working with people at risk of homelessness
- More GPs qualified and trained in the provision of Provide trauma informed care, including the use of GP trainees
- More GPs trained in the early detection and management of family and domestic violence
- Expanded employment and use of Aboriginal and multicultural health workers in existing homelessness health outreach services and clinics
- Provision of education and training to GP reception staff to help build trust and reduce shame and stigma experienced by people who are homeless.
- Training of general GPs and practice staff to identify of people at risk of homelessness at the earliest opportunity, linking people to the care they need at the earliest opportunity
- Providing access to ongoing support from the appropriate range of services including mental health, psychosocial and housing providers
- Improved care coordination to help people to navigate health, homeless and housing services to receive the support they need

Geographic location of services

- Most of the homelessness and primary health care services within our region are focused around areas with higher proportions of homelessness. This result is high provider density in the Inner-city and Inner west regions
- It has been reported that the service environment can be difficult to navigate and access, and services lack flexibility to respond to other areas in the CESPHN region
- Opportunity exists to review and map the homelessness and primary health care supports across the CESPHN region to help inform, shape, and coordinate services to meet the needs of more marginal and underserved regions, where access to homelessness and primary health care.

Collaborative partnerships

- There are multiple health housing and homelessness service providers and other community organisations such as councils, emergency services, charities, real estate agencies and community managed organisations providing services to people experiencing or at risk of homelessness
- Opportunity exists to collaborate with a broader range of partners, including Homes NSW, community housing providers and community managed organisations such as hot meal

service providers to embed primary health care services including, health assessments and clinics
- Opportunity exists to scaling up existing work addressing the needs of people residing in crisis accommodation and in Boarding Houses
- Opportunity exists to build on evolving multi-agency service models and approaches to improve service coordination and improve access to primary healthcare across the spectrum (i.e. prevention, early intervention, crisis and post crisis care and assistance)
- Further opportunities exist to target delivery of mental health and drug and alcohol detox and support services for people experiencing homelessness through provider partnerships, use of existing commissioned service providers, and expanded presence of mental health and alcohol and other drug practitioners in existing homelessness services.
- Opportunity exists for more innovative localised place-based responses for priority homelessness cohorts, e.g. Aboriginal people and those leaving correctional centres and mental health services.

Improved data collection and use

- Opportunity exists to expand collaboration and use of Advance to Zero - End Street Sleeping Collaboration framework and build on collection of real-time data and insights created through the by-name list registry of the Sydney Zero project.
- The purpose of the by-name list register is for those who are homeless to be known by name and for their housing, health and social needs to be recognised to facilitate the organisation of local services to assist people into permanent housing with necessary supports. Potential exists to explore expanding access to the register for GPs and primary care practitioners whose work focuses on homelessness

PHN Homelessness Access Program

- CESPHN is the lead agency for a new national PHN Homelessness Access Program and will be working with the Australian Alliance to End Homelessness to strategically improve PHN responses to improving access to primary health care for people who are homeless or at risk of homelessness. Key initiatives include commissioning of services, and PHN participation in a national intersectoral health, housing and homelessness community of practice to assist enhance collaboration and capacity between sectors.

Regional Intersectoral Homelessness Health Strategy 2020-2025

- CESPHN is a partner in a Intersectoral Homelessness Health Strategy which is a joint initiative between South Eastern Sydney Local Health, Sydney Local Health District, St Vincent's Health Network, Central and Eastern Sydney Primary Health Network, Department of Communities and Justice - Sydney, South Eastern Sydney and Northern Sydney District and City of Sydney.
- This Strategy identifies five priority areas for improving health outcomes for people experiencing or at risk of homelessness within region; Improving access to the right care at the right time, Strengthening prevention and public health, Increasing access to primary care, building workforce capacity, and establishing collaborative governance and shared planning.

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CENTRAL AND
EASTERN SYDNEY

An Australian Government Initiative

ACCESS TO PRIMARY CARE

2025-2027 Needs Assessment

Contents

List of tables

List of figures

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Overview

Summary

Workforce availability, increasing out of pocket expenses and patient health literacy are key factors impacting and limiting access to primary care. These factors collectively contribute to a growing disparity in healthcare access, particularly affecting vulnerable populations, further impacting health disparities.

Key issues

- **Workforce shortage:** There has been a 30% decline in the number of GPs visiting aged care facilities and 40% of GP workforce who currently visit these facilities intend to retire in the next 5 years
- **Financial constraints:** With increased out of pocket costs for consultations, medications and diagnostic tests, general practices in our region are experiencing viability issues. GPs have over the last 5 years moved to increase their fees with the gap between MBS payments and cost of consultation growing. This gap can be as high at $100 for a short consultation impacting individuals when the cost of living is so high.
- **Availability of after hours primary services**: Access to general practice after hours is a significant issue in our region as evidenced by attendances at local EDs for low acuity issues. The five urgent centres which began in 2023/2024 in our region are assisting access to primary care, but they would need to be expanded with additional support provided to general practice to significantly improve atter hours access.
- **Health literacy**: The region is home to a large multicultural community many recently arrived. In-language focus groups showed that they are used to a different medical system and many find it difficult to navigate the complex health system. Many CESPHN residents who do not understand the options in the system or cannot afford GP care, paying for testing, etc. result in higher attendances at ED.

Key gaps

- Expected ongoing reduction in GP workforce when measured against numbers, FTE and years intending to work against the expected increase in health service needs as the population increases and ages
- Reduction in number of GP registrars
- Rising out of pocket costs for individuals accessing GP services and subsequent lack of affordability
- Limited and costly access to psychiatry
- Long public outpatient service wait times.

Maintaining access to primary health care that is integrated with other services- particularly for those most vulnerable - is key to ensuring delivery of care at the right time, at the right place to prevent more serious disease and to reduce potentially preventable hospital admissions.

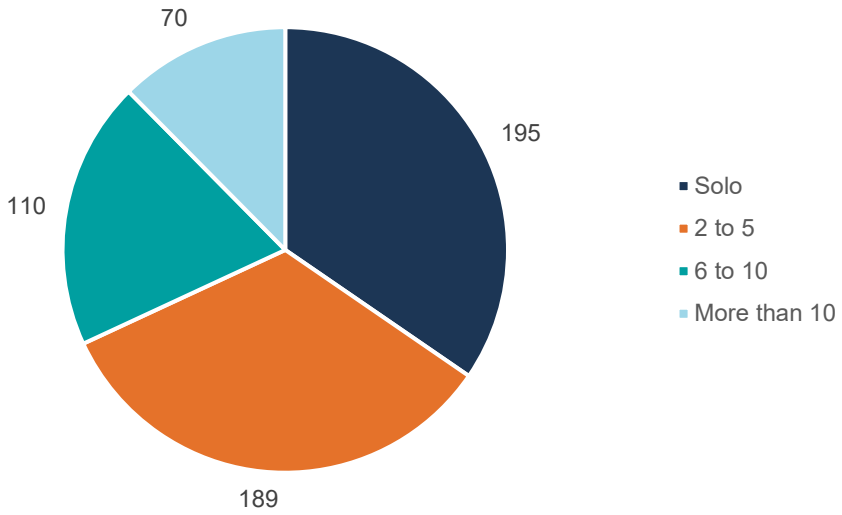
Improving access to affordable primary care continues to be a key focus for CESPHN. Having significant numbers of health professionals in our region improves access for those who can afford care but within our region there are very large vulnerable populations who are not receiving the care they should because of low health literacy, inability to meet increased out of pocket costs or for whom providers struggle to deliver care that does not threaten the viability of their business.

General practice

General practices

As of September 2024, there were 564 general practices operating within the central and eastern Sydney region, a slight reduction compared to the 578 practices in the region in September 2023. This includes one Aboriginal Medical Service in Redfern.

Figure 1: General practice size in central and eastern Sydney region, September 2024



Source: CESPHN CRM, 2024

Approximately two-thirds (69.5%) of general practices within the central and eastern Sydney region were accredited or registered for accreditation in September 2024 (1). This rate is low among PHNs in metropolitan areas, where the average accreditation rate was 78% in 2020-21 (2). 85.1% of GPs in the central and eastern Sydney region have an accredited (or registered for accreditation) practice as their primary organisation (1). The low accreditation rate could be attributed to the large proportion of solo/small practices as well as the ageing GP workforce in the Central and Eastern Sydney region.

Table 1: Accreditation status of general practices by SA3, central and eastern Sydney region, September 2024

SA3	Accredited	Registered for Accreditation	Not accredited	Total
Botany	8	0	8	16
Canada Bay	21	0	2	23
Canterbury	39	1	13	53
Cronulla - Miranda - Caringbah	23	1	3	27
Eastern Suburbs - North	28	1	19	48
Eastern Suburbs - South	25	3	9	37
Hurstville	33	1	10	44
Kogarah - Rockdale	35	1	23	59
Leichhardt	16	0	8	24
Marrickville - Sydenham - Petersham	10	0	10	20
Strathfield - Burwood - Ashfield	45	0	23	68
Sutherland - Menai - Heathcote	29	0	6	35
Sydney Inner City	71	1	37	109
Lord Howe Island	0	0	1	1
Total	383	9	170	564

Source: CESPHN CRM, 2024

General practitioners

Distribution

In 2022 there were 2,166 general practitioners (GPs) working in the central and eastern Sydney region (1,883.6 FTE) giving a rate of 138.7 per 100,000 population (120.6 FTE per 100,000 population), higher than state and national rates.

Table 2: GPs by region, 2022

Measure	CESPHN	NSW	Australia
Number of practitioners	2,166.0	9,810.0	31,926.0
Number of practitioners (rate per 100,000 population)	138.7	120.1	122.8
FTE total	1,883.6	8,996.1	28,985.6
FTE total (rate per 100,000 population)	120.6	110.2	111.5
FTE clinical	1751.4	8,416.1	27,007.8
FTE clinical (rate per 100,000 population)	112.2	105.2	111.5

Source: HWD, 2024

As seen in Table 3, the distribution of GPs across the region is very uneven. Across the central and eastern Sydney region in 2022, Sydney Inner City, Leichhardt, Eastern Suburbs-North and South, Canada Bay all had rates of general practitioners per 100,000 population higher than state and national rates for number of practitioners, FTE total and FTE clinical.

Conversely Botany, Marrickville-Sydenham-Petersham, Hurstville and Kogarah-Rockdale had the lowest rates across our region; significantly lower than state and national (3).

Table 3: GPs by SA3, central and eastern Sydney region, 2022

SA3	No. of practitioners (rate per 100,000)	FTE total (rate per 100,000 population)	FTE clinical (rate per 100,000 population)
Botany	60.8	61.1	57.7
Canada Bay	160.3	128	117.7
Canterbury	114.1	109.5	101.2
Cronulla-Miranda-Caringbah	110	101.7	94.7
Eastern Suburbs – North	193.1	157.4	145.1
Eastern Suburbs – South	134.1	115.8	108.4
Hurstville	98.2	88.3	84.3
Kogarah-Rockdale	89.8	85.0	80.0
Leichhardt	191.9	156.4	146.3
Marrickville-Sydenham-Petersham	74.7	76.3	71.4
Strathfield-Burwood-Ashfield	117.1	100.0	94.4
Sutherland-Menai-Heathcote	115.9	107.4	100.3
Sydney Inner City	238.9	198.5	181.9
CESPHN	138.7	120.6	112.2
NSW	120.1	110.2	103.1
Australia	122.8	111.5	103.9

Source: HWD, 2024

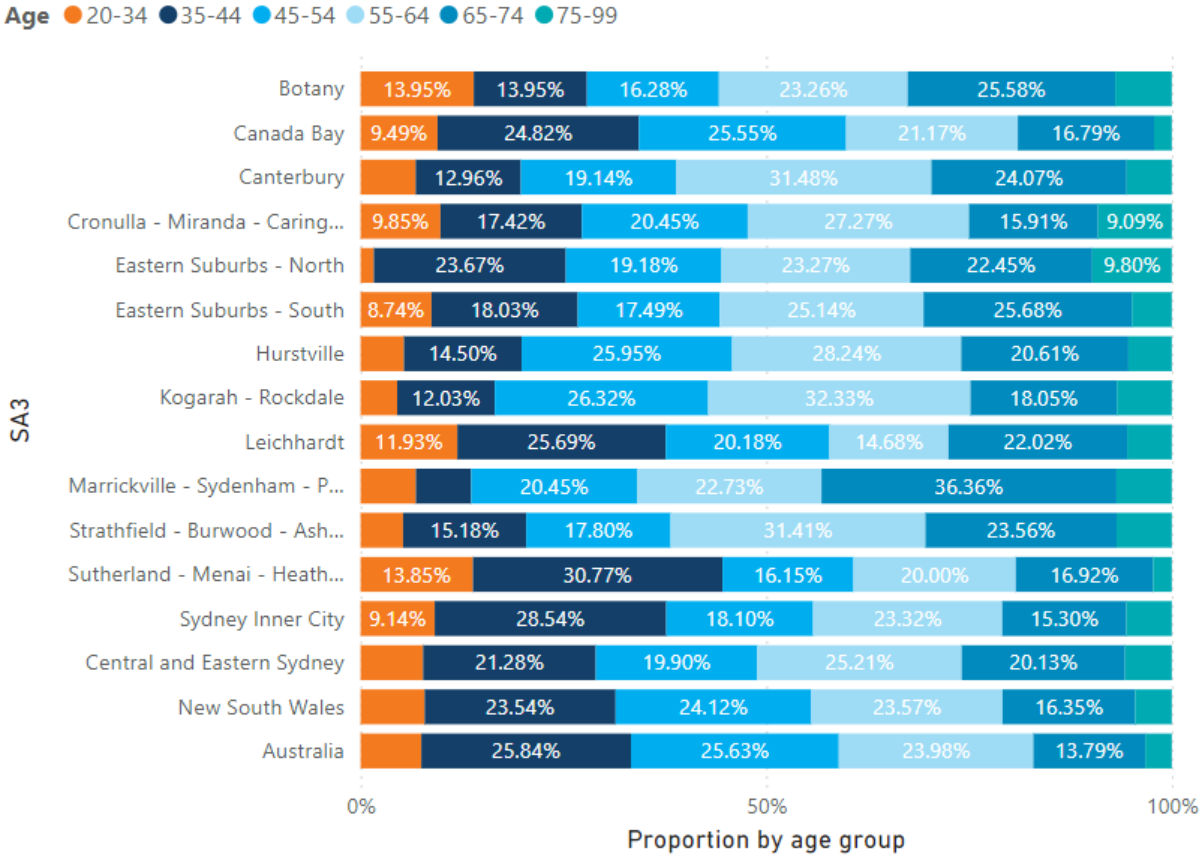
***Lord Howe Island figures have been excluded due to data suppression rules*

Demographics

As seen in Figure 2 fifty per cent (51.9%) of GPs working across the central and eastern Sydney region in 2022 were female while representing 46.3% of the region's FTE. Marrickville-Sydenham-Petersham had the highest proportion of male GPs with 76.7% of the FTE workforce, followed by Botany (70.7%) and Kogarah-Rockdale (64.5%) (3).

The CESPHN GP workforce is considerably older than state and national averages. In 2022, approximately 50% of FTE GPs across the central and eastern Sydney region were aged 55 years or older (50.9%), this is higher than both the state and national rates of 43.1% and 41.0% respectively; a further 41.3% were aged 35-54 years old. Marrickville-Sydenham-Petersham SA3 (68.2%), Strathfield-Burwood-Ashfield SA3 (63.8%) and Canterbury SA3 (59.9%) had the highest rates of GPs aged 55 years and over across the central and eastern Sydney region (3).

Figure 2: Proportion of GP workforce by age group, SA3, central and eastern Sydney region and New South Wales and Australia, 2022



Source: HWD, 2024

Years intend to work

Of the central and eastern Sydney region's SA3s, Strathfield-Burwood-Ashfield has the highest percentage of GPs only intending to work an additional five years or less, at 29.6%. The region had an average of 27% of GPs intending to work only another five years which is higher than the New South Wales and Australia averages of 24.9% and 23.4% respectively.

Table 4: GP years intended to work by SA3, central and eastern Sydney region, 2022

Geography	0-5 years	6-10 years	11-15 years	16-20 years	21-30 years	31-40 years	41+ years
Botany	8	13	3	3	7	3	0
Canada Bay	35	27	13	16	32	11	0
Canterbury	37	45	20	23	26	6	0
Cronulla-Miranda-Caringbah	42	20	11	19	30	4	3
Eastern Suburbs - North	68	65	25	30	37	15	3
Eastern Suburbs - South	52	45	20	32	20	8	0
Hurstville	37	28	19	22	19	3	3
Kogarah - Rockdale	35	34	21	21	15	3	0
Leichhardt	23	21	12	12	31	5	3
Marrickville - Sydenham - Petersham	12	16	4	4	4	0	0
Strathfield - Burwood - Ashfield	55	52	17	27	20	11	4
Sutherland - Menai - Heathcote	32	19	9	23	31	10	5
Sydney Inner City	137	95	47	81	115	38	8
Central and Eastern Sydney	573	480	221	314	387	117	29
New South Wales	2,380	1,930	1,144	1,594	1,877	494	130
Australia	7,232	5,794	3,908	5,506	6,461	1,616	397

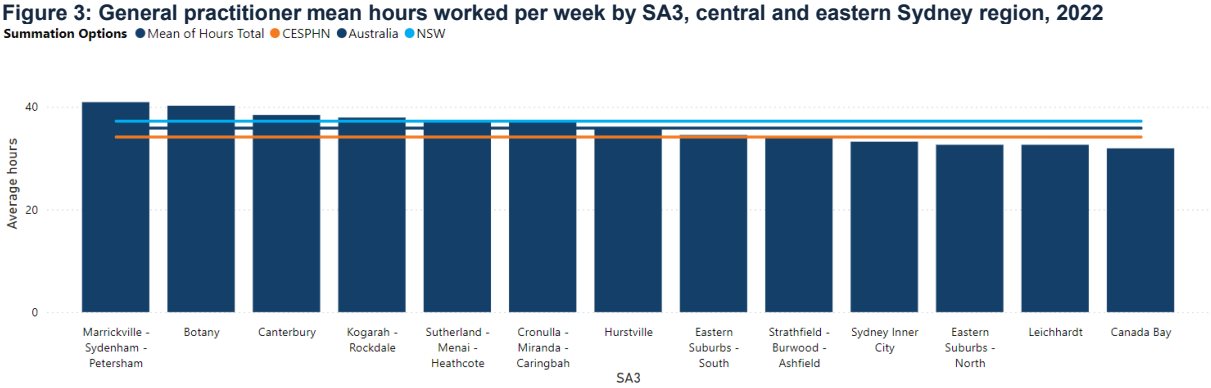
Source: HWD, 2024

Hours worked per week

In 2022, on average GPs in Australia worked 36.3 total hours per week, slightly lower than NSW (36.7 total hours per week). In the central and eastern Sydney region, GPs worked 34.8 total hours per week (4). Average weekly working hours ranged from 40.9 hours per week in Marrickville – Sydenham – Petersham SA3 to 31.9 hours per week in Canada Bay SA3.

In 2022, on average GPs in Australia worked 33.8 clinical hours per week, slightly lower than NSW where GPs worked on average 34.3 clinical hours per week. GPs in the central and eastern Sydney region worked, on average, 32.3 clinical hours per week (2). Average weekly clinical hours ranged from 38.2 hours in Marrickville – Sydenham – Petersham SA3 to 29.4 hours per week in Canada Bay SA3.

Figure 3: General practitioner mean hours worked per week by SA3, central and eastern Sydney region, 2022



Source: HWD, 2024

The GP full-time equivalent in the region has decreased in recent years despite the increase in population. Analysis of FTE between 2021 and 2023 shows a peak of 1,903.9 FTE in 2021 and a reduction to 1,730.4 FTE in 2023, a decrease of 9.1 percent despite the 4.5% PHN-wide population growth during the same period. Botany decreased by 31%, the largest change in the region, followed by Kogarah-Rockdale at 19.4%. Given Botany and Kogarah-Rockdale make up the Bayside LGA, which has the second-highest housing target, the area is considered underserviced.

Direct engagement with GPs and consultation as part of the workforce prioritisation program (WPP) identified factors attributed to the reduction in FTE, including the ageing GP workforce transitioning to part-time arrangements, and younger GPs prioritising work-life balance.

Table 5: General practitioner fulltime equivalent (FTE), central and eastern Sydney region, 2021-23

SA3	2021	2022	2023
Botany	54.2	46.8	41.4
Canada Bay	117.1	118.9	111.6
Canterbury	183.3	183.9	168.3
Cronulla - Miranda - Caringbah	133.5	124	117
Eastern Suburbs - North	166.2	149.4	147.3
Eastern Suburbs - South	143.3	135.5	129.7
Hurstville	150.9	154.9	147.7
Kogarah - Rockdale	155.9	151.4	143.4
Leichhardt	78.8	70.5	66
Marrickville - Sydenham - Petersham	51.7	49.5	46
Strathfield - Burwood - Ashfield	203.6	198.4	188.6
Sutherland - Menai - Heathcote	151.2	147.5	139.7
Sydney Inner City	322.5	304.6	291.3

Source: HeaDS UPP, 2024

Access

GPs are the first point of contact for most people seeking health care, with 81% of the population in the Central and Eastern Sydney region seeing a Medicare-subsidised GP in 2022-23. This is lower than the Australian average over the same period, at 86%, and NSW, at 87%.

In 2023, there were 9,953,091 GP attendances in the central and eastern Sydney region. This equates to an age-standardised rate of 6.4 services per 100 people, slightly lower than the national average of 6.5 services per person

For Medicare-subsidised GP attendances, the highest number of services per 100 people were attributed to the Canterbury and Sutherland-Menai-Heathcote SA3s in 2022-23, areas with notably high proportions of individuals aged 65+.

Table 6: Medicare-subsidised GP attendances by SA3, central and eastern Sydney region, 2022-23

SA3	No. services	Services per 100 people
Botany	315,644	518.48
Canada Bay	588,449	678.59
Canterbury	1,030,899	730.65
Cronulla-Miranda-Caringbah	790,510	663.69
Eastern Suburbs – North	720,237	563.17
Eastern Suburbs – South	786,470	579.66
Hurstville	866,165	654.61
Kogarah-Rockdale	955,279	649.82
Leichhardt	319,446	567.75
Marrickville-Sydenham-Petersham	324,557	591.16
Strathfield-Burwood-Ashfield	985,727	604.48
Sutherland-Menai-Heathcote	794,774	708.47
Sydney Inner City	1,069,525	476.76
CESPHN Average	769,337	622.40

** No data published for Lord Howe Island*
Source: AIHW, 2024

Medicare-subsidised care through GP bulk billing has reduced the financial barrier for people needing to access GP care. However, over the last 1 - 2 years, the number of GP practices and primary care services offering bulk billing as an option has decreased. CESPHN has fewer GP services bulk billing compared to the national and state bulk billing rates. This could be for several reasons, including:

- Rising costs associated with running a general practice
- Medicare rebates not being updated in line with inflation.

In 2023-24, the average cost per standard GP consultation was $83.20, a 3.2% increase over the previous twelve months. The average cost per long consultation was $129.0, a 3.7% increase over the same period. Moreover, the percentage of practices that bulk bill in the region reduced from 47.3% to 31.4% between 2023-24 and 2022-23. The Canterbury, Strathfield – Burwood – Ashfield and Marrickville – Sydenham – Petersham SA3s are the remaining SA3s in which more than half offer bulk billing.

Table 7: Bulk billing clinics and average cost per consultation by SA3, 2023-24, CESPHN region

SA3	Bulk Billing Clinics	Average Cost (Standard Consultation)	Average Cost (Long Consultation)	Bulk Billing %
Botany	1	$84.56	$133.00	7.7
Canada Bay	3	$80.22	$133.07	15.0
Canterbury	28	$76.31	$124.72	59.6
Cronulla - Miranda - Caringbah	6	$87.21	$144.51	23.1
Eastern Suburbs - North	2	$99.36	$158.41	4.9
Eastern Suburbs - South	5	$88.02	$138.67	18.5
Hurstville	15	$77.69	$121.00	37.5
Kogarah - Rockdale	15	$76.51	$122.09	30.0
Leichhardt	4	$91.49	$145.19	20.0
Marrickville - Sydenham - Petersham	9	$76.51	$126.61	52.9
Strathfield - Burwood - Ashfield	31	$74.52	$118.54	54.4
Sutherland - Menai - Heathcote	11	$79.55	$129.78	31.4
Sydney Inner City	20	$89.59	$143.43	23.5

Source: Cleanbill, 2024

Average out of pocket per service correspond to SEIFA scores; for example, Canterbury and Rockdale-Kogarah had the lowest average out-of-pocket cost and SEIFA values. However, some areas with high SEIFA scores pay significantly different amounts. Sutherland-Menai-Heathcote and Leichhardt differ in SEIFA scores by only one point, however residents in Sutherland on average pay substantially less.

The decrease in general practices that bulk bill means people are expected to pay a larger out-of-pocket expense to access primary care, which in turn influences health-seeking behaviours, especially for those who are financially struggling or unable to afford a consult.

GP Registrars

The central and eastern Sydney region had 238 Australian General Practice Training (AGPT) registrars in 2023, showing a decrease from 365 in 2018 (6). This 34.8% decrease in registrars between 2018 and 2023, combined with older GPs planning to retire in the next five years poses a challenge for the central and eastern Sydney region, especially given its projected population increase of 9.3% by 2041 that will increase pressure on general practice to maintain access.

Table 8: Number of GP trainees, central and eastern Sydney region, 2020-23

Year	2018	2019	2020	2021	2022	2023
No. Registrars	365	319	269	293	260	238

Source: HeaDS UPP, 2024
**GP trainees includes participants on the Australian General Practice Training Program*

A 34.8% decrease in registrars between 2018 and 2023, combined with decreasing numbers of GPs to replace them, poses a challenge for the central and eastern Sydney region, especially given its projected population increase of 9.3% between 2024 and 2041 that will increase pressure on general practice to maintain access.

Primary Care Nurses

Primary care nursing refers to nurses whose main area of work is in a primary care setting, such as a GP practice. In 2024, there was a reported 743 primary care nurses working in the central and eastern Sydney region (445.1 FTE) giving a rate of 28.5 per 100,000 population (27.0 FTE per 100,000 population).

While this is a substantial increase over the previous year (440 nurses and 385.8 FTE, the central and eastern Sydney region continues to lag behind the state and national rates. Low rates of primary care nurses in our region could be linked to a high proportion of solo GP practices, lower pay rates in practice nursing compared to hospital settings, and not working to their scope of practice.

As of November 2024, 44.6% of general practices in CESPHN do not employ a practice nurse. 19.6% employ one nurse and 35.8% employ more than one nurse (3).

Table 9: Primary care nurses by region, 2022

Measure	CESPHN	NSW	Australia
Number of Practitioners	515	3,379	11,949
Number of Practitioners (rate per 100,000 population)	33.0	41.4	46.0
FTE Total	445.1	2,788.9	10,171.0
FTE Total (rate per 100,000 population)	28.5	34.2	39.1
FTE Clinical	422.2	2,647.2	9,567.2
FTE Clinical (rate per 100,000 population)	27.0	32.4	36.8

Source: HWD, 2024

The number of nurses in primary and community settings has increased substantially in recent years, by 25.7% between 2018 and 2023.

Table 10: Number of nurses in primary and community settings, central and eastern Sydney region, 2018-2023

	2018	2019	2020	2021	2022	2023
Number of nurses	3,138	3,213	3,285	3,859	3,809	3,946

Source: HeaDS UPP, 2024

Years intend to work

In 2021, 53.3% of primary care nurses in the central and eastern Sydney region intended to only work up to another 10 years. This is despite 44.9% of nurses in CESPHN falling within the 20 to 34 age

group, which is significantly higher than New South Wales and Australia at 30.8% and 30.1%, respectively (3).

Table 11: Primary care nurses years intended to work by SA3, central and eastern Sydney region, 2022

SA3	0-5 years (%)	6-10 years (%)	11-15 years (%)	16-20 years (%)	21-30 years (%)	31-40 years (%)	41+ years (%)
Botany	33.3	0.0	0.0	33.3	33.3	0.0	0.0
Canada Bay	18.8	50.0	0.0	31.3	0.0	0.0	0.0
Canterbury	31.8	22.7	13.6	0.0	31.8	0.0	0.0
Cronulla-Miranda-Caringbah	43.5	30.4	13.0	13.0	0.0	0.0	0.0
Eastern Suburbs – North	34.6	42.3	0.0	0.0	23.1	0.0	0.0
Eastern Suburbs – South	30.6	20.4	6.1	24.5	10.2	8.2	0.0
Hurstville	31.3	25.0	18.8	25.0	0.0	0.0	0.0
Kogarah-Rockdale	27.8	38.9	0.0	33.3	0.0	0.0	0.0
Leichhardt	16.7	16.7	0.0	50.0	16.7	0.0	0.0
Marrickville-Sydenham-Petersham	0.0	100.0	0.0	0.0	0.0	0.0	0.0
Strathfield-Burwood-Ashfield	58.8	23.5	0.0	0.0	17.7	0.0	0.0
Sutherland-Menai-Heathcote	40.6	18.8	9.4	12.5	9.4	9.4	0.0
Sydney Inner City	23.4	22.6	8.8	21.2	18.3	3.7	2.2
CESPHN	28.5	24.8	7.0	19.1	14.6	3.7	2.2

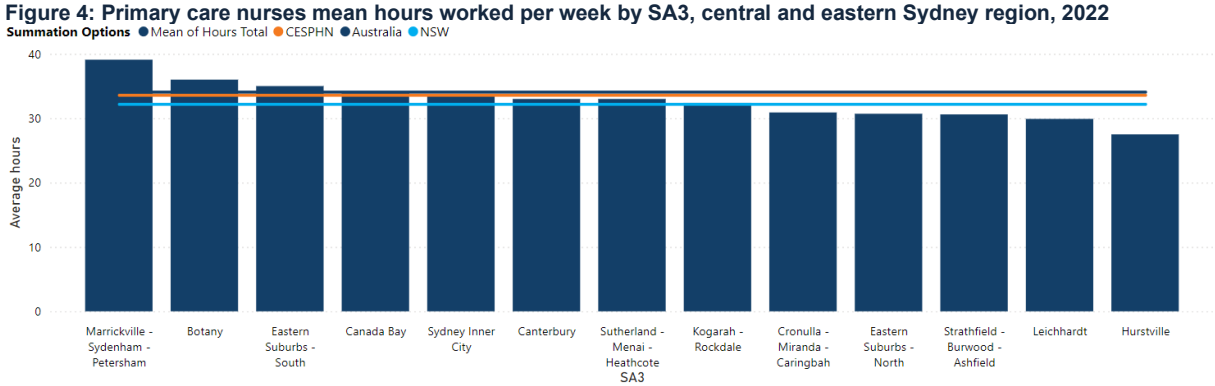
*** Lord Howe Island figures have been excluded due to data suppression rules*
Source: HWD, 2024

Hours worked per week

Total hours

In 2022, on average primary care nurses in Australia worked 32.3 total hours per week, slightly higher than NSW where primary care nurses worked on average 31.4 total hours per week. Across the central and eastern Sydney region, primary care nurses worked 32.8 total hours per week (3). Average weekly total hours ranged from 39.9 hours in Marrickville-Sydenham-Petersham SA3 to 27.5 in Hurstville SA3.

Figure 4: Primary care nurses mean hours worked per week by SA3, central and eastern Sydney region, 2022



Source: HWD, 2024

Clinical hours

In 2022, on average primary care nurses in Australia worked 30.4 clinical hours per week, similar to NSW where primary care nurses worked on average 29.8 clinical hours per week, an increase of 0.5 hours over the preceding year. Primary care nurses in the central and eastern Sydney region worked, on average, 31.1 clinical hours per week (3).

Allied Health Professionals

Rates for other Medicare-subsidised services (allied health and diagnostic imaging) in the central and eastern Sydney region were similar to national rates as shown in the following table.

Table 12: Medicare-subsidised services per 100 people (age standardised), central and eastern Sydney region, 2022-2023

Medicare-subsidised service	CESPHN	Metropolitan (greater capital city)	Australia
Allied health attendances (total)	105.47	105.30	102.12
Diagnostic imaging (total)	104.05	106.08	106.41
GP attendances (total)	611.72	656.71	639.23
Specialist attendances (total)	128.39	102.47	97.84

Source: AIHW, 2023

In 2022, there were 13,604 Australian Health Practitioner Regulation Agency (AHPRA) registered allied health professionals (AHPs) working in the central and eastern Sydney region (12,565.9 FTE), giving a rate of 895.8 per 100,000 population (827.3 FTE per 100,000 population). (3) Psychologists had the highest rate of AHPs per 100,000 population (177.8), followed by physiotherapists (149.5) and pharmacists (114.3) (5).

Demographics

Almost two in three (59.6%) of AHPRA registered FTE AHPs working across the CESPHN catchment in 2022 were female. This reflects national proportions, where 61.1% of AHPRA registered FTE AHPs were female (3).

In 2021, 59.3% FTE AHPs across the central and eastern Sydney region were aged 20-44 years old; this is slightly lower than both the state and national rates of 65.6 and 68.3% respectively (3).

Table 13: Proportion of FTE AHP workforce by age groups, CESPHN, 2022

AHP	20-34 years (%)	35-44 Years (%)	45-54 Years (%)	55-64 Years (%)	65-74 Years (%)	75-99 Years (%)
Chinese medicine practitioners	8.09	14.80	27.02	30.46	16.70	2.93
Chiropractors	35.02	25.58	23.04	12.9	3.46	0.0
Dental practitioners	28.53	26.8	18.93	15.8	8.54	1.4
Medical radiation practitioners	49.00	25.69	12.51	9.29	3.22	0.28
Occupational therapists	56.46	23.37	12.67	6.26	1.23	0
Optometrists	36.85	22.71	17.73	14.54	8.17	0
Osteopaths	9.73	21.24	29.2	23.01	14.16	2.65
Paramedicine practitioners	50.86	22.99	17.82	7.61	0.72	0
Pharmacists	40.62	30.36	13.61	10.14	3.98	1.29
Physiotherapists	54.05	20.77	13.62	8.44	2.83	0.3
Podiatrists	47.76	21.79	14.74	12.18	3.53	0
Psychologists	22.04	28.74	24.41	14.40	8.03	2.38
Total	35.58	23.74	16.86	13.75	6.21	0.94

Source: HWD, 2024

Hours worked per week

In 2021, on average AHPs in Australia worked 32.9 total hours per week, in line with NSW where AHPs worked on average 32.1 total hours per week. Within the central and eastern Sydney region, AHPs worked, on average, 34.2 total hours per week (3).

In 2022, on average AHPs in Australia worked 32.3 clinical hours per week, slightly higher than NSW where AHPs worked on average 32.1 clinical hours per week (3).

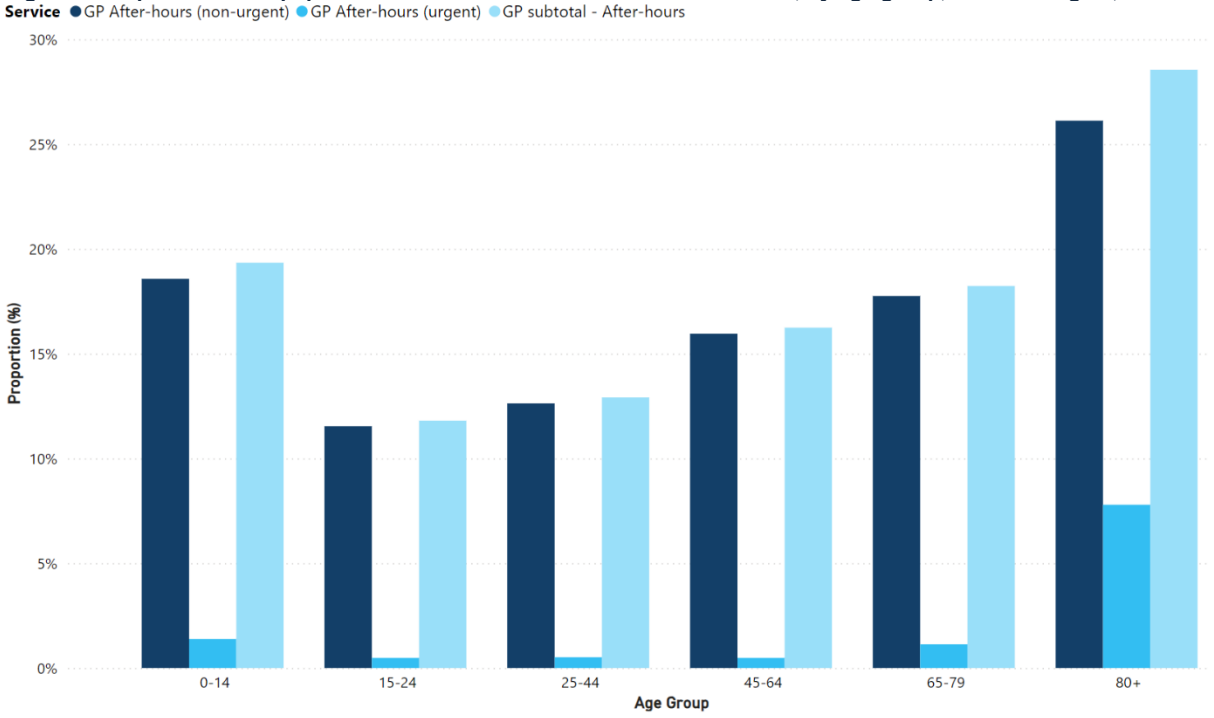
After Hours

After Hours GP services

In 2022-23, 244,484 people (15.2% of the population) in the CESPHN region received an after-hours GP service. People were more likely to receive a non-urgent after-hours GP service (14.7%) than an urgent after-hours GP service (1.0%). A higher proportion of females received an after-hours GP service than males (16.0% compared to 14.3%).

People aged 80 years and over were most likely to receive an after-hours GP service (28.5%) followed by 14 years and younger (19.3%) and then 65-79 years old (18.2%). In 2022-23, there were 495,486 after-hours GP services provided in the CESPHN region, equivalent to 31.8 services per 100 people. People aged 80+ years received the highest number of services per 100 people (12,010.62), followed by those aged 65-79 years (45.5 services per 100 people) (7).

Figure 5: Proportion of the population who received an after hours GP service, by age group, CESPHN region, 2022-23



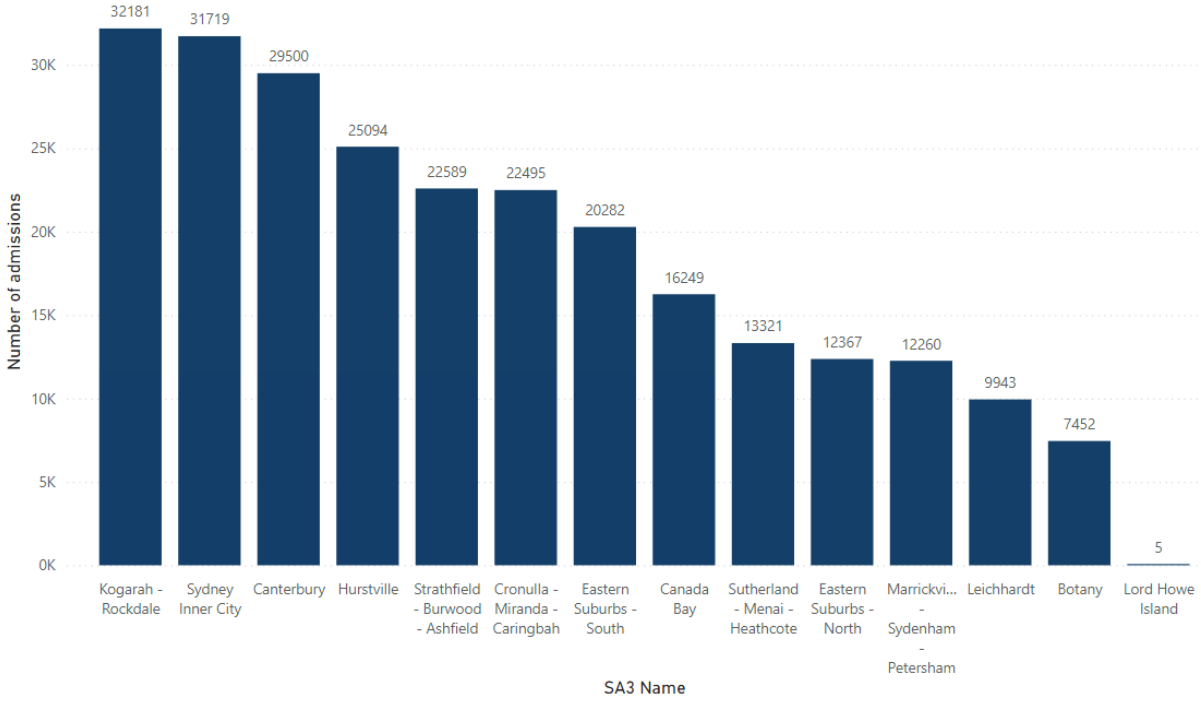
Source: AIHW, 2023

Emergency Department (ED) admissions

The Lumos program provides insights on the patient journey through the NSW health system by linking general practice and NSW Health data. Of the general practices in the region participating in Lumos the highest number of emergency department admissions between January 2023 and December 2023 is in the Sydney Inner City SA3 at 70,728, likely due to the presence of two major hospitals (Royal Prince Alfred Hospital and St Vincent's Hospital) within the region. This is followed by Kogarah – Rockdale (which contains St George Hospital) at 51,347 and Eastern Suburbs – South (which contains Prince of Wales Hospital) (8).

The highest number of ED admissions in 2023 were attributed to residents living in the Kogarah – Rockdale SA3, followed by the Sydney Inner City SA3 (8).

Figure 6: ED admissions by SA3 of patient residence, CESPHN region, 2023

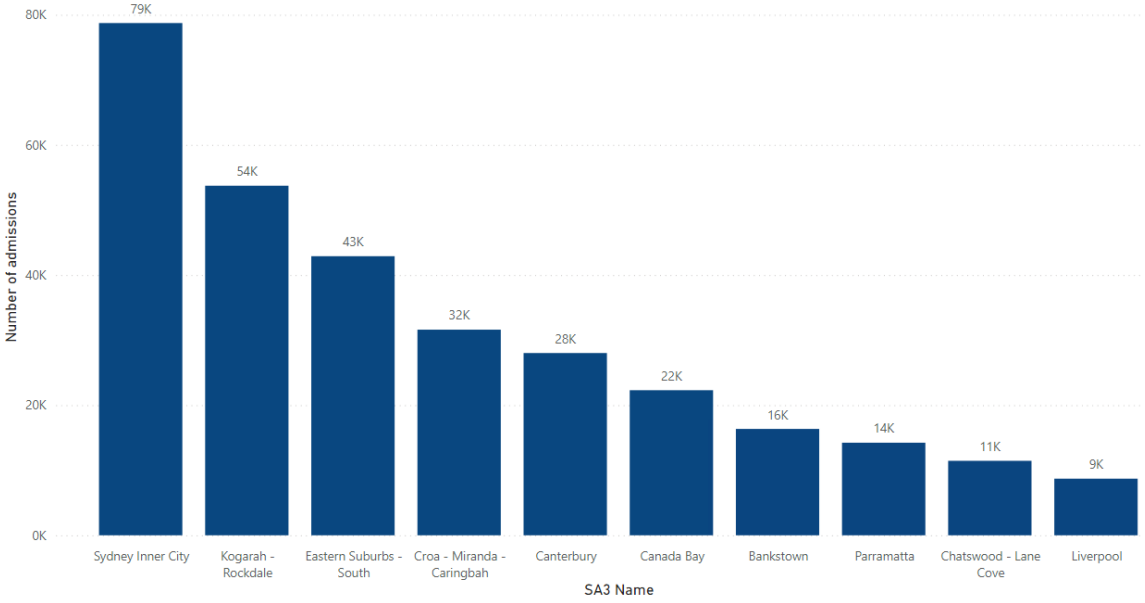


Source: Lumos, 2024

Admissions by SA3 broadly correlate with the region's population distribution. A notable exception is the Kogarah – Rockdale SA3 which, despite representing 9.4% of the region's population, had an ED admission rate of nearly 13% (8).

There were 16,347 patients in the Bankstown SA3 who had visited a participating practice and were admitted to a hospital in the central and eastern Sydney region in 2023. This is followed by the Parramatta and Chatswood – Lane Cove SA3s at 14,228 and 11,445, respectively (8).

Figure 7: Top 10 ED admission by facility SA3, 2023



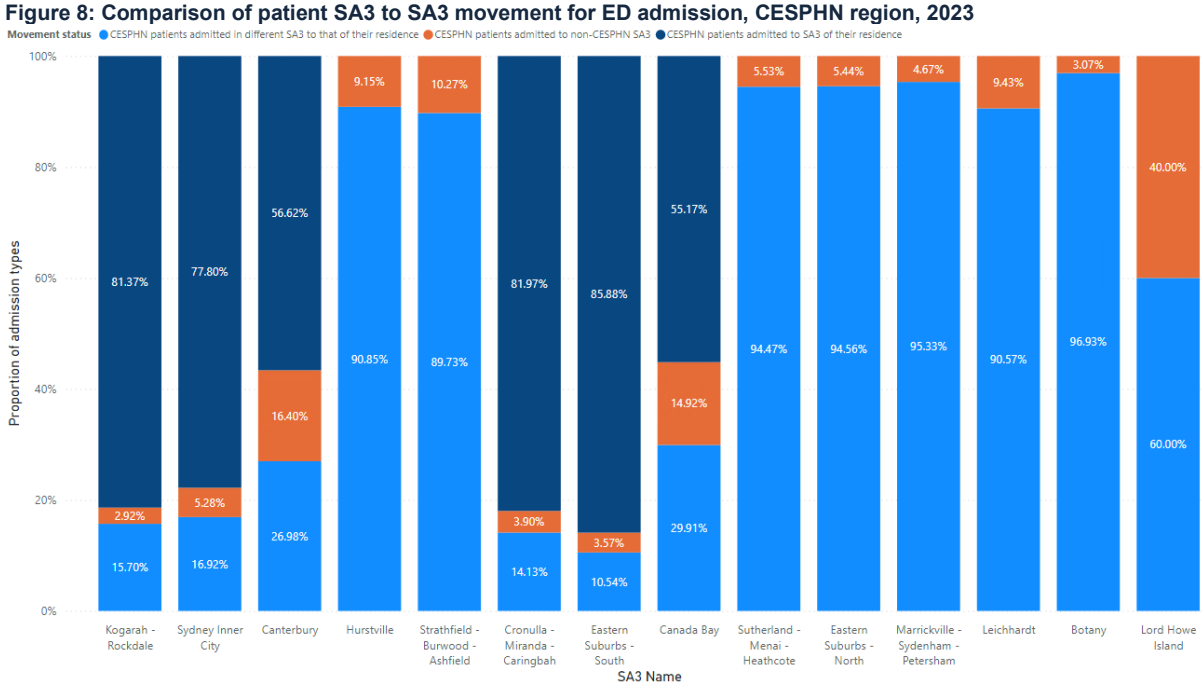
Source: Lumos, 2024

When comparing the SA3s where patients reside to the SA3s where they were admitted, it was found that most patients in the following SA3s were admitted within the same SA3 during the 2023 calendar year:

- Sydney Inner City
- Kogarah – Rockdale
- Canterbury
- Eastern Suburbs – South
- Canada Bay
- Cronulla – Miranda – Caringbah.

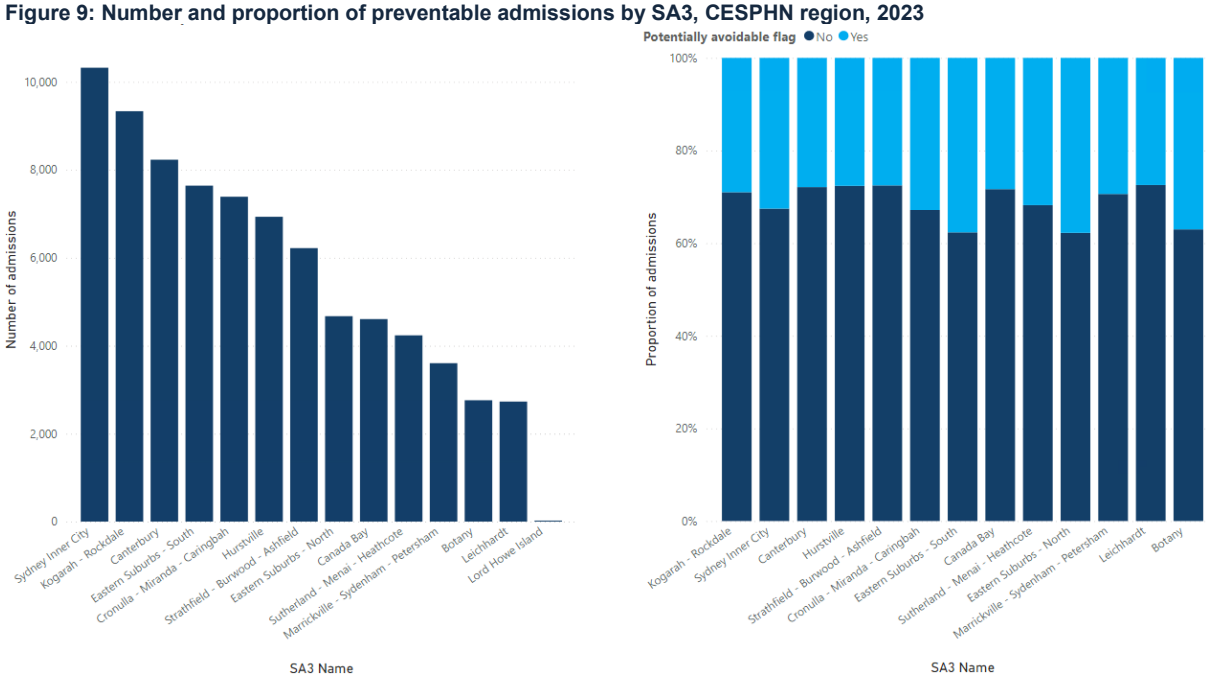
This can be attributed to each of the SA3s containing one or more major hospital. However, Canterbury and Canada Bay ranked relatively low, at 56.0% and 55.3% respectively, suggesting there may be opportunities to improve the local capacity of these areas (8).

Figure 8: Comparison of patient SA3 to SA3 movement for ED admission, CESPHN region, 2023



Source; Lumos, 2024LLOf the region's SA3s, Eastern Suburbs – North contains the highest percentage of preventable admissions as determined by the admitting hospital, at 37.8%. The Maroubra UCC is well positioned to reduce the burden of the local hospital by addressing the needs of patients who would otherwise present to the ED (8).

Figure 9: Number and proportion of preventable admissions by SA3, CESPHN region, 2023



Source: Lumos 2024

Urgent Care Clinics

NSW Health and the Commonwealth Department of Health and Aged Care have funded CESPHN to commission urgent care clinics (UCC) /services across the region, increasing access to primary care and easing the demand for emergency services (ED). UCC clinics include doctors, nurses, and other specialists who provide non-urgent care across extended hours. UCCs provide bulk-billed services, making them affordable and accessible for people who face financial barriers to accessing health care and would otherwise present to ED.

As of September 2024, there are five UCC facilities in the CESPHN region. These are located in:

- Belmore
- Caringbah
- Carlton
- Green Square, and
- Maroubra

As of November 2024, the five clinics are seeing approximately 1,000 patients per week in total with the number of presentations the highest on weekends and Mondays. The busiest times at the clinics are in the mornings (8am-11am) and evenings (4pm-7pm). Highest usage of urgent care is among children aged 0-14 years, with approximately 30% of presentations.

Dental care

In 2021-22, per capita spending on dental services in Australia amounted to $432 (9). NSW Health provides safety net dental services for eligible NSW residents. Public dental clinics are usually located in public hospitals and community health centres. All children (0-18 years of age) who are NSW residents are eligible for public dental services in NSW. Adult NSW residents must be eligible for Medicare and be listed on one of the following Australian Government concession cards: Health Care Card, Pensioner Concession Card, Commonwealth Seniors Health Card.

Access to affordable dental care was a need highlighted in the consultations. When assessing the LHD where the service was provided and excluding patients waiting for specialist dental services, as at June 2024 there were 9,669 adults waiting for public dental assessments and treatment in Local Health Districts (LHDs) within the CESPHN region, an increase of 17.8% over the 24 months prior. In South Eastern Sydney LHD there were 3,372 adults awaiting assessment or treatment and in Sydney LHD there were 6,297 (10).

Affordability is a key issue impacting access to dental care with care delayed. Access to dental care is even more difficult for people that live in aged care facilities or are homeless.

Issues impacting access

Aging GP workforce

The central and eastern Sydney region has an older GP workforce than the NSW or Australian average. In a survey conducted in 2022 of all GPs who visited RACFs in central and eastern Sydney, 50% stated they intend on either decreasing or stopping their visits to RACFs in the next two years. New initiatives to attract GPs to visit aged care facilities may not be enough to encourage GP attendance and new GPs are increasingly unlikely to visit aged care facilities because of the low remuneration, lack of IT interoperability and the increased administration.

Changing work arrangements for GPs

The working arrangements of GPs have evolved over time, The number of GPs working part-time compared with the conventional full-time schedule has significantly increased. After a steady FTE ratio of 0.7 between 2018 and 2022, the average FTE per GP dropped to 0.6 in 2023 (6). This could be attributed to several factors. As GPs near retirement, they also transition to part time. It is critical that we work to maintain GP participation and that includes supporting those working part time.

Utilisation of practice nurses

Utilisation of primary care nurses in the region has been limited by traditional perception of the role and the MBS item system, as items need to be billed under GPs. Furthermore, remuneration is generally less attractive when compared with nursing in secondary care. Additional aspects identified in the forementioned Practice Nurse Strategy 2024-2027 include the need for leadership in general practice to drive quality improvement, and more opportunities are needed to support career progress.

Effective use of primary care nurses could work to address workforce shortages in primary care. This could involve allowing the role to take on more responsibilities and provide more high-quality care. This could be most impactful in areas of chronic disease management and education. Additionally, utilising nurses could reduce costs for patients accessing primary care and provide better professional opportunities and career opportunities for nurses. The Central and Eastern Sydney region is well positioned for this as the number of nurses in primary and community settings is increasing year by year.

Low practice accreditation rate

The low practice accreditation rate (69.5% of general practices within the central and eastern Sydney region when compared with the metropolitan average of 78% in 2020-21) is attributed to multiple factors, including large numbers of solo practices. The introduction of MyMedicare, which aims to improve the relationship between patient and practice, and the General Practice Aged Care Incentive (GPACI) could offer additional reasons for practices to register.

Increasing out of pocket GP consultation costs

The increasing out of pocket cost of GP consultations, combined with the reducing number of practices that offer bulk billing, imposes financial strain on residents in the Central and Eastern Sydney region and may result in patients not receiving timely care. This issue was raised as a major health concern in every consultation held as part of the development of this needs assessment. The increase in out-of-pocket expenses is disproportionate across the region.

CESPHN's current work

- CESPHN commissions five urgent care services in our region. (Maroubra, Carlton, Caringbah, Green Square and Belmore). Urgent care services enable people to receive GP led care for urgent but nonlife threatening conditions and support nearby hospital emergency departments.
- MyMedicare and GP Aged Care Incentive (GPACI): supporting general practices and providers to register for MyMedicare and GPACI. CESPHN will offer ongoing support to non-accredited general practices to achieve accreditation so they can participate in MyMedicare and GPACI.
- CESPHN supports general practices with quality improvement (QI) activities in line with the requirements of the PIP QI incentive and to promote a team approach to QI in general practice.
- The General Practice Workforce Planning and Prioritisation (WPP) Program provides independent, evidence-based advice to inform the geographic distribution and placement of GP Registrars to meet the community's current and future GP workforce needs. This program is led by ACT PHN (Capital Health Network), the ACT/NSW WPP Consortium consists of the ACT and NSW PHNs. Consultation with CESPHN stakeholders, workforce, population and environmental data contributes to this program.
- CESPHN has developed general practice, digital health, practice nurse and allied health strategies to drive the support it provides to health professionals in the region.

Opportunities

- The changes to Medicare Benefits Schedule items for chronic disease management in July 2025 could also help strengthen the practice nurse role.
- Supporting the primary care workforce to manage their self-care and their connections to colleagues and other health professionals
- Develop innovative primary care workforce models
- Incentivise retention and recruitment
- Optimise nurse roles and career progression
- Promote virtual care services
- Exploring artificial intelligence systems that are being tailored to general practice to optimise efficiency and patient care
- Enable all primary care professionals to work at full scope of practice.

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phn
CENTRAL AND
EASTERN SYDNEY

An Australian Government Initiative

COORDINATED CARE

2025-2027 Needs Assessment

Table of contents

List of tables

Overview

Summary

Coordinated care focuses on ensuring seamless and integrated healthcare services across various providers and stages of care. This approach emphasises the importance of maintaining consistent and coherent care over time, which is particularly crucial for patients with chronic conditions or complex health needs.

Key issues

- Low health literacy and lack of coordinated care between systems, particularly among vulnerable and priority groups including:
  - Veterans
  - People leaving the criminal justice system
  - People living with a disability
  - People experiencing family and domestic violence
  - Older people.
- Workforce scopes of practice and provider issues with identifying appropriate services and connecting with other providers due to lack of system interoperability
- The NSW Health implementation and rollout of the Single Digital Patient Record across NSW over the next five years
  - Though this has the potential to improve communications between general practice, acute and virtual care services.

Key gaps

- More effective communication and information sharing among healthcare providers, including system interoperability that enables continuity of care across primary, secondary and tertiary care
- Increased multidisciplinary teamwork
- Increased patient-centred care that respects individual preferences and needs
- Utilisation of My Health Record.

Service navigation

Community and stakeholder consultations identified the following key issues impacting the ability to navigate health services in the CESPHN region:

- Low health literacy
- Provider and consumer challenges with identifying and navigating services.

Health literacy

Low health literacy is associated with a range of factors including poorer health outcomes, limited engagement with the healthcare sector, limited ability to navigate the healthcare system, limited knowledge, and uptake of preventive actions, as well as impaired self-management and increased use of emergency care, hospitalisations, and mortality rates. The combination of low health literacy

and complex health needs amplify the difficulties patients experience when navigating a fragmented health care system.

In the 2018 Health Literacy Survey, only 41% of adult Australians had a level of literacy that would allow them to meet their complex health needs. The survey also indicated that health literacy was lower in those who speak English as a second language (21%), highlighting the requirement for health-related information to be available in languages other than English.

CESPHN has commissioned a Multicultural Health Navigator Service to assist people within the region with limited or no English proficiency who speak Mandarin, Cantonese, Arabic, Korean or Nepali to navigate health and related services. The service is due to commence in early 2025. More broadly as part of our Multicultural Health Plan we are working with primary care providers and our commissioned providers to ensure their services are responsive to cultural issues.

Further education for consumers around when to go to the GP, pharmacy or Emergency Department is required.

Tools to support service navigation and referrals

Identification and navigation of services most appropriate to a patient's needs is a challenge for providers, particularly when their patients have complex health needs. CESPHN, SLHD, SESLHD and SVHN jointly fund HealthPathways, an online health information portal to support local GPs and health professionals. It provides clinical decision support frameworks on how to assess and manage medical conditions and how to appropriately refer patients to local services and specialists.

CESPHN has also developed a health and community services directory and a mental health services directory to assist people and providers find services within the region. Headstart is a mental health service directory aimed at helping community members find mental health support.

Nationally Healthdirect operate a website and phone line that provides 24-hour health advice. The website includes information on individual general practice, pharmacy and allied health services. People calling the phone line are directed to the most appropriate health service for their condition. Community awareness of this service is still relatively low and greater promotion would be beneficial.

Eight NSW PHNs are co-funding a Medicare Mental Health Phone Line whose aim is to direct people to the right mental health services and support and avoid people having to re-tell their story multiple times. The phone line provides 24 hour support.

Specific care coordination challenges

We have identified a range of groups within the CESPHN population who would benefit from improved care coordination. These include veterans, people exiting the justice system, people with a disability and people experiencing family and domestic violence.

Veterans

In a collectivist culture, service members are taught to prioritise service above their own needs. This can lead to issues in accessing health and mental health support, such as feelings of shame, worry about letting the team down, and a sense of loss upon discharge. There is significant underreporting among members; the 2020-2022 National Study of Mental Health Wellbeing found that veterans were less likely to have reported a mental health disorder in the previous 12 months when compared with

non-veterans, at 17% and 22%, respectively. PTSD is often underreported, minimised, or not coded appropriately, and there are high levels of suicide ideation among veterans (1). According to the 2021 Census, a total of 152,170 individuals have served or are serving in New South Wales of which 18,007 are currently serving in the regular service and 6,506 are currently serving in the reserves service (2).

Primary care providers often struggle to support veterans because they do not have access to medical histories from within the military. Although veterans are given their medical history and a handover letter, they do not always share these with primary care providers. Serving members or veterans might not link their service history to their medical presentations, but if clinicians ask, it can lead to better understanding and potentially more entitlements to health checks and other benefits. A new system is being developed to link military medical history with civilian history, which should be released soon.

People leaving the criminal justice system

NSW has the largest prisoner population with 12,897 adults and 209 juveniles in custody as of September 2024, 12-month increases of 5.1% and 6.1% respectively (3). There is an overrepresentation of Aboriginal persons (31.3% of adults and 50% of juveniles in custody) (4).

The prisoner population is fluid with people constantly entering and being released from the system. This constant movement means that the health issues of people in custody become the health issues of the community. Over the 12-month period to September 2024, 1,388 adults and 16 juveniles in NSW were discharged due to their sentence expiring (3). By December 2023, 43.6% of adults and 73.6% of juveniles who were released from sentenced custody had reoffended within 12 months of discharge (5).

Although the Justice Health and Forensic Mental Health Network has implemented several projects aiming to better support people when they leave prison, such as reminders to collect their medications and health summaries, these projects can be challenging due to the ad-hoc nature and constant movement of people. For example, a large number of prison departures may not be planned. The Single Digital Patient Record (SDPR) system may overcome some of these issues however this is also dependent on the capability of SDPR to integrate with primary care systems.

Mental health and alcohol and other drug support services are delivered through Community Corrections, a division within Corrective Services NSW that manages and supervises offenders sentenced to various types of community-based orders by the courts or released from prison on parole to complete the remainder of their sentence in the community. Often these are people with very complex needs that often end up sleeping rough and experiencing recidivism.

People living with a disability

There are approximately 180,000 people living with a disability in the CESPHN region. There is a need for improved coordination between primary care and disability services and multidisciplinary, integrated models of care. AIHW data indicates that 26.4% of people with a severe or profound disability who saw 3 or more health professionals for the same condition felt the health professional did not help coordinate care. CESPHN hosts a Disability Network that includes a broad range of stakeholders including people with a lived experience, disability providers and primary care providers. This group provides an opportunity to strengthen coordination. CESPHN also delivers training to primary care providers on how to best support people with an intellectual disability and the importance of working together with the person's Disability Support Team.

People experiencing family and domestic violence

Primary care has a role in recognising domestic and family violence (DFV) and providing trauma informed and culturally safe care to victims. There is a need for a more coordinated approach between primary care and domestic violence support services as well as increased training and support provided to primary care services to respond better to DFV. Navigating the DFV service sector to seek support for a patient can be challenging and CESPHN has established DFV Assist to provide a navigation service for health professionals to better support their patients experiencing DFV.

Older people

As people age their care typically becomes more complex and reliant on a range of service providers including community aged care, residential aged care, primary care and acute care. It is currently very difficult to share information between these various providers creating delays and inefficiencies in the system. CESPHN has provided telehealth equipment to residential aged care homes to enable telehealth consultations with their GPs and other health care providers. Further work needs to occur to better integrate community aged care providers.

Joint planning

Joint planning between primary health networks, local health districts, and other consumer and provider organisations can assist to improve care coordination.

CESPHN participates in numerous partnership committees with the local health districts and speciality health networks in our region that cover mental health, alcohol and other drugs, disability, sexual health and viral hepatitis, diabetes and aged care.

There are a number of regional plans that have been developed with partners including the Joint Regional Mental Health and Suicide Prevention Plan, the Intersectoral Homelessness Health Strategy and the Inner West Child Health and Wellbeing Plan.

Digital health and interoperability

The COVID-19 pandemic accelerated the rollout of technologies that streamline the flow of relevant patient information between service providers, however ensuring the consistent and meaningful use of these tools is a continuing challenge for the region. Consultations with GPs, allied health professionals, hospitals and local health districts demonstrated that the use of digital health technologies by clinicians and services were related to the level of digital health maturity within each setting, as well as the interoperability between digital health systems across service providers and between acute and primary care.

NSW Health has commenced rolling out the Single Digital Patient Record (SDPR) program across the state and this system has the capacity to share data between providers as well as with patients. Primary health networks are advocating strongly for the involvement of primary care in the design of the SDPR and especially the portal between general practice and acute care.

Between 2023 and 2024, the number of computerised general practices increased from 90.1% to 96.8%. My Health Record uptake remained stable at 85.7% of general practices, while the number of practices registered for secure messaging increased from 89.3% to 94.5% (6).

Table 1: Digital health initiatives in the CESPHN region, as at September 2024

Digital health initiatives	No. of general practices 2023	No. of general practices 2024	% of computerised practices 2023	% of computerised practices 2024	% of general practices 2023	% of general practices 2024
Computerised practices (clinical software)	523	545	100.0	100.0	90.1	96.8
Registered to access MyHR	484	484	92.5	88.8	83.9	85.7
Use secure messaging solution	515	532	98.5	97.6	89.3	94.5

Source: CESPHN CRM database, 2024

*** % of computerised practices value is against the aggregate number of computerised practices*

My Health Record

Meaningful use of My Health Record (MyHR) can improve health outcomes by supporting the sharing of patient information between providers across the health system, which can reduce duplication of services, lessen medication errors and increase patient participation in their care. As organisations decommission faxes, MyHR offers a suitable enhancement for the transfer of patient data. MyHR statistics generally demonstrate increases in views and uploads by various health care services in the CESPHN region, largely propelled by software vendors continuing to integrate MyHR functionality. As of September 2024, 438 out of 453 pharmacies were MyHR registered (6).

Despite the high rate of general practice MyHR registration in the CESPHN region, uptake has slowed and few practices upload at least one summary per week indicating that more work is required to integrate MyHR into daily practice activity. As the upload of shared health summaries is one of the requirements of the Practice Incentive Program eHealth Incentive (ePIP), with the required number being a proportion of the practice's standard whole patient equivalent (SWPE), uploads are often performed to meet the requirement rather than utilise the MyHR system for its intended purpose. As such, the viewing and uploading of documents that are not associated with incentives demonstrates legitimate use of the system.

From an allied health perspective, technology integration with MyHR is poor. Most platforms used by allied health are not able to integrate with MyHR, and the National Provider Portal only facilitates viewing and downloading, not uploading. To date, 600 allied health practices are registered in our region.

Secure messaging

Secure messaging is a core capability for safe, seamless, secure, and confidential provider-to-provider communication, enabling electronic access to patient information. It has not reached its potential in terms of application, however the introduction of online solutions such as the MyHealthLink Portal has helped increase uptake by providers that would otherwise be ineligible due to their software configuration. Furthermore, the industry-wide push for interoperability is continuing to increase the efficiency of secure messaging, particularly between general practices using differing platforms. The need for improved access to patient information from hospitals is continually raised by GPs. The rollout of the Single Digital Patient Record (SDPR) in NSW presents an opportunity to address this long-running issue. Until more permanent solutions are implemented CESPHN continues to work closely with the local health districts and specialty health networks to resolve specific problems.

Smart forms and eReferrals

Smart Forms and eReferrals allow for documents to be pre-filled with clinical data and transmitted point-to-point. As with secure messaging, the promotion of technologies that facilitate the efficient transfer of information between service providers has resulted in a significant increase in the number of providers configured to send Smart Forms and eReferrals. However, medical specialist practice adoption remains low, which can be attributed to ongoing interoperability issues and the high cost of secure messaging services, which limits secure messaging to those who are both able to afford the service and have the digital health maturity to use it. The recent acquisition of Argus by Healthlink will help with increasing adoption by medical specialist practices.

As of June 2024, 510 general practices and 424 medical specialist practices were configured to send Smart Forms and eReferrals. Between July 2023 to June 2024, 129,327 eReferrals were sent in the CESPHN region and 78,162 specialist letters were uploaded to MyHR.

Electronic prescribing

Electronic prescribing provides an option for prescribers and their patients to use an electronic Pharmaceutical Benefits Scheme (PBS) prescription in place of a paper prescription and is delivered via a prescription exchange service. As of September 2024, 96.1% of pharmacies were able to dispense electronic prescriptions and 86.8% of computerised general practices were able to issue electronic prescriptions.

Table 2 Electronic prescribing capable practices in the CESPHN region, September 2024

Type	No. of practices
General practice	373
Pharmacy	424

Source: CESPHN CRM database, 2024

Shared Care

CESPHN and the local health districts are working together on a ranged of shared care initiatives to ensure coordinated care for people requiring complex care. These initiatives exist in mental health, antenatal care, cancer care and alcohol and other drugs. Having an electronic shared health care plan would further streamline the delivery of shared care but this has proven problematic given system interoperability issues.

MyMedicare

MyMedicare is a voluntary patient registration model that provides incentives for both general practices and patients when patients register with a particular practice. This link between patients and their preferred general practice has the possibility to lead to greater continuity of care. Currently, this is for telehealth items only, but the Department of Health and Aged Care plans to expand to chronic disease manage management that can only be conducted at their registered GP in 2025. As of December 2024, 362 general practices in the central and eastern Sydney region have enrolled in the MyMedicare program.

Disaster management

Primary care needs to be better integrated in disaster management plans. CESPHN is establishing a Primary Care Emergency Response Team to ensure continuity of access to primary care when there is a disaster or critical incident and to support the emergency response by addressing immediate health needs in a disaster situation or an unexpected event. The team will include GPs, practice

nurses, pharmacists and mental health professionals. Once the team is established, we will look to integrate further with local councils and other key stakeholders.

The types of events that may require an emergency response could include:

- Natural events – bushfires, heatwaves, severe storms, flooding, earthquake
- Public safety threats and major transport accidents
- Hazardous materials accidents
- Major public health threats.

Key issues for the Central and Eastern Sydney region

Improving care coordination for specific population groups

Groups most impacted by lack of coordinated care include veterans, people leaving the criminal justice system, people living with a disability, people experiencing family and domestic violence and older people. Further work needs to occur with partners to improve care for these groups of people.

Uptake of My Health Record

While a large number of general practices in the region are registered for My Health Record, allied health and medical specialist organisations are lagging due to incompatible vendor software. General practice uploads of data to My Health Record are low. Furthermore, patient awareness has not been a key focus since the end of the opt-out period for My Health Record registration in January 2019.

Need for more connection between general practice and allied health

There is a need to provide a more holistic approach to care that acknowledges the connection to mental and physical health and the impact of social determinants that affect people's health. For this to occur, there needs to be a continued focus on designing models of service delivery where GP services work closely with allied health, either via outreach models, co-location, or joint care plans. There are small scale pilots being undertaken by CESPHN attempting to offer models for multidisciplinary team care.

Central and Eastern Sydney PHN has an Allied Health Engagement Strategy that focuses on increasing participation of allied health professionals through various avenues, including an allied health network providing professional connections and training, promoting the adoption of digital health tools so that there is consistency between allied health professionals and with primary care, supporting with quality improvement activities and creating professional development and recognition pathways.

Need for improved information sharing between primary and acute care

Improving system integration between primary and acute care provides many advantages for continuity of care, including more effective and efficient treatment in the hospital setting and, in turn, a reduction in preventable hospitalisations. Health system interoperability is the key to addressing this issue.

Supporting care transition across the lifecycle

As people transition through life they receive support from different care providers. There is an opportunity to improve this transition process such as when a child receiving care through local paediatric services over many years becomes an adult and has to receive care under different protocols and by different providers. Similarly, the care needs of someone aged 20-65 is likely to be

very different to that of older people aged in their 70s requiring aged care support. Patient education and improving health literacy and working with service providers will help facilitate this transition.

Opportunities

- Continued focus on improving usage of digital tools among general practices
- Ensure follow up and handover of care to a GP for people leaving justice system
- Improved identification and support of veterans in primary care
- Continued focus on supporting better integration of primary care with disability services
- Work to facilitate improved care coordination between primary care and community aged care
- Implementation of a centralised mental health intake and assessment model to combine intake, assessment, and referral services
- Over the next four years, CESPHN will commission the GP+ program. This program will support smaller general practices to connect to local allied health providers, improve health outcomes through a multidisciplinary approach and enhance patient experiences in primary care
- Consumer education on digital solutions and how to navigate the health system
- Promotion of service directories and Healthdirect
- Incentivise allied health and specialist adoption of My Health Record
- Re-engage general practices on the My Health Record, providing them with updates on new features
- Facilitate communication between GPs and acute care via access to Single Digital Patient Record and an electronic shared care plan
- Improved engagement of primary care in disaster management.
- Supporting care transitions across the lifecycle.

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