Care Finder Supplementary Needs Assessment

NORTHERN TERRITORY PHN

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An Australian Government Initiative

RURAL Workforce AGENCY NT

Document Details

Document Name	NT PHN Care Finder Supplementary Needs Assessment
Document ID	
Authority	
Responsible Role	

Instructions

Background

Prior to the initial commissioning of care finder services, the PHN must undertake additional activities, to supplement its existing Needs Assessment, to identify local needs in relation to care finder support.

These additional activities will provide the evidence base for the PHN's initial commissioning approach to care finder services and will therefore determine the services that the PHN will commission alongside the existing Assistance with Care and Housing (ACH) providers who will be offered a contract as care finders.

Purpose

The Once-off Report on Supplementary Needs Assessment Activities will:

- provide information on the additional activities undertaken by the PHN to identify local needs in relation to care finder support
- set out the evidence base for the PHN's initial commissioning approach to care finder services
- be a stand-alone update to the PHN's existing Needs Assessment
- inform development of the PHN's amended Activity Work Plan due by 31 August 2022.

Following the Once-off Report on Supplementary Needs Assessment Activities, the PHN will report on the outcomes of needs assessment activities relevant to the care finder program as part of its annual updated Needs Assessment.

Guidance

This template includes guidance to support the PHN in undertaking the additional activities to identify local needs in relation to care finder support. This guidance should be read in conjunction with, and is intended to complement, the guidance provided in the PHN Program Needs Assessment Policy Guide.

Submission requirements

The PHN must provide the information required in each section of this template. Limited supplementary information may be provided in attachments, but the PHN must not use attachments as a substitute for providing the information required in each section of this template.

The PHN must submit its completed template electronically, in the format of Microsoft Word 2003 or above, to the relevant state/territory PHN Program Manager mailbox and cc carefinders@health.gov.au. The instructions and guidance in this template (marked in italics) should be deleted prior to submission.

Reporting period

The Once-Off Report on Supplementary Needs Assessment Activities will set out the evidence base for the PHN's initial commissioning approach to care finder services and will therefore address the three-year period from 1 July 2022 to 30 June 2025.

The PHN will review and, where relevant, update the information in this Report as part of its annual updated Needs Assessment.

Public reporting

At a minimum, the PHN is required to make Section 2 of the Once-off Report on Supplementary Needs Assessment Activities publicly available on its website.

Contents

Acronyms

ACH	Assistance with Care and Housing
ACSN	Aged Care System Navigator
CALD	Culturally and Linguistically Diverse
CHSP	Commonwealth Home Support Program
COTA NT	Council on the Aging NT
FECCA	Federation of Ethnic Communities' Council Australia
MAC	My Aged Care
MCNT	Multicultural Council of the Northern Territory
NT	Northern Territory
NT PHN	Northern Territory Primary Health Network
PICAC	Partners in Culturally Appropriate Care
TIF	Trusted Indigenous Facilitators

1. Narrative

1.1. Actions to determine additional activities

In developing our approach to the Care Finders Needs Assessment, NT PHN:

- Participated in COTA Australia co–design and COTA Australia ACERT meetings.
- Joined with Queensland PHNs in a working group to collaborate and share information.
- Collaborated with North Queensland PHN to discuss methods of approaches to stakeholder and community consultations.
- Reviewed key documents including the funding schedule, policy guideline, questions and answers, ACHA fact sheets etc.
- Reviewed existing NT PHN data, including the Program Needs Assessment 2019 to identify information relevant to local needs in relation to care finder support.
- Identified where further information was required.
- Developed a brief describing the background, purpose, scope, audience, outcomes, activities, partners and informants and governance for the needs assessment activity.
- Used internal and external informants including NT PHN's Clinical and Community Advisory Councils to inform our needs assessment plan, and to identify relevant stakeholders for engagement in the needs assessment process.

1.2. Additional activities undertaken

Additional activities undertaken:

- Analysed data to build an understanding of the profile and needs of the local population in relation to care finder support.
- Conducted 40 interviews, with 31 held face to face, and nine online or via telephone.
- Followed up with all interviewees to provide a copy of meeting notes recorded to ensure accuracy and opinions reflected were true and approved for inclusion in this report, including six unique case studies.
- Analysed information to build an understanding of the local service landscape including who was falling the cracks as well as geographic gaps in service.

1.2.1 Data analysis undertaken to understand the profile and needs of the local population in relation to care finder support

Data was analysed to understand:

- Population and population distribution.
- Population ageing in the NT.
- The profile and needs of groups within the NT who have special needs and who may have a higher need for Care Finder services including those who are:
    - experiencing Homelessness
    - Aboriginal and Torres Strait Islander people
    - from a culturally and linguistically diverse background
    - gender diverse
    - living in rural and remote locations
    - experiencing socio-economic disadvantage.

Sources included:

- AIHW. (2018). *Australia's Health 2018 In Brief*. https://www.aihw.gov.au/reports/australias-health/australias-health-2018-in-brief/contents/all-is-not-equal
- AIHW. (2020). *Australian Institute of Health and Welfare 2020 Aboriginal and Torres Strait Islander Health Performance Framework 2020 key health indicators - Northern Territory.* https://indigenoushpf.gov.au/getattachment/1c21c8f3-b754-42a5-b595-f07987e64735/2020-nt-aihw-ihpf-5.pdf
- AIHW. (2021). *Homelessness and Homelessness Services*.
- AIHW. (2022a). *Indigenous Health and Wellbeing*. https://www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing
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- Bourke S, et al (2018). Evidence review of Indigenous culture for health and wellbeing. *International Journal of Health, Wellness & Society*. https://cgscholar.com/bookstore/works/evidence-review-of-indigenous-culture-for-health-and-wellbeing
- Commission P. (2018). *Report on Government Services 2018: part f, chapter 14, aged care services attachment tables*. https://www.gen-agedcaredata.gov.au/resources/reports-and-publications/2018/january/report-on-government-services-2018-part-f,-chapter
- Health inequity in the Northern Territory, Australia, Zhao, Y., You, J., Wright, J. et al. International Journal Equity Health 12, 79 (2013). https://equityhealthj.biomedcentral.com/articles/10.1186/1475-9276-12-79#citeas
- Li SQ, et al (2014). Dementia prevalence and incidence among the Indigenous and non-Indigenous populations of the Northern Territory. *The Medical Journal of Australia*, *200*(8), 465–469. https://www.mja.com.au/journal/2014/200/8/dementia-prevalence-and-incidence-among-indigenous-and-non-indigenous
- National Commissioner for Defence and veteran Suicide Prevention. (2021). *Summary of round table with Northern Territory government agencies*.
- Northern Territory Government Department of Treasury and Finance. (2022, March). Northern Territory Economy. https://nteconomy.nt.gov.au/population
- Northern Territory Government. (2020a). *Homelessness in the Northern Territory.*
- NT Shelter. (2022). *NT Shelter.* ntshelter.org.au
- NTPHN. (2018). *LGBTQI Needs Assessment: Transgender Health and Service Needs*.
- People's care needs in aged care, Australian Institute of Health and Welfare 2022 https://www.gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care
- Quilty S, W. L. and G. A., & School of Population and Global Health, T. U. of W. A. P. W. A. (2019). *Katherine Individual Support Program First Evaluation Report*.
- Wood L, T. J. G. A. (2021). *Health Justice Partnership Project First Evaluation Report*.

1.2.2 Stakeholder and community consultations undertaken to identify local needs in relation to care finder support

NT PHN conducted an extensive consultation process to identify the local needs in relation to care finder support including engagement with the lived experience. The Needs Assessment included 40

interviews, with 31 held face to face, and nine held online or via telephone. See Attachment 1 for a full list of interviews conducted.

Through these interviews, NT PHN has developed a unique insight to identifying:

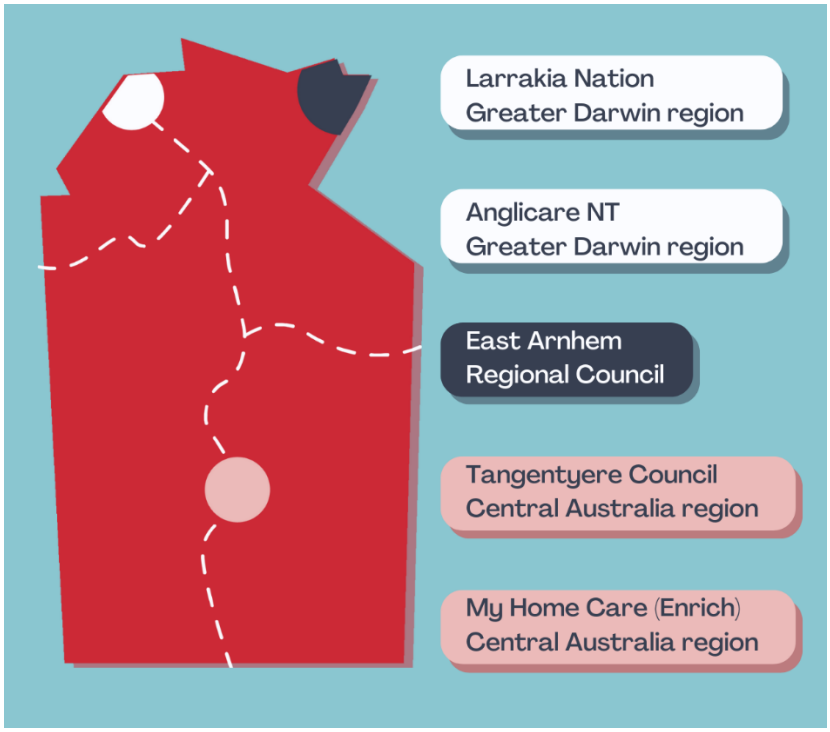
- Effectiveness of current service delivery models.
- Barriers to accessing services.
- Challenge of determining the difference between 'access to services' and 'availability of services to access.'

1.2.3 Analysis undertaken to understand the local service landscape as relevant to care finder support

The needs assessment included interviews with the existing Assistance with Care and Housing and Aged Care System Navigator providers in the NT. These interviews identified current scope and models of service delivery and future capacity and intent.

Each of the Assistance with Care and Housing providers have a specific geographical reach.

Figure 1 Assistance with Care and Housing Providers, consultations 2022



- Anglicare NT: Greater Katherine region, Rockhole, Binjari, Airport, Kalano (office in Katherine) and Greater Darwin (office in Darwin)
- East Arnhem Council services nine remote communities of Arnhem Land: Milingimbi, Ramingining, Galiwin'ku, Gapuwiyak, Yirrkala, Gunyangara, Umbakumba, Angurugu and Milyakburra. Five of the nine communities are islands.

- Enrich Living: Alice Springs central, up to 16 km out of town. Do not outreach to town camps due to safety concerns.
- Larrakia Nation: Greater Darwin. Larrakia country runs from Cox Peninsula in the west to Gunn Point in the north, Adelaide River in the east and down to the Manton Dam area southwards.
- Tangentyere Council: Urban Alice Springs (80km east and west of Alice Springs) incudes Alice Springs town camp (16 town camps each with a President).

Detailed service profiles of the existing Assistance with Care and Housing providers and the Aged Care System Navigator sites are compiled and provided in Attachment 2 - Service Profiles.

There are two organisations that are delivering existing Aged Care System Navigation programs in the NT:

Greater Darwin Region

1.3. Processes for synthesis, triangulation, and prioritisation

Issues and needs arising from the data and identified through community, professional and stakeholder consultations has been summarised into consistent themes. Triangulation has been used to verify the issues identified through community and stakeholder consultations with the findings of the analyses of data and service utilisation patterns.

Where possible, needs have been validated through feedback processes, and multiple sources of normative, felt, expressed, and comparative need were considered. Significant volumes of data have been sourced and reviewed to establish breadth of knowledge from key informants.

Prioritisation required balancing the challenging considerations of:

- Need and demand
- Equity and equality
- Financial viability
- Key principles of the Care Finder program

This balancing has been particularly challenging given the criticality of both the face to face requirement of a service of this nature, and the viability issues of delivering services to small population across more than 1.2 million square kilometres. In addition is the complexity of meeting the unique requirements of sub-groups with the small number of people in these groups and the associated challenges with economies of scale.

1.4. Issues encountered and reflections/lessons learned

1.4.1 Data issues

Whilst NT PHN had access to data, it is difficult to attain data which accurately reflects the invisible homeless, and diverse and vulnerable groups throughout their aged care journey.

SEIFA data only available from 2016 for the NT.

Participants noted there are data gaps concerning the extent of the veteran community in the NT, and that many who do not identify through the Department of Veteran's Affairs (DVA) system remain quietly in the community.

1.4.2 Additional issues and lessons learned/reflections

The NT is characterised by a small population dispersed across a large geographical area. Services are very limited, and the needs assessment found that discussion around access to services was consistently overshadowed by reports of a lack of services to access.

Stakeholders unfailingly reported that should a Care Finder service be commissioned to support people to access services, their capacity to deliver would continue to be impeded by the lack of services for those people to access.

2. Outcomes

2.1. Population Snapshot

- Over the 20 years between 2000 and 2020, the proportion of the population in Australia aged 65 years and over increased from 12.4% to 16.3%. This group is projected to increase more rapidly over the next decade, as further cohorts of baby boomers turn 65[1]
- In the year ending 30 June 2020, the population aged 65 years and over grew in all states and territories. According to the Australian Bureau of Statistics (2020) the largest proportional increase in this group was in the NT (6.4%).
- According to the NT Population Projections (2019 Release) the projections of both the Aboriginal and non-Aboriginal populations show steady population ageing, with the proportion of persons aged 65 and over projected to increase.
- In 2020, the three NT Local Government Areas with the highest number of persons aged 65+ were Greater Darwin, Alice Springs, and Litchfield. For First Nations aged 45+ it was Darwin, East Arnhem, and Alice Springs[2]

2.2. Population Characteristics

Care Finders will target senior Australians who need intensive support who could otherwise fall through the cracks. This includes people who are not yet receiving aged care services, as well as those who are.

Specifically, the Care Finder target group are people who are eligible for aged care services, and have one or more reasons that require intensive support to:

- Interact with My Aged Care and access aged care services; and/or
- Need assistance to connect and access other relevant supports in the community

The Care Finder target group are the most vulnerable, hard to reach clients. They will require assertive outreach to engage with and build rapport. High level support, check in and follow up will be a requirement of Care Finder organisations so as to strengthen trusted relationships with potential clients. A commitment to person centred and culturally safe care is essential.

The general characteristics of the care finder target group for NT PHN will include:

- People that face barriers to access aged care services and/or relevant supports in community.
- People that are homeless, at risk of homelessness, live in overcrowded conditions or are living in insecure or unaffordable housing.
- People that are isolated or have no support person.
- Vulnerable people with complex health and psychosocial issues.
- People that experience communication barriers, including limited literacy skills.
- People that find it difficult to process information to make decisions.

[1] Australian Bureau of Statistics. (2020). *Region summary: Northern Territory*. https://dbr.abs.gov.au/region

[2] Australian Bureau of Statistics. (2020). *Region summary: Northern Territory*. https://dbr.abs.gov.au/region

- People that resist engagement with aged care for reasons including discrimination and/or negative past experiences with institutions or government.

The Care Finder target population is not a one-size-fits-all approach. It has been determined that the Care Finder target group definition needs to be flexible to enable providers to support people who need their help. Where possible, the process of 'warm referrals' will be embedded into Care Finder organisations to support clients to remain engaged to receive aged care supports and services.

There are unique characteristics of the NT environment that affect successful operation of aged care and amplify disadvantage including:

- Remoteness - small population spread across a large geographic area with many small communities.
- Small size of minority groups.
- Transient population – with the Darwin service context and the remote service context very different from each other (often referred to as Darwin centric).
- High population of Aboriginal and Torres Strait Islander people- demonstrating ageing characteristics earlier in the life span and considered as part of the senior's population from the age of 50 or 45 if homeless.
- Significant disparity in health outcomes for Northern Territorians, particularly Aboriginal and Torres Strait Islander peoples.
- Substantial disparity in the social determinants of health for Northern Territorians, particularly Aboriginal and Torres Strait Islander people.

2.2.1 Rural and Remote Location

It is well documented that people who live in remote and very remote areas experience unique challenges due to their geographic location and often have poorer health outcomes than people living in metropolitan areas. Data show that people living in rural and remote areas have higher rates of hospitalisations, deaths, injury and have poorer access to, and use of, primary health care services, than people living in major cities[3]. People in rural and remote areas are also more likely to engage in behaviours associated with poorer health[4]. In 2018, after adjusting for age, the total burden of disease and injury in Australia increased with increasing remoteness, with the rate of disease burden in remote and very remote areas being 1.4 times as high as that for major cities[5].

76.6% of the NT's Aboriginal and Torres Strait Islander population lived in remote or very remote areas[6]. They also experience very high levels of disadvantage, with this exacerbated in more remote locations.

Stakeholders describe populations of isolated older people living on large properties on the rural outskirts of the Northern Territories rural centres in sub-standard accommodation including caravans, converted containers or 'dongas'. Local information suggests that these individuals may

[3] AIHW. (2022b). *Rural and Remote Health*. https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health

[4] AIHW. (2018). *Australia's Health 2018 In Brief* . https://www.aihw.gov.au/reports/australias-health/australias-health-2018-in-brief/contents/all-is-not-equal

[5] AIHW. (2022a). *Indigenous Health and Wellbeing*. https://www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing

[6] Northern Territory Government Department of Treasury and Finance. (2022, March). Northern Territory Economy. https://nteconomy.nt.gov.au/population

have complex social and health needs including alcohol and other drug misuse, mental illness, complex chronic conditions, and a history of interactions with the justice system.

2.2.2 Small size of minority groups

Many groups within the NT population experience poorer health and social outcome and difficulties accessing services.

LGBTQI people experience higher rates of harassment and discrimination than the general population[7] . According to the ABS 2015 Survey of Disability, Ageing and Carers, around two-thirds (65%) of DVA payment recipients (veterans and dependants) aged 55 and over reported living with disability[8]. The effects of deployment and combat exposure are cumulative, time dependent and emerge slowly across multiple domains over time. Specifically, the level of exposure to traumatic events while deployed accumulates over time, and it is the cumulative burden of exposure that is most important in relation to disorder emergence (in particular, PTSD and other anxiety disorders). Lifetime trauma exposure adds to this burden and risk[9]

The Stolen Generations and their families are a particular group who experience greater disadvantage than other Aboriginal and Torres Strait Islander people. Analysis of data from the 2014–15 National Aboriginal and Torres Strait Islander Social Survey showed that people who reported being removed from family were more likely than those who did not to have been imprisoned or arrested in the previous five years, to have low income, to have poor self-assessed health, to have poor mental health, and to have experienced homelessness in the previous ten years[10]

While evidence indicates that services run for and by minority groups achieve improved outcomes[11], the viability of this given the highly dispersed and small size of these groups in the NT is limited. Where key elements of a service (such as the Care Finder service) require significant relationship building and face to face interaction, the viability of specialised solutions is even more limited. Both the size and relative need of the Aboriginal and Torres Strait Islander population in the NT can further reduce the priority and viability of dedicated solutions for smaller sub-groups. In this environment it will be critical that generic Care Finder solutions that aim to support all older people have very close relationships with their intermediaries in those specialist spaces and provide significant and ongoing education and support for staff to ensure they are able to access, connect with, understand, and meet the unique needs of a wide range of sub-groups.

[7] NTPHN. (2018). *LGBTQI Needs Assessment: Transgender Health and Service Needs*.

[8] Australian Bureau of Statistics. (2016). *Census of Population and Housing.* https://profile.id.com.au/rda-northern-territory/seifa-disadvantage-small-area

[9] National Commissioner for Defence and veteran Suicide Prevention. (2021). *Summary of round table with Northern Territory government agencies*.

[10] AIHW. (2022a). *Indigenous Health and Wellbeing*. https://www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing

[11] Campbell, M.A. et al. *Contribution of the Aboriginal Community-Controlled Health Services to Improving Aboriginal Health: an Evidence Review*, Australian Health Review (http://www.publish.csiro.au/ahr [6 March 2017]).

2.2.3 Transient Population

The NT has a highly transient population, with 17% of residents in 2016 reporting that they lived at a different address one year ago (national average 15%)[12]. A transient population poses unique challenges to the implementation and maintenance of an integrated and coordinated primary health system, as continuity of care is difficult to maintain, and records are not always easily transferred.

NT mobility reflects two discrete types of migration. The transient movement, largely of Aboriginal and Torres Strait Islander people, to/from and between homelands, remote communities, and regional towns (including Darwin). This movement is often seasonal and may involve cultural obligations, visiting kin, accessing services, climate-driven relocation, or a combination of any of these. In addition is the economic relocation of a short-term workforce who come to the NT for a specific contract or position and leave again after several months or years. Many of these workers are employed in health, as described by all service interviews conducted in Katherine with a high proportion of Nepalese care workers (Personal Communication).

2.2.4 Aboriginal and Torres Strait Islander Population

The Aboriginal and Torres Strait Islander population is ageing faster, with the proportion of persons aged 65 and over increasing by two and a half times from 2016 to 2046.

At 30 June 2016 there were an estimated 74,546 Aboriginal and Torres Strait Islander people living in the NT, the highest proportion of residents among its population nationally, representing 30.3% of the Territory's population[13]

As at 2017 there remains a discrepancy not only in life expectancy between Aboriginal and non-Aboriginal Territorians of 11.5 years for males and 12.8 years for females, but in life expectancy between Aboriginal people living in the NT and those living in other states and territories of 3.4 years for males and 4.5 years for females[14]

The high population of Aboriginal and Torres Strait Islander people in the NT PHN region, which demonstrate ageing characteristics earlier in the life span, will be a specific target group of care finders in the NT.

2.2.5 Health Inequity

The older population is less connected with the primary health sector, has a higher incidence of risky health behaviours, experiences poorer health and has poorer access to aged care than other states and territories, and accounts for a high proportion of acute care presentations. There is a distinct dichotomy in health outcomes with older Aboriginal and Torres Strait Islander people having significantly poorer health outcomes. Unlike other states and territories, risky behaviours are less

[12] Northern Territory Government Department of Treasury and Finance. (2022, March). *Northern Territory Economy* . https://nteconomy.nt.gov.au/population

[13] Northern Territory Government Department of Treasury and Finance. (2022, March). *Northern Territory Economy*. https://nteconomy.nt.gov.au/population

[14] Australian Institute of Health and Welfare (AIHW). *Aboriginal and Torres Strait Islander Health Performance Framework 2020 summary report*. Canberra: AIHW; 2020.

likely to reduce as Territorians grow older[15]. There are a significantly greater number of years lived with a disability for older Territorians for most conditions including cardiovascular diseases, endocrine disorders, hearing and vision disorders, infectious diseases, musculoskeletal disorders, neurological conditions and oral disorders[16].

Older Aboriginal and Torres Strait Islander Territorians have a higher incidence of dementia, hearing and vision loss and chronic renal disease due to causes other than ageing such as smoking, inadequate nutrition, substance abuse, previous head injury, recurrent infection, and poor living conditions, compared to other states and territories.[17] [18]

2.2.6 Socio-Economic Disadvantage

According to the 2016 Index of Relative Socioeconomic Disadvantage (IRSD) all areas except Greater Darwin and Alice Springs are classified most disadvantaged (below National average) however there is significant disparity within Darwin and Alice Springs that has a small proportion of very disadvantaged among large proportion of more advantaged.

In 2016, the ten most disadvantaged Local Government Areas (LGA) in Australia were found in Queensland and the NT. In 2016, West Daly in the NT was the second most disadvantaged LGA in Australia[19]

2.2.7 Housing and Homelessness

- People experiencing homelessness, and those at risk of homelessness are among Australia's most socially and economically disadvantaged[20].
- Housing as a social determinant, has been associated with the gap in health status between Aboriginal and non-Aboriginal Australians.[21]
- NT Shelter identified that the NT has the highest homelessness rates in the nation (rate per 10,000 population) which is 12 times the national average rate of homelessness, 20% of Aboriginal people in the NT are experiencing homelessness and the NT has 13 times the national rate of people sleeping rough.[22]
- In the NT, 50.5% of Aboriginal households are overcrowded compared with 4.5% of non-Aboriginal households. Self-reported data shows that 33.3% of Aboriginal households live in dwellings of an unacceptable standard. A dwelling of acceptable standard is one with four

[15] McConville V, Dempsey K, Tew K, Malyon R, Thompson F, Guthridge S, et al. The health and wellbeing of older Territorians. Darwin: Department of Health; 2013.

[16] Australian Institute of Health and Welfare (AIHW). Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011. Canberra: AIHW; 2016.

[17] Shu Qin Li, Steven L Guthridge, Padmasiri Eswara Aratchigo, Michael P Lowe, Zhiqiang Wang, Yuejen Zhao, et al. Dementia prevalence and incidence among the Indigenous and non-Indigenous populations of the Northern Territory. MJA. 2014;200(8):465–9.

[18] M Lowe. Effect of an ageing population on services for the elderly in the Northern Territory. Aust Health Rev. 2019;43(1):71–7.

[19] Australian Bureau of Statistics. (2016). *Census of Population and Housing*. https://profile.id.com.au/rda-northern-territory/seifa-disadvantage-small-area

[20] AIHW. (2020). *Australian Institute of Health and Welfare 2020 Aboriginal and Torres Strait Islander Health Performance Framework 2020 key health indicators - Northern Territory.* https://indigenoushpf.gov.au/getattachment/1c21c8f3-b754-42a5-b595-f07987e64735/2020-nt-aihw-ihpf-5.pdf

[21] AIHW. (2021). *Homelessness and Homelessness Services*.

[22] NT Shelter. (2022). *NT Shelter*. ntshelter.org.au

working facilities for washing people, washing clothes/bedding, storing/preparing food, and sewerage.[23]

- Severely overcrowded households (requiring four or more extra bedrooms) accounts for 81% of the homelessness rate in the NT. This rate is highest in remote areas particularly Arnhem and Daly regions, Barkly, and Central Australia. Rough sleeping increased by 20% between 2011 and 2016 and is most seen in Darwin and Katherine.[24]
- Indigenous Australians in the NT continue to be highly over-represented in lower-income households. In 2018–19, 59% of Indigenous adults in the NT were living in a household with an income in the lowest 20% nationally[25].
- Australians known to be at particular risk of homelessness include those who have experienced family and domestic violence, Indigenous Australians, people leaving health or social care arrangements, and Australians aged 55 or older.[26]

There is growing recognition of the connection between health and housing and the need for stronger referral pathways between these two sectors. This specifically applies for care finder organisations with some of the complexities identified including:

- Difficulty in registering people with My Aged Care with no address or transient address.
- Lack of understanding of risk factors or stereotypes around homelessness amongst workforces.
- Lack of awareness of services available.
- Home care difficult to receive without a secure and safe home which may lead to premature entry into residential care.

In interview, Tangentyere Council explained the essential need for a Community Housing Model for the Town Camps and that they are working with its corporate members and subsidiaries in partnership with the Executive Director of Township Leasing (Commonwealth); the NT Department of the Chief Minister (DCM) and the NT Department of Local Government, Housing and Community Development towards this. This would mean an equal collaboration with the Commonwealth, Territory, and the National Affordable Housing Consortium (NAHC). In 2019, Tangentyere Council moved a step closer to this goal and signed a Commitment Agreement for Local Decision Making with the Territory Government.

Below is a case study that directly reflects the ongoing issues around tenancy and complexities of homelessness for older people.

[23] Northern Territory Government Department of Treasury and Finance. (2022, March). Northern Territory Economy. https://nteconomy.nt.gov.au/population

[24] Northern Territory Government Department of Treasury and Finance. (2022, March). *Northern Territory Economy*. https://nteconomy.nt.gov.au/population

[25] AIHW. (2020). *Australian Institute of Health and Welfare 2020 Aboriginal and Torres Strait Islander Health Performance Framework 2020 key health indicators - Northern Territory.* https://indigenoushpf.gov.au/getattachment/1c21c8f3-b754-42a5-b595-f07987e64735/2020-nt-aihw-ihpf-5.pdf

[26] AIHW. (2021). *Homelessness and Homelessness Services*.

Case Study provided by an ACH provider

Older family members resided together in public housing, all of whom receive Aged Care services from one provider. One family member was the sole tenant and ultimately responsible for paying rent and maintaining the home.

The elderly people had chronic conditions requiring regular treatment and experienced significant mobility issues requiring mobility aids. They struggled with the steps to access their home.

Due to their vulnerability, they would quite often have visitors to their home where antisocial behaviour and drinking would occur. Family members would often frequent to ask for a "loan" in return for a lift to town to go shopping. The interior of the home was so badly damaged due to the antisocial behaviour and the struggle to use mobility aids in the home that they moved their bedding outside.

Following a home inspection of the property by Housing and noting the amount of damage and number of repairs completed by housing, a decision was made to temporarily vacate the home to make essential repairs. The provider was asked to make arrangements for the older tenants to stay with family with the promise from housing that the home will be fixed and available following this period.

While the repairs to the home were completed, the tenants were then advised that they were unable to reside in the home unless a responsible 24-hour carer/family member could assume responsibility for the tenancy. Unable to do so, the older tenants camped in the nearby dry riverbed, with supports from a provider (transport to day centre for personal care, shopping, banking, medical appointments, appointments to Services Australia, Physio and OT specialist appointments, medications, linen service etc). Alternative supported accommodation was sought however this was short-lived as their needs were too high for this style of accommodation, so they returned to the river bed.

The older family members were asked to reapply for housing, which had a waitlist of seven years. Moved off the riverbed by Council rangers, they found shelter on the veranda of another home, where one of the older people resided until an admission to hospital resulted in her being moved to permanent residential care, which adversely affected their overall wellbeing until their passing. The remaining family members continued to receive supports with their current accommodation until a suitable home became available three years later.

After a long wait and adversity, the family members remain in their home. They still experience humbug from family and would benefit from "rest-home" accommodations as opposed to "residential-care" which they continue to refuse as they are happiest living together, connected to country and the community, especially when they attend day centre to yarn with the ladies, participate in events and share stories.

2.3. Who is falling through the cracks?

Consultations identified a wide range of vulnerable people who do not access the services for a range of reasons (Figure 2). Many services described people that do not access mainstream services *as "hiding in plain sight"* (Anglicare NT).

In interview the Aged Care Assessment Team (ACAT) based in Alice Springs reported that more than half of Central Australian ACAT referrals are for Aboriginal and Torres Strait Islander clients. A significant number of these referrals are for clients aged 50 – 65 years who may be eligible and benefit from the NDIS. This makes the service quite unique compared to other ACATs in the NT. They also stated that a significant number of referrals are for care leavers/fostered/stolen generation; a small number of veterans and a small number LGBTIQ+. In addition, they reported that it takes more time to do their assessments due to the burden of disease being highest in remote communities and town camps. Many of the clients have limited English however the team do have an Aboriginal Liaison Officer who speaks five different languages and provides culturally safe care. When an ACAT assessor does assessments "some clients disclose information such as family violence, hum bugging or elder financial abuse" (Personal Communication).

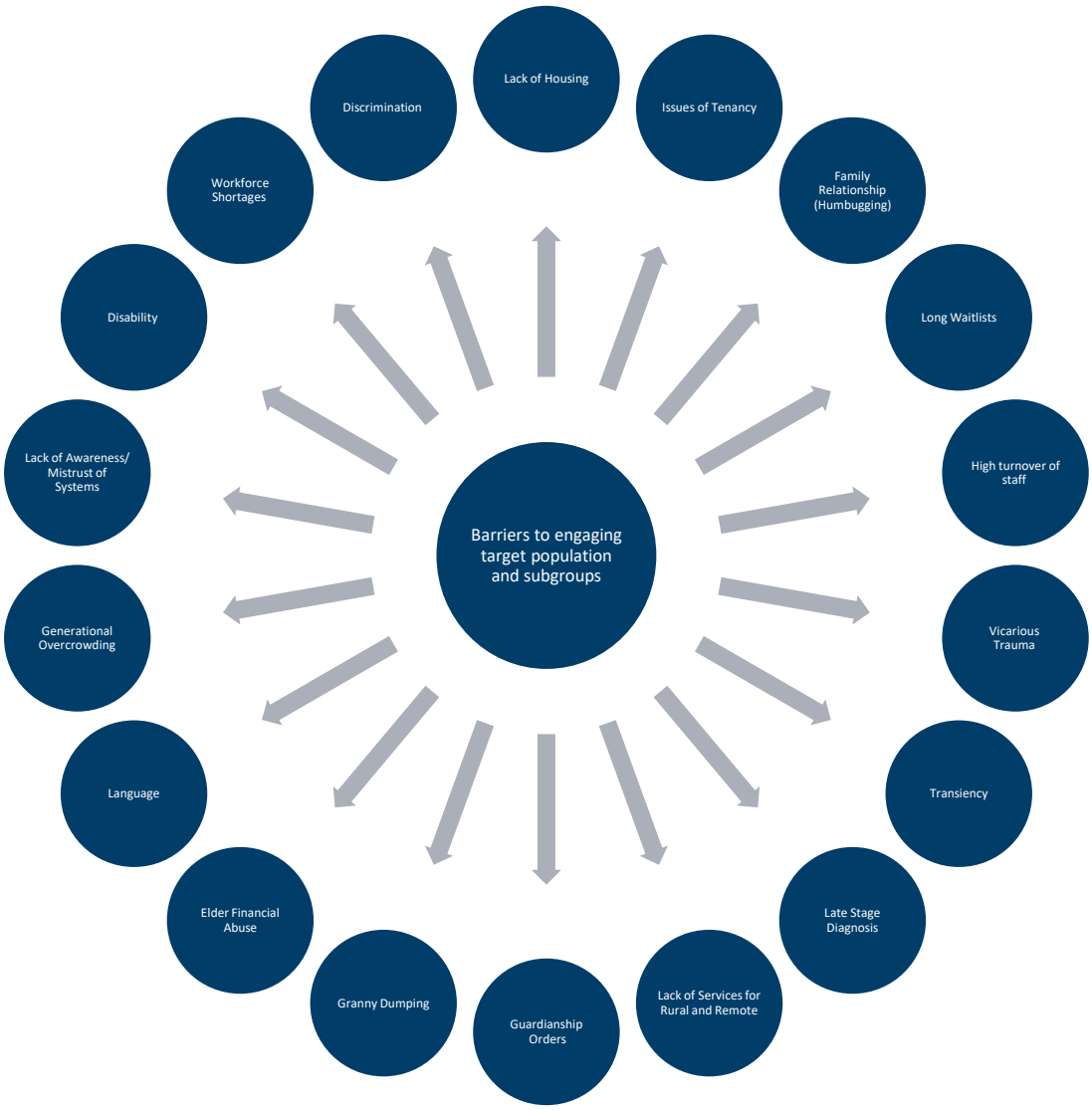
The consultations identified by location (Alice Springs, Katherine, East Arnhem Region, Greater Darwin, Tennant Creek, Barkly) the types of individuals who are perceived to be "falling through the cracks" however the reasons were consistent across all the NT. The following diagram provides a summary of the key reasons identified through feedback. More detailed feedback on who is falling through the cracks via region is outlined in Attachment 4.

Figure 2 Who is falling through the cracks, consultations 2022

2.3.1 Barriers to engaging with target population and subgroups

Through the consultation process, key informants identified a significant range of barriers to individuals and family members accessing services to receive care finder support (Figure 2).

Figure 2 Barriers that impact on supporting the target group effectively, consultations 2022



Some of the barriers identified included barriers to accessing services that are available while other barriers highlighted the lack of services available.

The following summarises the key barriers that will impact Care Finders.

Lack of access to services

Informants highlighted that the lack of trust in the system and stigma often prevented individuals and families from accessing services that were available. Some individuals experienced difficulty accessing services due to being unable to provide information required such as identification, financial and medical information.

Lack of services available

Services and supports for older people must be available, geographically accessible, affordable, accommodating, timely, acceptable, and older people must be aware of them.

According to the Report on Government Services 2018, there is inequitable access to aged care services for Territorians with lower Commonwealth spending, fewer services, and less capacity to deliver higher levels of care[27].

- Workforce issues including shortages and high turnover of staff often made it difficult for agencies to be able to maintain services including the lack of clinical capacity at times.
- Remoteness of some communities created complexities and often prohibited individuals from being able to access services that were only available in Darwin, but not locally.
- Informants identified a range of significant barriers relating to the lack of stable and secure housing citing that they have been informed that NT Housing waitlist for priority housing is between five and seven years. They advised that there have been almost no improvements to housing availability in the past ten years in some areas, and there is no emergency housing that people can be referred to in most areas. Feedback was also received that elders did not always want to leave family or country to access housing.

This lack of services will impact on the ability for care finders to deliver an outcome.

Bed Blockers

Currently the NT has 17 Residential Aged Care Facilities. The Government have submitted for an additional 60 beds annually to support the Territory's needs but are already short 300 aged care beds to cover current needs. As a result of this, there is a fluctuating number of older people in hospital who are described as 'bed blockers' due to no facilities to be able to discharge to (Personal Communication)

As of July 2022, there are 45 patients occupying a hospital bed at Royal Darwin Hospital when there is no medical need. This figure fluctuates between 23 – 45 patients. These patients are currently in a 40-bed interim care ward, but they are also placed in beds around the hospital when needed. One person has been occupying a bed for 3.5 years – with major complexities (behaviours and severe obesity requiring a 3-person lift). Long stay patients are predominantly Caucasian males, followed by Caucasian females and Aboriginal and Torres Strait Islander patients with renal failure.

"*These patients are in long term because there is nowhere for them to go. Aged care workforce shortages further exacerbate the challenges, with many reoccurring failed discharges*" (Personal Communication).

[27] Commission P. (2018). *Report on Government Services 2018: part f, chapter 14, aged care services attachment tables*. https://www.gen-agedcaredata.gov.au/resources/reports-and-publications/2018/january/report-on-government-services-2018-part-f,-chapter

Cultural Factors

Cultural factors including country and caring for country, knowledge and beliefs, language, self-determination, family and kinship, and cultural expression can be enabling and protective, positively influencing Aboriginal and Torres Strait Islander people's health and wellbeing[28].

Summary

The following list (Figure 4) are key barriers identified by informants in their own words. Approval was sought from the informants to use their quotes and case studies to reflect communities' voices in understanding the barriers they experience. As well as the case studies included in the body of this report, additional case studies have been included in Attachment 3.

Whilst addressing many of these identified barriers will require extensive whole of government and community action, there are a few that can be addressed through the implementation of the Care Finders program.

[28] Bourke S, et al (2018). Evidence review of Indigenous culture for health and wellbeing. *International Journal of Health, Wellness & Society*. https://cgscholar.com/bookstore/works/evidence-review-of-indigenous-culture-for-health-and-wellbeing

Figure 3 Key barriers to engaging target population and subgroups, consultations 2022

Lack of Housing	
The NT Housing wait list is getting longer, at present priority listing wait time is approximately 5+years: *Anglicare NT*	The waitlist for high priority housing currently 5 – 7 years. That is what Territory Housing is saying. Longer wait for 1 bedroom: *Larrakia Nation*
It is very difficult to find housing, lack of suitable housing for older people, always been a shortage: *Enrich Living*	The NT Housing wait list is years: *Tangentyere Council*
There is no emergency housing that we can refer people to: *East Arnhem Regional Council*	Lack of emergency accommodation to support less humbug on family members when visiting to access medical services: *Catholic Care Tennant Creek*
There has been no improvement in housing in past 10 years: *Tangentyere Council*	Overall, the NT housing wait list is too long at up to 8 years. There is need for additional community housing for seniors: *COTA NT*
Issues of Tenancy	
The only option for homeless/evicted is a hostel (3 available locally) but all of them overcrowded: *Tangentyere Council*	Those having issues in paying rent; it is hard to get them into hostels. Elders don't want to go to hostel without their families: *Enrich Living*
The Hostel is expensive and not always an option: *NT Health ACAT Team*	There is a push from housing to evict (anti-social behaviour, repair, or maintenance), then we are unable to adequately support them: *Tangentyere Council*
Sometimes the head tenant is the older person – they lose control of the household – become evicted – then the only option is hostel which is shared accommodation and doesn't cater to mobility issues. Then the older person becomes at risk of homelessness and care from multiple people. Issues around managing visits themselves (older person maintaining occupancy). Unsafe for visiting services, physically and culturally: *East Arnhem Regional Council*	There is a lack of smaller accommodation options on town camps, many 5-bedroom places. Unnecessary complexities and rigidity around tenancy. Houses can be vacant for 12 months (magnet for squatters): *Tangentyere Council*
Family Relationships (Humbugging)	
Services refusing services to household availability due to high number of unemployed adults living rent free on site and not participating in chores or activities to support no rent paying status: *Catholic Care Tennant Creek*	Family damaging accommodation and drinking on properties creating long term housing stability challenges: *Catholic Care Tennant Creek*
Late-Stage Diagnosis	
No dementia diagnosis for those that live remote; stigma attached to memory decline: *Dementia Australia*	Lack of early intervention so we see residents at complex late-stage chronic disease/dementia: *NT Health Allied Health Services and SARC Barkly*

Lack of Services for Rural and Remote	
Lack of services and access to services for rural and remote: *Team Health*	Lack of services is underpinned by lack of staffing – we have a high expense of bringing in FIFO agency staff: *NT Health Allied and ARRCS Alice Springs*
Decreased workforce across many services: *MCNT and COTA NT*	Lack of skilled staff specialised in aged care provision and delivery in Tennant Creek understandings: *Catholic Care Tennant Creek*
Guardianship Orders	
Guardianship orders and difficulty for end-of-life care, many First Nations "don't usually have Advance Care Plan, default (in facility) is not to provide CPR unless stated otherwise: *ARRCS Rocky Ridge*	Difficult to ascertain who is a family spokesperson. Many residents (of RACF) are homeless or have poor connection with family or no next of kin on arrival: *Kalano Flexible Aged Care Red Cross*
Granny Dumping	
Granny dumping phenomenon. People arrive to a RACF with scant information, which is difficult to attain: *ARRCS Rocky Ridge and Kalano Flexible Aged Care Red Cross*	
Elder Financial Abuse (coercion from families)	
In most cases older people are paying the rent/electricity on behalf of others that are not on the leases. There is a cultural obligation, they can't say no; *East Arnhem Regional Council*	Humbugging and financial abuse, always managing the fine line: *Tangentyere Council*
Elder financial abuse is rife: *East Arnhem Regional Council; NT Health ACAT, Larrakia Nation, Enrich Living, Anglicare NT, Tangentyere Council and NT Health Allied Health Services and SARC Barkly*	Clients with high Centrelink debts and not being able to co contribute: *Tangentyere Council and ARRCs Alice Springs*
Inefficiencies of My Aged Care	
My Aged Care is not user friendly; many presenting consumers have no referral code therefore were not able to see them upon initial presentation: *ARRCS Rocky Ridge*	Many consumers don't present with an ACAT assessment, rather they ask a GP to refer: *Kalano Flexible Aged Care Red Cross*
Every admission is like starting from scratch: *ARRCS Rocky Ridge and Kalano Flexible Aged Care Red Cross*	People don't get formal referrals, so providers are trying to do things in partnership through a 'link worker': *Kalano Flexible Aged Care Red Cross*
Poor referral pathway to MAC and the level of oversite: *Team Health*	Clients want to speak to someone in person to show them how to access services or change providers: *PICAC*
Lack of Transport	

Clients needing Purple House which provides dialysis in the most remote parts of Australia are struggling to meet demand for transport: *Disability Advocacy Service*	A few points need to be raised about the homelessness issues in very remote NT such as the East Arnhem region. There is nowhere to refer older people to in community. There are no emergency housing options, EARC can rarely get aged care clients into respite anywhere and the cost of transport to somewhere to access this service, even if there were any available, is prohibitive: *East Arnhem Regional Council*
Lack of Awareness and/or trust of systems	
Majority of people are unfamiliar with the aged care system; they don't understand what is available to them or where to go (shame/pride) *East Arnhem Land Council*	Many people, particularly First Nations don't trust the system: *Larrakia Nation and NT Health Allied Health Services and SARC Barkly*
Due to ongoing discrimination peers don't trust the system: *NTAHC*	Some clients are mistrusting of the system in general: *PICAC*
Disability	
Potential clients are hearing impaired, not specifically deaf: *East Arnhem Regional Council*	Providing care for those on dialysis requires good personal relationships underpinned by trust, reputation, and reliability: *Larrakia Nation*
Those with a mix of psychosocial disability as well as physical disability are always hard to reach: *Step Out Disability Service*	
Generational Overcrowding	
Many live in squalor and/or neglect due to many people living in overcrowded generational housing. Overcrowding and putting up with and making things work with what you do or don't have is how it is and has been for a long time. All the houses the Government have built or are promising is not even going to make a dent: *East Arnhem Regional Council*	For every person/client seen in a home, many more are eligible: *Larrakia Nation*
Language	
Language is a barrier and exhaustion of constantly translating, particularly over the phone. Clients just lose interest and give up then go without much needed supports *MCNT*	
Vicarious Trauma	
There is an expectation that staff know how to manage vicarious trauma. "Trust is not appreciated in the Western world" *Larrakia Nation*	
Transiency	
Movement of people during tropic dry season, people will come up *Larrakia Patrol Services*	

Workforce shortages/high turnover of staff	
High turnover of staff and system changes: *PICAC and COTA NT*	Time from assessment to receiving services – people come to us when they need services, and this can take up to 6 weeks: *NT Health Allied Alice Springs*
ACAT and RAS are visiting teams (from Darwin or Alice Springs). Need them locally. Slow timeline from ACAT assessment to receiving services *NT Allied Health Katherine*	Systems not talking to each other - Limited or no hospital discharge summary unless you chase it (Medicare/Immunization Records): *ARRCS Rocky Ridge and Kalano*
Long Waitlists	
Long RACF waiting list – even though patient cleared medically, they can't get a bed and stuck waiting in Hospital. Currently have 3 waiting for RACF placement. 5 on NDIS plans: *NT Health Alice Springs*	Long wait lists for AOD referrals: *Disability Advocacy Services, Larrakia Nation, Anglicare NT, Tangentyere Council*
Lack of crisis beds at hospital. Moving people through the assessment process from respite to permanent placements *ARRCS Rocky Ridge*	
Discrimination	
Homophobia of LGBTIQ + and lifelong stigma *NTAHC*	Faith based aged care services, supports and facilities. Clients need to connect in their own terms: *NTAHC*
Building rapport takes time: *Larrakia Nation and Anglicare NT*	There is stigma of needing counselling: *Open Arms*

2.3.2 Service Mapping

Existing Navigator Services

Assistance with Care and Housing

Each of the five ACH providers deliver assertive outreach to meet the local needs in relation to Care Finder support and have been able to clearly articulate their model of service delivery within the program guidelines. Each provider has demonstrated that they are currently providing elements of a Care Finder program and would transition to a Care Finder program smoothly, with appropriate support. All of them:

- Proactively identify and engage with their target group.
- Recognise that the client is the expert in their own life.
- Supports their clients to lead in decision making.
- Have a track history of breaking down barriers that may impede clients access to aged care.
- Meet people in their own environment, such as their home, the park, town camp or other environment familiar to them.
- Connect with people over several occasions to build a relationship and rapport.
- Build, maintain and leverage existing networks of intermediaries and local connections to support identification of and engagement with potential clients.

Aged Care System Navigators

There are two organisations that are delivering existing Aged Care System Navigation programs in the Northern Territory:

- COTA NT (in Greater Darwin and Alice Springs)
- EnCompass navigation services with FECCA in partnership with Multicultural Council of the Northern Territory (MCNT) (operating in Greater Darwin area)

COTA NT currently have two navigator staff, one in Alice Springs (Part time) and one in Greater Darwin (Part time).

Of the service providers interviewed as part of the care finders Needs Assessment, four referenced collaborations with one of COTAs Navigators. They were:

- Enrich Living (Alice Springs)
- Dementia Australia (Darwin)
- NT Health ACAT Team (Alice Springs)
- Partners in Culturally Appropriate Care (PICAC) (managed by COTA NT)

COTA NT also manage and work closely with PICAC. The service with PICAC provides an opportunistic internal referral opportunity for the CALD community to either of the navigator staff, predominantly the position in Greater Darwin. When asked about PICAC's existing relationships, they noted working with the Seniors Card Program and Aged Care Assessment Team (ACAT). The Aged Care System Navigator trial at COTA NT meets the needs of a key group of older people in the Northern Territory.

This target group was identified as being somewhat different to that intended for the Care Finders program.

EnCompass navigation services is a partnership with Multicultural Council of the NT (MCNT). The Federation of Ethnic Communities Councils of Australia (FECCA) assume the lead organisation with MCNT delivering on the operational model which has only been running for less than a year, with another 12 months of funding to June 2023. They are just finding their feet in how to deliver the pilot with dedicated service delivery staff. It was identified that they have a solid intensive outreach model with all face-to-face delivery and link in with other community stakeholders to obtain referrals for the identified cohort. Their model also has touchpoints along the full continuum from initial referral to ensuring ongoing engagement in appropriate services.

MCNT feel the information of the service has just begun to ripple through the community. Whilst they are working across several cultures, they believe they need males and females to provide a culturally appropriate service.

Trusted Indigenous Facilitators (TIF)

TIF is a juxtaposing care finder program with the Aboriginal and Torres Strait Islander community as its target. The National Aboriginal Community Controlled Health Organisation (NACCHO) have recently been engaged to roll out the program locally with its contracted stakeholders. This activity has not yet commenced. With Aboriginal and Torres Strait Islander people making up more than 30% of the NT population and more than 90% of the population in 80+ remote communities, engagement of TIF providers is paramount to ensure both care finder and TIF run in collaboration, ensuring limited resources are used effectively to ensure all geographical areas and key subgroups are addressed equitably.

This collaboration is impeded by the difference in timing of the implementation of the Care Finders and Trusted Indigenous Facilitators programs.

Geographical Distribution

The needs assessment highlighted gaps in geographic distribution in relation to current and planned service provision. It is expected that the Trusted Indigenous Facilitator program will support Aboriginal and Torres Strait Islander communities. While Care Finder services will support all vulnerable populations, ensuring limited resources are used effectively to ensure all geographical areas and key subgroups are addressed equitably while ensuring solutions are viable given the large size and small population of the Northern Territory will be critical. In this context, clear geographical gaps were identified in the following communities:

a. Gaps in target groups of existing services in Greater Darwin including rural fringe.
b. Gaps in target groups of existing services in Alice Springs.
c. Katherine.
d. Tennant Creek.

Vulnerable populations

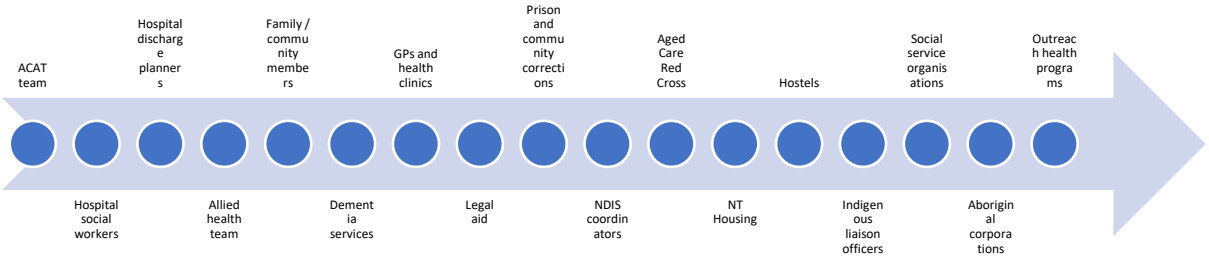
Within the NT, there are a wide range of vulnerable populations as identified in the data and confirmed during consultations. Feedback from stakeholders highlighted that the vulnerable groups more likely to experience significant difficulties in accessing aged care services in the NT include:

- Aboriginal and Torres Strait Islander people
- People who live in rural and remote areas
- People who are homeless or at risk of homelessness

2.4. Intermediaries and referrers

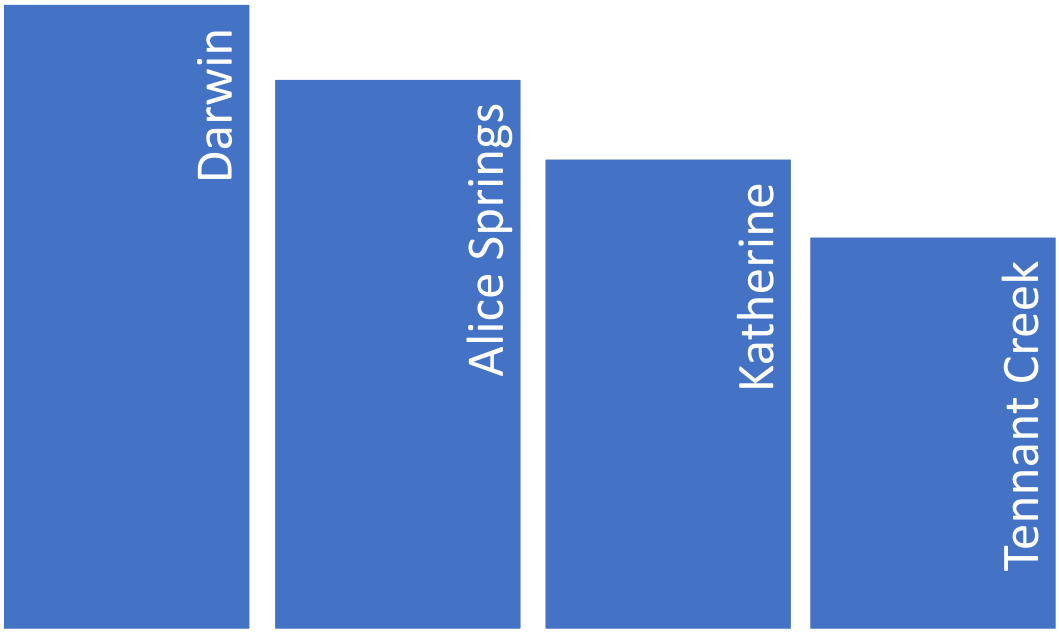
Key informants identified a wide range of organisations who currently refer into the Assistance with Care and Housing providers (Figure 4).

Figure 4 Who are the intermediaries and referrers, consultations 2022



Interview participants also identified a range of services available within their communities that provide support to care finder population groups. Figure 5 below outlines a sample of the agencies identified by region.

Figure 5 Relevant supports in the community identified by region, consultations 2022



Greater Darwin

Larrakia Nation have a close working relationship with Aged Care Assessment Teams (ACAT) and Dialysis teams from the Palmerston Renal Unit, Royal Darwin Hospital Renal Unit and Nightcliff Renal Unit. In addition, they work closely with NT Housing; Anyinginyi Health Aboriginal Corporation

(Tennant Creek); ILOs (Indigenous Liaison Officers) who do not have time to do the referral but will call. As well as Hostels; Anglicare NT, Mission Australia, Catholic Care; Open Arms; Team Health; Danila Dilba Health Service in Darwin; Centrelink and internal Larrakia programs that refer to ACH, particularly the Tenancy Support Program.

It was noted that clients of Larrakia Nation are reluctant utilise some services citing concerns with cultural awareness, s "People would worry that information is negotiated and may become lost" (Personal Communication).

Anglicare NT work with a range of services and providers across the community and aged care sector to fulfill client needs. This includes close association with the Salvation Army, Catholic Care, Mission Hub, and Sunrise Health Aboriginal Corporation and Wurli-Wurlinjang Aboriginal Health Service (community-controlled health service organisations based in Katherine) (Anglicare Katherine). Anglicare NT based in Darwin works closely with Relationships Australia, Darwin Community Legal Services and Hoarding support in housing.

East Arnhem Region

East Arnhem Regional Council work with Hospital Discharge Planners (who at times 'handball clients'), local clinics, council stakeholders, advocates, legal services as well as community members and families. They reportedly have a very good relationship with the ACAT that visit every six to eight weeks and always do teleconference (Personal Communication).

However, it must be stated that East Arnhem has very limited services to access and access to services.

Central

Tangentyere Council also work closely with NT Health's ACAT; Enrich Living (an ACH service); My Aged Care; Central Australian Aboriginal Congress; NT Health dialysis units; NT Health Community Nursing and Alice Springs Hospital.

MyHomecare (Enrich Living Services) work collaboratively with Tangentyere Council (an ACH service) and their Tenancy Support Program; they also have an excellent relationship with the Aged Care Assessment Teams in Alice Springs; Hospital Discharge Planners and Social Workers; NT Health Memory Clinic; NT Health Allied health team; Central Australian Aboriginal Congress, and at times Dementia Australia.

2.5. Success factors and models of service delivery

Cross sectoral collaboration

A major theme identified through the Needs Assessment is that Care Finder organisations need to consistently interface with other sectors such as housing, disability, health, welfare, and social support to enable them to provide service to the most vulnerable. All of the five existing ACH providers have demonstrated this because each already work with the most vulnerable, predominantly Aboriginal and Torres Strait Islander people, as well as the homeless and/or people at risk of homelessness.

It is well documented that the aged care system is difficult to access and navigate with reports of people finding it repetitive, time-consuming, overwhelming, and intimidating. This is amplified for vulnerable groups with multiple barriers to engagement. Many respondents of the Needs Assessment interviews suggested that the greatest weakness for aged care services and supports in the NT was in not knowing what each other is doing.

However, all face-to-face interviews conducted in Katherine described how well they worked together specifically during the COVID 19 pandemic, see 'Excellence in Katherine' below. They described an interorganisational collaboration that complemented each other, not duplicated, for their most vulnerable residents. Integrating aged care, primary health, mental health, and disability services at different levels and in innovative ways maximised efficiencies, capacity, and service scope. Information was being shared more freely, services were meeting more frequently which in turn, for this period, meant everyone knew what each other was doing. This joined up model of care could be very beneficial for the Care Finder program.

The shared resources and co- location of services at the Salvation Army's Doorway Hub in Katherine, which is a drop-in centre and community space supporting people experiencing or at risk of homelessness, is an example of a successful community collaboration.

Excellence in Katherine

According to the First Evaluation Report of the Health Justice Partnership Project (HJPP)[29], the region of Katherine is home to many people facing enormous health and social disadvantage with intertwined legal, economic, environmental, and psychosocial factors. These result in health inequalities that present barriers to accessing appropriate care and support. As indicated in the 2019 Katherine Individual Support Program (KISP) Evaluation [30], homelessness, overcrowding, and unsuitable accommodation conditions are common issues amongst people frequently presenting to Katherine. In addition, there is a lengthy waiting list for public housing in Katherine, noting that people awaiting housing may be removed from waitlists if they do not respond to letters from Territory Housing. "Given the challenges of accessing mail while rough sleeping or moving between temporary accommodation, this is a common experience for HJPP clients and is a common type of legal assistance provided to HJPP clients"

[29] Wood L, T. J. G. A. (2021). *Health Justice Partnership Project First Evaluation Report*.

[30] Quilty S, W. L. and G. A., & School of Population and Global Health, T. U. of W. A. P. W. A. (2019). *Katherine Individual Support Program First Evaluation Report*.

The HJPP in Katherine is funded by NT PHN and was established in 2019 to provide legal advice and assistance to complement the support provided through the KISP; a collaborative project involving key health and community services designed to support vulnerable people with complex health and psychosocial needs who frequently attend the Emergency Department (ED) at Katherine Hospital.

As of December 2020, the HJPP had supported 149 clients; of which 86% were First Nations. This included 57% males 43% females with an average age of 43.5 years. Collaborative case management meetings for KISP were coordinated by Wurli-Wurlinjang Aboriginal Health Service and held fortnightly to facilitate tailored case management for shared clients. This led to substantial benefits for those clients and more broadly for stakeholder organisations working to support vulnerable people in Katherine.

It was reported that a similar model of interagency engagement was adopted during the emergence and management of COVID 19 in Katherine. The NT Government nominated a lead organisation (Salvation Army) with tailored brokerage to cover the coordination of the model. This saw The Katherine Hub take the lead in coordinating daily meetings with relevant local organisations in managing emergency and ongoing services, such as accommodation, food, and support services. This included the NT Legal Aid Commission (NTLAC) who continues to attend the hub on a weekly basis to ensure clients have access to appropriate legal supports. The NTLAC provide out of scope unfunded case management activities which include referral processes for aged care services. This model of collaborative coordination saw positive outcomes as the first remote Indigenous community within the NT was quickly overcome with COVID infections.

Post the pandemic crisis, the collaboration ceased with services resuming normal patterns of service delivery. Services in Katherine involved in this collaboration indicated its effectiveness with an opportunity to have this model funded for ongoing collaboration and coordination of services.

Workforce considerations

Possible challenges in terms of Care Finder implementation include recruitment of appropriately skilled staff due to their remote location.

A prominent theme emerging from consultations indicates Care Finder providers will need to show their capability to provide inclusive care for people from diverse backgrounds, including those from the nine Special Needs Groups, regardless of whether they elect to specialise.

A significant workforce consideration attained from the Needs Assessment interviews is recommended training. Whilst it is acknowledged that all Care Finders, their managers, and triage staff will be required to complete mandatory online induction training, NT PHN took the opportunity to discuss with stakeholders their thoughts on additional supplementary training to complement existing care finder experience.

The following list summarises training recommendations for care finders as shared by respondents.

- Aged care quality standards including dignity and risk.
- Confidentiality and information handling.
- Cultural awareness training for CALD communities (existing and emerging communities).

- Cultural awareness training for First Nations people (to include Stolen Generation).
- Cultural safety training.
- Dementia awareness training.
- LGBTIQ+ inclusivity training.
- Maintaining professional roles and boundaries.
- Older person financial abuse awareness training program.
- Older person mental health first aid training program.
- Recognising individual client's changing needs.
- Risk assessment in the Home.
- Support for older people living with a disability.
- Trauma informed care to include vicarious trauma.
- Understanding the veteran's experience training.

Models Supporting Remote Viability

East Arnhem Regional Council have a unique service delivery model that allows them to deliver face to face support across their many small communities by adding their limited ACH funds to other similar resources including their Remote Community Connectors Program, and providing a holistic community wide approach to supporting access to services generally.

"This role is shared by all local Indigenous staff employed under our aged and disability program. This ensures greater buy in from staff and community through trusted relationships and family and kinship connections. This gives us greater access and understanding of any real issues and concerns for participants and their families. Better factual communication and understanding of all aspects of a problem or request. This model alleviates language barriers and results in better and successful outcomes for all parties including, NDIA, stakeholders, visiting health professionals and most importantly the participant and their families. This would not be possible by funding a single person or two to fulfil this role" (Personal Communication).

2.6. Future opportunities

Emerging themes from respondents of the Needs Assessment interviews regarding opportunities to enhance integration between health, aged care and other systems at local levels revealed the following:

- Existing Assistance with Care and Housing services can strengthen and build upon their existing intermediaries and referrals, in particular with ACAT and Hospital Discharge Planners. These partnerships will be integral to enhancing care finder integration.
- It was suggested that a partnership with Centrelink services could add considerable value in collectively addressing potential elder financial abuse and coercion from families. The only respondents that already have a good working relationship with Centrelink are the two Residential Aged Care Facilities based in Katherine (ARRCS Rocky Ridge and Kalano Flexible Aged Care Red Cross).
- Care Finder needs flexibility allowing the program to be adapted when required (crisis events). This approach could leverage networks and partnerships otherwise not considered.
- Networking between providers can improve the interface between key local agencies including health, housing, disability, health, welfare, and social support. NT PHN through developing and delivering orientation presentations from key agencies such as Dementia

Australia, Open Arms, Northern Territory AIDS and Hepatitis Council, and Disability Services, as well as ongoing professional development for care finder staff will promote potential referrers/intermediaries and create connectivity and collaborations.

- Development of NT Communities of Practice (care finder).
- Health and social service organisations responsible for caring for older people in a given area (particularly rural or remote) could potentially attend coordinated meetings within an existing system (for example ACAT and Hospital Discharge weekly meetings) which could enable integration across sectors such as health, disability and homelessness and help client triage and priorities of care. Regular interagency meetings and regular clinical handover meetings could effectively enhance integration of systems, as demonstrated in Alice Springs and Katherine.
- Whilst it was reported that ACAT teams do not do much work with Centrelink (just refer clients in) they could be encouraged to enhance collaboration given they have the case management experience to do this.
- Programs for vulnerable target groups need to be delivered with an eye to local context. Where possible care finder staff should be local to the delivery site. Lack of community knowledge and/or understanding has been identified as a significant barrier to successful integration.
- If the fragility of the aged care system in the NT is in not knowing what each other are doing, or of duplicating services then interagency opportunities should be strongly encouraged and could be led by the NT PHN.

2.6.1 Expansion capacity of existing services

All existing ACH services described a capability to expand their service model within the care finder scope. Workforce shortages and lack of funding currently inhibits capacity to take on more clients. While the subject matter expertise of some existing providers may not easily transfer to a broader client group, this opportunity should be considered given providers existing networks and experience with working in this challenging environment.

Anglicare NT, believe they have capability and capacity of its service to expand or broaden the focus to meet other local needs in relation to care finder support. Specifically, they believe they have the model which could be replicated in the Big Rivers region (an identified gap in service). Care Finders would be complementary to other programs at Anglicare which would serve as referral points.

East Arnhem Regional Council want to propose that the Care Finder program uses the same model as their current Remote Community Connectors Program, delivered for the NDIS.

Enrich Living believe Care Finders would be complementary to the work they are already doing. They state that the “current number of clients does not reflect need, and that some clients are difficult to fit into a funding model” (Personal Communication).

Larrakia Nation and **Tangentyere Council** provide a very person-centred approach to ACH, which will easily transition to Care Finder. Clients are the centre of ACH delivery as they respect and respond to the unique needs, preferences, values, and life experiences of each client. Larrakia Nation and Tangentyere Council already provide services to the most vulnerable.

2.7. Outcomes (Summary Table)

Identified Need	Key Issues	Evidence
Demand and Geography		
Demand for services for senior Territorians will continue to increase and future planning to accommodate an increasing ageing population needs to be prioritised.	All existing ACH service providers in the NT advise that they are currently working to their funded capacity. This puts significant pressure on the services that are delivering care finders to link individuals with available services where they can receive care in a timely manner.	The largest proportional increase of the population in Australia aged 65 years and over is in the NT[31].
Aged care services and supports including care finders need to focus delivery in areas of greatest disadvantage and where gaps in service provision were identified.	Consideration needs to be given to the areas where TIF programs will be established and prioritise other areas that have been identified with significant gaps. Remaining priority areas include: Gaps in target groups supported by existing services in Greater Darwin including rural fringe Gaps in target groups supported by existing services in Alice Springs including rural fringe Integrated and efficient solution in Katherine Integrated and efficient solution in Tennant Creek NT wide CALD service	These gaps were highlighted in the service mapping profiles. Assumptions have been made regarding the locations and scope of Trusted Indigenous Facilitator services in the NT as these decisions have not yet been made.

[31] Australian Bureau of Statistics. (2020). Region summary: Northern Territory. https://dbr.abs.gov.au/region

Identified Need	Key Issues	Evidence
Increased access to services/support/resources for rural and remote older people.	Consideration and planning need to be given to the development of innovative solutions and service model for care finders that can viably operate in remote locations.	The NT has a small population spread across a large geographic area with many small communities. It is well documented that people who live in remote and very remote areas have higher rates of hospitalisations, deaths, injury and have poorer access to, and use of, services, than people living in major cities[32]
Need for services that meet the needs of the transient population. This population group is largely of Aboriginal and Torres Strait Islander people, to/from and between homelands, remote communities, and regional towns (including Darwin). This movement is often seasonal.	The Darwin service context and the remote service context are very different from each other. Consideration in the service model needs to be given to how continuity of care can be provided to the transient population. This may include mechanisms for service delivery that continue to follow the individual as they move across the NT. Territorians, particularly Aboriginal and Torres Strait Islander people, can experience challenges when accessing care across borders, particularly around language and cultural safety issues.	The NT has a highly transient population, with 17% of residents in 2016 reporting that they lived at a different address one year ago (national average 15%)[33]
Housing and Homelessness		
Assertive outreach programs that specifically meet the needs of the homeless /at risk of	Assertive outreach is a requirement of care finders to build, maintain and leverage networks to support	The NT has the highest homelessness rates in Australia, which is 12 times the national average

[32] AIHW. (2022b). Rural and Remote Health. https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health

[33] Northern Territory Government Department of Treasury and Finance. (2022, March). Northern Territory Economy. https://nteconomy.nt.gov.au/population

Identified Need	Key Issues	Evidence
homelessness and those living in overcrowded or sub-standard accommodation.	identification and engagement with vulnerable clients especially invisible homeless. Within the NT, service environment, most agencies do not have the capacity to be able to deliver specific services for all specific need's groups. Most of the services are generic services. Strong links and relationships need to be encouraged with all sectors and specialty services such as Aboriginal and Torres Strait Islander people, LGBTQI, Veterans, Disability, Mental Health, Dementia etc.	rate with 20% of Aboriginal and Torres Strait Islander people in the NT experiencing homelessness. The NT has 13 times the national rate of people sleeping rough[34]
Services for senior Territorians need to be inclusive of Aboriginal and Torres Strait Islander people who are homeless or at risk of homelessness from the age of 45 years.	The care finders service model needs to be flexible enough to meet the needs of the homeless population and culturally appropriate with Aboriginal and Torres Strait Islander staffing. Homelessness was identified as a key barrier to accessing services.	The Aboriginal and Torres Strait Islander population make up an estimated 30% of the NT population which is significantly higher than the national average.[35] Because this population experiencing multiple health and social disadvantage, they are more likely to develop serious medical conditions earlier in life and have a lower life expectancy than their non-Indigenous counterparts[36]
Healthcare needs		

[34] NT Shelter. (2022). NT Shelter. ntshelter.org.au

[35] Northern Territory Government Department of Treasury and Finance. (2022, March). Northern Territory Economy. https://nteconomy.nt.gov.au/population

[36] Northern Territory Government Department of Treasury and Finance. (2022, March). Northern Territory Economy. https://nteconomy.nt.gov.au/population

Identified Need	Key Issues	Evidence
Due to a lack of early intervention, NT RACFs are seeing residents at complex late-stage chronic disease/dementia.	Due to the limited number of services that address the increasing high care and complex care needs of older people, the care finder program may be impacted on their ability to link individuals with services to meet their needs.	The proportion of people assessed as having high care needs when they first enter permanent residential care has increased. People with dementia tend to have higher care needs than people without dementia[37]
Workforce		
A range of workforce solutions to address the workforce shortages including high turnover of staff. Many of the challenges for aged care services are systemic, and workforce design must be reconfigured across the entire aged care sector.	Care finder model of service will need to consider these additional costs associated with workforce shortages. This might have implications for budgets as well as consideration of recruitment and retention strategies. Lack of suitable local workforce is creating an additional expense with organisations needing to utilise expensive FIFO agency staff. Economic relocation of a short-term workforce who come to the NT for a specific contract.	Participants of the Needs Assessment often spoke of difficulty of recruitment and retention of staff in aged care services, heavy workloads, stress, long work hours, and dissatisfaction with wages.
Social Disadvantage		
People receiving care in the NT are more likely to be financially disadvantaged than recipients in other states and territories.	Include in all service model activities that specifically address individuals needs who experience high levels of social disadvantage. The need to include flexible	Approximately 25-30% of the NT Aboriginal and Torres Strait Islander people health disparity may be explained by socioeconomic disadvantage[38]

[37] People's care needs in aged care, Australian Institute of Health and Welfare 2022 https://www.gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care

[38] Health inequity in the Northern Territory, Australia, Zhao, Y., You, J., Wright, J. et al. International Journal Equity Health 12, 79 (2013). https://equityhealthj.biomedcentral.com/articles/10.1186/1475-9276-12-79#citeas

Identified Need	Key Issues	Evidence
	funding to address individual needs is essential. This might include people having money they need to travel to meet with services or to pay for new birth certificate.	
Diversity		
Service models require a high level of flexibility and collaborative practice to address the high levels of diversity and unique needs in the care finder target group, not a one size fits all. Person Centred Care model that is culturally safe is essential to care finder target group, and a positive and supportive worker experience underpins high-quality, person-centred care. Trauma informed care essential for Care Finders.	Aged care service providers need to increase service viability and capacity to work in collaboration with housing, disability, health, welfare, and social support. Intersectionality of the Care Finder target group where there is 'diversity within diversity' needs to be recognised. People who belong to more than one group have unique needs which requires an appreciation of the interconnectedness of the entire healthcare system.	The ongoing devastating impact of colonization on Aboriginal and Torres Strait Islander people that has resulted in trauma compounded by ongoing racism, discrimination, and loss of identity, language, culture, and land all of which directly impact on healthcare outcomes and trust in services was frequently discussed and highlighted in the Needs Assessment interviews. Many people who identify as LGBTQI experience direct or indirect discrimination and wont access mainstream services as a result. For LGBTQI people it is thought 'community will care for community' (Personal Communication NTAHC, 2022). Members of the ADF carry with them often extensive trauma histories, including those who deploy; thus, deployment, particularly in combat roles, may convey risk for the development of

Identified Need	Key Issues	Evidence
		mental disorder by adding to the cumulative trauma load carried by everyone.[39]
Raise awareness of prevention strategies and respond to the abuse of older persons through specialist and mainstream services and community awareness initiatives.	Contribute to cross jurisdictional work on the abuse of older persons including coercion from families.	Majority of Need Assessment participants shared recommendation of all care finder staff to attend older person financial abuse awareness training program and older person mental health first aid training program
Improved communication and collaborations		
Assistance with Care and Housing Services in the Northern Territory need to have an improved coordinated approach for its care finders – systems response.	The integration of the care finder network into the existing aged care system is essential in improving collaboration. This includes developing and delivering orientation and ongoing Professional Development activities to promote and raise awareness of care finder personnel to promote potential referrers and intermediaries.	Participants of the Needs Assessment recommended regular aged care interagency meetings and attendance at weekly hospital clinical handover meetings. During the COVID-19 pandemic, an increase of interagency meetings in Katherine resulted in improved partnerships, collaborations, and service delivery for its older population.

[39] National Commissioner for Defence and veteran Suicide Prevention. (2021). Summary of round table with Northern Territory government agencies.

3. Priorities

Based on the information collected during this needs assessment, NT PHN has identified the key priorities to be progressed in the implementation of the Care Finders program. These include:

1. Support transition of the ACH program to the Care Finder program, by offering existing ACH providers a contract as care finders from January 2023 to June 2025. This includes:
    - Anglicare NT
    - East Arnhem Regional Land Council
    - Enrich Living
    - Larrakia Nation
    - Tangentyere Council
2. Work with the providers to develop a transition plan to identify the supports and change management processes that may be required with each organisation to transition to Care Finders.
3. In collaboration with providers, develop a service model for commissioning that incorporates flexibility to address the issues identified including remoteness, ability for generalist services to meet needs of various sub-groups, needs of transient population and workforce shortages.
4. Support the integration of the Care Finder network into the local aged care system and undertake activities to support this integration. This includes working with providers to develop and deliver orientation and ongoing professional development activities to promote and raise awareness of care finder personnel to promote potential referrers and intermediaries. This will improve approaches to be prioritised for meeting the needs of all diverse groups that will form part of the care finder target population.
5. Actively build on existing relationships and partnerships with the sector to support effective implementation and management of Care Finder services as already progressed through the many face to face meetings held as part of this Needs Assessment.
6. Work with the TIF program to confirm the geographical gaps that will be addressed by the TIF program and ensure care finders resources are targeted to remaining sub-groups or geographical gaps.
7. Subject to (3 – above), commission services to fill:
    a. Gaps in target groups of existing services in Greater Darwin including rural fringe.
    b. Gaps in target groups of existing services in Alice Springs.
    c. Integrated and efficient solution in Katherine.
    d. Integrated and efficient solution in Tennant Creek.
    e. NT wide CALD service.
8. Ensure service models (particularly for Katherine and Tennant Creek) demonstrate innovation and integration with other local services to ensure the solution is viable given the small population and limited resources.
9. Ensure Care Finder organisations consistently interface with other sectors such as housing, disability, health, welfare, and social support; to access the ‘hard to reach’ all the time with a focus on the person rather a specific system to help people age respectfully. This aspect is to be built into the service model of each commissioned service provider.
10. Facilitate required and recommended training for all Care Finder staff to support their capacity to address the needs of the broad range of subgroups who may require Care Finder services. At a minimum, the training should include:
    - Cultural awareness training CALD communities (existing and emerging communities)
    - Cultural awareness training First Nations (to include Stolen Generation)
    - Cultural safety training
    - Dementia awareness training
    - LGBTQI+ inclusivity training
    - Older person financial abuse awareness training program

- Older person mental health first aid training program
- Recognising individual client's changing needs
- Support for older people living with a disability
- Trauma informed care to include vicarious trauma
- Understanding the veterans experience training