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An Australian Government Initiative

Primary Health Network Program Needs Assessment Reporting

This template has been used to submit the Primary Health Network's (PHN's) Needs Assessment to the Department of Health (the Department).

Adelaide PHN

The Adelaide PHN has ensured that all internal clearances have been obtained and the Report has been endorsed by the CEO before submitting this Needs Assessment to the Department of Health.

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Abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and Other Drugs
Adelaide PHN	Adelaide Primary Health Network
ASD	Autism Spectrum Disorders
ASR	Age-Standardised Rate
BBV	Blood-Borne Viruses
CAC	Community Advisory Council
CALHN	Central Adelaide Local Health Network
CALD	Culturally and Linguistically Diverse
CC	Clinical Council
ED	Emergency Department
DASSA	Drug and Alcohol Services South Australia
DOH	Department of Health (Commonwealth)
GP	General Practitioner
HPG	Health Priority Group
LGA	Local Government Area
LGBTIQ+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer +
LHN	Local Health Network
MBS	Medicare Benefits Schedule
NA	Needs Assessment
NALHN	Northern Adelaide Local Health Network
NDSHS	National Drug Strategy Household Survey
PBS	Pharmaceutical Benefits Scheme
PCC	Priority Care Centre
PEP	Post-Exposure Prophylaxis
PHA	Population Health Area
PHIDU	Public Health Information Development Unit
PHN	Primary Health Network
PIP	Practice Incentive Program
PPH	Potentially Preventable Hospitalisation
PrEP	Pre-Exposure Prophylaxis
RACF	Residential Aged Care Facility
RACGP	Royal Australian College of General Practitioners
SA	South Australia
SA2	Statistical Area Level 2
SA3	Statistical Area Level 3
SA4	Statistical Area Level 4
SALHN	Southern Adelaide Local Health Network
STI	Sexually Transmitted Infections
WCH	Women's and Children's Hospital

Acknowledgement

The Adelaide Primary Health Network (Adelaide PHN) acknowledge the Kaurna peoples who are the Traditional Custodians of the Adelaide Region. We pay tribute to their physical and spiritual connection to land, waters and community, enduring now as it has been throughout time. We pay respect to them, their culture and to Elders past, present and future.

The term “Aboriginal” is used respectively in this document as an all -encompassing term for Aboriginal and Torres Strait Islander people and culture. The term “Indigenous” is used in this document in line with how the data is presented to Adelaide PHN.

1 Introduction

Established and funded by the Federal Government, Adelaide PHN is a not-for-profit organisation. We are one of 31 PHNs operating across Australia, and one of two in South Australia. The Needs Assessment is an important process for Primary Health Networks to identify and analyse health and service needs within their regions. The Needs Assessment (NA) is a key step in the commissioning process, and supports core strategic activities such as planning, procuring and prioritising activities to address those most in need.

1.1 Background

Since 2015 Adelaide PHN has completed seven NA reports by triangulating health, service and community¹ needs, and input from Adelaide PHN membership groups². Together with our Board, they bring together a diverse range of experience and knowledge informing our evidence-based planning process to determine the local needs and priorities of our catchment area.

Table 1 lists all the reports completed in chronological order. Further information on the reports can be found on Adelaide PHN website.

Table 1. Adelaide PHN Needs Assessment (NA) Reports and locally identified NA Priorities

Name of Needs Assessment Report	Number of Priorities	Submission to DoH
Baseline Needs Assessment (BNA)	32	March 2016
Update to BNA	37	November 2016
Core Flexible NA Update	28	November 2017
Alcohol and Other Drug (AOD) NA Update	4	November 2017
Mental Health and Suicide Prevention NA Update	2	November 2017
NA Report	47	November 2018
NA Report – Update	47	December 2019

1.2 This Report

This report has been recategorized to the PHN (seven) priority areas for targeted work. The priority areas (here forth called the National Priority Area (NPA)) are:

- Aboriginal and Torres Strait Islander Health
- Aged Care
- Alcohol and Other Drugs (AOD)
- Digital Health
- Mental Health
- Population Health
- Workforce

This template is called the Adelaide PHN Needs Assessment 2019-2022 – Update for 2021/22.

¹ The definition of community here encompasses consumers, service providers, stakeholders and health professionals (primary and allied health care providers).

² Community Advisory Councils, Aboriginal Community Advisory Council, Clinical Councils and Health Priority Network (priority interest areas of Mental Health, Aboriginal Health, Consumers and Carers, Disability, Childhood and Youth, Older People and Aged Care, Palliative Care, Alcohol and Other Drugs and Culturally and Linguistically Diverse Communities)

Given the iterative nature of the Needs Assessment process, this report has been reviewed and updated for the period 1 July 2020 to 30 June 2021 and inform the Commonwealth Department of Health PHN Activity Work Plan reporting deliverable for the period 1 July 2021 to 30 June 2022.

2020-21 Inclusions

In February 2019, the Adelaide PHN membership groups' recommendation to the Board was endorsed to further investigate the Lesbian, Gay, Bisexual, Transgender, Intersex and Queer + (LGBTIQ+) communities' health and wellbeing needs. This report presents some of the health and service needs and priorities of the LGBTIQ+ communities in the Adelaide PHN region, identified from analysis of national and local datasets and research, as well as of the findings from consultation with a number of local LGBTIQ+ service providers.

In addition, the Adelaide PHN undertook a comprehensive analysis, synthesis and priority setting process to review the Alcohol and Other Drugs (AOD) treatment key needs and priorities of the community. Simultaneously, the Adelaide PHN has been working closely with Drug and Alcohol Services South Australia (DASSA) on their soon to be released *South Australia Alcohol and Other Drugs Needs Assessment*. While findings from this assessment were not able to be included in this report, the Adelaide PHN will use this information to inform the Adelaide PHN Activity Work Plan, including commissioning approaches in delivering treatment services in the region. Any new findings from the DASSA report will be included into the Needs Assessment update for 2022/23. Please see Chapter 7 for new information about AOD.

New priorities with respect to General Population Health, AOD and Indigenous Health have been added to the Adelaide PHN list of priorities. See Chapter 9 for more information.

Process

From January 2020, the Adelaide PHN began to redesign the NA process by developing a Needs Assessment Framework (the Framework). The Framework will inform the Adelaide PHN NA process from 2021 onwards and aims to improve the iterative and relevant annual NA by documenting and guiding the processes and procedures including the evidence informed methodologies and tools.

The Adelaide PHN membership groups were consulted via online surveys to inform the redesign process and help inform the priority setting process and identify any new needs of the communities in the region.

In addition to this, the new process will undertake a comprehensive analysis and subsequent priority setting process of specific National Priority Areas (NPAs) each year rather than reviewing and updating all the information from our previous NAs. In addition to informing the commissioning approach for the Adelaide PHN, the new process will also guide any partnership strategies and advocacy roles of the organisation.

For this update, we have begun the transition to a new report format, which brings together the content from the previous NA reporting templates as well as new quantitative and qualitative information into discreet NPA sections. From 2021, the Adelaide PHN will redesign the reporting format again to (better) translate the key needs and priorities.

Gaps and Limitations

The Adelaide PHN has taken every step to include all information and data relevant to the health and wellbeing of the community. Data available on the Commonwealth's PHN website provided base reference for the Adelaide PHN to analyse the health and service needs. Data from the Public Health Information Development Unit (PHIDU) and more recently the Australian Institute of Health and Welfare (AIHW) have provided further evidence into the health, and to a certain extent, service needs of the Adelaide PHN region.

However, it must be noted that there are still limitations and gaps to the findings presented in this report. Notable, there is some information which is only available at a national level and can not be

reported on at a local level. Additionally, throughout the report there is mention of data older than five years. Whilst while this is not ideal, it is the most up to date and recent data currently available.

Further access to data specific to Aboriginal and Torres Strait Islander people and Culturally and Linguistically Diverse (CALD) people will provide additional insight into the needs of the Adelaide metropolitan community.

As part of the review of the Adelaide PHN NA and NA process, including the development of the NA Framework, a data collection framework will be developed to better understand the gaps in data, supplementary data collections processes and opportunities to collect, collate and analysis these data sources. This may include partnering with key stakeholders such as research institutions (e.g. AIHW, the National Centre for Education and Training on Addiction (NCETA) and the South Australian Health and Medical Research Institute (SAHMRI)), local health networks and general practices.

2 Adelaide PHN region

2.1 Our region and people

The Adelaide Primary Health Network is one of two Primary Health Networks (PHNs) in South Australia. The Adelaide PHN region covers 1,553 square kilometres and stretches from Sellicks Hill in the south to Angle Vale in the north, and from the beaches in the west to the foothills in the east.

In 2019 an estimated 1,247,000 people resided in the region, which is 71% of the population of South Australia, and 5% of the total Australian population (25.36 million people) (PHIDU 2020).

The Adelaide PHN boundary encompasses three Local Health Networks (LHNs) – Northern Adelaide, Central Adelaide and Southern Adelaide, and seventeen Local Government Areas.

Population

The Adelaide PHN has a diverse population with varying levels of advantage and disadvantage in terms of include household income, education, employment, occupation, and housing.

The Socio-Economic Indexes for Areas (SEIFA) Index of Relative Socio-Economic Disadvantage (IRSD) is an indicator that quantifies the relative level of socio-economic disadvantage and/or advantage based on these characteristics as measured in the Census. A lower score on the index means a higher level of disadvantage.

In 2016, the Adelaide PHN region has an overall IRSD of 985.4, with scores by Local Government Area ranging from the most disadvantaged at 855.0 (City of Playford) and 971.0 (City of Salisbury) to 1072 (Town of Walkerville) and 1081 (City of Burnside) (ABS, 2017a).

Demographic profile

Children and young people

In 2016, as counted at the last Census, there were 246,856 people aged 17 years and under living in the Adelaide PHN region. This included 70,069 babies and pre-schoolers (0 to 4 years) (5.9% of total region population), 96,383 (8.1%) primary schoolers (5 to 11 years) and 80,404 (6.8%) secondary schoolers (12 to 17 years) (ABS, 2017a).

Older people

In the five years between 2011 and 2016, the largest changes in the age structure in the Adelaide PHN were in the older age groups: Empty nesters and retirees (60 to 69) (+16,551 people), Seniors (70 to 84) (+11,143 people) and Older workers and pre-retirees (50 to 59) (+8,068 people) (ABS, 2017a).

As counted at the last Census (2016), there were 203,923 people aged 65 years and over, including 31,629 people aged 85 years and over, living in the Adelaide PHN region (PHIDU, 2017a). The five Local Government Areas within the region with the largest numbers of residents aged 65 years and over include Onkaparinga (C) (28,900, 14%), Charles Sturt (C) (21,214, 10%), Salisbury (C) (19,544, 10%), Port Adelaide Enfield (C) (18,798, 9%) and Tea Tree Gully (C) (17,799, 9%) (PHIDU, 2020a). The largest populations of people aged 85 years and over were in the Local Government Areas of Charles Sturt (C) (3,365, 11%), Onkaparinga (C) (3,469, 11%), Port Adelaide Enfield (C) (3,161, 10%), Marion (C) (2,763, 9%), and Mitcham (C) (2,226, 7%) (PHIDU, 2020a).

By 2026, the population aged 65 years and over is expected to increase to 266,855 (20% of total population), including 36,350 people aged 85 years and over (3% of total population) (PHIDU, 2020a).

Aboriginal and Torres Strait Islander population

The Kurna people are the Traditional Owners of Adelaide and the Adelaide Plains. As well as Kurna, Adelaide Aboriginal communities come from about 200 diverse Aboriginal and Torres Strait Islander clan groups and speak many different languages.

According to the 2016 Census of Population and Housing 21,365 Aboriginal and Torres Strait Islander people resided in the Adelaide PHN region, comprising 1.8 per cent of the region's total population (PHIDU, 2020b).

A young population where the median age is 22 years and 1 in 2 (56%) Aboriginal and Torres Strait Islander people in the Adelaide PHN region are aged 24 years and below. By age group, 5,125 people (24%) were aged 0-9 years, 4,687 people (22%) were aged 10-19 years, 3,975 people (19%) were aged 20-29 years, 2,453 people (11%) were aged 30-39 years, 2,189 people (10%) were aged 40-49 years, 1,636 people (8%) were aged 50-59 years, and 1,301 people (6%) were aged 60 years and older (PHIDU, 2020b).

The majority (65%) of Aboriginal and Torres Strait Islander population reside in four areas within the Adelaide PHN: Playford (3,897, 18%), Port Adelaide – Enfield (3,538, 17%), Salisbury (3,350, 16%) and Onkaparinga (3,188, 15%) (PHIDU, 2020b).

Culturally and linguistically diverse communities

Demographics

Data from the 2011 Census of Population and Housing indicate that 16% of Adelaide PHN residents were born in predominately non-English speaking countries (NESC) (PHIDU, 2015); this has increased to 18% based on the 2016 Census data (ABS, 2017a).

In 2016, the top 10 birthplaces of people from Non-English Speaking Countries in the Adelaide PHN were: India, China, Italy, Vietnam, Philippines, Greece, Germany, Malaysia, Afghanistan, and Poland (ABS, 2017a).

The largest changes in birthplace countries in the Adelaide PHN region between 2011 and 2016 were for those born in India (+8,630 persons), China (+8,427 persons), United Kingdom (-5,689 persons) and Afghanistan (+2,856 persons) (ABS, 2017a).

The Statistical Areas 3 (SA3s) of Port Adelaide-East (22.1% of the population), Campbelltown (22.0%), Salisbury (17.5%), Charles Sturt (17.2%) and Port Adelaide-West (17.1%) had the highest proportion of people born in NESC and resident for longer than five years (PHIDU, 2017b).

Whereas the SA3s with the highest proportion of people born in NESC and resident for less than five years (recent arrivals) were Adelaide City (21.9% of the population), Port Adelaide-East (8.5%), West Torrens (7.6%), Norwood-Payneham-St Peters (6.8%), and Burnside (5.9%) (PHIDU, 2017b).

In South Australia, the three population groups with the highest inequality ratio of Quintile 5 (most disadvantaged) to 1 (least disadvantaged), by proportion of the South Australian population, are people born in Vietnam, the Philippines and India (Principe, 2015).

Language and literacy

In 2016, the top 10 languages other than English spoken at home for people living in the Adelaide PHN region were: Mandarin, Italian, Greek, Vietnamese, Persian/Dari, Cantonese, Arabic, Punjabi, Filipino/Tagalog, and Hindi (ABS, 2017a).

The SA3s with the highest proportion of people born overseas reporting poor proficiency in English were Port Adelaide-West (6.0%), Port Adelaide-East (5.9%), Salisbury (5.6%), Adelaide City (4.8%), Campbelltown (4.4%) and Charles Sturt (4.3%) (PHIDU, 2017b).

Nationally in 2006, of those born overseas in a mainly non-English speaking country, only 26% achieved literacy levels of 3 or above, the minimum required for individuals to meet the complex

demands of everyday life and work'. Additionally, 74% of those born overseas in a mainly non-English speaking country have less than adequate levels of literacy and health literacy. This means that they may not be able to effectively exercise their choice or voice when making healthcare decisions (ABS, 2006). While dated, this is the latest health literacy data from the ABS.

A recent report by the ABS reported that for 2011-12 the literacy skills of people born overseas from a non-English speaking country is lower than those born in Australia (i.e. Level 3 and below; Level 1 or below being very basic and Level 5 being the highest) (ABS 2013).

The report shows that for Literacy skills of \geq Level 3:

- If born overseas from a non-English speaking country: 39%;
- If born in Australia but 1st language not English: 48.5%
- All of SA: 51%

And for Literacy level of 1 or below (i.e. lowest level- very basic)

- If born overseas from a non-English speaking country: 28%;
- If born in Australia but 1st language not English: 15%
- All of SA: 13% (ABS 2013).

Lesbian, Gay, Bisexual, Transgender, Intersex and Queer + (LGBTIQ+) Communities

There are currently no specific LGBTIQ+ population counts for the Adelaide PHN region. National estimates indicate that 3% of adults in Australia identify as gay, lesbian or an 'other' sexual orientation; if this proportion was reflective of the Adelaide PHN region, in 2016 there would have been approximately 28,300 people aged 18 years and identifying as gay, lesbian or other sexual orientation (ABS, 2017a).

3 Population Health

3.1 Health status

Health risk factors

Health risk factors are attributes, characteristics or exposures that increase the likelihood of a person developing a disease or health disorder. Behavioural risk factors are those that individuals have the most ability to modify.

The Adelaide PHN membership groups recognise the link between behavioural and lifestyle factors and are concerned about the levels of the following lifestyle factors and the impact on our community's health: smoking; inadequate nutrition; unemployment; lack of exercise; lack of skills to cook health foods; education level on understanding of good health, healthy lifestyles, impact of junk food (APHN, 2017a). Levels of obesity and the impacts on chronic disease and ultimately on use of resources was also a concern as was linked to a lack of education related to choices about behaviour including food choices and exercise (APHN, 2016a).

Smoking

Estimates from the 2011-13 Australian Health Survey highlight that when compared to other LGAs in the Adelaide PHN region, there was a higher proportion of both male and female smokers in the LGAs of Playford, Salisbury, Port Adelaide Enfield and Onkaparinga (PHIDU, 2015).

In the two years from 2012 to 2014, the average proportion of females smoking during pregnancy was higher in Adelaide PHN compared to other Capital Cities, 11.4% compared to 9.3% respectively (PHIDU, 2017a). Rates of smoking during pregnancy were highest in the Local Government Areas of Playford (24%), Salisbury (16%), Onkaparinga (15%), Tea Tree Gully (10%) and Charles Sturt (10%) (PHIDU, 2017a).

Physical inactivity

In 2015, approximately half of all South Australians aged between 18-64 years and one-third of South Australians aged 65+ years undertook physical activity in line with recommended national levels, and these proportions have remained unchanged in the thirteen years between January 2003 to December 2015 (SA Health, 2015b). Recent data (between July 2016 and March 2018) also shows similar trends - 46.7% of South Australians undertook physical activity (SA Health, 2018a).

Between July 2014 and June 2016, the SA3s within the Adelaide PHN region with the lowest percentage of physical activity (below State average) were Playford, Port Adelaide – West, West Torrens and Onkaparinga respectively (SA Health, 2018a). However recent data (between July 2016 and March 2018) shows variations in the percentages of physical activity. The SA3s with the lowest percentage of physical activity (below State average) were Playford (0.5% increase from previous period), Port Adelaide – East (6.3% decrease), Salisbury (4.2% decrease), Port Adelaide – West (4.7% increase) and Campbelltown (4.6% decrease) respectively (SA Health, 2018a).

Unhealthy weight

In 2015, 6 in every 10 South Australians aged 18 years and over (62%) were overweight or obese (unhealthy weight), and this proportion has increased from 54% since July 2002 (SA Health, 2015d). Recent data (between July 2016 and March 2018) also shows similar trends – 61.4% of South Australians were overweight or obese (SA Health, 2018a).

Between July 2014 and June 2016, the SA3s within the Adelaide PHN region with the highest percentage of people with an unhealthy weight (above State average) were Playford, Salisbury, Port Adelaide – West, Tea Tree Gully and Charles Sturt respectively (SA Health, 2018a). However recent data (between July 2016 and March 2018) shows variations in the percentages of unhealthy weight. The SA3s with the highest percentage of people with an unhealthy weight (above State average) were Playford (0.3% increase from previous period), Salisbury (0.3% increase), West Torrens (15.4% increase) and Marion (2.8% increase) respectively (SA Health, 2018a).

Vegetable consumption

Between July 2014 and June 2016, the SA3s within the Adelaide PHN region with the lowest percentage of people consuming the recommend number of serves of vegetables for adults (below State average of 10.3) were Port Adelaide – East, Unley, Prospect-Walkerville, Playford, West Torrens, Port Adelaide – West and Marion respectively (SA Health, 2018a). However recent data (between July 2016 and March 2018) shows variations in the percentages of vegetable. The SA3s with the lowest percentage of people consuming the recommend number of serves of vegetables for adults (below State average of 10.5) were Unley (1.9% decrease from previous period), Port Adelaide – East (2.6% increase), Salisbury (3.7% decrease), Burnside (2.3% decrease), Marion (0.1% decrease), Onkaparinga (1.4% decrease), West Torrens (2.4% increase), Norwood-Payneham-St Peters (7.4% decrease), Port Adelaide – West (1.1% increase) and Mitcham (no change), respectively (SA Health, 2018a).

Fruit consumption

Between July 2014 and June 2016, the SA3s within the Adelaide PHN region with the lowest percentage of people consuming the recommend number of serves of fruits for adults (below State average of 42.8) were Playford, West Torrens, Port Adelaide – West, Unley, Salisbury and Campbelltown respectively (SA Health, 2018). However recent data (between July 2016 and March 2018) shows variations in the percentages of fruit consumption. The SA3s with the lowest percentage of people consuming the recommend number of serves of fruits for adults (below State average of 42.1) were Burnside (24.9% decrease from previous period), Port Adelaide - West (5.2% decrease), Playford (3.3% increase), Marion (3.3% decrease) and Salisbury (1.2% decrease) respectively (SA Health, 2018a).

Children and young people

Around a quarter (23.0%) of non-Aboriginal children aged 5-17 years in South Australia were overweight or obese, slightly lower the national average of 24.8% (HPCSA, 2018), but still a growing concern given it is above the 2025 target of 21.6% for 5-11 year olds (AHPC, 2017). The AHPC data also indicates a growing concern for young people – nearly one in three (29.5%) are overweight or obese. The 2025 target for 12-17 year olds is 28.3% (AHPC, 2017). Note: Data for Aboriginal and Torres Strait Islander children is reported in the Aboriginal Health section.

Although the 2014-15 Adelaide PHN average rate for children or young people aged 2-17 years who are obese or overweight (24.1 per 100 children) is consistent with the Capital Cities rate (26.3 per 100), rates are higher than the Adelaide PHN average in the northern sub-region of the Adelaide PHN. The highest rates are in the LGAs of Port Adelaide Enfield (27.0), Playford (26.1) and Salisbury (25.6) (AHPC, 2017).

The Northern Adelaide Clinical Council raised their concerns on the increasing obesity rates in childhood and the fact that the condition progresses into adulthood. They suggested that education, patterns of behaviour, technology use and not being able to play outside safely were causal factors (APHN, 2016a).

Early intervention and preventive health

Cancer Screening

Bowel cancer screening

In 2016-2017, in comparison to other PHNs, the Adelaide PHN had the 6th highest rate - 46.0%, of 50-74 year olds participating in the national bowel cancer screening program (AIHW, 2019b). The national rate being 41.3%. The 2016-2017 participation rate for Adelaide PHN was consistent with the 2015-16 rate of 46.5% (AIHW, 2019b).

In 2016-2017, participation in the program varied across the Adelaide PHN region, with the lowest rates of participation in the SA3's of Playford (37.3%), Port Adelaide-West (40.7%), Adelaide City (41.6%), Salisbury (42.0%) and Port Adelaide-East (43.3%) (AIHW, 2019b).

The Northern Adelaide Clinical Council suggested that the lower rates of bowel screening in the northern Adelaide PHN region are likely attributed to levels of education and literacy (APHN, 2016a).

Breast cancer screening

In 2016-2017, the Adelaide PHN had the 3rd highest rate of participation in the national breast cancer screening program (BreastScreen), at 59.9% of 50-74 year old women, in comparison with other PHNs. The national rate was 55.0 % (AIHW, 2019b). The 2016-2017 participation rate for Adelaide PHN was consistent with 59.4% in 2015-2016 (AIHW, 2019b).

Participation in the program increased with age, ranging from 53.9% of 50-54 year olds to 65.5% of 65-69 year olds, then declining to 58.0% in 70-74 year olds (AIHW, 2019b).

The 2015-2016 participation rates also varied by Adelaide PHN sub-region. The lowest rates of participation being in the SA3's of Playford (51.7%), Port Adelaide-East (52.4%), Port Adelaide-West (55.7%), and Salisbury (56.5%) (AIHW, 2019b).

Cervical cancer screening

In 2015-2016, the Adelaide PHN had the 8th highest rate of participation in the national cervical cancer screening program, at 57.5% of 20-69 year olds, with Country SA PHN 10th highest at 57.0%; the national rate was 55.4% (AIHW, 2019b). The 2015-2016 participation rate for Adelaide PHN is consistent with the 2014-2015 rate of 58.0% (AIHW, 2019b).

Participation in the program increased with age, ranging from 42.0% of 20-24 year olds to 63.7% of 50-54 year olds, then declining to 56.9% when 65-74 years of age (AIHW, 2019b).

The 2015-2016 participation rates also varied by Adelaide PHN sub-regions. The lowest rates of participation in the SA3s of Adelaide City (45.0%), Playford (46.8%), Port Adelaide-East (53.6%), West Torrens (54.4%) and Port Adelaide-West (54.5%) (AIHW, 2019b).

These patterns of geographical variation across the Adelaide PHN are consistent with the 2014-15 participation rates in the three national screening programs; residents of the northern, western and city areas of the Adelaide PHN having much lower participation rates compared to both the Adelaide PHN and national rates (AIHW, 2019b).

There appears to be a correlation between areas of low cancer screening participation and socio-economic status with three of these regions, Playford, Salisbury and Port Adelaide, having the lowest Index of Relative Socio-Economic Disadvantage (IRSD) scores in the Adelaide PHN region (PHIDU, 2017a).

Promotion of national cancer screening programs

In the April 2019 the Population Health Survey Module System (PHSMS), asked a series of questions about the Cervical and Bowel Screening program in South Australia as well as the Get Screened advertising campaign. The latter campaign was a joint project developed by the Adelaide PHN with SA Health and Country SA PHN (SA Health 2019a).

The cervical screening program encourages women to have a Cervical Screening Test every five years in line with the national policy, and the bowel screening program provides free screening for men and women aged from 50 to 74 years every two years. The PHN co-funded the joint Get Screened advertising campaign - "get screened and get on with living" slogan aimed to encourage South Australians to get screened for cervical, bowel and breast cancer.

The Survey showed that two-thirds of respondents reported participation in cervical screening within the last three years (N=1,231) and of these respondents (n=814) reporting participation in cervical screening, over a third (38%) booked an appointment because of a letter from their GP, a quarter (25%) due to a discussion with their GP, nearly a fifth (18%) because of a letter from the Cervical Screening Register and just over 10% after a text message from their GP (SA Health 2019a).

For Bowel screening, the Survey showed that 70% of respondents reported participation in bowel screening within the last three years (total respondents=1,128). Of the n=790 respondents reporting participation in bowel screening, over three-quarters (76%) did so because the kit came in the mail. Other common reasons were; due to recommendation by GP (23%), cancer experience of friends or family (13%), and promotion on TV or radio (8%). Not surprisingly, most of the respondents received their bowel screening kit through the National Bowel Cancer Screening Program (86%), while some respondents received their kit from the GP (10%) and only 1% bought their own. Of the n=329 respondents that did not report participation in bowel screening, over a quarter (29%) reported that they did not participate because they did not have the time or get around to it. The next most common reasons were; that the respondent had a colonoscopy (13%), that they hadn't received the kit in the mail (11%), and that they didn't have symptoms (6%) (SA Health, 2019a).

The Survey showed that the majority of respondents (81%) reported seeing or hearing any advertisements about getting screened for breast, bowel or cervical cancer in the past 12 months. The most commonly recalled advertisement was about bowel cancer screening which features footballers and Ita Buttrose (41%). The three advertisements with the "get screened and get on with living" slogan reported similar levels of recollection by respondents (14-15%). Of the n=947 respondents that reported seeing a cancer screening advertisement with the slogan "get screened and get on with living" (excluding the footballers and Ita Buttrose advert) over three-quarters (77%) saw an advertisement on free-to-air television. Only 12% recalled hearing a screening advertisement on radio, 10% on Facebook and approximately 8% on either websites, catch-up TV or newspapers (SA Health, 2019a).

Of the n=433 respondents that recalled a screening advertisement on a medium other than free-to-air television, over half of respondents believed that the main message of the advertisements were that early detection of cancer means a better chance of successful treatment (61%), and that a simple cancer screening test can save your life (60%) (SA Health, 2019a).

Childhood immunisation

As of March 2018 (April 2017 to March 2018 data), the 94% immunisation coverage rates for 1 – 5 year old children living in the Adelaide PHN region were close to reaching the national aspirational immunisation coverage target of 95% (DOH, 2018a). The immunisation coverage for 2-year-olds living in the Adelaide PHN region was lower, at 90% (DOH, 2018a). These rates were similar to the previous period. However, these coverage rates were not consistent across Adelaide PHN. Note: Data for Aboriginal and Torres Strait Islander children is reported in the Aboriginal Health section.

For the period October 2017 to September 2018, 1 year old children immunisation rates were lowest (when compared to Adelaide PHN rate of 94%) in the SA3s of: Adelaide City (89%), Holdfast Bay (91%), Port Adelaide – West (93%), and Norwood-Payneham-St Peters (93%). However, these SA3s have improved their rates (all 3% increase) from the previous reporting period (DOH, 2018b). Mitcham (96%), Salisbury (96%), Tea Tree Gully (96%), West Torrens (95%), Prospect-Walkerville (95%), Marion (95%) and Playford (95%) had higher rates than the Adelaide PHN average rate (DOH, 2018b).

For 2-year olds, none of the SA3s in the Adelaide PHN region had rates higher than the Adelaide PHN average rate. However, the majority of SA3s saw improvements in their rate when compared to the previous reporting period. The following SA3s had rates lower than 90% but had increment in their rates from previous reporting period: Adelaide City (87% - 11% increase), Charles Sturt (87% - 2% increase), Salisbury (89% - 1% increase), Norwood - Payneham - St Peters (89% - 1% increase), Marion (89% - 2% increase), Playford (87% - 5% increase) (DOH, 2018b).

For 5-year olds, immunisation rates had also improved when compared to previous reporting period. The SA3s which had the lowest (in comparison to Adelaide PHN average rate) were: Adelaide City (84% - 14% increase from reporting period), in Norwood - Payneham - St Peters (91% - 1% increase), Charles Sturt (91% - 2% increase), Salisbury (93% - 2% increase), Playford (93% - 2% increase) (DOH, 2018b).

Additionally, analysis of the Australian Immunisation Register (AIR) indicates that children from culturally and linguistically diverse backgrounds have lower coverage rates (AIR, 2016). Full detailed data not available.

Sexual Health and Blood Borne Viruses

In 2019, Adelaide PHN has been working collaboratively with SA Health (Communicable Disease Control Branch) in providing General Practice data to assist in the monitoring and surveillance of recent outbreak of infectious Syphilis among Aboriginal and Torres Strait Islander people living in South Australia. Consequently, Adelaide PHN is contributing to inform SA Health – Sexually Transmissible Infection (STI) and Blood Borne Virus (BBV) policy and service planning for Aboriginal and Torres Strait Islander people in SA. In 2020, the PHN will work with the CBC Branch to inform quality improvement initiatives for Adelaide Metropolitan General Practitioners. Furthermore, Adelaide PHN is a member of the SA Sexually Transmissible Infection and Blood Borne Virus Advisory Committee (SASBAC), a high-level committee, which monitors, BBV and STIs across metro, regional and remote South Australia.

In 2018, there were 8,556 new notifications of Sexually Transmitted Infections (STIs) and Blood-Borne Viruses (BBVs) in South Australia (Fearnley et al. 2018). This is a 3% increase in the number of new notifications since 2017. In 2018, there were 6,256 notifications of Chlamydia (*Chlamydia trachomatis*), making this the most commonly notified STI in South Australia (Fearnley et al. 2018). Data was not available by PHN or lower Statistical Areas within the PHN.

SA Health has indicated that sex workers, men who have sex with men, transgender people, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people and young people are at greater risk of sexually transmitted infections (SA Health, 2019b).

Analysis of Adelaide PHN General Practice data for 2018 (APHN 2019f), indicates there were a total of 1,029 patients who visited a general practice within the time period and have a coded diagnosis for Chlamydia, Gonorrhoea, Trichomoniasis, or Syphilis.

By gender, females tend to be over-represented in the total coded diagnosis for all STIs than males and in particular, for coded diagnosis of Chlamydia. Regardless, Chlamydia had the greatest number of coded diagnosis for all patients who visited a general practice in 2018 (APHN 2019f).

By age groups, in both male and female sub-groups, aged 20 to 29 years old, had the greatest number with a coded diagnosis for Chlamydia. The data also shows that there is growing concern for coded diagnosis of STIs for the older age groups of 30 to 49 years old (APHN 2019f).

A recent 2019 survey of 2,380 South Australians aged 16–29 years, asked a number of questions related to their sexual health (SAHMRI 2019). [Participant demographics included: 10% of Aboriginal and/or Torres Strait Islander origin; 3% born outside of Australia; 74% identified as heterosexual, 17% bisexual, 2% lesbian, and 4% gay]. Survey participants responded that 43% had ever had a test for STIs. Of concern was the lack of knowledge on STIs. For example, only 2 out of 10 youth who participated in the survey were aware there was a medication to cure Hepatitis C, and 45% did not know Chlamydia could lead to a woman becoming infertile. Condom use (in the past 12 months) was also reported to be low, with only 21% of those with regular partners and 36% of those with casual partners, using condoms (SAHMRI 2019).

In the Adelaide 2018 Gay Community Periodic Survey (Broady et al. 2019), nearly three-quarters of men who have sex with men (71.3%) reported knowing that post-exposure prophylaxis (PEP) was available. PEP awareness has increased over time, from 59.2% in 2011 to 71.3% in 2018. There has also been a rapid increase in the awareness of pre-exposure prophylaxis (PrEP), from 25.5% in 2014 to 77.7% in 2018. The proportion of non-HIV-positive men who reported taking a prescribed course of PEP in the six months prior to the survey increased from 2.4% in 2014 to 4.9% in 2018.

The increase in PrEP use was more dramatic, with the proportion of non-HIV-positive men who reported PrEP use increasing from 0.8% in 2014 to 16.1% in 2018. Among men who reported taking a prescribed course of PrEP in the six months prior to the 2018 survey, more than half

obtained PrEP through a trial or study (59.2%) and one in four obtained it from a chemist (25.4%). Men who obtained PrEP from a chemist are assumed to have received a prescription for PrEP from their doctor, reflecting the listing of PrEP on the Pharmaceutical Benefits Scheme in 2018. The listing of PrEP on the PBS has opportunities for the Adelaide PHN in providing further support (e.g. education) to General Practitioners in the region.

Chronic Conditions

Chronic conditions are long lasting with persistent effects. Their social and economic consequences can impact on peoples' quality of life.

Between July 2014 to June 2016, the SA3s within the Adelaide PHN region with the highest percentage of chronic disease overall were, Port Adelaide-West followed by West Torrens and Salisbury. In recent data (July 2016 to March 2018), only Port Adelaide-West was in the top three, and Adelaide City, followed by Playford were now highest (SA Health, 2018a).

Chronic disease prevalence data shows substantial geographical variation within the Adelaide PHN, with rates generally higher in the northern, western and southern areas (PHIDU 2018). The following section present the prevalence rate for Adelaide PHN, the national comparison rate and the sub-regions with the highest rates for selected chronic conditions.

Diabetes

Modelled estimates for 2011-12 indicated that Adelaide PHN had a diabetes prevalence of 6.8 per 100 population, slightly above the Australian rate of 5.4 per 100 people (PHIDU 2018).

Across the region, the PHAs with the highest rates in this period were Port Adelaide Enfield (9.1 per 100, 29% higher than APhN), Playford and Charles Sturt (both 8.0 per 100, 16% higher) (PHIDU 2018).

Between July 2014 to March 2018, the Statistical Area 3s within the Adelaide PHN region with the highest diabetes prevalence were Marion, Playford and Port Adelaide-West from July 2014 to June 2016, and Port Adelaide-East, Salisbury and Port Adelaide-West from July 2016 to March 2018 (SA Health, 2018a).

Cardiovascular conditions

Modelled estimates for 2011-12 indicated that Adelaide PHN had a circulatory system disease prevalence of 16.7 per 100 people, consistent with the Australian rate of 16.9 per 100 (PHIDU 2018).

Across the region, the PHAs with the highest rates in this period were Playford and Norwood Payneham St Peters (both 17.5 per 100 people) and Charles Sturt (17.3 per 100) (PHIDU 2018).

Between July 2014 to March 2018, the Statistical Area 3s within the Adelaide PHN region with the highest cardiovascular disease prevalence were Norwood-Payneham-St Peters, West Torrens and Marion from July 2014 to June 2016, and Campbelltown, Playford, and Port Adelaide-West from July 2016 to March 2018 (SA Health, 2018a).

Modelled estimates for 2011-12 indicated that 34.4 per 100 people in Adelaide PHN had high blood cholesterol, consistent with the Australian rate of 34.7 per 100 people (PHIDU 2018). The PHAs of Adelaide and Mitcham (both 36.3) and Burnside (35.9 per 100) had slightly higher rates compared to Adelaide PHN (PHIDU 2018).

Respiratory conditions

Modelled estimates for 2011-12 indicated a respiratory disease prevalence of 30.7 per 100 people in Adelaide PHN, marginally higher than the Australian rate of 28.7 per 100 people (PHIDU 2018).

The PHAs of Onkaparinga (34.4 per 100, 11% higher than APhN rate) and Playford (34.2 per 100, 11% higher) had the highest rates in the region (PHIDU 2018).

Asthma

Modelled estimates for 2011-12 indicated that 10.2 per 100 people in Adelaide PHN had asthma, consistent with the Australian rate of 10.1 per 100 people (PHIDU 2018). The PHAs of Playford (11.4) and Onkaparinga (10.9) had the highest rates (PHIDU 2018).

Between July 2014 to March 2018, the SA3s within the Adelaide PHN region with the highest asthma prevalence were Playford, Marion and Salisbury from July 2014 to June 2016, and Playford, Marion and Port Adelaide – West from July 2016 to March 2018 (SA Health, 2018a).

Chronic Obstructive Pulmonary Disease (COPD)

Modelled estimates for 2011-12 indicated that 2.2 per 100 people in Adelaide PHN had COPD, consistent with the Australian rate of 2.4 per 100 people (PHIDU 2018). The PHA of Playford (2.7) had the highest rate (PHIDU 2018).

Between July 2014 to March 2018, the SA3s within the Adelaide PHN region with the highest prevalence were Playford, West Torrens, Campbelltown from July 2014 to June 2016, and Playford, Port Adelaide – East and Salisbury from July 2016 to March 2018 (SA Health, 2018a).

Musculoskeletal system conditions

Modelled estimates for 2011-12 indicated a musculoskeletal system disease prevalence of 27.8 per 100 people in Adelaide PHN, consistent with the Australian rate of 27.7 per 100 people (PHIDU 2018). The PHAs of Playford (30.0 per 100) and Salisbury (29.3) had the highest rates in the region (PHIDU 2018).

Arthritis

Modelled estimates for 2011-12 indicated that 15.3 per 100 people in Adelaide PHN had arthritis, consistent with the Australian rate of 15.6 per 100 people (PHIDU 2018). The PHAs of Playford (17.4) and Port Adelaide Enfield (16.1) had the highest rate (PHIDU 2018).

Between July 2014 to March 2018, the SA3s within the Adelaide PHN region with the highest prevalence were West Torrens, Playford and Adelaide City from July 2014 to June 2016, and Unley, Port Adelaide – East and Salisbury from July 2016 to March 2018 (SA Health, 2018a).

Osteoporosis

Between July 2014 to March 2018, the SA3s within the Adelaide PHN region with the highest osteoporosis prevalence were Norwood - Payneham - St Peters, West Torrens and Mitcham from July 2014 to June 2016, and Norwood - Payneham - St Peters, Port Adelaide – East and Onkaparinga from July 2016 to March 2018 (SA Health, 2018a).

Kidney disease

Modelled estimates for 2011-12 indicated a chronic kidney disease prevalence of 7.7 per 100 people, lower than the Australia rate of 10.0 per 100 (AIHW 2017a). The PHAs of Adelaide and (9.6) and Elizabeth/ Smithfield - Elizabeth North (9.5) had the highest rates in the region (AIHW 2017a).

Comorbidities

Comorbidities are a growing challenge for health professionals and patients in managing their chronic conditions in Australia. Latest (PHN level) data indicates 25% of the Adelaide PHN population had two or more chronic conditions, and 16% had three or more (BEACH, 2016). Between April 2011 and March 2015 approximately 60% encounters with General Practitioners in Adelaide PHN were for chronic conditions, a higher rate compared with Other Australian Capital Cities (52%) and the national rate (56%) (BEACH, 2016). No recent PHN data was available for comparison (in addition to types of chronic conditions).

A joint Adelaide PHN and Country SA PHN HealthPathways Consumer survey (N=110) targeting consumers (i.e. those with chronic conditions and carers) reported that for Adelaide PHN

participants (n=101), chronic pain, mental health, arthritis, asthma, diabetes and COPD were the top conditions respectively for HealthPathways prioritization. Other conditions reported included Myalgic Encephalomyelitis/Chronic Fatigue Syndrome or ME/CFS, Fibromyalgia, and Hashimoto's Thyroiditis (APHN, 2018a).

The survey also reported that majority of the participants had a range of comorbidities. The majority had chronic pain and mental health as comorbidities while those with chronic pain reported multiple comorbidities (e.g. mental health, arthritis, and asthma) while participants with mental health reported chronic pain and asthma as top comorbidities (APHN, 2018a).

Chronic pain

For Chronic Pain, the most recent prevalence study in South Australian in 2010 showed that:

- 17.9% of the overall population have chronic pain.
- 5% of people have severe pain that interfered with daily activity.
- Chronic pain was associated with older age, living alone, lower income, not being in full-time work and lower educational levels (Currow et al., 2010).

This study highlights the high levels of pain with extreme effects on day-to-day life (one in 20 people), the complex inter-relationship of the factors including educational achievement and work status associated with chronic pain, and the impact that these factors have on the people experiencing disabling pain in the longer term. Based on SA population, approximately 250,000 people experience chronic pain, of these approximately 70,000 have severe pain requiring input from a tertiary chronic pain service. Approximately one in ten of these patients experience pain related to cancer. There are around 3,000 new cases referred to chronic pain services each year (Currow et al. 2010).

As mentioned earlier the dedicated (joint Adelaide PHN and Country SA PHN) HealthPathways SA survey targeting consumers (i.e. those with chronic conditions and carers) reported that the majority of Adelaide PHN participants had chronic pain and mental health as comorbidities while those with chronic pain reported multiple comorbidities (e.g. Mental health, arthritis, and Asthma) while participants with mental health reported chronic pain and asthma as top comorbidities (APHN, 2018a).

The key challenges for those with chronic pain included experiences of long waiting lists (3+ years) for LHN pain services, frustration at not being believed or taken seriously by health professionals and maintaining active lifestyles despite being in pain. Participants found peer support (face-to-face and online), physiotherapy and mental health services such as CBT, mindfulness and group therapy most beneficial for managing their condition (APHN, 2018a).

Cancer

Prevalence

Between July 2014 to March 2018, the SA3s within the Adelaide PHN region with the highest cancer prevalence were West Torrens, Marion and Norwood - Payneham - St Peters from July 2014 to June 2016, and Norwood - Payneham - St Peters, Holdfast Bay, Marion from July 2016 to March 2018 (SA Health, 2018a).

Cancer Incidence

There are some variations in cancer incidence rates for several cancer types when compared to the national Age-Standardised Rate. Apart from lymphoma (17% higher than national rate), other cancer incidences (i.e. melanoma, head and neck, leukemia, colorectal, lung, ovarian, thyroid) for the Adelaide PHN was lower than the national rate (AIHW, 2016a).

In comparison to the national ASR rate, for cancer incidence by Statistical Area Level 3 in the Adelaide PHN region, the data shows that Melanoma rates were lower in all SA3s with Salisbury (SA3) at 52% below national rate. However as seen in the geographical variation below, breast, colorectal, lung and prostate cancers incidences are of concern (AIHW, 2016b).

- Adelaide City: 26% higher for breast cancer for women (all ages) and 39% higher for women aged 50 to 69 years old; 6% higher for prostate cancer
- Burnside: 18% higher for breast cancer for women (all ages) and 17 % higher for women aged 50 to 69 years
- Prospect-Walkerville: 46% higher for breast cancer for women (all ages) and 62% higher for women aged 50 to 69 years old; 11% higher for colorectal cancer (all ages); 9% higher for lung cancer
- Unley: 6% higher breast cancer for women (all ages)
- Playford: 5% higher for colorectal cancer (all ages) and 11% higher for people aged 50 to 74 years; 47% higher for lung cancer
- Port Adelaide – East: 20% higher for lung cancer
- Port Adelaide – West: 13% higher for colorectal cancer (all ages) and 8% higher for people aged 50 to 74 years; 29% higher for lung cancer
- Salisbury: 10% higher for colorectal cancer for people aged 50 to 74 years; 16% higher for lung cancer
- Holdfast Bay: 8% higher for breast cancer for females aged 50 to 69 years; 8% higher for prostate cancer
- Marion: 8% higher for breast cancer for females (all ages) and 5% higher females aged 50 to 69 years; 8% higher for prostate cancer
- Onkaparinga: 5% higher for breast cancer for females (all ages)
- West Torrens: 7% higher for breast cancer for females (all ages)

Cancer Mortality

When compared the national ASR rate, the mortality rates for the Adelaide PHN varied for selected cancers. The Adelaide PHN mortality rates for breast (3%), colorectal for all ages (5%), pancreas (6%), colorectal for 50 to 74 years old (11%) and lymphoma (19%) cancers were above the national rates (AIHW, 2016a).

There were geographical variations by mortality by cancer types by SA3's when compared to the national rates. As reported below, mortality rates for breast, colorectal and lung are of concern (similar to incidences rates of these cancers) (AIHW, 2016b).

- Burnside: 14% higher for Melanoma cancer
- Prospect-Walkerville: 28% higher for breast cancer for females (all ages) and 18% higher for colorectal cancer
- Playford: 26% higher for breast cancer for females (all ages) and 13% higher for females 50 to 69 years; 20% higher for colorectal cancer (all ages) and 33% higher for people aged 50 to 74 years; 62% higher for lung cancer; 13% higher for prostate cancer
- Port Adelaide – East: 36% higher for breast cancer for females (all ages); 11% for colorectal cancer; 36% higher for colorectal cancer for people aged 50 to 74 years
- Port Adelaide – West: 41% higher for colorectal cancer (all ages) and 41% higher for people aged 50 to 74 years; 39% higher for lung cancer
- Salisbury: 15% higher for breast cancer for females (all ages) and 33% higher for females aged 50 to 69 years; 11% higher for colorectal cancer (all ages) and 24% higher for people aged 50 to 74 years; 22% higher for lung cancer
- Tea Tree Gully: 10% higher for colorectal cancer for people aged 50 to 74 years
- Marion: 37% higher for colorectal cancer for people aged 50 to 74 years
- Mitcham: 23% higher for breast cancer for females (all ages)
- Onkaparinga: 8% higher for breast cancer for females (all ages) and for females aged 50 to 69 years; 9% higher for colorectal cancer for people aged 50 to 74 years; 11% higher for Melanoma
- Charles Sturt: 12% higher for breast cancer for females (all ages) and 35% females aged 50 to 69 years; 19% higher for colorectal cancer and 22% higher for people aged 50 to 74 years

3.2 Health service utilization

General Practice visits

Between July 2016 to March 2018, 88% of the participants in the State reported visiting a general practitioner in the past 12 months at least once (SAMSS, 2018a). The top three SA3s with the highest proportion of participants visiting a general practitioner (in the past 12 months) were: Port Adelaide-West (95%), Adelaide City (94%), Norwood-Payneham-St Peters (93%) respectively (SAMSS, 2018). For the same reporting period, 31.4% of participants indicated visiting a general practitioner in the past four weeks (SAMSS, 2018). The top three SA3s with the highest proportion of participants visiting a general practitioner (in the past four weeks) were: West Torrens (53%), Port Adelaide-East (39%) and Tea Tree Gully (39%) (SAMSS, 2018).

After-Hours services

PHN analysis of SA Health data indicated that approximately two-fifths of all unplanned Emergency Department (ED) presentations in the 2013/14 and 2014/15 financial years occurred in the after-hours period, and two-fifths of these presentations were triaged as semi-urgent or non-urgent (SA Health, 2015d). Approximately two-thirds of these presentation were self-, relative- or friend-referrals. The Local Government Areas of Playford, Onkaparinga, Adelaide City and Walkerville had the highest presentation rates in this period.

Approximately 1 out of every 10 presentations was for a potentially preventable-type condition. Ear, Nose, Throat infections, Cellulitis, Urinary Tract infections, Dental conditions and Asthma were potentially preventable conditions presenting at EDs in the after-hours period in Adelaide PHN region especially the LGAs of Playford and Onkaparinga (SA Health, 2015d).

Data provided by the National Health Performance Agency (NHPA, 2017) indicate that in the 2013/14 financial year, the SA3s with the highest average number of unplanned, non-urgent, semi-urgent and urgent after-hours ED attendances in the Adelaide PHN region were SA3s of Playford (135 attendances per 1,000 people), Onkaparinga (125 attendances) and Adelaide City (102 attendances). Other SA3s of Salisbury (101 attendances), Port Adelaide-East (96 attendances), and Charles Sturt (97 attendances) had rates higher than the Adelaide PHN average of 93 attendances per 1,000 people (NHPA, 2017a).

For 2015/16, there were 90 after-hours ED attendances per 1,000 people for the Adelaide PHN region. The 2015-16 data shows the following SA3s had higher after-hours ED attendances when compared to the Adelaide PHN average: Playford (132 attendances), Onkaparinga (117), Port Adelaide-West (101), Salisbury (97), Charles Sturt (95) and Adelaide City (94) (NHPA, 2017b).

Between 2012/13 and 2014/15, non-urgent after-hours attendances by general practitioners increased by 23%, and urgent after-hours attendances by 26% in the same period (DOH, 2015). Trend data by the National Health Performance Agency (NHPA, 2017a) indicates that the after-hours GP attendances has increased from 0.53 attendances per person (age-standardised) in 2013/14 to 0.65 attendances in 2016-17. In 2013/14, the SA3s of Playford, Port Adelaide-West and Charles Sturt had the highest rates after-hours GP attendances per person respectively (NHPA 2017b). These SA3s still had the highest rates in 2015-16. However, in 2016-17, the following SA3s had the highest rates of after-hours GP attendances respectively: Playford, Port Adelaide-West, Port Adelaide-East and Salisbury (note: rates has increased from previous reporting periods) (NHPA, 2017b).

The rate of use of GP services use in the after-hours period is higher in Adelaide PHN compared to rates for all metropolitan PHNs (grouped) and the National rate (AIHW, 2019h). Rates of GP after-hours activity in the Adelaide PHN have increased by 19% in over the five years from 2013-14 to 2017-18 with rates of use remaining consistent for last 3 years.

In 2017-18, 29% of Adelaide PHN residents, approximately 360,000 people, had used an After-Hours GP service, with 25% using a non-urgent service and nine percent an urgent service. Over

800,800 services were delivered in the after-hours period in 2017-18 equivalent to an ASR of 65 services per 100 people (AIHW, 2019h).

Almost one out of every ten people (9.1%) in Adelaide PHN had used an urgent GP after-hours service in 2017-18. This equates to a rate of 15.0 services per 100 people, more than twice the national rate of 6.3 services per 100 people (AIHW, 2019h).

Use of After-hours GP services was highest amongst children aged 0-14 years and older adults aged 80+ years for non-urgent, urgent and total service types (AIHW, 2019h). The rate of GP after-hour services provided to people aged 80+ years was three times the rate for Adelaide PHN residents aged 15-24, 45-64, and 65-79 years, and twice the rate for people aged 25-44 and 0-14 years (AIHW, 2019h).

Use of HealthDirect helpline

In 2016 there were 82,567 calls to the HealthDirect helpline (Nurse Triage) while in 2017, there were 87,008 calls. In 2017, residents living in the LGAs of Playford, Salisbury, Tea Tree Gully, Onkaparinga and Adelaide City made the most call episodes to the HealthDirect helpline (Nurse Triage) (HealthDirect Australia, 2018). In the 2016 and 2017 approximately 4% of all calls made by Adelaide PHN residents to the Nurse (Triage) Helpline were triaged to the After-Hours GP Helpline (HealthDirect Australia, 2018).

Analysis of the HealthDirect Australia data shows that for 2016 there were 3,345 calls made to the After-Hours GP Helpline consistent with the 2017 figure of 3,363 calls. In 2017, residents living in the LGAs of Playford, Salisbury, Tea Tree Gully, Marion and Onkaparinga made the most calls to the After-Hours GP Helpline (HealthDirect Australia, 2018).

Recent data shows that for 2018, 36% of the 3,980 calls made to the After-Hours GP Helpline concerned children, with 1,120 calls for patients aged 0-4 years old (HealthDirect Australia, 2019).

After-hours service awareness

While there are currently a number of Medical Deputising Services operating in the after-hours period across the Adelaide PHN, analysis of their service boundaries show that there are pockets within in the north of the Playford LGA, and south-eastern region of the Onkaparinga LGA that are not being serviced (APHN, 2016f).

Community consultations conducted by the former Medicare Locals in the Adelaide PHN region raised a number of issues including limited understanding of the available after-hours services in the metropolitan region, especially in the outer northern and southern metropolitan suburbs and for those residing in aged care facilities (CAHML, 2015; SAFKIML, 2015; NAML, 2015).

There was also concern that a lack of appropriate after-hours health care services, e.g. mental health, crisis support, leading to preventable hospital presentations (CAHML, 2015; SAFKIML, 2015; NAML, 2015).

In 2019, the Adelaide PHN membership groups (CAC and CC's) raised the need to improve awareness of after-hours services among the community and providers was still an issue in the Adelaide PHN region. The Central CC commented on the need for greater promotion of after-hours services in primary health care to ensure community uptake, particularly in culturally and linguistically diverse communities. The Northern CAC raised the need for GP's to improve the promotion of after-hours services to their patients. The Northern CC commented that GPs are referring patients to ED rather than after-hours services and greater awareness is needed among GPs in order to avoid this (APHN, 2019b).

The Southern Adelaide Clinical Council reported during a planning workshop that young people in crisis do not always receive help in a timely manner. The Central Adelaide Clinical Council also reported that there is a lack of available psychiatric services and the Northern Adelaide Clinical Council raised the issue that mental health services were 9 to 5 and an extended hour 'walk in clinic' was needed in the North (APHN, 2016a).

Members also considered there to be a lack of after-hours mental health services to address the needs of children and youth, people with AOD issues, Aboriginal and Torres Strait Islander populations, and the LGBTIQ community. Members also identified that more after-hours services are required for other vulnerable population groups including people experiencing homelessness, those with low incomes, and the elderly (APHN, 2019b).

As well as mental health services, members suggested that after-hours services for pharmacy, dental health, sexual health, and domestic violence support were also lacking across in the region. Council members also suggested that more phone services, counselling, allied health and nursing specialists, and community related services such as those associated with community centres and lived experience support were needed in the after-hours period (APHN, 2019b).

Feedback gained from the workforce (GPs, Business and Practice Managers, SA Ambulance Service staff, and LHN Nurses) participating in the Priority Care Centre (PCCs) trial identified several accessibility barriers that limit the service ability in the after-hours. These included access to support services such as pharmacy, radiology and pathology due to restricted operating hours; GP recruitment issues in the after-hours period; current operating hours of PCCs (in-hours) mismatch high demand times in emergency departments (sociable after-hours) (APHN, 2019c).

Potentially preventable hospitalisations (PPH)

Hotspots

Following the work by Duckett and Griffiths (2016) published as “Perils of Place: identifying hotspots of health inequalities”, a recent PHIDU analysis on PPH provides another framework to identify the existence of areas with persistently high PPH rates over time. It utilises two measures; (i) “hotspots” or the degree of temporal persistence of PPHs over time and (ii) difference in PPH (ASR) rates, with the Australian rates via heatmaps. Adelaide PHN regards this new PHIDU work as another suite of evidence to highlight areas where interventions can be targeted.

The below Population Health Areas (PHAs) are regarded as “hot” with rates of 50% more than the Australian average for the period 2012/13 - 2016/17 for specified PPHs categories (i.e. PPH rates consistently over specific Australian rate in recent four out of five years) (PHIDU, 2019):

All PPHs (categories) – 2 PHAs:

- Davoren Park (Northern Adelaide Local Health Network (NALHN) region); and
- Elizabeth/Smithfield-Elizabeth North (NALHN).

Acute PPHs

- Elizabeth/ Smithfield-Elizabeth North (NALHN).

Chronic PPHs – 3 PHAs:

- Davoren Park (NALHN);
- Elizabeth/ Smithfield-Elizabeth North (NALHN); and
- Christie Downs/ Hackham West – Huntfield Heights (SALHN).

Vaccine-preventable conditions PPHs – 6 PHAs:

- Davoren Park (NALHN);
- Elizabeth/ Smithfield-Elizabeth North (NALHN);
- Enfield-Blair Athol (NALHN);
- Christie Downs/ Hackham West – Huntfield Heights (SALHN);
- Charles Sturt-North West (CALHN); and
- Dry Creek-South/ Port Adelaide/ The Parks (CALHN).

Overall observation of the data shows the following 3 PHAs have continued temporal persistence of PPHs over time and significant rates above the Australian average:

1. Davoren Park (NALHN);
2. Elizabeth/ Smithfield-Elizabeth North (NALHN); and
3. Christie Downs/ Hackham West – Huntfield Heights (SALHN) (PHIDU, 2019).

PPH conditions

In 2013-14 the age-standardised rate of potentially preventable hospitalisations (PPH) in the Adelaide PHN was 2,446 hospitalisations per 100,000 people, consistent with the Australian average rate (NHPA, 2015b). The 2016-17 data reported that the PPH rate for the Adelaide PHN had slightly increased to 2,653 per 100,000 people (note: is similar to the national rate for 2016-17) (AIHW, 2018f).

In 2013-14, approximately six percent (6%) of hospitalisations were for vaccine preventable conditions. Acute conditions, primarily dental conditions, kidney and urinary tract infections, cellulitis and ear, nose and throat infections, accounted for 47% of PPH. Chronic conditions also accounted for 47% of PPH, with the highest rates for chronic obstructive pulmonary disease (COPD), congestive heart failure, diabetes complications, iron deficiency anaemia and angina (NHPA, 2015b). In 2016-17, the majority of PPH hospitalisations in the Adelaide PHN were for chronic (42%) and acute conditions (49%), with vaccine-preventable conditions accounting for 9%. This was analogous to national trends. The highest PPH for acute conditions and chronic conditions were similar to the 2013-14 trends with pneumonia and influenza the highest for vaccine preventable conditions for both reporting periods (AIHW, 2018f).

In 2013-14, the top five conditions (out of 22 conditions) contributed to approximately half of the total PPH in the region and almost two-thirds of total bed days. Heart failure contributed to the highest proportion of bed days with 16.3% (and 9.1% of PPH), followed by COPD, 14.8% bed days (10.7% of PPH), kidney and urinary tract infections 13.1% (11.7% of PPH), diabetes complications 10.1% bed days (7.2% of PPH) and cellulitis 9.7% of bed days (8.9% of PPH) (NHPA, 2015b). This trend was similar for the 2016-17 data (AIHW, 2018f).

In 2013-14, age-standardised rates of PPH varied across the Adelaide PHN region (NHPA, 2015b). Rates for Total PPH were highest in the north and north-west areas of the Adelaide PHN, specifically the Statistical Area Level 3s of Playford, Port Adelaide – West, Salisbury and Port Adelaide – East. Rates were lowest in Burnside, Unley and Prospect – Walkerville. For 2016-17, the same SA3s had the highest (and increased) PPHs although the rates for Port Adelaide-West has somewhat reduced. The SA3 of Playford had the highest PPH rate of 3,941 hospitalisations per 100,000 people in Adelaide PHN. (AIHW, 2018f).

In 2013-14, the four SA3s (i.e. Playford, Port Adelaide – West, Salisbury and Port Adelaide – East) as well as Onkaparinga in Adelaide PHN's south, had the highest rates of PPH for Chronic conditions respectively (NHPA, 2015b). In 2016-17, the trends were similar although Prospect – Walkerville is now 4th highest instead of SA3 of Port Adelaide-East (AIHW, 2018f).

There was less variation in the PPH rates for Acute and Vaccine-preventable across the region, but they were highest in the SA3s of Playford, Adelaide City, Port Adelaide – East, Salisbury, Tea Tree Gully, Marion and West Torrens respectively (NHPA, 2015b).

Children and young people

Analysis of data (2012/13 – 2014/15) from SA health have shown increasing concern for specific potentially preventable conditions - Ear, Nose and Throat infections, Asthma, Dental conditions, Urinary tract infections and Diabetes complications, among the child and youth presenting at Emergency Departments in Adelaide PHN region (SA Health, 2016a).

Young children have the highest rates of preventable hospitalisation due to dental conditions. More than half (52%) of the almost 24,500 Dental Caries potentially preventable hospitalisations (PPHs) in the past seven years (2007-08 to 2013-14) were for children aged under ten years old (SA Health, 2015a).

Between July 2012 and June 2014, a total of 12,037 South Australians were admitted to hospital for acute preventable dental conditions, making dental conditions the leading cause of PPHs in this period. (SA Health, 2015a).

Lower urgency care

Recent analysis of AIHW data of the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD), for period 2015–16, 2016–17 and 2017–18 for ED presentation for lower urgency care showed variations in age-standardised rates (per 1,000 population) for All hours, In-hours and After-hours in Adelaide PHN region (by SA3s and LHNs) (AIHW, 2019g).

In 2017-18 the lower urgency ED rates for all persons by LHNs were (AIHW, 2019g):

Geography	All hours (% difference with APHN)	In-hours (% difference with APHN)	After-hours (% difference with APHN)
APHN	85.7	43.6	42.1
NALHN	91.5 (6.8%)	46.3 (6.1%)	45.2 (7.3%)
CALHN	71.9 (-16.2%)	34.3 (-21.3%)	37.5 (-10.9%)
SALHN	96.9 (13.1%)	52.4 (20.3%)	44.5 (5.6%)

The following SA3s had the highest lower urgency ED per 1,000 population rates across All hours, In-hours and After-hours for all persons when compared to the Adelaide PHN rates:

1. Onkaparinga (SALHN)
2. Charles Sturt (CALHN)
3. Port Adelaide-West (CALHN)
4. Playford (NALHN) (AIHW, 2019g)

Factors impacting service use and provision

Health literacy

Australian research indicates that health literacy is limited in a significant proportion of the general Australian population (Barber et al., 2009). In 2006, 59% of South Australians aged 15-74 years had low health literacy levels indicating they may not have the health literacy skills needed to navigate and understand health information and services (ABS, 2006). While dated, this is the latest health literacy data from the ABS. More recent research by Adams et al. (2009) suggest that 45% of South Australians were 'at risk' or 'of high likelihood' of having low functional health literacy. A 2011-12 ABS (2012) reported in SA, 47% of people (aged 15 to 74) had low literacy, compared to 44% Australia wide.

Consultations facilitated with the membership groups of the Adelaide PHN identified that improving health literacy of both the community and primary care workforce was a key need that required addressing in a coordinated manner (APHN, 2016b APHN, 2016c; APHN, 2016d). Members determined that improvements to health literacy of the community could have the following impacts:

- Improve and encourage the uptake and application of preventative measures
- More informed about healthy child development and developmental behaviours
- More empowered and involved in their own care
- Increased ability to make informed decisions and better understand health conditions
- Have awareness where to access appropriate services.

Members determined that improvements to health literacy of health professionals could have the following impacts (APHN 2016a, 2016b, 2016c, 2016d):

- Improve and encourage consumer uptake and application of preventative measures, particularly early intervention for chronic diseases

- Reduce unwarranted variation in care
- Improve communication with consumers through use of plain language, provide transparent information about fees and reasons for referral pathways selected
- Better understanding of the health needs of people with disabilities
- Improve the cultural safety of services, including specialist services.

Access, integration and coordination

The need to address current service access, integration, coordination and navigation barriers were raised as a priority by multiple APHN membership groups (APHN, 2016a, 2016c, 2016d) and during APHN facilitated GP's Roundtable Workshops with GPs in the region (APHN, 2019d). A summary of the barriers and specific needs raised under each theme are provided below:

Timely access and navigation

- Urgent mental health care was difficult to access and that there were often long waiting times for other mental health services, including commissioned ones
- Access to services is hampered by challenging pathways and referral processes, including eligibility criteria, lack of clear processes and follow-up
- Limited availability of primary health services and community-based after- hours services
- Limited knowledge of what services are available for people experiencing chronic pain.
- A need for better pathways for consumers to enable navigation through the primary health care system (particularly for the socially isolated, at risk families, mental health, and vulnerable populations)
- Too complex for consumers and users in navigate system properly – consequently the inability to access information or programs pertinent to them
- The importance of consumers and carers knowing about services and how to access them
- The need to improve coordination and access to primary health care services and programs and build the capacity of the primary health care workforce (incl. GPs) to meet the needs of at risk and vulnerable people.
- Staff to be adequately trained to enable timely and accessible services
- Affordability and cost of accessing health services despite the availability of quality and quantity of chronic disease services.
- GPs identified that a range of people in the Adelaide PHN region cannot access services that meet their needs. This includes services for underserved groups and populations as well as overall preventive care and condition management.

Integration and coordination

- Lack of system integration e.g. standardized access and integration processes between primary care and both public and private hospital services
- Need to increase integration through coordination and communication between services and practitioners
- Integrated approaches are the key need for (improving) care coordination, integration and navigation
- Less fragmentation and more cooperation and linkages both within the primary health care sector and between primary and intermediate care settings
- The need to coordinate pathways to primary health care
- Coordination of care and systems and where health providers communicate and share information about patients in minimising the duplication of information
- A primary health care service model which is interagency and interdisciplinary, particularly for people with additional needs e.g. living with a disability
- Inclusive of and supportive of formalised carers and care coordinators.

- Currently a lack of a unified / interfacing communication system and culture of care coordination
- Primary health system is not responsive – conditions need to escalate before able to access services, and currently there is a lack of holistic discharge planning

Collaboration with acute services

To identify issues and opportunities to achieve successful and productive working relationships between the primary and acute services, Adelaide PHN facilitated workshops with GPs in the region and representatives from the three Local Health Networks. In line with the findings of the Adelaide PHN membership group consultations presented above, the GP and LHN workshops also identified a lack of collaboration as an important issue and opportunity (APHN, 2019d).

- Communication

The largest common theme when looking at what GPs raised as issues in collaboration between them and the acute sector was communication. This was not just timely clinical communication about patients and associated issues, but also extended to general communication around service availability and changes.

- Access

Access to LHN services was also identified as an issue. They reported the services were unevenly distributed and difficult to refer patients to, either because of length of waiting time or a complicated referral process (APHN, 2019d).

Further and more detailed findings of these workshops are provided in the Workforce and Digital Health chapter under *Issues and opportunities*.

3.3 Primary care needs for priority populations

Children and young people

Adelaide PHN consultations identified that access to appropriate and timely services for children and young people, particularly in relation to early intervention, prevention and support services and mental health services were key needs for this population group (APHN 2016a, 2016d, 2018d).

Support and coordinated services for families with complex needs was also identified as a need for this population group, as was the need to improve the (current) disjointed service delivery models which present multiple barriers to the provision of services being child-focused (APHN, 2016d). A lack of identified care coordinators and a lack of funding and capably skilled workforce were identified as impacting levels of care coordination and collaboration (APHN, 2016d).

Another issue raised that specifically impacts this population group was the current long wait times for autism diagnostic assessments (APHN 2016a, 2016d, 2018d). Diagnosis of Autism Spectrum Disorders (ASD) in South Australia is impeded by long wait lists, particularly at public hospitals, and significant costs of private assessment services, which can be upwards of a thousand dollars (Taylor et al. 2016).

In 2010, Autism SA reported that wait times in public hospitals varied between 8–14 months (Autism SA 2010), with more recent figures from the Women’s and Children’s Hospital (WCH) Child Development Unit (CDU) (WCH, 2019b) and Local Health Networks (NALHN 2019) indicating current waiting times (as of 2018-2019) were between 14–18 months and 25 months respectively.

From January to December 2018, the Women’s and Children’s Hospital (WCH) Child Development Unit (CDU) reported a total of 1,104 referrals received for Autism Diagnostic Assessments and 417 patient assessments conducted; of these 90% were diagnosed with ASD (WCH 2019a). As of October 2019 there were 419 young people on the wait list for assessments at the NALHN CDU (NALHN 2019).

In a Position Statement on the ‘Early Intervention for Children with Developmental Disabilities’ (RACGP, 2013), the RACGP emphasized that access to early intervention support services for

children with developmental disabilities, including ASD, maximises positive life-long outcomes. However, early intervention can be highly dependent on obtaining a diagnosis (Taylor et al. 2016).

A recent Productivity Commission Draft Report on Mental Health also reiterates the need for early identification of mental health risks in children (PC 2019). Although ASD is not considered a mental health disorder by the Productivity Commission, ASD has a high comorbidity with other disorders.

Culturally and Linguistically Diverse Communities

Adelaide PHN's membership groups identified Culturally and Linguistically Diverse (CALD) and new and emerging communities' health as one of the target population groups for the Adelaide PHN (APHN 2016a, 2016c, 2016d). Mental health and alcohol and other drug needs of these communities, and access to mental health, alcohol and other drug and primary health care services in the region were specific areas of concern (APHN, 2016, 2016d, 2016e).

Research by Principe (2015) identified that people from CALD backgrounds are among the population groups missing out on accessing suitable services or gaining equitable health care outcomes. Analysis of patient data between 2011-15 reported that 8.2% of patients visiting General Practices were of CALD backgrounds in the Adelaide PHN region when compared to 13.2% for other capital cities and 8.9 nationally (BEACH, 2016). A study of women with culturally diverse backgrounds (Lam et al., 2018) found that just 19% identified as "breast aware", and only 27% aged over 40 had participated in annual clinical breast exams. Australian research has also identified that CALD communities particularly from Asia and the Pacific are disproportionately affected by Hepatitis B (ASHM, 2015).

Many older people from CALD backgrounds have higher levels of disadvantage and other risk factors compared to older Anglo-Australians. These risk factors include socioeconomic disadvantage, cultural translation difficulties, lack of exposure to Australian services and systems, and lower rates of access to services (Principe, 2015). Older people from CALD backgrounds have a higher risk of mental health issues and tend to present at later stages of illness compared to other older people in Australia. Those who migrated to Australia at an older age or who are from refugee background, face a higher risk of mental and physical health issues. Older migrants, in particular women, are recognised as ageing prematurely and experiencing social isolation (Principe, 2015).

Consultations with local stakeholders representing the multicultural sector, primary health care and research identified that refugee and new arrival populations have limited understanding of the Australian health system and lack access to appropriate and timely primary health care services. Low health literacy also limits their ability to make informed decisions about their health and health care (APHN, 2017c). Inclusion and empowerment; access and equity; quality and capacity building were identified as key principles of care for persons from CALD backgrounds (Principe, 2015).

Local stakeholders also suggested that primary health care providers, including general practice don't have the support, training and capacity to deliver culturally safe and culturally appropriate services to refugee and new arrival populations (APHN, 2017c). The lack of formalised partnerships and referral pathways between the migrant health sector and primary health care services impact access and effectiveness of services; system integration of primary health care services for refugees and new arrivals would improve access and delivery of culturally appropriate and sensitive primary care services to these populations (APHN, 2017c).

Lesbian, Gay, Bisexual, Transgender, Intersex and Queer + (LGBTIQ+) Communities

The Adelaide PHN's Community Advisory Council identified that Lesbian, Gay, Bisexual, Transgender, Intersex and Queer + (LGBTIQ+) Communities should be a priority population group for the APHN (2019a). To better understand the health and service needs of this population and build upon the evidence presented in previous Needs Assessment submissions, the Adelaide PHN undertook an environmental scan of recent relevant literature, conducted consultations with the Adelaide PHN memberships groups and interviews with several LGBTIQ+ service providers in the region. This section summarises the general primary health care and service needs and issues that

were identified from this process; health and service needs relating to mental health and alcohol and other drugs treatment for LGBTIQ+ communities are reported in those respective chapters.

It is important to note that the majority of data quantifying local prevalence and utilisation are generalisations based on national and international data and research; this lack of consistent, rigorous or reliable data regarding the size and demographics of South Australia's LGBTIQ+ communities, and their utilisation of health services is acknowledged as a distinct issue (FFF 2018; CCYP SA 2019; APHN 2020a). The lack of systematic, nuanced data is identified as a significant barrier to understanding and recognising the magnitude of the issues and the burden faced by these communities (McNair, 2003) (APHN 2020a). It is also a barrier to inclusion, addressing health needs of this group, and the development of evidence-based policy and service planning (APHN 2020a; CCYP SA 2019).

While many LGBTIQ people live happy and healthy lives, as a group they may be more likely than the general population to experience poor social, physical and mental health (Australian Government Department of Health 2019), have higher rates of substance use (FFF 2018, AHIW 2019c), and poorer outcomes compared to general population (Karen et al 2017). LGBTIQ people also have a higher incidence of life-limiting illness and tend to present to health care services later and with more advanced disease than the general population (Bristowe et al. 2018; Australian Government Department of Health 2019).

There is a large and consistent evidence base showing that a range of social, psychological and economic factors are recognised as increasing the risk of adverse impacts on physical and mental health, and contribute to the higher health burden and poorer outcomes in LGBTIQ communities. These factors, including social exclusion, violence, homelessness, stigma, discrimination and marginalisation also create substantial barriers to accessing health and social care services (McNair, 2003; FFF 2018; Mooney-Somers et al. 2018; Leonard et al 2012; Strauss et al 2017). In line with the above, fear of and experiences of stigma and discrimination as a barrier to accessing primary health services was a reoccurring issued identified in recent Adelaide PHN membership and stakeholder consultations (APHN 2020a).

Consultations also raised a number of workforce-specific barriers to the accessibility, appropriateness and effectiveness of primary health care in our region. They included service providers: lacking cultural competency when engaging with LGBTIQ+ people e.g. misgendering, asking inappropriate questions and using inappropriate language; having limited knowledge of the specific health needs of LGBTIQ+ people; providing services that did not adequately meet communities' needs; and having limited capability to connect, integrate or refer consumers to appropriate services (APHN 2020a). These issues are reflective of national and international research (Australian Government Department of Health 2019; Mullens 2017; SARAA 2019; Strauss et al 2017; Waling et al., 2019).

A lack of safe and inclusive LGBTIQ+ specific sexual health, mental health and alcohol and other drug treatment services in the region was also a reoccurring need identified during Adelaide PHN consultations (APHN 2020a). The Adelaide PHN consultations also highlighted that some LGBTIQ+ communities, specifically transgender, gender diverse and intersex people as well as older people and men who have sex with men, have unique health and service needs which require dedicated and specific LGBTIQ+ services and models of care (APHN 2020a).

4 Aboriginal and Torres Strait Islander Health

4.1 Health status

Health risk factors

Recent analysis of health conditions, health-related behaviours and social determinants undertaken by Gibson et al. (2017a) identified that Aboriginal and Torres Strait Islander South Australians have higher prevalence of nearly all health conditions, compared to non-Aboriginal South Australians.

The *Aboriginal and Torres Strait Islander Health Performance Framework 2017* report for South Australia lists the following concerns for the State (AIHW 2017e):

- The age-standardised proportion of Indigenous women that smoked during pregnancy was 48%, this was 3 times the rate for non-Indigenous women (15%) in 2014;
- A smaller proportion of Indigenous women accessed antenatal care services in the first trimester of pregnancy (53%) compared with for non-Indigenous women (78%) in 2014;

Chronic conditions

The prevalence rates for a number of chronic conditions are substantially higher for Aboriginal and Torres Strait Islander people in South Australia compared to the prevalence for all persons. For example, in 2012-13, asthma rates were almost double (19.7% compared to 10.8%), as were rates of diabetes (8.9% compared to 4.6%). Cardiovascular disease rates were also substantially higher, 12.5% compared to 4.5% (HPCSA, 2016).

In 2012-13, 35.7% of Aboriginal people in South Australia reported living with three or more long-term health conditions. This was higher than the national rate of 32.7% for Aboriginal people. However, it was lower than the 40.5% all-person rate for South Australia recorded in 2011-12 (40.5%). Age-standardised rates for diabetes were almost six times the non-Indigenous rate, chronic lower respiratory was three times, and intentional self-harm was twice the non-Indigenous rate (ABS, 2016a).

The all-cause mortality rate was also higher for Aboriginal and Torres Strait Islander populations in South Australia compared to the population as a whole, 9.2 deaths per 1,000 population compared to a rate of 6 deaths per 1,000 from 2010-2014 (ABS, 2016a). Data on the underlying causes of death for Aboriginal and Torres Strait Islander populations in the Adelaide PHN are currently not available; however the six leading causes of death for Aboriginal and Torres Strait Islander people in SA in 2013-17 were:

- Ischaemic heart diseases
- Diabetes mellitus
- Malignant neoplasm of trachea, bronchus and lung
- Chronic lower respiratory diseases
- Intentional self-harm
- Cirrhosis and other liver diseases (ABS, 2018).

The Aboriginal and Torres Strait Islander Health Performance Framework 2017 report for South Australia lists the following concerns for the State (AIHW 2017e):

- Age-standardised death rates for some chronic diseases in 2011–2015 were higher for Indigenous Australians than for non-Indigenous Australians: more than 4 times as high for diabetes (74 compared with 18 per 100,000); and twice as high for digestive diseases (46 compared with 21 per 100,000); and
- The incidence rate for Indigenous Australians with end-stage kidney disease increased from 24 per 100,000 in 1997, to 40 per 100,000 in 2014.
- Indigenous Australians had a higher age-standardised rate of hospitalisation for injury from July 2013 to June 2015 compared with non-Indigenous Australians (47 compared with 24

per 1,000). The most common injuries resulting in hospitalisation were: assaults (22%), falls (19%), and complications of medical and surgical care (14%) of all hospitalisations.

Cancer Screening Participation

The SA3s of Playford, Salisbury, Port Adelaide – West, Port Adelaide – East, West Torrens and Adelaide City, have higher proportions of both Aboriginal and Torres Strait Islander and culturally and linguistically diverse populations in the target screening age groups compared to other regions of the Adelaide PHN (AIHW, 2018e). Lower rates of participation in breast and bowel cancer screening are recorded in Indigenous Australians. Screening rates for indigenous vs. non-indigenous populations in Australia are as follows:

- Breast cancer: 37.3% vs. 53.2%
- Bowel cancer: 23.5% vs. 40% (AIHW, 2018e).

Information is not available on Indigenous participation in the National Cervical Screening Program, however a growing body of evidence indicates that Indigenous women are under-screened (AIHW 2019i).

In line with evidence in national reports (AIHW 2019i), the Adelaide PHN Aboriginal Health HPG reported that people are presenting late with cancer, leading to high mortality rates and there is a lack of early detection of cancer (APHN, 2016d).

Child and Youth Health

Analysis of data (2012/13 – 2014/15) from SA health have shown increasing concern for specific potentially preventable conditions: Ear, Nose and Throat infections, Asthma, Dental conditions, Urinary tract infections and Diabetes complications, among the child and youth presenting at Emergency Departments in Adelaide PHN region (SA Health, 2016a). Recent data not available.

The burden of poor oral health is not evenly distributed across the population with Aboriginal children experiencing more than 50 per cent tooth decay than non-Aboriginal children. Furthermore, children in the lowest socio-economic areas have 50 to 70 per cent more tooth decay compared to those in the highest socio-economic areas, and untreated tooth decay is 70 per cent more prevalent in the most disadvantaged children. However, 18 to 27 per cent of children in the highest socio-economic groups also had untreated tooth decay (SA Health, 2015a). Aboriginal children experience approximately 70 per cent more dental caries than non-Aboriginal people and they have more teeth with untreated dental decay. The rate of decay is the major cause for hospital admissions (SA Health, 2010).

The prevalence of self-reported asthma among Aboriginal children aged 0-14 years was 1.8 times higher than among non-Aboriginal 0-14 year olds; Aboriginal children were also more likely to be hospitalised (Gibson et al, 2017a).

Infant mortality rates were also substantially higher, with 7.6 deaths per 1,000 live births from 2012-2014 for Aboriginal and Torres Strait Islander populations in South Australia, compared to 2.6 deaths per 1,000 live births for the state as a whole (ABS, 2015). In 2017 in SA the Infant mortality rate (calculated per 1,000 live births) was 4.7 for the Indigenous community, and 3.0 for the non-Indigenous. Indigenous infant mortality has decreased since 2014, when it was 7.2 (ABS, 2017d).

Although the immunisation rates for Aboriginal and Torres Strait Islander children living in the Adelaide PHN region have significantly increased since 2013-14, Aboriginal and/or Torres Strait Islander children still have a lower rate of fully immunised children at 1-, and 2-years of age, compared to non- Aboriginal and/or Torres Strait Islander children in the region (NHPA, 2015a). As of June 2017, immunisation coverage rates for 5-year old for Aboriginal and Torres Strait Islander children living in the Adelaide PHN region were at 95%, which is in line with the national target (DOH, 2017c).

For Aboriginal children, over a third (37.6%) aged 5-17 years in South Australia were overweight or obese. This percentage is higher when compared to non-Aboriginal children and to the national

average for Aboriginal children (32.8%) (HPCSA, 2018). Compared to other states and territories, South Australia is ranked second highest (HPCSA, 2016). The AHPC national data indicated that unhealthy weight in childhood is a significant issue for Aboriginal children and young people (AHPC, 2017).

Areas of concern raised during consultations with the Adelaide PHN Aboriginal Health Health Priority Group (HPG) included:

- maternal, child and youth health immunisation (APHN, 2016d),
- prevention of obesity in children, to reduce future health issues such as diabetes and hypertension (APHN, 2016d), and
- ear health and access to screening and treatment for children (APHN, 2018d).

4.2 Mental Health

Mental health was an area of priority for the Aboriginal Health HPG. The Aboriginal Health HPG described mental health as an underlying issue that impacts on other health issues. Loss and grief are part of that and are not fully understood or addressed in a culturally effective manner. There is also stigma associated with the label of 'mental' illness/health (APHN, 2016d). The HPG highlighted that it is important that these are addressed in culturally effective and safe ways. Additionally, they mentioned the stigma associated with the label of "mental illness/health" so the first contact with mental health services is critical along with early intervention across the life span (APHN, 2016d).

The provision of mental health and suicide prevention training and education to the Aboriginal and Torres Strait Islander workforce within the Integrated Team Care Program was raised as an area of need in further consultations (APHN, 2017f).

Psychological Distress

Rates of high or very high psychological distress in the South Australian Aboriginal and Torres Strait Islander population aged 18 years and over are 2.5 times those of non-Indigenous South Australians aged 18 years and over, 34% compared to 14% (HPCSA, 2016; ABS, 2016).

Utilisation of community health and hospital services

Aboriginal people have significantly higher utilisation rates of community health and hospital services when compared to non-Aboriginal people in South Australia however it is unclear if this is due to improved access to services or higher prevalence of mental health conditions. Patterns of use by Local Health Network highlighted:

- Aboriginal people living in CALHN region had four times the rate of use of the community mental health services compared to non-Aboriginal people in CALHN, and were hospitalised for mental health-related conditions at 4.5 times the rate (Gibson et al., 2017b),
- Aboriginal people in NALHN had three times the rate of use of the community mental health service compared to non-Aboriginal people in NALHN, and five times the rate of hospital separations (Gibson et al., 2017c), and
- Aboriginal people in SALHN have almost four times the rate of use of the community mental health services compared to non-Aboriginal people in SALHN, and five times the rate of hospital separations (Gibson et al., 2017d).

These high rates of service utilisation clearly indicate a burden of mental health issues in the community. There is a need to reduce the burden of mental health issues, and to address issues in primary and specialist care to prevent acute episodes. There are a wide range of support services for people with mental health issues, however given the exceedingly high rate of use of community health and hospital services, there may be need to expand and/or adapt these services to reach Aboriginal clients. Barriers in accessing affordable, timely psychology and psychiatry services should be addressed (Gibson et al., 2017a).

Mental health-related hospitalisations

Age standardised rates of hospitalisations for Aboriginal and Torres Strait Islander people living in Greater Adelaide were substantially higher in 2012/13 compared with the annual average rate for all-persons in Greater Adelaide. Per 100,000 population rates were 174% higher for mental health related conditions, and 25% higher for injuries, poisoning and other external causes (PHIDU, 2016).

Aboriginal people living in the Central Adelaide Local Health Network (CALHN) were hospitalised for mental health-related conditions at 4.5 times the age-standardised rate of non-Aboriginal people (54 per 1,000 people compared to 12 per 1,000 people). This equated to 42 extra Aboriginal hospitalisations per 1,000 people. While the age-standardised rate of mental health hospitalisation in non-Aboriginal people in CALHN was slightly lower than the state rate, Aboriginal people in CALHN had a higher rate of hospitalisation than the state rate (Gibson et al., 2017b).

Aboriginal people living in Northern Adelaide Local Health Network (NALHN) were hospitalised for mental health-related conditions at 5.2 times the age-standardised rate of non-Aboriginal people (54.9 per 1,000 compared to 10.6 per 1,000 population). This equated to 44 extra Aboriginal hospitalisations per 1,000 population. While the age-standardised rate of mental health hospitalisation in non-Aboriginal people in NALHN was slightly lower than the state rate of 12.4 per 1,000 population, Aboriginal people in NALHN had a higher rate of hospitalisation than the state rate of 48.5 per 1,000 population. This difference between NALHN and the state was driven by higher rates for Aboriginal females in NALHN compared to their state counterparts. Between 2011 and 2015, mental health separations for Aboriginal people declined in both NALHN and the wider state (Gibson et al., 2017c).

Aboriginal people living in Southern Adelaide Local Health Network (SALHN) were hospitalised for mental health-related conditions at almost 3 times the age-standardised rate of non-Aboriginal people (34.4 per 1,000 compared to 12.4 per 1,000 population). This equated to 22 extra Aboriginal hospitalisations per 1,000 population. While the age-standardised rate of mental health hospitalisation in non-Aboriginal people in SALHN was the same as the state rate of 12.4 per 1,000 population, Aboriginal people in SALHN had a lower rate of hospitalisation (34.4 per 1,000) than the state rate of 48.5 per 1,000 population. This difference between SALHN and the state was driven by higher rates for Aboriginal females in SALHN compared to their state counterparts. Between 2011 and 2015, mental health separation rates for Aboriginal people declined in both SALHN and the wider state (Gibson et al., 2017d).

Community mental health services

For the period 2010-11 to 2015-16, Aboriginal people in South Australia had an age-standardised rate of occasions of service of 96.0 per 100 population, compared to 32.7 occasions of service per 100 population in non-Aboriginal people. This difference in rates corresponded to an excess 63 occasions of service per 100 population for Aboriginal people (Gibson et al., 2017a).

Aboriginal people in CALHN had an age-standardised rate of service occasions almost five times higher in the Aboriginal population compared to the non-Aboriginal population. This corresponded to almost 116 extra service occasions per 100 people in the Aboriginal population (Gibson et al., 2017b).

Aboriginal people in NALHN the age-standardised rate of service occasions was 3 times higher in Aboriginal people compared to non-Aboriginal people, and this corresponded to 94 extra service occasions per 100 Aboriginal population (Gibson et al., 2017c).

Aboriginal people in SALHN the age-standardised rate of service occasions was over 3 times higher in Aboriginal people compared to non-Aboriginal people in SALHN, and this corresponded to 93 extra service occasions per 100 Aboriginal population (Gibson et al., 2017d).

The most common reason for community mental health occasions of service for all LHNs and the State, regardless of Aboriginal status or sex, was 'schizophrenia, schizotypal and delusional disorders' (Gibson et al., 2017a).

Suicidality

Suicide accounted for a higher proportion of deaths among Aboriginal and Torres Strait Islanders populations, 4.2%, compared to non-Indigenous South Australians, 1.6% of deaths (ABS, 2016a). Intentional self-harm [suicide] was the 5th ranked cause of death for Aboriginal and Torres Strait Islanders but ranked 13th for non-indigenous population (ABS, 2017c).

Furthermore, the 2012-2016 age-standardised death rate from intentional self-harm for Aboriginal and Torres Strait Islander South Australians was 70% higher compared to the rates for non-Indigenous South Australian, 21.3 deaths per 100,000 population and 12.6 deaths per 100,000 population respectively (ABS, 2017c).

The four reports by Gibson et al. (2017a-d) indicate that between 2006-2012, in South Australia, age-specific rates of intentional self-harm deaths were higher in Aboriginal people compared to non-Aboriginal people for ages 15–34 and 45–64. The highest rate of intentional self-harm deaths in Aboriginal people was in young people aged 25–34 years (4.5 per 10,000 population), with the second highest rate in the 15–24 age group (3.8 per 10,000 population). For non-Aboriginal people, the highest rate was in the 35–44 age group (2.0 per 10,000 population). The 15–24 age group had the lowest rate for non-Aboriginal people (0.9 per 10,000 population) (Gibson et al., 2017a).

There were differences by Local Health Network:

- In CALHN, the highest rate of intentional self-harm deaths in Aboriginal people aged 15 years and over were in young people aged 15–24 years, with the second highest rate in the 35–44 age group (Gibson et al., 2017b),
- In NALHN, the highest rate of intentional self-harm deaths in Aboriginal people were in people aged 55–64 years (8.0 per 10,000 population), with the second highest rates in people aged 15–34 (2.6 to 2.7 per 10,000 population) (Gibson et al., 2017c), and
- In SALHN, the highest rate of intentional self-harm deaths in Aboriginal people were for young adults aged 25–34 years (3.1 per 10,000 population) (Gibson et al., 2017d).

4.3 Alcohol and Other Drugs

Note that this section is duplicated in the Alcohol and Other Drugs chapter: Priority Populations - Aboriginal and Torres Strait Islander people.

Overview

Compared to other Australians, Aboriginal and Torres Strait Islander peoples experience a disproportionate amount of harms from alcohol, tobacco and other drug use. Drug-related problems play a significant role in disparities in health and life expectancy between Aboriginal and Torres Strait Islander people and non-Indigenous Australians (Wilson et al. 2010).

In 2016 Aboriginal and Torres Strait Islander people comprised 1% of the total PHN population, however they represented 11% of all AOD-related emergency department (ED) presentations (2015/16), 9% of all AOD-related hospital separations (2015/16), 14% of specialist AOD treatment episodes (2014/15) and 3% of Alcohol and Drug Information Service (ADIS) calls (2015) (Roche et al. 2017a).

It is important to recognise the broader socio-economic context and the complex and interrelated factors that contribute to elevated risk and harms from substance use among Aboriginal people (Roche et al. 2017a). The interconnected issues of cultural dislocation, personal trauma and the ongoing stresses of disadvantage, racism, alienation and exclusion can all contribute to a heightened risk of harmful substance use, mental health problems, and suicide (Purdie, Dudgeon, & Walker, 2010). A lack of, and lack of access to adequate, and appropriate treatment services and prevention strategies also contribute (DOH 2017; APHN 2020c).

It is critical to ensure that any efforts to reduce the disproportionate harms experienced by Aboriginal and Torres Strait Islander people are culturally responsive and appropriately reflect the broader social, cultural and emotional wellbeing needs of Aboriginal and Torres Strait Islander

people (APHN 2020c). Planning and delivery of services should have strong community engagement including joint planning and evaluation of prevention programs and services provided to Aboriginal and Torres Strait Islander communities taking place at the regional level (DOH 2017). Wherever possible, interventions should be based on evidence of what works specifically for Indigenous people (DOH 2017; APHN 2020c).

Alcohol

Alcohol misuse is a contributing factor to a wide range of health and social problems, including: violence; social disorder; family breakdown; child neglect; loss of income or diversion of income to purchase alcohol and other substances; and, high levels of imprisonment (Wilson et al., 2010).

As presented below, Aboriginal and Torres Strait Islander people living in Adelaide PHN, South Australia or Australia experience harms associated with alcohol use at a rate much higher than non-Indigenous people.

In 2018-19, 14% of Aboriginal and Torres Strait Islander people living in the Adelaide PHN region aged 15 years and over consumed alcohol at long-term risk levels, and 46% consumed alcohol at short-term risk levels (ABS 2020). Although this is a reduction since 2012-13 of 23% and 55% respectively (Roche et al. 2017), rates for short-term risk for Aboriginal and Torres Strait people are still substantially higher than total region rates of 27% (AIHW 2020c).

The age-standardised rate of hospitalisation relating to alcohol use for Indigenous South Australia declined from 15.8 per 1,000 people in 2008–09 to 10.8 per 1,000 people in 2014-15, however despite the decline the rate was significantly higher (7.7 times) the hospitalisation rate for non-Indigenous South Australians in the same period (1.4 per 1,000 in 2014–15) (AIHW 2017e). In 2015 - 16, Aboriginal and Torres Strait Islander people accounted for 12% of all alcohol-related ED presentations and 17% of all alcohol-related treatment episodes in Adelaide (Roche et al. 2017a).

In terms of AOD-related services, alcohol was the primary drug of concern for Aboriginal and Torres Strait Islander people in the Adelaide PHN region, accounting for 66% of AOD-related ED presentations, 43% of hospital separations, and 46% of treatment episodes (Roche et al. 2017a).

Tobacco

The proportion of Indigenous South Australians who currently smoke has significantly declined since 2001, however rates are still more than double the proportion of non-Indigenous South Australians who smoke (Roche et al. 2017a).

In 2018-19, 33% of Aboriginal and Torres Strait Islanders aged 15 years and over living in the Adelaide PHN were daily smokers, three times the overall rate of 11% for the region (ABS 2020; AIHW 2020a). Indigenous women living in the Adelaide PHN were also more likely to smoke during pregnancy compared to non-Indigenous women, 49% compared to 12% from 2012 to 2014 (PHIDU 2020d).

In 2014–15, 76% of Indigenous South Australians aged 15 and over who reported being a current smoker, had tried to quit or reduce smoking; this is higher than the national rate of 69% (AIHW, 2017e).

Non-medical substance use

Substance use rates are higher in the Aboriginal and Torres Strait Islander population in the Adelaide PHN region compared to non-Aboriginal people: in 2019, 16% of people in Adelaide PHN had recently used an illicit substance (AIHW 2020a), compared to 40% of Aboriginal and Torres Strait Islander people living in APHN in 2018-19 (ABS 2020). This was also a substantial increase from the 2012-13 rate of 27% (Roche et al. 2017a).

Substance use was more prevalent for Indigenous males than females (43% compared with 31% in 2014-15) in South Australia (AIHW 2017e). An estimated 5% of mothers of Indigenous children aged 0–3 reported illicit drug or substance use during pregnancy (AIHW 2017e).

Nationally, cannabis was the most common recently used substance by Aboriginal and Torres Strait Islander people (16%) (as it was for the non-Indigenous population (12%)). Pharmaceuticals for non-medical purposes were the second most commonly used illicit drug type by Aboriginal people (8%), followed by pain-killers/pain-relievers and opioids (6%), cocaine (4%), tranquilisers (4%) and methamphetamines (3%) (AIHW 2020c). Compared to rates of use for non-Indigenous people, rates for Aboriginal people were 2.4 times higher for methamphetamines and tranquilisers and 2.3 times for pain killers and opioids (AIHW 2020d).

National estimates indicate that in 2018, Aboriginal and Torres Strait Islander people were almost three times as likely to die from an unintentional drug-induced death, with a rate of deaths of 17.3 per 100,000 population, compared with 6.0 deaths per 100,000 population for non-Aboriginal people. Nationally, the rate of unintentional drug-induced deaths among Indigenous Australians has increased between 2001 and 2018 (from 9.5 to 17.3 deaths per 100,000) (Penington Institute 2020).

Within the Adelaide PHN region Aboriginal people accounted for 16% of cannabis-related ED presentations, 11% of cannabis-related hospitalisations and 14% of other drug-related hospitalisations (Roche et al. 2017)

Service gaps

Gaps in AOD treatment service provision include gaps in access to a full range of services, limited access to culturally safe or secure services, services for families, and a paucity of ongoing support and relapse prevention for those completing intensive treatment (NDRI 2014; APHN 2020c).

The services that are most likely to effectively address drug use among Aboriginal and Torres Strait Islander people are those that originate within and are controlled by the community, are culturally appropriate, person and family centred, provide holistic service and create strong partnerships with other organisations in order to provide clients with a complete continuum of care (NDRI 2014; Adelaide PHN 2016d, 2020c).

Local stakeholder consultations identified that there is an increased need to provide more timely services for clients currently presenting for AOD support (APHN, 2017f). Currently a lack of trust and cultural barriers often lead to reduced access for Aboriginal and/or Torres Strait Islander people, and commended the use of cultural healers. This was felt to be a positive move to identify and meet the needs of these communities. It is acknowledged that there is a need for more culturally appropriate services to enable better treatment and navigation through the system (APHN 2020c).

It is also important to recognize the language and cultural differences that exist within the Aboriginal and/or Torres Strait Islander populations in our region, highlighting that there is no 'one size fits all' approach (APHN 2020c).

4.4 Use of primary health services

Uptake of Indigenous Health Checks

Analysis of Medicare Benefits Statistics on item number 715 by PHN (AIHW, 2017f) highlighted that Aboriginal Health Assessments are lower in the Adelaide PHN when compared to other PHNs (ranked 21 out of 32 PHNs nationally). Further analysis of Medicare Benefits Statistics by PHN (DoH, 2016) identified variation within sub-regional levels within Adelaide PHN; rates were lower in the Statistical Area Level 3s (SA3) of Playford, Port Adelaide-East and West, Salisbury, Onkaparinga, and Charles Sturt (DoH, 2016).

During the Priority setting workshops, the Aboriginal Health HPG emphasised the need to improve the uptake of the Aboriginal (children and adult) health check (APHN, 2016d).

Factors impacting service use, provision and health outcomes

Access

Consultations with Adelaide PHN membership groups and Aboriginal community stakeholders identified a range of barriers that impact the delivery of health services to Aboriginal people (APHN, 2016a; 2016d; 2017e). They included:

- available transport
- financial barriers
- limited cultural sensitivity and safety
- perceptions about care and experiences of racism
- awareness and knowledge of available services
- poor support, communication and coordination between services
- long wait times, and
- poor follow up.

Cultural safety and appropriateness

The lack of respect and sensitivity from service providers and the need to ensure that health services particularly Adelaide PHN commissioned services are culturally safe for Aboriginal people were reoccurring theme across multiple community consultations (APHN, 2016c; 2016e; 2017e; 2018d)

The Adelaide PHN Community Advisory Council members and participants at our Aboriginal Engagement workshops identified factors that would make local service delivery more culturally appropriate (APHN, 2016c; 2016d; 2016e). They included:

- Being treated with dignity and respect and without prejudice
- Providers that can address the specific needs of Aboriginal and Torres Strait Islander people
- Well-coordinated holistic approach to services
- Sensitivity and nonjudgment to social determinants
- Easy access to services when they are needed, and
- Increase the number of Aboriginal Health Workers and Aboriginal Health Practitioners.

5 Older persons and aged care

5.1 Population

South Australia has an 'aged' population, with a higher proportion of older people than the national average (Roche et al, 2017a). The Office for the Ageing states that for South Australia over the next 10 years it is expected that the percentage of the population living beyond the age of 65 years will rise from the current figure of 15% to 22% (OFTA, 2014).

In the 2016 Census, there were 203,923 people aged 65 years and over, including 31,629 people aged 85 years and over, living in the Adelaide PHN region (PHIDU, 2017a).

5.2 Health status

A South Australian survey of older people found that 92% of survey respondents selected health and wellbeing as an important aspect of growing older. The results also indicated a decline in self-rated health with age, with approximately 40% of those aged 70-79 years, and more than 50% of those aged over 80 years rated their health as fair or poor. The health issues that most affected daily activities were vision (22%) and mobility (19%) (OFTA, 2014).

In 2017, approximately half of all South Australian males (54%) and females (53%) aged 75 years and over were living with two or more of the following health risk factors: high blood pressure, high cholesterol, no physical activity, obesity, smoking, alcohol risk, and/or insufficient consumption of fruit and vegetables. For 65-74-year olds, 59% of males and 60% of females were living with two or more of the health risk factors (HPCSA, 2018).

Chronic conditions

Multimorbidity of chronic conditions increases with age. In South Australia in 2014, 29% of males and 35% of females aged 65-74 years old, and 39% of males and 47% of females aged 75 years and over lived with two or more chronic health conditions (diabetes, asthma, cardiovascular disease, arthritis, osteoporosis and/or a mental health condition). These proportions were double the state averages of 16% for males and 19% females aged 65 years and over (HPCSA, 2016).

Disability

In the Adelaide PHN region, there were 27,918 people (14%) aged 65 years and over living in the community with a profound or severe disability, which was lower than the national rate of 16% for other capital cities (PHIDU, 2017a).

Mental health

Dementia

The risk of developing dementia increases with age (CAHML, 2015). In South Australia, the 2011 estimate of dementia prevalence is 30,500 people (11,400 males, 19,100 females). This is expected to increase to 33,500 people by 2020 (AIHW 2012). The most common type of dementia is Alzheimer's disease, which accounts for around 75% of all dementia diagnoses. PHN level dementia data not available.

Mental health-related medication

In 2013-14, for people aged 65+ years, the highest rates of dispensing of antidepressant medications in the Adelaide PHN region was in the Statistical Area Level 3 (SA3) of Playford with 244,017 prescriptions per 100,000 people; the South Australian rate was 206,606 per 100,000 (ACSQHC, 2015). Rates for antidepressant dispensing were also high in Onkaparinga (217,803), Tea Tree Gully (217,739), Salisbury (216,313), and Norwood-Payneham-St Peters (216,138) (ACSQHC, 2015).

Playford SA3 had the 2nd highest rate of PBS prescriptions dispensed for anxiolytic (anti-anxiety) medicines in Australia for people aged 65 years and over with 74,380 per 100,000 people, twice the

Australian rate (ACSQHC, 2015). Rates for anxiolytic dispensing were also high in Port Adelaide - West (59,011), Salisbury (58,342), Tea Tree Gully (54,215), and Marion (52,324) (ACSQHC, 2015).

The highest rates of antipsychotic medicines dispensing for people aged 65 years and over occurred in the SA3s of Port Adelaide - West (33,404), Norwood-Payneham-St Peters (32,932), Adelaide City (31,730), Playford (31,364), and Unley (31,002) (ACSQHC, 2015).

Rates of PBS prescriptions dispensed for anticholinesterase medicines, which are used to treat Alzheimer's, in people aged 65 years and over were notably higher in the SA3s of Charles Sturt (21,369), Port Adelaide - West (19,923), Adelaide City (18,004), and Playford (17,666) compared to the Australian rate, 12,650 prescriptions per 100,000 people (ACSQHC, 2015).

While there is a correlation between areas of lower socioeconomic status particularly in the north of the Adelaide PHN region, and higher rates of mental health-related PBS prescriptions dispensing to people aged 65 years, the patterns may also reflect the distribution of older residents and the density of aged care facilities across the Adelaide PHN region. The Adelaide PHN also notes that based on the available data, it is not possible to determine the extent to which antidepressant and antipsychotic medicines were prescribed for conditions other than mental health.

Falls

Falls represent a significant health issue among older people. Twice as many women as men were hospitalised for a fall, and the number of falls cases increased with age (CAHML, 2015). In 2012-13, the estimated number of serious injuries due to falls in people aged 65 and older was 98,704. Females accounted for most of these fall injury cases, and rates of cases were higher for females than for males for all age groups (AIHW, 2017b).

Age-standardised rates of hospitalised fall injury cases increased over the 11 years to June 2013 (3% per year). There were more than 24,000 extra fall injury cases for people aged 65 and older in 2012-13 than there would have been if the rate of falls had remained stable since 2002-03 (AIHW, 2017b). In 2014-15, an estimated 111,222 people aged 65 and over were hospitalised due to falls (AIHW, 2018a). Also, for unintentional fall injury deaths: SA recorded the lowest rate (12.2 deaths per 100,000) (AIHW, 2018b).

Around 85% of fall injury cases in 2014-15 were recorded as having occurred in either the home or in residential aged care. The age-standardised rate of falls in the home for older people living in the community was 1,814 per 100,000 population, while the rate of falls for older people living in residential aged care was 10,090 per 100,000 population. These rates are likely to be underestimated because of missing information on the places in which falls occurred (AIHW, 2018b).

Overall, 1 in every 10 days spent in hospital by a person aged 65 and over in 2014-15 was attributable to an injurious fall. Nationally, the days of patient care attributable to fall-related injury rose from 0.8 million patient days in 2002-03 to 1.4 million patient days in 2014-15 (AIHW, 2018b).

5.3 Use of primary health services

After-hours services

Use of After-hours GP services was highest amongst children aged 0-14 years and older adults aged 80+ years for non-urgent, urgent and total service types (AIHW, 2019h). The rate of GP after-hour services provided to people aged 80+ years was three times the rate for Adelaide PHN residents aged 15-24, 45-64, and 65-79 years, and twice the rate for people aged 25-44 and 0-14 years (AIHW, 2019h).

5.4 Hospitalisations

In South Australia people aged 65 years and over take up a disproportionately large amount of overnight stays in hospital, with people aged between 65-75 years of age twice as likely as the rest of the population to be admitted to hospital. In particular, despite being only 4.9% of the population,

people aged 80 and over take up more than 25% of overnights stays, with those aged over 85 years are more than five times as likely to be admitted to hospital (OFTA, 2014).

Potentially Preventable Hospitalisations (PPHs)

In 2015-16 people aged 65+ years and living in the Adelaide PHN region made up 48% of potentially preventable hospitalisations in South Australian hospitals; people aged 85 years and over made up 14% (SA Health, 2017). This remained consistent at 48% through 2016-17 and 2017-18 (SA Health, 2018b). The rates of potentially preventable hospitalisations in the region generally increased with age, with people 80 years and older with the highest rates each year. In 2015/16 the four most common conditions leading to a 'potentially preventable' hospitalisation in people aged 65 years and older were chronic obstructive pulmonary disease, congestive cardiac failure, urinary tract infections, and diabetes complications (SA Health, 2017). This trend continued in 2017-18 - the most frequent acute conditions for PPH in those over 65 years were urinary tract infections and cellulitis, and chronic conditions were chronic obstructive pulmonary disease, congestive cardiac failure, diabetes complications, and angina (SA Health, 2018b).

Medication-related hospitalisations

Feedback from the Central Adelaide Clinical Council reported that one in four people over age 75 have an unplanned hospital admission due to a medication related problem (APHN, 2016a).

AOD-related hospitalisations

At the Adelaide PHN level, older people residing in the region accounted for 9% of AOD-related hospital separations. However, they comprised higher proportions of separations for alcohol (15%) and opioids (16%) (Roche et al., 2017a).

The number of fentanyl-related deaths in Australia increased between 2002/03 and 2010/11. While fentanyl prescriptions were most prevalent among females over 80 years, fentanyl-related deaths most commonly occurred among males aged 30-49 years (Roxburgh et al., 2011).

5.5 End of life care

There is a need for good palliative care for people in our region, especially those with comorbidities and requiring mental health support (APHN, 2016a). End of life and palliative care was raised as an area of concern in multiple consultations conducted with Adelaide PHN's membership groups. Some of the issues and needs that were identified included:

- a lack of palliative care beds in the South Australian community (APHN, 2016a)
- a lack of standardised documentation of clinical instructions, and a poor understanding and lack of access to palliative medicines (APHN, 2016a).
- limited knowledge of health care providers available, and a lack of out-of-hours continuity of care (APHN, 2016a)
- promote end-of-life and advanced care planning in primary care (APHN, 2016d).
- encourage and support GPs with an interest in the field, and expand the GP shared care model (APHN, 2016d), and
- raise awareness in the community, and recognise the role the aged care sector can play in providing palliative care (APHN, 2016d).

In the priority setting workshops, our Palliative Care HPG prioritised that capacity needs (to be built) at the primary care level to maximise care and support for people in the community when they are dying. They emphasised that GPs and palliative care nurses are critical to the whole system working (APHN, 2016d).

The need to shift focus from the acute system to the role of GPs and the navigation issues from the perspective of consumer, clinician and service provider was raised by the Palliative Care HPG. Additionally, they identified that pathways need to be simple and easy to access – a stepped model

of care that is responsive and timely with one person, a case manager / coordinator, to help sort care when needed will improve care coordination, integration and navigation (APHN, 2016d).

5.6 Factors impacting service use and provision

Community consultations conducted by the former Medicare Locals in the APHN region reported a number of issues for older adults including access to transport, social isolation, coordination of health and social services, capacity to navigate the health system and coordination of end of life and palliative care (CAHML, 2015; SAFKIML 2015; NAML 2015).

Barriers to accessing primary health care services, particularly for older CALD communities include language, the reliance on online information and registration for services, and changes to and within community support agencies (Principe, 2015).

Consultations with the Adelaide PHN's Older People and Aged Care Health Priority Group identified a number of key issues and needs that need to be addressed to improve service provision for older persons living in the region. The findings included the following:

- the importance of building the capacity of health professionals and GPs to undertake mental health assessments, support older people with advance care and palliative care needs better and address overprescribing of medications (falls risk) by providing support, training and education
- awareness of services and where to go for what (including for those who do not have access or skills to use the internet.
- the need for advocacy for older people by health professionals.
- build the capacity of health professionals and GPs to understand the issues for older people by providing support, training and education
- the need for awareness of services and case coordination for those who do not have access or skills to use the internet.
- need to improve case management, care coordination and advocacy for older people on behalf of consumers by health professionals, and
- increase incentives to encourage collaboration and integration across aged care, acute and primary care sectors (APHN, 2016d).

The Older Persons and Aged Care HPG also identified the following issues as priority needs for the region:

- loneliness (social isolation),
- quality use of medications leading to increased mortality, morbidity and falls,
- lack of access to primary mental health care services (for older people),
- lack of care coordination and pathways between acute, primary health care and aged/social care services,
- raising awareness of health professionals to the early warning signs of dementia, and
- palliative care (e.g. communication of end of life transition, knowledge in workforce about palliative care referral pathways, use of Advanced Care Plans). (APHN, 2016d)

6 Mental Health

Note: Data for Aboriginal and Torres Strait Islander people is reported in the Aboriginal Health section while data for people with alcohol and other drugs misuse is reported in Alcohol and Other Drugs section.

6.1 Mental health prevalence

Mental health disorders

In the Adelaide PHN region, long term mental and behavioural problems are 8% higher than the average of other Australian capital cities, (PHIDU, 2017a, based on 2011-12 modelled estimates) and psychological distress is 20% higher (PHIDU, 2017a, based on 2014-15 modelled estimates).

In 2017 approximately 207,000 people living in the Adelaide PHN region were likely to seek or require treatment for a mental health disorder or risk factors for mental illness (National Mental Health Services Planning Framework - Planning Support Tool (the tool)). By 2022, this is expected to increase by 10,000 additional people, to 217,000 people seeking or requiring treatment (DoH, 2016a).

The tool estimates that 38,000 people in the Adelaide PHN region are expected to require treatment for a severe mental disorder, including 25,600 people aged 18-64 years and 7,000 people aged 65 years and over. By 2022 the number of people experiencing a **severe mental health disorder** and requiring treatment is expected to increase to over 40,000.

A further 45,000 people are expected to require treatment for a **moderate mental health disorder** in 2017 (29,000 aged 18-64 year olds and 6,800 people aged 65 years and over), increasing to 47,000 people by 2022. The tool also reports that approximately 55,600 people are expected to require treatment for a **mild mental health disorder** (36,300 aged 18-64 year olds and 8,100 people aged 65 years and over), increasing to 58,500 people by 2022. It also reports that a further 68,000 people in the region (44,400 aged 18-64 year olds and 3,300 people aged 65 years and over) will experience some indication of mental ill health or risk factors for mental illness in 2017 and would benefit from early intervention and relapse prevention treatment options. This number is expected to increase to 71,100 people by 2022 (DoH, 2016a).

Psychological distress

Compared to the Adelaide PHN average rate, the 2014-15 age-standardised rates of psychological distress were markedly higher in the Local Government Areas (LGAs) of Playford (22.1 per 100 people), Salisbury (18.1 per 100 people) and Port Adelaide Enfield (16.5 per 100 people) (PHIDU, 2017a). These findings correlate strongly with socioeconomic status, with these three regions having the lowest Index of Relative Socio-Economic Disadvantage (IRSD) scores in the Adelaide PHN region. Conversely the lowest rates of psychological distress were in the LGAs of Burnside (7.1 per 100), Unley (9.2 per 100) and Mitcham (9.7 per 100) which had the highest IRSD scores in the region (PHIDU, 2017a). No new data was available for comparison.

It is important to note that prevalence of psychological distress varies by the smaller Population Health Areas (PHAs) sub-regions within these LGAs, with rates between 59-98% higher compared to the PHN average in the PHAs of Elizabeth/Smithfield – Elizabeth North, Davoren Park, Elizabeth East and Salisbury/ Salisbury North in the northern LGAs and 50% higher in the southern PHA of Christies Downs/Hackham West – Huntfield Heights (PHIDU, 2017a). No new data was available for comparison.

A similar pattern is evident when looking at the areas in the Adelaide PHN region with the highest prevalence rates of mental and behavioural disorders. In the north, rates were highest in the PHA of Elizabeth/Smithfield – Elizabeth North, Davoren Park, in the LGA of Playford, with Enfield–Blair Athol PHA in the Port Adelaide Enfield LGA and Adelaide City PHA having the highest rates in the central Adelaide PHN region. Christies Beach/Lonsdale and Christies Downs/Hackham West – Huntfield Heights PHAs in the Onkaparinga LGA had the highest rates in the southern Adelaide PHN (PHIDU, 2015). No new data was available for comparison.

The Southern Community Advisory Council (CAC) indicated that mental health is a growing concern in the south and needs to be addressed in a holistic manner (APHN, 2016c).

Suicidality

Suicide ideation

In 2015 5.2% of South Australians aged 18 years and over were estimated to experience suicidal ideation (SA Health, 2016). Based on this estimate, approximately 47,000 people aged 18 years and over in the Adelaide PHN region had experienced suicidal ideation in the past year (ABS, 2017a). The overall prevalence of suicidal ideation has remained constant at the State-level over the past ten years (SA Health, 2016).

Hospitalisations from intentional self-harm

In 2015-16 Playford Statistical Area Level 3 (SA3) had the highest rate of hospitalisations due to intentional self-harm with 35 hospitalisations per 10,000 population (AIHW, 2018d). Rates were also high, and higher than the APHN average of 19 hospitalisations per 10,000 in the SA3s of Adelaide City (25), Salisbury (20), Marion (24) and Onkaparinga (23) (AIHW, 2017c).

Within the Adelaide PHN region between 2013-14 and 2014-15, Mitcham SA3 had the largest increase in hospitalisations due to intentional self-harm, 8 hospitalisations in 2013-14 (AIHW, 2016c) to 13 hospitalisations in 2014-15 (AIHW, 2017c). But Mitcham was down to 15 per 10,000 people in 2015-2016.

Deaths from intentional self-harm

In Greater Adelaide, which includes all of the Adelaide PHN region plus areas of Adelaide Hills and Gawler which are part of Country SA PHN, rates of deaths from intentional self-harm have increased by 21% in the five years from 2012 to 2016, from 11.0 deaths per 100,000 population to 13.3 deaths per 100,000 population (ABS, 2017c). In 2016, deaths from suicide and self-inflicted injuries were 33% higher in Greater Adelaide compared to the average rate for all other Australian capital cities (ABS, 2017c).

Within the Adelaide PHN region, in the four years from 2010 to 2014, the highest annual average mortality rates occurred in the Local Government Areas of Playford (17.3 deaths per 100,000), Norwood-Payneham-St Peters (17.3 deaths per 100,000), Adelaide (14.6 per 100,000) and Marion (14.2 per 100,000) (AHPC, 2017).

At-risk populations

By age and sex

In South Australia, the rates of deaths from intentional self-harm in 2016 were almost three times higher for males than females across the 15-44 year age groups and twice the rate for 45-54 year olds (ABS, 2017c).

In 2016, intentional self-harm was the leading cause of death for South Australians aged 15-24 years old (28 deaths), 25-34 years old (43 deaths) and 35-44 years old (38 deaths), and the third-leading cause for 45-54 year olds (41 deaths) (ABS, 2017c). In Greater Adelaide between 2012-2016, 18 children aged 5-17 years old died from intentional self-harm, 12 males and six females (ABS, 2017a).

LGBTIQ+ communities

Although there is limited local data from the Adelaide PHN region, national and international research indicated that people identifying as LGBTI have higher rates of suicidality compared to the general population (National LGBTI Health Alliance, 2020). Specifically:

- LGBTI people aged 16-27 years were five times more likely to attempt suicide (16% vs 3%) and a third had engaged in self-injury, nearly twice the rate of their peers of a similar age (Robinson et al., 2013)

- Over a third of transgender people aged 18 and over had attempted suicide, nearly eleven times the average rate, and over half (53%) had self-harmed, six and a half times the average rate (McNeil et al., 2012)
- People with an Intersex variation aged 16 years and over were nearly six times more likely to attempt suicide, with 16% having attempted suicide, 60% experiencing suicidal ideation and 26% had self-harmed (Jones et al., 2016)
- LGBT young people who experience abuse and harassment are more likely to attempt suicide, have thoughts of suicide, and are more likely to have self-harmed (National LGBTI Health Alliance, 2020)
- Higher rates of suicidal ideation and depression in this community than any other population in Australia; and, rates were even higher for the transgender population (Morris, 2016)
- Data reported from Beyond Blue, showed that LGBTIQ people are 14 times more likely to commit suicide than heterosexual people (Morris, 2016), and
- Lesbian women were more likely to engage in self harm and attempt suicide than Gay men, but Gay men were more likely to have suicide ideation (Morris, 2016).

6.2 Mental health services

Primary mental health care services

Analysis of MBS data (2014/15) by provider location indicates that the central SA3s of Adelaide City and Unley had the highest rates of Mental Health Treatment Plan preparation and review, and along with Playford, had the highest rates of GP mental health consultations (DoH 2016b).

However, service mapping undertaken by Adelaide PHN still identifies a concentration of providers of psychological and psychiatry services in the centre of the Adelaide PHN region (APHN, 2017d). Previous service mapping identified that approximately two-thirds of providers of psychological services, and two-thirds of mental health services are in the centre of the Adelaide PHN region (NHSD, 2015).

Three aspects of psychological management were reported by the Bettering the Evaluation and Care of Health (BEACH) study. Firstly, the Adelaide PHN had significantly higher psychological counselling management action rate (i.e. General practitioners providing psychological services) (29.4 encounters) per 100 psychological problem contacts when compared to Other Capital cities (24.5) and nationally (24.0) (BEACH, 2016). Second, the Adelaide PHN had a lower referral (i.e. referral outs) management action rate (13.0) per 100 psychological problem contacts when compared to Other Capital cities (16.3) and nationally (15.7) (BEACH 2016). Lastly, the Adelaide PHN had similar rates (45.7) of management of psychological issues with psychotropic medication when compared to Other Capital cities (45.4) but lower than the national rate (46.1) (BEACH 2016).

There is a strong correlation between areas of lower socioeconomic status, particularly in the north of the region, and higher rates of mental health-related PBS prescriptions dispensing within the Adelaide PHN; the exception to this is antidepressant medication in people aged 17 years and under and antipsychotic medicines in adults, where rates are also high in more socioeconomic advantaged areas of Adelaide PHN (ACSQHC, 2015).

The Statistical Area Level 3s (SA3s) of Playford and Onkaparinga had the highest rates of dispensing of antidepressants across all age groups in 2013-14 (ACSQHC, 2015). For anti-anxiety medications, Playford had the fourth highest rate in Australia for people aged 18-64 years, and the 2nd highest rate in Australia for people aged 65 years and over (ACSQHC, 2015). High rates of anti-psychotic medicines dispensing occurred in the Playford, Salisbury, Adelaide City, Onkaparinga, Port Adelaide-West and Norwood-Payneham-St Peters across varying age groups (ACSQHC, 2015). Onkaparinga, Playford and Salisbury had highest rates of dispensing for attention deficit hyperactivity disorder medicines for people aged 17 years and under in 2013-14 (ACSQHC, 2015). The Adelaide PHN notes that based on the available data, it is not possible to

determine the extent to which antidepressant and antipsychotic medicines were prescribed for conditions other than mental health.

Between July 2014 to June 2016, the SA3s within the Adelaide PHN region with the highest proportion of people who used a mental health service (in the past four weeks) were, Burnside followed by Walkerville and Playford. The SA3s with the greatest proportions of mental health service use varied between reporting periods. In the recent data (July 2016 to March 2018), the following SA3s were in the top three, Norwood- Payneham-St Peters, followed by Holdfast Bay and Charles Sturt/Adelaide City (SA Health, 2018a).

Acute mental health services

The most recent 2015-16 Adelaide PHN average age-standardised rate of mental health hospitalisations of 106 hospitalisations per 10,000 people was consistent with the national average (102 per 10,000 people). However, this (2015-16) rate is higher than the previous reporting periods of 2014-15 (92 per 10,000) and 2013-14 (84 per 10,000 people) (AIHW, 2017c).

Some areas of the Adelaide PHN region had exceptionally high rates of mental health hospitalisations (AIHW 2017c). Trend data shows that the SA3 of Adelaide City had the highest and increased rate in Adelaide PHN and Australia when compared with previous reporting periods with 224 hospitalisations per 10,000 people in 2015-16 when compared to 200 per 10,000 in 2014-15 and 187 per 10,000 in 2013-14. Marion, Playford, Port Adelaide – East, Onkaparinga SA3s had the remaining top five highest mental health hospitalisation rates respectively in 2015-16 (AIHW, 2017c). It should be noted that the mental health hospitalisation rates for all SA3s in the Adelaide PHN region has increased over reporting period years.

There have been changes between the three reporting periods by primary groups of mental health condition for mental health hospitalisations. In 2013-14, Schizophrenia and delusional disorders, intentional self-harm, and bipolar and mood disorders were the top three primary groups of conditions. The top three mental health conditions were the same in 2014-15 with anxiety and stress episodes and drug and alcohol episodes sharing equal third. In 2015-16, Schizophrenia and delusional disorders, intentional self-harm, and drug and alcohol episodes were the top three primary groups of conditions (AIHW, 2017c).

In 2015-16 the average Adelaide PHN rate was 19 hospitalisations per 10,000 people. There were however geographical variations and changes for the most recent reporting period (AIHW 2018). In 2015-16, Playford (35 hospitalisations per 10,000 people), Adelaide City (25) and Marion (24) had the top three highest hospitalisation due to intentional self-harm, respectively (AIHW, 2017c). Within the Adelaide PHN region between the three reporting periods of 2013-14, 2014-15, and 2015-16, Playford had the highest increase (21 in 2013-14, 22 in 2014-15 and 35 in 2015-16) followed by Adelaide City (21 in 2013-14, 19 in 2014-15 and 24 in 2015-16) (AIHW, 2017c).

Stakeholder feedback

The following section outlines key qualitative findings across community, stakeholder and membership findings about how mental health services should be delivered, and key components of service models which communities have identified as being lacking or necessary in future service delivery.

Consultations have been conducted across iterations of the Adelaide PHN membership models, and may include consultations which pre-date the PHN from respective medical locals.

Person-centred care

Holistic and person centred is core to quality primary mental health services in the Adelaide PHN region. Key themes relating to integrated care have been raised consistently in stakeholder consultations, including membership and key stakeholders.

Key issues have included:

- need to ensure a coordinated approach between services that focuses on the whole person and their circumstances, including coexisting physical health needs and complex social factors which interact with mental health (APHN, 2016d).
- need to improve awareness and education of Advance Care Planning (ACP) to vulnerable groups including Aboriginal and Torres Strait Islander people with mental illness by health professionals (APHN, 2016a).
- mental health cannot be seen in isolation to a person's wellbeing, and primary health care workers need to be equipped to address the needs of people experiencing social and mental health related issues (APHN, 2016c).
- the importance in the simplification of mental health services and integration with drug and alcohol services (APHN, 2016c).

Additionally, results from analysis of South Australian data from the 2013 National Drug Strategy Household Survey undertaken by the National Centre for Education and Training on Addiction (NCETA) substantiates the issues raised by Adelaide PHN membership groups in relation to the needs of people accessing both mental health and alcohol and other drug treatment services (Roche et al., 2017).

Equity and access

Over the years, the Adelaide PHN has conducted a number of consultations with community. Access and equity relating to mental health have come up consistently. Key themes include:

- Access and equity for specific population groups including Aboriginal and Torres Strait Islander people, children, youth, older people, people with disability, people with co-morbidities, LGBTI, CALD communities and people at different stages of crisis and urgency (APHN, 2016c, 2016e)
- Availability and affordability (APHN, 2016a, 2016c, 2016d)
- Having access to information to make informed choices, including understanding what services are available (APHN, 2016c).
- Clear pathways and timely access, particularly in the south (APHN, 2016a)
- Identifying barriers including cost to accessing health services, and recognising mental health and comorbidity (APHN, 2016a, 2016c).
- Improved coordination, navigation and access to services (APHN, 2016a, 2016d).

Health Literacy

In 2006, the ABS found that 59% of South Australians aged 15-74 years had low health literacy levels indicating they may not have the health literacy skills needed to navigate and understand health information and services (ABS, 2006). While dated, this is the latest health literacy data from the ABS. A more recent study by Adams et al. (2009) found that 45% of South Australians were 'at risk' or 'of high likelihood' of having low functional health literacy.

Community consultations, including consultations with Adelaide PHN membership and stakeholders have consistently found health literacy as a key enabler to better health outcomes. These findings include:

- Improving health literacy and education as a potential way to reduce unwarranted variation in care and increase the quality use of medicines particularly opiate prescribing, respectively (APHN, 2016a).
- The importance of increasing knowledge and skills to facilitate improved access to available services was raised by both the clinical and community representatives of the APHN membership groups (APHN, 2016a, 2016c).
- The importance of improving health literacy and education by providing training in disability and the health needs of people with disabilities for GPs, nurses, allied health, support workers, planners and case managers (APHN, 2016d).

- The need for consumers to be empowered and involved in their own care, to use plain language, access to transparent information about fees and reasons for particular referral pathways, enable more online patient reviews of primary health services, and for general practices to have up to date and accessible websites (APHN, 2016c).
- The need for awareness of services and where to go for what (including for those who do not have access or skills to use the internet). They also identified the need to advocate for older people by health professionals (APHN, 2016d).

Early intervention

Community consultation, including consultations with membership and key stakeholders have consistently raised early intervention as a need. This includes:

- Prioritisation of early intervention of childhood mental health disorders and prevention of relapse/adult development of serious and more chronic mental health issues and crises (APHN, 2016a).
- Need to provide better education to consumers and professionals across the health sector to improve and encourage the take-up and application of preventative measures particularly in relation to the socially isolated, at risk families, mental health, health ownership, advanced care planning and vulnerable populations (APHN, 2016a, 2016c, 2016d).
- Need to invest in early intervention and prevention with inclusive criteria which facilitates access to services such as services which increase protective factors and improve health illiteracy, brief interventions, flexible community based services, specialist development services for children, adolescents and adults and geographically targeted services) in the stepped care model (APHN, 2016d)
- The need more and health literacy in the community and increased access to culturally safe services, including specialist services, for chronic diseases. They emphasised the need to improve the uptake of the Aboriginal health check (APHN, 2016d).

Coordination and integration

The lack of current coordination and integration between services and health sectors and the urgent need to improve it was raised by the Adelaide PHN membership groups, including Clinical Councils, Community Advisory Councils and Health Priority Groups as a priority mental health issue across the region (APHN, 2016a, 2016c, 2016d). Key issues include:

- the lack of coordination / screening / capacity in the system to meet the multiple and complex needs of children and young people living in difficult social situations, domestic violence and poverty (APHN, 2016d).
- need to improve case management, care coordination and integration for non-acute mental health issues including management of medication for older people (APHN, 2016d).
- the need for a primary health care service model for people with disabilities which is interagency and interdisciplinary (APHN, 2016d)
- needs to be inclusive of and supportive of formalised carers and care coordinators (APHN, 2016d)
- conditions need to escalate before able to access services, and currently there is a lack of holistic discharge planning and limited availability of primary health services and community-based after- hours services (APHN, 2016d)
- importance of consumers and carers knowing about services and how to access them.
- improve the experience of entry to and navigation of the stepped care and broader service system, including visible points and accessible service information that connects people with the right service at the right time, reduced duplication of intake, assessment and planning processes, mechanisms which support effective handover, coordination and communication between services and improved knowledge for GPs, clinicians and providers about available services (APHN, 2016d).

- system integration to develop, improve and standardised access and processes between primary care and both public and private hospital services, as a priority need for (improving) care coordination, integration and navigation (APHN, 2016a).
- prioritised increasing integration through coordination and communication between services and practitioners (APHN, 2016a).
- integration with drug and alcohol services (APHN, 2016c).
- fragmentation and more cooperation and linkages both within the primary health care sector and between primary and intermediate care settings (APHN, 2016c).

After-hours MH services

The importance of having after-hours access to support for deteriorating (mental) health was raised by the Consumers and Carers Health Priority Group (APHN, 2016d).

Consultation with Community Advisory Councils received feedback that a lack of available after-hours mental health services for this age group was leading to more ED visits. This was particularly commented upon for the outer northern and southern Adelaide PHN suburbs (APHN, 2019b).

Community consultations conducted by the former Medicare Locals in the region raised a number of issues including limited understanding of the available after-hours services in the metropolitan region, especially in the outer northern and southern metropolitan suburbs and for those residing in aged care facilities. There was also concern that a lack of appropriate after-hours health care services, e.g. mental health, crisis support, leading to preventable hospital presentations (CAHML, 2015; SAFKIML, 2015; NAML, 2015).

6.3 Priority populations

Aboriginal and Torres Strait Islanders

See Mental Health section of the Aboriginal and Torres Strait Islander Health chapter for a summary of the mental health needs.

Children and Youth

Prevalence

Limited data is available to demonstrate the status of mental health and wellbeing in children and adolescents at a local level. Data that is available is primarily at the National level, with minimal South Australian and PHN data available.

Recent AIHW data (AIHW, 2019a) associated with the indicators in the 'A picture of Australia's children 2012', report that almost 1 in 7 (13.9%) of children and adolescents (4-17 years) in Australia had a mental health disorder in the 12 months prior to the study. The most common mental disorders in order of prevalence were:

- Attention Deficit Hyperactivity Disorder (ADHD) (7.4% of all 4–17 year olds, or N= 315,000)
- Anxiety disorders (6.9% or N= 293,000)
- Depressive disorder (2.8% or N= 119,000)
- Conduct disorder (2.1% or N= 89,000).

Furthermore, there was high comorbidity, as 30.0% of those with mental health disorders, or 4.2% of all 4–17 year olds, had 2 or more mental disorders at some time in the previous 12 months (AIHW, 2019a).

The demand on mental health services for children also appears to be increasing, as the 2013 'National Mental Health Report' states that there was a three-fold increase in the number of children and young people receiving Medicare-funded primary mental health care services from 2006-07 (79,139) to 2011-12 (337,177) (DoHA, 2013). This represents an increase from 1.1% to 4.6% of

children and young people. The increase was most marked for those aged 18-24 (2.2% to 7.5%), followed by those aged 12-17 (1.1% to 5.5%) (DoHA, 2013).

Estimates from the National Mental Health Services Planning Framework - Planning Support Tool (the tool) suggest that in 2017 approximately 5,800 people aged 0-17 years in the Adelaide PHN region are expected to require treatment for a severe mental disorder. A further 9,000 people aged 0-17 years are expected to require treatment for a moderate mental health while 11,300 in the same age group require treatment for mild mental health disorder. The tool also reports that a further 20,300 people aged 0-17 years will experience some indication of mental ill health or risk factors for mental illness in 2017 and would benefit from early intervention and relapse prevention treatment options (DoH, 2016a).

Research indicates that 25% of young people are at risk of serious mental illness, and mental illness risk increases as adolescents age, becoming most prevalent in the older teen years, and even greater for Indigenous young people and young women (Bailey et al., 2016).

The Adelaide PHN Childhood and Youth Health Priority Group (HPG) identified youth mental health as a focus across all their priorities and activities and was concerned about the increased risk of poor mental health for children from families with high levels of social disadvantage, low income or family breakup, unemployment or poor family functioning, or parental mental illness and alcohol and drug use (APHN, 2016d).

Australian and overseas studies have identified the estimated prevalence of trauma exposure in childhood to be approximately 31% (Price-Robertson et al. 2010; Douglas and Wodak 2016; Lewis et al. 2019). If applying this proportion to the Adelaide PHN population, it indicates that 82,075 people under 18 years old may be at risk of trauma exposure.

Emergency department presentations and hospital admissions

The 2015 'The Mental Health of Children and Adolescents' report stated that one in six (17.0%) young people in Australia (4-17 years) with mental disorders had attended a hospital emergency, or outpatient department, or been admitted to hospital due to their emotional or behavioural problems (Lawrence et al., 2015).

Recent AIHW data on ED presentations in 2017-18 for Mental and behavioural disorders (ICD F00-F99), listed South Australia as having the highest rate of ED presentations of all States, at 4.8% (for all ages). This was compared to a National rate of 3.6% of all presentations. More than one-quarter (26.3%) of these mental health-related ED presentations were for people aged under 25yrs. More mental health-related ED presentations were for males (51.8%) than females (48.2%) (AIHW, 2019e).

In 2017-18, South Australia had the highest proportion of ED presentations (all ages) in public hospitals for 'behavioural and emotional disorders with onset usually occurring in childhood and adolescence (ICD-10-AM-code F90–F98), at 7.2% of all mental health presentations. This was over triple the rate of other states, with a National rate of 2.6% (AIHW, 2019a).

In 2017-18 in the Adelaide PHN, 2.4% of all ED presentations in public hospitals for children and youth (0-17 years) were mental health related (Mental and behavioural disorders (ICD F00-F99)). This was the highest proportion for all PHN's and compared to an average across all PHN's of 1.4% (AIHW, 2019a).

Autism

ABS (2015a) estimates the proportion of the population with ASD in South Australia (all ages) to be 0.7% or 16,900 people in 2015. The ABS (2015a) also estimates that approximately 70% of those diagnosed with ASD are under 20 years. In South Australia this is equivalent to approximately 11,730 young persons who have been diagnosed with ASD. (ABS, 2015a). According to the ABS Survey of Disability, Ageing and Carers (SDAC), an estimated 164,000 Australians had autism in 2015 and the number of people with autism in Australia has increased considerably in recent years,

from an estimated 64,400 people in 2009 (ABS 2015a). Of those who were estimated to have autism in 2015, 143,900 were identified as also having disability (88%) (ABS 2015a).

Analysis of Adelaide PHN General Practice data for FY 2018-19 indicates there were 2,174 patients aged 0 to 18 years who visited a general practice and have a coded diagnosis of ASD. This is equivalent to 1.3% of all patients aged 0 to 18 years (APHN, 2019a). Most of these ASD coded diagnoses in this age group are patients visiting practices in the NALHN region (44.7% of the APHN). SALHN and CALHN had 31.3% and 24.0% of the Adelaide PHN diagnoses coded for ASD respectively.

Mental health-related medicines

The pattern of mental health-related PBS prescription dispensing for people 17 years and under varied across the Adelaide PHN region. In 2013-14 the highest rate and number of prescriptions dispensed for antidepressant medications were in Onkaparinga SA3, 3,581 prescriptions equating to a rate of 9,334 prescriptions per 100,000 population (ACSQHC, 2015). The SA3s of Mitcham and Prospect-Walkerville had the next highest rates with 6,588 per 100,000 and 6,584 per 100,000 respectively (ACSQHC, 2015).

Rates of dispensing for antipsychotic medication in people aged 17 years and under varied across the Adelaide PHN, with the highest rates and number of prescriptions dispensed correlated with areas of lower socioeconomic status. In 2013-14 the highest rates were SA3s of Playford (2,916 per 100,000), Onkaparinga (2,524 per 100,000) and Salisbury (2,458 per 100,000) (ACSQHC, 2015).

Overall, rates of PBS dispensing for attention deficit hyperactivity disorder in people 17 years and under were lower in South Australia compared to other states and territories. However, a wide variation was evident across the Adelaide PHN. In 2013-14 rates and numbers of ADHD prescriptions were substantially higher in the SA3s of Playford (2,248 prescriptions, a rate of 10,432 per 100,000), Onkaparinga (3,240 prescriptions, 8,541 per 100,000) and Salisbury (2,265 prescriptions, 7,648 per 100,000) (ACSQHC, 2015). The Adelaide PHN notes that based on the available data, it is not possible to determine the extent to which antidepressant and antipsychotic medicines were prescribed for conditions other than mental health.

People with mental and physical health comorbidities

An analysis by the Australia Bureau of Statistics indicated that the age-standardised mortality rate for persons who lived in the Adelaide PHN region and accessed Medicare Benefits Schedule (MBS) and/or Pharmaceutical Benefits Scheme (PBS) subsidised mental health-related treatments was 70% higher than the overall Adelaide PHN age-standardised mortality rate (ABS, 2017b).

Of all Australians with psychosocial disability, almost two in five (38.2%) reported profound levels of core activity limitation, and a further one in five (21.7%) reported severe levels of core activity limitation. Of the remaining people with psychosocial disability, 9.7% reported moderate levels of core activity limitation, 17.8% reported mild core activity limitation, and 8.7% reported school or employment restrictions. Just 3.9% of all people with psychosocial disability reported no core activity limitation, schooling or employment restrictions (ABS, 2015a).

In 2014-15, 15.8% of all Australians (3.6 million people) reported co-existing long-term mental and behavioural and physical health conditions. In addition, people with co-existing mental and physical health conditions were more likely to be unemployed, have a lower level of educational attainment, and be living in a lone-person household compared with those with physical health conditions only (ABS, 2015c). No new data available for comparison.

Compared to 15% of all South Australians (PHIDU, 2014), 28% of South Australians with a profound or severe activity limitation had a mental or behavioural disorder (ABS, 2014). The ABS defines “core activity limitation” as limitation to self-care, mobility or communication, or were restricted in schooling or employment.

People with a mental and behavioural condition were almost twice as likely than those without a mental and behavioural condition to report having diabetes (8.1% compared with 4.5%), almost

three times as likely to report chronic obstructive pulmonary disease (COPD) (5.7% compared with 2.0%) and around twice as likely to report osteoporosis (6.3% compared with 2.9%) (ABS, 2015c). For South Australia, 8.8% of people with a mental and behavioural condition reported having diabetes while 5.8% are likely to report COPD. Compared to other States and national rates, South Australians with a mental and behavioural conditions reported having higher rates of heart, stroke and vascular disease (ABS, 2015c).

People with two or more mental and behavioural conditions only were 5 times as likely as the general adult population to report high or very high levels of psychological distress, 55.9% compared with 11.7% (ABS, 2015c). No new data available for comparison.

People with substance use issues

In 2013, 19% of South Australians who were diagnosed with or treated for a mental illness in the previous 12 months participated in a treatment program to reduce or quit consumption of tobacco, alcohol or other drugs. This is compared to 5% of South Australians who had not been diagnosed with/treated for a mental illness. Counselling was the most common form of drug treatment accessed (16%) followed by telephone helpline, online support, or information and education (11%) (Roche et al., 2017).

South Australians with very high levels of psychological distress were more likely to participate in a treatment program to reduce or quit consumption of tobacco, alcohol or other drugs (29%), compared to 5% of South Australians with low psychological distress (Roche et al., 2017).

Counselling (27%), and opioid pharmacotherapy (20%) were the most common forms of treatment used by South Australians with very high levels of psychological distress. Telephone helpline, online support, or information and education was the form of treatment most often used by South Australians with low psychological distress (Roche et al., 2017).

Lesbian, Gay, Bisexual, Transgender, Intersex and Queer + (LGBTIQ+) communities

Prevalence data on the rates of mental health issues faced by people who identify as LGBTIQ+ living in the Adelaide PHN region are not currently available. However national and international research into the health needs of LGBTIQ+ communities shows that a disproportionate number of LGBTIQ+ people experience anxiety, depression and psychological distress at markedly higher rates than their heterosexual peers, and are at greater risk of suicide and self-harm (National LGBTI Health Alliance, 2020, Corboz et al, 2008).

Overall levels of psychological distress and mental health wellbeing, experiences and outcomes vary greatly within LGBTI populations, according to gender identity, sexual identity and age (Leonard et al., 2015). The following mental health issues have been identified in the Australian LGBTIQ+ community:

- Homosexual or bisexual people (28%), as well as people who were not sure/other (23%), were more likely to be experiencing high or very high psychological distress compared with heterosexuals (11%) (AIHW, 2018c)
- People identifying as homosexual/bisexual aged 16 and over had higher rates of anxiety disorder (32% vs. 14.5%) and affective disorder (19% vs. 6%) than heterosexual people (ABS, 2008)
- Compared to the general population, LGB people aged 16 years and over are over three times more likely to be diagnosed with anxiety in their lifetime, and Transgender people aged 18 years and over are nearly three times more likely to be diagnosed with an anxiety disorder in their lifetime (Pitts et al., 2006)
- The LGBTIQ population were twice as likely to be diagnosed with a mental health disorder, with 41.1% aged over 16yrs meeting the criteria for a mental health disorder in the last 12 months (Morris, 2016)

- Over one-third (37%) of LGBT people aged 16 and over reported being diagnosed or treated for any mental disorder in the past three years, twice the rate of the general population (Leonard et al. 2015)
- Over a half (57%) of Transgender and Gender Diverse people aged 18 and over have been diagnosed with depression in their lifetime, and 30% of LGBT people aged 16 and over have been diagnosed or treated for depression in the last three years compared to 12% in the general population (Leonard et al 2015)
- A South Australian survey on LGBTIQ health identified that 74% of transgender respondents reported seeking psychological or medical help in relation to their transgender status (DCSI, 2017)
- Older South Australian LGBTIQ people face challenges associated with social isolation, housing, aged care and health and wellbeing. Mental health challenges such as suicide ideation were linked with social isolation (COTA SA and SARAA, 2018).

To gain a better understanding of the health and service needs of our local LGBTIQ+ communities Adelaide PHN consulted our memberships groups and interviewed several LGBTIQ+ service providers in the region. Mental health and suicide were identified by all as an urgent and serious problem (APHN 2020a). LGBTIQ+ communities were acknowledged as having substantially higher rates of poor mental health compared to the general population, often associated with social determinants such as social isolation and limited social supports particularly for younger and older people. Stigma and discrimination were noted as substantial barriers to accessing local mental health services, as was the lack of appropriately and inclusive trained service providers and a peer workforce. Transgender, intersex, non-binary and gender diverse communities were highlighted as having greater mental health needs and should be a population of focus. The invisibility of mental health prevalence and needs of the LGBTIQ+ communities due to inadequate data collection was also raised as an issue to address (APHN 2020a).

Culturally and linguistically diverse (CALD) communities

Many older people from CALD backgrounds have higher levels of disadvantage and other risk factors compared to older Anglo-Australians. These risk factors include socioeconomic disadvantage, cultural translation difficulties, lack of exposure to Australian services and systems, and lower rates of access to services. Research suggests that older people from CALD backgrounds have a higher risk of mental health issues and tend to present at later stages of illness compared to other older people in Australia. Those who migrated to Australia at an older age or who are from a refugee background, face a higher risk of mental and physical health issues. Older migrants, in particular women, are recognised as ageing prematurely and experiencing social isolation (Principe 2015).

Refugees and new arrival communities are affected by mental health issues and social isolation when adapting to life in a new country (APHN 2017b).

Providing (culturally) appropriate mental health services for high risk communities like new arrivals in Australia from refugee backgrounds, culturally and linguistically diverse (CALD) and minority groups (including transgendered people) was prioritised by the Mental Health HPG (APHN 2016d).

People with Severe Mental Illness Requiring Psychosocial Support

The needs of people with severe mental illness are not homogenous. Some people have episodic illness which can be supported through time-limited clinical services in the primary care setting. Others have more persistent mental illness that requires more acute, hospital based services and a need of some form of social support, ranging from group-based activities delivered through mainstream social services to extensive and individualised disability support (DoH, 2018a).

Health needs analysis

Estimates from the National Mental Health Services Planning Framework - Planning Support Tool (the tool) suggest that in 2018 approximately 6,786 people with severe and complex mental health

disorders in Adelaide PHN region require high intensity adult community support services (DoH, 2018b).

Specific data or health needs for people with severe and complex mental health disorders in APHN region requiring psychosocial support is not available but a 2010 (Australian) report on people living with psychotic illness provides some information on the health needs of this cohort of individuals (DoH, 2011).

Gender and Age Groups

Nationally, the report estimates that 3.1 cases per 1,000 population aged between 18 and 64 years had a psychotic illness and were in contact with public specialised mental health services. The prevalence of psychotic disorders was higher in males than females (3.7 cases per 1,000 compared to 2.4 per 1,000). Males aged 25-34 years had the highest rates of psychotic illness (5.2 cases per 1,000). The age groups with the next highest prevalence for males were those aged 35-44 and 45-54 years. For females prevalence was more even across age groups at almost 3 cases per 1,000 population in those aged between 25 and 54 years (DoH, 2011).

Through community consultations during the LGBTIQ+ Needs Assessment, analysis has indicated that there is a lack of data regarding gender identity, intersex status or sexual orientation (APHN 2020a).

Type of disorder

The most common psychotic disorder was schizophrenia (47.0%), accounting for the majority of males (56.3%) and one third (33.2%) of females, followed by bipolar, mania (17.5%), schizo-affective disorder (17.5%), Severe depression without psychosis (8.7%), Delusional (5.0%), depressive psychosis (4.4%) and other (not classified) (1.4%) (DoH, 2011).

Nature of Illness

The report states that one in twelve people (8.1%) had experienced just one episode of psychotic illness, while the majority (61.5%) had experienced multiple episodes with periods of good or partial recovery in between (29.7% and 31.8% respectively). Many people (30.5%) receiving services through the public system have continual chronic illness and one third of these experiences marked deterioration over time. The most common symptoms of psychotic illness are delusions and hallucinations. A range of other symptoms, some of which are associated with other mental disorders, such as depression and anxiety, are also commonly experienced by people with psychotic illness (DoH, 2011).

Functioning

Most people (90.4%) reported deterioration of functioning after illness onset. One third (32.3%) were assessed as having a significant level of impairment in their ability to care for themselves in the previous 4 weeks and almost one-fifth (18.4%) was unable to complete a simple chore such as cleaning their room. Two thirds (63.2%) were assessed as having a significant level of dysfunction in their capacity to socialise over the past year (DoH, 2011).

Literacy Skills

Almost one in five (18.4%) people with a psychotic illness reported difficulty with reading and/or writing (DoH, 2011).

Physical conditions

Chronic back, neck or other pain were common (31.8%) amongst people with psychotic illness, followed closely by above average asthma rates (30.1% compared to 20.2% for the general population) and heart or circulatory conditions (26.8% compared to 16.3% for the general population). One quarter (24.0%) of people with psychosis were at high risk of cardiovascular disease. Almost half (45.1%) of people with psychotic illness were obese. Physical activity levels were far lower in people with psychosis, with 96.4% classified as either sedentary or undertaking

low levels of exercise in the previous week compared to 72.0% for the general population (DoH, 2011).

Smoking, alcohol and drug use

Two thirds (66.1%) of people with psychosis smoke, smoking on average 21 cigarettes per day. Alcohol abuse was high, with 58.3% of males and 38.9% of females assessed by interviewers as consuming alcohol at levels that constitute abuse or dependence at some point in their lifetime. Rates of lifetime use of cannabis or other illicit drugs were very high, with 63.2% of males and 41.7% of females assessed by interviewers as using at levels that constitute abuse or dependence. Only 12.9% of people with psychotic illness were participating in drug and alcohol treatment programs (DoH, 2011).

Suicide ideation

Just over one-tenth (11.5%) of people reported that they were thinking about suicide at the time of interview and two thirds (67.0%) had done so in their lifetime. Half (49.5%) reported they had attempted suicide at some point in their lifetime. This compares to only 3.7% in the general population. Females were more likely to have attempted suicide than males (57.5% and 44.2% respectively) (DoH, 2011).

Service needs analysis

The Adelaide PHN acknowledges that the (service) needs of the individuals requiring psychosocial support in our region will be unique based on the funding arrangement provided by the Commonwealth – to assist people with severe mental illness resulting in psychosocial disability who are not eligible for the National Disability Insurance Scheme (NDIS). The Adelaide PHN has conducted two (online) surveys and a consultation workshop (with clients) in October 2018. The online survey targeted existing service providers providing psychosocial support services in the Adelaide PHN region with 16 organisations (note: one consisting of 7 consortium agencies) participating in the survey. The other online survey targeted a wider audience ranging from health professionals, support workers, carers and the general community with a total of 96 people completing the survey. The (client) consultation consisted of two face-to-face workshops (Northern and Southern regions) with total of 25 existing clients of service providers providing psychosocial support services. The findings below summarises themes, issues, challenges and opportunities from respective surveys/consultations.

Service mapping undertaken by the Adelaide PHN shows that the majority of current services providing psychosocial support services have footprints in the LGAs of Adelaide City, Onkaparinga, Port Adelaide Enfield, Playford, Salisbury and Charles Sturt and West Torrens (APHN, 2018f).

Service Provider Survey

More than three quarters, 86.7% of the service providers who participated in the online survey indicated being concerned for vulnerable individuals in specific circumstances who may not be eligible for services through the NDIS or psychosocial services (APHN, 2018c).

Although all LGAs in the Adelaide PHN region have a service footprint, the LGAs of Port Adelaide Enfield, Salisbury, Charles Sturt, Prospect, Adelaide, Playford, Tea Tree Gully and West Torrens have the most coverage by existing service providers of psychosocial support services (APHN, 2018c).

As reported in the health and service needs of Primary Mental Health sections, there is a higher need of supporting people with mental health conditions in Local Government Areas of Playford, Salisbury, Port Adelaide Enfield and Onkaparinga in the Adelaide PHN region.

Community Survey

When participants were asked which best describes them or their role, case manager/care coordinator was the most common response followed by allied mental health professional, support workers and mental health clinicians. One in ten were clients of current services while four percent

were family members of those require psychosocial support services (APHN, 2018e). Adelaide, Port Adelaide Enfield, Playford, Charles Sturt and Onkaparinga were the top five LGAs where participants live or work (APHN, 2018e).

Client consultations

Clients of existing psychosocial support services identified lack of timely, responsive services that met their needs, lack of empathy understanding and respect and underfunded programs and services as the top 3 irritants from their experience of service use (APHN, 2018d). Conversely, clients valued services tailored to (their) specific needs, skilled relatable knowledgeable support staff and suitable transport as their top 3 opportunities for experiencing good services (APHN, 2018d).

Respondents in the community survey indicated: Housing support, making connections (e.g. group support, with community) and independent living skills (e.g. housing, budgeting and employment) as the three most important things to consider when designing a new psychosocial support (services) for people with complex mental health issues (who are not eligible for the NDIS) (APHN, 2018e).

Service Provider Survey

Service providers provide a range of psychosocial support services and/or programs to clients. Coordination and liaison (provided by 81.3% of service providers), social skills and social inclusion (81.3%), independent living skills (62.5%) and other broad services (such as carer respite and support, counselling, group activities) were common (psychosocial support) services provided to clients with severe mental health conditions (APHN, 2018c). Providers also indicated their clients, who are not eligible for the NDIS, will continue to need these services (i.e. coordination and liaison, social skills and social inclusion, independent living skills) (APHN, 2018c).

Service providers reported a range of challenges for their clients when participating in psychosocial support services. Social skills and isolation due to mental health conditions was a major barrier to their clients being able to participate in services. They also reported that lack of flexible and response service which adapts to client needs was a challenge to client participation. Although transport challenges were highlighted (including during client consultations (APHN, 2018d)), the episodic nature of (client population) mental conditions, effects of medication and anxiety were associated to this barrier than cost (although plays a contributing role given majority of clients are not in full time employment) (APHN, 2018c,d).

Community Survey

When asked what psychosocial support services or programs participants are aware of in the Adelaide PHN region for people with severe mental health illness, majority of the them indicated being aware of: Partners in Recovery (PIR) (81.5%), Personal helpers and mentors (81.5%), and Carer respite programs (67.4%). Individual Psychosocial Rehabilitation Support Services (IPRSS) were the most common response for “Others” (APHN, 2018e).

Participants rated the following current availability and accessibility of services and supports as “Poor” or “Very Poor” (Top three respectively):

- Finding and maintaining a home
- Social skills
- Friendships and family connections

While reported the housing and accommodation, social skills and social inclusion and independent living skills as the top 3 psychosocial support gaps and unmet needs for people with severe mental illness (APHN, 2018e).

Conversely, the following current availability and accessibility of services and supports as “Good” or “Very Good” (Top three respectively):

- Managing drug and alcohol addictions

- Mental health literacy and education
- Physical health and wellbeing (APHN, 2018e).

More than half (64.2%) indicated that people with severe mental health illness require on average between 1 to 4 hours of psychosocial support services during the week (APHN, 2018e). However, more than one quarter or 35.8% of respondents response indicated that support should be varied based on needs regardless of time of day. This aspect of support (needs base) was also voiced during the client consultation workshops (APHN, 2018d).

Similar to identified needs highlighted in this NA report, clients and service providers highlighted the importance in easy access of information on services for people (with severe mental health conditions). During the client consultations, participants selected information about service (that are) easily available as the fifth most important value and indicated the importance of knowing someone to call who knows them when they need them as the next most importance as the factor for experiencing good service (APHN, 2018c).

Clients of existing psychosocial support services identified lack of timely, responsive services that met their needs, lack of empathy understanding and respect and underfunded programs and services as the top three irritants from their experience of service use (APHN 2018d). Conversely, clients valued services tailored to (their) specific needs, skilled relatable knowledgeable support staff and suitable transport as their top 3 opportunities for experiencing good services (APHN ,2018d).

7 Alcohol and other drugs

As stated in the South Australian Specialist Alcohol and Other Drug Treatment Service Delivery Framework (SANDAS and DASSA 2018):

“Alcohol and other drug issues impact the health, social, and economic wellbeing of individuals, families and the whole community. Harms from alcohol and other drug use include injury, preventable diseases, mental health issues, risky behaviour, violence and other criminal behaviour. Harms also include social, family and financial problems.”

Alcohol and other drug use occurs on a spectrum from occasional use to dependence. The cohort of people who require interventions to prevent or reduce harms differ greatly in their levels of substance use and associated social, economic and health risk factors. Treatment interventions vary accordingly to meet the individual needs of each client.

7.1 Priority drugs of concern

The Adelaide PHN has identified a number of specific priority drug types based on prevalence among the population, level of harms that these substances bring to an individual and/or the community and alignment with the substances identified in the *National Drug Strategy 2017-2026*.

The current priority drug types for the Adelaide PHN include alcohol; methamphetamines; cannabis; opioids; non-medical use of pharmaceuticals benzodiazepines, analgesics and anxiolytics; and other drugs of concern including tobacco, ecstasy and cocaine. These are the drug types associated with the most harm in Australia and within the Adelaide PHN region. With the availability of new data, these priority drug types will be reviewed and may change over time based on national evidence and local circumstances.

Alcohol

Alcohol consumption has resulted in significant fiscal and health costs in Australia. In 2010, the cost of alcohol-related harm (including harm to others) was reported to be \$36 billion. Nationally, alcohol is also associated with over 5,000 deaths and more than 150,000 hospitalisations every year (DOH 2017). Alcohol related harm has a significant impact on Australian society with almost 250,000 Australians estimated to have been the victims of an alcohol-related physical assault in 2015-16. Alcohol also has an impact on frontline police and health workers (DOH 2017).

Rates of alcohol consumption in the Adelaide PHN region are consistent with national rates (AIHW 2020a). Data from the 2019 National Drug Strategy Household Survey estimate that for people aged 14 years and over living in the Adelaide PHN region in past 12 months:

- 22% have not consumed alcohol
- 60% consumed at low risk levels, and
- 18% consumed at lifetime risky levels (AIHW 2020a).

Since 2016 rates of low risk drinking have decreased, however lifetime risky consumption has increased by 20% (AIHW 2020a).

Risk score estimates for Adelaide PHN suggest that approximately 7% of Adelaide PHN's residents aged 14 years and over, equivalent to 73,000 people, could have an alcohol dependence issue and are likely to require specialist assessment and treatment for their use. A further 23% of residents, approximately 240,000 people, qualified as having harmful or hazardous use (a moderate risk score). These rates are consistent with the Australian score proportions (AIHW 2020a).

Levels of lifetime risky drinking varied within region, with rates ranging from 15% in Adelaide-North SA4 to 20% in Adelaide-South SA4 in 2016. Rates of single occasion risky drinking increased significantly in Adelaide-South SA4, from 20% in 2016 to 29% in 2019 (AIHW 2020a).

Alcohol consumption also varied by demographic characteristics:

- More males drank at lifetime risky levels than females, 21 per 100 compared to 7 per 100 respectively in 2017-18 (PHIDU 2020b)
- 25-59 year olds were more likely to drink at lifetime risky levels (1 in every 2, 46%), compared to 1 in 3 12-24 year olds (40%), and 1 in 5 persons aged 60 years and over in 2013 (Roche et al. 2016), and
- Rates are increasing in older people (50+ years) and young women (18-35 years), and decreasing in teenagers and the general population (SANDAS and DASSA, 2018).

In contrast to some other drug use patterns, risky consumption of alcohol does not appear to be correlated with socioeconomic status in the Adelaide PHN region (Roche et al 2016).

In South Australia, the number of estimated hospitalisations attributable to the use of alcohol has increased over 10 years from 11,899 in 2007-08 to 13,893 in 2016-17, the rate has also increased slightly, from 74.2 to 81.1 persons per 10,000 population. In contrast, the estimated number and rate of metropolitan emergency department injury presentations attributable to the use of alcohol for persons aged 15 years and over decreased between 2007-08 and 2016-17 (the overall number from 16,416 to 16,007 presentations and the rate from 169.6 to 155.1 per 10,000 persons) (DASSA 2018). In the Adelaide PHN region, alcohol contributed over half (57%) of all AOD-related ED presentations and over a third (38%) of all AOD-related hospitalisations in 2015-16 (Roche et al. 2017b).

There has been a small decrease over time in the estimated rate of alcohol-related deaths in South Australia, from 3.4 per 10,000 population in 2005 to 3.1 per 10,000 in 2011. Men comprised 68% of all alcohol-related deaths from 2005-2011, and alcohol-related mortality rates among men were more than double that of women (DASSA 2018). In 2018, almost 100 deaths in South Australia were as a result of alcohol use, equivalent to approximately 1,700 Years of Potential Life Lost, premature mortality due to alcohol use (ABS 2019).

Meth/amphetamine

Methamphetamine comes in a range of forms, including powder, paste, liquid, tablets and crystalline. Methamphetamines are part of a broader category of stimulants that also includes cocaine, and 3,4-Methylenedioxymethamphetamine (MDMA). Stimulants can be taken orally, smoked, snorted/inhaled and dissolved in water and injected. Some of the physical harms that can arise from the use of methamphetamines and other stimulants include mental illness, cognitive impairment, cardiovascular problems and overdose (DOH 2017). Other personal harms include increased risky behaviours including unsafe sex, the sharing of needles by injecting users, and driving under the influence of drugs; disruption to education and employment; family breakdown; violent behaviour and potential risk to frontline workers (COA 2015).

After alcohol, amphetamines are the most common drug of concern in South Australia and prevalence is steadily increasing across metropolitan Adelaide (DASSA 2016). Analysis of wastewater indicates that methamphetamine is the predominant stimulant consumed in metropolitan Adelaide and consumption levels fluctuate over time, showing increases from 2012-2017, and from mid-2018 to mid-2019 (DASSA 2020).

The number of people using methamphetamine has remained low in South Australia (1.9% in 2016), however compared with 2010, the proportion of people reporting that crystal methamphetamine or 'ice' was their main form of meth/amphetamine used in the previous 12 months has increased from 38% in 2010 to 78% in 2016 (AIHW 2017d). As crystal methamphetamine is the most potent form this has led to an increase in harms and people seeking treatment (SANDAS and DASSA, 2018).

Prevalence of recent methamphetamine in the Adelaide PHN region was marginally higher for males compared to females, 3% and 2% respectively, and varied across the region from 1% in Adelaide-North SA4 to 4% in Adelaide-South (Roche et al. 2016). Data on methamphetamine use within the Adelaide PHN region by age is unavailable due to small numbers (Roche et al. 2016).

In 2015-16, stimulants including methamphetamines accounted for 6% of all AOD-related ED presentations (463 presentations) and 22% of AOD-related hospitalisations (924 hospitalisations, the 2nd highest contributor after alcohol) in Adelaide PHN region (Roche et al. 2017b).

Non-medical use of pharmaceuticals including opioids and benzodiazepines

The range of pharmaceutical drugs commonly used for non-medical reasons include opioids (such as oxycodone, fentanyl, morphine, methadone, pethidine and codeine), benzodiazepines (such as diazepam, temazepam and alprazolam), and other analgesics (such as paracetamol and ibuprofen in preparations combined with codeine) and performance and image enhancing drugs (such as anabolic steroids, phentermine and human growth hormones). The harms that can arise as a result of the use of pharmaceutical drugs depend on the drug used, but can include fatal and non-fatal overdose. Harms also include infection and blood vessel occlusion from problematic routes of administration, memory lapses, coordination impairments and aggression (DOH 2017).

The misuse of prescribed opioid medication and over-the-counter (OTC) codeine is low in Australia but there are indications that it is increasing across Australia and globally (DOH 2017). Australia has seen an increase in the prescription and use of licit opioids. In particular, the supply of oxycodone and fentanyl increased 22-fold and 46-fold respectively between 1997 and 2012 and the number of prescriptions for opioid prescriptions subsidised by the Pharmaceutical Benefits Scheme (PBS) increased from 2.4 million to 7 million between 1992 and 2007. Consistent with these trends, hospital separations associated with prescription opioid poisoning have increased substantially (DOH 2017).

Since February 2018, products containing codeine are only available via prescription in Australia (SANDAS and DASSA, 2018).

In South Australia, illicit use of pharmaceuticals (excluding OTC codeine) increased from 3.3% (2013) to 5.5% (2016). Compared to other Australians, South Australians were more likely to misuse painkillers/opiates (4.3%) than people in any other state or territory in 2016 (AIHW 2017d). Within the Adelaide PHN region, use of opioids/painkillers in the last 12 months ranged from 1% in Adelaide-Central SA4 to 5% in the SA4s of Adelaide-South and Adelaide-West (Roche et al. 2016). There was minimal variation in use of opioid/painkillers by gender, with males 4% and females 3%, but prevalence is higher among persons aged 12-24 years compared to those aged 25 years and over (Roche et al. 2016).

In 2015-16, opioids accounted for 5% of all AOD-related ED presentations (350 presentations) and 7% of AOD-related hospitalisations (425 hospitalisations) in the Adelaide PHN region. Non-opioid analgesics accounted for 9% of AOD-related ED presentations (n=619) and 12% of AOD-related hospitalisations (n=717) (Roche et al. 2017b).

Opioids and benzodiazepines are the main drug groups associated with unintentional drug-induced deaths in Australia. Deaths involving other prescription medications – such as anti-convulsant medications and anti-psychotics – have increased markedly in the last few years, although they account for only a small proportion of all unintentional drug-induced deaths. Between 2014 – 2018 there were 575 drug-induced deaths of people from the Adelaide PHN region, 368 of them being unintentional (Penington Institute 2020).

Patterns of opioid prescription dispensing

Rates of PBS prescriptions dispensed for opioid medicines have decreased since 2013-14 (ACSQHC, 2015), however they are higher in Adelaide PHN compared to the national rate. In 2016-17, there were 893,316 opioid prescription dispensed in Adelaide PHN, representing a rate of 63,175 prescriptions per 100,000 population, compared to 58,595 per 100,000 population nationally (ACSQHC and AIHW, 2018).

There were large variations in the rate of dispensing of opioid medicine prescriptions across the region. Rate of dispensing in the Statistical Area Level 3 (SA3) with the highest rate (Playford) was 2.9 times higher than SA3 with the lowest rate, Burnside SA3 (37,749 per 100,000 population) (ACSQHC and AIHW 2018). Playford SA3 had the highest age-standardised rate for dispensed

prescribed opioids in South Australia and the second highest rate nationally, with 111,262 prescriptions per 100,000 population (ACSQHC and AIHW, 2018). This is also an increase in the rate since 2013/14 of 109,191 per 100,000 population (ACSQHC, 2015).

There is also a clear social gradient in the age-standardized rate of dispensed prescribed opiates; SA3 areas with a lower socio-economic status have substantially higher rates of PBS dispensed prescribed opioids (ACSQHC and AIHW, 2018; Roche et al., 2016).

Patterns of anxiolytics prescription dispensing

Like opioid prescribing, the age-standardised rate of PBS prescriptions dispensed for anxiolytic medicine are higher in the Adelaide PHN compared to the national rates. In 2013/14 for 18-64 year olds the Adelaide PHN rate was 21,523 per 100,000 persons compared to 17,201 per 100,000 for 18-64 year olds nationally. A rate of 49,060 per 100,000 for people aged 65+ years in Adelaide PHN was higher than the national rate of 37,695 per 100,000 (ACSQHC, 2015).

In 2013/14, the rate of PBS prescriptions dispensed for anxiolytic medicine to persons aged 65+ years in Adelaide PHN was 138% higher than among 18-64 year olds (Roche et al. 2016).

There were large variations in the rate of dispensing of anxiolytic medicine prescriptions across the region. For 18-64 year olds, the Statistical Area Level 3 (SA3) of Playford had the highest rate for both age groups, a rate of 36,292 per 100,000 population for 18-64 year olds and 74,380 per 100,000 for 65+ year olds. These rates were 2.5 and 2.1 times the rate in the SA3 with the lowest rate for each age group (ACSQHC 2015).

Like opioid dispensing a clear social gradient was apparent in the age standardised population rate of dispensed prescribed anxiolytics. As socio-economic status within an SA3 declined, the rate of dispensed prescribed opiates increased (ACSQHC 2015). The difference in rate of age standardised population prescribed anxiolytic dispensing between persons aged 18-64 and 65 years widened as SEIFA quintile declined (Roche et al. 2016).

Cannabis

As the most widely used of the illegal drugs in Australia, cannabis carries a significant burden of disease. The use of cannabis can result in various health impacts, including mental illness, respiratory illness, and cognitive defects. In particular, cannabis dependence among young adults is correlated with, and probably contributes to, mental disorders such as psychosis (DOH 2017).

Cannabis was the most common drug used in the Adelaide PHN region and use has remained relatively stable in recent years; in 2016, the prevalence was 11% of the general population (Roche et al 2016; DASSA and SANDAS 2018). Analysis of wastewater suggests that average consumption levels in metropolitan Adelaide have fluctuated over 2019 and 2020, but on average appeared to have remained consistent with 2018 consumption levels. Overall average consumption declined from 2012 to 2017 (DASSA 2020).

Within Adelaide PHN region, recent cannabis use ranged from 6% in Adelaide-North SA4 to 14% in Adelaide-South SA4 (Roche et al. 2016). More males used cannabis than females, 13% compared to 8%, and use was higher among 12-24 year olds (15%) than those aged 25 years and over (9%) (Roche et al. 2016).

Approximately two percent of the Adelaide PHN population aged 14 years and over, equivalent to 21,000 people are estimated as using cannabis at harmful or hazardous levels (AIHW 2020a).

In 2015-16, cannabinoids accounted for 1% of all AOD-related ED presentations (99 presentations) and 4% of AOD-related hospitalisations (174 hospitalisations) in Adelaide PHN region (Roche et al. 2017b).

Other drugs of concern

Ecstasy

Analysis of wastewater suggests that within metropolitan Adelaide overall average ecstasy consumption level have been increasing since February 2019, in contrast to the previous pattern of decline from 2012 to 2018 (DASSA 2020).

At the state-level a significant decline in ecstasy use in the previous 12 months was reported for people in South Australia; a reduction from 2.8% in 2013 to 1.6% in 2016 (AIHW 2017d).

Cocaine

Cocaine use has been increasing incrementally since 2004, reaching 2% in 2016. It is now the second most commonly used illegal drug in Australia after cannabis. Its use in South Australia remains below the national average and less than methamphetamine (SANDAS and DASSA 2018).

Analysis of wastewater suggests that cocaine consumption levels are increasing in metropolitan Adelaide, with the July 2020 consumption level the highest since 2014 (DASSA 2020).

Tobacco

Tobacco remains a significant cause of death and disability in Australia. Tobacco smoking also carries the highest burden of drug-related costs on the Australian community (DOH 2017). Nicotine was the most common secondary drug of concern in data collected from local treatment services (SANDAS and DASSA 2018).

Latest prevalence for tobacco smoking rates in the Adelaide PHN were consistent with the national rates in 2019; 11% of people were daily smokers equivalent to approximately 137,200 people. This is an 11% increase since 2016 (AIHW 2020a). Almost two-thirds (64%) of the Adelaide PHN have never smoked, a minimal 3% decrease since 2016 (AIHW 2020a).

7.2 Priority Populations

A number of population groups experience disproportionate levels of ill-health, disability and disproportionate harms (direct and indirect) associated with alcohol and other drug use (DOH 2017). In the Adelaide PHN region, and in line with the *National Drug Strategy 2017-2026*, they include Aboriginal and Torres Strait Islander people, people with mental health conditions, culturally and linguistically diverse populations, young people, people identifying as lesbian, gay, bi-sexual, transgender, intersex or queer (LGBTIQ) and people in contact with the criminal justice system (DOH 2017; APHN 2020a, 2020c; Purdie, Dudgeon, & Walker, 2010). The following section describes the burden of alcohol and substance use and some of the specific barriers these specific groups face to accessing treatment.

Aboriginal and Torres Strait Islander people

Compared to other Australians, Aboriginal and Torres Strait Islander peoples experience a disproportionate amount of harms from alcohol, tobacco and other drug use. Drug-related problems play a significant role in disparities in health and life expectancy between Aboriginal and Torres Strait Islander people and non-Indigenous Australians (Wilson et al. 2010).

In 2016 Aboriginal and Torres Strait Islander people comprised 1% of the total PHN population, however they represented 11% of all AOD-related emergency department (ED) presentations (2015/16), 9% of all AOD-related hospital separations (2015/16), 14% of specialist AOD treatment episodes (2014/15) and 3% of Alcohol and Drug Information Service (ADIS) calls (2015) (Roche et al. 2017a).

It is important to recognise the broader socio-economic context and the complex and interrelated factors that contribute to elevated risk and harms from substance use among Aboriginal people (Roche et al. 2017a). The interconnected issues of cultural dislocation, personal trauma and the ongoing stresses of disadvantage, racism, alienation and exclusion can all contribute to a heightened risk of harmful substance use, mental health problems, and suicide (Purdie, Dudgeon, &

Walker, 2010). A lack of, and lack of access to adequate, and appropriate treatment services and prevention strategies also contribute (DOH 2017; APHN 2020c).

It is critical to ensure that any efforts to reduce the disproportionate harms experienced by Aboriginal and Torres Strait Islander people are culturally responsive and appropriately reflect the broader social, cultural and emotional wellbeing needs of Aboriginal and Torres Strait Islander people (APHN 2020c). Planning and delivery of services should have strong community engagement including joint planning and evaluation of prevention programs and services provided to Aboriginal and Torres Strait Islander communities taking place at the regional level (DOH 2017). Wherever possible, interventions should be based on evidence of what works specifically for Indigenous people (DOH 2017; APHN 2020c).

Alcohol

Alcohol misuse is a contributing factor to a wide range of health and social problems, including: violence; social disorder; family breakdown; child neglect; loss of income or diversion of income to purchase alcohol and other substances; and, high levels of imprisonment (Wilson et al., 2010).

As presented below, Aboriginal and Torres Strait Islander people living in Adelaide PHN, South Australia or Australia experience harms associated with alcohol use at a rate much higher than non-Indigenous people.

In 2018-19, 14% of Aboriginal and Torres Strait Islander people living in the Adelaide PHN region aged 15 years and over consumed alcohol at long-term risk levels, and 46% consumed alcohol at short-term risk levels (ABS 2020). Although this is a reduction since 2012-13 of 23% and 55% respectively (Roche et al. 2017), rates for short-term risk for Aboriginal and Torres Strait people are still substantially higher than total region rates of 27% (AIHW 2020c).

The age-standardised rate of hospitalisation relating to alcohol use for Indigenous South Australia declined from 15.8 per 1,000 people in 2008–09 to 10.8 per 1,000 people in 2014-15, however despite the decline the rate was significantly higher (7.7 times) the hospitalisation rate for non-Indigenous South Australians in the same period (1.4 per 1,000 in 2014–15) (AIHW 2017e). In 2015 - 16, Aboriginal and Torres Strait Islander people accounted for 12% of all alcohol-related ED presentations and 17% of all alcohol-related treatment episodes in Adelaide (Roche et al. 2017a).

In terms of AOD-related services, alcohol was the primary drug of concern for Aboriginal and Torres Strait Islander people in the Adelaide PHN region, accounting for 66% of AOD-related ED presentations, 43% of hospital separations, and 46% of treatment episodes (Roche et al. 2017a).

Tobacco

The proportion of Indigenous South Australians who currently smoke has significantly declined since 2001, however rates are still more than double the proportion of non-Indigenous South Australians who smoke (Roche et al. 2017a).

In 2018-19, 33% of Aboriginal and Torres Strait Islanders aged 15 years and over living in the Adelaide PHN were daily smokers, three times the overall rate of 11% for the region (ABS 2020; AIHW 2020a). Indigenous women living in the Adelaide PHN were also more likely to smoke during pregnancy compared to non-Indigenous women, 49% compared to 12% from 2012 to 2014 (PHIDU 2020d).

In 2014–15, 76% of Indigenous South Australians aged 15 and over who reported being a current smoker, had tried to quit or reduce smoking; this is higher than the national rate of 69% (AIHW, 2017e).

Non-medical substance use

Substance use rates are higher in the Aboriginal and Torres Strait Islander population in the Adelaide PHN region compared to non-Aboriginal people: in 2019, 16% of people in Adelaide PHN had recently used an illicit substance (AIHW 2020a), compared to 40% of Aboriginal and Torres

Strait Islander people living in APHN in 2018-19 (ABS 2020). This was also a substantial increase from the 2012-13 rate of 27% (Roche et al. 2017a).

Substance use was more prevalent for Indigenous males than females (43% compared with 31% in 2014-15) in South Australia (AIHW 2017e). An estimated 5% of mothers of Indigenous children aged 0–3 reported illicit drug or substance use during pregnancy (AIHW 2017e).

Nationally, cannabis was the most common recently used substance by Aboriginal and Torres Strait Islander people (16%) (as it was for the non-Indigenous population (12%)). Pharmaceuticals for non-medical purposes were the second most commonly used illicit drug type by Aboriginal people (8%), followed by pain-killers/pain-relievers and opioids (6%), cocaine (4%), tranquilisers (4%) and methamphetamines (3%) (AIHW 2020c). Compared to rates of use for non-Indigenous people, rates for Aboriginal people were 2.4 times higher for methamphetamines and tranquilisers and 2.3 times for pain killers and opioids (AIHW 2020d).

National estimates indicate that in 2018, Aboriginal and Torres Strait Islander people were almost three times as likely to die from an unintentional drug-induced death, with a rate of deaths of 17.3 per 100,000 population, compared with 6.0 deaths per 100,000 population for non-Aboriginal people. Nationally, the rate of unintentional drug-induced deaths among Indigenous Australians has increased between 2001 and 2018 (from 9.5 to 17.3 deaths per 100,000) (Penington Institute 2020).

Within the Adelaide PHN region Aboriginal people accounted for 16% of cannabis-related ED presentations, 11% of cannabis-related hospitalisations and 14% of other drug-related hospitalisations (Roche et al. 2017)

Service gaps

Gaps in AOD treatment service provision include gaps in access to a full range of services, limited access to culturally safe or secure services, services for families, and a paucity of ongoing support and relapse prevention for those completing intensive treatment (NDRI 2014; APHN 2020c).

The services that are most likely to effectively address drug use among Aboriginal and Torres Strait Islander people are those that originate within and are controlled by the community, are culturally appropriate, person and family centred, provide holistic service and create strong partnerships with other organisations in order to provide clients with a complete continuum of care (NDRI 2014; Adelaide PHN 2016d, 2020c).

Local stakeholder consultations identified that there is an increased need to provide more timely services for clients currently presenting for AOD support (APHN, 2017f). Currently a lack of trust and cultural barriers often lead to reduced access for Aboriginal and/or Torres Strait Islander people, and commended the use of cultural healers. This was felt to be a positive move to identify and meet the needs of these communities. It is acknowledged that there is a need for more culturally appropriate services to enable better treatment and navigation through the system (APHN 2020c).

It is also important to recognize the language and cultural differences that exist within the Aboriginal and/or Torres Strait Islander populations in our region, highlighting that there is no 'one size fits all' approach (APHN 2020c).

Children and young people

Young people (between the ages of 10 and 24) face specific risks in relation to alcohol, tobacco and other drug problems. The young brain is more susceptible to permanent damage from alcohol, tobacco and other drug use which makes this group a core priority. To reduce the harm caused by substance use it is important to delay initiation (DOH 2017).

Nationally, in 2015, alcohol and illicit drug use were the leading causes of total burden of disease in males aged 15–24 and the second and third leading causes for females (AIHW 2019j). While

tobacco smoking and the use of alcohol and illicit drugs is declining among young people, the consumption of alcohol at risky levels remained high in 2019 (AIHW 2020b).

Young people (aged 12-24 years) within the Adelaide PHN region have high rates of risky behaviours, particularly related to the use of alcohol, cannabis and non-opioid analgesics, which places them at increased risk of harm (Roche et al. 2017a). Rates for Adelaide PHN region indicate that:

- 1 in 3 young people (40%) drink alcohol at risky levels
- 1 in 10 young people (15%) had used cannabis in past 12 months
- 1 in 13 young people (8%) had used ecstasy in past 12 months, and
- 1 in 20 young people (5%) had used opioids/painkillers (Roche et al. 2017a).

Overall, usage rates for school age children (12-17 year olds) in the Adelaide PHN region were consistent with or lower than national rates:

- 1 in 6 (17%) had consumed alcohol at risky levels
- 1 in 7 (14%) had ever used an illicit drug
- 1 in 10 (10%) had used cannabis in past 12 months
- 1 in 100 (1%) had used ecstasy in the past 12 months (Roche et al. 2017a).

However, the alcohol and substance use of school aged children in the south of the region is of concern (APHN 2016c), with rates of use for some substances almost twice the Adelaide PHN rate. In 2016, 22% of 12-17 year old school students in the Adelaide-South SA4 had participated in risky drinking in the past fortnight, 24% had used cannabis in the past 12 months, 18% had used an illicit drug (Roche et al. 2017a).

In 2015-16, 15% of AOD-related emergency department (ED) presentations in the Adelaide PHN involved young people aged 10-19 years. Young people accounted for 44% of presentations for non-opioid analgesics and 34% of cannabinoid presentations. Similarly, 13% of AOD-related hospital separations in 2015/16 were for young people in the Adelaide PHN, with non-opioid analgesics accounting for 36% of separations (Roche et al., 2017a). Young people from Adelaide-North and Adelaide-South SA4s had higher rates of AOD-related ED presentations and hospitalisations compared to young people living in Adelaide-Central or -West (Roche et al. 2017a).

National data indicates that in 2016–17 83% risky drinkers aged 14-19 were injured as a result of their drinking in the last 12 months (AIHW 2020b,d) and 7% attended the emergency department for an alcohol related injury (Lam et al. 2017)

Culturally and linguistically diverse communities

There is limited data about substance use in culturally and linguistically diverse (CALD) populations within the Adelaide PHN region which leaves them vulnerable to lack of appropriate treatment options.

As outlined in the *National Drug Strategy 2017-2026* some CALD populations have higher rates of, or are at higher risk of, alcohol, tobacco and other drug problems. For example, some members of new migrant populations from countries where alcohol is not commonly used may be at greater risk when they come into contact with Australia's more liberal drinking culture. Some types of drugs specific to cultural groups, such as kava and khat, can also contribute to problems in the Australian setting and some individuals may have experienced torture, trauma, grief and loss, making them vulnerable to alcohol, tobacco and other drug problems. Other factors that may make CALD groups susceptible to alcohol, tobacco and other drug problems include family stressors, unemployment, language barriers, lack of awareness of programs available, and limited access to programs that are culturally appropriate (DOH 2017).

The Adelaide PHN consultations have identified that CALD communities within our region face barriers to treatment services, mostly due to a lack of culturally and linguistically appropriate treatment services in the region (APHN 2016b, 2016d, 2016f).

Lesbian, gay, bisexual, transgender, intersex and queer + (LGBTIQ) communities

People who identify as lesbian, gay, bisexual, transgender, intersex and/or queer (LGBTIQ+) can be at an increased risk of alcohol, tobacco and other drug problems. These risks can be increased by stigma and discrimination, familial issues, social isolation, marginalization within their own community as a result of sexually transmitted infections (STIs) and blood borne viruses (BBVs), fear of identification or visibility of LGBTIQ, and a lack of support (DOH 2017).

National trend data from the National Drug Strategy Household Survey (NDSHS) shows that for homosexual or bisexual people from 2010 to 2019 there has been a reduction in daily tobacco use (-35%), ecstasy (-19%), methamphetamine (-12%) and lifetime risky drinking (-10%) (AIHW 2020c). However rates of use have increased for cocaine (+116%), inhalants (+90%) and hallucinogens (+53%) (AIHW 2020c).

Compared to the general population, LGBTIQ+ populations are disproportionately represented in substance use rates. In 2019, homosexual or bisexual Australians had higher rates of risky alcohol use, substance use overall and tobacco use (AIHW 2019c, 2020c). For specific substances, compared to heterosexual Australians rates of use amongst homosexual or bisexual Australians were approximately:

- 9 times higher for recent use of inhalants
- 4 times higher for recent use of methamphetamine
- 3 times higher for recent use of hallucinogens and
- 2 times higher for recent ecstasy use, cannabis and tranquillisers (AIHW 2020c).

There is limited data about substance use in LGBTIQ+ populations within the Adelaide PHN region which leaves them vulnerable to lack of appropriate treatment options. The rates of substance use for people who identify as LGBTIQ+ living in the Adelaide PHN region are estimated based on limited national data collections and local research studies that capture alcohol and drug use in the LGBTIQ+ community.

Historically, AOD treatment services have not collected sexuality within standard assessment tools therefore the rates of treatment seeking, presentations to emergency departments, hospital admissions, and calls to AOD information services amongst LGBTIQ people are largely unknown (Mullens et al., 2017). For this reason, the true magnitude of alcohol and drug use issues and the resultant health and social burden in the region is somewhat unknown.

To gain a better understanding of the health and service needs of our LGBTIQ+ communities Adelaide PHN consulted our memberships groups and interviewed several LGBTIQ+ service providers in the region. LGBTIQ+ communities were acknowledged as having substantially higher rates of rates of substance use compared to the general population, often associated with social determinants such as social isolation and limited social supports particularly for younger and older people. It was acknowledged that AOD needs vary across the LGBTIQ+ community, and treatment services need to be able to cope with clients with complex issues and in varying life stages (APHN 2020a).

A lack of access to appropriate, safe and inclusive AOD treatment services, and the lack of dedicated LGBTIQ+ AOD treatment services in the region were needs identified by all consulted (APHN 2020a). Stigma and discrimination were also noted as substantial barriers to accessing local alcohol and other drug treatment services, as was the lack of appropriately and inclusive trained service providers and a peer workforce. The invisibility of substance use prevalence and needs of the LGBTIQ+ communities due to inadequate data collection was also raised as an issue to address (APHN 2020a).

Older people

Harmful use of prescription medications, effects of illicit drug use and alcohol is increasing in older people (ages 60 or over) in Australia. Older people can be more susceptible to alcohol, tobacco and other drug problems as a result of difficulties with pain and medication management, isolation, poor health, significant life events and loss of independent living (DOH 2017).

Older people make up a considerable proportion (23%) of Adelaide PHN's population. In 2019, over 1 in 6 people were aged 65 and over and the number and proportion of older people in the region is expected to increase by over 50,000 by 2030 (PHIDU 2020c). Older people often have unique health circumstances including pain, co-morbidities, and social circumstances such as isolation (DoH 2017). These factors are important to consider in the context of alcohol and other drug use.

Recent national trend data indicate that there is an ageing cohort of people who use drugs; the proportion of older people recently using illicit drugs doubled between 2001 to 2019 from 7% to 13%, and the proportion of older people who have recently used cannabis has increased over time. (AIHW 2020c). Recent trend data for older people in the Adelaide PHN is not currently available however a previous review by Roche et al. (2017a) identified that as well as alcohol, opioids, analgesics, anxiolytics (particularly benzodiazepines) and cannabis were the main drugs of concern for older people residing in the region.

Nationally, the number of older people drinking at risky level has declined, however people aged in their 50s (21%) and 60s (17%) were more likely to drink at levels that exceeded the lifetime risk guidelines compared to the general population (AIHW 2020c). Within the Adelaide PHN two out of every 10 (20%) older people (aged 50+ years) had consumed alcohol at risky levels in the past year (Roche et al. 2017a).

For all AOD-related services in Adelaide PHN region, alcohol was the primary drug of concern for older people, accounting for 76% of AOD-related ED presentations, 63% of hospital separations, 95% of treatment episodes and 80% of ADIS calls (80%) (Roche et al. 2017a). In 2015/16, older people in the Adelaide PHN region accounted for 12% of all opioid-related ED presentations, 16% of opioid-related hospital separations, 10% for alcohol-related ED presentations and 6% of non-opioid analgesic ED presentations (Roche et al. 2017a).

To better understand the emerging alcohol and other drug treatment needs for older residents, Adelaide PHN has commissioned an *AOD Treatment Services Mapping, Research and Planning Project* to gain further insight into substance use among older persons with a particular emphasis on alcohol, opioids/analgesics and anxiolytics substance use. Interim findings should be available in mid-December 2020, with the final report and findings from mid-February 2021.

People in contact with the criminal justice system

People in contact with the criminal justice system in Australia are one of the most vulnerable groups in the community; they experience a range of complex and chronic health problems (Fazel & Baillargeon 2011), entrenched poverty and social disadvantage (Baldry et al. 2002; 2006) and cycles of imprisonment (AIHW 2016; Baldry et al. 2006; Kinner et al. 2013). In 2018, 30% of South Australian prison discharges identified as Aboriginal or Torres Strait Islander (AIHW 2019k).

Compared to the general population people in prison have higher rates of mental health conditions, chronic disease, communicable disease, acquired brain injury, tobacco smoking, high-risk alcohol consumption, recent illicit drug use, and recent injecting drug use (AIHW 2016).

Data also indicates that they have high underlying rates of alcohol, tobacco and other drug problems compared to the general population. National data for 2018 indicates that 75% of prison entrants were current smokers, 65% reported using an illicit drug in the 12 months prior to entering prison (43% used methamphetamine and 40% used cannabis), and 34% reported injecting drugs prior to incarceration (AIHW 2019k).

In 2018, of people who have been detained in Australia:

- One in three reported consuming alcohol 48 hours prior to arrest
- On average, the last drinking occasion for detainees consisted of 12 standard drinks
- Three in four who undertook a urine sample tested positive for at least one drug type
- One in three interviewed stated their drug use contributed to their offending (AIHW 2019k).

In 2015, 13% of South Australian prisoners used illicit drugs in prison and six percent injected drugs while in prison (AIHW 2015, in Roche et al 2017a). Nationally in 2018, 8% of prison discharges reported being on opioid substitution therapy (OST), and most (88% of those on OST, or 7% of all discharges) planned to continue OST after release from prison (AIHW 2019k).

Post-release, discharges are at disproportionate risk of poor outcomes including a significant risk of drug-related death (Kinner et al., 2011; Merrall et al., 2010). Merrall et al. (2010) found that recently released Australian prisoners were four times more likely to die from drug-related causes within two weeks of release, compared with 3-12 weeks post release.

Given this knowledge there is a strong need for wrap-around support services for people exiting the criminal justice system; services to provide stable environments, safe from the presence of AOD particularly after a medical detox period or release from incarceration; and culturally safe AOD treatment services (APHN 2020c).

People with mental health or physical health comorbidity

People with mental health conditions use alcohol, tobacco and other drugs for the same reasons as other people. However, they may also use substances because the immediate effect can provide an escape from symptoms. The use of alcohol, tobacco and other drugs can interact with mental health in ways that create serious adverse effects on many areas of functioning, including work, relationships, health and safety (DOH 2017).

Population estimates indicate that more than one-third of individuals with a substance use disorder have at least one comorbid mental health disorder and this rate is even higher for those in alcohol or drug treatment programs (Marel et al, 2016). In fact, illicit drug users in South Australia report high levels of psychological distress at more than twice the Adelaide PHN average rate (NDARC 2014).

The *2017 South Australian Drug Trends Report* identifies over two-fifths of the sample (41%) self-reported mental health problems in the six months preceding interview (Karlsson, 2018). The report also shows that:

- Among those who had suffered from a mental health problem, depression and anxiety continued to be the most commonly reported disorders.
- Forty-eight per cent of the IDRS sample was assessed as having 'high' to 'very high' levels of psychological distress, much higher than general population norms (11%).

Co-morbidity, or the co-occurrence of an alcohol, tobacco and other drug use disorder with one or more mental health conditions, complicates treatment and services for both conditions. They can also co-occur with physical health conditions (e.g., cirrhosis, hepatitis, heart disease, and diabetes), intellectual and learning disabilities, cognitive impairment, and chronic pain (DOH 2017). It is important to note that people with substance misuse disorders with dual diagnoses or co-morbidities have the greatest risk of poor outcomes (APHN 2020c).

Given the strong relationship between mental health and alcohol, tobacco and other drugs, it is imperative to improve the collaboration and coordination between services to ensure that the most appropriate treatment and supports is being made available to the individual (DOH 2017).

Based on literature reviews and secondary analysis of various data sets, Roche et al., 2017a has reported the main drugs of concern for people with mental health conditions are alcohol, tobacco,

illicit drug use in general, cannabis, methamphetamine, pharmaceuticals, and painkillers/analgesics/opioids (Roche et al., 2017a).

Alcohol use

Survey data suggests that people diagnosed with or treated for a mental illness, and those people with very high levels of psychological distress were more likely to consume alcohol at risky levels on a daily basis (greater than four standard drinks a day), compared to South Australians with low psychological distress or no mental illness diagnosis (Roche et al. 2017a).

There was little variation in the prevalence of weekly, monthly or yearly risky drinking when comparing South Australians with or without a diagnosed or treated mental illness. The prevalence of abstinence was higher for people with very high psychological distress compared to those with low psychological distress (Roche et al. 2017a).

Tobacco use

Tobacco smoking rates in South Australians who had been diagnosed or treated for a mental illness in the past year or who had very high levels of psychological distress were twice the rate compared to people who had low psychological distress or had not been treated for or diagnosed with a mental illness (Roche et al. 2017a).

Use of other drugs

South Australians who had been diagnosed with, or treated for, a mental illness in the past year were more likely to have recently used an illicit drug than South Australians who had not been diagnosed with/treated for a mental illness (30% and 13% respectively). They were also more likely to have used an illicit drug than their Australian counterparts (30% and 23% respectively). Cannabis and methamphetamine were the most common illicit drugs used by South Australians who had been diagnosed with, or treated for, a mental illness in the past year. They were also more likely to use painkillers/analgesics, 8% compared to 2% (Roche et al. 2017a). This is consistent with the pattern of use nationally.

When compared with those with low psychological distress, South Australians with very high levels of psychological distress were more likely to have used:

- an illicit substance in the past 12 months (47% vs 13%)
- painkillers/analgesics (23% vs 2%) (Roche et al., 2017a).

In comparison to other Australians with very high levels of psychological distress, South Australians are more likely to have used:

- an illicit substance in the past 12 months (47% vs 33%)
- painkiller/analgesics (23% vs 12%) (Roche et al., 2017a).

Cannabis and methamphetamine were also the most common illicit drugs used by South Australians who had very high psychological distress, (Roche et al., 2017a).

National data indicates that between 2000 and 2013, more than half of codeine-related deaths in Australia occurred in people with a history of mental health problems (Roxburgh et al., 2015). Furthermore, between 2000 and 2011 more than 40% of Australian fentanyl-related deaths occurred in people with a mental health problem (Roxburgh et al., 2013). Likewise, from 2001-2011, approximately half the oxycodone-related deaths involved people with a history of mental illness (Pilgrim et al., 2015).

7.3 Priority actions

The National Drug Strategy (DOH 2017) outlines several priority actions around improving the outcomes and experiences of people seeking and accessing treatment services. Through further research and consultation, Adelaide PHN has identified three key areas where actions are required in the local AOD treatment sector and supporting systems. These are:

- Treatment services actions
- Primary care workforce actions
- System integration actions

The following sections examine the components of each of these areas.

Treatment services actions

Treatment for substance use issues in the Adelaide PHN regions occurs in both health and community services and is provided by a broad range of service providers. Treatment settings include specialist AOD treatment services and primary healthcare services such as general practices and other primary health care services including Aboriginal Community Controlled Health Organisations (APHN 2020c).

Currently within the Adelaide PHN region specialist alcohol and other drug treatment services are delivered by service providers including SA Health, non-government organisations, not-for-profits, private hospitals and private services (SANDAS and DASSA, 2018). Hospitals (emergency and specialist units), mental health providers and family and child protection workers also provide alcohol and other drug interventions as part of their general services (SANDAS and DASSA 2018).

The local alcohol and other drug treatments workforce includes a wide range of health and human service professions including clinicians, case-managers, alcohol and other drug workers, peer-support workers and volunteers, social workers, Aboriginal and Torres Strait Islander health workers, general practitioners, addiction medicine specialists, nurses, pharmacists, psychologists, psychiatrists and allied health workers (SANDAS and DASSA, 2018).

The following components are key areas of need for the Adelaide PHN when supporting the AOD treatment sector to meet the needs of people seeking and accessing treatment.

Choice of services for Aboriginal and Torres Strait Islander people

'Aboriginal programs delivered by Aboriginal workers to Aboriginal clients.' (APHN 2020c) This quote highlights the importance of ensuring that Aboriginal and Torres Strait Islander people have access to services that meet their cultural needs. Services operated by community-controlled organisations are considered a key part of ensuring Aboriginal and Torres Strait Islander people can access culturally safe and respectful care.

However, it is also important to minimise the potential for social conflict and disruption within kinship networks in Aboriginal and Torres Strait Islander communities (Gomez, 2014). Consultations support this by identifying that it is important that clients wishing to preserve confidentiality and anonymity should have access to services besides community-controlled (APHN 2020c).

To this end, the National Aboriginal and Torres Strait Islander Peoples' Drug Strategy identifies the need to 'Build capacity and capability of the AOD service system, particularly Aboriginal and Torres Strait Islander community-controlled services and its workforce, as a part of a cross-sectoral approach with the mainstream AOD services to address harmful AOD use' (Intergovernmental Committee on Drugs, 2014). Both community-controlled AOD services and mainstream services that are culturally safe and appropriate, are needed to ensure Aboriginal and Torres Strait Islanders people can choose the service that suits their needs.

Where mainstream organisations are providing services to Aboriginal and Torres Strait Islander people, they need to adapt their programs to take into consideration specific cultural needs and

adapt interventions and activities, which when underpinned by culturally specific practices, are more relevant to the person seeking treatment and therefore more effective (Gomez, 2014).

Culturally safe and appropriate services and interventions

Aboriginal and Torres Strait Islander people need access to culturally appropriate programs and services, which work to improve their health and wellbeing by preventing and reducing the impacts of substance use on individuals and communities (Intergovernmental Committee on Drugs, 2014). It is important that all health services, such as AOD services, understand and respect the diversity of culture that exists for Aboriginal and Torres Strait Islander people. Aboriginal cultures are many and varied but share elements that are important across all culture, including emphasis on spirituality; connection to 'country' as place and as the embodiment of spirit and creation; networks of family, kin and community, and the reciprocal social obligations between members of those networks including inter-generational and gender relations; and common ways of relating to each other in social interactions (Gomez, 2014).

Local Aboriginal and Torres Strait Islander communities in the Adelaide region have highlighted that cultural awareness and cultural safety strategies are essential components of AOD treatment services (APHN 2020c), reflecting previous consultation in which the community identified a need to feeling respected and safe within the [MH and] AOD system (APHN 2017e).

Current AOD services in the Adelaide region appreciate and understand their responsibility in this area but acknowledge that further work is needed to maintain and improve cultural responsiveness. Of note is that stakeholders feel that training for mainstream providers needs to inform the development of culturally safe practices which focus on potential individual biases and actions, rather than simply improving cultural awareness. Areas of specific focus for further development include Aboriginal workforce, data management, and intake processes (APHN 2020c).

Person-centred treatment services

The National Framework for Alcohol, Tobacco and other Drug Treatment 2019-2029 (2019) is clear on the importance of AOD treatment services being person-centred. They describe person-centred being focused on the needs and rights of the person, recognising individual preferences and inclusion in decision making. Substance use disorders are chronic relapsing conditions usually embedded in a web of other health and social problems. Rates of homelessness, unemployment, and other factors related to social instability are also high amongst individuals seeking treatment for alcohol and drug dependence, and affect treatment outcomes (Turning Point 2017). For this reason, treatment strategies should be broader than clinical responses, include social support services and focus on long-term provision of services in a seamless manner (NDRI 2014).

Previous consultation with the Adelaide PHN community has identified holistic service delivery approaches focusing on the whole person and their circumstances (such as coexisting physical health needs and social factors) as a priority area (APHN 2016d, 2016e, 2017e). This is reflected in more recent consultations where stakeholders identified that complexity is often the norm, (APHN 2020c) with complexity being a term describing the interrelation of substance use and co-occurring issues such as social, financial or legal issues, or physical or mental health conditions (SANDAS & DASSA, 2018).

The need for treatment services and interventions to be person-centred is an ongoing one, as service must be responsive to the changing needs of individuals and the population.

Family-informed strategies

Building on the need for person-centred AOD treatment services, is the recognition of the role of family within the interventions and activities supporting those with substance use issues. In discussions with the Adelaide PHN, stakeholders have previously highlighted a need for alcohol and drug services to be family-centred and consider the impacts on children (APHN 2016d). Others have discussed the need for support for families, including safe environments for disclosure of substance use (APHN 2016c).

In more recent consultations, both providers and client/family representatives have emphasised the important role of family and peer support in AOD services, with stakeholder groups identified family and peer support as a key determinant of client outcomes (APHN 2020c).

Family-informed strategies are of particular importance in Aboriginal and Torres Strait Islander communities where family and kinship relationships remain fundamental to contemporary social life (Bishop, Colquhoun, & Johnson, 2006 in Gomez 2014). It is important to ensure that Aboriginal and Torres Strait Islander people have the opportunity to include family in their treatment journey if they wish (APHN 2020c).

Measuring performance and outcomes

The National Drug Strategy (DOH 2017) has determined that it is a priority for the AOD sector to improve the development and sharing of data to measure performance and evaluate outcomes. This concurs with the National Aboriginal and Torres Strait Islander Peoples' Drug Strategy (Intergovernmental Committee, 2014) which states that meaningful performance measures with effective data systems supporting community-led monitoring and evaluation is a priority area.

Stakeholder consultation also supports the need for strong data and performance management, noting issues such as consistency in treatment definitions, adequate and appropriate performance and outcome measurement, and existence of measures to determine cultural appropriateness. These may form a critical component in improving the quality of data collected and subsequently the services being provided (APHN 2020c)

Peer workforce

The value of peer workers in the AOD sector is immense and often quoted as a necessary part of recovery. People seeking help are less likely to feel judged or stigmatized by those who have a similar experience (DHHS 2018). In a recent survey, a majority (65%) of AOD workers reported AOD lived experience (personal, family, other), of whom two thirds (63%) declared it to their workplace (Skinner 2020).

Recent Adelaide PHN consultations with key stakeholders from the local AOD treatment sector identified that lived experience peer workforce is a valuable, but under-developed resource (APHN 2020c). It is important that the lived experience workforce is recognised and understood (Skinner, 2020). Supporting the development of this workforce is essential for the creation of appropriate care teams, particularly for Aboriginal and Torres Strait Islander people (APHN 2020c).

Peer workers are undervalued in the current local system, and stigma of utilising and disclosing lived experience is still a barrier to workforce participation (APHN 2020c). Defining and supporting pathways from 'service user' to 'peer worker' was recognized as an important aspect of growing the workforce in Victoria's AOD treatment sector (DHHS 2018). Adelaide PHN stakeholders identified that an AOD peer workforce development strategy is needed in South Australia (APHN 2020c).

Local stakeholder groups also championed the benefits of peer support roles in AOD services. Examples of peer support roles included female support workers supporting female clients and traditional healers being used to ensure culturally appropriate services are available for Aboriginal and/or Torres Strait Islander clients (APHN 2020c)

Primary care workforce actions

The primary health care workforce has an important role in the prevention, early intervention, and treatment of substance use issues. With prescription drugs such as opioids, antipsychotic medicines and sedative hypnotics having the potential to displace the demand for illicit drugs (Roche, 2013), primary care workers, such as general practitioners, may be required to play a more important part in the AOD sector. However, it has been noted that AOD is not a particularly popular area of medicine (NSDC GP Working Group, 2019) and this can impact on the care provided to people with substance use concerns.

The establishment of a GP Working Group reporting to the National Drug Strategy Committee has allowed for further investigation into the needs of GPs when supporting people with substance use issues. Some of the findings (NDSC GP Working Group, 2019) include:

- Significant and real opportunities to expand the scope of work
- Income and business sustainability concerns

Consistent prescribing practices

Primary health care workers, including general practitioners (GPs) need support to deliver consistent care to people with substance use issues. This has been recognised by the Australian Government's investment in training and education for GPs through the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine.

There is limited public data on the nature and extent of alcohol and drug treatment activity in the general practice sector (NDSC GP Working Group 2019) however around 8% of GPs nationally are accredited under a Medication assisted treatment for opioid dependence (MATOD) program. This represents a shortage of GPs appropriately trained to undertake this work (NDSC GP Working Group).

In South Australia there is an imbalance in the prescriber – client numbers. On the snapshot day in 2018, 170 prescribers treated a total of 276 clients (1:1.6), while the remaining 104 prescribers treated a total of 2,867 clients (1:27.6) (NDSC GP Working Group, 2019). Some prescribers are reluctant to take on more than a few AOD patients due to comparative complexity and length of care required. This places a significant strain on prescribers looking to support new patients seeking to access the MATOD program.

In a survey on the prescribing and use of opioids in the Australian population, 60% of prescribers identified that they had formal policies or procedures in place in their practice that related to the prescribing of opioid medicines. Furthermore, the research identified a clear link between identified behaviours such as provision of information and planned review of opioid use, and positive patient outcomes. However, it was also evident from the research that these safe and effective prescribing behaviours were not universally or consistently undertaken by all prescribers (Orima Research, 2020).

There is also a great deal of confusion over the MBS items GPs can use to support people with substance use issues. The NDSC GP Working group (2019) noted that these numbers can be used for some patients but not others, creating access barriers. They also discussed the relationship between the population who drink at risky levels and the use of pharmacotherapy for alcohol addiction and noted that GP knowledge of the various treatment options available to them may be limited.

Awareness for screening, early intervention and referral

Previous consultation with Adelaide PHN stakeholder and membership groups has prioritised a need for health literacy, early intervention and better education for consumers and professionals across the health sector (APHN 2016a, 2016b, 2016c, 2016d). This would be aimed at improving and encouraging the take-up and application of preventative measures. Whilst this issue is generic it is applicable to substance use issues. Stakeholders have previously identified that primary health care workers need to be better equipped to address the needs of people experiencing complex health issues. There is a need to ensure health services and programs are sustainable and focus on both early intervention and recovery programs (APHN 2016c). For example, an earlier consultation identified the quality use of medicines as a priority to be embedded as a principle across all Adelaide PHN programs, specifically around improving health literacy and education with regards to opioid prescribing (APHN 2016a).

The evidence from data and stakeholder consultations in the NDSC GP Working group paper shows that although GPs are engaging with people with substance use issues, it appears to be

limited and more could be done. This is despite the fact that respondents to the consultation described that GPs are well placed to play a central role in the education and prevention of substance use and dependence. In fact, they noted that GPs are in a good position to put early interventions strategies into place, to make appropriate referrals, and to support people throughout their treatment (NDSC GP Working Group, 2019)

There is also a clear need for better education for primary health care services on the methods and benefits of brief interventions in treating mild disorders. This is particularly relevant given the reliability and ease of the screening process, could increase engagement with people with substance use disorders (NDSC GP Working Group, 2019)

Reducing stigma

Substance dependence is a chronic health condition that disproportionately affects disadvantaged and marginalised populations. Illicit drug dependence is the most stigmatised health condition in the world, and alcohol dependence the fourth most. It is common to see moralistic or sensationalist views demonising people who are dependent on alcohol and/or other drugs in the media and society. This stigmatisation and associated discrimination add barriers such as stress and shame that prevent people from seeking treatment (SANDAS and DASSA, 2018).

In recent consultations numerous stakeholders, including treatment providers, client / family, peak bodies and academics, all identified that the stigma associated with substance use is often a deterrent to seeking treatment. The majority of both clients and providers surveyed identified stigma as a major barrier to service access (APHN 2020c). Furthermore, earlier consultations with Adelaide PHN membership groups identified themes related to an appropriately skilled and empathic primary health workforce in MH and AOD sector (APHN 2016d).

The stigmatisation of substance use issues has led to individuals being apprehensive of requesting or receiving assistance from the GP or other primary health care provider. GPs reported that they sometimes felt uncomfortable broaching substance use with patients because they were concerned about it causing offence or negative responses. Some GPs report negative experiences with patients with substance use issues and some hold a view that they are not able to form enduring relationships with these patients, limiting their ability to provide meaningful help. In support of this, it is interesting to note that concerns had previously been raised on the growing need for further support and training for GP around substance use and referral pathways (APHN 2016c).

Communications skills of some prescribers when prescribing medicines which can potentially cause dependence are also limited. Qualitative research conducted into opioid prescribing found some prescribers had limited confidence and skills in relation to communicating with their patients about opioid risks. The research showed that some prescriber participants only implied some information (e.g. about the risk of dependency), rather than explicitly stating it to consumers (Orima, 2020).

Normalising the treatment of substance use issues and dependence in the same manner as chronic health conditions will support more people to seek help and treatment. Reoccurrence rates are no higher than other conditions when applying a comprehensive continuity of care (NDSC GP Working Group, 2019). Staff familiarity with patients receiving alcohol and drug care also reduces feelings of stigmatisation, fear and avoidance. There is also an established effectiveness of approaches such as opportunistic screening and brief interventions which are particularly suitable for the primary care setting (Berends, 2014).

System integration

Coordination of care

Adelaide PHN facilitated a community workshop on mental health and alcohol and other drugs in which participants identified a key principle and element of service delivery is a system which enables service provision to be integrated ensuring continuity of care (APHN, 2016b). Consultations also identified that MH and AOD services lacked non-flexible pathways and are confusing systems for the most vulnerable and at-risk consumers (APHN 2016b). Participants from all Adelaide PHN

membership groups prioritised the importance of connection of services and care coordination as elements of best practice. Whilst this is a generic statement it is inclusive of AOD treatment services. On a different occasion, a membership group also prioritised the importance of simplifying mental health services and improving integration with drug and alcohol services (APHN 2016c).

In a more recent consultation, all stakeholder groups reported that pathways in and out of AOD services are underdeveloped and more robust pathways were required to support client access into the appropriate services. The access criteria for services were considered to be inappropriate and overly prescriptive. This leads to individuals being rejected without alternative referral pathways being available (APHN 2020c). Adelaide PHN consultation reinforces this need by highlighting that aftercare support, which is a key opportunity for relapse prevention and long-term harm minimisation, is not adequately available in primary care (APHN 2020c).

Furthermore, consultations conducted with general practitioners also identified issues such as inadequate referral pathways; lack of detailed clinical handover between service providers and lack of continuity of service provision in the [MH and] AOD sectors (APHN 2016b). There are also weak communication pathways between treatment service providers and GP clinics. GPs are not aware of the best way to refer patients, or which treatment services are appropriate. Lack of or changing referral pathways are often an additional limiting factor in an already complex case (NDSC GP Working Group, 2019).

The extent of complexity and comorbidities for people with substance use issues adds to the importance of providing continuous, integrated care. In recent consultations providers, GPs, client and family representatives, LHNs, police and corrections representatives, and peak bodies and academics highlighted the significant difficulties working with clients with a dual diagnosis of AOD and mental health, and the lack of appropriate pathways for such clients. Providers surveyed reported that there were not robust pathways in place with mental health services (DASSA 2020). This reinforces an older consultation which found that local service providers and stakeholders reported AOD workers are frequently required to manage co-morbid mental health symptoms that can impact on their ability to treat clients' AOD use (APHN, 2016a, 2016c, 2016d) because of a need for improved referral pathways.

Another concern is that the system is difficult to navigate due to the lack of collaboration and cohesion across the sector, resulting in fragmented services. Stakeholder groups highlighted that the sector was especially difficult to navigate for clients from the Aboriginal and Torres Strait Islander community (APHN 2020c).

Partnerships

There is long standing debate regarding the best place for services targeting problematic substance use. Specialist alcohol and drug services often have poor visibility and patients rely on word of mouth, including peer networks, to identify services. Even when patients are engaged with specialist alcohol and drug services, they will need access to primary healthcare for other medical concerns and ongoing care (Berends, 2014). In recent consultations providers, GPs, client/ family representatives, and others described an increase in the physical health impacts of substance use issues, which are placing pressure on the wider health and social care system in South Australia. These stakeholder groups also referred to a range of physical health impacts of AOD use including brain damage, liver damage and kidney failure (APHN 2020c).

AOD services are not always able to address the multiple and complex needs of clients within their service. Care has traditionally been delivered as serial treatment or parallel care. This means that people are often left to undertake the navigation of social systems on their own (Savic et al. 2017).

In the recent consultation, GPs, client / family representatives, and others reported an increase in societal factors impacting upon AOD use, including homelessness, unemployment and financial insecurity. Stakeholders felt this had been exacerbated by the COVID-19 pandemic. Eight out of fourteen providers reported that access to social support, such as housing and employment, was a

main concern relating to the inequality of services for their client group. Additionally, LHNs, and police / corrections representatives reported a rise in domestic violence associated with an increase in substance misuse (DASSA 2020).

Research has indicated the necessity of integrated and coordinated models that operate across primary health and specialist alcohol and drug services as important to reduce practical barriers by simplifying referral pathways between services and improving organisational efficiencies and patient outcomes (Berends, 2014).

8 Workforce and digital health

8.1 Primary health care workforce

Within the Adelaide PHN region primary health care services are provided by a broad range of health professionals including general practitioners, nurses (including general practice nurses, community nurses and nurse practitioners), allied health professionals, midwives, pharmacists, dentists, and Aboriginal health workers.

Health Service Landscape

A brief snapshot of selected health workforces and services in the region is provided below.

General Practice

The Adelaide PHN has:

- 319 General Practices
(82 in SALHN, 142 in CALHN, 95 NALHN), (APHN 2020b)
- 1,623 General Practitioners
(444 in SALHN, 728 in CALHN and 451 in NALHN) (DOH 2020), and
- 604 Practice Nurses
(184 in SALHN, 246 in CALHN and 174 in NALHN) (DOH 2020)

Pharmacy

The Adelaide PHN has:

- 382 Pharmacies
(102 in SALHN, 179 in CALHN, 101 NALHN), (APHN 2020b), and
- 797 Community pharmacists
(224 in SALHN, 371 in CALHN and 202 in NALHN) (DOH 2020)

Mental health

The Adelaide PHN has:

- 252 Psychiatrists
(51 in SALHN, 166 in CALHN, 35 NALHN), and
- 1,086 Registered Psychologists
(230 in SALHN, 683 in CALHN and 173 in NALHN) (DOH 2020)

Issues and opportunities

Consultations summary

Following the findings from the Adelaide PHN General Practice Support Survey (reported in the previous NA report), the Adelaide PHN consulted further (directly) with General Practitioners between November 2018 and May 2019. A total of 36 General Practitioners in the region were consulted through workshops on the Issues and Opportunities to achieve a successful and productive working relationship between Adelaide PHN and GP's, for better health outcomes for the community in the region. Findings from this workshop are reported in this section, referenced as "GP's Roundtable Workshops". The consolidated Pareto chart of themes from the workshop shows that approximately 50% of the total weight is coming from three Issues and Opportunities:

1. Lack of collaboration and poor relationships between primary and acute;
2. Education, training and business support for GP practices; and
3. Difficulty accessing mental health services and other specialised services.

Following feedback from the GP's Roundtable Workshops, between June 2019 and October 2019 the Adelaide PHN consulted with Local Health Networks on the issues and opportunities to achieve

a successful and productive working relationship between Adelaide PHN, the three Local Health Networks (CALHN / SALHN / NALHN), General Practitioners and Hospital Consultants for better health outcomes for the community in the region. Findings from this workshop are reported in this section, referenced as “LHN/GP/Hospital Workshops”. The consolidated Pareto chart of themes (from the workshop) shows that approximately 50% of the total weight is coming from two Issues and Opportunities:

1. Improved clinical communication (interpersonal) and
2. Functional, integrated technology that facilitates clinical communications.

A summary of the top critical issues and opportunities (those accounting for at least 80% of the total weight of all issues raised) for each Local Health Network as identified by the participants of the workshops is provided below (APHN, 2019e):

Central Adelaide LHN	Southern Adelaide LHN	Northern Adelaide LHN
<ul style="list-style-type: none"> • Poor clinical communication • Respectful and productive relationships between all parties • Lack of collaborative vision • Functionality of technology • Poor access and understanding of CALHN & Adelaide PHN services 	<ul style="list-style-type: none"> • Shared IT solutions • Lack of two-way clinical communication between all parties • Clear, transparent referral processes. 	<ul style="list-style-type: none"> • Unified forward-thinking strategy for better health outcomes • Collaboration, understanding and trust to build relationships • Sharing of clinical information • Structure of care

More detailed information about the themes identified in these consultations are provided below.

Navigation and access

Findings from the GP’s Roundtable Workshops reported that difficulty in accessing mental health services and other specialised services is the third most important issues and opportunities for the participants (APHN, 2019d). The below is summary of themes from the workshops (difficulty in accessing mental health services and other specialised services):

- Person-centred care

GPs identified that a range of people in the Adelaide PHN region cannot access services that meet their needs. This includes services for underserved groups and populations as well as overall preventive care and condition management.

- Navigation

Access to services is hampered by challenging pathways and referral processes, including eligibility criteria, lack of clear processes and follow-up.

- Timely access

GPs mentioned that urgent mental health care was difficult to access and that there were often long waiting times for other mental health services, including commissioned ones (APHN, 2019d).

Skills, capabilities and knowledge

Findings from the Adelaide PHN General Practice Support Survey 2018 indicated that Mental health, Chronic conditions (includes diabetes and its management, chronic condition management and cycles of care) and Aged care (includes aged care access, health checks and healthy ageing), were the top three main priorities or concerns of their patients. Access to health care was a close fourth priority or concern for the practices (APHN, 2018b).

Mental health (including support for low-intensity mental health), immunisation and alcohol and other drugs were the highest ranked health issues that practices selected as an area where they required assistance from the APHN (APHN, 2018b).

Disability was also raised as an area of potential concern for GPs; although 24% reported that they have patients with approved plans, 28% of the practices indicated that they were not aware how the National Disability Insurance Scheme (NDIS) works. Another 15% reported that they have used the Access Request Form but have no approved plans in place with patients (APHN, 2018b).

Large consultations and priority setting workshops with Adelaide PHN membership groups, stakeholders and community throughout 2016 identified that the primary health workforce currently lacked the skills and knowledge to provide truly safe and quality health care services (APHN, 2016d). Specific areas for improvement included:

- improving health literacy and education by providing training in disability and the health needs of people with disabilities for GPs, nurses, allied health, support workers, planners and case managers (Disability HPG, APHN, 2016d).
- upskilling practitioners in the impacts of trauma on children's health and development was a priority. There was also concern that there is a lack of knowledge by primary health practitioners (including GPs) in paediatrics; especially developmental and behavioural issues (Childhood and Youth HPG, APHN, 2016d).
- health service providers need to inform themselves to address and cater for the needs of vulnerable individuals – Aboriginal and Torres Strait Islander people, CALD, elderly, youth, and others. (Northern CAC, APHN, 2016c).

Culturally safe services have also been identified as an area that requires attention. To better understand how the local workforce could better address the needs of refugees and new arrivals Adelaide PHN conducted workshops with key stakeholders representing the multicultural sector, primary health care and research which identified the following areas of concern:

- capacity building for primary health workers supporting the health of refugees and new arrivals. Primary health care providers, including general practice don't have the support, training and capacity to deliver culturally safe and culturally appropriate services to refugee and new arrival populations (APHN, 2017c)
- system integration of primary health care services for refugees and new arrivals. The migrant health sector and primary health care services are not integrated due to the lack of formalised partnerships and referral pathways that increase and improve access and delivery of culturally appropriate and sensitive primary care services to new arrival and refugee populations (APHN, 2017c).

Practice improvement

The Adelaide PHN General Practice Support Survey found that 85% of General Practices are accredited. While 15% of the Practices reported that they were not accredited, 7% (n=77, 4th most common response) indicated requiring support from the Adelaide PHN for accreditation (APHN, 2018b).

Findings from the GP's Roundtable Workshops reported that education, training and business support for General Practitioners and practices was identified as the second most important issues/opportunities for the participants (APHN, 2019d).

The below are summary of workforce support themes from the workshops:

- Professional development

GPs clearly expressed a desire for Adelaide PHN to provide a range of professional development opportunities. Of particular note, was the request for training and development opportunities for their staff.

- Business support

GPs are also interested in receiving support from Adelaide PHN around matters pertaining to the ongoing improvement of their practices. This includes mentoring and networking opportunities and information and training about business sustainability and improvement.

- Face to face support

Face to face support is still seen as a vital part of developing the relationship between Adelaide PHN and the GPs working in our region (APHN, 2019d).

Clinical communication

Findings from the LHN/GP/Hospital Workshops which built upon the findings of the earlier Adelaide PHN GP's Roundtable Workshops identified improved clinical communication (interpersonal) as the most important issue/opportunity for the participants (APHN 2019e).

The below are summary of themes from the workshops:

- Flexible methods

On both sides (primary and acute), medical professionals agreed that there needs to be more flexibility and variety in the methods used to communicate with each other. Depending on the requirements of the situation, medical professionals felt that there should be options available – emails, phone calls, hot lines, formal letters, web portal access – that suit the identified needs.

Within this there was also a sub-theme around a need for automation and interoperability of clinical software.

- Quality

The quality of communications between the sectors was noted to be of high importance to all medical professionals. Accuracy, respect, relevance, consistency and patient need were identified as key factors in high quality communication, particularly when communicating clinical information.

- Inclusive

GPs requested to be included in communications and discussions about their patients' care during and after a hospital admission or presentation. Access to current hospital information, through software access, being able to identify and contact those providing care in the hospital and involvement in multi-disciplinary discussions was seen to be a path to better patient care.

- Easy

Both parties identified a need for streamlined and seamless two-way communication without barriers such as unclear pathways. Single point of access was mentioned – such as a contact person within the hospital, dedicated phone numbers or a web-enabled access point.

- Timely

The timing of communication was noted as another area for improvement. Having available options for urgent contact, as well as improving timelines for 'non-urgent' communication, such as discharge summaries, referrals etc. (APHN 2019e).

8.2 Digital health systems

Awareness and use

Nearly three quarters or 74% of the practices reported that they are actively uploading and viewing patient My Health Records while 12% reported that they are aware of My Health Record but are not planning to use it. Two percentage (2%) of the practices indicated they are not aware how the Record can benefit their work and their patients. Only 5% (n=49, 11th most common response) selected requiring assistance from the Adelaide PHN in using My Health Record (APHN, 2018b).

Fax service and postal services were the top two responses/choices for more than half (53%) of the practices surveyed to receive/send patient/client information to other health professionals. Health Link, Argus and Email were the other most common choices by the practices. Six percentage (6%) (n=61, 9th most common response) of the practices indicated requiring assistance from the Adelaide PHN in the utilisation of secure messaging services to receive/send patient/client information to other health professionals (APHN, 2018b).

More than half or 67% of the practices reported that they are not aware of HealthPathways SA and a majority of those who are aware of it have indicated that the general practitioners in the practice have not utilised it. Additionally, 13% (n=132, the (first) most common response) indicated requiring assistance from the Adelaide PHN with HealthPathways SA (APHN, 2018b).

More than ninety percentage (93%) of the practice indicated that they are computerised with Best Practice the most common clinical software and billing package used (APHN, 2018b).

- It should be noted that 1% of the practices reported that they were not computerised (i.e. not using any clinical software) while another 5% indicated using both paper documentation and computers for their operation/organisation (APHN, 2018b).

Findings from the LHN/GP/Hospital Workshops identified functional, integrated technology that facilitates clinical communication as the second most issue/opportunity for the participants (APHN 2019e).

The below are summary of themes from the workshops:

- Interoperability

The biggest issue identified was the inability of the large variety of software platforms to communicate with one another. There is no current functionality that allows the flow of information directly between the software of the acute system and that being used in primary care.

Other themes that was identified were:

- Choose to use (Implementing and getting people to use available tech)
- Administrative, and
- Access (APHN 2019e).

Quality improvement

Practice Incentives Program

More than three quarters (82%) of the practices were currently participating in the Practice Incentives Program (PIP) which are aimed at supporting general practice activities that encourage continuing improvements and quality care, enhance capacity and improve access and health outcomes for patients (APHN, 2018b).

- eHealth, Diabetes, Asthma, Cervical and After Hours are the top five PI programs respectively.
- Challenges in participation (in PIP) including administration and understanding the process were the top key challenges for practices.
- Quality improvement and PIP were 6th (n=69) and 7th (n=67) most common response respectively selected by practices requiring assistance from the Adelaide PHN (APHN, 2018b).

Clinical data

Findings from the *Adelaide PHN General Practice Support Survey 2018* indicated that 27% of all practices do not actively code their clinical data despite all of the practices use a clinical extraction tool to analyse data, devise the necessary strategies to improve patient care and report on quality improvement activities, (APHN, 2018b). PENCAT was the most common data extraction tool used by the practices (APHN, 2018b).

Assistance from the Adelaide PHN with data extraction tools and data coding and or cleaning of un-coded data were the second (n=89) and third (n=81) most common responses by the practices when asked about required assistance (APHN, 2018b).

With regards to the frequency in actively cleaning un-coded clinical data, more than half (59%) of the practices frequently or occasionally undertake this process. The rest (n=83) either never or rarely or unfrequently clean un-coded clinical data (APHN, 2018b).

9 Opportunities, priorities and options

This section summarises the Adelaide PHN priorities including those arising from this Needs Assessment update.

9.1 General Population Health (including General Practice Support and After Hours)

Table 2. List of General Population Health Priorities

Adelaide PHN Needs Assessment 2019-22 - Priorities for General Population Health	
GPH 1.	The CALD community are disproportionately affected by Hepatitis B.
GPH 2.	Accessibility to and appropriateness of primary health care services, particularly for CALD and new and emerging communities, LGBTIQ and older people.
GPH 3.	Identified areas of the Adelaide PHN region have childhood immunisation rates below the national average.
GPH 4.	Selected areas of the Adelaide PHN region have high rates of smoking which correlates with areas of high prevalence of COPD.
GPH 5.	Selected areas of the Adelaide PHN region have high rates of obesity and overweight and correlate with areas of low physical activity and poor nutrition.
GPH 6.	Selected Adelaide PHN LGAs have higher rates of a range of chronic conditions (respiratory disease, diabetes, circulatory system disease, chronic kidney disease, musculoskeletal) and multi-morbidities.
GPH 7.	Services for people living with persistent pain are limited with long delays to access hospital-based services.
GPH 8.	Higher rates of multimorbidity among the aged population lead to increased utilisation of health care services.
GPH 9.	Selected Adelaide PHN regions have higher rates of PPH resulting from a range of chronic (Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, diabetes complications, angina, iron deficiencies) and acute conditions (dental issues, urinary tract infections, cellulitis).
GPH 10.	Medication misadventure including poor quality use of medicines contributes greatly to the burden of potentially preventable hospitalisations.
GPH 11.	Early screening of selected cancers (cervix, bowel, breast) can assist in intervention measures which can help reduce mortality as part of a wider cancer control strategy.
GPH 12.	A need to increase the ease of navigation and visibility of the health care system in selected Adelaide PHN regions, population groups and for particular health issues.
GPH 13.	Lack of easily understood and accessible referral pathways across systems and settings.
GPH 14.	A need to increase communication and collaboration between service providers including hospitals to improve clinical handover.
GPH 15.	Lack of community awareness about existing health care services for different population groups, consumers and providers.
GPH 16.	Lack of person-centred care and responsiveness to individual circumstances, including co-morbidities.
GPH 17.	Need to improve provision of education to consumers and professionals across the health sector to encourage the take-up and application of preventative health measures.

Adelaide PHN Needs Assessment 2019-22 - Priorities for General Population Health	
GPH 18.	Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity.
GPH 19.	Minimise instances of poor quality and unwarranted variations of care and follow up.
GPH 20.	Prevention and early intervention strategies for childhood and youth health conditions
GPH 21.	Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers
GPH 22.	A coordinated approach to improve navigation and pathways for patients to manage their conditions
GPH 23.	LGBTIQ+ communities can access safe, inclusive and appropriate primary health care services
GPH 24.	Primary health care workforce have knowledge, skills and capacity to safely support and meet the specific needs of LGBTIQ+ communities
GPH 25.	LGBTIQ+ communities can access safe, inclusive and appropriate mental health services and alcohol and other drugs treatment options

Table 3. List of General Practice Support Priorities

Adelaide PHN Needs Assessment 2019-22 - Priorities for General Practice Support	
GPH-GPS 1.	Increase awareness and uptake of digital health systems and benefits for patients
GPH-GPS 2.	Targeted support to increase awareness and utilisation of HealthPathways SA and specific pathways for patients
GPH-GPS 3.	Promote and targeted support to adopt best practice in utilisation of clinical software to improve patient care and quality improvement activities

Table 4. List of After-Hours Priorities

Adelaide PHN Needs Assessment 2019-22 - Priorities for After Hours	
GPH-AH 1.	Lack of community awareness about appropriate after-hours health care services leading to increased potentially preventable hospitalisations
GPH-AH 2.	RACFs have a low capacity to support their residents in the afterhours setting leading to increased transportation to emergency departments and medical deputising services

9.2 Primary Mental Health Care (including Suicide Prevention and Psychosocial Support)

No new priorities were identified for Primary Mental Health care including Suicide Prevention and Psychosocial Support. Specific mental health priorities for Aboriginal and Torres Strait Islander people are reflected in Indigenous Health section.

Table 5. List of Primary Mental Health Care Priorities

Adelaide PHN Needs Assessment 2019-22 - Priorities for Primary Mental Health Care (including Suicide Prevention)
PMH 1. High prevalence of mental health/behavioural issues and psychological distress in selected areas across the region.
PMH 2. Provision of psychological services comparatively low in areas of highest need.
PMH 3. Comparatively high numbers of people attempting to access psychological services in areas with minimal psychological service provision.
PMH 4. Disproportionate quantities of mental health related medicines prescribed in women, disadvantaged areas and population groups such as people aged 75 and over.
PMH 5. Difficulty in identifying and accessing appropriate mental health treatment services.
PMH 6. Increase integration between AOD and Primary Mental Health (PMH) service providers to improve health outcomes.
PMH 7. Increase awareness of appropriate mental health services to health professionals and community and carers through the provision of information and resources.

Table 6. List of Psychosocial Support Services Priorities

Adelaide PHN Needs Assessment 2019-22 - Priorities for Psychosocial Support Services
PMH-PSM 1. Responsive and appropriate psychosocial support services that meets the needs of people with severe mental health conditions.
PMH-PSM 2. Increase awareness and promotion of psychosocial support services for people with severe mental health conditions and their carers.
PMH-PSM 3. Increase the health workforce capacity to provide appropriate care to people with severe mental health conditions.

9.3 Alcohol and Other Drug Treatment Needs

Four new priorities were identified for Alcohol and Other Drugs Treatment. One Alcohol and Other Drugs Treatment priority for Aboriginal and Torres Strait Islanders people is reported as an Indigenous Health priority.

Table 7. List of Alcohol and Other Drugs Treatment Needs Priorities

Adelaide PHN Needs Assessment 2019-22 - Priorities for Alcohol and Other Drugs Treatment Needs	
AOD 1.	Priority populations have access to high quality alcohol and other drug treatment services and interventions
AOD 2.	Primary health care providers can identify and support people with substance use issues and understand the scope of AOD treatment services and PHC services.
AOD 3.	People requiring AOD treatment services in Adelaide are supported by a sufficient, safe, skilled and appropriate workforce
AOD 4.	Integration and partnership between AOD and Primary Health Care services improves continuity of care and experiences

9.4 Aboriginal and Torres Strait Islander Health

One new priority was identified for Indigenous Health, specific to Alcohol and Other Drug Treatment needs.

Table 8. List of Aboriginal and Torres Strait Islander Health Priorities

Adelaide PHN Needs Assessment 2019-22 - Priorities for Indigenous Health	
General Population Health (GPH)	
IH-GPH 1.	Immunisation rates for Aboriginal and Torres Strait Islander children are lower than non- Aboriginal and Torres Strait Islander children.
IH-GPH 2.	Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non- Aboriginal and Torres Strait Islander people.
IH-GPH 3.	Accessibility to and appropriateness of primary health care services for Aboriginal and Torres Strait Islander people.
IH-GPH 4.	Access and information to Breast, Cervix and Bowel cancer screening services for Aboriginal and Torres Strait Islander people.
IH-GPH 5.	Awareness of timely access to appropriate services (including after-hours services) for Aboriginal and Torres Strait Islander people.
Primary Mental Health (including Suicide Prevention) (PMH)	
IH-PMH 1.	Greater prevalence of intentional self-harm and suicide in selected areas and specific population groups across the region including Aboriginal and Torres Strait Islander people.
Alcohol and Other Drug Treatment Needs (AOD)	
IH-AOD 1.	Aboriginal and Torres Strait Islander people can access culturally safe and appropriate AOD treatment services

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