Australian Government
Department of Health

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Primary Health Network Needs Assessment Reporting Template – Alcohol & Other Drugs

Name of Primary Health Network

Adelaide PHN

When submitting this Needs Assessment Report to the Department of Health, the PHN must ensure that all internal clearances have been obtained and the Report has been endorsed by the CEO.

Submitted 15 November 2017

Section 1 – Narrative

This section provides brief narratives on the process and key issues relating to the <u>update</u> to the Adelaide PHN (APHN) Alcohol & Other Drugs Baseline Needs Assessment (BNA) Update submitted in November 2016.

Needs Assessment process and issues

The Adelaide Primary Health Network (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.

An iterative engagement and consultation process forms the basis to the Adelaide PHN (APHN) ethos. Our membership group model comprising our geographically aligned Clinical and Community Advisory Councils and seven Health Priority Groups (Mental Health, Aboriginal Health, Consumers and Carers, Disability, Childhood and Youth, Older People and Aged Care, and Palliative Care) are essential to this process. 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.

The Baseline Needs Assessments (BNA) Update submitted in November 2016 collated consultations including dedicated workshops on Mental Health and Alcohol & Other Drugs (AOD), alongside community workshops and input from our Clinical and Community Advisory Councils and Health Priority Groups. The November 2016 BNA Update (template) included both the Mental Health and Suicide Prevention and AOD BNA Updates. The four strategic priorities identified by the APHN membership groups: (1) Timely Access and Equity, (2) Health Literacy and Education, (3) Care Coordination, Integration and Navigation, and (4) Mental Health, Alcohol & Other Drugs and Physical co-morbidities, have been incorporated into the BNA Updates and as key issues in this reporting template.

Using the BNA Update template as a reference document, Primary Health Networks (PHNs) have been tasked to develop three separate Needs Assessments; (i) Core Flexible (Commonwealth Department of Health PHN funding schedule name), (ii) Mental Health and Suicide Prevention and (iii) AOD, for submission in November 2017. Additionally, PHNs are to analyse (any new) information and or trends since submitting the November 2016 assessment and *update* the identified needs and priorities accordingly.

This template is called the **2017/18 Adelaide PHN Alcohol & Other Drugs Needs Assessment Update**. This AOD Needs Assessment Update has a major rewrite due to availability of new quantitative data[1] on prevalence, at-risk groups and utilisation of healthcare services which was a

[1] *Adelaide PHN and Country SA PHN commissioned the National Centre for Education and Training in the Addictions (NCETA) to research literature and analyse appropriate secondary data from a variety of State and National sources (e.g. SA Health hospital Emergency Department presentations and inseparations, National Drug Strategy Household Survey (NDSHS), Australian Secondary Students' Alcohol and Drug Survey ASSAD),*

data gap in the previous BNA Update. As such, any *previous* information in Sections 2 to 4 of the template are highlighted in red font. In addition to this, the APHN has taken the opportunity to refine the information (as reported in the BNA Update), specifically the outcomes of the health and service needs analysis, by articulating clearly the key issue and identified need to (better) reflect each Needs Assessments template. Nevertheless, the APHN BNA Update process (consultations, health and service needs analysis and priorities setting) was extensive and comprehensive.

The APHN established an internal working group to oversee the methodology and completion of the Needs Assessment Update (NA Update). In addition to this, all new information for example, the APHN and Country SA PHN commissioned AOD reports (on prevalence, at-risk groups and utilisation of healthcare services) by the National Centre for Education and Training in the Addictions (NCETA)[2], APHN Alcohol & Other Drugs Treatment Services Reference Group[3], Commonwealth Department of Health, Australian Bureau of Statistics, Australian Institute of Health and Welfare, SA Health (hospital activities) and Drug and Alcohol Services of South Australia (DASSA), Public Health Information Development Unit, and all consultations with our membership groups have been incorporated into the triangulation process.

The triangulation process has identified **four new** priorities for the 2017/18 Adelaide PHN Alcohol & Other Drugs Needs Assessment Update. Two of the new priorities have replaced the previously identified three AOD priorities from the BNA Update (see Section 4 for more information). The APHN will be working collaboratively with our stakeholders and partners including commissioned service providers to refine and improve service delivery through our commissioning, monitoring and evaluation processes.

Additional Data Needs and Gaps

In addition to the data analysed for the previous BNA Update, the three reports developed by NCETA provide sufficient base reference for the APHN to analyse the AOD health and service needs of its catchment. However, effective commissioning of localised programs and initiatives to meet the needs of identified vulnerable populations requires a lower level data granularity (geographic and population/demographic).

At a geographic level, Statistical Area Level 3 or 2 data is preferred but prevalence of cannabis use was difficult to establish due to small numbers. Limited data is also available on patterns of heroin use at South Australian PHN levels. The prevalence of heroin use is too low for population surveys (such as the NDSHS) to yield reliable data. A lack of primary health care data (e.g. general practice and allied health) on AOD related risks and harms continues to be a key data gap and need for the needs assessment process.

Additional comments or feedback
Nil

Pharmaceutical Benefits Scheme (PBS), Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS)) on AOD prevalence, at-risks groups and utilisation of healthcare services for both PHN regions (three reports respectively).

[2] Upon request from the Commonwealth Department of Health, the APHN can forward the reports for perusal.

[3] Since commissioning AOD services in January 2017, the APHN has established an AOD Treatment Services Reference Group, chaired by the APHN and including membership from the South Australian Network of Drug and Alcohol Services (SANDAS), Drug and Alcohol Services South Australia (DASSA), the Aboriginal Drug and Alcohol Council (ADAC) SA, a GP Prescriber of the Medically Assisted Treatment of Opioid Dependence (MATOD) program and a consumer representative. In addition to this, the APHN also meets regularly with the peak non-government organisation representing the AOD treatment services sector in SA, and regularly participates in community and stakeholder consultations and forums on AOD issues.

Section 2 – Outcomes of the health needs analysis

Since submitting the (Alcohol & Other Drugs) Baseline Needs Assessment (BNA) Update in November 2016, the APHN has analysed relevant recent quantitative and undertaken consultations with stakeholders to further investigate and refine the alcohol & other drugs health needs. The following health needs refine and or supplement previously identified needs (in red font) from the BNA Update which relate to Alcohol & Other Drugs (AOD).

Outcomes of the health needs analysis			
Identified Need	Key Issue	Description of Evidence	Source
Higher alcohol consumption by sub-regional levels, particularly in Western and southern areas when compared with other areas in APHN region.	Higher prevalence of risky rates of alcohol consumption at sub-regional levels	Recent secondary analysis of the 2013 National Drug Strategy Household Survey reported that the highest prevalence of **monthly** risky drinking occurred in Statistical Area Level 4 (SA4) areas of Adelaide-South (29%) and Adelaide-West (33%) within APHN region. The Western SA4 prevalence exceeded the APHN (26%), State (28%) and National (26%) averages (Roche et al., 2016). Previous DASSA analysis reported that high rates of risky alcohol use are also present in the western and southern Metropolitan regions (DASSA, 2013). Conversely the 2011-13 estimates from Australian Health Survey reports the rates of alcohol consumption considered to be at risky levels to health were highest in the northern region of APHN (PHIDU, 2015). The risk levels were defined here as modelled estimates of alcohol consumption of more than two standard drinks **per day** on average (PHIDU, 2015). At Statistical Area Level 3 (SA3) areas, **monthly** risky drinking ranged from 10% (Unley) to 37% (Port Adelaide-West). In addition to Port Adelaide-West, Holdfast Bay (32%), Charles	*Roche, A.M., Fischer, J., Nicholas, R., Kostadinov, V. 2016, Alcohol & Other Drugs Use in South Australia: Adelaide Primary Health Network Patterns and Prevalence, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.* *Drug and Alcohol Services South Australia (DASSA), 2013, Alcohol consumption and related harm in South Australia.* *Public Health Information Development Unit (PHIDU), 2015, Social Health Atlas of Australia.* *Roche, A.M., Fischer, J., Nicholas, R., Kostadinov, V. 2016, Alcohol & Other*

Outcomes of the health needs analysis			
		Sturt (32%), Tea Tree Gully (31%) and Adelaide City (29%) had the highest prevalence of **monthly** risky alcohol consumption. There was no consistent pattern in risky drinking by Socio Economic Indexes for Areas (SEIFA) (Roche et al., 2016). Among the 12-17 year old school students, highest prevalence of risky drinking in the **past fortnight** occurred in Adelaide-South (22%) and exceeded the APHN and State averages (Roche et al., 2016).	*Drugs Use in South Australia: Adelaide Primary Health Network Patterns and Prevalence, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.* *Ibid.*
Cumulatively, use of cannabis, methamphetamine and opioids/painkillers was consistently higher in the Southern areas when compared with than other areas in APHN region.	High prevalence of drug use at sub-regional levels	Prevalence of recent **cannabis** use among people aged 18 years and over for South Australia overall was 11% and 10% nationally. South Australian and national prevalence rates for **methamphetamine** and **opioid/painkiller** use are 2.2% and 2.1% respectively among persons aged 18 years and over (AIHW, 2014). Recent secondary analysis of the 2013 National Drug Strategy Household Survey reported that **cannabis** (10%) was the most common illicit drug use in the APHN region. Prevalence of recent **meth/amphetamine** and **opioid/painkiller** use was 2% and 4% respectively (Roche et al., 2016). Within APHN region, recent **cannabis** use (i.e. in the last 12 months) ranged from 6% (Adelaide-North SA4) to 14% (Adelaide-South SA4). **Meth/amphetamine** use ranged from 1% (Adelaide-North) to 4% (Adelaide-South) while use of **opioids/painkillers** in the last 12 months ranged from 1% (Adelaide-Central) to 5% (Adelaide-South and Adelaide-West). Cumulatively, use of cannabis, methamphetamine and opioids/painkillers was consistently higher in Adelaide-South SA4 (Roche et al., 2016). However, a recent report indicated that in South Australia amphetamines are the most common drug of concern after	*Australian Institute of Health and Welfare (AIHW), 2014, National Drug Strategy Household Survey detailed report 2013, Drug statistics series no. 28, Cat. No. PHE 183, Canberra, AIHW.* *Roche, A.M., Fischer, J., Nicholas, R., Kostadinov, V. 2016, Alcohol & Other Drugs Use in South Australia: Adelaide Primary Health Network Patterns and Prevalence, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.* *Ibid.* *Drug and Alcohol Services South Australia (DASSA), 2016, Identifying the*

Outcomes of the health needs analysis			
		alcohol and prevalence is steadily increasing across metropolitan Adelaide (DASSA, 2016). The report also indicated that the highest proportion of people using an illicit drug in the past 12 months was in Adelaide-South, followed by Adelaide-West, and Adelaide-North (DASSA, 2016). Prevalence of lifetime **illicit drug** use among 12-17 year olds ranged from 8% (Adelaide-Central SA4), to 18% (Adelaide-South SA4). Adelaide-North had the second highest at 14% followed by Adelaide-West at 13%. APHN and State-wide, the prevalence of illicit drug use (ever) among 12-17 year olds was 14% for both regions (Roche et al., 2016). For APHN region, one in ten (10%) 12-17 year olds have used **cannabis** in the past 12 months. The prevalence ranged from 6% in Adelaide-Central SA4 to 23% in Adelaide-South SA4. Among 16-17 year olds, prevalence ranged from 13% (Adelaide-Central) to 24% (Adelaide-South) (Roche et al., 2016). Among South Australian secondary school students residing in APHN, 1% had used ecstasy in the last 12 months (Roche et al., 2017a). Among 16-17 year olds in APHN, 3% had used ecstasy in the last 12 months (Cancer Council Victoria, 2016).	*Gaps: Report on South Australian Drug and Alcohol Service Planning, unpublished.* *Roche, A.M., Fischer, J., Nicholas, R., Kostadinov, V. 2016, Alcohol & Other Drugs Use in South Australia: Adelaide Primary Health Network Patterns and Prevalence, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.* *Ibid.* *Roche, A.M., Fischer, J., McEntee A., Pidd K., 2017a, Drug and Alcohol Use Among Select South Australian At-Risk Groups, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.* *Cancer Council Victoria. (2016). Australian secondary school students' use of tobacco, alcohol and over-the-counter and illicit substances in 2014. Melbourne: Cancer Council Victoria.*

Outcomes of the health needs analysis			
		The Southern Community Advisory Council (CAC) identified a high level of substance abuse (alcohol and drugs, in particular methamphetamine) in the southern region of APHN requiring timely services and education for young people.	*Community Advisory Council, priority setting workshops, 2016.*
High levels of alcohol, tobacco and other drug comorbidity among people with mental health conditions	Higher prevalence of daily risky drinking, tobacco use, illicit drug use amongst South Australians being treated for a mental illness or with high or very high levels of psychological distress	*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). *Illicit drug use* 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). South Australians with, or treated for, a mental illness in the past year were more likely to have used an illicit	*Roche, A.M., Fischer, J., McEntee A., Pidd K., 2017a, Drug and Alcohol Use Among Select South Australian At-Risk Groups, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.* *Ibid.* *Ibid.* *Ibid.*

Outcomes of the health needs analysis			
		drug than their Australian counterparts (30% and 23% respectively) (Roche et al., 2017a).	
		South Australians with very high levels of psychological distress were more likely to have used an illicit substance in the past 12 months (47% South Australia; 33% nationally) compared with those with low psychological distress (13% South Australia; 12% nationally) (Roche et al., 2017a).	*Ibid.*
		Cannabis and methamphetamine were the most common illicit drugs used by South Australians who had very high psychological distress, or who had been diagnosed with, or treated for, a mental illness in the past year (Roche et al., 2017a).	*Ibid.*
		Illicit use of licit drugs	
		Illicit use of painkillers/analgesics was higher for South Australians who had been diagnosed with, or treated for, a mental illness in the past year, compared to levels of illicit use amongst South Australians who had not been diagnosed with/treated for a mental illness, 8% compared to 2% (Roche et al., 2017a). This is consistent with the pattern of use nationally.	*Ibid.*
		The illicit use of painkillers/analgesics was substantially higher in South Australians with very high levels of psychological distress compared to those with low psychological distress, 23% compared to 2% respectively. The rate of use for South Australians with very high psychological distress was also twice the national rate (12%) (Roche et al., 2017a).	*Ibid.*
		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	*Roxburgh, A., Hall, W. D., Burns, L., Pilgrim, J., Saar, E., Nielsen, S., & Degenhardt, L., 2015, Trends and characteristics of accidental and intentional codeine overdose deaths in Australia, The Medical Journal of Australia, 203(7), 299.*

Outcomes of the health needs analysis			
		involved people with a history of mental illness (Pilgrim et al., 2015). Population estimates indicate that more than one-third of individuals with an AOD use disorder have at least one comorbid mental health disorders and this rate is even higher for those in AOD treatment programs (Marel et al., 2016).	*Roxburgh, A., Burns, L., Drummer, O., Pilgrim, J., Farrel, M., & Degenhardt, L., 2013, Trends in fentanyl prescriptions and fentanyl-related mortality in Australia, Drug and Alcohol Review, 32(2), 269-275.* *Pilgrim, J., Yafistham, S., Gaya, S., Saar, E., & Drummer, O., 2015, An update on oxycodone: Lessons for death investigations in Australia, Forensic Science, Medicine, and Pathology, 11(1), 3-12.* *Marel, C., Mills, K.L., Kingston, R., Gournay, K., Deady, M., Kay-Lambkin, F., Baker, A., Teesson, M., 2016, Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition). Sydney, Australia: Centre of Research Excellence in Mental Health and Substance Use, National Drug and Alcohol Research Centre, University of New South Wales.*
High alcohol consumption and other drugs use (cannabis, meth/amphetamine and opioids/painkillers) by males and people in the age groups 25-59 year olds	Varying patterns & prevalence of alcohol consumption and other drugs use by gender and age groups	Alcohol consumption in APHN region by gender: • Higher prevalence of risky drinking at least **yearly** among males compared to females (48% vs 29%); • One in five males (20%) and 7% of females consumed alcohol at risky levels **monthly**; and • One in three males (34%) and 17% of females consumed alcohol at risky levels **weekly** (Roche et al., 2016). Alcohol consumption in APHN region by age groups:	*Roche, A.M., Fischer, J., Nicholas, R., Kostadinov, V. 2016, Alcohol & Other Drugs Use in South Australia: Adelaide Primary Health Network Patterns and Prevalence, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.*

Outcomes of the health needs analysis			
		• Four in ten (40%) of 12-24 year olds, 46% of 25-59 year olds and 20% of persons aged 60 years and over consumed alcohol at risk levels at least **yearly**; • Prevalence of risky drinking at least **monthly** was 40% among 12-24 year olds, 46% among 25-59 year olds and 20% among persons aged 60 years; and • Prevalence of risky drinking at least **weekly** was 10% among 12-24 year olds, 18% among 25-59 year olds and 7% among persons aged 60 years (Roche et al., 2016). Other Drugs use in APHN region by gender: • **Cannabis** was the most common illicit drug use by 13% and 8% of males and females respectively (among South Australian males and females over 18 years it was 15% and 9% respectively); • Prevalence of recent **meth/amphetamine** among males and females was 3% and 2% respectively (among South Australian males and females over 18 years it was 2.8% and 1.7% respectively); and • Use of **opioid/painkillers** among males was 4% and among females 3% (Roche et al., 2016). Other Drugs use in APHN region by age groups: • Prevalence of recent **cannabis** use was higher among 12-24 year olds (15%) than those aged >25 years (9%); • Data on **meth/amphetamine** use by age unavailable (unreliable due to small numbers); and • Prevalence of **opioids/painkillers** use appears higher among persons aged 12-24 years than those aged 25+ years (note: unreliable due to small numbers) (Roche et al., 2016).	*Ibid.* *Ibid.* *Ibid.*

Outcomes of the health needs analysis			
Treatment services to consider main drugs of concern by different population groups	Varying patterns & prevalence of alcohol consumption and other drugs use by specific population groups	Based on literature reviews and secondary analysis of various data sets, Roche et al. (2017a) has reported the main drugs of concern for the following at-risk groups in South Australia for APHN region depending on availability of data. Young people (12-24 years including school students): • Alcohol (APHN) • Cannabis (APHN) • Non-opioid analgesics Older people: • Alcohol (APHN) • Opioids • Analgesics • Anxiolytics, particularly benzodiazepines (APHN, SA) • Cannabis (estimates) Employed people: • Alcohol (all employees; mining, public administration/safety, retail, agriculture, administration industries at higher risk) • Tobacco (construction, transport, mining and agriculture industries) • Cannabis (all employees; construction, transport, agriculture, manufacturing, administration, financial, scientific/professional industries at higher risk) • Methamphetamine (construction industry) • Painkillers (construction industry) Unemployed people: • Tobacco • Cannabis • Methamphetamine • Ecstasy	*Roche, A.M., Fischer, J., McEntee A., Pidd K., 2017a, Drug and Alcohol Use Among Select South Australian At-Risk Group, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.*

Outcomes of the health needs analysis			
		Single people: • Alcohol • Tobacco • Cannabis • Methamphetamine • Ecstasy People identifying as Lesbian, Gay, Bisexual, Transgender and/or Intersex (LGBTI): • Alcohol • Tobacco • Illicit drug use in general • Opioids • Cannabis • Methamphetamine • Heroin People in contact with the criminal justice system: • Alcohol • Tobacco • Illicit drug use in general • Opioids • Cannabis • Methamphetamine • Heroin People with mental health conditions: • Alcohol • Tobacco • Illicit drug use in general • Cannabis • Methamphetamine • Pharmaceuticals, painkillers/analgesics/opioids	

Outcomes of the health needs analysis			
High risky use of alcohol, tobacco, illicit drugs (especially cannabis and methamphetamine) by Aboriginal people	Varying patterns & prevalence of alcohol consumption and other drugs use by Aboriginal people	The Australian National Drug Strategy 2017-2016 (CoA, 2017) and the South Australian Alcohol and Other Drug Strategy 2017-2021 (DASSA, 2017) both identified Aboriginal people as a priority population for AOD related harm reduction. It is important to understand the broader socio-economic context and the complex and interrelated factors which contribute to elevated AOD risk and harms among Aboriginal people (Roche et al., 2017a). **Alcohol** The proportion of Aboriginal people in the state drinking at risky levels (single occasion, past 2 weeks and lifetime) has decreased between 2008 and 2014-15, while the proportion of abstainers increased (Roche et al., 2017a). In 2014–15 in South Australia, an estimated 25% and 10% of Indigenous Australians aged 15 and over reported exceeded the single occasion risk (past year) and lifetime risk guidelines, respectively. Nationally in 2014–15, it was estimated 31% and 15% respectively (AIHW, 2017). Data was not available for APHN region. Non-Indigenous comparisons for single occasion and lifetime risk are not available for 2014–15 because the data were not collected as part of the ABS General Social Survey 2014 (AIHW, 2017). Previous data in 2012-13, reported that for Adelaide 55% and 23% of Aboriginal people aged 15+ years in South Australia	*Commonwealth of Australia (CoA), 2017, National Drug Strategy 2017-2026, Canberra, Commonwealth of Australia.* *Drug and Alcohol Services South Australia (DASSA), 2017, South Australian Alcohol and Other Drug Strategy 2017-2021, Adelaide, Government of South Australia.* *Roche, A.M., Fischer, J., McEntee A., Pidd K., 2017a, Drug and Alcohol Use Among Select South Australian At-Risk Group, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.* *Ibid.* *Australian Institute of Health and Welfare (AIHW), 2017, Aboriginal and Torres Strait Islander Health Performance Framework: 2017 report, Catalogue number IHW 181, Canberra.* *Ibid.* *Roche, A.M., Fischer, J., McEntee A., Pidd K., 2017a, Drug and Alcohol Use Among Select South Australian At-Risk*

Outcomes of the health needs analysis			
		exceeded the single occasion risk (past year) and lifetime risk guidelines, respectively. For South Australia, it was 51% and 21% respectively (Roche et al., 2017a). Comparative data between Indigenous and non-Indigenous people shows that between 2010-13, Indigenous people have a higher percentage of single occasion risk (past year) and lifetime risky drinking when compared to non-Indigenous people (38% and 23% versus 26% and 18%) (Roche et al., 2017a). **Tobacco** The proportion of Indigenous Australians aged 15 and over in South Australia that reported being a current smoker declined by 17 percentage points over time, from 58% in 1994 to 41% in 2014–15 (AIHW, 2017). However, Aboriginal Australians were significantly more likely to smoke daily than their non-Aboriginal counterparts (Roche et al., 2017a). In 2014–15 in South Australia, 41% of Indigenous Australians reported they were current smokers. The age-standardised rate for Indigenous Australians aged 15 and over reporting to be a current smoker was 40%, 27% were ex-smokers and 34% had never smoked. This is consistent with the pattern of smoking nationally (AIHW, 2017). In 2014–15 in South Australia, the age-standardised rate for Indigenous Australians aged 15 and over reporting to be a current smoker was 2.8 times the rate for non-Indigenous Australians (40% compared with 14%). This is consistent with national rates (AIHW, 2017). In 2014–15 in South Australia, 76% of Indigenous 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, 2017).	*Group, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.* *Ibid.* *Australian Institute of Health and Welfare (AIHW), 2017, Aboriginal and Torres Strait Islander Health Performance Framework: 2017 report, Catalogue number IHW 181, Canberra.* *Roche, A.M., Fischer, J., McEntee A., Pidd K., 2017a, Drug and Alcohol Use Among Select South Australian At-Risk Group, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.* *Australian Institute of Health and Welfare (AIHW), 2017, Aboriginal and Torres Strait Islander Health Performance Framework: 2017 report, Catalogue number IHW 181, Canberra.* *Ibid.*

Outcomes of the health needs analysis			
		Illicit Drugs use In 2014–15 in South Australia, an estimated 37% of Indigenous Australians aged 15 and over reported using substances in the last 12 months. Substance use was more prevalent for Indigenous males than females (43% compared with 31%) in South Australia. This is higher than the national rate of 31% (AIHW, 2017). Data was not available for APHN region. In 2014–15 in South Australia, an estimated 5% of mothers of Indigenous children aged 0–3 reported illicit drug or substance use during pregnancy. This is consistent with the national rate of 4% (AIHW, 2017). Data was not available for APHN region. Non-Indigenous comparisons for single occasion and lifetime risk are not available for 2014–15 because the data were not collected as part of the ABS General Social Survey 2014 (AIHW, 2017). Previous data in 2012-13, reported that 48% and 27% of Aboriginal people aged 15+ years in Adelaide had used an illicit substance in their lifetime and in the past year respectively. For South Australia, it was 45% and 24% respectively while nationally it was 45% and 22% respectively. Nationally in 2013, Aboriginal people were 1.6 times more likely to use methamphetamines than the general population (3% vs 2%). Similar proportions of Aboriginal people used methamphetamines in 2010 and 2013 (Roche et al., 2017a). In 2014-15, cannabis was the most common illicit substance use by Aboriginal people (as it is for the general population). Analgesics and sedatives for non-medical purposes was the second most commonly used illicit drug type by Aboriginal people (Roche et al., 2017a).	*Ibid.* *Ibid.* *Ibid.* *Roche, A.M., Fischer, J., McEntee A., Pidd K., 2017a, Drug and Alcohol Use Among Select South Australian At-Risk Group, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.* *Ibid.*

Outcomes of the health needs analysis			
		A 2016 report by DASSA also indicates elevated illicit drug use with nearly one quarter of Aboriginal South Australians aged 15 years and over had used at least one illicit substance in the last 12 months (DASSA, 2016).	*Drug and Alcohol Services South Australia (DASSA), 2016, Identifying the Gaps: Report on South Australian Drug and Alcohol Service Planning, unpublished.*

Section 3 – Outcomes of the service needs analysis

Since submitting the (Alcohol & Other Drugs) Baseline Needs Assessment (BNA) Update in November 2016, the APHN has analysed relevant recent quantitative and undertaken consultations with stakeholders to further investigate and refine the alcohol & other drugs service needs. The following service needs refine and or supplement previously identified needs (in red font) from the BNA Update which relate to Alcohol & Other Drugs (AOD).

Outcomes of the service needs analysis			
Identified Need	Key Issue	Description of Evidence	Source
Increase and improve access to culturally appropriate AOD treatment services for Aboriginal people	Access to and availability of culturally appropriate AOD treatment services for Aboriginal people	Between 2004–05 and 2014–15, the age-standardised rate of hospitalisation relating to alcohol use for Indigenous Australians in South Australia increased from 10.7 in 2004–05 to 15.8 in 2008–09, then decreased to 10.8 per 1,000 in 2014-15. In this period, rates remained steady for non-Indigenous Australians (1.4 per 1,000 in 2004–05 and 2014–15). For NSW, Vic, Qld, WA, SA and the NT combined, the age-standardised rate of hospitalisation related to alcohol use for Indigenous Australians increased from 7.2 per 1,000 in 2004–05 to 9.0 per 1,000 in 2014–15. For non-Indigenous Australians the rate increased from 1.9 to 2.3 per 1,000 over the same period (AIHW, 2017). In 2016, for the APHN region, Aboriginal people comprised 1% of the PHN population however they represented 11% of AOD Emergency Department (ED) presentations (2015/16), 9% AOD 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). For APHN region in 2016 by primary and secondary drugs of concern, Aboriginal people accounted for:	*Australian Institute of Health and Welfare (AIHW), 2017, Aboriginal and Torres Strait Islander Health Performance Framework: 2017 report, Catalogue number IHW 181, Canberra.* *Roche, A.M., Fischer, J., McEntee A., Pidd K., 2017a, Drug and Alcohol Use Among Select South Australian At-Risk Group, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.*

Outcomes of the service needs analysis			
		• 16% of cannabis-related and 12% of alcohol-related ED presentations respectively, • 14% for other drug-related and 11% for cannabinoids of hospital separations respectively, • 17% of alcohol-related and 16% of both heroin- and pharmaceutical-related for treatment episodes respectively; and • 6% of all benzodiazepine and 5% miscellaneous drug calls to ADIS respectively (Roche et al., 2017a).	*Ibid.*
		However, among aboriginal people in APHN region, alcohol accounted for the highest proportion of AOD-related ED presentations (66%), hospital separations (43%), treatment episodes (46%) and ADIS calls (32%) (Roche et al., 2017a).	*Ibid.*
		Aboriginal Family Clinic reported high percentage of clients presenting for AOD support, using methamphetamines with a need for increase of timely services.	*APHN Capacity Building process, 2017.*
		In 2013-14, the Drug and Alcohol Services South Australia (DASSA) which provides treatment services from counselling and brief intervention, through to inpatient withdrawal, reported 11% of clients (N=1204) identified as being from an Aboriginal and/or Torres Strait Islander background and this figure has been constant over the previous 2 years (DASSA, 2016).	*Drug and Alcohol Services South Australia (DASSA), 2016, Identifying the Gaps: Report on South Australian Drug and Alcohol Service Planning, unpublished.*
		Available data shows that among Aboriginal and Torres Strait Islander people, AOD related problems are at least twice as prevalent as in the non-Indigenous population (NDRI, 2014).	*National Drug Research Institute (NDRI), 2014, Harnessing Good Intentions Report.*
		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	

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		support and relapse prevention for those completing intensive treatment (NDRI, 2014). 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, provide holistic service and create strong partnerships with other organisations in order to provide clients with a complete continuum of care (NDRI, 2014). This was also suggested by the Childhood and Youth HPG within the context of person and family centred care.	*Ibid.* *Ibid.* *Childhood and Youth HPG priority setting workshop, 2016.*
Need for AOD services to focus on targeted population groups	AOD treatment services for population groups	**Gender and age groups** Males were more likely than females to present for AOD-related ED presentations and slightly more (53%) likely to be admitted to hospital for AOD problems (Roche et al., 2017). Males accounted for the higher proportion of hospital separations due to alcohol, cannabinoids, stimulants, and other drugs while females accounted for the higher proportion of hospital separations due to opioids, non-opioid analgesics and anti-depressants/psychotics (Roche et al., 2017a). The 20-29 year age group are more likely to present to ED for AOD-related presentations. The highest proportion of hospital separations for stimulants were aged 30-39 years (36%) and for opioid separations, the highest proportion were aged 40-49 years (25%) in APHN region (Roche et al., 2017a). By gender, proportionally more males than females received treatment for AOD use in APHN region (e.g. males comprised approximately 72% of cannabis-, 70% amphetamines-, 68% heroin-related treatment episodes) (Roche et al., 2017a).	*Roche, A.M., Fischer, J., McEntee A., Pidd K., 2017a, Drug and Alcohol Use Among Select South Australian At-Risk Group, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.* *Ibid.* *Ibid.*

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		The gender profile of APHN callers varied slightly at the SA4 level. Approximately equal proportions of male and female callers were from Adelaide-North SA4 (51% female vs 49% male). The highest proportion of female APHN callers resided in Adelaide-South SA4 (55%). Within APHN SA3s, there was a higher proportion of male callers in Campbelltown SA3 (56%), and Salisbury SA3 (54%). Equal proportions of calls were received from males and females from West Torrens SA3. The highest proportion of female callers within the APHN region resided in Holdfast Bay SA3 (64%) (Roche et al., 2017a).	*Ibid.*
		Young people In 2016, for the APHN region, young people (10-19 years) comprised 12% of the PHN population however they represented 13% of AOD Emergency Department (ED) presentations (2015/16), 13% AOD hospital separations (2015/16), 15% of specialist AOD treatment episodes (2014/15) and 8% of Alcohol and Drug Information Service (ADIS) calls (2015) (for callers aged 24 years or under) (Roche et al., 2017a).	*Ibid.*
		For APHN region in 2016 by main drug of concern, young people accounted for: • 44% of non-opioid analgesics ED presentations with Adelaide-North SA4 having the highest ED presentations, • 36% of non-opioid analgesics of hospital separations, • 42% for cannabis-related treatment episodes with Adelaide-West and South SA4s having the highest episodes, and • 21% of cannabis-related drug calls to ADIS with Adelaide-North having the highest calls (Roche et al., 2017a).	*Ibid.*
		Among young people in APHN region, alcohol accounted for the highest proportion of AOD-related ED presentations (46%), Non-opioid analgesics for hospital separations (32%), Cannabis for	*Ibid.*

Outcomes of the service needs analysis			
		both treatment episodes (66%) and ADIS calls (32%) (Roche et al., 2017a). **Older people** In 2016, for the APHN region, older people (60+ years) comprised 23% of the PHN population however they represented 8% of AOD Emergency Department (ED) presentations (2015/16), 9% AOD hospital separations (2015/16), 5% of specialist AOD treatment episodes (2014/15) and 4% of Alcohol and Drug Information Service (ADIS) calls (2015) (for callers aged 24 years or under) (Roche et al., 2017a). For APHN region in 2016 by main drug of concern, older people accounted for: • 12% and 16% of opioids ED presentations and hospital separations respectively, • 8% for alcohol-related treatment episodes with Adelaide-Central SA4s having the highest episodes, and • 21% of benzodiazepines-related drug calls to ADIS (Roche et al., 2017a). Among older people in APHN region, alcohol accounted for the highest proportion of AOD-related ED presentations (76%), hospital separations (63%), treatment episodes (95%) and ADIS calls (80%) (Roche et al., 2017a). **Employed people** In South Australia, 8% of the employed workforce aged 14 years and older had participated in an alcohol, tobacco and other drugs (ATOD) treatment program. Telephone helpline, online support, or information and education (5%); opioid pharmacotherapy (3%);	*Ibid.* *Ibid.* *Ibid.* *Ibid.*

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		and counselling (3%) were the most commonly used forms of treatment by employed South Australians (Roche et al., 2017a).	
		Unemployed people In South Australia, 7% of the unemployed workforce aged 14 years and older have participated in an ATOD treatment program. Counselling was the form of treatment most often used (5%) by unemployed South Australians (Roche et al., 2017a).	*Ibid.*
		Single people In South Australia, 8% of single people aged 18 years and older had participated in an ATOD treatment program. Telephone helpline, online support, or information and education was the form of treatment used by 6% of single South Australians (Roche et al., 2017a).	*Ibid.*
		People identifying as Lesbian, Gay, Bisexual, Transgender and/or Intersex (LGBTI) Homosexual and bisexual South Australians and Australians were at least two times more likely to have participated in any treatment program than heterosexual members of the community. While counselling, telephone helpline and any treatment was the preferred treatment program by homosexual and bisexual South Australians the small sample size impacts on the validity of the findings (Roche et al., 2017a).	*Ibid.*
		Rates of treatment seeking amongst LGBTI people (Mullens et al., 2017), presentations to emergency departments, hospital admissions, and calls to AOD information services are largely unknown. Historically, AOD services have not included sexuality within standard assessment tools.	*Mullens, A., Fischer, J., Stewart, M., Kenny, K., Garvey, S., & Debattista, J., 2017, Comparison of government and non-government alcohol and other drug (AOD) treatment service delivery for the lesbian, gay, bisexual, and transgender (LGBT)*

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		Lack of inclusion of LGBTI-specific issues (e.g. opportunity to identify as LGBTI, addressing stigma and AOD use relationship) within AOD services may impact willingness to access such treatment services (Eliason, 2001; Eliason & Schope, 2001). Treatment barriers may also stem from workers' attitudes, organisational factors or both (Mullens et al., 2017). A recent study found many government and faith-based AOD services were supportive of LGBTI individuals accessing their treatment services. However, organisational policies and practices were neutral or unclear about ways they were sensitive to and/or inclusive of LGBTI clients (Mullens et al., 2017). **People in contact with the criminal justice system** No data on treatment utilisation but post-release, dischargees are at significant risk of drug-related death (Kinner et al., 2011; Merrall et al., 2010). 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 (Merrall et al., 2010).	*community, Substance Use & Misuse, 52(8), 1027-1038.* *Eliason, M., 2001, Substance abuse counselor's attitudes regarding lesbian, gay, bisexual, and transgendered clients, Journal of Substance Abuse, 12(4), 311-328.* *Eliason, M., & Schope, R., 2001, Does "don't ask don't tell" apply to health care? Lesbian, gay, and bisexual people's disclosure to health care providers, Journal of the Gay and Lesbian Medical Association, 5(4), 125-134.* *Mullens, A., Fischer, J., Stewart, M., Kenny, K., Garvey, S., & Debattista, J., 2017, Comparison of government and non-government alcohol and other drug (AOD) treatment service delivery for the lesbian, gay, bisexual, and transgender (LGBT) community, Substance Use & Misuse, 52(8), 1027-1038.* *Kinner, S., Preen, D., Kariminia, A., Butler, T., Andrews, J., Stoove, M., & Law, M. (2011). Counting the cost: Estimating the number of deaths among recently released prisoners in Australia. The Medical Journal of Australia, 195(2), 64-68.* *Merrall, E., Kariminia, A., Binswanger, I., Hobbs, M., Farrell, M., Marsden, J., Bird, S.M. (2010). Meta-analysis of drug-related deaths soon after release from prison. Addiction, 105(9), 1545-1554.*

Outcomes of the service needs analysis			
Higher use of AOD treatment services, particularly for alcohol, cannabis and illicit drugs, and in Adelaide-North, Adelaide-Central and Adelaide-South SA4 regions.	Variations in specialist and non-specialist healthcare services for AOD problems	**Emergency Department (ED) Presentations** AOD accounted for 1.5% of all South Australian hospital Emergency Department (ED) presentation in 2015/16 with the majority (80%) of AOD patients residing in APHN region. In APHN, a higher proportion of AOD ED presentations came from Adelaide-North (33%) and Adelaide-South (29%) SA4s (Roche et al., 2017b). In APHN region, 32% of AOD ED presentations were categories 1 and 2 with the majority (68%) triaged as category 3 and above (categories 4 and 5; 23%). The highest proportion of categories 4 and 5 ED presentations occurred in Adelaide-Central SA4 (Roche et al., 2017b). Alcohol (57%) was the most common AOD ED presentation with Adelaide-North SA4 having the most presentations for alcohol (Roche et al., 2017b). **Hospital Separations** In the financial year 2015/16 there were 701,551 public and private hospital separations in South Australia, of which 0.9% (n=6,222) were alcohol and other drug (AOD) related. Of the 6,222 AOD hospital separations, two out of three patients (69%) came from APHN region (Roche et al., 2017b). Of the 4,296 AOD hospital separations in the APHN region, the majority of patients were from Adelaide-North (35%) and Adelaide-South (30%) SA4s (Roche et al., 2017b). Alcohol (38%) followed by stimulants (22%) accounted for the largest proportions of AOD hospital separations in APHN region. For alcohol, residents in Adelaide-Central was the most common	*Roche, A.M., McEntee, A., Fischer, J., Duraisingam, V., Kostadinov, V., 2017b, Utilisation of Specialist and Non-Specialist Healthcare Services for Alcohol and Other Drug Problems in South Australia. National Centre for Education and Training on Addiction, Flinders University, Adelaide South Australia, unpublished.* *Ibid.* *Ibid.* *Ibid.* *Ibid.* *Ibid.*

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		AOD separation while for stimulants, it was Adelaide-Central and Adelaide-West SA4s (Roche et al., 2017b). **AOD Treatment (from the AOD Treatment Services National Minimum Data Set (AODTS-NMDS)** In 2014/15 there were 12,283 alcohol and other drug (AOD) closed treatment episodes in South Australia. Three quarters (75%, n=9,168) were clients in APHN region (Roche et al., 2017b). The following services were provided in the APHN region, in descending order of prevalence: • Amphetamines (31%) • Alcohol (28%) • Cannabis (17%) • Heroin (8%) • Pharmaceuticals (8%) • other drugs (7%) (Roche et al., 2017b). Among clients from the APHN SA4 regions, Adelaide-Central had the highest proportion of treatment episodes for alcohol (35%) whilst Adelaide-North had the lowest (12%). Adelaide-North had the highest proportion of treatment episodes for cannabis (23%) whilst Adelaide-Central had the lowest (14%). Amphetamines comprised 25-35% of treatment episodes within the APHN SA4 regions. (Roche et al., 2017b). Three in 10 clients from APHN receiving treatment for alcohol were aged 40-49 years while one in 25 APHN clients receiving treatment for alcohol were aged 10-19 years. Clients receiving treatment for cannabis were younger (under 20 years) than those receiving treatment for any other drug in APHN region. Clients from APHN receiving treatment for amphetamine were aged 30-	*Roche, A.M., McEntee, A., Fischer, J., Duraisingam, V., Kostadinov, V., 2017b, Utilisation of Specialist and Non-Specialist Healthcare Services for Alcohol and Other Drug Problems in South Australia. National Centre for Education and Training on Addiction, Flinders University, Adelaide South Australia, unpublished.* *Ibid.* *Ibid.*

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		39 years (40%) with the highest proportion of clients from APHN receiving treatment for heroin were aged 30-39 years (41%). Of clients receiving treatment for amphetamines, 4% of the clients were aged 10-19 years. One in five clients seeking treatment for pharmaceuticals in APHN were aged less than 30 years. In APHN, more than 90% of those receiving treatment for amphetamines (92%) and other drugs (94%) were non-Indigenous (Roche et al., 2017b).	*Ibid.*
		For clients from APHN region, the majority being treated for amphetamines (57%), cannabis (55%) and all other drugs (89%) received Assessment Only treatment. Withdrawal management was the main form of treatment for alcohol (32%), followed by Counselling (26%). Pharmacotherapy was the main form of treatment for heroin (50%) and pharmaceuticals (39%) (Roche et al., 2017b).	*Ibid.*
		Alcohol and Drug Information Service (ADIS) South Australia In 2015, ADIS received 13,357 calls of which the majority came from APHN region (84%). Callers were slight more likely to be females than males (53% vs 47%) with the more than half (61%) of the total callers between the ages of 30-49 years old (Roche et al., 2017b).	*Ibid.*
		Among callers from both APHN, males were more likely to be calling about their own AOD use (72% and 68%, respectively); whilst females were more likely to be calling about someone else's AOD use (Roche et al., 2017b).	*Ibid.*
		Alcohol was the principal drug of concern in the highest proportion of calls from APHN region followed by methamphetamine and opioids (excluding heroin). Alcohol accounted for the highest proportion of calls from all APHN SA3 regions. Methamphetamine	

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		accounted for the second highest proportion of calls in most APHN SA3 regions. The exceptions were the following SA3s: Adelaide City, Norwood, Port Adelaide – East and Port Adelaide – West where opioids (excluding heroin) accounted for the second highest proportion of calls (Roche et al., 2017b).	*Ibid.*
		Dependency was the most common reason why people from APHN region contacted ADIS while DASSA Service Information was the second most common reason followed closely by Patterns of Use (Roche et al., 2017b).	*Ibid.*
		Information/Education was the service most commonly provided to APHN callers with one in five callers from Adelaide-Central SA4 received two or more services compared to one in four callers from Adelaide-South SA4. Information/Education was the most common service ADIS provided to all APHN SA3 regions (39-48%). Ten of the 17 APHN SA3 regions recorded internal referral as the second most common reason for calling ADIS (equal second with counselling and consultation for Onkaparinga SA3). The second most common service provided in the seven other regions were transfer to other services (Adelaide City and Norwood SA3s), Counselling and Consultation (Unley, Tea Tree Gully and Mitcham SA3s), and counselling to friends or family (Burnside and Holdfast Bay SA3s) (Roche et al., 2017b).	*Ibid.*
		In APHN, two or more referrals were made for one in five callers from Adelaide-Central SA4 and one in four callers from Adelaide-North, Adelaide-South and Adelaide-West SA4s. DASSA: Withdrawal Services was the most common referral made for callers from SA4 APHN regions, followed by referral to a Hospital, GP or Health Services (Roche et al., 2017b).	*Ibid.*

Outcomes of the service needs analysis			
Need for targeted approaches to address over prescriptions of opioids and anxiolytics in specific sub-regional areas and population groups	Quality use of medicines	There is a lack of General Practice data on the proportion of patients reporting AOD issues in general and referrals to AOD services. Analysis of patient data between 2011-15 reported that 21.9% of patients visiting General Practices can be classified as drinking alcohol at hazardous levels in the APHN region (22.4% for other capital cities and 23.7% nationally) (BEACH, 2016). The BEACH study reported that 3.2% of problem or encounters with General Practices were managed with opioid in the APHN region (2.8% for other capital cities and 3.2 nationally) and 2.4% managed with benzodiazepine, slightly higher than the 2.0% for other capital cities and national averages (BEACH, 2016). **Prescribed opioid use** In 2013/14, the non-age standardised rate of Pharmaceutical Benefits Scheme (PBS) prescriptions dispensed for opioid medicine was 69,682 per 100,000 persons for APHN region while it was 72,925 per 100,000 persons for South Australia (ACSQHC, 2015). In 2013/14 the rate of PBS prescriptions dispensed for opioid medicine in APHN SA4 ranged from 50,950 (Adelaide-Central) to 77,533 (Adelaide-North) per 100,000 persons (Roche et al., 2016). In 2013/14, within APHN Adelaide-Central SA4, the age standardised rate of PBS prescriptions dispensed for opioid medicine ranged from 34,245 (Burnside SA3) to 45,695 (Norwood SA3) per 100,000 persons (Roche et al., 2016). In 2013/14, within APHN Adelaide-North SA4, age standardised rates of PBS prescriptions dispensed for opioid medicine ranged from 55,575 (Tea Tree Gully SA3) to 109,191 (Playford SA3) per 100,000 persons. Adelaide-North SA4 had two SA3 divisions with some of the highest age standardised rates for dispensed prescribed opioids in South Australia: Playford (SA3) had the	*Bettering the Evaluation and Care of Health (BEACH), 2016, Family Medicine Research Centre, School of Public Health, The University of Sydney, customised report for Adelaide Primary Health Network, unpublished.* *Ibid.* *Australian Commission on Safety and Quality in Health Care (ACSQHC), 2015, Australian Atlas of Healthcare Variation. Sydney: ACSQHC.* *Roche, A.M., Fischer, J., Nicholas, R., Kostadinov, V., 2016, Alcohol and Other Drug Use in South Australia: Patterns and Prevalence. Summary Report - One. National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide South Australia, unpublished.*

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		highest rate and Salisbury (SA3) the third highest (Roche et al., 2016). In 2013/14, within APHN Adelaide-South SA4, age standardised rates of PBS prescriptions dispensed for opioid medicine ranged from 43,695 (Mitcham SA3) to 78,380 (Onkaparinga SA3) per 100,000 persons with Onkaparinga (SA3) having second highest rate of dispensed prescribed opioids in the APHN region (Roche et al., 2016). In 2013/14, within APHN Adelaide-West SA4, age standardised rates of PBS prescriptions dispensed for opioid medicine per 100,000 ranged from 49,994 (West Torrens SA3) to 68,443 (Port Adelaide – West SA3) (Roche et al., 2016). Within all APHN SA4s, a clear social gradient was apparent in the age standardised rate of dispensed prescribed opiates with areas with a lower socio-economic status within an SA4 had higher rates of dispensed prescribed opioids (Roche et al., 2016). **Patterns of Anxiolytics (alprazolam, bromazepam, buspirone, diazepam, oxazepam) dispensed** The non-age standardised rate of PBS prescriptions dispensed for anxiolytic medicine in 2013/14 for 18-64 year olds was 22,094 per 100,000 persons in APHN region, and among persons aged 65 years and over was 52,578 per 100,000. For 18-64 year olds and 65+ year olds in South Australia the rate was 21,500 and 47,177 per 100,000 persons, respectively (ACSQHC, 2015). In 2013/14, in APHN region, the relative difference in the rate of prescribing between persons aged 65+ years to persons aged 18-64 years was 2.38. The rate of PBS prescriptions dispensed for anxiolytic medicine to persons aged 65+ years in APHN was 138% higher than among 18-64 year olds (Roche et al., 2016). In 2013/14, the rate of PBS prescriptions dispensed for anxiolytic medicine among 18-64 year olds in APHN SA4 regions ranged	*Ibid.* *Ibid.* *Ibid.* *Ibid.* *Australian Commission on Safety and Quality in Health Care (ACSQHC), 2015, Australian Atlas of Healthcare Variation. Sydney: ACSQHC.* *Roche, A.M., Fischer, J., Nicholas, R., Kostadinov, V., 2016, Alcohol and Other Drug Use in South Australia: Patterns and Prevalence. Summary Report - One. National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide South Australia, unpublished.*

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		from 16,855 (Adelaide-Central SA4) to 25,474 (Adelaide-North SA4) per 100,000 persons (Roche et al., 2016).	*Ibid.*
		In 2013/14, for persons aged 65 years and older, the rate of PBS prescriptions dispensed for anxiolytic medicine in APHN SA4 ranged from 46,257 (Adelaide-Central SA4) to 57,635 (Adelaide-North) per 100,000 persons (Roche et al., 2016).	*Ibid.*
		In 2013/14, within APHN Adelaide-Central SA4, the age standardised rate of PBS prescriptions dispensed for anxiolytic medicine among 18-64 year olds ranged from 14,531 (Burnside SA3) to 29,137 (Adelaide City SA3) per 100,000 persons (Roche et al., 2016).	*Ibid.*
		In 2013/14, among persons aged 65 years and over in Adelaide-Central SA4, the age standardised rate of PBS prescriptions dispensed for anxiolytic medicine ranged from 34,815 (Adelaide City SA3) to 49,445 (Norwood SA3) per 100,000 persons (Roche et al., 2016).	*Ibid.*
		In 2013/14, within APHN Adelaide-North SA4, the age standardised rate of PBS prescriptions dispensed for anxiolytic medicine among 18-64 year olds ranged from 19,804 (Tea Tree Gully SA3) to 36,292 (Playford SA3) per 100,000 persons (Roche et al., 2016).	*Ibid.*
		In 2013/14, among persons aged 65 years and over in APHN Adelaide-North SA4, the age standardised rate of PBS prescriptions dispensed for anxiolytic medicine ranged from 54,215 (Tea Tree Gully SA3) to 74,380 (Playford SA3) per 100,000 persons (Roche et al., 2016).	*Ibid.*
		In 2013/14, the rates of anxiolytic dispensing for people aged 18-64 years were relatively high in Adelaide City SA3. The dispensing rates were also relatively high for people aged 65+ years in Norwood and Unley SA3s (Roche et al., 2016).	*Ibid.*

Outcomes of the service needs analysis			
		In 2013/14, within APHN Adelaide-South SA4, the age standardised rate of PBS prescriptions dispensed for anxiolytic medicine among 18-64 year olds ranged from 16,626 (Mitcham SA3) to 24,026 (Onkaparinga SA3) per 100,000 persons (Roche et al., 2016). In 2013/14, among persons aged 65 years and over in APHN Adelaide- South SA4, the age standardised rate of PBS prescriptions dispensed for anxiolytic medicine ranged from 39,701 (Mitcham SA3) to 52,324 (Marion SA3) per 100,000 persons (Roche et al., 2016). In 2013/14, within APHN Adelaide- West SA4, the age standardised rate of PBS prescriptions dispensed for anxiolytic medicine among 18-64 year olds ranged from 20,698 (West Torrens SA3) to 24,592 (Port Adelaide – West SA3) per 100,000 persons (Roche et al., 2016). In 2013/14, among persons aged 65 years and over in APHN Adelaide-West SA4, the age standardised rate of PBS prescriptions dispensed for anxiolytic medicine ranged from 48,682 (Charles Sturt SA3) to 59,011 (Port Adelaide – West SA3) per 100,000 persons (Roche et al., 2016). In 2013/14, within all APHN SA4s, a clear social gradient was apparent in the age standardised population rate of dispensed prescribed anxiolytics. As socio-economic status within an SA4 declined, the rate of dispensed prescribed opiates increased. 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).	*Ibid.* *Ibid.* *Ibid.* *Ibid.* *Ibid.*
Need for services to focus on the whole person and their circumstances, particularly social factors and physical comorbidities	Inability of services to have a holistic view to improve health	A priority setting workshop with the APHN Membership Advisory Council, 2016, identified mental health, alcohol and other drugs and physical co-morbidities as an overarching strategic priority for the APHN. This is to ensure a holistic service delivery approach that focusses on the whole person and their circumstances.	*Membership Advisory Council priority setting, 2016*

Outcomes of the service needs analysis			
		In South Australia, 19% of those diagnosed with/treated for a mental illness in the past 12 months participated in an AOD treatment program compared to 5% of South Australians who had not been diagnosed with/treated for a mental illness. Counselling was the most common form of treatment (16%) used by South Australians diagnosed with/treated for a mental illness in the past 12 months whilst those without a diagnosis/treatment for a mental illness were more likely to access telephone helpline, online support, or information and education (3%) (Roche et al., 2017a).	*Roche, A.M., Fischer, J., McEntee A., Pidd K., 2017a, Drug and Alcohol Use Among Select South Australian At-Risk Group, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.*
		In South Australia, 29% of people with very high psychological distress levels participated in an AOD treatment program compared to 5% of South Australians with low psychological distress. Counselling was the form of treatment most often used by South Australians with very high levels of psychological distress (27%; 12% nationally). Telephone helpline, online support, or information and education was the form of treatment most often used by South Australians with low psychological distress (3%) (Roche et al., 2017a).	*Ibid.*
		The Mental Health and Childhood and Youth Health Priority Groups (HPGs) prioritised that a holistic service delivery approach is needed that focusses on the whole person and their circumstances including coexisting physical health needs and social factors. In addition, the Childhood and Youth HPG felt alcohol and drug services for adults should be family centred and take into account the impacts on children.	*Health Priority Groups, priority setting workshops, 2016.*
		Priority setting workshops with the Central Community Advisory Council (CAC) prioritised the importance in the simplification of mental health services and integration with drug and alcohol services.	*Community Advisory Council, priority setting workshops, 2016.*

Outcomes of the service needs analysis			
		Priority setting workshops with the Southern CAC prioritised that mental health cannot be seen in isolation to a person's wellbeing. Additionally, the CAC highlighted that primary health care workers need to be equipped to address the needs of people experiencing social and mental health related issues. We need to ensure mental health services and programs are sustainable and developed to meet the needs of individuals with a focus on early intervention and recovery programs. Substance use disorders are chronic relapsing conditions usually embedded in a web of other health and social problems. 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).	*National Drug Research Institute (NDRI), 2014, Harnessing Good Intentions Report.*
Timely access to appropriate health services for target population groups	Timely access and equity to health services and care	All the APHN membership groups prioritised the need for health literacy, early intervention and better education for consumers and professionals across the health sector to improve and encourage the take-up and application of preventative measures. Whilst this issue is generic it is applicable to the AOD sector. The Southern CAC prioritised the timely access to AOD services and support for their families in a safe environment for disclosure of AOD use, in addition to education on growing methamphetamine use. A joint Community Advisory Committee (CAC) workshop with the Northern, Central and Southern CAC members identified a key principle and element of service delivery to address consumer and carer needs in regards to mental health, and alcohol and other drug (MHAOD) services is: • **Respect/Safety/Appropriateness/Timeliness:** Consumers' need of feeling respected and safe within the MH&AOD system and receiving services that are appropriate in a timely manner to prevent escalation;	*Clinical Councils, Community Advisory Councils, Health Priority Groups, priority setting workshops, 2016*. *Community Advisory Council, priority setting workshops, 2016.* *APHN Mental Health & Alcohol and Other Drugs (MHAOD) Reform Consultations, 2016.*

Outcomes of the service needs analysis			
		Furthermore, the APHN membership groups identified timely access and equity to health services as an overarching priority for the APHN including the need to (following applicable to the AOD sector too): - improve coordination and access to primary health care services and programs for consumers - identify the barriers including cost to accessing health services - access pathways that are culturally and/or linguistically appropriate and sensitive and nonjudgmental with consideration of the social determinants (MHAOD consultations, 2016).	*Membership Advisory Council priority setting, 2016*
Increase health literacy through early intervention and prevention programs	Health literacy	The Southern CAC prioritised the timely access to AOD services and support for their families in a safe environment for disclosure of AOD use, in addition to education on growing methamphetamine use. The Mental Health and Childhood and Youth HPGs prioritised the 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 e.g. in Children's Centres and schools, specialist development services for children, adolescents and adults and geographically targeted services in the stepped care model. The Central Adelaide CC prioritised early intervention of childhood mental health disorders and prevention of relapse/adult development of serious and more chronic mental health issues and crises.	*Community Advisory Council, priority setting workshops, 2016.* *Health Priority Groups, priority setting workshops, 2016.* *Clinical Council, priority setting workshops, 2016.*

Outcomes of the service needs analysis			
		The Southern Adelaide CC prioritised the need to reduce unwarranted variation in care by improving health literacy and education. The Central Adelaide CC prioritised in the quality use of medicines – the need to be embedded as a principle in the implementation of all APHN programs and focus on specific national priorities including opiate and antibiotic prescribing by improving health literacy and education. The Northern CAC prioritised the need for better education for consumers and professionals across the health sector to improve and encourage the take-up and application of preventative measures. The Central CAC prioritised during the workshops on 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. The Southern CAC prioritised that community members and service providers need to better inform themselves about services available throughout the primary health care sector and how to access those services, by improving health literacy and education. The Older people & Aged Care HPG prioritised 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 tfor advocacy for older people by health professionals. The Older People & Aged Care HPG also stressed the importance to build the capacity of health professionals and	*Community Advisory Council, priority setting workshops, 2016.* *Health Priority Groups, priority setting workshops, 2016.*

Outcomes of the service needs analysis			
		GPs to understand the issues for older people by providing support, training and education. The Aboriginal Health HPG prioritised the need more focus on early intervention and health literacy in the community and increased access to culturally safe services, including specialist services, for chronic diseases. The Disability HPG prioritised 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.	
Increase the capacity of service providers to deliver: • culturally safe and appropriate services, • integrated services, and • services that enable navigation and pathways to appropriate care.	Culturally appropriate training and education for health professionals	Currently there is a lack of local data available for the Adelaide metropolitan area however consultations held with local service providers and stakeholders have reported that AOD workers are frequently required to manage mental health symptoms that can impact on their ability to treat clients' AOD use. In addition, the Childhood and Youth HPG reported that the mental health and AOD workforce also need to be aware of the impact of these issues on clients' children and their parenting, and also what effect parenting has on their substance use and illness. The Northern CC raised concerns on the growing need for further support and training for General Practitioners on AOD use(rs) and referral pathways. The Aboriginal Health HPG identified the need for training and education (particularly in loss and grief) across the community and workforce, empowering Aboriginal communities and addressing real and perceived racism. They reported on the need to increase the number of Aboriginal Health Workers and Aboriginal Health Practitioners and provide integrated bi-cultural training in order to have culturally appropriate services.	*Community workshops, 2016.* *Clinical Councils, Community Advisory Councils, Health Priority Groups, priority setting workshops, 2016*. *Health Priority Group priority setting workshops, 2016* *Health Priority Group priority setting workshops, 2016*

Outcomes of the service needs analysis			
		The APHN hosted 3 Aboriginal community engagement workshops to identify with the community the factors which contribute to the provision of culturally safe and responsible primary care services. Across the workshops the most important elements of culturally safe and responsible services include: • Easy access to services when they are needed • Being treated with dignity and respect and without prejudice • Well-coordinated and holistic approach to services • Providing early intervention and education for healthy living • Having more Aboriginal workers in the workforce	*APHN Aboriginal Engagement workshops, 2017.*
		Priority setting from all APHN membership groups also raised the need to provide training and education sessions for health professionals in all areas of service delivery which includes AOD. A joint Community Advisory Committee (CAC) workshop on mental health and alcohol and other drugs (MHAOD) with the Northern, Central and Southern CAC members identified a key principle and element of service delivery to address consumer and carer needs in regards to mental health, and alcohol and other drug services is: • **Funding/Workforce/Quality:** Sustainability and longevity of a service ensuring a highly skilled workforce that provides good quality, accessible and affordable care (MHAOD consultations, 2016). Furthermore, the Consumer and Carers HPG identified themes related to an appropriately skilled and empathic primary health workforce in MH and AOD sector.	*Clinical Councils, Community Advisory Councils, Health Priority Groups, priority setting workshops, 2016*. *APHN Mental Health & Alcohol and Other Drugs (MHAOD) Reform Consultations, 2016.* *Health Priority Groups, priority setting workshops, 2016*.

Outcomes of the service needs analysis			
Improve communication and coordination of care particularly for target population across the health system	Care Coordination, Integration and Navigation	The priority setting workshops from all APHN 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 services. APHN facilitated a joint Community Advisory Committee (CAC) workshop on mental health and alcohol and other drugs (MHAOD) with the Northern, Central and Southern CAC members. They identified that a key principle and element of service delivery to address consumer and carer needs in regards to mental health, and alcohol and other drug services includes: • **Service Connection/Continuity/Integration:** A system which enables service provision to be integrated between services ensuring continuity of care (MHAOD consultations, 2016). The consultations also identified that MH &AOD services lacked non-flexible pathways and are confusing systems for the most vulnerable and at-risk consumers (MHAOD consultations, 2016). 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&AOD sectors (MHAOD consultations, 2016). The Central Community Advisory Council (CAC) prioritised the importance in the simplification of mental health services and integration with drug and alcohol services. 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. In	*Clinical Councils, Community Advisory Councils, Health Priority Groups, priority setting workshops, 2016*. *APHN Mental Health & Alcohol and Other Drugs (MHAOD) Reform Consultations, 2016.* *Ibid.* *Ibid.* *Clinical Council, priority setting workshops, 2016* *Berends L., 2014, Obstacles to alcohol and drug care, Australian Family Physician, Vol. 42, No. 5, May 2014, assessed 2016.*

Outcomes of the service needs analysis			
		reality, 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). 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. Staff familiarity with patients receiving alcohol and drug care 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).	*Ibid.*

Section 4 – Opportunities, priorities and options

This section summarises APHN <u>new</u> priorities arising from the Alcohol & Other Drugs Needs Assessment by triangulating <u>new</u> Health Needs and Service Needs Analysis with consultations undertaken with our membership groups, stakeholders and community.

The four (4) new priorities listed below replace the three (3) priorities reflected in the Baseline Needs Assessment Update specifically relating to Alcohol & Other Drugs completed in November 2016. Please see page 43 for the previous BNA Update priorities.

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead

1. Increase access to and availability of culturally appropriate AOD treatment services particularly alcohol and illicit drugs for Aboriginal and Torres Strait Islander people.	• Targeted services and activities in collaboration with stakeholders and service providers for Aboriginal and Torres Strait Islander people specifically:
	  ○ Risky alcohol consumption
	  ○ Illicit drug use
	• Support targeted coordination and integration of treatment services for Aboriginal and Torres Strait Islander people
	• Targeted health promotion activities supporting lifestyle and behavioural change for Aboriginal and Torres Strait Islander people
	• Build capacity and support service providers to provide culturally appropriate services for Aboriginal and Torres Strait Islander people
		• Aboriginal and Torres Strait Islander people receiving the right care, at the right time in the right place.
		• Improved access to culturally appropriate and safe services for Aboriginal and Torres Strait Islander populations
		• Increased culturally relevant treatment supports available for Aboriginal and Torres Strait Islander people.
		• Provide opportunities to commissioned service providers and other health professionals to cultural competency information and education in order to improve the experience of
			• Number of APHN commissioned episodes of care for Aboriginal and Torres Strait Islander people in the PHN catchment
			• Rate of APHN commissioned episodes of care for Aboriginal and Torres Strait Islander people in the PHN catchment
			• Formalised partnerships/collaborations established with local key Aboriginal and Torres Strait Islander stakeholders including ACCHOs, Aboriginal Medical Services NGOs (including specialist drug
				• APHN
				• DASSA
				• APHN commissioned AOD service providers
				• APHN commissioned cultural competency training providers
				• Community agencies (e.g. NGOs)

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
		Aboriginal and Torres Islander populations accessing AOD treatment services (AODTS).	and alcohol treatment services), local health networks, state government, Commonwealth Government, Indigenous peak bodies and primary health services • Proportion of APHN AODTS commissioned services delivered to the Indigenous population where the services are culturally appropriate	
2. Increase accessibility to appropriate alcohol and other drugs treatment options for targeted population groups and identified areas of need in APHN region.	• Coordination of services and activities in collaboration with stakeholders and service providers to improve access to counselling services for target population specifically: ○ Risky alcohol consumption ○ Illicit drug use • Coordination of services and activities in collaboration with stakeholders and service providers to improve access to counselling services in identified areas of need in APHN region.	• Targeted population groups receiving the right care, at the right time in the right place. • Reduced risky alcohol consumption in targeted population groups • Reduced illicit drug use in targeted population groups • Increased alcohol treatment services and illicit drug use rehabilitation programs in identified areas of need in APHN region.	• Number of PHN commissioned episodes of care for specialist drug and alcohol treatment services in the PHN catchment • Number of APHN commissioned episodes of care for Aboriginal and Torres Strait Islander people in the PHN catchment • Rate of APHN commissioned episodes of care for Aboriginal and Torres Strait Islander	• APHN • DASSA • APHN commissioned AOD service providers • Community agencies (e.g. NGOs)

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	• Support targeted coordination and integration of treatment services for targeted population groups • Targeted health promotion activities supporting lifestyle and behavioural change for targeted population groups and identified areas of need	• Improved health literacy of AOD risks and harm by targeted population groups	people in the PHN catchment • Number of targeted population groups accessing APHN commissioned AOD treatment services • Formal referral pathways established between APHN commissioned service providers and mental health treatment services, allied health care, not for profit organisations (i.e. sexual health clinics) and community and social services.	
3. Build the capacity of health professionals through the provision of information, education and resources to support health professionals in the management of drug and alcohol dependence and related morbidities	• Build capacity and support health professionals to improve unwarranted variations of care and quality use of medicines • Build the capacity of health professionals through the provision of information to improve unwarranted variations of care and quality use of medicines (QUM). • Targeted health promotion activities supporting lifestyle and behavioural change for targeted	• Health professionals have an improved understanding of best practice prescribing of opioids and anxiolytics of health professionals • GPs and other health professionals have increased access and support in the management of drug and alcohol dependence	• Formalised partnerships/collaborations established with local key stakeholders including NGOs (including specialist drug and alcohol treatment services), local health networks, state government, peak bodies and primary health services	• APHN • DASSA • APHN commissioned Mental Health and AOD service providers • APHN commissioned education providers for health professionals

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	population groups and identified areas of need • activities to support health professionals in the management of drug and alcohol dependence and related morbidities (e.g. development of referral pathways, GP practice support activities) • numbers of health professionals attending education and training events	• health professionals have improved access to information related to the management of drug and alcohol dependence and related morbidities • Health professionals have improved access to information related to the understanding of alternatives to opioid and anxiolytic prescribing • Increased referral pathways between health professionals and APHN commissioned AODTS services	• Number of GPs and other health professionals attending AOD related education activities by PHN commissioned education providers • Number of APHN commissioned AODTS providers accredited in their region. • Usage rates of HealthPathways associated with opioid and anxiolytic prescribing and alternative options • Number of health promotion activities developed and accessed by targeted population groups	• Community agencies (e.g. NGOs)
4. Increase integration between AOD and Primary Mental Health (PMH) service providers to improve health outcomes.	• Coordination of AOD and PMH services and activities in collaboration with stakeholders and service providers to improve access to counselling services in identified areas of need in APHN	• Improved understanding in the relationship between AOD risks and harm and mental health conditions by AOD and PMH service provides	• Formal referral pathways established between APHN commissioned service providers and mental health treatment services, allied health care, not for profit	• APHN • DASSA • APHN commissioned Mental Health and AOD service providers

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	region and targeted population groups • Support the integration and targeted delivery of AOD and PMH treatment services across the region particularly in identified areas of need in APHN region and targeted population groups • Build capacity and support health professionals and (AOD and PMH) service providers to improve unwarranted variations of care and referral pathways	• Increased referral pathways between targeted services for risky alcohol consumption and illicit drug users and PMH services	organisations (i.e. sexual health clinics) and community and social services. • Number of referrals to APHN commissioned AOD treatment services received from PHM service providers • Number of referrals to APHN commissioned PHM treatment services received from AOD service providers	

Priorities identified in the APHN Baseline Needs Assessment Update (APHN BNA Update) submitted in November 2016 specifically relating to Alcohol & Other Drugs Needs Assessment (the numbers listed below align to the priorities listed in the APHN BNA Update template)
7. Alcohol is the most common principal drug of concern in particular areas of the APHN region and for population group including Aboriginal and Torres Strait Islander people.
8. Significantly less South Australians with AOD problems access counselling as a treatment than the Australian average.
9. Higher prevalence of illicit drug use in selected areas and specific population groups, particularly Aboriginal and Torres Strait Islander populations.

Section 5 - Checklist

Requirement	✓
Governance structures have been put in place to oversee and lead the needs assessment process.	✓
Opportunities for collaboration and partnership in the development of the needs assessment have been identified.	✓
The availability of key information has been verified.	✓
Stakeholders have been defined and identified (including other PHNs, service providers and stakeholders that may fall outside the PHN region); Community Advisory Committees and Clinical Councils have been involved; and Consultation processes are effective.	✓
The PHN has the human and physical resources and skills required to undertake the needs assessment. Where there are deficits, steps have been taken to address these.	✓
Formal processes and timeframes (such as a Project Plan) are in place for undertaking the needs assessment.	✓
All parties are clear about the purpose of the needs assessment, its use in informing the development of the PHN Annual Plan and for the department to use for programme planning and policy development.	✓
The PHN is able to provide further evidence to the department if requested to demonstrate how it has addressed each of the steps in the needs assessment.	✓
Geographical regions within the PHN used in the needs assessment are clearly defined and consistent with established and commonly accepted boundaries.	✓
Quality assurance of data to be used and statistical methods has been undertaken.	✓
Identification of service types is consistent with broader use – for example, definition of allied health professions.	✓
Techniques for service mapping, triangulation and prioritisation are fit for purpose.	✓
The results of the needs assessment have been communicated to participants and key stakeholders throughout the process, and there is a process for seeking confirmation or registering and acknowledging dissenting views.	✓
There are mechanisms for evaluation (for example, methodology, governance, replicability, experience of participants, and approach to prioritisation).	✓