Australian Government
Department of Health

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An Australian Government Initiative

Primary Health Network Needs Assessment Reporting Template – Mental Health and Suicide Prevention

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 update to the Adelaide PHN (APHN) Mental Health 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 Mental Health & Suicide Prevention Needs Assessment Update**. Any *new* information in Sections 2 to 4 of the template are highlighted in red front. The APHN has also taken this opportunity to refine the information, 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. 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). For the Mental Health & Suicide Prevention NA Update, APHN staff who undertook all three stages of training on the Primary Mental Health

Service Planning Framework (PMHSPF)) Tool were involved in providing relevant information to inform the needs accordingly. As well as this new information, other quantitative data for example, from the Commonwealth Department of Health, Australian Bureau of Statistics, Australian Institute of Health and Welfare, SA Health (hospital activities), Public Health Information Development Unit, and all consultations with our membership groups have been incorporated into the triangulation process.

Based on new information added accordingly in the health and service needs analysis sections (Sections 2 and 3) **two new** priorities have been identified for the 2017/18 APHN Mental Health Needs & Suicide Prevention Assessment Update. The first new priority aligns to alcohol and other drugs needs assessment specifically the need to address alcohol, tobacco and other drug comorbidity among people with mental health conditions while the second addresses the need to increase awareness of appropriate mental health services to health professional and community. Together with the six priorities as previously reported from the BNA Update, the APHN will address the **eight (8)** priorities through our existing activities implementing the primary mental health stepped-care model of service delivery and integrating the national and state initiatives relevant to primary mental health care services. For example, based on local need, there is still a maldistribution of mental health services in the northern, western and southern APHN regions. However, despite the availability of services in the Central APHN region, the rates of mental health related and intentional self-harm hospitalisations have increased in the region. Working collaboratively with our membership groups, stakeholders and partners including commissioned service providers, the APHN will be investigating these issues and importantly making continuous refinement and improvements to service delivery through our commissioning, capacity building, monitoring and evaluation processes[1].

Additional Data Needs and Gaps

Health related data from the Public Health Information Development Unit (PHIDU) was not available for the November 2017 submission. Important for 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 2 data is preferred, and while the Commonwealth provides (MBS/PBS) data by Statistical Area Level 3, for in-depth service mapping e.g. access to After-hours services, we require MBS (all item numbers including psychiatry services) and PBS data for both client location and provider location. 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.

Having said that, the APHN needs assessment process including consultations, analysis of health and service needs and identified priorities has been comprehensive and as such any new data would (rather) reinforce the reported health and service needs and priorities accordingly.

Additional comments or feedback
Nil

[1] The APHN may not be commissioning any new Mental Health and Suicide Prevention service providers but may rather incorporate any new or amend activities based on identified needs and priorities from the iterative Needs Assessment, monitoring and evaluation processes.

Section 2 – Outcomes of the health needs analysis

Since submitting the (Mental Health) Baseline Needs Assessment (BNA) Update in November 2016, the APHN has analysed relevant recent quantitative data (including the national Primary Mental Health Service Planning Framework (PMHSPF)) and undertaken consultations with stakeholders to further investigate and refine the mental health needs. The following health needs (in red font) refine and or supplement previously identified needs from the BNA Update which relate to Mental Health and Suicide Prevention.

Outcomes of the health needs analysis			
Mental Health			
Identified Need	Key Issue	Description of Evidence	Source
Higher prevalence of mental health conditions in APHN compared to other capital cities, with prevalence expected to increase future	Numbers of people with severe, moderate and mild mental health disorders	The estimated prevalence of mental health issues is higher in the APHN compared to the average of other Australian capital cities, with long term mental and behavioural problems 8% higher (PHIDU, 2014), and psychological distress 22% higher (PHIDU, 2017). Estimates from the National Mental Health Services Planning Framework - Planning Support Tool (the tool) suggest that in 2017 approximately 207,000 people living in the APHN region are likely to seek or require treatment for a mental health disorder or risk factors for mental illness. By 2022, this is expected to increase by 10,000 additional people, to 217,000 people seeking or requiring treatment (DoH, 2016a).	*Public Health Information Development Unit (PHIDU), 2014, Social Health Atlas of Australia.* *Public Health Information Development Unit (PHIDU), 2017, Social Health Atlas of Australia.* *Department of Health (DoH) 2016a, The Primary Mental Health Service Planning Framework (PMHSPF) Planning Support Tool – developed by the University of Queensland, Brisbane, data extracted October 2017, unpublished.*
Higher prevalence of mental health conditions in Local Government Areas of Playford, Salisbury, Port Adelaide Enfield and Onkaparinga when compared to the APHN averages	High prevalence mental health conditions at sub-regional levels	Compared to the APHN 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, 2017). These findings correlate strongly with socioeconomic status, with these three regions having the lowest Index of Relative Socio-Economic Disadvantage (IRSD) scores in the APHN region.	*Public Health Information Development Unit (PHIDU), 2017, Social Health Atlas of Australia.*

Outcomes of the health needs analysis			
		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, 2017). 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, 2017). A similar pattern is evident when looking at the areas in the APHN 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 APHN region. Christies Beach/Lonsdale and Christies Downs/Hackham West – Huntfield Heights PHAs in the Onkaparinga LGA had the highest rates in the southern APHN (PHIDU, 2015). 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.	*Ibid.* *Ibid.* *Public Health Information Development Unit (PHIDU), 2015, Social Health Atlas of Australia.* *Community Advisory Council priority setting workshops, 2016.*
Mental health treatment services to consider the mental health issues of children, youth, older people, people with disability, people with comorbidities, lesbian, gays, bisexual, trans or intersex, and culturally and	Disparity in mental health for specific population groups	*Children and Young People* 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 APHN Childhood and Youth Health Priority Group (HPG) identified youth mental health as a focus across all their priorities	*Bailey, V., Baker, A-M., Cave, L., Fildes, J., Perrens, B., Plummer, J. and Wearring, A. 2016, Mission Australia's 2016 Youth Survey Report, Mission Australia.* *Health Priority Group, priority setting workshop, 2016*

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linguistically diverse communities		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. *People with mental and physical health comorbidities* People living with mental illness have poorer physical health and higher rates of mortality, compared with people with good mental health (NMHC, 2016). An analysis by the Australia Bureau of Statistics indicated that the age-standardised morality rate for persons who lived in the APHN region and accessed Medicare Benefits Schedule (MBS) and/or Pharmaceutical Benefits Scheme (PBS) subsidised mental health-related treatments was 70% higher than the overall APHN age-standardised mortality rate (ABS, 2017a). 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). *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,	*National Mental Health Commission (NMHC) 2016 Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia, Sydney.* *Australian Bureau of Statistics (ABS) 2017a, Mortality of People Using Mental Health Services and Prescription Medications, Analysis of 2011 data.* *Public Health Information Development Unit (PHIDU), Social Atlas of Health, 2014.* *Australian Bureau of Statistics (ABS), 2014, Disability, Ageing and Carers, Australia: Summary of Findings, 2012.* *Principe, I., 2015, Issues in Health Care in South Australia for People form Culturally and Linguistically Diverse Backgrounds – A Scoping Study for the Health Performance Council SA, accessed February 2016.*

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		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 (PHCSA for RANA Workshop, 2017). *Lesbian, Gay, Bisexual, Transgender, or Intersex (LGBTI) communities* National and international evidence indicates that Lesbian, Gay, Bisexual, Transgender, or Intersex (LGBTI) populations experience anxiety, depression and psychological distress at markedly higher rates than their heterosexual peers, and are at greater risk of suicide and self-harm (Corboz et al, 2008). Data from national studies have found that 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). 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). Unfortunately, prevalence data on the rates of mental health issues faced by people who identify as LGBTI living in the APHN region are not currently available. It is also important to note that	*Primary Health Care Service Access (PHCSA) for Refugees And New Arrivals (RANA) Workshop, March 2017.* *Corboz, J., Dowsett, G., Mitchell, A., Couch, M., Agius, P., and Pitts, M., 2008, Feeling Queer and Blue: A Review of the Literature on Depression and Related Issues among Gay, Lesbian, Bisexual and Other Homosexually Active People, A Report from the Australian Research Centre in Sex, Health and Society, La Trobe University, prepared for beyondblue: the national depression initiative. Melbourne: La Trobe University, Australian Research Centre in Sex, Health and Society* *Leonard, W., Lyons, A., & Bariola, E. (2015). A closer look at Private Lives 2: Addressing the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) Australians. Monograph Series No. 103. The Australian Research Centre in Sex, Health & Society, La Trobe University: Melbourne* *Pitts, M., Smith, A. Mitchell, A. and Patel, S. (2006) Private Lives: A report on the health and wellbeing of GBLTI Australians, Australian Research Centre*

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		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). *People with alcohol or drug use disorder* Illicit drug users living in South Australia also reported high levels of psychological distress, at more than twice the APHN average rate (NDARC, 2014). Population estimates indicate that more than one-third of individuals with an alcohol or drug 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 Sex, Health and Society, La Trobe University, Melbourne* *Leonard, W., Lyons, A., & Bariola, E. (2015). A closer look at Private Lives 2: Addressing the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) Australians. Monograph Series No. 103. The Australian Research Centre in Sex, Health & Society, La Trobe University: Melbourne* *National Drug and Alcohol Research Centre (NDARC), 2014, SA Drug Trends.* *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.*
Higher prevalence of psychological distress and mental health conditions in Aboriginal and Torres Strait Islander populations living in APHN and South Australia compared to the non-Indigenous population	Significant health inequalities across a number of health and wellbeing indicators for Aboriginal people	The Aboriginal Health Heath Priority Group described mental health as an underlying issue that impacts on other health issues. Loss and grief is part of that and is not fully understood or addressed in a culturally effective manner. There is also stigma associated with the label of 'mental' illness/health. 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	*Health Priority Group, priority setting workshops, 2016.* *Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017. South Australian Aboriginal Health*

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		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., 2017a).	*Needs and Gaps Report: Central Adelaide Local Health Network, 2017a, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.*
		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., 2017b).	*Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017. South Australian Aboriginal Health Needs and Gaps Report: Northern Adelaide Local Health Network, 2017b, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.*
		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., 2017c).	*Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017. South Australian Aboriginal Health Needs and Gaps Report: Southern Adelaide Local Health Network, 2017c, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.*

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		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). 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 43% higher for all admissions, 174% higher for mental health related conditions, and 25% higher for injuries, poisoning and other external causes (PHIDU, 2016).	*Health Performance Council of South Australia (HPCSA), 2016, State of Our Health Report.* *Australian Bureau of Statistics (ABS), 2016, National Aboriginal and Torres Strait Islander Social Survey, Australia, 2014–15* *Public Health Information Development Unit (PHIDU), 2016, Aboriginal and Torres Strait Islander Social Health Atlas of Australia.*
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., 2017). 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., 2017). *Tobacco use* Rates of tobacco smoking 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	*Roche, A.M., Fischer, J., McEntee A., Pidd K., 2017, 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.*

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		been treated for or diagnosed with a mental illness (Roche et al., 2017). *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 drug than their Australian counterparts (30% and 23% respectively) (Roche et al., 2017). 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., 2017). 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., 2017). Based on literature reviews and secondary analysis of various data sets, Roche et al., 2017 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., 2017). *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	*Ibid.* *Ibid.* *Ibid.* *Ibid.* *Ibid.*

Outcomes of the health needs analysis			
		illness, 8% compared to 2% (Roche et al., 2017). This is consistent with the pattern of use nationally. 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., 2017). 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). The Childhood and Youth Health Priority Group (HPG) was very concerned about the impacts on children of mental health and drug and alcohol comorbidities, and the importance of early intervention in environments accessible to families e.g. schools.	*Ibid.* *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.* *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.* *Health Priority Group, priority setting 2016.*

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		The Southern Community Advisory Council (CAC) reported that mental health is a growing concern in the south and therefore can no longer be ignored or seen in isolation to a person's well-being.	*Community Advisory Council, priority setting workshop, 2016.*
Suicide Prevention			
Identified Need	Key Issue	Description of Evidence	Source
Suicide prevention efforts to target specific population groups, specifically Aboriginal and Torres Strait Islanders, CALD communities, youth and young adults, males, and people identifying as Lesbian, Gay, Bisexual, Transgender, or Intersex (LGBTI).	Higher prevalence of suicide ideation, mental health conditions and deaths in specific population groups	*Gender and age* 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, 2017b). In 2016, intentional self-harm was the leading cause of death for South Australians aged 15-24 years old (23 deaths), 25-34 years old (45 deaths) and 35-44 years old (50 deaths), and the second-leading cause for 45-54 year olds (47 deaths) (ABS, 2017). In Greater Adelaide between 2012-2016, 18 children aged 5-17 years old died from intentional self-harm, 12 males and six females (ABS, 2017b). A review of Australian and International studies by Nock et al. (2008) identified that between 12% and 26% of adolescents (ages 12–17 years) reported having had thoughts about suicide in the previous year. For the APHN, this equates to between 9,648 and 20,905 people aged 12-17 years old potentially experiencing suicidal ideation in the past 12 months (ABS, 2017c). *Aboriginal and Torres Strait Islander status* 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).	*Australian Bureau of Statistics (ABS), 2017b, 3303.0 Causes of Death, Australia, 2016.* *Ibid.* *Nock, M., Borges, G., Bromet, E. et al., 2008, Suicide and suicidal behaviour. Epidemiological Reviews, 30(1). 133-154* *Population estimates: Australian Bureau of Statistics (ABS), 2017c, Census of Population and Housing 2016 (Enumerated), compiled by profile.id and presented in Adelaide Primary Health Network community profile* *Australian Bureau of Statistics (ABS), 2016a, National Aboriginal and Torres Strait Islander Social Survey, Australia, 2014–15*

Outcomes of the health needs analysis			
		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, 2017b).	*Australian Bureau of Statistics (ABS), 2017b, 3303.0 Causes of Death, Australia, 2016*
		The four reports by Gibson et al. (2017d) indicates that between 2006-12, 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., 2017d).	*Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017. South Australian Aboriginal Health Needs and Gaps Report: Women's and Children's Health Network, 2017d. Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.*
		In CALHN, the highest rate of intentional self-harm deaths in Aboriginal people aged 15 years and over was in young people aged 15–24 years, with the second highest rate in the 35–44 age group. For non-Aboriginal people, the highest rates were in the 35–54 age group, however the 15 – 24 age group had the lowest rate for non-Aboriginal people (Gibson et al., 2017a).	*Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017. South Australian Aboriginal Health Needs and Gaps Report: Central Adelaide Local Health Network, 2017a, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.*
		In NALHN, the highest rate of intentional self-harm deaths in Aboriginal people was 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). For non-Aboriginal people, the highest rates were in the 35–44 age group (2.2 per 10,000 population) (Gibson et al., 2017b).	*Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017. South Australian Aboriginal Health Needs and Gaps Report: Northern Adelaide Local Health Network, 2017b, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.*
		In SALHN, the highest rate of intentional self-harm deaths in Aboriginal people was in young adults aged 25–34 years (3.1 per 10,000 population). For non-Aboriginal people, the highest rates	

Outcomes of the health needs analysis			
		were in the 35–44 age group (2.1 per 10,000 population) (Gibson et al., 2017c). *LGBTI communities* Although there is limited local data from the APHN region, national and international research indicated that people identifying as LGBTI have higher rates of suicidality compared to the general population. 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). Furthermore, 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).	*Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017. South Australian Aboriginal Health Needs and Gaps Report: Southern Adelaide Local Health Network, 2017c, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.* *Robinson, KH, Bansel, P, Denson, N, Ovenden, G & Davies, C 2013, Growing Up Queer: Issues Facing Young Australians Who Are Gender Variant and Sexuality Diverse, Young and Well Cooperative Research Centre, Melbourne.* *McNeil, J., Bailey, L., Ellis, S., Morton, J. & Regan, M., 2012, Trans Mental Health Study 2012, Scottish Transgender Alliance, Scotland* *Jones, T., Carpenter, M., Hart, B., Ansara, G., Leonard, W. and Lucke, J., 2016, Intersex: Stories and Statistics from Australia. Open Book Publishers: London.*
Suicide prevention efforts to target specific sub-regional areas, specifically in Local Government Areas of Playford, Adelaide City, Onkaparinga, Marion, Norwood and Mitcham	Higher prevalence of suicide ideation, mental health conditions and deaths at a sub-regional level	*Suicide ideation* The most recent published survey estimates suggest that in 2015 5.2% of South Australians aged 18 years and over experience suicidal ideation (SA Health, 2016). Based on this estimate, approximately 47,000 people aged 18 years and over in the APHN region had experienced suicidal ideation in the past year (ABS, 2017c). The overall prevalence of suicidal ideation has remained constant at the State-level over the past ten years (SA Health, 2016).	*SA Health, 2016, Suicidal ideation: Adults July 2003 to December 2015.* *Population estimates: Australian Bureau of Statistics (ABS), 2017c, Census of Population and Housing 2016 (Enumerated), compiled by profile.id and presented in Adelaide Primary Health Network community profile*

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		However, within the APHN region prevalence varies slightly at the Local Health Network (LHNs) level. Using the 2015 prevalence estimates, the following number of adults were expected to experience suicidal ideation in the past year: 13,337 people in the NALHN, 19,114 people in the CALHN and 14,225 people in the SALHN (ABS, 2017c). *Hospitalisations from intentional self-harm* In 2014-15 Playford Statistical Area Level 3 (SA3) had the highest rate of hospitalisations due to intentional self-harm with 218 hospitalisations per 100,000 population (AIHW, 2017). Rates were also high, and higher than the APHN average of 154 hospitalisations per 100,000 in the SA3s of Adelaide City (212), Mitcham (212), Marion (209) and Onkaparinga (183) (AIHW, 2017). Within the APHN region between 2013-14 and 2014-15, Mitcham SA3 had the largest increase in hospitalisations due to intentional self-harm, 76 hospitalisations in 2013-14 (AIHW, 2016) to 131 hospitalisations in 2014-15 (AIHW, 2017). *Deaths from intentional self-harm* In Greater Adelaide, which includes all of the APHN 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, 2017b). 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, 2017b).	*Ibid.* *Australian Institute of Health and Welfare (AIHW), 2017, Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2014–15.* *Australian Institute of Health and Welfare (AIHW), 2016, Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2013–14.* *Australian Institute of Health and Welfare (AIHW), 2017, Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2014–15.* *Australian Bureau of Statistics (ABS), 2017b, 3303.0 Causes of Death, Australia, 2016.*

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		Within the APHN 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). Geographical variation is also evident across the APHN at the smaller Population Health Areas (PHAs); rates in Davoren Park and Elizabeth/ Smithfield - Elizabeth North in the north, Christie Downs/ Hackham West - Huntfield Heights and Mitchell Park/ Warradale in the south, West Lakes in the west of the region, and Norwood/ St Peters - Marden in the east have substantially higher rates of death from suicides and self-inflicted injuries compared to the Greater Adelaide average (AHPC, 2017).	*Australian Health Policy Collaboration (AHPC), 2017, Australia' Health Tracker Atlas.* *Ibid.*

Section 3 – Outcomes of the service needs analysis

Since submitting the (Mental Health) Baseline Needs Assessment (BNA) Update in November 2016, the APHN has analysed relevant recent quantitative data (including the national Primary Mental Health Service Planning Framework (PMHSPF)) and undertaken consultations with stakeholders to further investigate and refine the mental health service needs. The following service needs (in red font) refine and or supplement previously identified needs from the BNA Update which relate to Mental Health and Suicide Prevention.

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Identified Need	Key Issue	Description of Evidence	Source
There is an inequitable distribution of mental health services across the region especially in the high need areas of Northern, Western and Southern APHN regions	Distribution of primary mental health and suicide prevention services according to need	*Primary mental health care services* Recent service mapping undertaken by APHN still identifies a concentration of providers of psychological and psychiatry services in the centre of the APHN region (APHN, 2017). 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 APHN region (NHSD, 2015).	*APHN CRM records, APHN analysis, September 2017, unpublished.* *National Health Services Directory (NHSD), APHN analysis, November 2015, unpublished.*

Outcomes of the service needs analysis			
		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).	*Department of Health (DoH), 2016b, Medicare Benefits Schedule data by Statistical Area Level 3 2014/15, APHN analysis, unpublished.*
		Three aspects of psychological management were reported by the Bettering the Evaluation and Care of Health (BEACH) study. Firstly, the APHN 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 APHN 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 APHN 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).	*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.*
		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 APHN; 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 APHN (ACSQHC, 2015).	*Australian Commission of Safety and Quality in Health Care (ACSQHC) and the National Health Performance Authority, 2015, Australian Atlas of Healthcare Variation.*
		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	*Ibid.*

Outcomes of the service needs analysis			
		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 APHN 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. *Acute mental health services* While the 2014-15 APHN's average age-standardised rate of mental health hospitalisations of 927 hospitalisations per 100,000 people was consistent with the national average (944 per 100,000 people), the 2014-15 rate is higher than the 2013-14 rate of 849 hospitalisations per 100,000 people due to an increase of 1,000 hospitalisations from the previous year 10,585 in 2013-14 (AIHW, 2016) and 11,585 in 2014-15 (AHIW, 2017). Some areas of the APHN region had exceptionally high rates of mental health hospitalisations (AIHW 2016, 2017). The SA3 of Adelaide City still had the highest and increased rate in Australia when compared with 2013-14, with 2,289 hospitalisations per 100,000 people in 2014-15 (2,179 hospitalisations per 100,000 people in 2013-14). Port Adelaide – East, Playford, Marion and Onkaparinga SA3s had the remaining top five highest rates per 100,000 of 1,152, 1,096, 1,071 and 1,008 respectively (AHIW, 2017). In 2013-14, Playford – East (1,170), Holdfast Bay (1,028), Playford (946) and Marion (941) were among the top 5 for the period (AIHW, 2016). With the exception of Holdfast Bay, all the SA3s listed increased in hospitalisations rates for 2014-15 when compared to 2013-14.	*Ibid.* *Australian Institute of Health and Welfare (AIHW), 2017, Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2014–15* *Australian Institute of Health and Welfare (AIHW), 2016, Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2013–14* *Australian Institute of Health and Welfare (AIHW), 2017, Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2014–15* *Australian Institute of Health and Welfare (AIHW), 2016, Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2013–14*

Outcomes of the service needs analysis			
		For the periods 2013-14 and 2014-15, Schizophrenia and delusional disorders, and bipolar and mood disorders were still the primary groups of conditions with the highest admission rated for specialised care with increases in admissions for the most recent period for the conditions (AHIW 2016, 2017). However, there was a substantial increase in specialised care admissions for Depressive conditions between the two periods (AHIW, 2017). There was no change in hospitalisation due to intentional self-harm for the APHN's average rate (154 hospitalisations per 100,000 people) for the periods 2013-14 and 2014-15. There were however geographical variations and changes for the two periods within the APHN region (AIHW 2016, 2017). In 2013-14, Adelaide City SA3 had high rates of hospitalisation due to intentional self-harm 228 hospitalisation per 100,000 people, notably higher than the APHN average of 154. Rates were also high in Playford (209), Marion (200), Holdfast Bay (194) and Onkaparinga (190) (AIHW, 2016). In 2014-15 however Playford (218) had the highest rate followed Adelaide City (212), Mitcham (212), Marion (209) and Onkaparinga (183) (AIHW, 2017). Within the APHN region between 2013-14 and 2014-15, Mitcham SA3 had the largest increase in hospitalisations due to intentional self-harm, 76 hospitalisations in 2013-14 to 131 hospitalisations in 2014-15 (AIHW 2016, 2017). *Community mental health services for Aboriginal people* 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., 2017d). Aboriginal people in CALHN had a crude rate of occasions of service with community mental health services of 132.2 per 100 people,	*Australian Institute of Health and Welfare (AIHW), 2016, Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2013–14* *Australian Institute of Health and Welfare (AIHW), 2017, Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2014–15* *Australian Institute of Health and Welfare (AIHW), 2016, Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2013–14* *Australian Institute of Health and Welfare (AIHW), 2017, Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2014–15* *Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W., 2017d, South Australian Aboriginal Health Needs and Gaps Report: Women's and Children's Health Network, 2017. Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.*

Outcomes of the service needs analysis			
		compared to 33.5 occasions of service per 100 people in the non-Aboriginal population. The age-standardised rate of service occasions was 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., 2017a). While the non-Aboriginal rate of service occasions was similar in CALHN to the state rate, Aboriginal people in CALHN had a substantially higher rate of service occasions than the state rate, leading to a wider gap between Aboriginal and non-Aboriginal people in CALHN than seen at the state level (Gibson et al., 2017a). Aboriginal people in NALHN had a crude rate of occasions of service with the community mental health services of 115.7 per 100 population, compared to 40.9 occasions of service per 100 non-Aboriginal population. 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., 2017b). Aboriginal people in NALHN had a substantially higher age-standardised rate of service occasions than the state rate (135.7 per 100 in NALHN versus 96.0 per 100 at the state level). There was a wider gap between Aboriginal and non-Aboriginal people in NALHN than seen at the state level (94.3 extra presentations in NALHN compared to 63.4 state-wide). Aboriginal people in SALHN had a crude rate of use (occasions of service) of community mental health services of 121 per 100 population, compared to 35 occasions of service per 100 non-Aboriginal population. 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., 2017c).	*Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W., 2017a, South Australian Aboriginal Health Needs and Gaps Report: Central Adelaide Local Health Network, 2017. Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.* *Ibid.* *Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017b, South Australian Aboriginal Health Needs and Gaps Report: Northern Adelaide Local Health Network, 2017. Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.* *Ibid.* *Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W., 2017c, South Australian Aboriginal Health Needs and Gaps Report: Southern Adelaide Local Health Network, 2017. Wardliparingga Aboriginal*

Outcomes of the service needs analysis			
		Aboriginal people in SALHN had a substantially higher age-standardised rate of service occasions than the state rate (128.4 per 100 in SALHN versus 96.0 per 100 at the state level). There was a wider gap between Aboriginal and non-Aboriginal people in SALHN than seen at the state level (92.6 extra presentations in SALHN compared to 63.4 state-wide) (Gibson et al., 2017c). 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., 2017d).	*Research Unit, SAHMRI, Adelaide, unpublished* *Ibid.* *Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W., 2017d, South Australian Aboriginal Health Needs and Gaps Report: Women's and Children's Health Network, 2017. Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.*
Need for mental health service delivery to be integrated and to provide holistic care to address social, physical and comorbidity issues.	Inability of services to have a holistic view to improve mental health	Priority setting workshops undertaken by APHN's membership groups raised a number of key related issues, which highlighted the need for services to focus on the whole person and their circumstances. For example, the Central Community Advisory Council prioritised the importance in the simplification of mental health services and integration with drug and alcohol services. The Southern Community Advisory Council raised that 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. Furthermore, there is a 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. The Mental Health and Childhood and Youth Health Priority Groups (HPGs) both advised 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. The	*Community Advisory Council (CAC), priority setting workshops, 2016.* *Health Priority Groups, priority setting workshops, 2016*

Outcomes of the service needs analysis			
		Childhood and Youth HPG also stressed the importance of service providers who provide interventions for adults with mental health and alcohol and other drug issues, being aware of and trained in both the impacts of parenting on their mental illness and substance use and also of the impacts of these on their parenting. 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 APHN membership groups in relation to the needs of people accessing both mental health and alcohol and other drug treatment services The analysis found that in 2013, 19% of South Australians diagnosed with or treated for a mental illness in the past 12 months participated in a treatment program to reduce or quit consumption of tobacco, alcohol or other drugs, 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).	*Roche, A.M., Fischer, J., McEntee A., Pidd K., 2017, 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.*

Outcomes of the service needs analysis			
		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,2015). 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, 2015). 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 2015). 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, 2015). APHN facilitated a joint Clinical Council (CC) workshop with the Northern, Central and Southern CC members with representatives from medical, specialist and allied health workforce (including Aboriginal Health, Nursing and Pharmacy). The workshop developed ten elements for a well-functioning mental health and alcohol & other drugs system for consideration. Listed below are three elements which related to integrated and holistic health services:	*Australian Bureau of Statistics (ABS), 2015, National Health Survey: Mental Health and co-existing physical health conditions, Australia, 2014–15.* *Ibid.* *APHN Mental Health & Alcohol and Other Drugs (MHAOD) Reform Consultations, 2016*

Outcomes of the service needs analysis			
		• Flexible, patient centred community-based service for urgent care, regardless of co morbidities • Health Service model that addresses mental health, alcohol and other drugs dependency, social, cultural and physical health needs • Social and community services which recognise and respond to MHAOD needs of clients (MHAOD consultations, 2016). The Southern Community Advisory Council (CAC) highlighted the need for mental health services and programs are sustainable and developed to meet the needs of individuals with a focus on early intervention and recovery programs.	*Community Council Advisory, priority setting workshop, 2016*
Increase the availability of culturally safe and appropriate services, and services targeted to vulnerable population groups	Importance of providing culturally appropriate services	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. 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 The Aboriginal Health HPG prioritised that mental health, loss and grief are underlying issues that impact on other health issues. The HPG highlighted that it is important that these are addressed in culturally effective and safe ways. Additionally, they mentioned the	*Health Priority Groups, priority setting workshops, 2016.* *APHN Aboriginal Engagement workshops, 2017.* *Health Priority Groups, priority setting workshops, 2016.*

Outcomes of the service needs analysis			
		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 (Aboriginal Health HPG, 2016).	
Difficultly accessing appropriate mental health services for vulnerable population groups.	Timely access and equity to health services and care	Findings from the community consultation undertaken by the APHN as part of the mental health and alcohol and other drug service planning reform stressed the importance of appropriate and timely responses to individual population groups including children, youth, older people, people with disability, people with co-morbidities, LGBTI, CALD communities and people at different stages of crisis and urgency (MHAOD consultations, 2016). Improving equity of and timely access to mental health services was further supported and raised as priority areas of need during consultation with the APHN membership groups. Access, in terms of availability and affordability was an issue raised by the Clinical Council (CC), the Community Advisory Council (CAC) representing the southern APHN region, and the Childhood and Youth HPG. The Southern CAC prioritised the importance of health equity as a basic health care principle - that people should have access to health services; are in a position to afford health services; understand what services are available; and have access to relevant information to enable informed choices. The Southern CC prioritised the importance of improving pathways, and increasing timely access to mental health services (in the south). The two APHN membership groups representing the central APHN region also raised the importance of improving access and equity. The Central CC raised the need to focus on mental health and suicide prevention services to Aboriginal and Torres Strait Islander people. The Central CAC on the other hand raised the importance of identifying the barriers including cost to accessing health services, and recognising mental health and comorbidity.	*APHN Mental Health & Alcohol and Other Drugs (MHAOD) service reform consultations, 2016.* *Clinical Council, Community Advisory Council, Health Priority Groups, priority setting workshops, 2016* *Clinical Council (CC), priority setting workshops, 2016.* *Community Advisory Council, priority setting workshops, 2016.* *Clinical Council, priority setting workshops, 2016.* *Community Advisory Council, priority setting workshops, 2016.*

Outcomes of the service needs analysis			
		The importance of having timely access to oral care for people with mental health was raised by the Consumers and Carers HPG. The need to improve coordination and access to primary health care services and programs for consumers, and better pathways for consumers to enable navigation through the primary health care system including mental health (particularly for the socially isolated, at risk families, and vulnerable populations) was also raised by the Northern CC, and the Childhood and Youth HPG. This was reiterated by the Northern CAC who raised the need for health service providers to be informed to address and cater for the needs of vulnerable individuals – Aboriginal and Torres Strait Islander people, CALD, elderly, youth, and others. Additionally, they stressed that people need to be able to access pathways that are culturally and/or linguistically appropriate and sensitive and nonjudgmental with consideration of the social determinants. APHN facilitated a joint Clinical Council (CC) workshop with the Northern, Central and Southern CC members with representatives from medical, specialist and allied health workforce (including Aboriginal Health, Nursing and Pharmacy). The workshop developed ten elements for a well-functioning mental health and alcohol & other drugs system for consideration, one of which related to improving the appropriateness of services through carer involvement as part of the treating team and improved carer support (MHAOD consultations, 2016). Aboriginal people have significantly higher utilisation rates of community health and hospital services when compared to non-Aboriginal people in South Australia. Aboriginal people have a rate of 1.3 presentations per person in CALHN (Gibson et al., 2017a).	*Health Priority Groups (HPG), priority setting workshops, 2016*. *Clinical Council, priority setting workshops, 2016.* *Community Advisory Council, priority setting workshops, 2016.* *APHN Mental Health & Alcohol and Other Drugs (MHAOD) Reform Consultations, 2016.* *Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W., 2017a, South Australian Aboriginal Health Needs and Gaps Report: Central Adelaide Local Health*

Outcomes of the service needs analysis			
		Aboriginal people have 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. Rates of community mental health use and hospitalisations are higher in NALHN for Aboriginal people compared to the state average, however it is unclear if this is due to improved access to services or higher prevalence (Gibson et al., 2017b). Aboriginal people 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. Rates of community mental health use and hospitalisations are higher in SALHN for Aboriginal people compared to the state average, however it is unclear if this is due to improved access to services or higher prevalence of mental health conditions (Gibson et al., 2017c). 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 e al., 2017d).	*Network, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.* *Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W., 2017b, South Australian Aboriginal Health Needs and Gaps Report: Northern Adelaide Local Health Network, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.* *Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W., 2017c, South Australian Aboriginal Health Needs and Gaps Report: Southern Adelaide Local Health Network, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.* *Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W., 2017d, South Australian Aboriginal Health Needs and Gaps Report: Women's and Children's Health Network, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.*
Increase awareness of mental health services by improving the health literacy of community and carers.	Community and carers 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.	*Australian Bureau of Statistics (ABS), 2006, Adult Literacy and Life Skills Survey, accessed October 2017.* *Adams RJ, Appleton SL, Hill CL, Dodd M, Findlay C, Wilson DH. (2009). Risks associated with low functional health literacy in an Australian population*. Medical Journal of Australia, 191*(10), 530-534.*

Outcomes of the service needs analysis			
		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. By improving health literacy and education the Southern CAC indicated that community members and service providers could be better informed about services available throughout the primary health care sector and how to access those services. Similarly, the Central CAC raised 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 importance of improving health literacy was also raised as a key issue by the Health Priority Groups (HPG). 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 to advocate for older people by health professionals. APHN facilitated a joint Clinical Council (CC) workshop with the Northern, Central and Southern CC members with representatives from medical, specialist and allied health workforce (including Aboriginal Health, Nursing and Pharmacy). The workshop developed ten elements for a well-functioning mental health and alcohol & other drugs system for consideration, one of which related to the importance of a system that encourages community independence and empowerment (MHAOD consultations, 2016).	*Clinical Council, Community Advisory Council, Health Priority Groups, priority setting workshops, 2016* *Community Advisory Council, priority setting workshops, 2016.* *Health Priority Groups, priority setting workshops, 2016.* *APHN Mental Health & Alcohol and Other Drugs (MHAOD) Reform Consultations, 2016.*
Increase the capacity of service providers to deliver: • culturally safe and appropriate services • Integrated service	Training and education for health professionals	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	*Health Priority Groups, priority setting workshops, 2016.*

Outcomes of the service needs analysis			
• Services that enable navigation and pathways to appropriate care		Practitioners and provide integrated bi-cultural training in order to have culturally appropriate services.	
		The Northern CC prioritised the 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.	*Clinical Council, priority setting workshops, 2016*
		The participants at the Aboriginal Engagement workshop process reported that they are treated with a lack of compassion and understanding and that there is a need for culturally appropriate rehabilitation services	*APHN Aboriginal Community Engagement workshops, 2017.*
		There is an identified need to provide mental health and suicide prevention training and education to the Aboriginal and Torres Strait Islander workforce within the Integrated Team Care Program.	*APHN Capacity building process, 2017.*
		The Older People & Aged Care HPG also stressed the importance to build the capacity of health professionals and GPs to understand the issues for older people by providing support, training and education.	*Health Priority Groups, priority setting workshops, 2016.*
		Likewise, the Disability HPG prioritised 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.	*Health Priority Groups, priority setting workshops, 2016.*
		Improving health literacy and education was prioritised by the Southern and Central Clinical Councils as a potential way to reduce unwarranted variation in care and increase the quality use of medicines particularly opiate prescribing, respectively.	*Clinical Council, priority setting workshops, 2016.*
		APHN facilitated a joint Clinical Council (CC) workshop with the Northern, Central and Southern CC members with representatives from medical, specialist and allied health workforce (including	*APHN Mental Health & Alcohol and Other Drugs (MHAOD) Reform Consultations, 2016.*

Outcomes of the service needs analysis			
		Aboriginal Health, Nursing and Pharmacy). The workshop developed ten elements for a well-functioning mental health and alcohol & other drugs system for consideration, two of which related to workforce: • Service size, structure and workforce balanced to be expert and also local • Accountability mechanisms for health outcomes (MHAOD consultations, 2016).	
Increase awareness and promotion of early intervention and low intensity services for vulnerable population groups	Promotion of early intervention and low intensity programs by health professionals	The Central Clinical Council (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. The priority setting workshops with the Northern CC prioritised the 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. Likewise, the Mental Health and Childhood and Youth Health Priority Groups (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, specialist development services for children, adolescents and adults and geographically targeted services) in the stepped care model. The Childhood and Youth HPG saw partnerships with education and community development sector to provide services in education and child development sites as a key priority. The need for better education for consumers and professionals across the health sector to focus on early intervention and improve	*Clinical Council, priority setting workshops, 2016.* *Health Priority Groups, priority setting workshops, 2016.* *Community Advisory Council, priority setting workshops, 2016.*

Outcomes of the service needs analysis			
		and encourage the take-up and application of preventative measures was an issue raised by both the Northern Community Advisory Council (CAC) and Aboriginal Health HPG. The Aboriginal Health HPG also prioritised 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.	*Health Priority Groups, priority setting workshops, 2016.*
Improve the navigation experience to primary health care, particularly for vulnerable population groups to ensure a seamless consumer experience through more effective service coordination, collaboration and communication	Care Coordination, Integration and Navigation	The lack of current coordination and integration between services and health sectors and the urgent need to improve it was raised by Clinical Councils, Community Advisory Councils and Health Priority Groups as a priority mental health issue across the region. The Childhood & Youth HPG prioritised 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. The HPG also prioritised access to coordinated and integrated services including training for adult mental health services about the impacts of mental illness on parenting and vice versa. The Older People & Aged Care HPG prioritised the need to improve case management, care coordination and integration for non-acute mental health issues including management of medication for older people. The Disability HPG prioritised the need for a primary health care service model for people with disabilities which is interagency and interdisciplinary. The Consumers & Carers HPG prioritised that the (health) system needs to be inclusive of and supportive of formalised carers and care coordinators. They reported that there is a lack of a unified / interfacing communication system and culture of care coordination. The Consumers & Carers HPG also stressed the importance of	*Clinical Council, Community Advisory Council, Health Priority Groups, priority setting workshops, 2016* *Health Priority Groups, priority setting workshops, 2016*. *Health Priority Groups, priority setting workshops, 2016*. *Ibid.* *Ibid.*

Outcomes of the service needs analysis			
		consumers and carers knowing about services and how to access them. The HPG reported that the 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 and limited availability of primary health services and community-based after- hours services.	
		The Mental Health HPG prioritised the need to 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.	*Ibid.*
		Improving integration was the priority issue raised by the Clinical Councils (CCs). The priority setting workshops with the Central CC identified 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. The Southern CC also prioritised increasing integration through coordination and communication between services and practitioners. Similarly, the Northern CC prioritised an integrated systems approach as the key need for (improving) care coordination, integration and navigation.	*Clinical Council, priority setting workshops, 2016.*
		The Central Community Advisory Council (CAC) prioritised the importance in the simplification of mental health services and integration with drug and alcohol services. The Central CAC also prioritised the need for less fragmentation and more cooperation and linkages both within the primary health care sector and between primary and intermediate care settings.	*Community Advisory Council, priority setting workshops, 2016.*
		The Northern CAC prioritised the need to coordinate pathways to primary health care. Additionally, they reported that the health	*Ibid.*

Outcomes of the service needs analysis			
		system is way too complex for consumers and users in navigate it properly – consequently inability to access information or programs pertinent to them. The Southern CAC prioritised the coordination of care and systems and staff to be adequately trained. This will enable timely, affordable and accessible services where health providers communicate and share information about patients in minimising the duplication of information. APHN facilitated a joint Clinical Council (CC) workshop with the Northern, Central and Southern CC members with representatives from medical, specialist and allied health workforce (including Aboriginal Health, Nursing and Pharmacy). The workshop developed ten elements for a well-functioning mental health and alcohol & other drugs system for consideration, three of which related to the need for improved care coordination, integration and navigation: • Simple system access, referral and treatment for consumers and providers • Care navigation – enabled by formal agreements • Clinical handover mechanisms across services	*Ibid.* *APHN Mental Health & Alcohol and Other Drugs (MHAOD) Reform Consultations, 2016.*
Access to and awareness of appropriate afterhours primary mental health care services, amongst both the community and healthcare providers	Access to and awareness of primary mental health care after-hours services	The importance of having after-hours access to support for deteriorating (mental) health was raised by the Consumers and Carers Health Priority Group. Community consultations conducted by the former Medicare Locals in the APHN 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).	*Health Priority Groups (HPG), priority setting workshops, 2016*. *Central Adelaide and Hills Medicare Local (CAHML), 2015, Health Profile: a population health needs assessment of the Central Adelaide and Hills region, 2015; Southern Adelaide Fleurieu Kangaroo Island Medicare Local (SAFKIML), 2015, Comprehensive Needs Assessment Report; Northern Adelaide Medical Local (NAML), 2015, Comprehensive Needs Assessment Report.*

Section 4 – Opportunities, priorities and options

This section summarises APHN new priorities arising from the Mental Health & Suicide Prevention Needs Assessment by triangulating new Health Needs and Service Needs Analysis with consultations undertaken with our membership groups, stakeholders and community.

Any new priorities listed below (in red font) are additional to the six (6) priorities reflected in the Baseline Needs Assessment Update relating to Mental Health (inclusive of Suicide Prevention) completed in November 2016. Please see following page for the priorities.

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
7. 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 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	• Improved understanding in the relationship between AOD risks and harm and mental health conditions by AOD and PMH service provides • Increased referral pathways between targeted services for risky alcohol consumption and illicit drug users and PMH 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. • 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	• APHN • DASSA • APHN commissioned Mental Health and AOD service providers

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
8. Increase awareness of appropriate mental health services to health professionals and community and carers through the provision of information and resources.	• Coordination of early intervention and low intensity PMH services that appropriately link to other services across the stepped care model • Build capacity of health providers and communities to ensure people are able to access the right service which best meet their needs. • Collaborate to address a shared understanding of early intervention and low-intensity interventions and pathways	• Improved referral pathways to early intervention and/or low-intensity services where appropriate • Improved community and service provider awareness of services for groups at risk or experiencing mild mental illness • Primary mental health care services are operating along a stepped-care model of service delivery	• Formal referral pathways established between early intervention and low intensity APHN Commissioned PMH services with General Practice and allied health providers • Increased uptake of commissioned early intervention and low intensity services • Usage rates of HealthPathways associated with early intervention and low-intensity pathways	• APHN • Potential Influencers ○ Relevant Peak bodies ○ Local and state government ○ Relevant NGOs ○ Relevant mental health providers ○ Relevant education institutions

Priorities identified in the APHN Baseline Needs Assessment Update (APHN BNA Update) submitted in November 2016 specifically relating to Mental Health and Suicide Prevention
1. High prevalence of mental health/behavioural issues and psychological distress in selected areas across the region.
2. Provision of psychological services comparatively low in areas of highest need.
3. Comparatively high numbers of people attempting to access psychological services in areas with minimal psychological service provision.
4. Disproportionate quantities of mental health related medicines prescribed in women, disadvantaged areas and population groups such as people aged 75 and over.
5. Difficulty in identifying and accessing appropriate mental health treatment services.
6. 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.

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).	✓